HEALTH
KwaZulu-Natal

ANNUAL REPORT

2008/2009

FOREWORD BY THE MEMBER OF THE EXECUTIVE COUNCIL (MEC) FOR HEALTH - KWAZULU-NATAL

Health is an investment in our human resources and the health of the citizens of our Province is a prerequisite for sustainable social and economic growth. The Department's vision to *Achieve optimal health status for all persons in KwaZulu-Natal* is geared towards improving the productivity and the quality of provincial human capital, and optimising the health status and life expectancy of our citizens. The public health system remains the provider of healthcare to the vast majority of people within the Province. In the 2008/09 financial year in excess of 23 million visits were made annually to our 553 primary health care clinics with an under-5 case load of 21%.

The Department increased utilisation rates for under-5 years from 4.2 to 4.4 visits per child per year as it strives to reach the national goal of 5 visits per child per year. This achievement is in line with our primary aim to intercept and reduce the poverty cycle by targeting those most vulnerable to illness: historically disadvantaged communities, children, women, disabled people and the elderly. In this regard access to services in underserved communities was increased by increasing mobile stopping points to 3,449 reaching a total 2,304,816 patients. Community participation in PHC services delivery also improved with the appointment of Community Committees in 81% of PHC clinics and 81% of CHC's.

The health profile of the province indicates that the greatest burden of disease continues to be associated with poverty and the lifestyle of developing communities. The strategic objectives of the Department endeavour to tackle priority areas that would enhance the health status of the people in KwaZulu-Natal. These include:

Maintaining health and preventing diseases through activities such as good nutrition, immunisation programmes and health education. Malnutrition remains a major co-morbidity and together with HIV and AIDS contributes significantly to under-5 mortality in the Province. Improving the vitamin A status of children increases their chances of survival and can reduce child mortality by 25%. To raise and improve awareness, a Vitamin A campaign was undertaken during which the Province achieved an 82% coverage rate and exceeded the national target of 80%.

The department has also supplied fortified porridges to patients initiating treatment for HIV and TB. A total of

203,772 patients starting HIV treatment and 106,155 starting TB treatment benefited from this initiative. In an effort to contribute towards Household Food Security, more than 400 clinic gardens have been established in the Province, and most districts have food gardens in approximately 80% of health facilities. This initiative aims to empower citizens to provide for their own sustainable food security and is undertaken in collaboration with the Department of Agriculture. An analysis of the adequacy of current micronutrients being issued to pregnant women has also been undertaken to inform the incorporation of comprehensive micronutrient supplementation for all pregnant women. However, the increased demand for nutritionists as well as the criteria for nutritional support at ART accredited sites severely challenges service delivery with the current ratio of Nutritionists at 1: 100,000 and Dieticians at 2: 100,000.

A major focus has been on expanding and strengthening existing programmes for maternal and child care. Dual therapy, introduced in April 2008, is implemented in 98% of all facilities that offer the full package of PMTCT services. However, timely access to the PMTCT programme including HAART is limited by the low ANC attendance before 20 weeks (32%) and a coherent communication strategy of early booking will be implemented as part of the Accelerated Plan. Improvement of early booking is evident in eThekwini (from 28% to 34%) and Umgungundlovu (from 51% to 59%). The transmission rate at 15 months has been reduced from 21% in 2007/08 to 12% in 2009/09.

Detecting disease development early and preventing the spread of the disease by screening those at risk. Cervical cancer screening coverage is still very low at 5.2% and staff shortages at the Cytology Department result in extended turn-around times for Pap smear results, while inadequate smears have serious financial implications. The women-year protection rate is also low at 23% although it increased slightly from 19.2% in 2005/06. Additionally, contraceptive uptake is still unacceptably low and integrated strategies are included in the Accelerated Plan. Integration strategies will continue to be investigated to ensure increased coverage especially in consideration of the changing disease profile. Changing disease profiles with high incidence of communicable, non-communicable and chronic diseases require scales-up efforts to improve access and utilisation of contraceptive services.

Reducing the burden of disease of lifestyle e.g. hypertension, diabetes through health promotion, appropriate screening and effective interventions that will enhance optimal functionality. The management of chronic illnesses is imperative and our aim is to ensure that we prevent complications such as heart attacks, strokes and blindness.

Consolidating programmes that will limit the impact of communicable diseases i.e. tuberculosis, sexually transmitted disease and HIV and AIDS. The department has focused on strengthening inter-sectoral, and inter-governmental local programmes for HIV and AIDS, the prevention of new infections, the improvement of treatment of opportunistic infections, and home-based care. In spite of the high HIV prevalence in the Province that places a major strain on resources and capacity, the Province made significant progress in 2008/09 as evident in the increased number of patients accessing HIV and AIDS services. To address the increasing numbers of patients on waiting lists, the Department introduced community based services, clinical staging, ART literacy training and the introduction of mobile service to address issues of access for the high risk communities who are normally unable to access ART services. To address overcrowding in facilities, initiatives such as two months supply to ARV's to ART stable patients are in the development phase.

To improve access and service delivery, a total 2,800 Traditional Health Practitioners and Traditional Leaders have been trained on HIV and AIDS issues and clinics at Truck Stops have been expanded. The monitoring of adverse drug reactions has also been improved with the implementation of a Pharmacovigilance system and a learnership programme for Youth Ambassadors has been implemented.

The integration of programmes is strengthened through integrated business planning meetings with MC&WH, TB and Nutrition. The Department commenced with training programmes on the integrated management of adult illnesses (IMAI) in 2008/09 to improve the integrated management of illness of operational levels. The accreditation of Specialised Hospitals as CCMT Services Points commenced in 2008/09.

To improve access and utilisation of VCT services the Department upgraded 28 PHC facilities to accommodate VCT services and sustained VCT at 63 non-medical sites. VCT services are routinely offered at health entry points, hours of operation have been extended in some facilities to accommodate more clients and community based

screening has been expanded. As a result, VCT uptake improved from 2% in 2007/08 to 3% in 2008/09. This however, still falls short of the national target of 4%.

The clinical and professional expertise in our health services is as important as the hospitality and support services in ensuring excellent high quality client-centered care. Critical vacancies have a serious impact on service delivery, including availability of services, quality and staff morale. The vacancy rate for Medical Officers shows a consistent increase from 20.7% in 2004/05 to 38.6% in 2008/09, and the vacancy rate for Medical Specialists increased sharply from 39.6% in 2004/05 to 69.5% in 2008/09. This has implications for the delivery on specialist services at Regional and Tertiary levels. It is anticipated that the OSD will impact positively in reducing these vacancy rates.

The vacancy rates for Professional Nurses decreased from 42.2% in 2005/06 to 21.4% in 2008/09. In spite of the decline the changed disease profiles and increased clinical workload impacts on quality of care and staff morale.

In the context of limited resources and increasing demands on the public health system, we will continue to focus on investing in those areas that will yield the greatest benefits. We will target people most vulnerable to illness including the historically disadvantaged communities, children, women, people with disabilities and the elderly.

Dr S Dhlomo
MEC for Health - KwaZulu-Natal
Date: 20 August 2009

TABLE OF CONTENTS

LIST OF TABLES

LIST OF MAPS

LIST OF GRAPHS

LIST OF FIGURES

NOTES

PART A:

STRATEGIC VISION

Part A

STRATEGIC VISION

VISION

To achieve the optimal health status for all persons in KwaZulu-Natal

MISSION

To develop and deliver a sustainable, coordinated, integrated and comprehensive health system at all levels of care, based on the Primary Health Care approach through the District Health System

CORE VALUES

Trust build on truth
Integrity and reconciliation
Open communication
Transparency and consultation
Commitment to performance
Courage to learn, change and innovate

LEGISLATIVE MANDATE

Allied Health Professions Act (Act 63 of 1982)
Bargaining Council Resolutions
Basic Conditions of Employment Act (Act 75 of 1997)
Broad Based Black Empowerment Act (Act 53 of 2003)
Child Care Act (Act 74 of 1983) and Amendments
Choice on Termination of Pregnancy Act (Act 92 of 1996) and Amendments
Control of Access to Public Premises and Vehicles Act (Act 53 of 1985)
Conventional Penalties Act (Act 15 of 1962)
Council for Medical Schemes Levy Act (Act 58 if 2000)
Dental Technicians Act (Act 19 of 1979)
Designs Act (Act 195 of 1993)
Division of Revenue Act (Act 97 of 1998)
Employment Equity Act (Act 55 of 1998)
Foodstuffs, Cosmetics and Disinfectants Act (Act 54 of 1972)
Hazardous Substances Act (Act 15 of 1973)
Health Professions Act (Act 56 of 1974)
Inter-Governmental Fiscal Regulations Act (Act 97 of 1997)
International Health Regulations Act (Act 28 of 1974)
Medical Schemes Act (Act 131 of 1998)
Medicines and Related Substances Act (Act 101 of 1965)
Mental Health Care Act (Act 17 of 2002)
National Health Act (Act 61 of 2003)
National Health Laboratory Services Act (Act 37 of 2000)
Nursing Act (Act 33 of 2005)
Occupational Diseases in Mines and Works Act (Act 78 of 1973)
Occupational Health and Safety Act (Act 85 of 1993)
Pharmacy Act (Act 53 of 1974)
Preferential Procurement Policy Framework Act (Act 5 of 2000)
Promotion of Access to Information Act (Act 2 of 2000)
Promotion of Administrative Justice Act (Act 3 of 2000)
Promotion of Equality and the Prevention of Unfair Discrimination Act (Act 4 of 2000)
Protected Disclosures Act (Act 26 of 2000)
Public Finance Management Act (Act 1 of 1999) and Treasury Regulations
Public Service Act (Act 103 of 1994), Public Service Regulations
Public Service Commission Act (Act 46 of 1997)
SA Medical Research Council Act (Act 58 of 1991)
Skills Development Act (Act 97 of 1998)
State Information Technology Act (Act 88 of 1998)
State Liability Act (Act 20 of 1957)
Sterilisations Act (Act 44 of 1998) and Amendments
The Competition Act (Act 89 of 1998)
The Constitution of the Republic of South Africa (Act 109 of 1996)
The Copyright Act (Act 98 of 1998)
The Merchandise Marks Act (Act 17 of 1941)
The Patents Act (Act 57 of 1978)
Tobacco Products Control Amendment Act (Act 12 of 1999)
Trade Marks Act (Act 194 of 1993)
Unemployment Insurance Contributions Act (Act 4 0f 2002)

REPORT BY THE HEAD OF DEPARTMENT

Submission of the 2008/09 Annual Report to the Executive Authority by the Accounting Officer: Dr S Zungu

The KwaZulu-Natal Department of Health employs 67,241 people and has a budget of R 15,042,052 billion. Our primary constituency consists of vulnerable and poor communities, whose lives are most adversely affected by preventable diseases, including HIV and AIDS. Our services aim to reach the broad citizenry of the Province with a range of interventions that include health promotion and public health programmes to influence lifestyle and behavioural change, primary health care, hospital and emergency medical services and a vast range of clinical and non-clinical support services. Our environmental analysis and review show that while there has been progress on all fronts, this progress must be seen within the context of a relentless HIV and AIDS epidemic, and a burgeoning of chronic diseases of lifestyle.

The predominantly rural nature of the KwaZulu-Natal Province has a profound effect on the health problems that face the Province and the Department of Health in particular. 445 primary health care clinics, 16 Community Health Centres and 72 Hospitals serve a widespread population. Many citizens are in remote areas with poor road and communication infrastructure. This makes it difficult to recruit and retain health professionals in all categories. The provision of community service by health professionals assists significantly in resolving this problem.

Quality healthcare is of great significance in the healthcare sector. Quality of care has a number of key components: it encompasses effectiveness, efficiency, access, safety, equity, appropriateness, timeliness, acceptability, patient responsiveness and continuity of care. Quality of care is evidenced through compassion, empathy, respect for human dignity and a general orientation towards a human rights culture. It is also evidenced through a staff complement that has correct professional skills and professional competency to deliver effective healthcare that achieves good health outcomes.

There are a total of 14 designated Provincial Hospitals in the Province. Currently the hospitals are unevenly distributed with a concentration of higher levels of care in the urban districts. This distribution has a profound impact on access to health facilities and the associated cost of care. The ripple effect is evident in the pressures placed on planned patient transport and Emergency and Rescue Services provided by the Province. Additionally, continuity in the provision of specialist services remains a challenge as specialist skills are scarce throughout the world. This has implications for the delivery on specialist services at Regional and Tertiary levels. It is anticipated that the OSD will impact positively in reducing these vacancy rates. In the interim Provincial Hospitals are heavily dependent on

Community Service Officers for the rendering of medical, dental and rehabilitation services. Their provision contributes strongly to service delivery however; the unpredictability of community service allocations impacts on the maintenance of standards and continuity of services is very difficult under these circumstances.

The Emergency Medical Rescue Services (EMRS) structure has been centralised to improve strategic leadership and management and thus ensure well coordinated and standardised service delivery however; recruitment and retention of Advanced Life Support (ALS) Practitioners has been severely challenged due to a lack of financial resources. Late in 2008/09, permission was obtained to align the salary level of ALS Practitioners with those in other Provinces in an effort to stop the exit of this cadre of staff.

To further combat shortage of skills, the Department entered into a Service Level Agreement with the Durban University of Technology (DUT) to conduct Critical Care Assistant courses on behalf of the Department. The College of Emergency Care has also secured premises to accommodate the new Emergency Care Technician course which should also assist in alleviating the skills shortage.

Critical to achieving the Department's vision of *Achieving optimal health status for all persons in KwaZulu-Natal* is ensuring that sufficient skills exist to deliver on the promises made and to implement the numerous plans which have been developed over years. To this end, the commitment shown by this department to developing skills for the future can be seen by the allocation of 708 bursaries to students to study for degrees and diplomas in scarce skills categories. 412 bursaries were for medical students and the remaining 296 for related studies excluding nursing (e.g. occupational therapists, dentists and dieticians). The Cuban Exchange Programme is also progressing well, with 31 KZN students are currently studying in Cuba, 17 are completing their final year at a local South African tertiary institution with 69 KZN students having completed the Cuban Programme.

The Province is currently experiencing a shortage of Professional Nurses as indicated in the Departmental Human Resource Plan. During 2008/09, a total of 399 nursing students completed their bridging course from Staff Nurse to Professional Nurse and a further 419 Professional Nurses qualified (4 year course) during the same period bringing the total of Professional Nurses trained by the KwaZulu-Natal College of Nursing to 818. The number of post basic nursing graduates remained constant at 427 with 192 post graduate PHC nurses trained.

The HWSETA issued learnerships for this reporting period with PEPFAR funding Pharmacy Assistants training which commenced in January 2008. Fifteen PHC nursing learnerships started at Prince Mshiyeni Memorial Hospital in September 2008. The Auxiliary Nursing Learnerships which commenced in April 2009 were concluded in March 2010.

Special efforts have been made to reduce the costs associated with infrastructure. The department experienced a budget cut of R36 million and an accrual expenditure of R134 million for the infrastructure programme. In an effort to contain costs, especially with the building of new facilities, alternative methods of construction such as Lightweight Steel Framework (LSF) and Modular Construction were piloted during 2008/09 to improve service delivery turnaround time in respect of time, cost and quality. These interventions have been successful however, infrastructural challenges e.g. lack of adequate space to render the package of services may have a profound impact on availability, access and utilisation and hence impact negatively on health outcomes. These challenges call upon us to continuously explore new methods and tools which will enable us to find a fit between available resources and the needs of our people.

Notwithstanding the constraints of limited resources and the impediments of scarce skills the Annual Report of the department reflects a strategic definition of our challenges and how we have approached them. The ongoing review of performance within the context of processes and systems allows the department to comprehensively respond to the need to create efficiency gains

Dr Zungu
Head of Department
KwaZulu-Natal Department of Health
Date: 19.08.2009

PART B:

SITUATIONAL ANALYSIS

Part B – Situational Analysis

TABLE OF CONTENTS

THE PROVINCE OF KWAZULU-NATAL

The Province of KwaZulu-Natal stretches from Port Edward in the south to the borders of Swaziland and Mozambique in the north. It occupies 7.6% (92,100 sq km) of the total land surface of South Africa. Geographically it is divided into a low land region along the Indian Ocean, the central planes and mountainous area in the west and northern part of the Province.

The Province is divided into 50 Municipalities, 1 Metropolitan and 10 Districts. The health service boundaries are aligned to the municipal boundaries as determined by the Municipal Demarcation Board. *Map 1 depicts the Municipalities, Metropolitan and Districts in KwaZulu-Natal.*

Health Districts have been consolidated into three Service Delivery Areas namely:

Area 1 (South Eastern): Ugu District, Ilembe District and the eThekwini Metro.

Area 2 (Western): Umgungundlovu District, Uthukela District, Umzinyathi District, Amajuba District and Sisonke District.

Area 3 (North Western): Zululand District, Umkhanyakude District and Uthungulu District.

DEMOGRAPHIC CHARACTERISTICS

KwaZulu-Natal has an estimated total population of 10,158,820 (2009)[1], and a projected uninsured population of 8,939,761 (2009). It is estimated that approximately 54% of the total population lives in rural areas, and an estimated 10% of the urban population live in under-developed informal settlements,[2] which has serious health implications as a result of under-development and non-availability of the essential resources necessary to maintain health e.g. water, sanitation and employment opportunities.

Population statistics show that approximately 70% of the population in the Province are below the age of 35 years which has significant implications for service planning and delivery. The current burden of disease and the commitment to improve health promotion/ prevention as well as expand and improve Primary Health Care service delivery necessitates careful consideration of target groups and beneficiaries for health strategies and interventions. *Map 2 indicates the age and gender composition per district.*

Population statistics indicate the following breakdown of the Provincial population:

- 10% of the population are between the ages of 0-4 years;
- 36% between 5-19 years;
- 9% between 20-24 years;
- 8.33% between 25-29 years;
- 6.7% between 30-34 years; and
- 29.97 over the age of 35 years.

The population density is estimated at 107.52 people per km^2, which will have an impact on access to and utilisation of health services, disease profiles and out-reach programmes/ services. The eThekwini Metropolitan has the highest population density with approximately 1,394 people per km^2, and Sisonke the lowest with 42 people per km^2. This illustrates the diversity in the Province and the challenges it poses for equity in health service delivery. *Map 3 illustrates the population density per Municipality.*

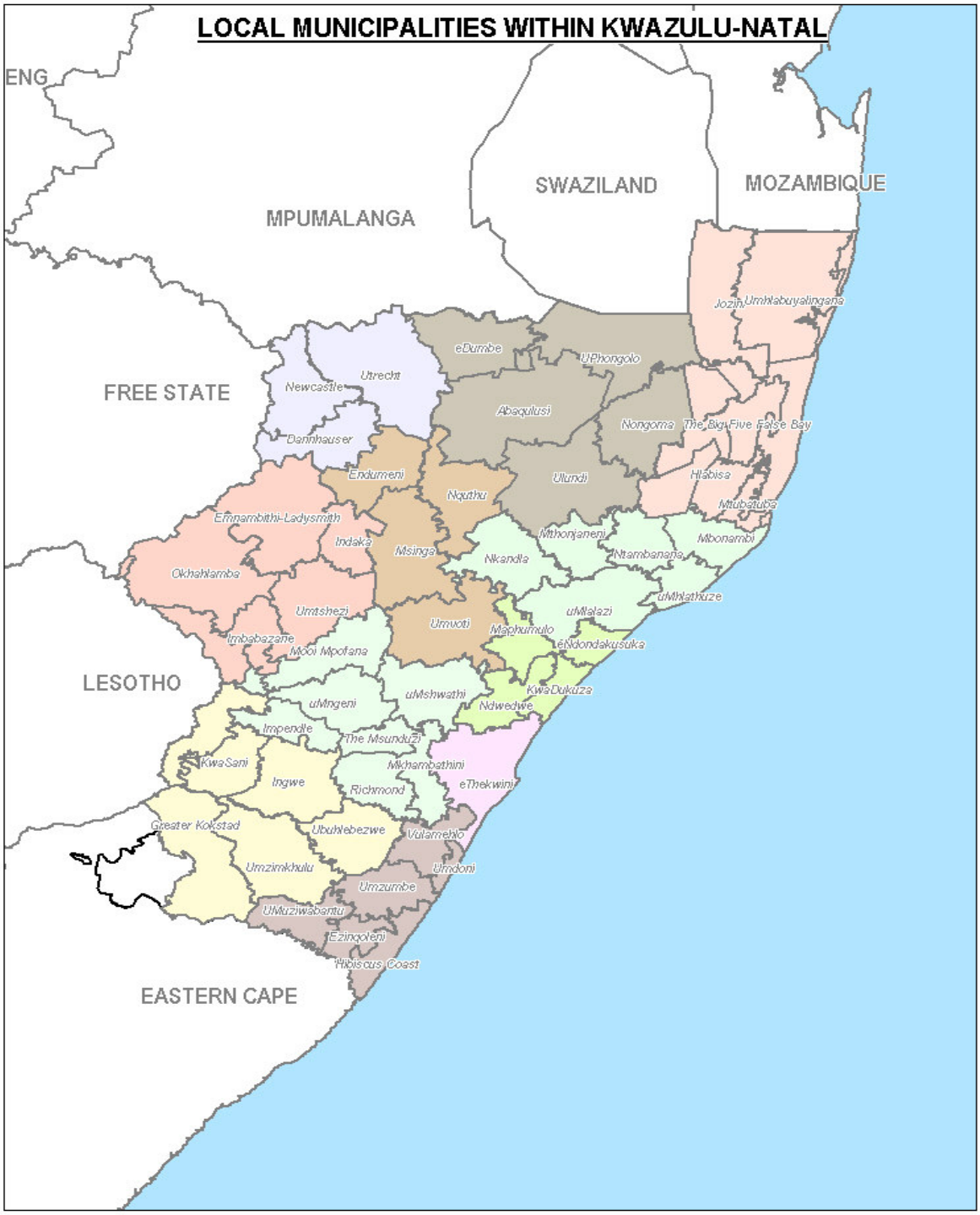
Population composition and density, age, male/ female distribution, development, etc. have a significant impact on health, service delivery and development and must be considered an integral part of the analysis of disease profiles and trends in order to contextualise health needs, service delivery imperatives and appropriate resource allocation to address inequality with respect to access and service delivery.

[1] Stats South Africa - Provincial Mid-Year estimates - 18/19 December 2008
[2] Extracted from Statistics South Africa and projected from 2001 using growth rates obtained from the mid-year estimates. Uninsured population is currently calculated at 88% of the total population

Part B – Situational Analysis

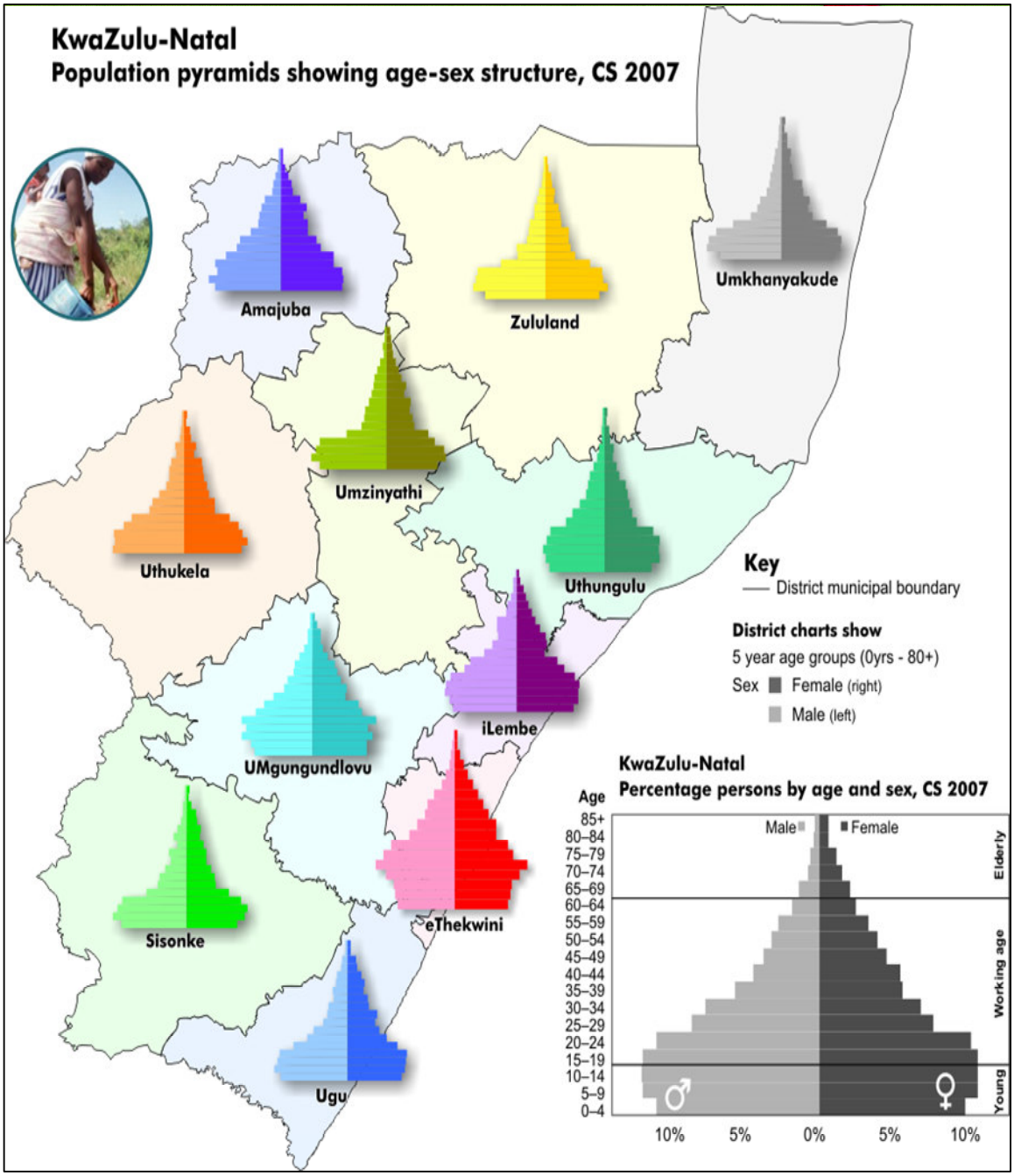
.

Map 1: Local Municipalities in KwaZulu-Natal



The map depicts the Municipalities and Districts in KwaZulu-Natal.

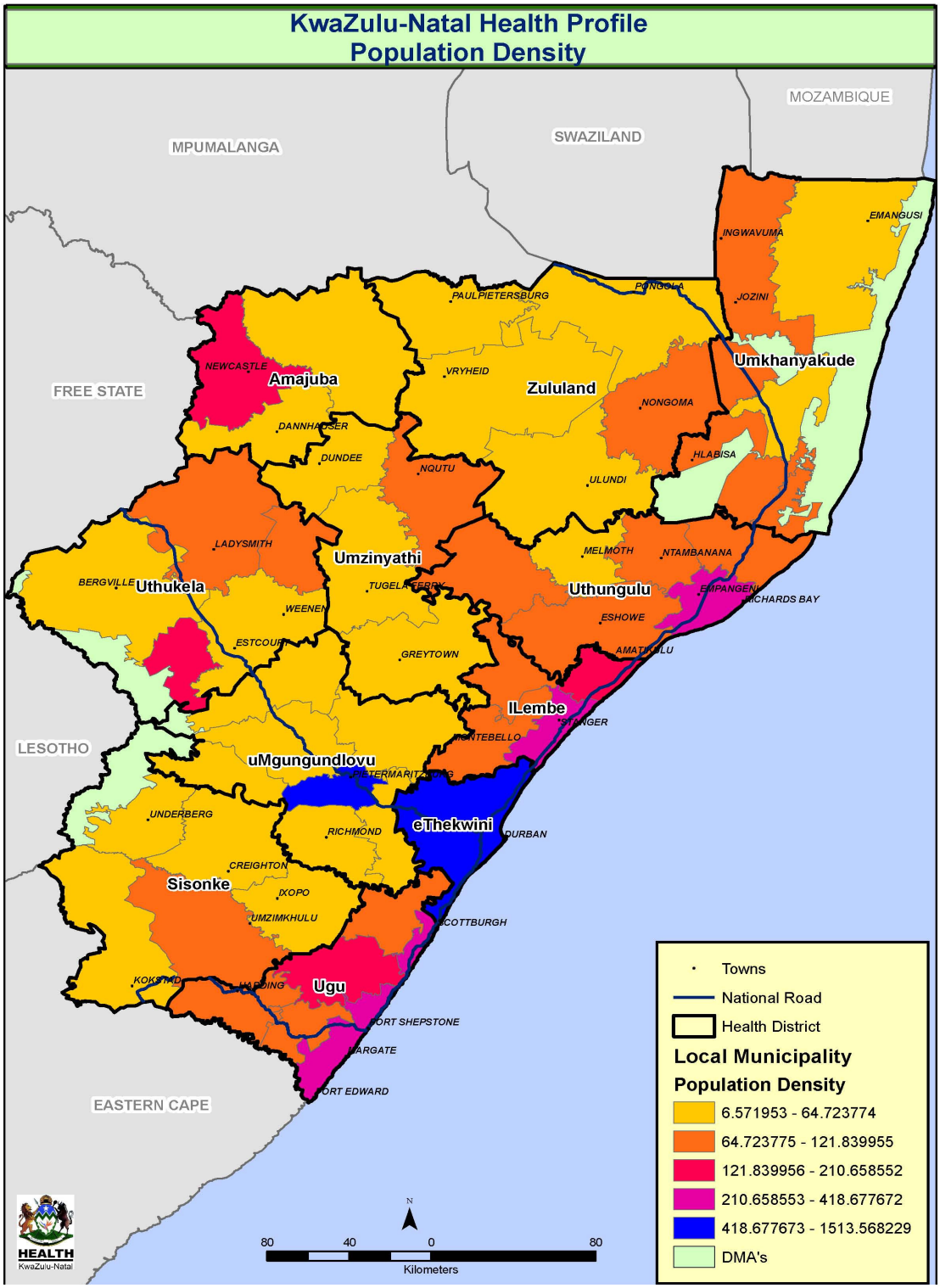
Map 2: Age and Gender Structure in KwaZulu-Natal[3]



Age and gender structure is of relevance for programme/ service focus e.g. Maternal, Child & Women's Health services and resource allocation.

[3] From KZN Provincial Government Five Year Report 2004-2009; Office of the Premier KZN

Map 3: Population Density in KwaZulu-Natal



Population density is considered for allocation of resources as well as mapping and profiling of disease patterns.

POVERTY AND HEALTH PROFILE

Map 5 visually illustrates the poverty index per Municipality in KwaZulu-Natal using data from Census 2001 and the Community & Household Survey of 2007. Variables, considered as priority for material and social deprivation, being weighted (from 1 – 5) for the construction of the poverty index. Indicators used for calculating the poverty index included data pertaining to the following: economic (income, dependency ratio); education (schooling); basic services at household level (water, sanitation, electricity, communication, refuge); demographic (population construction); social (heads of household); and roads (accessibility).

Ranking Municipalities and Districts according to socio-demographic/ economic and health profiles provides the Department with valuable insights into the gaps that exist between the least and most deprived Municipalities/ Districts with regard to health services. This also provides comprehensive evidence-based information to inform strategic direction and resource allocation. The information is fundamental when analysing disease profiles and assessing equity and access and must be used in conjunction with service delivery indicators to determine strategic direction and allocation of resources.

Map 6 visually illustrates the people living below the poverty line per Municipality. The increased influx of people into the eThekwini area has a huge impact on service delivery as can be seen in the increase in patient numbers vs. decrease in human resources. In-migration of people also increases catchment populations which present with unique challenges in determining norms and standards. Stats SA estimated the Provincial unemployment rate to be 29.9%. Map 4 illustrates the unemployed population per Municipality with eThekwini the most affected.

Multiple factors contribute to the attainment of health, many of which are outside the mandate of the Department. The contribution of environmental factors to morbidity and mortality is well documented. People living in unhygienic environments as indicated by poor drainage systems, inadequate sanitation, and lack of access to piped water suffer higher levels of morbidity and mortality,[4] and it is estimated that up to 40% of world deaths can be attributed to various environmental factors. Access to water correlates strongly with the survival of children under-5 years, while malnutrition, a major cause of child morbidity and mortality, can also be related to environmental degradation.[5]

Map 8 demonstrates access to piped water per Municipality, and clearly indicates the most deprived Municipalities being in eThekwini, Ugu, Sisonke, Umzinyathi and Zululand. Map 9 demonstrates access to adequate sanitation per Municipality.

The Strategic Planning and GIS Components developed a composite Provincial Health Profile using socio-demographic and economic indicators (Census data - Statistics South Africa), priority health indicators (data from the District Health Information System - DHIS), health facilities geographical location (data from the Geographical Information System) and roads (data from the KwaZulu-Natal Department of Transport). The health profile has the potential to alert the Department to inequalities and gaps in service delivery and pave the way for a more comprehensive analysis of health indicators linked with socio-demographic and economic variables.

DATA ANALYSIS

Data was analysed at Municipal level, with DHIS and the 2007 Community Survey data linked to GIS via Municipality names. GIS buffers were used to determine the coverage of health facilities within 5km, 10km and 15km from Municipal boundaries and the ease of access to health facilities from communities by calculating the length of road coverage by road type per Municipality. The data analysis and map creation was done through using ArcGIS.

SCORING

The measurement yardstick used to create a composite profile allocating each Municipality a rank score between 1 and 5 (score of 1 being least favourable and 5 most favourable) is based on the Jenks algorithm.

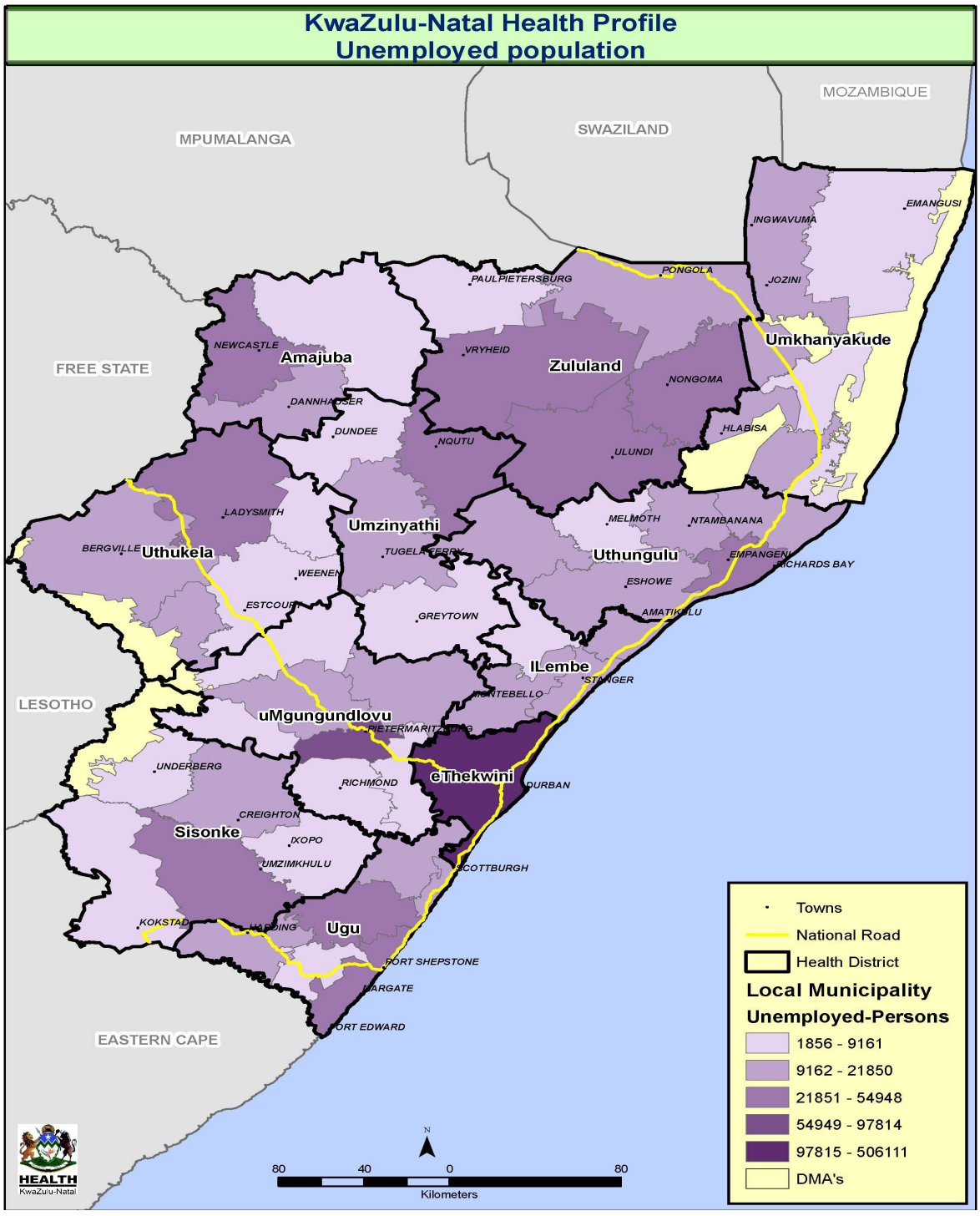
DATA MODELING

The weighting of the selected indicators and ranking of data to develop an overall score that can provide an accurate assessment of the health profile has the potential to produce multiple scenarios based on different indicators. It will therefore be possible to map additional indicators depending on identified needs.

[4] Caldwel JC & Caldwel BK 2002 - Poverty and mortality in the context of economic growth and urbanization - Asia-Pacific Population Journal 49-66

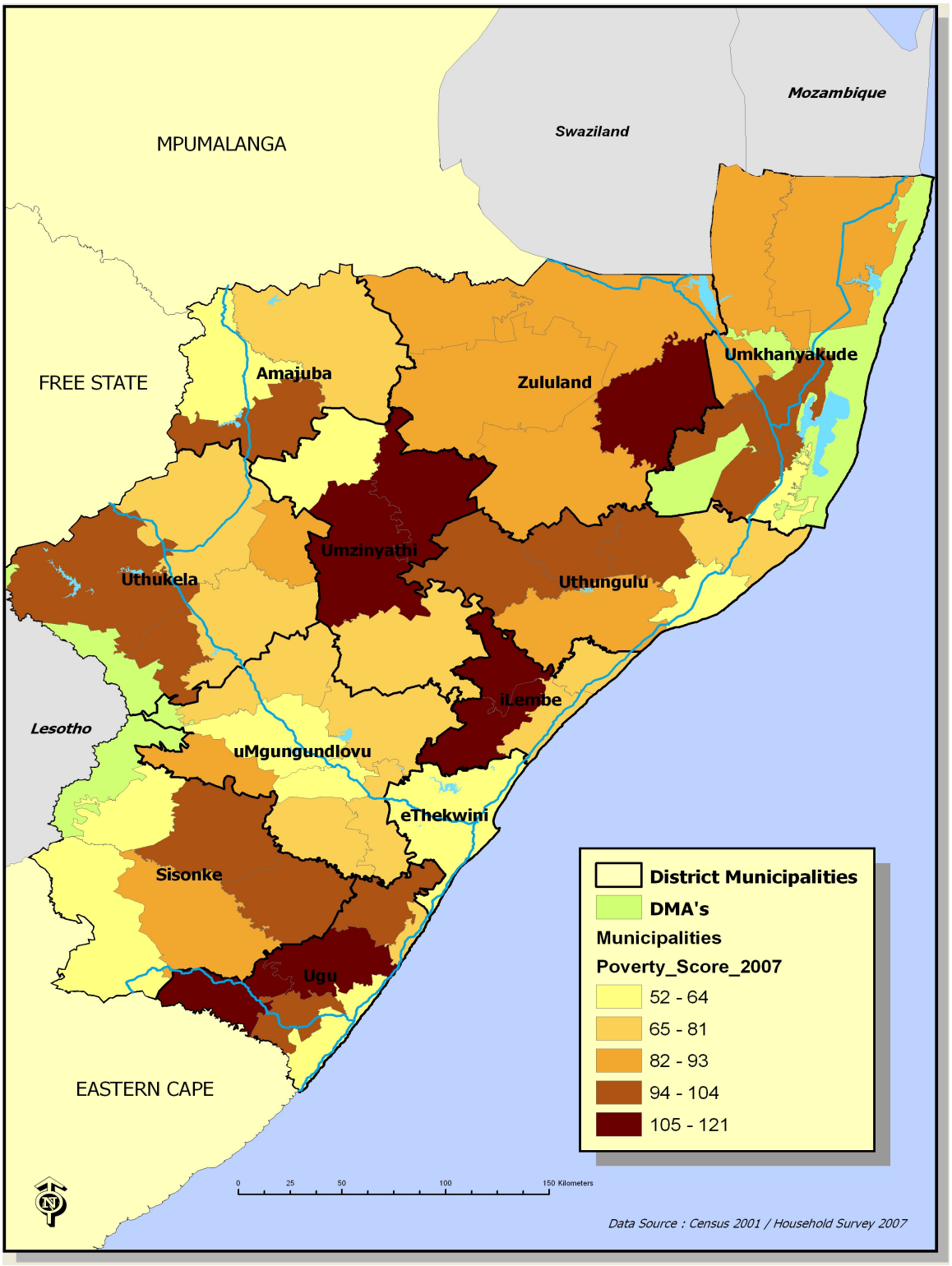
[5] Amuyynzu-Nyamono M, Taff N, 8 January 2004. The triad of poverty, environment and child health in Nairobi informal settlements - Journal of health and population in developing countries

Map 4: Unemployed population per Municipality



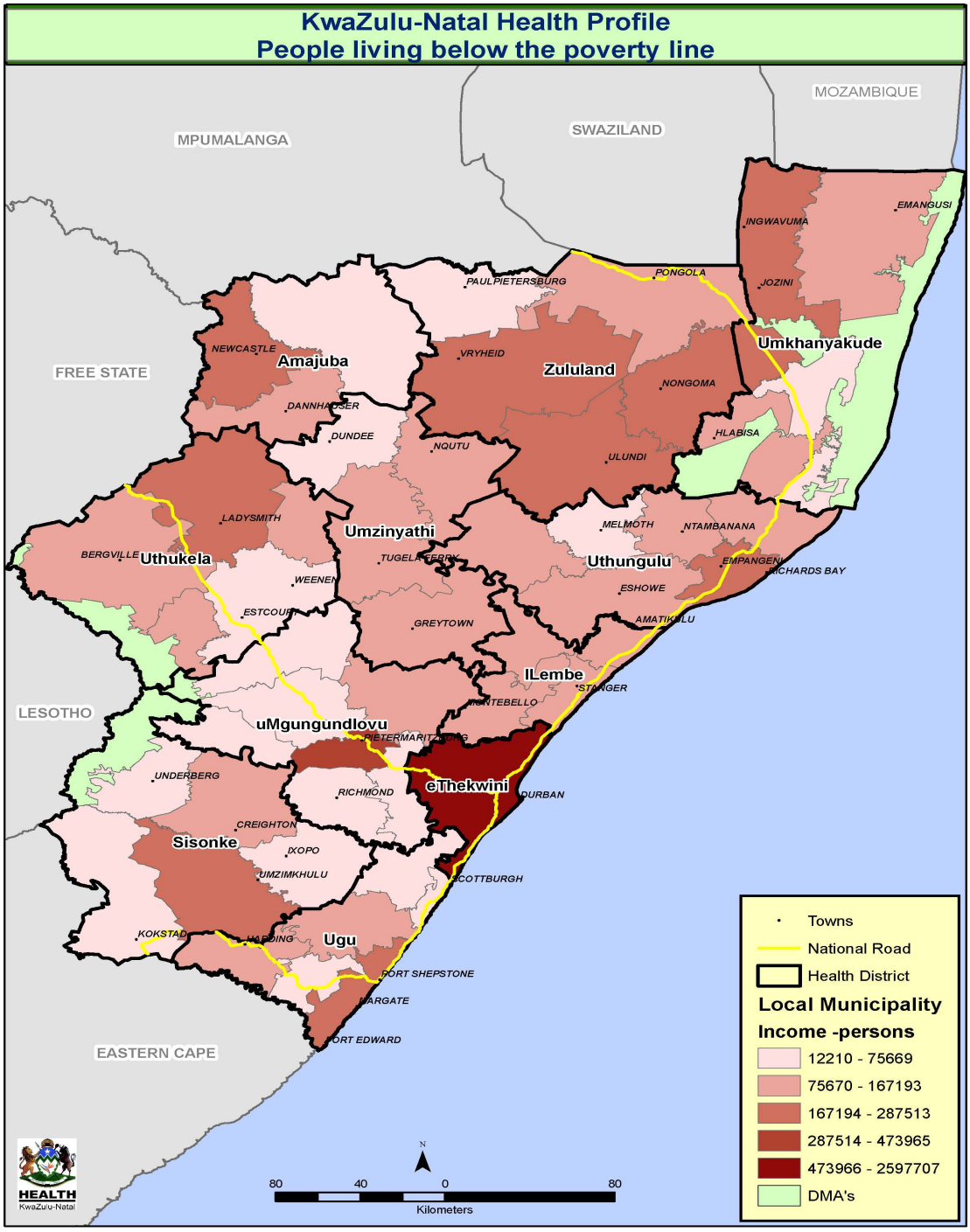
The map depicts a comparison of unemployment per Municipality in KwaZulu-Natal. The darker purple areas have the highest number of unemployed people per Municipality.

Map 5: Poverty Profile per Municipality



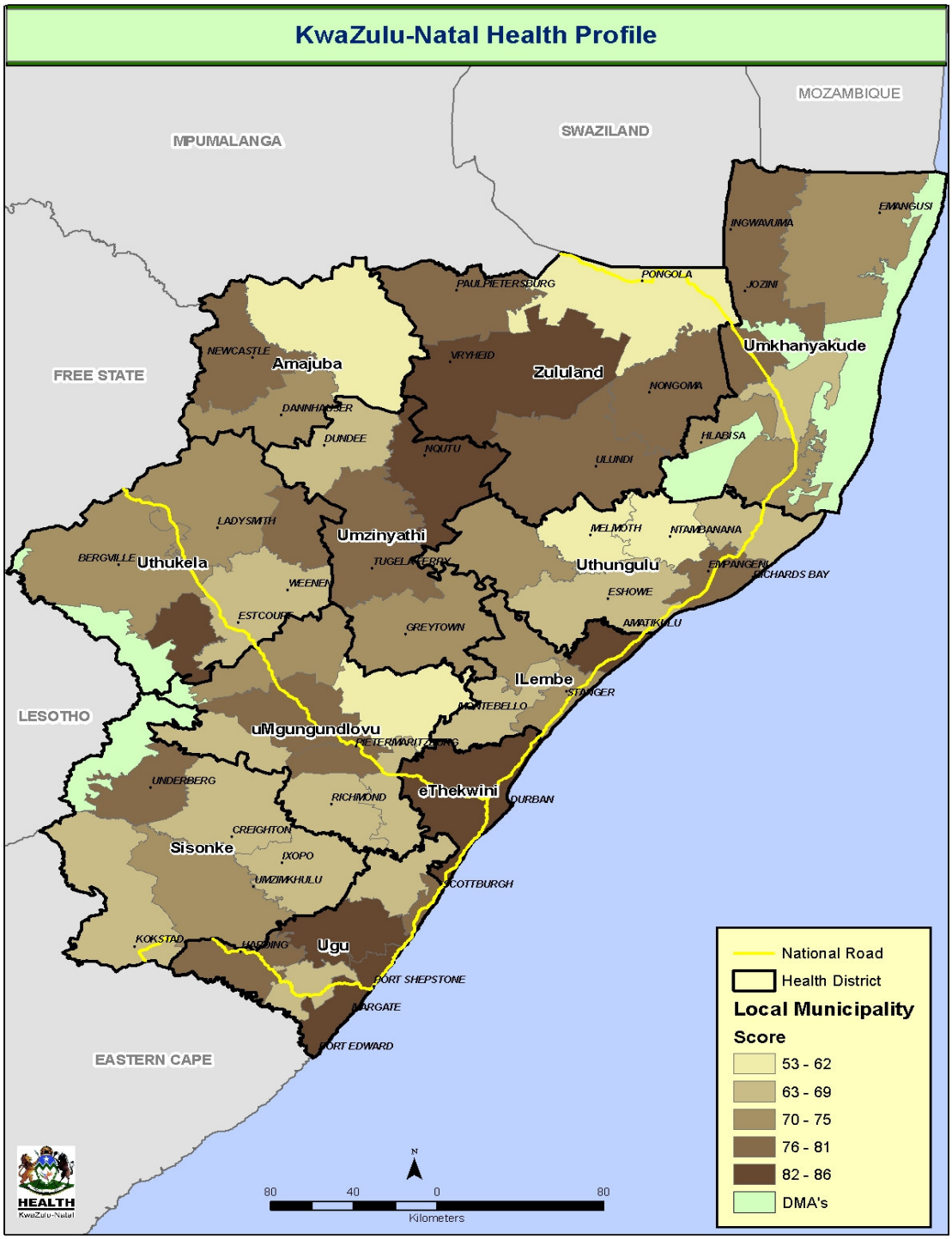
This map illustrates the Poverty index per Municipality in KwaZulu-Natal. The darker brown areas refer to the most deprived Municipalities with the highest poverty index.

Map 6: People living below the poverty line



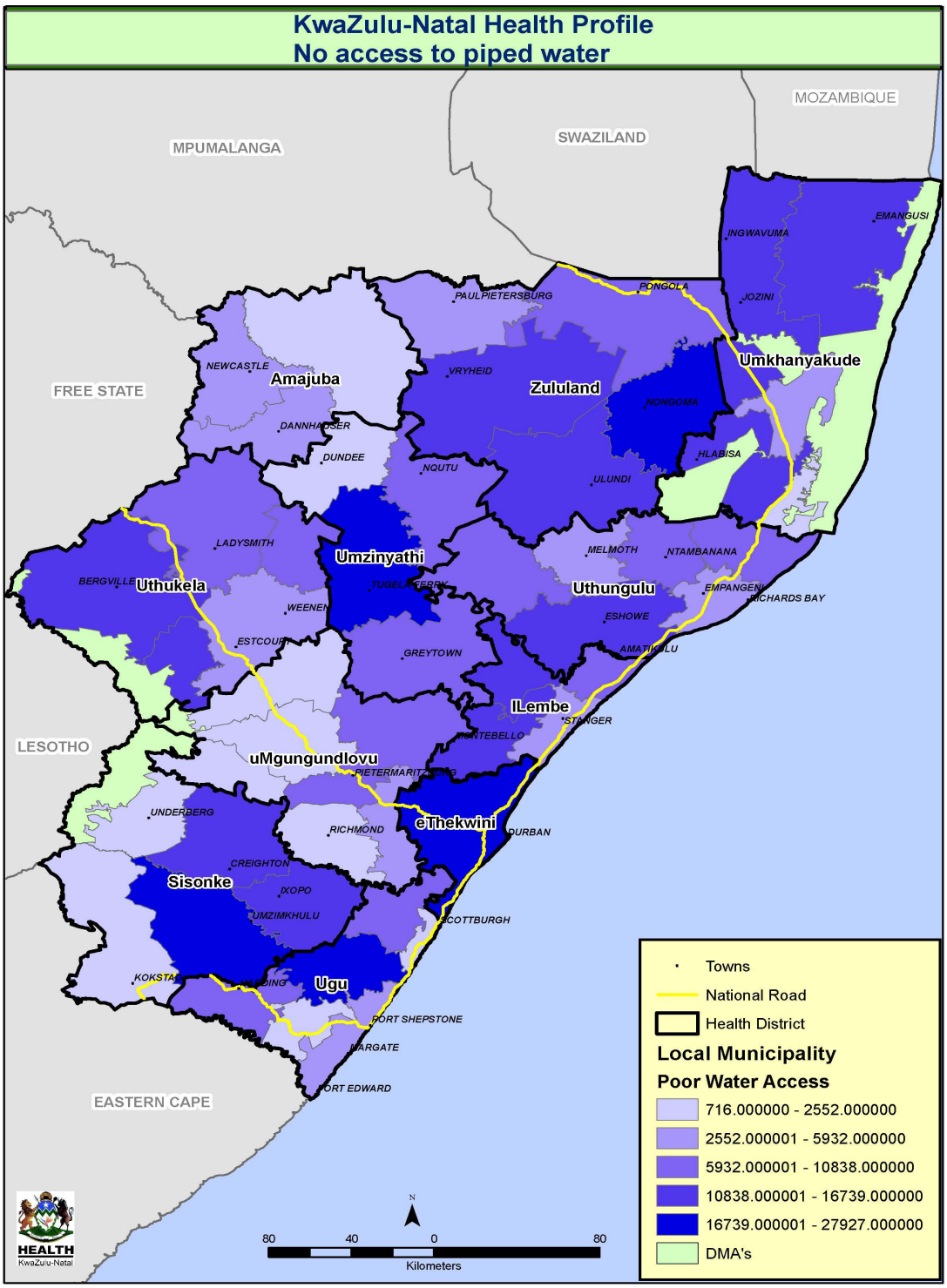
The map illustrates the number of people living below the poverty line. The darker brown indicates the greatest number of people living below the poverty line.

Map 7: KwaZulu-Natal Health Profile



The map visually illustrates the KwaZulu-Natal Health Profile based on core indicators. The darker brown indicates areas of high health service needs.

Map 8: No access to piped water



The map visually illustrates access to water per municipality. The dark blue areas hive the highest number of households without access to piped water. Information should be considered in relation to e.g. diarrhoea, etc.

Map 9: Poor sanitation

The map visually illustrates access to sanitation per municipality. The dark brown areas refer to Municipalities with poorest access to sanitation. Information can be linked to e.g. diarrhea, parasites etc.

Part B – Situational Analysis

POLICIES, STRATEGIC PRIORITIES AND PLANS

Table 1: Alignment of National and Provincial Priorities – 2008/09

Provincial Priorities 2008/09	Provincial Plan of Action 2004-2009	National Health Priorities 2008/09
Continue to accelerate & sustain the implementation of the Comprehensive HIV and AIDS Management Plan. *(12-Point Plan)*	Intensify campaign on communicable diseases. Accelerate the implementation of the Comprehensive HIV and AIDS Strategy for KZN. Treatment of MDR and XDR TB.	Implementation of Key Health Programmes: Implementation of the updated strategy on HIV and AIDS.
Continue to implement the TB Crisis Management Plan. *(12-Point Plan)*		Intensifying the campaign against TB strains.
Reduce morbidity & mortality due to non-communicable diseases.		Strengthening Malaria control. Non-Communicable diseases.
Implement and sustain a comprehensive programme for Chronic Diseases and Geriatrics.		
Re-orientate Oral Health from a curative to a preventive approach.		
Implement integrated Health Promotion and Healthy Lifestyle Programmes. *(12-Point Plan)*		Ongoing implementation of the Healthy Lifestyle Programme.
Decrease preventable causes of Maternal, Child & Women's Health morbidity and mortality. *(12-Point Plan)*	Integrated Anti-Poverty Campaign. Access to Nutrition i.e. food gardens at hospitals, schools and National Integrated Programme (NIP) centres.	Maternal, Child and Women's Health and Nutrition.
Accelerate and sustain the integrated Nutrition Programme.		
Operationalise the imperatives set by the Mental Health Care Act, 2002.		
Implement and sustain an integrated Disability and Rehabilitation strategy.		
Accelerate Infrastructure Development and purchase of medical equipment. *(12-Point Plan)*	New health infrastructure, including clinics and hospitals.	Quality improvement through the implementation of a Health Facilities Improvement Plan.
Mainstream PHC services.	Improvement in Health Care Services.*[6]	
Improve clinical governance including quality of care & infection prevention & control. *(12-Point Plan)*		
Strengthen and increase collaboration with stakeholders and service providers involved in the health sector.		
Ensure integrated planning for the provision of health services.		
Improve the quality and use of health data. *(12-Point Plan)*		Implementation of an integrated National Health Information System.

[6] Relevant to all strategic objectives

Provincial Priorities 2008/09	Provincial Plan of Action 2004-2009	National Health Priorities 2008/09
Provide geographical information systems services for health planning and service delivery.		
Implement an appropriate monitoring & evaluation system.		
Ensure equitable and appropriate distribution of Telehealth and Information Technology.		
National Health mandate.		Health financing, including designing the National Health Insurance System and reducing the rate of increase of tariffs in the Private Health Care System.
National Health mandate.		Further reduction in the prices of Pharmaceutical products.
Sustain and expand the health workforce through implementation of innovative Human Resource Management strategies. *(12-Point Plan)*		Strengthening Human Resources for health.
Design and implement a seamless quality service delivery system.		
Ensure appropriate Financial, Procurement and Human Resource Delegations. *(12-Point Plan)*		
Ensure that Supply Chain Management effectively & efficiently supports the service delivery needs of all institutions. *(12-Point Plan)*		
Ensure that key support services are effectively provided.		
MEC's Office - ongoing.		International Health relations.
Implement performance management & couching programmes. *(12-Point Plan)*		Strengthening Management and Communication.

MILLENNIUM DEVELOPMENT GOALS

Table 2: Progress towards targets of the Millennium Development Goals

Goal and Target	Indicator	National Progress 2004 - 2009	Provincial Performance 2008/09
Goal 1: Eradicate extreme poverty & hunger. Target: Halve, between 1990 and 2015, the proportion of people who suffer from hunger.	Prevalence of underweight children (under five years). *SA Target: Not more than 14,582 children presenting to health facilities with severe malnutrition.*	29,165 children suffered from malnutrition in 2007. *Source: Development Indicators Mid-Term Review, published by the Presidency, RSA, 2008.*	Incidence of severe malnutrition under-1 year: 0.6% in 2008/09. *Source: DHIS*
			Children under 5-years not gaining weight decreased from 6% in 2005/06 to 1.3% in 2008/09. *Source: DHIS*

Part B – Situational Analysis

Goal and Target	Indicator	National Progress 2004 - 2009	Provincial Performance 2008/09
			The proportion of severely under-weight children under-5 decreased from 0.55% in 2005/06 to 0.1% in 2008/09. *Source: DHIS*
Goal 4: Reduce Child Mortality. Target: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.	Under-five mortality rate. *SA Target: 19.7 per 1000 (or less).*	58 per 1000 *Source: South Africa Demographic and Health Survey (SADHS) 2003.*[7]	Estimated at 95 per 1 000. *Data Source: MRC*
	Infant mortality rate. *SA Target: 14.3 per 1000 (or less).*	43 per 1000 *Source: SADHS 2003.*[8]	Estimated at 60 per 1 000. *Data Source: MRC*
	Proportion of one-year-old children immunised against measles. *SA Target: 100%*	85,8% in 2007 *Source: District Health Information System (DHIS), National DOH, 2007.*	Measles coverage increased from 79% in 2005/06 to 89.3% in 2008/09. *Source: DHIS*
Goal 5: Improve Maternal Health. Target: Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate.	Maternal mortality ratio. *SA Target: 36.8 per 100 000 (or less).*	147 per 100 000 *Source: National Confidential Enquiries into Maternal Deaths 2002-2004.*	Estimated at 224.4/100 000 308 Maternal deaths reported in KZN in 2008/09. *Source: Confidential Enquiry into Maternal Deaths - KZN 2004 - 2007*
	Proportion of births attended by skilled health personnel. *SA Target: 100%*	92% *Source: SADHS 2003.*	The proportion of births attended by skilled personnel: 91.1% in 2008/09. *Source: SADHS 2003*
Goal 6: Combat HIV and AIDS, Malaria and other diseases. Target: Have halted by 2015, and begin to reverse the spread of HIV and AIDS.	HIV prevalence among 15 to 24-year-old pregnant women. *SA Target: 9.5 (or less) 50% reduction in prevalence.*	19% *Source: National HIV and Syphilis Prevalence Survey of South Africa 2007.*	HIV prevalence 39.1% (constant). *Source: ANC Sero-Prevalence Survey 2007*
			HIV prevalence of women under 20 years decreased from 15.9% in 2005 to 13.7% in 2008/09.
			From 36.4% in 2005 to 37% for women 30 - 35 years.
	Contraceptive prevalence rate. *SA Target: 85%*	65% *Source: SADHS 2003.*	Condom distribution rate remains constant at 7. *Source: DHIS*
			Contraceptive prevalence: 23% in 2008/09. *Source: DHIS*
Target: Have halted by 2015, and begin to reverse the incidence of malaria and other	Proportion of tuberculosis cases detected and cured under directly observed treatment, short-course	64% *Source: DHIS, 2008.*	TB treatment interruption rate decreased from 13.4% in 2005/06 to 9.9% in 2008/09. *Source: Electronic TB Register*

[7] Data considered unreliable - survey report
[8] Data considered unreliable - survey report

Goal and Target	Indicator	National Progress 2004 - 2009	Provincial Performance 2008/09
major diseases.	(DOTS). *SA Target: 85%*		Smear conversion rate increased from 48.4% in 2005/06 to 52.1% in 2008/09. *Source: Electronic TB Register*
			Cure rate increased from 31.9% in 2005/06 to 54.2% in 2008/09. *Source: Electronic TB Register*
	Proportion of the population in malaria risk areas using effective malaria prevention and treatment measures.		Malaria incidence is currently less than 1/1000 population. *Source: Notifiable Conditions Database*
			Malaria case fatality rate is 0.9%. *Source: Notifiable Conditions Database*
			Indoor residual spraying coverage is 93%. *Source: Malaria Programme Database*

VOTED FUNDS

Table 3: Voted Funds

Budget Allocation	2008/09 R'000
Original Budget	15,042,826
Rollovers	44, 738
Additional Adjustments	695,421
Final budget appropriated (adjustment budget)	**15,782,985**
Total Expenditure	17,103,101
(Over) / Under Expenditure	(1,320,116)
(Over) / Under Expenditure (%)	8.4%

Table 4: Collection of Departmental Revenue

	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual	% Deviation from target
Tax Revenue	-	-	-	-	-	
Non-Tax Revenue	114,122	111,693	142,275	136,592	168,049	
Sale of Goods and Services other than Capital Assets	114,095	111,065	142,248	136,508	158,432	
Sales of Capital Assets (Capital Revenue)	36	15	29	21	-	
Financial transactions (Recovery of Loans and Advances)	23,531	9,581	6,240	5,565	9,603	
Total Departmental Receipts	**114,122**	**111,693**	**142,275**	**136,592**	**168,049**	

Part B - Situational Analysis

Table 5: Departmental Expenditure

Programmes	Voted for 2008/09	Roll-overs and Adjustments	Virement	Total Voted	Actual Expenses	Variance
Programme 1 Administration	305,488	(16,004)	-	289,484	284,066	5,418
Programme 2 District Health Services	6,915,052	447,851	27,373	7,390,276	8,132,272	(741,996)
Programme 3 Emergency Medical Rescue Services	632,501	8,734	31,125	672,360	672,360	-
Programme 4 Provincial Hospital Services	3,899,492	185,786	43,782	4,085,278	4,378,814	(249,754)
Programme 5 Central Hospital Services	1,440,152	54,472	-	1,538406	1,821,221	(326,597)
Programme 6 Health Sciences and Training	578,293	14,582	-	592,875	676,601	(83,726)
Programme 7 Health Care Support Services	34,130	-	-	34,130	34,209	(79)
Programme 8 Health facilities	1,237,718	44,738	(102,280)	1,180,176	1,103,558	76,618
Total	**15,042,826**	**740,159**	**-**	**15,782,985**	**17,103,101**	**-1,320,116**

Table 6: Summary of the Department's Conditional Grants for 2008/09

Name of Conditional Grant	Schedule	Original Allocation R'000	Roll-Over from 2007/08 R'000	Available Funds R'000	Expenditure R'000	Variance R'000
Forensic Pathology Services	5	150,809	96,476	247,285	149,093	98,192
Health Professional Training & Development	4	201,992	-	201,992	212,092	10,100
Hospital Revitalisation	5	268,433	91,761	360,194	330,404	29,790
National Tertiary Services	4	789,578	-	789,578	911,898	-122,320
Comprehensive HIV and AIDS Grant	5	466,922	-	466,922	757,615	-290,693
Provincial Infrastructure	4	259,758	-	259,758	294,832	-35,074
TOTAL		**2,137,492**	**188,237**	**2,325,729**	**2,655,934**	**141,755**

Table 7: Expenditure on Conditional Grants

Conditional Grants	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Actual
National Tertiary Services	691,451	732,167	789,578	911,898
HIV and AIDS	251,468	344,304	466,922	757,615
Hospital Revitalisation	111,821	225,528	333,523	330,404
Integrated Nutrition Programme	26,954	0	0	0
Hospital Management and Quality Improvement	19,514	0	0	0
Health Professions Training and Development	180,087	204,659	201,992	212,092
Provincial Infrastructure Grant	157,561	174,098	259,758	294,832
Forensic Pathology Services	2,624	63,884	132,201	149,093
TOTAL	**1,441,480**	**1,744,640**	**2,183,974**	**2,655,934**

Table 8: Evolution of Expenditure by Budget per Capita Sub-Programme (constant 2007/08 prices)

	2005/06	2006/07	2007/08	2008/09
Population [9]	9,851,464	9,924,000	9,997,070	10,070,677
% Insured	12%	12%	12%	12%
Uninsured Population	8,669,289	8,733,120	8,797,421	8,862,196
Conversion to constant 2007/08 prices	1.1	1.05	1.00	0.96
Programme	**Exp per capita Uninsured**	**Exp per capita Uninsured**	**Exp per capita Uninsured**	**Exp per capita Uninsured**
Programme 1: Administration	R21.54	R23.81	R27.98	R26.50
Programme 2: District Health Services	R624.90	R645.68	R819.51	R900.34
Programme 3: Emergency Medical Services	R53.37	R56.99	R62.38	R70.55
Programme 4: Provincial Hospital Services	R354.78	R377.40	R441.47	R480.55
Programme 5: Central Hospital Services	R135.59	R143.29	R160.01	R193.60
Programme 6: Health Sciences and Training	R51.80	R50.63	R59.60	R73.56
Programme 7: Health Care Support Services	R0.96	R3.55	R1.44	R3.70
Programme 8: Health Facilities Management	R93.48	R97.77	R124.22	R110.02
Total: Programmes	**R1,339.36**	**R1,402.38**	**R1,700.43**	**R1.862.43**

** Calculate by (expenditure) x (conversion factor)/ (uninsured population)*

Table 9: Expenditure by Budget Sub-Programme (R'000)

Programme	2005/06 Expenditure	2006/07 Expenditure	2007/08 Expenditure	2008/09 Budget	2008/09 Expenditure	Variance % under/ over expenditure
Programme 1: Administration	**192,917**	**225,035**	**279,730**	**289,484**	**284,066**	**1.87%**
Programme 2: District Health Services	**4,924,947**	**5,370,301**	**7,390,276**	**7,362,903**	**8,132,272**	**-10.45%**
District Management	81,393	113,596	145,144	1510,532	150,532	0.%
Clinics	932,180	1,027,389	1,294,981	1,500,999	1,578,640	-5.17%
Community Health Centres	220,615	285,742	435,897	503,862	503,302	-3.48%
District Hospitals	2,660,326	2,702,998	3,568,351	3,221,936	4,020,233	-24.78%
Community Based Services	70,977	84,505	103,291	92,769	92,769	0%
Other Community Services	396,607	375,667	411,552	429,132	429,132	0%
Coroner Services	2,936	44,840	107,176	87,757	96,664	-10.15%
HIV and AIDS	528,093	703,970	1,058,570	1,239,349	1,239,365	7.35%
Nutrition	31,820	31,594	84,647	21,635	21,635	38.78%
Programme 3: Emergency Medical Services	**420,604**	**474,023**	**548,796**	**672,360**	**672,360**	**-4.85%**
Emergency Transport	401,178	454,943	528,185	636,096	636,096	-5.51%
Planned Patient Transport	19,426	19,080	20,611	36,264	36,264	5.49%

[9] Population figures were extracted from Statistics South Africa and projected from 2001 using growth rates obtained from the mid-year estimates for July 2006

Part B – Situational Analysis

Programme	2005/06 Expenditure	2006/07 Expenditure	2007/08 Expenditure	2008/09 Budget	2008/09 Expenditure	Variance % under/ over expenditure
Programme 4: Provincial Hospital Services	**2,796,081**	**3,138,945**	**3,883,814**	**4,085,278**	**4,378,814**	**-7.19%**
General Hospitals (Regional)	2,212,986	2,405,363	2,890,364	2,876,392	3,169,928	-10.98%
TB Hospitals	230,332	314,451	481,772	653,625	653,625	-1.69%
Psychiatric Hospitals	295,734	334,552	409,527	451,429	451,429	4.97%
Sub-Acute, Step-Down and Chronic Hospitals	49,052	76,140	92,364	93,865	93,865	5.67%
Dental Training Hospitals	7,977	8,439	9,787	9,967	9,967	14.98%
Other Specialised	0	0	0	0	0	0
Programme 5: Central Hospital Services	**1,068,606**	**1,191,810**	**1,407,703**	**1,538,406**	**1,821,221**	**-21.85%**
Central Hospitals	317,398	368,108	427,508	495,386	502,028	-1.69%
Provincial Tertiary Hospitals	751,208	823,702	980,195	1,043,020	1,319,193	-31.80%
Programme 6: Health Sciences and Training	**408,227**	**421,069**	**524,333**	**1,538,406**	**676,601**	**-14.12%**
Nurse Training Colleges	219,498	229,513	278,799	307,792	336,812	-9.43%
EMS Training Colleges	14,786	11,220	13,452	17,304	16,969	1.94%
Bursaries	33,818	24,471	33,573	41,945	44,894	-7.03%
PHC Training	49,084	39,980	46,892	53,735	65,343	-21.60%
Other Training	91,041	115,885	151,617	172,099	212,583	-23.52%
Programme 7: Health Care Support Services	**7,600**	**29,560**	**12,649**	**34,130**	**34,209**	**-0.23%**
Medicines Trading Account	7,600	29,560	12,649	34,130	34,209	-0.23%
Programme 8: Health Facilities Management	**736,770**	**813,208**	**1,092,807**	**1,180,176**	**1,103,558**	**13.95%**
Community Health Facilities	224,420	164,980	240,029	280,625	280,625	-20.04%
EMRS	6,410	8,296	8,817	26,843	4,734	82.36%
District Hospitals	238,641	330,874	521,236	615,946	615,946	-21.82%
Provincial Hospitals	227,624	250,336	158,455	170,428	111,763	68.01%
Central Hospitals	0	17,610	12,001	15,436	15,401	38.46%
Other Facilities	39,675	41,112	152,269	93,007	75,089	47.06%
Total: Programmes	**10,555,752**	**11,663,816**	**14,959,400**	**15,782,985**	**17,103,101**	**-8.36%**

NOTE!

The following tables are included in the Annual Financial Statements and are NOT duplicated in the Situational Analysis:

1. (DHS 8): Transfers to Municipalities and Non-Government Organisations (R '000).
2. (DHS 8): Service Level Agreements signed with Non-Government Organisations (R '000).
3. Transfers/ Subsidies to Non-Profit Institutions.
4. Statement of Grants and Transfers to Municipalities until 31 March 2009.

PROGRAMME 1:

ADMINISTRATION

Part B – Programme 1: Administration

TABLE OF CONTENTS

PROGRAMME 1: ADMINISTRATION

CORPORATE COMMUNICATION

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities - 2008/09

Priority 8: Planning, budgeting and monitoring & evaluation

↓

Provincial Strategic Plan 2005 - 2009/10

Goal 5

Infrastructure investment in health technology, communication, management information and buildings

↓

Annual Performance Plan 2008/09

Goal 3

Strategic Objective 15: To ensure that key support services are effectively provided.

↓

Corporate Communication Priorities 2008/09

1. Ongoing communication towards progress of strategic goals.
2. Hosting the 2010 FIFA Soccer World Cup preparedness.
3. Building communication partnerships.
4. Expanding access to opportunities.
5. Promoting institutions and programmes.
6. Enhance the Departmental Communication system.
7. Promote internal communications.

EXECUTIVE SUMMARY

During 2008/09 the Communication Unit improved the communication system by integrating hospitals, districts and Head Office communication systems. Various policies were developed and implemented to guide implementation and ensure uniformity in branding, media liaison, public relations and internal communications.

The improved communication system has had various positive outcomes i.e.:

- Media relations with various media houses and journalists improved resulting in more positive media coverage.
- The improved multi-media approach used to promote services and programmes reached an average of 5 million people in 2008/09.
- The Departmental image has been improved as a result of the adoption of a corporate identity/branding.
- Media liaison has been delegated to hospital level thus improving communication at district level. Public Relation Officers and District Clinical Managers have been trained and a follow-up is planned for 2009/10.

The main thrust of advertising has been redirected from 30 second adverts to short drama's that convey the message in a manner that educates and entertains. Other channels, based on research, include mobile billboards, internet advertising and news bulletin sponsorships.

The IGR mandate has been maintained.

PROGRAMME PERFORMANCE

Inaccuracies in media coverage have been addressed through quarterly training workshops on key issues around media liaison with Hospital Public Relations Officers.

The vacancy in the Ombudsman Office has created a greater strain on Communications as complaints are not acknowledged within the 3 day timeframe as managers are requested to report on matters prior to a response being formulated. This has also been relevant to letters published in the media as responses are sometimes not published due to timeframes not being met.

A number of community-based campaigns were undertaken during 2008/09 to mobilise communities to play an active role in health promoting behaviour, forging partnerships with communities to improve quality of life and promoting Departmental messages around health themes. Limited budgets and differing viewpoints on the importance of campaigns challenged this form of communication.

The IGR Component continued to liaise with the Office of the Premier as official contact and liaison for international relations in the Province. Monitoring and evaluation of international relations has been done quarterly. The Department has become a best practice provider in communicable disease management (TB, HIV and AIDS & Malaria) with many African countries sending delegations to the Province to learn from various health system initiatives. The Department promoted the African Agenda through training of Environmental Health Officers from Mozambique and Swaziland in Port Health management.

Compliance with the Social Cluster was maintained and the Department participated in the Anti-Poverty Campaign, Child Protection Week, Anti-Drugs and Substance Abuse Campaign, Youth and Women's Month, Public Service Week and Izimbizo's.

⇒ PRIORITY 1: COMMUNICATION ON PROGRESS TOWARDS MILLENNIUM DEVELOPMENT GOALS (MDG'S) AND NATIONAL & PROVINCIAL STRATEGIC GOALS

The Department introduced a more positive and focussed communication strategy for reporting on progress/achievements towards international commitments i.e. MDG's and National and Provincial focus areas including HIV and AIDS, Maternal and Child Health, Tuberculosis and Malaria. Media coverage since has shown a positive response towards achievements in critical areas in spite of negative publicity with regards to over-spending during 2007/08 and 2008/09.

! CHALLENGES

- Limited impact of one-dimensional communication strategies versus cost.
- Funding for communications allocated to programmes which impose vertical strategies with limited outcome and impact.

⇒ PRIORITY 2: HOSTING THE 2010 FIFA SOCCER WORLD CUP PREPAREDNESS

No progress reported.

⇒ PRIORITY 3: BUILDING COMMUNICATION PARTNERSHIPS

Due to financial constraints the Communication Section was limited in the implementation of initiatives to improve partnerships. It is however estimated that ±90% of journalists rely on the Department to provide balanced reports on health issues. Through improved partnerships the Department has been able to link health messages with related media e.g. injuries and trauma with road safety message during holidays.

! CHALLENGE

- Budgetary constraints affected initiatives to build partnerships with the media.

⇒ PRIORITY 4: EXPANDING ACCESS TO OPPORTUNITIES

Planned activities and interventions had to be postponed due to budgetary constraints.

! CHALLENGE

- Expansion of internet services, development of communication materials/systems for the blind and partially illiterate and information materials for other languages (spoken by people using our services) was postponed due to budget constraints.

⇒ PRIORITY 5: PROMOTING INSTITUTIONS AND PROGRAMMES

Limited marketing were done to promote institutions. Priority programmes i.e. HIV and AIDS, Maternal & Child Health, Malaria and TB received high coverage in 2008/09. Community radio and printed media were utilised to promote health campaigns (Immunisation and Vitamin A), events (Child Health Week and School Health Week), health days/weeks (TB, HIV and AIDS, Pregnancy Week), etc. Approximately 85% of Health Calendar events were covered in 2008/09.

Services were promoted through improved signage at hospitals, clinics and Community Health Centres although this still needs to improve. Signage in some institutions is still available in English only and needs to be duplicated in isiZulu.

! CHALLENGES

- Programme communication conflicted with Departmental public relations protocol, as every contact with the media is seen as an "external

communication" by the Communications Unit.

- Financial constraints limited promotional activities.

⇒ PRIORITY 6: ENHANCE THE DEPARTMENTAL COMMUNICATION SYSTEM

Various policies have been developed to regulate and guide media liaison, public relations/ public relation officers, branding and internal communications. This has clarified the roles and responsibilities of role players at institutional, district and Head Office levels.

! CHALLENGES

- Budget constraints did not allowe for the capacitating of senior managers with regards to the media or the broadcast of preventative messages.
- Capacity building in handling of media in line with the Government Communication and Information Systems principle that "*everyone in government is a communicator*".
- Development of a long-term communication strategy addressing promotive and preventive health messages to reduce preventable causes of disease and to promote healthy living.

⇒ PRIORITY 7: PROMOTE INTERNAL COMMUNICATIONS

No progress has been reported.

An Internal Communication Framework is required to improve communication between staff and management and encourage lateral communication between sections to limit the "silo" effect. It is envisaged that implementation of the framework would improve unity in the organisation.

! CHALLENGE

- Development and implementation of an Internal Communication Framework.

NOTES

LEGAL SERVICES

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities 2008/09

Priority 9: Prepare and Implement legislation.

↓

Provincial Strategic Plan 2005 – 2009/10

Goal 4: Human Resource Management for Public Health.

↓

Annual Performance Plan 2008/09

Goal 3

Strategic Objective 15: To ensure that key support services are effectively provided.

↓

Legal Services Priorities 2008/09

1. To render professional legal services which comprises of efficient litigation, contract drafting, legislative drafting and interpretation and well researched legal advisory services.

EXECUTIVE SUMMARY

The Legal Unit has achieved 80% of the targets set for the 2008/09 reporting period, including promulgating the KZN Health Act 1 of 2009 and compiling a compendium of National and Provincial legislation which applies to the Department.

The Unit spent 48% of the 2008/09 allocated budget of R 8,632,728 due to cost containment restrictions. There are many cost drivers within the Legal Unit with medico-legal litigation the greatest. The Department has an overall contingent liability amount of R 376,239,253.

The Litigation Support Unit works in partnership with the State Attorney's Office. During 2008/09 there were 920 litigation files, compromising of 319 medico-legal matters, 153 civil and labour matters and 448 collusion claims. There are 188 potential litigation matters pending, including the non-completion of Road Accident Fund claims. The number of ad hoc legal advice matters was 430 with most matters coming in for legal opinions where administrative decisions had to be taken.

The Contract Management Section currently manages 1,874 contracts; however due to lack of resources the operational database has only been partially completed.

ACTS & POLICIES

Table 10: Acts, Policies, Protocols & Guidelines

Acts, Policies, Protocols & Guidelines 2008/09	Comments including strategies to strengthen policy implementation & monitoring
1. KZN Health Act 1 of 2009.	• The Act was passed on 5 March 2009.
2. Regulations to the Act.	• Regulations to be issued after the passing of the Act are in the process of being completed. The Act serves to reinforce the legal mandates of the Department in line with National Legislation and also provides for the Member of the Executive Council to perform certain functions as regulated by National Legislation. In this financial year the Department has scheduled workshops to create awareness to all internal users pending on the availability of budget.
3. Litigation Policy (G52/2008).	• The Policy serves to inform all internal stakeholders on the processes to be followed in litigation proceedings. It categorizes the types of litigation and the timeframes involved in litigation processes. The Policy was drafted on the framework document issued by the Department of Justice namely the Draft Blueprint Strategy Framework which seeks to reinforce the relationship of the State Attorney as the preferred supplier of Government legal services and individual government Departments in the conduct of state litigation. • The Unit has also drafted an Acknowledgement of Debt form to be utilised during recoveries of state debt in terms of Regulation 12 of the Public Finance Management Act and is awaiting ratification thereof from the Office of the State Attorney.
4. Contract Drafting Policy	• The Policy assists in identifying requirements that initiators have to comply with prior to a request for

Acts, Policies, Protocols & Guidelines 2008/09	Comments including strategies to strengthen policy implementation & monitoring
G48/2008.	the drafting of contracts. The requirements identified in the Policy are aligned to the Auditor General's requirements and are designed to protect the interests of the Department from a fiscal perspective in that it seeks to ensure that financial resources are confirmed prior to components entering into contractual obligations on behalf of the Department and also to ensure legislative compliance in respect of specific contracts. The process of review is being undertaken for legislative compliance and is hampered by a lack of current capacity.
5. Compendium of all legislation and policy prescripts.	• The compilation of a compendium of all National and Provincial legislation including legislation which applies to the Department transversally and the applicable policy prescripts emanated as the final phase in the Premier's Office Rationalisation of Laws Project. The compendium will be housed in the resources section and will serve as an introductory tool for all new incumbents as well as existing members of staff, as part of the induction process to enable all staff to fully comprehend the legal and policy mandates of the Department.

PROGRAMME PERFORMANCE

The renewal of contracts has been a contentious issue during the 2008/09 period. Written notices are dispatched 3 months prior to date of expiry of contacts, followed by a monthly reminder and in the final month initiators are advised in writing of the PFMA requirements of services being rendered in the absence of contracts. Depending on the initiators instructions either a written extension for 1 - 3 years or a new contract is drafted, following expiry. Compliance with policy directives has proven problematic within the Department, and the Auditor-General has commenced with a compliance audit on a sample of contracts.

The promulgation of the KwaZulu-Natal Health Act will have several implications for the Department especially with regard to structures and governance. The Act regulates the delegation, roles, responsibilities and powers bestowed upon Clinic and Community Health Centre Committees and Hospital Boards and will ensure the appointment of permanent Boards which will assist in service delivery. During 2008/09 these structures were operating on an interim basis.

The KZN Health Act allows for the formation of a formally appointed Provincial Health Research and Ethics Committee to monitor health research in the Province and set the research agenda based on public health needs.

⇒ PRIORITY 1: REDUCING LITIGATION COSTS AND ANALYSING TRENDS

Litigation costs for the Department have been reduced by settling matters, closing dormant files and ensuring expert reports from appointed expert witnesses are received. The process of managing litigation occurs under severe constraints as cases are governed by court timeframes and the Component has limited capacity in terms of human resources. Pre-litigation preparation is co-ordinated from this component, including consultations with Counsel and expert witnesses. Timeframes and deadlines might be inadvertently missed due to the shortage of staff.

Experts from the Nelson Mandela School of Medicine (UKZN) are utilised as experts, as expert reports are required to determine liability in medico-legal cases. These experts assist the Department under their own challenges of severe work pressure and are sometimes reluctant to opine on matters involving colleagues. In these instances, external independent experts are sourced hence increasing costs. Matters involving Obstetrics and Gynaecology are still high risk factors for the Department and have proven to be high cost drivers, especially where future medical costs are claimed.

! CHALLENGES

- Limited human resource capacity resulted in challenges in meeting timeframes and deadlines.
- Availability of expert witnesses to assist the Department on case reports to determine liability in medico legal matters.
- Obstetrics and Gynaecology have been identified as high cost drivers for the Department, especially where future medical costs are claimed by plaintiffs.

⇒ PRIORITY 2: REDUCE ADVERSE JUDGMENTS AGAINST THE DEPARTMENT

The Office of the State Attorney is provided with timeously instructions to ensure that no adverse judgements were awarded against the Department. The implementation of

the Litigation Policy aims to reduce adverse risks such as default judgements being awarded against the Department, and ensure that all Components and Institutions are aware of the processes to be followed with regards to litigation matters.

Missing medical records creates a problem as the Department was not in a position to defend itself against civil litigation resulting in the Department settling out of court. This raises a concern around record keeping, security and confidentiality of patient information. In instances where the plaintiff is found to be in possession of the patient records, an urgent application is lodged increasing litigation costs.

! CHALLENGE

- Missing medical records results in increased litigation costs.

⇒ PRIORITY 3: REPORTING OF PROFESSIONALS CONDUCT TO STATUTORY BODIES

Matters settled in court are referred to the Area General Managers Offices for internal investigations and disciplinary action, if necessary. It has been noted that several institutions opted to deal with professional competence matters internally, and do not always report them to the statutory councils. There is a risk involved with this practice as adverse events may be repeated if professional competence is not addressed. The recovery of costs incurred is also hampered in this situation.

! CHALLENGE

- Professional incompetence not reported to statutory councils can lead to offences being repeated.

⇒ PRIORITY 4: INSTITUTING RECOVERIES IN TERMS OF THE PUBLIC FINANCE MANAGEMENT ACT (PFMA)

The existing Acknowledgement of Debt (AOD) has not been approved or ratified and therefore makes recovery of funds difficult, forcing the Legal Services Unit to limit this method to collusion matters only.

Recovery of monies for medico-legal matters is difficult especially in instances where the incident was not reported to the professional body and disciplinary proceedings were not instituted. Recoveries take the form of civil action, if the matter is settled prior to going to trial.

! CHALLENGE

- Recovery of monies takes the form of civil action in respect of Medico-legal matters where the incident was not reported to the professional body and disciplinary proceedings were not instituted.

⇒ PRIORITY 5: LEGISLATIVE DRAFTING AND INTERPRETATION AND WELL RESEARCHED LEGAL ADVISORY SERVICES

Service delivery has been affected by inadequate SCM processes with regards to legal advisory services and legislative drafting.

! CHALLENGES

- Shortage of human and physical resources impacted on delivery.
- Inefficient SCM processes jeopardised legislative drafting and legal advisory services.

NOTES

CORPORATE GOVERNANCE AND ISC

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities - 2008/09

Priority 8: Planning, budgeting and monitoring and evaluation.

↓

Provincial Strategic Plan 2005 - 2009/10

Goal 5: Infrastructure investment in health technology, communication, management information systems and buildings.

↓

Annual Performance Plan 2008/09

Goal 3

Strategic Objective 15: To ensure that key support services are effectively provided.

↓

Corporate Governance & ISC Priorities 2008/09

1. To strengthen the record and document management system to ensure compliance with the National Archives Act, 1996 and other related legislative prescripts.
2. To implement the donor co-ordination framework in order to streamline processes and procedures and ensure compliance with the Official Development Assistance policies, the PFMA and the relevant Treasury Regulations.
3. To improve the general work environment at Head Office in terms of the health and hygiene aspects.
4. To enhance revenue collection and revenue recovery in terms of shared utilities at the Head Office.
5. To facilitate the process of co-ordination of activities in respect of Youth, Gender, Disability and Special Focus Groups.
6. To strengthen the investigation services within the Department in order to address fraud and corruption.
7. To formalise the appointments of Hospital Boards in line with the relevant legislative prescripts.

EXECUTIVE SUMMARY

The portfolio of the Corporate Governance and ISC Unit was reviewed during 2008/09 and the IGR and Human Resource functions relocated to the office of the MEC and Human Resources Management Services respectively. In addition, the Corporate Services model which included Supply Chain Management and Financial Administration functions was not fully implemented as a result of ExCo decisions taken previously. The ISC functions that were performed by the Unit were limited to donor coordination services and ad hoc activities as and when they arose.

Other functions were added to the Unit in the previous financial year i.e. investigative services, the Joint Health Establishment (since relocated to Human Resource Management services) and management of the Registrar Programme. Location of the Youth, Gender, Disability and other Special Focus Groups function is still being considered and the Unit was assigned custodianship as an interim arrangement. In spite of the profound impact of these changes the Unit continued to deliver on its mandate.

- The introduction of revenue recovery and revenue generation mechanisms resulted in an increase in revenue for parking facilities, shared utilities and telephony from tenant departments.
- The re-established systems for record and document management are now maintained in accordance with the National Archives Act, 1996.
- The Donor Coordination Framework, acknowledged by Provincial Treasury, has been utilised in the development of the Practice Note for the Province.
- Investigative mechanisms and processes to address fraud and corruption in the Department have been improved to enhance case management.
- Implementation of the turnaround strategy to streamline recruitment and selection processes for the Registrar Programme has increased efficiency, overall coordination and control, and ensured compliance with policies and prescripts.
- Appointment of Hospital Board members is now in line with relevant legislative prescripts following an audit on Hospital Boards and consequent review of processes.

The major cost drivers for 2008/09 were Compensation of Employees (COE), municipal services, telephones (including cell router system), security services to Head Office and maintenance of Head Office buildings.

Part B – Programme 1: Administration

POLICIES

Table 11: Acts, Policies, Protocols & Guidelines

Acts, Policies, Protocols & Guidelines 2008/09	Comments including strategies to strengthen policy implementation & monitoring
1. Donor Co-ordination Framework, Guidelines & General Information for Donor Funded Projects and Donations.	• The document is aligned to key priorities identified for the reporting period, has been circulated and is available on the Intranet. • The donations procedure is being adhered to and is an enabling mechanism for the enhancement of service delivery through donations/ donor funding received.
2. Parking Policy for the Department.	• The Policy, aligned to the PFMA, was adopted in July 2008 and is being implemented. • This was an identified priority and implementation has enhanced revenue collection.
3. Telephone Policy for the Department.	• The Policy is aligned to the PFMA and implementation has resulted in decreased costs and enhanced revenue recovery. • Service delivery has not been compromised with the implementation of this policy but the utilisation of the official telephone for private calls has been minimised.
4. Procedure Manual for Record and Document Management.	• The manual is fully aligned to the National Archives Act, 1996 and was widely distributed by way of a circular and is available on the Intranet. • Enhanced record and document management at Head Office and institutions ensures preservation of institutional memory and history.

PERFORMANCE

Despite the substantial changes in the functions of the Unit, the fact that additional functions did not transfer with the requisite human resources, inadequate financial allocation and human resources, the Unit continued to deliver although was not able to fulfil all the objectives as reflected in the 2008/09 Annual Performance Plan.

The major cost drivers during 2008/09 were:

- COE - 39% spent from the Units budget and 95% from the Registrar Programme budget;
- Goods and Services (R 22,419,000) - Municipal services (40%); Telephony including cell router system (22%); Security services to Head Office (14%).
- High cost of maintenance of Head Office buildings due to ageing infrastructure.

Significant improvements have been introduced for the management of the Registrar Programme. The turn-around strategy, aimed at streamlining the recruitment and selection processes, increased efficiency, overall coordination and control, and ensured compliance with Departmental policies and prescripts.

Phase 1 of the Luwamba Project, to which the Department contributed R2 million, was completed in 2008/09 and launched in April 2009.

One of the objectives emanating from the previous Annual Performance Plan was to strengthen collaboration between the University of KwaZulu-Natal and the Department with specific reference to the Joint Health Establishment. This aspect was removed from the Unit's portfolio and a Task Team was appointed by the MEC to deal with this matter.

! CHALLENGES

- Inadequate human resources led to severe pressure on the functionality of the Unit and the ultimate achievement of certain objectives. Challenges were mainly related to youth, gender and disability activities, investigation of alleged fraud and corruption, and the implementation of the Donor Coordination Framework.
- Inadequate budget for Goods and Services prohibited implementation of projects to improve the work environment for employees.
- Non-finalisation of the Head Office organisational structure and changes made to the Unit's portfolio impacted on the capacity to deliver on newly acquired mandates and morale of staff.
- The absence of a Multi-Year Plan for Head Office, coupled with the age of the building and delays in the awarding of periodic tenders, posed serious

challenges to the provisioning of corporate services.

- Delayed supply chain management processes delayed the implementation of property maintenance projects.

⇒ PRIORITY 1: STRENGTHEN THE RECORD AND DOCUMENT MANAGEMENT SYSTEM IN COMPLIANCE WITH LEGISLATION

The record and document management system was improved and complies with the National Archives Act, 1996. Compliance was strengthened through ongoing technical support, monitoring visits to 16 institutions and in-service training in accordance with identified institutional needs. The improved management systems strengthened the control environment with regard to the maintenance and security of records and documents of archival value. The process to streamline and consolidate the filing needs of Head Office Units and Components is on-going.

⇒ PRIORITY 2: IMPLEMENT A DONOR COORDINATION FRAMEWORK IN LINE WITH LEGAL PRESCRIPTS

The Framework has been finalised, disseminated and is available on the Departmental intranet. Compliance with the procedure to accept donations of a once-off nature in either cash or kind was strengthened and all recorded donations have been disclosed to the Departmental financials. The Framework has been acknowledged by Provincial Treasury and was utilised for the development of a Practice Note for the Province.

! CHALLENGES

- Staffing capacity, coupled with severe financial constraints, delayed full implementation and monitoring of the Framework at institutional level.
- Compliance with the reporting requirements of donor funded projects remained a challenge.

⇒ PRIORITY 3: IMPROVE THE GENERAL WORK ENVIRONMENT AT HEAD OFFICE IN TERMS OF HEALTH AND HYGIENE

Deep cleaning was completed in the Natalia Building for the first time in ten years, and the fumigation programme that commenced in 2008/09 shows improved pest control in the six Head Office buildings. Maintenance services in Head Office have been improved with the appointment of artisans for day-to-day maintenance and repairs.

! CHALLENGES

- Financial constraints and a number of vacant posts impacted on maintenance of the six Head Office buildings.
- Inability to procure office furniture, equipment, etc. due to cost containment measures seriously impeded the provisioning of corporate services to Head Office.
- Ageing infrastructure and the absence of a multi-year plan led to continued and frequent breakdown of air conditioners and lift services at Natalia Building.
- Insufficient office accommodation and parking has further exacerbated maintenance costs. Head Office is spread across six buildings in the city, with five other departments sharing offices and parking in the Natalia Building. This resulted in major cost drivers in terms of leases, rentals, security, cleaning services and general maintenance and repair.

⇒ PRIORITY 4: ENHANCE REVENUE COLLECTION AND REVENUE RECOVERY

Improved billing systems for parking and telephones increased revenue collection and recovery.

The successful implementation of the parking policy improved revenue collection and control of parking facilities. A total of R50,080 was recovered from two tenant Departments during 2008/09.

Implementation of the telephone policy reduced telephony costs considerably. Revenue has been recovered from Head Office staff to the amount of R35,821 and from tenant departments (full telephony costs) to the amount of R2,329,870 totalling R2,365,691. Implementation of the cell barring system resulted in significant cost saving.

! CHALLENGES

- Three out of five tenant departments do not reimburse the Department of Health for parking fees which impacted negatively on revenue collection and general maintenance and upkeep of the building. The matter has been referred to Provincial Treasury for consideration and fines have been imposed for parking transgressions.
- Compliance to telephone policy is still a challenge that

impacts on recovery of monies for private calls.

⇒ PRIORITY 5: COORDINATION OF ACTIVITIES FOR YOUTH, GENDER, DISABILITY AND SPECIAL FOCUS GROUPS

The Unit co-hosted the 3rd National Youth Health Indaba with the National Department of Health in June 2008. A full report was submitted to the Social Sector Cluster Technical Committee in line with the Provincial Programme of Action requirements. An article on the event featured in the Youth for Life 2008 publication.

! CHALLENGE

- Incomplete restructuring impacted on this function, especially with regards to location, staffing and operational activities.

⇒ PRIORITY 6: STRENGTHEN INVESTIGATION SERVICES WITHIN THE DEPARTMENT TO ADDRESS FRAUD AND CORRUPTION

Following a review of the investigative services in the Department a number of interventions were implemented to improve investigation processes and strengthen mechanisms to address fraud and corruption in the Department. A total of 111 investigations were finalised, and recommendations approved for implementation at institutional level. The Unit commenced with a concept document for a database to improve case management and reporting.

! CHALLENGES

- Case reporting and shortage of staff impeded investigations, including the turn-around time for finalisation.
- Centralised case management and monitoring could not be implemented due to staff shortages and the overall structure of the component.

⇒ PRIORITY 7: FORMALISE APPOINTMENT OF HOSPITAL BOARDS IN LINE WITH RELEVANT LEGISLATIVE PRESCRIPTS

An audit of existing Hospital Boards was completed in 2008/09. Results informed the development of procedures and processes to guide the appointment of board members, which is now in line with relevant legislative prescripts.

! CHALLENGE

- Compliance with procedure at institutional level is a challenge.

AUDIT AND RISK MANAGEMENT

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

Annual Performance Plan 2008/09

Goal 3

Strategic Objective 15: To ensure that key support services are effectively provided.

↓

Audit and Risk Management Priorities 2008/09

1. To ensure the provision of effective and efficient risk management support services.

PERFORMANCE

⇒ PRIORITY 1: ENSURE THE PROVISION OF EFFECTIVE AND EFFICIENT RISK MANAGEMENT SUPPORT SERVICES

The Audit and Risk Management component has performed a transversal function across the Department in that it dealt with audit matters affecting all health institutions and ensured that risks were identified and mitigated through the implementation of internal control measures. The component has worked closely with the Office of the Auditor-General and the Internal Audit Unit of the Provincial Treasury in the execution of its duties.

During the 2008/09 reporting period, the Department was subjected to a multitude of audits by the Office of the Auditor-General as well as by the Internal Audit Unit. These audits include audits of the financial statements of the Department as well as that of the Provincial Pharmaceutical Supply Depot (PPSD), a trading entity in the Department, as well as regular audits at thirteen (13) institutions, Head Office and the various Conditional Grants. The Auditor-General also undertook a review audit of the general Computer Controls Information System (SAP) at the Inkosi Albert Luthuli Central Hospital as well as commenced performance audits on the "Investment in Infrastructure" as well on the Public Private Partnership at the Inkosi Albert Luthuli Central Hospital.

In addressing the various audit queries, the Departments' Audit and Risk Management Component had developed Risk Mitigation Plans and subsequently met with the senior management officials of the audited entities and discussed the identified risks, as well as the risk mitigation plans. In addition, Risk Owners and Action Owners were identified and timeframes were agreed upon to address the identified risks. Further, review audits were conducted to verify the responses that were supplied by the institutions as well as to check on the status of the implementation of the action plans. In this regard, new Risk Response Plans were developed in relation to the findings of the review audit, which were communicated to the institutions.

The Department has, as part of its risk management strategy, conducted risk assessment exercises to determine the material risks to which the Department may be exposed to, and to evaluate the strategy for managing the identified risks. These exercises have involved the documenting of systems, procedures and processes with regards to risk areas at a functional/ operational level and to prioritise them within each focus area that has the highest potential to impact (positively or negatively) on the achievement of the Departments'/ Institutions' objectives. The functional/ operational focus areas of the risk assessments that have been developed involve financial management, supplies administration, procurement administration, human resource management, security administration as well as transport management.

The component had also embarked on and finalised various risk management initiatives as part of its strategy to combat fraud and corruption. In this regard numerous workshops were conducted in 2008/09 with the target audience being all officials falling within the management cadre/echelon. The campaign included *inter alia* workshops on the fundamentals of Risk Management, its effectiveness and analysis of the processes involved in mitigating potential risks; Fraud Prevention, which included the rollout of the Fraud Prevention Plan as part of the Departments' Strategy in reducing the incidents of fraud and corruption as well as presentations on Corporate Governance, which incorporated a module on the relevant sections of the Public Finance Management Act.

The Component has also been responsible for the management of the special project "Operation Cure" which is aimed at rooting out procurement related corruption in the Department. During the reporting period various suppliers as well as seven (7) officials of the Department were convicted on a total of 360 counts of corruption, 8

counts of fraud and 22 counts of money laundering. Further, the Department has been awarded compensation in the amount of approximately R 2.8 million emanating from these convictions.

SUPPLY CHAIN MANAGEMENT

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities - 2008/09

Priority 8: Planning, budgeting and monitoring and evaluation

↓

Provincial Strategic Plan 2005 - 2009/10

Goal 4

Human Resource Management for Public Health

↓

Annual Performance Plan 2008/09

Goal 3

Strategic Objective 14: To ensure that Supply Chain Management effectively & efficiently supports the service delivery needs of all institutions

↓

Supply Chain Management Priorities 2008/09

1. Development of a Specification Catalogue.
2. Intensive training on SCM prescripts.
3. Development of Asset Registers.
4. Development of a Contract Register.

EXECUTIVE SUMMARY

The appointment of three Area Coordinators during 2008/09 contributed towards achievements of Supply Chain Management (SCM) targets. Technical support was provided to all institutions and SCM practitioners within the Department. An Asset Management Register was developed and implemented during 2008/09. The Contract Management Register is still being discussed and reviewed with SITA.

POLICIES

Table 12: Acts, Policies, Protocols & Guidelines

Acts, Policies, Protocols & Guidelines 2008/09	Comments including strategies to strengthen policy implementation & monitoring
1. Supply Chain Management Monitoring & Evaluation Tools.	• Improved monitoring of performance.
2. Development of SCM Spent Analysis Monitoring Tool.	• Identification of high cost drivers which enabled management to plan for transversal contracts which will control the procurement spending.

PERFORMANCE

⇒ PRIORITY 1: DEVELOPMENT OF A SPECIFICATION CATALOGUE

A specification catalogue has been developed during 2008/09 and is being implemented. The finalisation of bids has been an area of concern due to the limited technical expertise available to develop specifications and limited human resources to conduct market research into bid specifications. Due to the shortage of staff, short-term contracts for temporary staff have been arranged to ensure continuity of services. Turn-around times for the finalisation of bids have improved during 2008/09.

! CHALLENGE

- Shortage of staff impacted on performance against targets.

⇒ PRIORITY 2: INTENSIVE TRAINING ON SCM PRESCRIPTS

All SCM Practitioners received training and improved application of SCM prescripts is noticeable. Review of the interim SCM delegations commenced in 2008/09 including the MANCO resolution to increase the delegation for the General Manager SCM to R500,000 to assist with the replenishment of stock at CPS. This has reduced the lead-time for the procurement of stock and better deals have been negotiated through bulk purchases. The turn-around time for stock requests has improved and stock-outs have been reduced.

It was identified in 2007/08 that BEE entities failed to respond appropriately when completing tender documents, coupled with the high incident of failure to comply with delivery timeframes. Targeted Enterprises was established and tasked to support BEE business enterprises during this process.

Although 40% of the Procurement Plans were received, the process was not continued due to financial constraints, therefore adherence wasn't measured.

! CHALLENGES

- Limited technical expertise in compiling specifications for tenders / quotations.
- BEE entities fail to respond appropriately when completing tender documentation and comply with delivery timeframes.

⇒ PRIORITY 3: DEVELOPMENT OF AN ASSET REGISTER

The procurement of the asset management electronic system (HARDCAT) has been put on hold due to financial constraints. In the interim, Asset Management Controls have been implemented utilising the Asset Register and the appointment of Asset Controllers and Sub-Inventory Controllers. Inventory lists have also been developed and posted at strategic areas with stock taking conducted on a quarterly basis.

! CHALLENGE

- Financial constraints resulted in HARDCAT not being purchased or implemented.

⇒ PRIORITY 4: DEVELOPMENT OF A CONTRACT REGISTER

In 2007/08 the tender to develop the database was awarded to SITA. SCM is currently reviewing this system as it does not meet any of the SCM specifications or requirements as it cannot be utilised as a monitoring and evaluation tool for SCM processes.

FINANCE MANAGEMENT

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities - 2008/09

Priority 8: Planning, budgeting and monitoring and evaluation

↓

Provincial Strategic Plan 2005-2009/10

Goal 5: Infrastructure investment in health technology, communication, management information and buildings

↓

Annual Performance Plan 2008/09

Goal 3

Strategic Objective 15: To ensure appropriate financial delegation and controls

↓

Finance Management Priorities 2008/09

1. Building financial capacity at institutions.
2. Improving monitoring of financial processes for the Department.
3. Enhance revenue collection for the Department.

EXECUTIVE SUMMARY

The Finance Management Cluster consists of 2 Units, namely Supply Chain Management & Budget and Accounting Services. Accounting Services consists of 3 Components namely Monitoring & Evaluation, Technical Support and Expenditure & Revenue.

In 2008/09 the Monitoring, Evaluation and Technical Support Component developed an effective monitoring schedule for suspense accounts, outstanding supplier accounts and accounts for employees that have left the Department. Institutions were trained on the compilation of reconciliation of suspense accounts and received ongoing technical support on financial management.

The Taxation Sub- Component complied with timeframes and submitted the reconciliation of the EMP 201 before the 7th of each month and the annual EMP 501 on 28 August 2008. The Banking Sub-Component cleared related accounts daily and reconciled all allocated suspense accounts on a monthly basis are submitted to Treasury. The Reporting Sub-Component reconciled BAS and PERSAL with reconciliations of IDA accounts which were submitted monthly. Interim Financial Statements were submitted on 31 December 2008 with the Annual Financial Statements for the Department and PPSD submitted on 30 May 2008 .

POLICIES

Table 13: Acts, Policies, Protocols & Guidelines

Acts, Policies, Protocols & Guidelines 2008/09	Comments including strategies to strengthen policy implementation & monitoring
1. Rolling out of Accounts Reconciliation Schedule to the institutions.	• To strengthen the management of suspense accounts in the Department.
2. Employees that have left KZN Health Service.	• To strengthen the management of exits from the Department and terminations on PERSAL.
3. Outstanding payments schedule.	• Strengthened management of supplier accounts and finances in the Department.
4. Patients fees Accruals template.	• Improved revenue recovery monitoring processes.
5. Prohibition on spending on non-health related items was introduced.	• Decreased spending on non-health service related items in the Department.

PERFORMANCE

⇒ PRIORITY 1: BUILDING FINANCIAL CAPACITY AT INSTITUTIONS

All institutions were visited on a monthly basis during 2008/09 during which time Institutional Finance Managers received training on financial management and competencies enhanced.

! CHALLENGE

- Moratorium on filling of posts has led to shortage of staff, especially with regards to Accounting Services staff. Temporary staff have been employed to ensure that core functions of the Accounting Services Unit

were achieved.

⇒ PRIORITY 2: IMPROVE MONITORING OF FINANCIAL PROCESSES FOR THE DEPARTMENT

New monitoring schedules were implemented in 2008/09 to strengthen monitoring and support. Monthly district visits and quarterly road shows improved the regular review of finances and expenditure, highlighted areas of concern to institutional management, and identified capacity or training needs that were addressed through focussed on-the-spot training and capacity building. Expenditure on non-health related items has decreased since this initiative commenced.

⇒ PRIORITY 3: ENHANCE REVENUE COLLECTION FOR THE DEPARTMENT

Roles and responsibilities within Central Revenue have been streamlined and with ongoing training should enhance revenue collection. During 2008/09, a Patient Fees Accruals Template was introduced in an effort to improve revenue recovery. All health departments participated in the Annual Review of Tariffs during 2008/09.

TELEHEALTH AND INFORMATION TECHNOLOGY

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities – 2008/09

Priority 6: Strengthen support services

↓

Provincial Strategic Plan 2005 - 2009/10

Goal 5

Infrastructure investment in health technology, communication, management information systems and buildings

↓

Annual Performance Plan 2008/09

Goal 2

Strategic Objective 9: To ensure equitable & appropriate distribution of tele-health & information Technology (IT) resources.

EXECUTIVE SUMMARY

Due to severe financial constraints the Telemedicine (and Information Technology (IT) Unit could only maintain the existing services through the State Information Technology Agent (SITA) Service Level Agreements. The Unit was unable to implement critical new projects, e.g. the development and implementation of the Master Systems Plan, upgrading of data lines in hospitals, the implementation of the Hospital Information System, implementation of telemedicine, etc.

POLICIES

Table 14: Acts, Policies, Protocols & Guidelines

Acts, Policies, Protocols & Guidelines 2008/09	Comments including strategies to strengthen policy implementation & monitoring
1. State Information Technology Agency Act 88 of 1998 (as amended).	• All Information Technology goods and services should be procured through this contract.
2. Electronic Communications & Transactions Act.	• The objects of this Act are: to enable and facilitate electronic communications and transactions in the public interest; to provide for the development of a national e-strategy for the Republic; to promote universal access to electronic communications and transactions and the use of electronic transactions by SMME's; to provide for human resource development in electronic transactions; to prevent abuse of information systems; to encourage the use of e-government services; and to provide for matters connected therewith.
3. Information Security Policy.	• The policy serves as a guideline for Departmental officials to assist in effecting legitimate changes to all existing system components. All applications for change will be channelled through the Information Technology Section, through a process of evaluation, decision making and implementation in a controlled manner, thereby ensuring that requested changes are necessary and add value to the line function, and all inter-operability aspects are investigated in compliance with the Minimum Inter-operability Standards (MIOS) document issued by the DPSA (Department of Public Service and Administration) as well as the current IT standards as defined by the Information Technology Section.
4. DPSA Guidelines on the functions and reporting of a Government Information Technology Officer (GITO) or Chief Information Officer (CIO).	• Information, Communication and Technology (ICT) is a strategic key to Service Delivery; therefore the reporting of the GITO/CIO to the Head of the Department is crucial.

PERFORMANCE

The IT and Telemedicine Unit has been under-funded for the last 3 years resulting in extensive delays in the implementation of critical projects i.e. Master Systems Plan. Inadequate IT systems have serious implications for service delivery especially with relation to data quality and utilisation that should inform decision-making and planning. Vertical and/or fragmented systems thus continue to impact on data availability and quality as well as waste limited resources.

Table 15: Information Technology Budget allocation versus Cost of Services

Financial Year	Budget	Cost of Existing Services
2006/07	R 100m	R 115m
2007/08	R 100m	R 130m
2008/09	R 100.7m	R 158m

Upgrading of the existing 128K lines to 1MB at the 5 Revitalisation sites (using National Department of Health funds) and the implementation of Meditech Hospital Information System are still in progress. Benefits of this system, aimed at improving management of patients and health resources, will contribute to evidence-based planning and decision-making.

The turn-around time of processing Service Level Agreements (SLA's) between the Department of Health and SITA, remains a challenge. Telehealth poses serious challenges as (i) various companies are currently responsible for maintenance of different components of the overall system i.e. medical equipment, data lines, and video conference; (ii) there is no telemedicine manager driving the service/project; (iii) technical support in sites; (iv) and budget. A single provider should be appointed for maintenance of the entire system. Seventy (70) percent of the ninety (90) kiosks were operational in 2008/09.

Little progress has been made with the development and implementation of the Master Systems Plan (MSP). The tender has been awarded in 2008/09 and the draft implementation plan presented to the Health Operations Committee. No further progress due to financial constraints.

! CHALLENGE

- Delay in implementation of the MSP due to financial challenges.

The implementation of Telemedicine has been hampered by numerous challenges both internal and external. The lack of a dedicated post within the Department to drive Telemedicine has exacerbated the situation further. One of the main reasons for non-implementation of this programme is the bandwidth and connectivity to rural areas. Other factors include the lack of IT support at peripheral hospitals, lack of diagnostic instruments and insufficient training of medical staff in telemedicine - all directly attributed to budget constraints.

The value of electronic data capturing at grassroot level (PHC service entry point) is well recognised and would contribute towards improved data quality and evidence-based planning, hence improving service delivery and health outcomes. Although great strides have been made in the provisioning of computers and printers to PHC services, the biggest challenge is to improve computer literacy at facility level. Staff shortage and financial constraints delayed training programmes resulting in under-utilisation of purchased equipment. This situation is exacerbated by the moratorium placed on training due to over-expenditure in 2007/08 and 2008/09, which led to the closure of the computer training centres. The backlog in training as a result of this will be difficult to address in 2009/10.

A uniformed electronic patient administration system for all tertiary hospitals was planned for implementation during 2008/09. This has been postponed due to budget constraints. Below is the anticipated implementation schedule.

- 2009/10 - 5 Hospitals on the Revitalisation project + 6 pilots.
- 2010/11 - All Regional Hospitals.
- 2011/12 - 50% of District Hospitals.
- 2012/13 - Remaining 50% of District Hospitals.
- 2013/14 - All CHC's + 50% of PHC clinics.
- 2014/15 - Remaining 50% of PHC clinics.

HEALTH SERVICE PLANNING, MONITORING & EVALUATION

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities 2006-2008/09

Priority 1: Improve Governance and Management of the Health System.

Priority 6: Strengthen support services.

↓

Provincial Strategic Plan 2005-2009/10

Goal 3: Promote health, prevent and manage illnesses with emphasis on poverty, lifestyle, trauma and violence.

Goal 5: Infrastructure investment in health technology, communication, management information systems and buildings.

↓

Annual Performance Plan 2008/09

Goal 1 and Goal 2

Strategic Objective 4: To ensure integrated planning for the provision of health services.

Strategic Objective 6: To provide Geographical Information Systems (GIS) service for health planning & service delivery.

Strategic Objective 7: To improve the quality and use of health data.

↓

Health Service Planning, Monitoring & Evaluation Priorities 2008/09

4.1 Monitoring & Evaluation

1. Developing a Monitoring & Evaluation Framework.
2. Sustaining Quality Assurance systems & processes.
3. Sustaining Infection & Prevention Control systems and processes.
4. Developing an Early Warning System for the Department.

Priorities 2008/09 Continue

4.2 Epidemiology

1. Conduct a Burden of Disease Study.
2. Develop Early Warning System.

4.3 Health Research & Knowledge Management

1. Process requests for approval of research in public health facilities.
2. Conduct 3 in-house research studies based on identified service delivery needs.
3. Establish a research website and maintain the research database.

4.4 Data Management

1. Roll-out of the District Health Information System (DHIS) 1.4
2. Submission of Quarterly Performance Reports.
3. Providing technical support to improve data quality.

4.5 Health Service Planning

1. Facilitate completion & submission of District Health Plans (DHP's) and District Health Expenditure Reviews (DHER's).
2. Collate and submit approved Annual Performance Plan & Annual Report as per Treasury imperatives.
3. Develop and implement the Service Transformation Plan.

4.6 Geographical Information System

1. Maintain GIS systems in support of health service delivery.

EXECUTIVE SUMMARY

In 2008/09, the Unit focussed on the development of integrated systems and processes to improve evidence-based planning and decision-making at all levels of care.

- The Provincial Result-Based Monitoring and Evaluation (M&E) Framework has been aligned with the 5-year Strategic Plan, Annual Performance Plan, District Health Plans and National Department of Health and Treasury priorities. The Framework incorporates all core indicators essential for performance measurement against strategic and measurable objectives and improved quarterly and annual reporting against performance targets.
- Core indicators has been identified in consultation with various Managers and incorporated into the DHIS 1.4 to ensure a reliable paper trail for reporting and audit purposes.
- Roll-out of DHIS 1.4 commenced to ensure an integrated health information system (replacing the previous vertical hospital system.)
- Commenced with critical analysis of core indicators and trends to determine effectiveness, outcome and impact of investment. Commenced with the mapping of

disease/ poverty profiles and health trends using geographical and spatial information. Growth and decline of priority conditions e.g. diarrhoea was profiled against service delivery indicators and Stats South Africa Community Survey 2007 data to measure outcome and impact.

- Commenced with in-house research studies (teenage pregnancy, caesarean section rate, bed occupancy rate and average length of stay) that were identified as challenges in the previous reporting cycle. Results will be available in 2009/10.
- Data collection for Phase 1 (PHC clinics and CHC's) of the Burden of Disease Study is complete. Data from the study will provide crucial information related to the disease burden in the Province.

The M&E and Epidemiology Components commenced with the development of an Early Warning System Framework to improve pro-active planning and timely response to health challenges. The Early Warning Surveillance System for Infection Prevention & Control (IPC) is functional in all facilities.

POLICIES

Table 16: Acts, Policies, Protocols & Guidelines

Acts, Policies, Protocols & Guidelines 2008/09	Comments including strategies to strengthen policy implementation & monitoring
1. Guidelines for the Development and Submission of Research Proposals and Clinical Trials. Approved by Provincial Health Research Committee.	• Guidelines available on the Health Research & Knowledge Management website. Good response has been received from service providers including research organisations. Quality of proposals improved resulting in reduced turn-around time for approval of research (<10 days - with an average of 5 working days).

PERFORMANCE

Monitoring and Evaluation

⇒ PRIORITY 1: DEVELOPMENT OF A PROVINCIAL MONITORING AND EVALUATION FRAMEWORK

To improve monitoring & evaluation and ensure diligent performance measurement at all levels of the health system, the M&E Component, through extensive consultation, commenced with the development of a Provincial Result-Based Monitoring and Evaluation (M&E) Framework, informed by the M&E Systems Situational Analysis. Draft 1 of the Framework, including a concept paper and implementation plan, was distributed for comments in January 2009. Finalisation of the M&E Framework is expected in 2009/10.

The Framework has been aligned with the Strategic, Annual Performance and District Health Plans and incorporates all core indicators essential for performance measurement against strategic and measurable objectives. Close collaboration with the Provincial Strategic Planning and Data Management Components as well as Programme and M&E Managers at both Provincial and District levels ensured alignment of Provincial and District Quarterly Reporting (including National Treasury and National Department of Health priorities) against core indicators to guarantee seamless reporting against priorities.

Quarterly Reporting indicators have been aligned to the Annual Performance and District Health Plans' indicators to improve focussed results-based quarterly reporting. Identification of core indicators in collaboration with Data Management, the Area Principal Technical Advisors, District Deputy Managers (Planning, M&E) and Strategic Planning have substantially decreased the number of indicators to be reported on and in so doing improved data completeness and quality.

Validation of data is done at every level before collation of the Provincial Quarterly Report done by the Provincial M&E Component where final validation of data is done. Current timeframes for reporting, as determined by National Treasury, posed a challenge to reporting and validation of data and therefore still impacts on ultimate data completeness and quality.

Regular feedback and consultation with M&E and Programme Managers have been sustained in 2008/09 to ensure timely responses to identified challenges. An on-line reporting system will be pursued in 2009/10 to streamline reporting and ensure improved access to data for planning and decision-making purposes.

The M&E Component, in collaboration with Epidemiology, commenced with the development of an Early Warning Systems concept paper to inform the development of the Provincial Early Warning System Framework. This will ensure timely and pro-active response to identified risk situations. This process will continue in 2009/10.

! CHALLENGES

- Finalisation of indicators (including definitions) for inclusion in the Framework. *Finalisation of the next 5-year Strategic Plan should assist with this process.*
- Financial constraints impacted negatively on capacity building programmes as well as the development of inventive systems to improve quarterly reporting i.e. on-line reporting.
- Unrealistic timeframes for submission of data impacted on data completeness and quality. *It is expected that the implementation of DHIS 1.4 should improve validation of DHIS data.*
- Discrepancies in routine data are still a major concern. *Continued feedback and collaboration with M&E and Programme Managers is expected to improve validation and quality.*
- Regularisation of Monitoring and Reporting at MANCO level. *If this is a standing item on a quarterly basis, then alignment to the Departmental Strategic Plan and Annual Performance Plan monitoring, Annual Reporting and subsequent reviews will be enhanced. Greater accountability to agreed outcomes in the respective plans will be encouraged.*

⇒ PRIORITY 2: SUSTAINED QUALITY ASSURANCE SYSTEMS AND PROCESSES

The draft Quality Assurance Policy is in the consultation phase and will be finalised in 2009/10. It is envisaged that the policy will improve integration of core standards and criteria at service delivery level as well as integrated reporting.

Thirteen facilities participated in the 2008/09 Departmental Service Excellence Awards competition. Three hospitals excelled i.e. Christ the King Hospital (Bronze award sponsored by the Metropolitan Umgungundlovu Branch), GJ Crookes Hospital (Silver award sponsored by Lechoba Medicals) and Estcourt Hospital (Gold award sponsored by Phill Medic Services CC). Four hospitals received Certificates of Commendation i.e. Bethesda, Eshowe, EG & Usher Memorial and St. Apollinaris Hospitals. One clinic (Mndozo clinic) and four hospitals received Certificates of Participation i.e. Benedictine, Lower Umfolozi War Memorial, Newcastle, Ngwelezana and Northdale Hospitals.

External Client Satisfaction Surveys were last conducted in 2005/06 due to delays with the tender process. Internal Client Satisfaction Survey's, using the National Tool, have however been conducted by 85% of District Hospitals, 70% of Provincial Hospitals and 100% of Tertiary/ Central Hospitals. According to the 2008/09 published results the main challenges were negative staff attitudes, poor utilisation of complaints procedures by clients, inadequate cleanliness of ablution facilities and treatment procedures/ client rights not being explained to clients. These challenges will receive attention in 2009/10.

Waiting Time Surveys were conducted in districts and some improvements were noted from districts.

! CHALLENGE

- Financial constraints and delays in tender processes jeopardised the External Client Satisfaction Survey which might impact on client participation and satisfaction.

⇒ PRIORITY 3: SUSTAINED INFECTION PREVENTION AND CONTROL SYSTEMS AND PROCESSES

The Early Warning Surveillance System for Infection Prevention & Control (IPC) is in place at all facilities. The University of KwaZulu-Natal (UKZN) and National Health Laboratory Services provide an early warning function related to microbiology, the development of the software to facilitate communication for early detection and technical expertise and support during out-breaks to peripheral hospitals that lack the assistance of a microbiologist.

Modules on hand washing, labour and delivery, isolation and employee health were implemented in 100% of facilities. Academic support is provided by UKZN with regards to district- and formalised training towards an Infection Control Honours Degree.

Epidemiology

⇒ PRIORITY 1: BURDEN OF DISEASE

Data collection for Phase 1 of the Burden of Disease was completed in April 2009. Data capturing commenced and should be completed at the end of May 2009. The second phase of the study, the hospital survey, is planned to commence in Jan 2010, once approval for the data-capturing tool has been received from UKZN. UKZN, through a Service Level Agreement, provides technical expertise and guidance on the implementation aspect of

this study, especially in relation to statistical data. Data analysis in collaboration with the various partners includes the Italian Co-operation, Institute of Tropical Medicine, Antwerp and the UKZN is not yet finalised due to funding constants.

! CHALLENGES

- Lack of technical expertise for result analysis and dissemination.
- Funding to fill vacant posts especially for a biostatistician and health economist is imperative.

HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT (HRKM)

⇒ PRIORITY 1: PROCESS HEALTH RESEARCH APPLICATIONS FOR APPROVAL

In 2008/09, the Health Research & Knowledge Management (HRKM) Sub-Component processed 121 research proposals of which 57 were approved for implementation and 64 'incomplete' proposals are still pending. During the same period, 12 Clinical Trial proposals were processed of which 5 were approved for implementation and 7 'incomplete' proposals are still pending. The turn-around time for approval of complete research proposals improved to 5 working days, and 10 working days for Clinical Trials.

! CHALLENGE

- Prolonged waiting time for ethics approval (average of 8 months). *Consultation commenced for the establishment of Level 1 Ethics Committees in the 3 Service Delivery Areas with Greys Committee as benchmark. This will be guided by the KZN Health Act of 2009.*

⇒ PRIORITY 2: CONDUCT 3 IN-HOUSE RESEARCH STUDIES BASED ON IDENTIFIED SERVICE DELIVERY NEEDS

Three in-house research studies commenced in 2008/09 i.e.:

- A study to determine reasons for the high Caesarean Section Rate in the Province;
- A study on Teenage Pregnancy;
- An Audit of Bed Occupancy Rates and Average Length of Stay in all hospitals in KZN. *Preliminary findings have been included in Annexure 2 of the 2008/09 Annual Report.*

The HRKM Sub-Component provided technical support for programme evaluation i.e.:

- Analysis of the Smoking Questionnaires, using the Statistical Package for Social Science (SPSS) Programme, has been conducted in 2008/09 and report has been submitted;
- Development of an evaluation tool to evaluate the outcome of the Health Promoting Schools Programme. The evaluation will commence in 2009/10;
- Development of an audit tool to determine the availability of the hospital package of services per level of care. The audit will commence in 2009/10; and
- HRKM participated in the Area 3 Learning Complex evaluation. A report was submitted.

⇒ PRIORITY 3: ESTABLISH A RESEARCH WEBSITE AND MAINTAIN THE RESEARCH DATABASE

The HRKM Sub-Component established and maintained the HRKM website to improve access to research policies and guidelines, information on development of research proposals and submission processes, research priorities (national), current research reports and general research information. [http://healthweb.kznhealth.gov.za/hrkm.htm]

The KZN research database has been established and is maintained. Health Systems Trust, contracted by the National Department of Health, is in the final stages of linking the provincial database with the national database to improve access to research information and to reduce duplication and improve utilisation of research results.

! CHALLENGE

- Unauthorised research (referring to research not being approved by the Research Committee) being conducted in health facilities is still a challenge in spite of established protocols. *Protocols and guidelines for submission of proposals on website slightly improved compliance with requirements.*

Data Management

⇒ PRIORITY 1: ROLL-OUT OF THE DISTRICT HEALTH INFORMATION SYSTEM (DHIS) VERSION 1.4

The DHIS 1.4 was rolled out to all hospitals and district offices in 11 districts in 2008/09. Data collection tools were revised in consultation with Programme Managers,

District Information Officers (DIO's) and M&E Managers at both provincial and district level to ensure effective integration into one dataset. Core service delivery indicators, aligned to the National Treasury and Department of Health priorities, were incorporated into the DHIS and the M&E Framework to improve data completeness, quality, more effective use of health data and supportive monitoring and evaluation. All District and Facility Information Officers completed the basic DHIS 1.4 training programme in March 2009, with the advanced DHIS 1.4 training scheduled for early 2009/10. Two Senior Technical Advisors were sent to the Winter School in Cape Town for the DHIS Intermediate Course where they were adequately skilled to provide technical support to district offices and institutions.

⇒ PRIORITY 2: SUBMISSION OF QUARTERLY PERFORMANCE REPORTS

Treasury Quarterly Performance Reports were compiled and submitted according to Treasury Guidelines.

⇒ PRIORITY 3: PROVIDING TECHNICAL SUPPORT TO IMPROVE DATA QUALITY

Data Management provided technical support for various projects in 2008/09 i.e.:

- Finalisation of indicators used in the Provincial M&E Framework under guardianship of the M&E Component;
- Facilitated the Ante Natal Care (ANC) Sero-Prevalence Survey in October 2008 in collaboration with the HIV and AIDS Component;
- Participated in the Vitamin A Campaign and conducted Vitamin A training for District Information Officers;
- Participated in conducting a Situational Analysis of current Mental Health indicators in three pilot districts (in collaboration with Mental Health and the University of Cape Town).

The Department commenced with the development of a web-based reporting system on a central server (hosting a relational database). The system will be linked with the Geographical Information System (GIS) and will be able to accommodate generic data requests and reports in various formats e.g. pivot tables, maps and graphs to illustrate trends, etc. This will improve access to data and reduce waiting times for programme reports. The system is expected to be operational in 2009/10.

! CHALLENGES

- Financial constraints limited technical support to districts; decreased the number of feedback meetings and training for DIOs; and delayed the roll out of the DHIS 1.4 which led to unrealistic deadlines and limited time to monitor implementation.
- Roles and responsibilities of Information Officers still pose a challenge at all levels, especially in light of current vacancy rates.
- Vertical data systems still jeopardise data quality and monitoring e.g. TB, EMRS, Notifiable conditions, etc.
- Inadequate equipment (computers and software) for health information/ data management functions. Current software specifications are unsuitable for standard requirements from Information Officers.
- Limited support from the National Department of Health Information Unit with regards to data systems and indicator definitions.
- The Provincial dataset is still too large leading to inaccurate data. *Indicators will be reviewed annually to ensure alignment with core indicator requirements.*
- Data Management Policy has not yet been finalised.
- Data quality improved slightly although it still needs to be improved in some areas.

Strategic Planning

⇒ PRIORITY 1: FACILITATE COMPLETION AND SUBMISSION OF DISTRICT HEALTH PLANS AND DISTRICT HEALTH EXPENDITURE REVIEWS

The District Health Plans (DHP's) have been aligned with the 5-Year Strategic Plan, 2008/09 Annual Performance Plan, Monitoring & Evaluation Framework and District Quarterly Reporting Format (selection of consulted core data elements). All districts completed DHP's as per requirements in the White Paper on the Transformation of Health Services in SA, the National Health Act of 2003 and with due regard to the requirements of the Integrated Development Plans in terms of the Medical Schemes Act (MSA) (Act No. 32 of 2000). All DHP's were signed off by the MEC for Health and submitted to the National Department of Health.

The Health Systems Trust, as part of a National project, provided technical support to eThekwini with the

development of the DHP and District Health Expenditure Review (DHER). All districts did not submit DHER reports in 2008/09 due to a lack of human resources to provide technical support for completion. The DHER database has not been completed as envisaged due to challenges with the service provider. This will be addressed in 2009/10.

! CHALLENGES

- Planning processes of DHP and APP not yet aligned at national level, with DHP submission dates prior to budget allocation. This resulted in poor planning and costing of intended strategies and activities.
- DHP's not yet aligned with District Human Resource Plans. *Development of District HR Plans will commence in 2009/10 with technical support from Provincial Human Resource Planning Component.*
- Due to inadequate human resources at provincial level to provide technical support as well as incomplete DHER database, the DHER's were not submitted in 2008/09. *Health Systems Trust will provide technical assistance to all districts in 2009/10.*

⇒ PRIORITY 2: COLLATE AND SUBMIT APPROVED ANNUAL PERFORMANCE PLAN & ANNUAL REPORT AS PER TREASURY GUIDELINES

In 2008/09 the Department commenced with a strategy to align the departmental planning framework through a process of consultation and feedback. This process has been aligned with the M&E Framework to ensure effective monitoring and evaluation of departmental performance against strategic and measurable objectives and targets incorporated in the Strategic and Annual Performance Plans.

The 2009/10 Annual Performance Plan and 2007/08 Annual Reports have been submitted as per Treasury Guidelines.

⇒ PRIORITY 3: UPDATE AND IMPLEMENT THE SERVICE TRANSFORMATION PLAN

The Service Transformation Plan (STP) has not been approved for implementation. The Strategic Planning Component commenced with the review of the STP and continued consultation with relevant Managers to effect inclusion of outstanding services/ programmes (i.e. Forensic and Bioethical Services, Mental Health and EMRS). Consultation will continue in 2009/10.

Geographical Information System

⇒ PRIORITY 1: MAINTAIN GIS SYSTEMS IN SUPPORT OF SERVICE DELIVERY IMPERATIVES

The GIS Sub-Component continued to represent health/ disease data from the DHIS on a spatial platform. The Sub-Component, in collaboration with Health Service Planning and Data Management, developed a composite health and poverty profile for the Province at a district/ municipal level as part of a critical analysis of health status per sub-district that will inform planning and resource allocation.

The household MDR and XDR TB have been mapped (in collaboration with the Italian Cooperation) in support of monitoring and evaluation of implementation of the Provincial Crisis Management Plan. The Cholera database has been updated to reflect the latest Census data (Community Survey 2007) which was especially relevant in light of the 2009 Cholera outbreak. The EMRS data system has been upgraded with data now based in a central warehouse which improved functionality. EMRS and Forensic Pathology data has been linked to ensure a more complete database to inform planning and decision-making.

The Component commenced with the production of district specific booklets indicating core health indicators linked with Stats South Africa 2007 Community Survey data for planning purposes. The booklets will assist with the interpretation of trends. This will be completed in 2009/10 and will be updated annually.

The online mapping website has been upgraded to ensure a more streamlined and efficient website. The website has been visited on a regular basis.

! CHALLENGES

- Data limitations i.e. census data not current, delays in availability of TB data for mapping, incomplete DHIS data.
- Inadequate human resources to respond to requests for GIS services.

PERFORMANCE INDICATORS

Table 17: NHS 1: Development of Service Transformation Plans

Activity	Indicators	2006/07 Targets	2007/08 Targets	2008/09 Targets	2008/09 Progress
Application of the Integrated Health Planning Framework.	Scenarios developed by the Province.	Completed and first draft STP submitted in May 2006.	Completed and second draft STP submitted in February 2007. Final draft submitted in May 2007.	Consultation with communities. Commence with implementation of STP.	STP has not been approved and is therefore not yet implemented.
Provincial APP.	APP Part A completed.	100% completed by end of May 2005. Approved by the HOD and MEC.	100% completed by end of May 2006. Approved by the HOD and MEC.	100% completed by end of May 2007. Approved by the HOD and MEC.	100% completed and approved.
	APP Part B.	100% completed by end of August 2005. Approved by the HOD and MEC.	100% completed by end of August 2006. Approved by the HOD and MEC.	100% completed by end of August 2007. Approved by the HOD and MEC.	100% completed and approved.
	Develop full plan for utilisation of telemedicine links to increase Specialist availability.	Plan developed by May 2007 as part of the STP.	Approval of Telemedicine Plan and commencement with Implementation.	Implementation of Telemedicine Plan.	Telemedicine Plan not implemented due to financial constraints.
Implementation Management.	Effective Planning, implementation & monitoring.	Developed strategic planning Unit closely linked to information, Monitoring and Evaluation Units.	Monitoring &E situation analysis completed. M&E Strategy formulated.	M&E framework completed and implemented. M&E System developed and implemented.	Draft M&E Framework widely consulted and available. M&E System has been developed and is being implemented.
	Timely data reporting into Quarterly Reporting System used at all levels of the health system by August 2006.	Quarterly reports submitted within the required time frames.	Quarterly reports submitted within the required time frames.	Quarterly reports submitted within the required time frames.	Quarterly reports submitted within timeframes.
	Health Information Systems.	Master Systems Plan (MSP) completed by March 2008.	Integrated hospital and patient information system implemented at all Tertiary and Regional Hospitals by March 2009.	Integrated hospital and patient information system implemented at all District Hospitals by March 2010.	Not implemented due to budget constraints.

Part B - Programme 1: Administration

Table 18: Provincial Objectives and Performance Indicators[10]

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
CORPORATE COMMUNICATIONS					
Strategic Objective 15: To ensure that key support services are effectively provided. (Goal 3)					
Measurable Objective: To provide efficient communication aligned to the Department's core functions.					
Number of media briefings.	4	4	4	4	4
Number of campaigns undertaken.	4	4	4	4	4
Provincial Council Indaba coordinated.	Not measured	1	1	1	0[11]
Imbizo per area per National Imbizo Focus Week.	5	12	12	12	15
LEGAL SERVICES					
Measurable Objective: To strengthen and maintain comprehensive legal services.					
Analysis of litigation cases.	Not measured	60%	370 cases[12]	80%	920 cases
Establishment of a compendium of all legislation.	20%	30%	80%*	70%	60%
Ad hoc legal advice rendered.	60%	60%	See Footnote[13]	70%	65%
Contract management system operational.	60%	70%	See Footnote[14]	80%	65%
CORPORATE GOVERNANCE AND ISC					
Measurable Objective: To provide effective ISC collaboration services.					
Coordination of donor services.	Not measured	30%	30%	50%	60%
Co-ordination of youth, gender and special focus groups.	Not measured	40%	40%	60%	35%
To strengthen collaboration between the University of KwaZulu-Natal & the Department.	Not measured	30%	30%	50%	See footnote[15]
Measurable Objective : To render effective and efficient corporate services to Head Office					
Coordination of General Administration Services for Head Office.	30%	45%	55%	70%	85%
Measurable Objective: To provide an effective document management system for the Head Office.					
% compliance with legal prescripts governing document - and archive management.	Not measured	30%	50%	70%	75%
% of Forms designed and systems established.	Not measured	10%	20%	40%	45%

[10] Information for previous years correspondences with information received for the APP 2009/10 unless indicated otherwise
[11] The Provincial Health Council Indaba was not held because most members have resigned. A new Council needs to be re-instituted
[12] This is an inappropriate measure for litigation as legal proceedings against or on behalf of the Department is dealt with as and when they arise and there is no specific "target" in a financial year as one cannot anticipate when or how many legal proceedings the Department will be party to
[13] This is also an inappropriate measure as one cannot anticipate what kind of or how many requests for legal advice will occur in the reporting period. The legal advice sought is wide and varied with requests for telephonic as well as for written advice. Advice is largely sought in respect of medico legal matters, legal compliance and contract issues including SCM queries and also advice in respect of Labour matters
[14] 450 Contracts drafted and managed in 2007/08
[15] Function was relocated to HRMS

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
INSTITUTIONAL SECURITY AND RISK MANAGEMENT SERVICE					
Measurable Objective: To ensure organisational integrity within the Department.					
Conduct high profile investigations in collaboration with Law Enforcement Agencies.	Not measured	50%	See Footnote[16]	80%	80%
Development of Anti-Fraud and Corruption Plan.	Not measured	80%	100%[17]	100%	100%
Measurable Objective: To strive towards the establishment of a safe and secure work environment.					
Development of a security manual relevant to the service delivery challenges of the Department.	Not measured	70%	Plan under review	100%	Not available
Vetting of staff (Percentage related to specified staff categories).	Not measured	20%	Not Measured	60%	Not available
Conduct security audit.	Not measured	20%	See Footnote[18]	60%	Not available
Implement asset protection system at all Health Institutions.	Not measured	20%	Not Measured	60%	Not available
Security advice on MEC's events.	Not measured	100%	100%	100%	Not available
Measurable Objective: To ensure the provision of effective and efficient risk management support services.					
Creation of a fully functional Risk management service.	Not measured	30%	See Footnote[19]	80%	See Footnote[20]
Development of a Departmental Risk Management Policy.	Not measured	100%	80%[21]	100%	100%
Development of Risk Management strategy for the Department.	Not measured	100%	80%[22]	100%	100%
Departmental risk profile assessments conducted.	Not measured	100%	100%*	100%	100%
Measurable Objective: To foster a risk management culture in the Department.					
Development and implementation of a Departmental Risk Mitigation Plan.	Not measured	80%	100%*	100%	100%
Conduct risk awareness programmes.	Not measured	80%	Unclear [23]	100%	40%
Ensure that risk management form an integral part of the Key Result Areas of relevant staff.	Not measured	50%	60%*	80%	30%
SUPPLY CHAIN MANAGEMENT (SCM)					
Strategic Objective14: To ensure that SCM effectively & efficiently supports the service delivery needs of all health institutions.					
Measurable Objective: To establish and maintain an integrated & developmentally orientated SCM system.					
SCM delegations approved and implemented.	60%	100%	80%[24]	100%	90%
% of Health Institutions included in training sessions on SCM.	50% of all Health	70% of all Health	100% of all Health	95% of all Health	95%

[16] Where the need arise
[17] The plan is being reviewed with the intention of revising certain aspects and process will unfold in 2008/09.
[18] Audit not complete - expected in 2008/09
[19] Head Office structure not approved/implemented.
[20] Head Office structure not approved/implemented.
[21] Awaiting approval from the Acting HOD
[22] Awaiting approval from the Acting HOD
[23] Denominator unclear for %
[24] Interim SCM delegations are being reviewed

Part B – Programme 1: Administration

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
	Institutions	Institutions	Institutions[25]	Institutions	
% of Procurement Plans completed to guide acquisition of goods and services by Head Office and Institutions.	40%	60%	75%	80%	40%
Accurate and updated asset register maintained in Institutions.	50%	60%	90%	95%	90%
Policies, processes and systems for safeguarding of assets and for inventory control developed and implemented.	40%	50%	100%*	100%	100%
Contract Management System implemented.	40%	50%	90%	100%	60%
Updated specifications for the acquisition of transversal goods and services developed and compiled in catalogue.	Not measured	55%	98%[26]	80%	100%
Logistical support systems implemented to reduce "stock outs" and improve service delivery.	Not measured	70%	80%	95%	80%
Measurable Objective: To promote business opportunities for emerging business.					
Strategic sourcing guidelines for targeted procurement formulated and implemented.	Not measured	50%	+10%*	100%	100%
% of business awarded to Small Medium and Micro Enterprises (SMME's).	+9%	+10%	+10%	40%	40%
% of businesses awarded to co-operatives.	+9%	+10%*	+10%	10%	10%
% of business awarded to persons with disabilities.	+0%	+20%	+10%	+10%	10%
% of business awarded to companies owned by the "youth".	0%	+30%	+10%	+10%	10%
% of business awarded to companies from rural areas.	+9%	+50%	+10%	+10%	10%
% of business awarded to companies owned by women.	+9%	+50%	+10%	+10%	10%
Measurable Objective: To establish & maintain performance driven Bid Specification Committees, Bid Adjudication Committees & Bid Award Committees					
Fully functional Bid Specification Committee at Head Office.	Not measured	100%	100%	100%	100%
Fully functional Bid Adjudication Committee at Head Office.	Not measured	100%	100%	100%	100%
Fully functional Bid Award Committee at Head Office.	Not measured	100%	100%	100%	100%
Required SCM Committees fully functional at all hospitals.	Not measured	90%	100%	100%	100%

[25] In addition to training provided a SCM Help Desk has been established to assist institutions
[26] Specifications are quantified as a number and are as follows: Services: 5 Specifications, Non-Medical: 23 Specifications and Medical Equipment: 70 Specifications

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Measurable Objective: To ensure community awareness on business opportunities in the Department					
Number of awareness campaigns conducted.	40	50	70	85	75%
% increase of targeted groups participating in the procurement process of the Department.	25%	30%	45%	60%	60%
Measurable Objective: To establish systems to support the acquisition of goods and services (database).					
Database established to support the acquisition of goods and services.	Not measured	40%	80%	100%	100%
FINANCIAL MANAGEMENT					
Strategic Objective 13: To ensure appropriate Financial, Procurement Delegations. (Goal 3)					
Measurable Objective: To review existing Finance delegations & realign them to ensure seamless & accountable service delivery.					
Written delegations in place.	Not measured	Not measured	Not measured	95%	Not available
Last review of written delegations.	Not measured	Not measured	Not measured	No target	Not available
Effective measures to ensure monitoring & measurement of delegations in the Department.	Not measured	Not measured	Not measured	No target	Not available
% of Departmental expenditure fruitless, unauthorised/lost due to theft.	Not measured	Not measured	Not measured	0%	Not available
% of Department's budget constituting donor funding.	Not measured	Not measured	Not measured	No target	Not available
Measurable Objective: To ensure that all finance systems & budgetary processes are aligned to the Strategic & Service Transformation objectives of the Department.					
An equitable & aligned budget.	88%*	90%*	90%	100%	Not available
Improved budget management & control.	Not measured	80%	95%	100%	Not available
Mechanism to guide prioritisation & budgeting processes for institutions.	Not measured	90%	95%	98%	Not available
Measurable Objective: To implement and maintain effective and efficient financial and revenue administration systems.					
An effective, efficient, disciplined and competent financial management at Institutions, including financial management, banking services, reporting and taxation services.	88%*	90%	Not available	97%	100%
TELEHEALTH AND INFORMATION TECHNOLOGY					
Strategic Objective 9: To ensure equitable & appropriate distribution of Telehealth & IT resources. (Goal 2)					
Measurable Objective: To expand the provision of clinical services to remote rural communities by December 2008.					
Number of tele-health sites operational.[27]	36*	37	37	37	37
Number of sites providing medical research, education & training to rural health care providers.	3	3	3	3	3
Number of sites providing access to medical research, education training to rural health providers.	3	3	3	3	3

[27] Figures obtained from the Annual Report 2007/08 as they appear to be more accurate

Part B – Programme 1: Administration

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Number of post graduate training programmes provided.	6	6	6	6	6
Measurable Objective: To acquire, install and maintain computer equipment, systems and networks supporting seamless service delivery processes.					
% redundant/obsolete Personal Computers (PC's) replaced.	25%	35%[28]	100%*	100%	60%
% of Hospitals, CHC's and Institutions other than PHC Clinics that are VPN compliant.	0%	100%	100%	100%	100%[29]
% of PHC Clinics with PC's and Printers.	8%	20%	100%*	100%	100%[30]
% of Hospitals with upgraded data lines.	Not Measured	0%	0%*	100%	0%[31]
% of Hospitals with functioning Kiosks.	0%	90%*	90%*	100%	70%
% of Health Professionals trained on Funda. La online training project.	0%	0%	100%*	50%	No information available.
Measurable Objective: To develop a MSP by December 2008.					
Master Systems Plan approved by December 2008.	0%	0%	0%	100%	See footnote[32]
All IT & Data Management systems being used in the Department aligned to the MSP.	-	0%*	0%*	20%	MSP not implemented
Measurable Objective: To implement a uniform electronic patient administration system.					
All tertiary hospitals implementing a uniform electronic patient administration system.	-	0%	-	3	0%[33]
NATIONAL HEALTH LABORATORY SERVICES					
Measurable Objective: To monitor the rendering of laboratory services by the NHLS to the Department.					
Departmental NHLS utilisation protocol developed and implemented.	Not measured	100%	100%	100%	Not available
Analysis of tariff structure.	Not measured	50%	80%	90%	Not available
Monitoring & evaluation of Service Level Agreement (SLA) for NHLS.	Not measured	50%	80%	100%	Not available
% of instances of non compliance with SLA imperatives reported resolved.	Not measured	50%	80%	90%	Not available
PRIVATE HOSPITALS					
Strategic Objective: To strengthen and increase collaboration with stakeholders involved in the health sector (Goal 3)					
Measurable Objective: To ensure that the private health care industry adheres to National Health Standards.					

[28] Figure obtained from the Annual Report 2007/08 as it appears to be more accurate
[29] This total excludes clinics
[30] Utilisation of technology is still a challenge due to lack of funding to improve computer literacy at clinic level
[31] No budget available for implementation
[32] Tender awarded in 2008/09 - implementation did not commence due to financial constraints
[33] No budget available

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Percentage of private hospitals inspected.	Not measured	100%	100%	100%	100%
Percentage of applications for re-licensing of private hospital services received and processed.	Not measured	100%	100%	100%	No applications processed
Percentage of applications for the provisioning of private services processed.	Not measured	100%	100%	100%	No applications processed
Percentage applications for new licences reviewed at a quarterly basis.	Not measured	50%	80%	100%	No quarterly meetings held
Fully established & functional Committees at Head Office to review all applications for licenses.	Not measured	50%	80%	100%	-
Measurable Objective: To develop health policies and systems ensuring seamless and effective health service delivery					
Health policy guidelines and systems developed, including norms and standards for service delivery.	Not measured	Not measured	5	5	No information available
Develop a framework to improve clinical governance in health facilities.	Not measured	Not measured	80%	100%	No information available
HEALTH SERVICE PLANNING, MONITORING AND EVALUATION					
Strategic Objective 4: To ensure integrated planning for the provision of health services. (Goal 1)					
Measurable Objective: To finalise a strategic Plan for the Department for the period 2010-2016 based on the STP by December 2008.					
Approved Strategic Plan for next 5 years reflecting Provincial needs & based on the STP.	Not measured	50%	60%	90%	Commence in 2009/10 as per Treasury requirement
Measurable Objective: To compile the Annual Performance Plan & District Health Plans (DHP) based on the disease profile & service delivery challenges.					
Approved APP reflecting Provincial needs.	Not measured	100%*	100%*	100%	100%[34]
Approved DHP's reflecting the outcome of District Health Expenditure Review (DHER) & District specific needs.	Not measured	60%	75%	100%	See footnote[35]
DHER completed for each District to determine efficiency, effectiveness, equity, sustainability & cost.	Not measured	60%	75%	100%	See previous footnote[3]
Service delivery targets determined.	Not measured	Not measured	Not measured	100%	100%
Measurable Objective: To implement the STP as from MTEF 2008/09.					
Finalised STP.	Not measured	60%	90%	100%	STP has not been approved
Analysis of key health trends to inform epidemiology profile.	Not measured	0%	60%	70%	Data analysis of PHC information commenced

[34] Approved 2009/10 APP (in accordance with Treasury requirements) - tabling of APP postponed as per National Treasury instruction
[35] DHER not conducted due to inadequate resources for technical support to districts - costing of services was however included in DHP template. All DHP's reflect district specific needs and has been signed of by the MEC for Health before submission to the National Department of Health

Part B - Programme 1: Administration

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Completed Health Profile Study for PHC 11 Districts for PHC for 2007.	Not measured	0%	0%	11 Districts	100% completed
Measurable Objective: To Compile Quarterly Reports & Annual Report in line with the indicators & targets indicated in the APP & DHP's.					
Approved Annual Report aligned to performance targets.	Not measured	100%*	100%	100%	100%[36]
Measurable Objective: To undertake & manage key research to inform health services planning & service delivery.					
Number of Appropriate research studies to improve health services.	Not measured	0	0	3	See footnote[37]
Fully functional & institutionalised Departmental Research & Ethics Committee.	Not measured	0 Meeting	1 Meeting	4 Meetings	See footnote[38]
Assessment of research proposals & analyses of research findings.	Not measured	0%	100%	100%	100%
Research findings updated on the Provincial database.	Not measured	0%	100%	100%	100%
Strategic Objective 6: To provide GIS services for health planning & service delivery (Goal 2).					
Measurable Objective: To provide timely & accurate GIS support.					
Updated dissemination of data.	Not measured	Not measured	60%	100%	100%
Compliance with National Spatial Information Framework.	Not measured	Not measured	100%	100%	100%
Updated STP database.	Not measured	Not measured	Not measured	90%	See narrative
Strategic Objective 7: To improve the quality & use of health data (Goal 2).					
Measurable Objective: To ensure that health data is correctly captured & analysed for MTEF 2008/09					
DHIS Version 1.4 implemented.	Not measured	Not measured	0%	100%	See footnote[39]
Data Management Policy implemented.	Not measured	Not measured	0%	100%	Draft Policy not yet approved
Measurable Objective: To use the M & E framework for rigorous review on health service delivery as from May 2008.					
Approved M&E Framework.	Not measured	Not measured	40%	100%	80%
Approved Early Warning System established on monitoring established.	Not measured	Not measured	Not measured	100%	20%
Strategic Objective 2: To improve clinical governance including quality of care & infection prevention & control. (Goal 1)					
Measurable Objective: To guide & assess the implementation of infection prevention & control.					
Two modules of the Infection Assessment Tool (ICAT) implemented. Modules: hand washing, labour & delivery, isolation & employee health.	Not measured	Not measured	Tool outstanding	100% Hospitals implementing	100% Hospitals Implementing
Approved implementation plan for Infection Prevention & Control (IPC).	Not measured	Not measured	20%	Approved Plan	Approved Plan

[36] 2007/08 Annual Report approved and tabled as per Treasury requirements
[37] Three in-house research studies in progress - see narrative
[38] Research Committee composition for review pending final the KZN Health Act. All functions of the Research Committee has been fulfilled with assistance from the Health Research & Knowledge Management Component
[39] Training of all DIO's and FIO's and upgrading of information systems (DHIS 1.3 and PTSS) to DHIS 1.4 completed in March 2009 - capturing in DHIS 1.4 will commence in April 2009

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Early Warning on IPC developed.	Not measured	Not measured	5%	100%	20%
Measurable Objective: To guide & assess health services against norms & standards of the Quality Improvement Plan.					
Quality Assurance (QA) policy & Integrated QA Tool.	Not measured	Not measured	Draft Policy & Integrated Tools	100%	100%
External Client Experience Survey conducted.	100%	0%	0%	2 CHC's & 26 Hospitals	0% (89%[40])
Waiting time survey conducted at hospitals.	Not measured	58%	Not measured	58%	63%
Integrated QA implemented at all Tertiary Hospitals.	Not measured	0%	100%	100%	100%

Note: * Denotes that data has been adjusted

[40] Reflects internal survey done by hospitals

NOTES

PROGRAMME 2:

DISTRICT HEALTH SERVICES

Part B – Programme 2: District Health Services

TABLE OF CONTENTS

Part B – Programme 2: District Health Services

Render comprehensive, integrated and sustainable health care services (preventive, promotive, curative and rehabilitative) based on the Primary Health Care approach through the District Health System

PROGRAMME STRUCTURE

Sub-Programme 2.1
District Management

Managing district health services including integrated and evidence-based planning, administration of services, managing of personnel, financial administration and monitoring and evaluation of district health services, including those rendered by District Councils and Non-Government Organisations.

Sub-Programme 2.2
Community Health Clinics

Rendering compassionate, dedicated, integrated, effective and efficient PHC services at fixed PHC clinics, mobile services, drop-in centres and out-reach/ community-based health care services. Services fall under the scope of practice of a Professional Nurse.

Sub-Programme 2.3
Community Health Centres

Rendering a broad range of out-patient and PHC services inclusive of accident, emergency and midwifery services, excluding surgery under general anaesthesia. Services fall under the scope of practice of a General Practitioner and Professional Nurse.

Sub-Programme 2.4
Community-Based Health Services

Rendering health services at non-health facilities including home-based care, community-based services for survivors of violence, mental health, chronic care and geriatrics, disability and rehabilitation, treatment support for TB and Anti-Retroviral Therapy, integrating services for children and youth and promoting healthy lifestyles.

Sub-Programme 2.5
Other Community Health Services

Rendering services for Environmental and Port Health, hazardous substances, water and sanitation, and storage/ labelling/ preparation and selling of food substances, monitoring services at abattoirs and dairies, monitoring air quality, pollution and ports of entry.

Sub-Programme 2.6
HIV & AIDS, STI's and TB

Rendering PHC services related to the comprehensive management of HIV, AIDS, STI's and TB - sustaining programmes for Sexually Transmitted Infections, Prevention of Mother to Child Transmission of HIV, Non-Occupational and Occupational Post Exposure Prophylaxis, Voluntary Counselling and Testing, Anti Retroviral Treatment and TB.

Sub-Programme 2.7
Nutrition

Rendering integrated, sustainable and community driven direct and indirect nutrition services aimed at the most vulnerable groups in communities.

Sub-Programme 2.8
Maternal, Child & Women's Health

Rendering comprehensive and integrated promotive, preventive and educational services and programmes targeting women, children and youth to reduce preventable causes of morbidity and mortality.

Sub-Programme 2.9
Coroner Services

Providing effective and efficient forensic pathology and forensic medical services in order to establish the circumstances and causes surrounding unnatural death.

Sub-Programme 2.10
District Hospitals

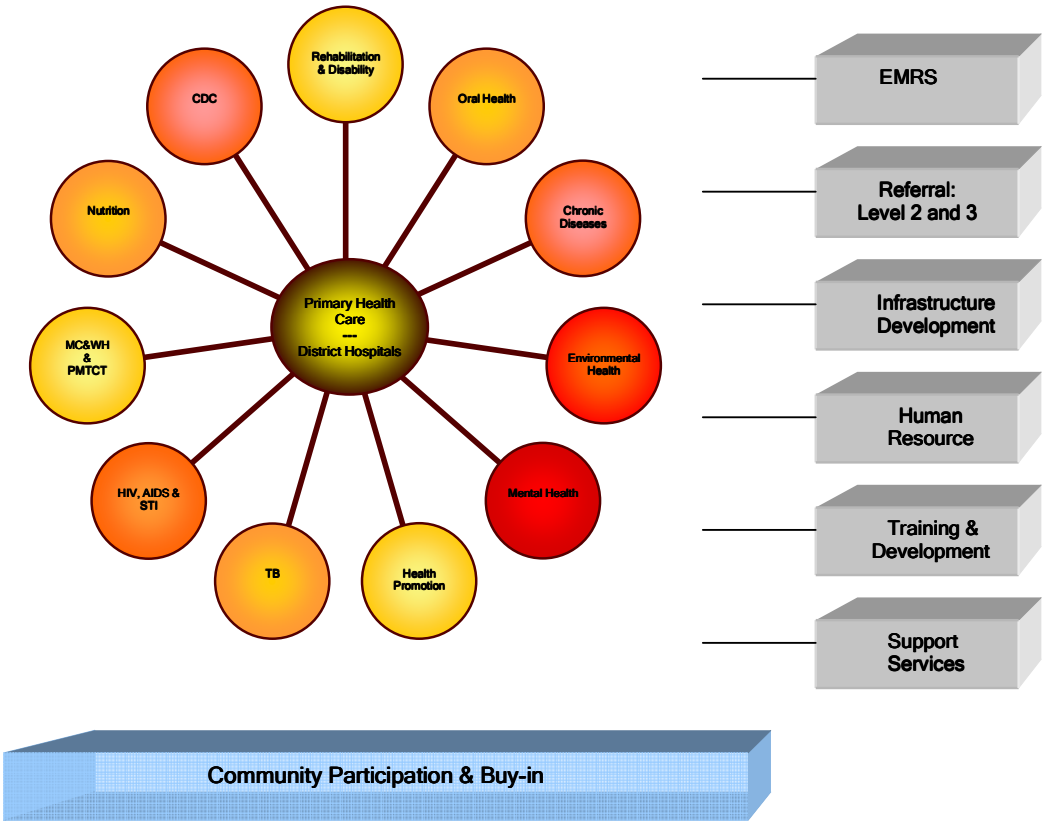
Rendering a designated range of diagnostic, curative in-patient and out-patient hospital services mostly under the scope of practice of a General Practitioner.

Global Fund

Funds are managed as part of Donor funding outside the Departmental accounting system.

PROGRAMME 2: DISTRICT HEALTH SERVICES

Figure 1: District Health Services



A combination of factors including inadequate financial and human resources, imbalances of resources versus service delivery needs, inequities in distribution of personnel/ skills/ resources, the complex and evolving burden of disease, and deficiencies in functional systems/ processes to deliver services at all levels of care continue to impact on the implementation of PHC services as contained in the Alma Ata Declaration.

Utilisation of health data to inform evidence-based planning is still a challenge due to fragmented data information systems that increase the challenges with regards to data collection, collation, verification, storage and reporting. Implementation of DHIS 1.4 that commenced in March 2009 is expected to improve data quality and utilisation. The alignment of the DHIS (containing core health indicators) with the results-based monitoring and evaluation (M&E) framework started to show improved reporting against performance targets and will be expanded in 2009/10.

The 10-year Service Transformation Plan (STP) which makes provision for the reform of health services has not been approved for implementation. The approved 10-year Human Resource Plan (HRP) is aligned with the STP, although PHC organisational structures and post establishments have not been finalised.

The current burden of disease necessitates an in-depth assessment of current systems, processes and resources to inform pro-active strategic vision that will accommodate a more comprehensive and integrated health system at hospital, clinic, community and household levels. The disease burden and financial constraints challenge the structural transformation of the health system including absorption of additional demands at PHC level.

The Province is committed to the implementation of the PHC approach as defined by the World Health Organisation's Alma Ata Declaration that provides the ideological framework for first level health care.

Part B – Programme 2: District Health Services

PRIMARY HEALTH CARE

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities 2006-2008/09

Priority 3: Contribute towards human dignity by improving quality of care

Priority 5: Strengthen PHC, EMS and Hospital delivery Systems

↓

Provincial Strategic Plan 2005-2009/10

Goal 2: Strengthen PHC and provide caring, responsive and quality health services at all levels

↓

Annual Performance Plan 2008/09

Goal 1

Strategic Objective 1: To mainstream PHC services

Strategic Objective 2: To improve clinical governance including quality of care & infection prevention & control

↓

PHC Priorities 2008/09

1. To increase access to health care services through implementation of the STP.
2. To implement the results-based monitoring & evaluation system at district level.
3. To strengthen PHC services through implementation of the STP.
4. To improve the quality of health care.
5. To continue to improve clinical governance and management within district health services.

Esidumbini Clinic: Clinic Staff Testing Patients BP

Church of Scotland Clinic

EXECUTIVE SUMMARY

Expansion of Primary Health Services was severely affected by financial constraints as a result of over-expenditure during the 2007/08 and 2008/09 financial years. The organisational structures and post establishments for PHC has not been finalised which impacted negatively on the alignment of human resource requirements with increased patient loads and emerging disease profiles.

A total of 10 new PHC clinics were completed in 2008/09 increasing the total number of Provincial PHC clinics from 542 in 2007/08 to 553. A total number of 23,838,854 patients utilised PHC services in 2008/09 with an under-5 case load of 21%. Utilisation rates increased to 2.5 visits per patient per year and under-5 utilisation to 4.4 visits per child per year. The doctor work load averaged at 25 patients per day, and the professional nurse work load at 40 patients a day. PHC expenditure decreased to R89 per patient in 2008/09 compared to R 97.46 in 2007/08.

Access to services in under-served communities was increased by increasing mobile stopping points to 3,449 reaching a total of 2,304,816 patients. 47 Health Posts offered preventive and promotive services at community level.

Supervision rates are still unacceptably low at 60% comparing extremely poor with the national target of 100%.

Community participation in PHC service delivery improved with the appointment of Community Committees in 81% of PHC clinics and 81% of CHC's.

POLICIES

Table 19: Acts, Policies, Protocols and Guidelines

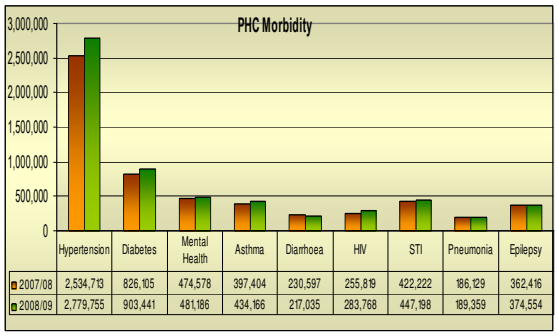
New Acts, Policies, Protocols & Guidelines	Comments
1. Primary Health Care Supervision Policy.	• Final draft Guidelines and Policies awaiting approval.
2. Guidelines for Doctors consulting at Primary Health Care Clinics.	
3. Guidelines for Community Clinic Committees.	
4. The National Community Health Worker Framework.	• Standardised practice framework for the Home and Community Based Carers (HCBC) Programme.
5. The Expanded Public Works National Cabinet Initiative.	• The Expanded Public Works Programme (EPWP) is well documented through the Social Sector and supported by Senior Management in the Department of Health.
6. The Traditional Health Act, No 22 of 2007.	• Legislation supports processes for the development of relevant policies and guidelines, as well as coordination of initiatives and consultation with relevant stakeholders to create a common understanding of the Traditional Health Practitioners Programme.
7. Draft Policy on Traditional Health Practitioners Gazetted by the National African Traditional Medicines Directorate.	• The Province has run workshops for the Traditional Health Practitioners (THP) to ensure understanding of the draft policy and encourage comments and inputs before finalisation.

PROGRAMME PERFORMANCE

2008 marked the 30th anniversary of the call for 'Health for All' made at the Alma Ata conference on PHC. In the recommended PHC system it is envisaged that primary health care services will take place at district level, and that all health care users should be able to access these services in an integrated seamless health care system.

The quadruple burden of disease, rapidly changing disease profiles, severe human resource challenges and financial inadequacies dealt a "wild card" to the transformation of the health system and implementation of the restructured PHC system. Persistent deficiencies placed immense strain on all aspects and levels of the health system and service delivery in 2008/09. Graph 1 illustrates the priority conditions seen at PHC level.

Graph 1: PHC Morbidity 2007/08 - 2008/09



Inadequate human and financial resources affected service delivery at all levels of care and delayed restructuring of the PHC system. Organisational structures for PHC (including District Hospitals) has not been finalised which had a major impact on service delivery including expansion of services, filling of vacant/ critical posts and quality of care.

There has been no progress with the take-over of Local Government clinics due to the unavailability of funding and a KwaNaLoGa embargo on negotiation of transfers. Negotiations will continue in 2009/10.

All districts developed and submitted District Health Plans aligned to the Departments' strategic goals and objectives and in compliance with the requirements of the White Paper on the Transformation of Health Services in South Africa and the National Health Act of 2003. District Health Plans were translated into District Operational Plans. Due to lack of human resources at Provincial level, the District Health Expenditure Reviews were not done except for eThekwini. This will be addressed in 2009/10.

In spite of the severe financial constraints, the Department sustained service delivery through dedication and perseverance and were able to report progress against identified priorities and most targets.

The Service Transformation Plan has not been approved and implementation has not commenced as envisaged in the 2008/09 Annual Performance Plan.

⇒ PRIORITY 1: TO INCREASE ACCESS TO PHC SERVICES

Fixed PHC clinics (Provincial) increased from 542 in 2007/08 to 553 in 2008/09 with 52 PHC clinics offering 24-hour services.

! CHALLENGES

- Extended hours of service are compromised by shortage of staff, infrastructural challenges and safety issues at some facilities. Under-utilisation and cost effectiveness of identified services will be investigated in 2009/10.
- After hour services is limited due to the resistance of some staff to provide the extended package of service after hours. Only emergency services are provided at some after hour services.

To improve availability and access to under-served communities, mobile stopping points were increased from 2,392 to 3,449 in 2008/09. A total of 2,790 points were serviced monthly, 537 twice a month and 122 weekly, reaching a total of 2,304,816 patients in 2008/09. Health Posts increased from 44 in 2007/08 to 47 in 2008/09 ensuring that communities have access to basic promotive and preventive health care services. Health posts in some districts are currently used as mobile clinic points. They operate either once a week or per fortnight. Staffing for health posts continue to be problematic especially for VCT services.

93% of PHC clinics had the essential equipment as per equipment list for offering basic PHC services. Although most clinics have essential equipment, timely repair and replacement of broken equipment is still a challenge especially as a result of financial constraints.

! CHALLENGE

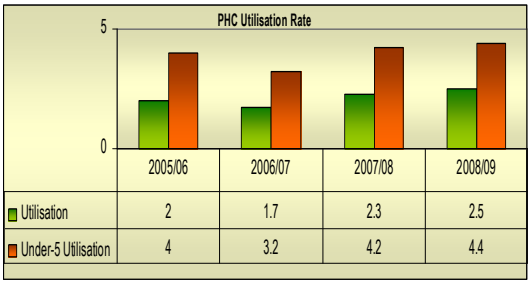
- The package of services offered in mobile clinics is sometimes limited due to a reported lack of space and human resources.

Utilisation of PHC services improved with 23,838,854 patients accessing PHC services in 2008/09 compared with 21,260,261 in 2007/08. The under-5 year case load was 21% for the same period. Budget and human resource allocations do not reflect the increased financial and human resource needs to cater for this increase.

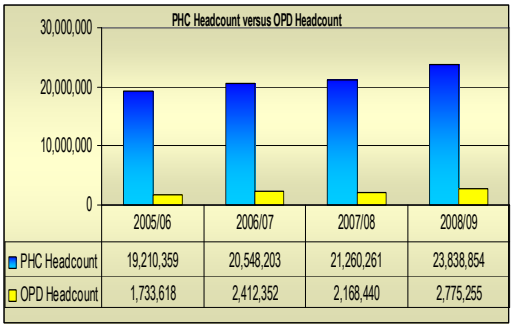
The utilisation rate increased slightly from 2.3 to 2.5 visits per person per year (below the National target of 3.5) and the utilisation rate for under-5 increased from 4.2 to 4.4 visits per child per year (below the National target of 5). Graph 2 reflects the utilisation rates for PHC.

It is generally assumed that the OPD headcount will decrease with improved access and utilisation at PHC level. Current data however indicates that the OPD headcount is still increasing steadily which might be as a result of changing disease profiles, clients still entering the health system at the wrong level, ineffective referral systems, or ineffective management of clients at PHC level. In some cases however, Gateway clinic data is calculated as OPD headcount hence misleading interpretation. This is corrected in DHIS version 1.4 that will be implemented from 2009/10. The following graphs reflect the increase in utilisation in both PHC and OPD.

Graph 2: PHC Utilisation Rate 2005/06 – 2008/09



Graph 3 PHC Headcount versus OPD Headcount: 2005/06 - 2008/09



	2005/06	2006/07	2007/08	2008/09
PHC Headcount	19,210,359	20,548,203	21,260,261	23,838,854
OPD Headcount	1,733,618	2,412,352	2,168,440	2,775,255

Staffing and workload norms have not been aligned or linked with service delivery packages and service norms. Workloads or case loads are currently articulated as patient or health worker ratios and based on utilisation rates. Changing disease profiles however challenges this definition or simplified interpretation and should be re-considered to effectively plan for service delivery and quality of care.

There is still considerable variation between case loads for doctors and nurses at PHC level, with case loads of doctors being determined by the current appointment system. Doctors consulting at PHC facilities attended to an average of 25 patients a day (1:23 in 2007/08) and professional nurses attended to an average of 40 clients a day (1:39 in 2007/08). It is however expected that the case load of doctors should be higher taking into consideration the large number of people attending services for non-communicable disease management. This might indicate that patients are not medically examined according to National Guidelines.

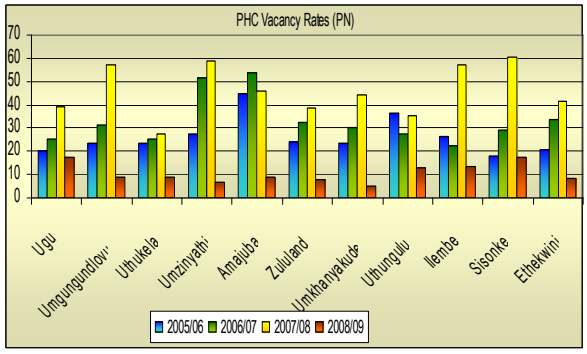
Human resource challenges, including vacancy rates and skills gaps, had a limiting impact on expansion of PHC services in 2008/09. The lack of an approved organisational structure for PHC severely delayed the filling of critical posts hence gaps in service delivery and poor sustainability of interventions.

Client flow at clinics often causes bottle necks that are sometimes subjectively perceived as being short staffed. Alternatives should be considered e.g. scope of practice to relieve high case loads of critical categories of staff - legal imperatives considered. Complete re-orientation is necessary as the 'one stop shop' may be impeding continuity of care and contributing to staff member burn-out.

The following graph reflects the vacancy rate for Professional Nurses at PHC level (clinics) for the years 2005/06 to 2008/09. The alignment between service delivery needs and Human Resource allocation has not yet been successfully incorporated into planning documents and strategies.

Please note! The significant drop in 2008/09 vacancy rates (compared to 2007/08) is due to the abolishment of unfunded posts at the end of July 2008 as per KZN Cabinet instruction.

Graph 4: PHC Vacancy Rate - Professional Nurses



Out-reach services from District Hospitals to PHC clinics improved through increased visits by Community Service Therapists and Medical Officers. Shortages of some specialities at PHC facilities, especially District Hospitals, however still impacted on certain programmes for example, dentistry due to limited dental assistant posts and a decline in the number of dieticians providing outreach to clinics. Some specialities are still based at hospitals not extending community-based services i.e. Psychologists.

⇒ PRIORITY 2: IMPLEMENT A RESULTS-BASED MONITORING & EVALUATION SYSTEM

The M&E Directorate developed a results-based M&E Framework in consultation with various stakeholders. Indicators (included in the Framework) have been aligned with the 5-year Strategic and Annual Performance Plan strategic objectives, the National Health and Treasury priorities as well as core programme indicators. A conceptual paper, detailing the results-based M&E, has been developed for reference to the performance measurement approach.

Core indicators have been included in the DHIS version 1.4 dataset to improve monthly, quarterly and annual

collection of data as well as monitoring and reporting of performance against targets. The M&E Directorate is coordinating the collation and dissemination of data and reports to ensure feedback and effective management of data.

⇒ PRIORITY 3: IMPROVE THE QUALITY OF HEALTH CARE

The 2008/09 DHP's have been aligned with National and Provincial priorities and have been submitted to the National Department of Health. Analysis of health trends improved and plans are more realistic although targets tend to be unrealistic in some instances. There are still challenges to integrate district health services in Integrated Development Plans (IDP's) although Municipal Councils participate in the development of the DHP's.

The low supervision rate (60%) is a concern, especially as it is well established and accepted that supportive and regular supervision impacts profoundly on quality of services and service delivery. Yet, despite overwhelming agreement on its importance, supportive and regular supervision remains one of the weakest aspects of service delivery.

! CHALLENGES

- Routine supervision is jeopardised as a result of cost containment measures i.e. cut in routine use of transport and regular visits to facilities.
- Staff shortages resulting in supervisors being re-allocated for hospital duties or relieving staff at service delivery level with no alternative arrangements for supervision. The span of supervision needs to be reduced to between 4 to 6 units to increase quality supervision.

⇒ PRIORITY 4: IMPROVE GOVERNANCE AND MANAGEMENT

Clinic Committees have been established in 81% of PHC services and 81% of CHC's to improve the link between health services and communities. Increased community participation and accountability for community action to improve health is evident in the number of support groups established for chronic diseases, TB, HIV and AIDS, etc. The Department further aims to expand initiatives to promote healthy lifestyles and health behaviour, prevent illness, promote health and increase quality of life.

Client Satisfaction Surveys were implemented in 64% CHC's in an effort to improve service delivery to the public. Complaints are generally resolved within 25 days although staff shortages and bogus addresses of clients sometimes increase the time taken to resolve complaints.

Community-Based Services

Clinic governance has been improved with more than 81% of PHC clinics and 81% of CHC's electing Clinic Committees. Although the training of the Committees has commenced through CUPB, and follow-up training was planned through the contract with KZNPPHC.[41] No training has been conducted for the Operations Managers at facility level which jeopardised the effective functioning of these committees.

The Provincial Community Health Committee has been appointed by the MEC. District Health Committee's have not been appointed yet.

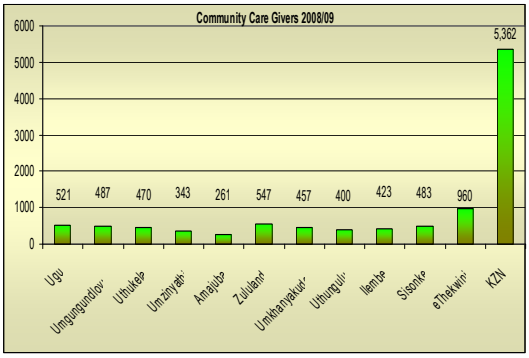
The Home and Community Based Care (HCBC) Programme has 1 Provincial Non-Profit Organisation (NPO) contracted for the Community Care Giver (CCG) Programme, and 13 local NPO's sub-contracted at district level. The Provincial target of contracting 33 local NPO's could not be met due to financial constraints.

There are currently a total of 5,362 CCG's rendering services in the Department as indicated in graph 5. All 5,362 that were contracted in 2008/09 received stipends as part of the poverty alleviation project of the Expanded Public Works Programme (EPWP). Improved partnerships resulted in approximately 4,500 CCG's and Community Governance Committee members benefiting from training and skills development programmes during the year thus improving services to the community.

Inter- and intra-departmental collaboration has been strengthened between the Department and Departments of Social Development, Agriculture, Education, and Home Affairs and internally the HAST Unit, Health Promotion, MC&WH, other Inter-Governmental Unit and Districts.

[41] KwaZulu-Natal Progressive Primary Health Care

Graph 5: Community Care Givers per District 2008/09



! CHALLENGES

The CCG Programme has faced numerous challenges in 2008/09 including:

- The Province could not reach the target of recruiting and training 1,000 new CCG's per year (*as per CCG Strategic Plan*) due to financial constraints.
- According to the contract with communities, all vacant CCG 'posts' must be filled when vacant. Communities selected volunteers on stand by to fill vacancies - however this has not been possible due to financial constraints.
- The contracted Service Provider (*3 year contract*), has an obligation to sub-contract, capacitate and mentor local NPO's to take responsibility for the programme in each district. This mandate could not be honoured due to a lack of payment from the Department.
- Training of the Governance Committees in districts to enhance governance and community participation is a contractual obligation. This has not been possible due to financial constraints.
- Late payment of the Service Provider with payments for 2007/08 still outstanding.
- Auxiliary Health Care Qualification NQF Level 1 was completed except for the HWSETA verification which delayed the starting of the NQF Level 2 skills programme training. Another qualification cannot commence unless an extension of the contract is guaranteed for the next financial year which is not the case.

The mandate for the EPWP is being determined by National Cabinet and includes:

- Creation of job opportunities;
- Training and skills development with special focus on vulnerable groups (youth, women and the people with disabilities); and
- Poverty alleviation by payment of stipends.

The Department attained the certificate of compliance with EPWP principles from the Department of Transport (lead Department) in 2008/09.

The National Youth Service HCBC Project, through a Service Level Agreement with different stakeholders, was able to improve youth development over a period of 18 months with shared responsibility. This project agreement was finalised at the end of 2008/09 and will be rolled out in 2009/10.

The Department of Social Development contracted 4 training providers to provide the accredited Auxiliary Health Care Training for a National Qualification over the 18 months of the project in 5 pilot districts. A total of 275 youth participants (55 per district) have been selected by the participating partners in the project to participate in the project. The Department is responsible for the payment of stipends to the value of R 1,000 per learner per month for the 18 months of the project. Training will commence in April 2009.

The Community Health Committee structures, responsible for community participation, are in place and active even though training did not take place as planned. The Provincial Home and Community Based Care Governance Committee provides monitoring of the programme activities on behalf of the communities served.

! CHALLENGE

- Sustainability of the Community Health Committees is a challenge due to the lack of financial support for transport and provision of meals at scheduled meetings.

Traditional Health Practitioners (THP) Programme in African Traditional Medicine

The THP Programme does not yet have any dedicated personnel or budget although the appointment of a dedicated Programme Manager is imminent within the next financial year. Due to the lack of capacity, the development of the THP database has been delayed, and finalisation is expected in 2009.

The Province mobilised participation of most of the Provincial THP's and facilitated a working session to develop draft regulations to inform and guide the THP Programme. Leaders of the three main Associations in the Province established the Provincial THP Coordinating Working Committee which improved collaboration between Associations. Through the Working Committee, District Coordinators have been nominated as representatives on the Associations hence improving communication and collaboration.

Education and training workshops were conducted in all the districts focusing on HIV, AIDS, STI and Infection Prevention and Control (IPC). Training was funded by the Global Fund through the HAST Unit and by PEPFAR through UKZN.

! CHALLENGES

- Cooperation between Associations is a challenge and tends to delay relevant progresses. Formation of the Working Committee is expected to improve cooperation and collaboration.
- The lack of dedicated staff makes it difficult to manage the programme appropriately.

Massification Programme

The **Massification Programme** is based on the 'geographic integration and coordination of joint area-based planning and implementation of projects where all role-players contribute comprehensively towards poverty eradication, human development and improved quality of life' in contribution towards the Millennium Development Goals.

Ugu District

Project areas are supported by Health Systems Trust (HST) with the primary focus being on the strengthening of VCT, TB, STI and the integration of HIV related programmes. Health promotion and education is prioritised through support from Khomanani, volunteers, youth ambassadors, the M2M2B Programme, Impact and Uvaa Projects. Broadreach Health Care Park is sponsoring park homes to extend services at Morrison's Post, Nyangwini, Assisi, St Faiths, Ndwebu, Phungashe and Khayelihle. The second Health Post at KwaLembe was completed and the keys handed over to the district in 2008/09.

eThekwini Metropolitan

Access to PHC services has been improved by including Family Planning and Cervical Cancer Screening services in clinics with extended hours and offering chronic medication at all mobile points. Chronic medication is also nurse initiated at KwaMashu CHC. Service quality has been improved through improved supportive supervision with coaching and mentoring programmes from the District Office. Minor upgrades and aesthetic improvements, including the upgrading of ablution facilities and partitioning to create additional consulting rooms has been done at the KwaMashu CHC. The Qadi Clinic has been upgraded; however insufficient funds have delayed some projects. A 'One Stop Centre' was opened at Mqhawe where preventive and promotive health programmes is offered although sustainability of this project is a challenge. The community radio station operating from Inanda is used to broadcast health messages to the community.

Sisonke District

Revitalisation projects at Rietvlei Hospital and the completion of 4 clinics and 1 CHC has been delayed in 2008/09 partly due to challenges related to the incorporation of Umzimkhulu Local Municipality into the Sisonke District. Community out-reach has been strengthened with ongoing capacity building programmes for NGO's, the upgrading of Home and Community-Based Carers to NQF level 4 that commenced in 2008/09, eye care and rehabilitative programmes, and numerous other outreach programmes to clinics in the district. Khanya Africa's activities and programme has significantly improved service delivery.

Msinga Municipality

The Municipality has been identified as one of the key priority areas within the Umzinyathi Health District. Many challenges have been identified including insufficient accommodation for health workers leading to a shortage of personnel and skills, poor infrastructure development and an increase in communicable and non-communicable diseases. Although the Municipality implemented the same package of services as other Municipalities, the liaison with other departments to improve road infrastructure, water, sanitation etc. was prioritised.

PROVINCIAL PERFORMANCE INDICATORS

Data completeness: 95%

Table 20: (DHS 5) Provincial Objectives and Performance Indicators for District Health Services

Performance Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Measurable Objective: To implement the roll-out of PHC Clinics and CHC's as per the imperatives of the STP.					
1. Number of PHC clinics operating as Category A.	Not collected	12	82	86	Not available
2. Number of PHC clinics operating as Category B.	Not collected	57	297	309	Not available
3. Number of PHC clinics operating as Category C.	Not collected	26	89	88	52[42]
4. Number of new PHC clinics.	Not collected	0	3	43	10
5. Number of new CHC's.	Not collected	0	4	8	Nil
6. Number of PHC clinics.	450	494	Fixed: 556 CHC: 17	83[43]	Fixed: 577[44] CHC: 17
Measurable Objective: To improve PHC access and utilisation.					
7. Provincial PHC expenditure per headcount.	R 92	R 64	R 97.46	R 74	R 89
8. PHC headcount.[45]	19,210,359	20,548,203	21,260,261	22,350,000	23,838,854
9. PHC utilisation rate.	2.0	1.7	2.3	2.4	2.5
10. PHC utilisation rate - under-5 years.	4.0	3.2	4.2	4.0	4.4
Measurable Objective: To improve PHC supervision.					
11. Supervision rate.	93%	50%	54%	100%	60%
12. Supervisor's manual implemented at all PHC facilities.	Not collected	50%	64%	100%	84%
13. % of PHC clinics displaying important health data.	Not collected	Not collected	Not collected	100%	88%
Measurable Objective: To improve clinical management at PHC level.					
14. PHC facilities supported by a Medical Officer at least once a week.	Not collected	Not collected	79%[46]	40%	56%
15. Doctor clinical workload.	1:22	1:23	1:23	1:24	1:25
16. Nurse clinical workload.	1:40	1:40	1:66[47]	1:36	1:23 (Nurse) 1:40 (PN)
17. Number of PHC clinics and CHC's implementing the Infection Prevention & Control Policy.	Not collected	Not collected	Not collected	Clinics: 110 CHC's: 14	125 clinics
Measurable Objective: To strengthen Community-Based PHC services.					
18. Number of active Home and Community-Based Care Givers.	4,000	7,000	15,700	21,000	14,525
19. Number of HCBC contracted by NGO's.	Not collected	HBC: 1,100 NIP: 252	CHW: 5,400 HBC: 2,200 NIP: 273	CHW: 6,000 HBC: 4,400 NIP: 309	6,312

[42] 4th Quarter District Reports
[43] Target based on classification in STP that is not yet implemented - thus not measured against that target
[44] Total includes Local Government clinics - Public Health clinics total 553
[45] Target calculated using a 5% increase - trends will be monitored
[46] Data refers to PHC clinics supported by a MO at least once a month
[47] Suspected that the wrong definition was used to calculate workload

Part B – Programme 2: District Health Services

Performance Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
20. Number of HCBC who meet SETA requirements.	Not collected	1,100	CHW: 3,000 HBC: 2,200	CHW: 4,000 RPL: 400 HBC: 3,500	Not available[48]
21. Number of HCBC receiving stipends.	Not collected	CHW: 2,500 HBC: 4,074	CHW: 5,400 HBC: 2,200	CHW: 6,000 HBC: 4,400	5,322 (HBC) 6,504 (CHW)
22. Number of patients served by HCBC.	Not collected	164,480	22,000	31,500	2,161,280 (CHW)
23. Number of home visits by HCBC.	Not collected	7,275,600	1,274,911	3,191,991	1,445,019 (CHW)
24. Number of patients referred by HCBC.	Not collected	Not collected	Not collected	50,000	343,473 (CHW)
Measurable Objective: To design and implement a monitoring tool to validate the effectiveness of Community-Based Services.					
25. Number of Districts implementing the standard monitoring tool for registered HCBC.	No Tool	No Tool	No Tool	11 Districts	No tool
26. Established and updated Provincial HBC database.	No database	No database	No database	Updated database	Not yet established

[48] 1,007 received accredited training during 2008/09 – not accounting for 'other' already trained

HEALTH PROMOTION

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities 2006-2008/09

Priority 2: Promote healthy lifestyles.

↓

Provincial Strategic Plan 2005-2009/10

Goal 3: Promote health, prevent and manage illnesses with emphasis on poverty, lifestyle, trauma and violence.

↓

Annual Performance Plan 2008/09

Goal 5

Strategic Objective 20: To ensure the effective implementation of programmes to reduce communicable and non-communicable diseases and diseases of lifestyle.

↓

Health Promotion Priorities 2008/09

1. Enhance capacity at district level to facilitate integrated and comprehensive health promotion and education interventions at all levels of care.
2. Focused capacity-building and monitoring of:
   - Hand washing (infection control);
   - Health promotion and education interventions targeting the care of pregnant women, nutrition, and HIV and TB prevention.

Health promotion interventions are aimed at deliberate attempts to promote healthy lifestyles to reduce risks of lifestyle diseases, to prevent illness and to improve quality of life.

EXECUTIVE SUMMARY

The Department sustained the momentum of integrated and participative client-centered health promotion interventions and programmes in a deliberate attempt to promote healthy lifestyles, prevent illness and improve health by reducing the risk, severity and duration of ill health. The increasing clinical workload at facility level, partly as a result of the increased burden of disease, changing disease profiles, vacancy rates and skills gaps at service delivery level, hindered the implementation of integrated interventions at grassroot level. Monitoring and evaluation of intervention outcomes has not yet been achieved and should be pursued to ensure return for money.

Decentralised competencies have been improved with the establishment of sub-district multi-sectoral and multi-disciplinary District Health Promotion Forums. To date, a total of 131 schools have been accredited as Health Promoting Schools, 88 PHC clinics are implementing the standard health promoting standards and criteria and 3 PHC clinics in the Amajuba District were formally accredited as Health Promoting Clinics. Screening services (focusing on primary prevention of disease) were prioritised by the Department and included as part of all health events in the Province.

Part B – Programme 2: District Health Services

POLICIES

Table 21: Acts, Policies, Protocols and Guidelines for Healthy Lifestyles

New Acts, Policies, Protocols & Guidelines	Comments
1. Provincial Concept Document for Health Promoting Schools (including Implementation and Assessment Guidelines).	• The Provincial policy will be finalised once the National policy (currently in draft) is approved.
2. Provincial Concept Document for Health Promoting Clinics.	• Policy will be finalised once the National policy (currently in draft) is approved.
3. Provincial Implementation Guidelines for Wellness in the Workplace.	• Guidelines (aligned to the National Framework) are included in the Occupational Health & Safety Strategy.
4. Guidelines for a smoke free environment.	• Guidelines are included in the Occupational Health & Safety and Employee Assistance Programme Strategies.
5. Guidelines for ordering and dissemination of Information, Education and Communication materials.	• Improved availability of material and facilitate effective and timeous ordering of Information material according to the health calendar and themes.

PROGRAMME PERFORMANCE

The National Burden of Disease Study identified a cluster of lifestyle and risk behaviours that contribute significantly to the emerging chronic disease burden. Emerging disease patterns thus require a re-orientation of health services to a more focused and integrated approach in primary and secondary prevention and screening interventions as part of the continuum of care.

Implementation of integrated health promotion programmes improved at district/facility level albeit challenged by staff shortages, increased workload at facility level and serious financial constraints. Although vertical planning, based on programme specific challenges is still evident, the ultimate health outcomes will benefit whole communities. Current financial constraints however necessitate a clearly defined and integrated health promotion strategy to ensure decisive action and optimum utilisation of available resources.

! CHALLENGE

- A more robust monitoring & evaluation strategy is fundamental to determine the benefits derived from specific health promotion and prevention interventions. This will ensure informed planning and decision-making and effective utilisation of existing resources.

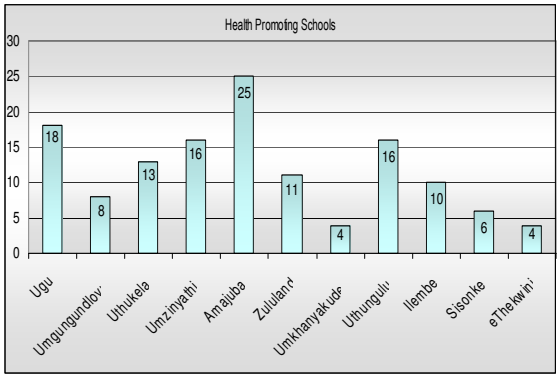
Health Promoting Schools

Health Promoting Schools (HPS), in line with the Ottawa Charter's 5 Action Areas, were prioritised to expand the role that learners can play as partners in health promotion, improve access to health information and services, improve health behaviour and expanding community support, buy-in and accountability for health at household level. Targeted schools were linked with PHC clinics to improve follow-up and support, access to health services and sustainability of programmes initiated in schools. Community workers provide support to schools and serve as link between schools and health facilities.

All districts actively promoted the HPS principles and introduced the concept to a total of 1,032 schools in 2008/09.[49] A total of 131 schools were accredited (indicating implementation of the HPS principles to improve healthy lifestyles) and 81 schools were formally launched as HPS (indicating community involvement and ownership). The following graph illustrates the number of Health Promoting Schools per district.

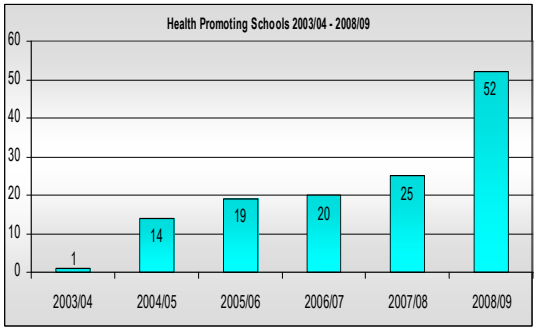
[49] District Reports

Graph 6: Number of accredited Health Promoting Schools per District[50]



Although the Department shows steady progress with the implementation of this programme (see following graph), challenges pertaining to intra-sectoral collaboration still hinder timely solutions and action to specific challenges outside the mandate of the Departments i.e. provisioning of adequate sanitation and access to potable water in schools. Failure to address these challenges might defeat the purpose and/or outcome of this internationally acknowledged approach.

Graph 7: Number of accredited Health Promoting Schools per year



To sustain the HPS initiative and ensure that investments contribute to the long-term constant development of the wider community, the Department strengthened its partnership with the Department of Education (DOE) and commenced with the integration of HPS into Full Service Schools (fully inclusive schools). Through this, it is envisaged that school communities will reciprocate by progressively becoming a resource for their schools and wider community which in turn will impact on the health status in the community.

The 5 healthy lifestyle components (nutrition, tobacco control, safe sexual practices, alcohol and drug use control and physical activity) are incorporated into the HPS programme and school curriculum, and although physical activity is not included in all learning areas, educators reported positive behaviour change in the nutritional habits of learners where nutrition and physical activity are effectively incorporated and implemented. All accredited HPS have school gardens.

Tobacco control (National Health priority) has been introduced in all accredited HPS, although it is too early to determine the impact thereof on learners' behaviour. Some districts reported an apparent lack of commitment from educators to recognise schools as tobacco-free environments which will ultimately defeat the purpose of positive role modeling in education. To sustain the momentum of this initiative, the essay competition for 2009/10 will focus on tobacco control in schools to stimulate debate on the topic.

Numerous health promotion programmes, based on specific needs in schools and communities, were implemented and included programmes covering HIV & AIDS, oral health, chronic diseases and eye care, TB, PHC including minor ailments, health and hygiene, mental health, nutrition, rehabilitation, malaria, etc. Decentralised multi-disciplinary teams ensured that the necessary links were established between the health system and schools.

During 2008/09, districts participated in a 'Full Service School Jamboree' in collaboration with the DOE, Social Development, Home Affairs, Agriculture, SAPS, and numerous NGO's. Multi-disciplinary teams offered a variety of programmes targeting learners and communities. The Department offered routine health assessments and screening for Grade R/1, screening for learners from other grades identified by educators or parents/caregivers, education on TB, nutrition, HIV & AIDS, pre and post test counselling, HIV testing, etc. This initiative raised awareness and served as introduction to future programmes.

The essay writing project, in collaboration with the DOE, focused on nutrition in 2008/09 and was supported by the Sugar Association of South Africa, ABSA and Departments of Sport & Recreation and Agriculture & Environmental Affairs. The competition inspired interactive debates on health issues from learners' perspectives and served as an opportunity for child to child

[50] Information from the Healthy Lifestyle Component

education widely regarded as one of the most effective ways to educate children and youth.

All districts have successfully integrated School Health Services and HPS to expand the reach of health messages at schools. Routine health assessments accompanied with relevant health education and promotion programmes ensured that learners have access to preventive and promotive programmes as well as the necessary clinical care. Multi-disciplinary teams provided integrated health promotion/education programmes during the National School Health Week, held from the 16th to the 20th of March 2009. Topics during the week included TB, HIV & AIDS, cholera, hand washing and hygiene, preparation of sugar salt solution, and treatment of diarrhoea at home, STI's, nutrition, drug and substance abuse, importance of exercise and tobacco control, teenage pregnancy, etc.

Other integrated projects in schools included:

- TB peer support groups;
- TB free schools;
- Malaria free schools;
- Integrated projects to prevent teenage pregnancy i.e. Project Baby and Peer Education programmes.

The Healthy Lifestyle Sub-Component, with technical support from Health Research and Knowledge Management, commenced with the assessment of HPS in the 4th quarter of 2008/09. The evaluation results (using SPSS for analysis) are expected in 2009/10 and will be used to inform programme planning and development.

! CHALLENGES

- The lack of adequate data to determine the outcome and impact of the HPS initiative negatively impacts on evidence-based programme planning and development, and in turn on budget and resource allocation to sustain the programme.
- The lack of a formal Memorandum of Understanding with the Department of Education impacts negatively on the sustainability of the programme.

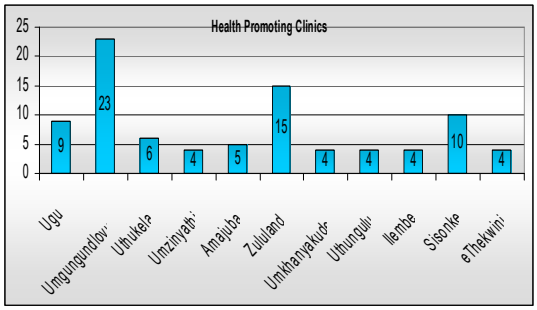
Health Promoting Clinics

The Health Promoting Clinic (HPC) initiative ensures that the 5 action areas outlined in the 1986 Ottawa Charter (skills development, reorientation to health services, policy development, creating a safe and supportive environment and community involvement) are complied with at clinic level. The Department linked HPS and HPC to ensure that learners are able to join fast queues at PHC level, that 1st level School Health Services can be rendered through clinics to 'catchment' schools, and that communities take responsibility for health issues in collaboration with health care workers.

Implementation of the HPC programme gained momentum in 2008/09 with a total of 88 PHC clinics implementing the HPC standards and criteria (Graph 8). Three clinics in the Amajuba District were formally accredited as HPC's in 2008/09 with clear evidence of community involvement, contact with neighboring schools and the development of user-friendly policies at clinic level. Results of the Amajuba Project showed that:

- Sustainability of HPC's are dependent on management support as well as dedicated support at clinic level;
- Client satisfaction and community participation improved as the project evolved;
- Community involvement in the development of clinic policies improved ownership by said communities;
- Partnerships and integration of services improved as a result of improved consultation and feedback; and
- Integration of Health Promoting Clinics and Schools improved communication between health services and the community, which is in line with the Department's commitment to '*listen to the voices of communities*'.

Graph 8: Health Promoting Clinics per District



! CHALLENGE

- Delays with the establishment of a Provincial Assessment Team affect technical support, assessment and accreditation of qualifying clinics. This in turn impacts on staff motivation and sustainability of the project.

Health Promoting Homes

The Department pursues the concept of 4 HPS each taking responsibility for supporting 2 homes (within their catchment area) to implement basic health promotion principles at household level. This initiative is still in its infancy, with only the Ugu District (16 homes) and Umzinyathi District (11 homes) implementing the programme.

The Department is currently pursuing partnerships with the Department of Housing and the Paraffin & Safety Association of South Africa to support these homes with the establishment of gardens (MDG 1), improved sanitation (MDG 4) and improved safety at homes. The profiles of the Community Based Health Carers are currently being reviewed to improve support and sustainability of the programme.

Wellness in the Workplace

Staff shortages, increased workloads, and staff being personally affected by disease resulted in an increased number of staff suffering from burn-out, increased absenteeism, etc. Improving the wellbeing of staff should therefore be a priority.

The Healthy Lifestyle Sub-Component developed a pilot programme for physical activity at work, and initiated team building activities for two Head Office groups in 2008/09 with plans to expand this in 2009/10. eThekwini District initiated weekly 'Vuka - Move for Health' aerobic classes in the District Office in partnership with Department of Sport & Recreation. Districts were able to reach 28,977 employees with the Wellness Programme in 2008/09.

Healthy Lifestyle 2010

The Department established a Provincial 2010 Forum to expand healthy lifestyle initiatives in the 5 districts with Fan Parks during the 2010 Soccer World Cup. The Forum will oversee implementation of health promoting activities.

⇒ PRIORITY 1: DECENTRALISED CAPACITY TO ENSURE INTEGRATED HEALTH PROMOTION PROGRAMMES

Sustainable integration of health promotion programmes is still a challenge although progress has been made with the establishment of integrated Health Promotion Forums at district and sub-district levels. Although numerous health promotion activities and programmes have been implemented during the year, the development of a Provincial integrated strategy has not been achieved.

The Healthy Lifestyle Sub-Component, in collaboration with programmes, developed and distributed a Healthy Lifestyle Booklet with themes based on the 5 Healthy Lifestyle Components to ensure standardised messages to communities. Health Calendar events in districts actively promoted healthy lifestyles and screening programmes (for chronic conditions) were offered at all such events.

District multi-sectoral forums actively participated in the Provincial School Health Weeks thus ensuring effective utilisation of resources and comprehensive and integrated service delivery. The Healthy Lifestyle Partnership Forum, in collaboration with NGO's and other health programmes, developed integrated health education pamphlets e.g. Sun Safety with CANSA, Woman's Health, Mental Health, Chronic Diseases, Oral Health, Disability & Rehabilitation and Healthy Lifestyles.

Improved partnerships at district level positively contributed towards health programmes, for example:

- ABSA donated trees, fertilizers and garden implements to schools as part of Arbor Day celebrations; and
- Kids & Care, a non-profit organisation from the Netherlands, participated in a diabetes project for children.

Health literacy has been improved through more effective distribution of health information material. The intranet is used to notify districts of available materials and to improve ordering and distribution of material. Since the development of Resource Centres at District level has been put on hold due to financial constraints, the Department used the Resource Centres of the Department of Education and Health Promoting Schools for distribution of health information. Districts succeeded in distributing material to 13,718 outlets during 2008/09.

⇒ PRIORITY 2: HEALTH PROMOTION FOR INFECTION CONTROL, CARE OF THE PREGNANT WOMAN, NUTRITION, AND HIV AND TB PREVENTION

A variety of health education and promotion programmes have been implemented at district level to raise awareness about priority programmes. Programmes and events included:

- Valentine's Day for clients on ART: Aimed at prevention of re-infection and protecting partners from being infected.
- Men in Partnership against AIDS (MIPAA): Aimed at motivating men to play an active role in prevention of HIV & AIDS.
- Community VCT programmes in partnership with NGO's: Reported an increase in VCT uptake since implementation of programmes.
- MC&WH Door to Door Campaigns: The focus was immunisation, ANC visit before 20 weeks and PMTCT.
- Mom and Baby Edu-Shows: Topics included PMTCT, breast and cervical cancer screening and immunisation.
- Nutrition and child abuse event: Aimed at preventing malnutrition and abuse.
- TB Door to Door Campaigns: Aimed at raising awareness, preventing infection and improving treatment completion rates.
- TB Puppet Shows: Aimed at raising awareness in primary schools.
- World TB Day: Commemoration of World TB Day. Approximately 10,700 community members reached and official opening of the MDR Unit and Gateway Clinic at Murchison Hospital.
- STI & Condom week: Door to door campaigns undertaken in 8 hostels - over 3,500 men reached of which 425 did VCT during this week.
- Khanya Africa initiatives in all districts. The impact should be measured in year or two.
- Radio programmes: Radio talk shows are done on Community Radio stations and covered topics aligned to the health calendar, specific health challenges as well as district needs.
- Youth Ambassadors visited communities and provided preventive and promotive programmes.

! CHALLENGE

- The lack of an integrated Provincial Health Promotion Strategy, an active results-based monitoring & evaluation component and inadequate allocation of resources affects implementation of integrated and comprehensive programmes and ultimate health outcomes. The lack of data to monitor input versus outcome affects long-term decision-making and planning.

PROVINCIAL PERFORMANCE INDICATORS

Data completeness: 95%

Table 22: Provincial Objectives and Performance Indicators for Communicable & Non-Communicable Diseases (Healthy Lifestyles)

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Strategic Objective: To ensure the effective implementation of programmes to reduce non-communicable & communicable diseases and diseases of lifestyle.					
Measurable Objective: To implement integrated health promotion and healthy lifestyle programmes.					
1. Number of schools accredited as Health Promoting Schools.	19*	54*	79*	176	131
2. Number of accredited Health Promoting Clinics.	0	0	0*	11*	3
3. Number of Health Promoting Homes implemented and supported.	0	0	8*	24*	27

* Refers to updated data (including targets) received from the Health Promotion Programme and based on data in the Health Promotion database.

MENTAL HEALTH

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities 2006-2008/09

Priority 2: Promote healthy lifestyles

Priority 4: Improve management of communicable diseases and non-communicable illnesses

Priority 9: Prepare and implement legislation

↓

Provincial Strategic Plan 2005-2009/10

Goal 3: Promote health, prevent and manage illnesses with emphasis on poverty, lifestyle, trauma and violence

↓

Annual Performance Plan 2008/09

Goal 5

Strategic Objective 20: To ensure the effective implementation of programmes to reduce communicable and non-communicable diseases and diseases of lifestyle

↓

Mental Health Priorities 2008/09

1. Facilitate and monitor the implementation of the Mental Health Care Act, 2002.
2. Facilitate and monitor the implementation of decentralised Mental Health services based on imperatives set in the STP.
3. Develop and implement policies and guidelines on substance abuse, violence prevention, psychological rehabilitation and suicide.
4. Develop and monitor the implementation of integrated strategies for prevention of violence against women and children.

Mental Health - Patients Crafts

EXECUTIVE SUMMARY

The transformation of mental health care services, from the predominantly authoritarian biomedical model towards a more comprehensive and integrated community-based care approach (as envisaged in the Alma Ata Declaration and the Mental Health Care Act, 2002) was severely challenged by inadequate systems, processes and resources at service delivery level. De-institutionalisation to ensure continuum of care to patients with severe and chronic mental disorders is complicated, and translation of policy into practice has been hindered by severe financial constraints in 2008/09. As a result, hospitals still serve a large residual of chronic long-term patients while the number of acutely ill patients seeking care is increasing.

The transformation of mental health services is further challenged by:

- Inadequate resources partly as a result of the current inability to transfer adequate resources from institutions to communities to ensure continuity of care. Current budget constraints do not allow for this transformation and districts are forced to render services within current limitations.
- The development of community residential care facilities and ambulatory services is a long drawn out process but crucial to reduce relapse and increased re-admission amongst de-institutionalised patients.

- Stigmatisation of mental health patients still exists which might be one of the reasons why people still prefer hospital as opposed to community care. Financial constraints limited communication strategies aimed at changing the paradigms of health workers, families and the community at large.
- Urbanisation is impacting negatively on extended families who are expected to participate in patient care, and high poverty levels exacerbate the ability of families to care for patients at home.
- Human resource constraints including attrition, absenteeism and skills gaps affect the provision of effective continuity of care and support to families and NGO's.

Although all hospitals are able to provide 72-hour observation for mental health care users, the observation period is often exceeded due to an inadequate number of step-down facilities and specialised psychiatric hospitals. This in turn translates into increased cost, and since only 34 hospitals have seclusion facilities for mental health care users the safety of patients and staff are compromised leading to possible legal implications.

Seven specialised Psychiatric Hospitals render specialised services in the Province.

POLICIES

Table 23: Acts, Policies, Protocols and Guidelines

New Acts, Policies, Protocols & Guidelines	Comments
1. Policy Guidelines for Mental Health Review Boards.	• Policy finalised in September 2008 and awaiting approval.
2. Psycho-Social Rehabilitation Policy.	• The intended pilot project to test policy implementation was delayed due to budget constraints.
3. Policy on Licensing and Funding of Mental Health Non-Governmental Organisation (NGO) Facilities.	• Approved and implemented.
4. Policy on the De-Institutionalisation of Patients.	• Implementation dependent on adequate financial resources.
5. The following Mental Health Policies are in draft: – Detoxification; – Dual Diagnosis; – Forensic Services; – Seclusion and Restraint; – Integration of Mental Health and Substance Abuse into PHC; and – Planned Patient Transport for Mental Health.	• Policies will be finalised in 2009/10.
6. There are currently no policy guidelines for psychiatric patients obtaining consent for VCT. Co-morbidity is a challenge as an increasing number of patients present at health facilities with HIV related psychosis.	

PROGRAMME PERFORMANCE

There still exists a significant gap between policy and adequate resources for translation of policy into effective service delivery. Severe financial limitations hindered the service delivery machinery in establishing the necessary systems and processes for the smooth transition of mental health services as prescribed in the Mental Health Care Act (MHCA).

The Occupation Specific Dispensation (OSD) was expected to improve attrition rates and skills gaps, increase service availability, access and smooth integration of mental health services into PHC. Early assessment however indicated that whilst OSD benefited some professionals the overall impact on mental health has been negative due to nurses with psychiatric skills being attracted to other nursing disciplines with incentives. The impact of the renewal of the danger allowance for Mental Health Professionals will be monitored to

determine if that has any impact on retention of this category of staff.

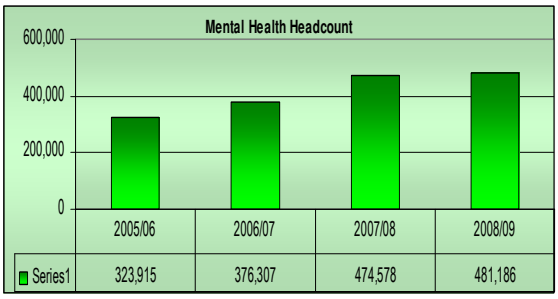
A Mental Health Situational Analysis was conducted in 2008/09 and the results, coupled with resolutions from the Mental Health Indaba, will be used to inform the Mental Health Strategic Plan in 2009/10.

Integration of mental health care services into PHC requires a reliable and valid information system to monitor disease profiles, programme performance and the transition of mental health care users from hospital to community-based care centres. The lack of a standard information system and indicators inspired an integrated project in collaboration with the University of Cape Town to develop a standardised Mental Health Information System fully aligned with the DHIS and Provincial M&E Framework. The project, implemented in the Umkhanyakude, Ilembe and Umgungundlovu Districts, commenced in 2008 and the results will be used to inform the information system nationally. Data elements for mental health (being tested in the pilot districts) have been included in the DHIS 1.4 and will be collected and monitored from 2009/10. Training on new data elements has been conducted in all districts in 2008/09.

⇒ PRIORITY 1: IMPLEMENTATION OF THE MENTAL HEALTH CARE ACT, 2002

Mental Health Care Act Flow Charts are available in all districts to improve the management and appropriate referral of patients. Staff shortages at PHC level however affect service delivery and the complete package of mental health services is not rendered at all facilities. The increased clinical workload, due to high vacancy and attrition rates, skills gaps, increased patient numbers in PHC, and changing disease profiles, challenge the rendering of comprehensive mental health services at PHC level. Counselling for mental health disorders is time consuming and still seems to be the responsibility of psychiatric nurses.

Graph 9: Mental Heath Headcount 2005/06 – 2008/09



Mental Health Forums have been established to drive community awareness and outreach activities, although multi-disciplinary teams are not yet fully functional. Some districts still experience challenges with the referral and management of violent patients by the SAPS and training programmes commenced to ensure compliance to the MHCA.

Capacity building and training of PHC staff in Mental Health and Substance Abuse was intensified and is ongoing to improve the management of mental health patients. High staff turnover and financial constraints however limited the number of providers exposed to training and orientation. Approximately 20 health care providers per district were trained in 2008/09, and stakeholders from the SAPS, EMRS and the Justice Forum received training in mental health and Forensic Psychiatry. Not all PHC Nurses/ Medical Officers have received orientation in mental health due to financial constraints.

Although all hospitals offer 72-hour assessment, patients are sometimes kept beyond 72 hours due to inadequate step-down facilities and beds in specialised hospitals. This extended stay has financial implications and also defeats the purpose of de-institutionalisation as prescribed in the MHCA.

The Infrastructure Development Plan makes provision for the building of seclusion rooms (as required in the MHCA) but this was restricted by cost saving measures implemented in 2008/09. The current 34 hospitals with seclusion rooms are inadequate to cater for patient numbers and therefore contravene implementation of the MHCA.

Mental Health Review Boards has been established, although some districts still experience challenges with appointments. This has been brought to the attention of the Mental Health Directorate and will be followed up in

2009/10. Challenges pertaining to roles and functions of the Mental Health Review Boards will be monitored once the policy is approved and implemented.

The Child and Adolescent Unit at King George V Hospital is fully operational and a Child Psychiatrist Specialist was appointed. Due to the shortage of specialised capacity in the Province the hospital is overcrowded resulting in a shortage of staff to deal with the increasing workload. Districts reported serious challenges with the referral of patients for specialised management, highlighting the need for financial support to establish the necessary infrastructure and systems for quality of care.

There are 7 Specialised Psychiatric Hospitals that are situated in 4 Districts in the Province (see following table). This distribution of specialised facilities may delay the shift from custodial care to patient and community care, especially if not linked with the necessary step-down and support functions. The Provincial mental health bed norms for District Hospitals (139 beds) and for Provincial Hospitals (75 beds) is currently being reviewed by the Mental Health Directorate for inclusion in the STP.

Table 24: Provincial Specialised Psychiatric Hospitals

District	Psychiatric Hospital	Bed Numbers
Umgungundlovu	Town Hill	425 (305 usable)
Umgungundlovu	Umgeni	624
Umgungundlovu	Fort Napier	350
Sisonke	Umzimkhulu	320
Amajuba	Madadeni	352
eThekwini	Ekuhlengeni	824
eThekwini	King George V	60

As a result of poor infrastructure, a shortage of trained mental health staff and budget constraints, in-patient services for Child and Adolescent units are not fully operational. The only in-patient service is rendered at the King George V Hospital (6 bed unit) while other hospitals offer out-patient services to children and adolescents – resulting in children and adolescents being admitted with adult patients (medico-legal implications). Children and adolescents that need further medical investigations done are admitted at Greys Hospital (Tertiary Hospital) in the Umgungundlovu District.

⇒ PRIORITY 2: DECENTRALISED MENTAL HEALTH SERVICES BASED ON IMPERATIVES SET IN THE STP

The Mental Health Care package of services (per level of care), norms and standards, referral patterns, etc. is currently being reviewed for inclusion in the STP. The STP has not yet been approved for implementation and the Psychosocial Rehabilitation Policy will in the interim provide the framework for decentralised service delivery.

The Department commenced with the shift from custodial care to patient and community orientated services, although specific data to measure progress was not available for this report. All districts made progress with outreach and support services in support of de-institutionalisation, improved screening at PHC level, early diagnosis and appropriate referral to specialised care. Challenges however still exist which will be factored into plans for 2009/10.

Partnerships and collaboration with the Mental Health Societies of Pietermaritzburg, Durban and Coastal areas, the Departments of Housing, Social Development, Labour, Social Welfare, SANCA and NGO's contributed to the establishment of residential, daycare and halfway houses in the Province. In addition, the Department intensified education for the establishment of community-based facilities (MHCA Regulation 43) and the implementation of the comprehensive strategy with communities and NGO's in support of half-way houses and residential care. In 2008/09 subsidies were paid to 14 Day Care Centres, 11 Residential Care Facilities and 5 Half-Way Houses.

⇒ PRIORITY 3: SUBSTANCE ABUSE, PREVENTION OF VIOLENCE AND PSYCHOSOCIAL REHABILITATION AND SUICIDE

Substance abuse is associated with many physical and psychological illnesses such as psychosomatic conditions, HIV & AIDS, depression, anxiety, stress, psychosis, and violent behavior and trauma with a debilitating impact on the quality of life. The provisions of the National Drug Master Plan seek to galvanize all stakeholders to develop and implement strategies for the management of substance abuse in South Africa. The Department of Health has committed itself to reducing the risks and harm caused by psychoactive drugs and to promote the responsible use of alcohol and tobacco.

The Department collaborated with the Departments of Community Safety and Liaison, Education and Social Development in the implementation of awareness

campaigns, providing technical support on detoxification programmes at treatment centres, appointment and support of medical personnel, capacity building and supervision. A health audit and inspection tool has been developed and implemented in the Province.

NGO's have been sensitised towards the inclusion of psychosocial rehabilitation programmes into existing activities. Three Day Care Centres have since started skills training programmes, two Half-way Houses involve patients in existing projects and one Psychosocial Club produces evidence-based psychosocial skills through their sales of products made by users and active participation on daily living activities.

⇒ PRIORITY 4: PREVENTION OF VIOLENCE AGAINST WOMEN AND CHILDREN

The partnership between UNODC and the National Maternal and Child Health commenced with a strategy to improve access to training of staff and support to survivors of sexual abuse. Output and outcome information is not yet available.

PROVINCIAL PERFORMANCE INDICATORS

Data completeness: 95%

Table 25: Provincial Objectives and Performance Indicators for Communicable & Non-Communicable Diseases (Mental Health)

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Strategic Objective: To ensure the effective implementation of programmes to reduce Non-Communicable & Communicable Diseases and diseases of lifestyle.					
Measurable Objective: To operationalise the imperatives set by the Mental Health Care Act, 2002.					
1. Percentage of Hospitals providing the designated package of services.	50%	75%	100%[51]	100%	100%[52]
2. Percentage of District Hospitals providing a 72-hour assessment service.	85%	80%	100%	100%	100%
3. Percentage of PHC Nurses trained in Mental Health Care Protocols.	70%	80%	See Footnote[53]	100%	See Footnote[54]
4. Number of institutions providing detoxification services.	22	22	64[55]	64 (100%)	16 (25%)
5. Percentage of Districts with community initiatives for the prevention of substance abuse.	Not reported	25%	100%[56]	100%	100% (11)
6. Percentage of planned Child and Adolescent Services operational.	Not reported	0%	50%	100%	33%[57]

[51] Quality is compromised due to staff & skills shortages - especially affecting level 2 and 3 services
[52] Vacancy rates and skilled staff compromise service delivery & package of services
[53] No database to monitor the training coverage/ gaps
[54] Information not available due to staff rotation and lack of a central database
[55] All Hospitals are able to provide the service
[56] Local Drug Action Committee established in 4 districts
[57] Not fully functional - limited number of beds (as indicated in narrative)

CHRONIC DISEASES

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Strategic Priorities 2006-2008/09

Priority 2: Promote healthy lifestyles

↓

Provincial Strategic Plan 2005-2009/10

Goal 2: Strengthen PHC and provide caring, responsive and quality health services at all levels

↓

Annual Performance Plan 2008/09

Goal 5

Strategic Objective 20: To ensure the effective implementation of programmes to reduce communicable & non-communicable diseases and diseases of lifestyle

↓

Chronic Diseases Priorities 2008/09

1. Increase the Provincial cataract surgery rate in collaboration with private partners.
2. Expand the provision of Low Vision services at all Sight Saver Centres.
3. Improve implementation of fast queues at PHC level.
4. Strengthen Family Medicine practice at District Offices to support and provide clinical governance for effective and efficient management of chronic diseases at all levels of care.
5. Promote the implementation of decentralised strategies to facilitate chronic medicine compliance and control through integrated health promotion.

Optometry student education at Ngwelezana Hospital

EXECUTIVE SUMMARY

Non-communicable diseases are a major contributor to the burden of disease in the Province and are increasing rapidly mainly as a result of changing lifestyles and demographic transition. These diseases are largely attributed to preventable and modifiable risk factors such as obesity, physical inactivity, unhealthy diet, tobacco use and inappropriate use of alcohol. These factors result in various long-term disease processes, culminating in high mortality rates as a result of stroke, heart attack, tobacco and nutrition-induced cancers, obstructive lung diseases and many others.

The Child Eye Care Project, in partnership with the Department of Education and International Centre for Eye Care Education (ICEE), is aimed at identification and treatment of children with refractive errors ceased in June 2008. Nissan donated a fully equipped mobile to provide services and grinding spectacles on site. A total of 237,556 children were screened across the Province, 6,687 received refraction and 1,900 received spectacles.

The Department signed a Memorandum of Understanding with the ICEE through the Giving Sight in Africa Project for the period June 2008 to July 2012. The aim of the project is to develop and provide an eye care delivery system that can be duplicated to other parts of Africa. Through this project, optometrist equipment worth R1.5 million was donated to the Province to improve eye care services, and Optometrists were appointed (through the project) in districts where vacant posts could not be filled due to financial constraints. Access to refraction services has increased from 40% to 100% and the refraction rate increased from 15% to 40% through affordable spectacle provision.

The Geriatric Clinic is functional at IALCH, however not readily accessible to most elderly people. The Provincial Older Persons Forum, which falls under guardianship of the Office of the Premier, is functional, and 60% of districts have their own forums. A total number of 23,696 older persons received the flu vaccine in 2008/09.

POLICIES

Table 26: Acts, Policies, Protocols & Guidelines

New Acts, Policies, Protocols & Guidelines	Comments
1. The Older Persons Act.	• The Act has been circulated to facilities and is available on the Departmental intranet. Facility Medical Managers are facilitating translation into facility protocols.
2. National Guidelines on the Management of Chronic Diseases and Geriatrics.	• Guidelines have been circulated to all facilities and to 65% of old age homes. Districts facilitate workshops on the Guidelines and monitor facility-based in-service training which promotes quality and standardised care.

PROGRAMME PERFORMANCE

The Province improved eye care programmes through partnerships with the ICEE, Bureau for Prevention of Blindness, Red Cross and Lions International. Staff shortages (high vacancy rates of specialised professionals), severe financial constraints, and inadequate equipment however impacted on service delivery and achievement of cataract surgery targets.

The vacancy rate for Optometrists and Opticians was 65.9% in 2008/09 with an annual turn-over rate of 7.1% and posts could not be filled due to financial constraints and the moratorium on the filling of posts. The Giving Sight Project employed 4 Optometrists to work full time in public sector hospitals. Cataract case findings were in many instances below expectation because of increased catchment populations to be served by case finders as a result of the shortage of staff and resources.

In spite of numerous challenges, the Department was able to make substantial progress towards improving availability and access of services.

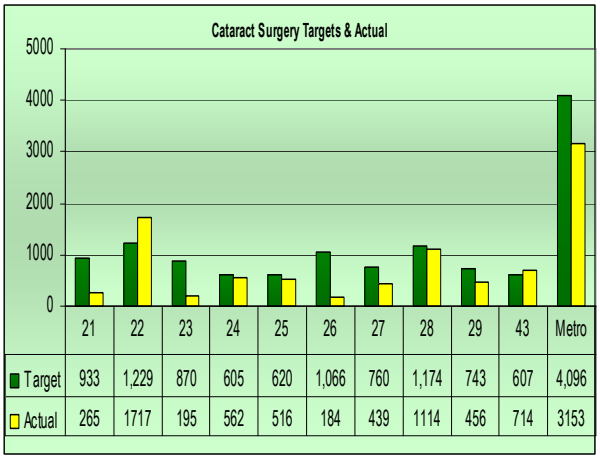
⇒ PRIORITY 1: INCREASE THE PROVINCIAL CATARACT SURGERY RATE

Staff shortages, inadequate resources for eye care, financial constraints and inadequate theatre time had a negative impact on programme performance in 2008/09. Although the Bureau for Prevention of Blindness, ICEE and Lions International donated eye equipment to some districts there are still shortages of specialised equipment, which in conjunction with insufficient theatre time impacts on service delivery and reaching targets for cataract surgery. The failure of OSD to recognise Ophthalmic Nurses in PHC has a negative impact on improving coverage at the primary level of care, which resulted in increased referral to hospitals.

Only Umgungundlovu (22) and Sisonke Districts (43) were able to exceed their cataract surgery targets for 2008/09, while the targets for other districts seem to be unrealistically high when considering the severe human and financial resource challenges experienced in districts (*See Graph 10*). When considered in context of the severe financial constraints in districts the programme did well in spite of under performance in most districts.

Outreach services, in support of facilities without specialised capacity, are actively pursued and supported by the ICEE, Bureau for Prevention of Blindness, University of KwaZulu-Natal Ophthalmology Registrars and the Red Cross. Districts increased sessional support to under-resourced hospitals where possible and are motivating for increased theatre time for cataract surgery.

Graph 10: Cataract Surgery Rate - 2008[58]



⇒ PRIORITY 2: EXPAND LOW VISION SERVICES AT ALL SIGHT SAVER CENTRES

Financial constraints limited the expansion of Low Vision

[58] 21=Ugu; 22=Umgungundlovu; 23=Uthukela; 24=Umzinyathi; 25=Amajuba; 26=Zululand; 27=Umkhanyakude; 28=Uthungulu; 29=Ilembe; 43=Sisonke; Metro=eThekwini

Services in 2008/09. Services are currently rendered at IALCH and Stanger Hospital although severe budget restrictions at Stanger Hospital challenged the rendering of the full package of services. Through the Giving Sight Project, 20 Optometrists were trained on Low Vision in 2008/09 in order to provide services when necessary.

There are 13 Sight Saver Hospitals (with a second Sight Saver Centre at Umphumulo Hospital in the Ilembe District) in the Province although all hospitals were not able to provide the full package of services for eye care due to a lack of resources. The ICEE funded a post for an Optometrist at the Mahatma Ghandi Hospital to ensure 8-hour coverage and free screening services. Hlabisa (Sight Saver Hospital) is not functional due to a lack of resources.

The ICEE donated Optometrist equipment worth R 1.5 million to the Province as part of the Giving Sight Project that aims to develop an effective and sustainable eye care delivery system in the Province.

The Child Eye Care Project, focusing primarily on identification and treatment of school children with refractive errors, has made huge strides in improving eye care services for children in the Province. The ICEE employed 3 Optometrists and funded 1 post to ensure Optometrist free screening services at primary health care level. They also donated optometrist equipment to ensure sustainability of services after completion of the project. Discovery will sponsor the programme with R 400,000 over the next 2 years.

To date, a total of 237,556 children were screened through the Child Eye Care Project, 1,900 children received spectacles and 41% of refractions were corrected. A total of 186 children were referred to the next level of care. Nissan donated a fully equipped mobile van to provide these eye care services as well as grinding spectacles.

Vision 2020 (Prevention of Blindness Programme)

A total of 9,315 cataract operations were done and 11,653 spectacles provided in 2008/09.

! CHALLENGES

- Allocation of OSD only recognised Ophthalmic Nurses working in hospitals with an eye ward as a specialist. This resulted in nurses exploring employment opportunities elsewhere.
- Infrastructural challenges (limited space) at hospitals inhibit the rollout of this eye care programme.
- Financial constraints resulted in cut down of elective surgery thus reducing the number of cataract surgeries performed in the Province. The Bureau for the Prevention of Blindness cancelled their Cataract Tours the last quarter of 2008/09 as a result of outstanding payment.
- Non-prioritisation of prevention of blindness by Regional Hospitals resulted in services not being accessible in some districts.

⇒ PRIORITY 3: IMPROVE IMPLEMENTATION OF FAST QUEUES AT PHC LEVEL

86% of PHC facilities have fast queues in 2008/09 as compared to 40% in 2005/06.

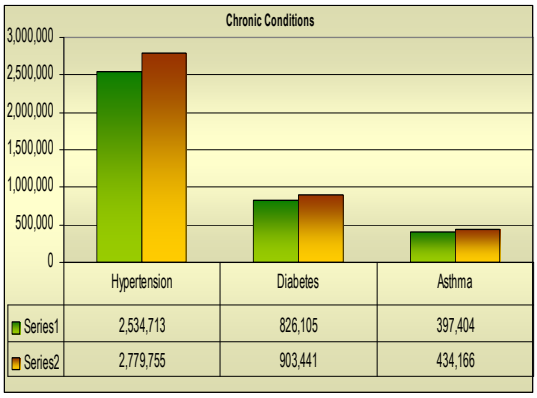
⇒ PRIORITY 4: STRENGTHEN FAMILY MEDICINE AT DISTRICT OFFICES

The Department has made progress in improving and establishing Family Medicine at district level. Family Medicine Components have been established at 50% of institutions, adding value to service delivery through improved monitoring of quality of care and management of chronic diseases. Most PHC clinics have visiting doctors on a weekly or monthly basis to ensure that patients have access to the necessary services.

⇒ PRIORITY 5: IMPROVE CHRONIC MEDICINE COMPLIANCE AND CONTROL THROUGH INTEGRATED HEALTH PROMOTION

The shortage of staff and consequent increased workload as a result of changing disease profiles at PHC level seriously impact on service delivery for chronic diseases. All districts reported an increase in the number of chronic diseases especially hypertension, diabetes and other diseases of lifestyle.

Graph 11: **Chronic Conditions 2007/08 – 2008/09**



Amputee clinics, operational once weekly, are rendered at King Edward VIII, Addington, Prince Mshiyeni Memorial, RK Khan and Clairwood Hospitals as well as Phoenix Assessment Therapy Center. Services are provided by Orthotic and Prosthetic services. A total of 519 amputations were conducted on people with diabetes in 2008/09.

Diabetes awareness and screening were improved in 2008/09 through the partnership with Novo Nodirks. During district awareness programmes a total number of 6,961 people were screened for diabetes; 536 people were newly diagnosed on the bus; 953 diabetes clients on oral medication and 229 on insulin were seen during district programmes. Research indicates that approximately 33% of males are at risk of developing diabetes and 68% uncontrolled diabetes. This should be considered in health out-reach programmes. 280 Professional Nurses were trained in diabetes through a partnership with the South African Sugar Association.

The lack of a fully funded and integrated Provincial Health Promotion Strategy results in vertical initiatives that are not sustainable and have limited impact. Current financial constraints limited out-reach and community interventions hence impacting on lifestyle and health behaviours as indicated in districts reports. Increased defaulting on chronic medication and poor nutritional and lifestyle habits challenge the management of chronic diseases including preventive and promotive programmes. The sustainability of established support groups in districts continues to be a challenge mainly as a result of financial challenges.

Information and education about chronic conditions are prioritised in districts and include promotion of healthy life styles, radio talk shows, establishment of support groups for people with chronic diseases, development and distribution of IEC material, health awareness activities held per quarter, etc. Active screening for chronic diseases was prioritised at all health events to promote early diagnosis, effective referral, treatment and treatment compliance. In 2008/09, the Department trained 224 Professional Nurses on Cervical Cancer Screening, Pap smears and breast cancer screening.

Tracing of defaulters is a challenge mainly attributed to the lack of integrated tracing teams, inadequate numbers of Community Care Givers (and supervisors/ facilitators) to fulfill community-based functions, and inadequate communication (telephones) at some clinics. Some districts reported a reduction in the detection of new hypertension and diabetic clients as a result of decreased outreach events due to financial constraints.

The Project to fast track the delivery of chronic medication in the eThekwini District is not yet concluded although early observation suggests positive compliance data. The final results will inform the development of a strategy to improve health promotion and compliance to treatment regimes. Extended services to communities commenced in the South of eThekwini where a Pharmacy Assistant from RK Khan Hospital issue pre-packed medication to stabilised clients after screening. This takes place in community halls, old age homes or churches to take health to the people.

The Geriatric Pilot Project at IALCH is still operational on Wednesdays with clients being referred from King Edward VIII and RK Khan Hospitals. The average age of patients attending the service is between 60 and 70 years of age.

There has not been any expansion of Stroke Units from the original 5 sites. A motivation was submitted to the Initiatives Funding Grant for an additional 6 sites to ensure that all districts are covered - no response to date.

PROVINCIAL PERFORMANCE INDICATORS

Data completeness: 95%

Table 27: Provincial Objectives and Performance Indicators for Communicable & Non-Communicable Diseases (Chronic Diseases and Geriatric Care)

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Strategic Objective: To ensure the effective implementation of programmes to reduce Non-Communicable & Communicable Diseases and diseases of lifestyle.					
Measurable Objective: To implement the comprehensive programme for Chronic Diseases & Geriatrics.					
1. Cataract surgery rate.	6,286	6,188	7,715	13,000	9,315[59]
2. Percentage of facilities providing flu vaccines the older persons.	50%	60%	80%	100%	60%
3. Number of Districts with Low Vision services.	0	1	2[60]	2	2
4. Percentage of PHC clinics with fast queues for chronic medicine collection.	40%	54%	80%	100%	86%

[59] The variance of DHIS and Programme data is contributed to the vertical reporting system currently used for cataract surgery done through partnerships. DHIS cataract surgery rate: 7,085

[60] Currently at IALCH and being developed at Mahatma Ghandi Hospital commencing in 2007/08

NOTES

REHABILITATION & DISABILITY

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities 2006-2008/09

Priority 4: Improve management of communicable diseases and non-communicable illnesses

↓

Provincial Strategic Plan 2005-2009/10

Goal 2: Strengthen PHC and provide caring, responsive and quality health services at all levels

↓

Annual Performance Plan 2008/09

Goal 5

Strategic Objective 20: To ensure the effective implementation of programmes to reduce communicable and non-communicable diseases and diseases of lifestyle

↓

Rehabilitation & Disability Priorities 2008/09

1. Provide Provincial policy guidelines to support institutions.
2. Facilitate processes to strengthen the provisioning of rehabilitation and other services to disabled persons at PHC level.
3. Develop and facilitate innovative solutions to address the backlog in the provisioning of assistive devices to qualifying patients.
4. Facilitate capacity building in health care workers and persons with disabilities around rehabilitation and disability issues.
5. Facilitate the implementation of the Strategy to prevent disability in the Province.

Khanya Africa campaign at Ilembe Health District

EXECUTIVE SUMMARY

Access to services for persons with disabilities improved significantly in 2008/09 as a result of increased community service programmes and the employment of 35 Speech Therapists and Audiologists, 46 Occupational Therapists and 59 Physiotherapists. During 2008/09, 80% of hospitals reported therapist coverage and 1,406 clinics were visited by therapists.[61]

Audiology services in the Province have been expanded with Vryheid Hospital (Zululand District) appointing a fulltime Audiologist and offering the full package of audiology services. Service delivery in the Umzinyathi District improved with audiology services being rendered at Church of Scotland (COSH), Dundee and Greytown Hospitals. Newborn hearing screening services commenced at IALCH, Mahatma Ghandi Hospital and the Phoenix Assessment Centre, ensuring early identification and management of hearing loss in babies.

In spite of financial constraints the Department issued 1,988 wheelchairs and 1,113 hearing aids in 2008/09.

[61] Information from District Quarterly Reports

Part B – Programme 2: District Health Services

POLICIES

Table 28: Acts, Policies, Protocols and Guidelines

New Acts, Policies, Protocols & Guidelines	Comments
1. Provincial Integrated Disability and Rehabilitation Policy.	• The policy regulates implementation of the International Classification of Functionality and Disability in the health system, and mitigates a reduction in preventable disabilities, effective management of acquired disabilities and prevention or mitigation of the longer term consequences of disability to people with disabilities, those at risk, and their families.
2. The following National Policies inform service delivery:	• National policy frameworks have been incorporated into Provincial Implementation Plans and are monitored through quarterly and annual district reports.
– National Rehabilitation policy (2000).	– Outlines the responsibility of the DOH to service provision for People with Disability and has been integrated in the above.
– Free Health Care Policy (2003).	– All indigent people with disabilities receive free health care. Also integrated and monitored through the processes above.
– Minimum criteria for physical accessibility.	– All hospitals meet the minimum criteria. Monitored as above as well as annually through the District Health Plans.
– Criteria for Dispensing Assistive Devices.	– Set criteria prioritising patients due to limited resources. Monitored through the district quarterly reports.

PROGRAMME PERFORMANCE

The post establishment reflected a total of 445 permanent therapists in the Province during 2008/09 including 235 Physiotherapists (vacancy rate 60%), 131 Occupational Therapists (vacancy rate 58.8%) and 79 Speech Therapists and Audiologists (vacancy rate 41%). The high turnover rates of 36.8%, 53.8% and 51.8% clearly indicate the importance of an effective recruitment and retention strategy.

Routine data elements and indicators are included in DHIS version 1.4 and collection and monitoring will commence in 2009/10.

⇒ PRIORITY 1: PROVIDE PROVINCIAL POLICY GUIDELINES

Policies and guidelines are available in all districts and institutions although implementation has been delayed due to financial constraints.

The Rehabilitation and Disability Programme is in the process of developing a Provincial policy to address reasonable accommodation for persons with disability. The Programme is consulting with the Human Resource Management Section in relation to the Provincial Employment Equity Strategy that will be supported by the newly formed Employment Equity Forum.

⇒ PRIORITY 2: STRENGTHEN SERVICES FOR DISABLED PERSONS AT PHC LEVEL

Disability and Rehabilitation has been included in the revised PHC Package of Services which will be piloted in the Sisonke District in 2009/10.

The placement of 140 Community Service Therapists has strengthened access to services at PHC level. Therapists spend 40% of their time in PHC clinics and CHC's which improved PHC coverage to a total of 1,406 clinic visits by therapists in 2008/09. The placement of community service therapists has greatly alleviated human resource shortages at hospitals with 80% of hospitals able to access some rehabilitative service in 2008/09.

The current number of therapists is however inadequate to manage the range of disabilities, amongst others stroke, trauma, motor vehicle accidents, disabilities as a result of HIV and AIDS, injury, hearing loss and genetic syndromes. The current lack of specialised skills required for screening, assessment, diagnosis, therapy, capacity building, etc. have a negative impact on service delivery and health outcomes.

There are currently 24 Audio Sites in the Province, with new sites established at Vryheid, Church of Scotland, Dundee and Greytown Hospitals. The Department will conduct an audit to determine the status and quality of services in 2009/10.

The Department signed 3 Service Level Agreements (SLA's) valid until August 2011. Disabled People South Africa manages the Wheelchair Repair and Maintenance Project with 23 workshops in which 54 people with disabilities are employed to repair wheelchairs. Workshops provide employment to people with disabilities and ensure that wheelchair repair services are available to disadvantaged people free of charge. This complies with key departmental priorities such as creation of employment, employment equity and poverty alleviation. The Department also renewed the SLA's with the Community Based Rehabilitation Project and Magaye Visually Impaired Peoples Organisation which ensures that persons with disabilities in communities are identified and managed appropriately. In addition, a total of 22 Community Based Rehabilitation Workers are employed through a service level agreement.

⇒ PRIORITY 3: ADDRESS BACKLOG IN PROVISIONING OF ASSISTIVE DEVICES

District Offices were encouraged to prioritise the procurement of assistive devices and to procure a small stock of wheelchairs for distribution in cases of emergency. Financial constraints however impacted negatively on the procurement of assistive devices resulting in growing waiting lists in all the districts. Some districts were able to secure sponsored wheelchairs through LOTTO funding which in some instances accounted for 50% of the total wheelchairs dispensed in a district. The table below reflects distribution of wheelchairs and hearing aids per district.

Table 29: Distribution of Wheelchairs and Hearing Aids per District[62]

District	Wheelchairs	Hearing Aids
Ugu	139	148
Umkhanyakude	372	108
Umzinyathi	136	16
Uthukela	157	119
Uthungulu	93	44
Zululand	211	73
Sisonke	189	13
eThekwini	235	203
Umgungundlovu	201	103
Amajuba	135	170
Ilembe	120	116
Total	**1,988**	**1,113**

Specifications for assistive devices have been accepted by Supply Chain Management, and the tender process will be finalised in 2009/10 for hearing aids and wheelchairs. The new tender proposed by the Programme on Alternative and Augmentative Communication devices will improve the quality of life of patients with cancers of the throat, children with cleft lip and palate and those with severe communication disabilities.

⇒ PRIORITY 4: CAPACITY BUILDING

The training curriculum for Speech Therapist Assistants has been completed in 2008/09 and has been circulated nationally for comment before finalisation.

The Department entered into a partnership with UKZN to train mid-level workers in the rehabilitation professions - consistent with the National Human Resources for Health Plan. Assistants, currently employed, were prioritised with 35 physiotherapy assistants being registered with HPCSA. The students will commence with "top-up" training that will enable them to enter the 2 year course towards a diploma in physiotherapy and occupational therapy. It is envisaged that this training will commence in 2009.

Minimum training was conducted in 2008/09 due to financial constraints. 96 Community Health Workers were trained on cerebral palsy in the Ugu District; Umkhanyakude District trained 38 CHW's on supported communication; 8 educators were trained on Nutrition and Autism; 96 CHW's were trained on early identification of cerebral palsy; 1 Occupational Therapist trained on the SITTER course and 1 Audio and Speech trained on BAAC.

Coordinators from eThekwini, Umgungundlovu, Umkhanyakude and Zululand Districts conducted in-service training on orientation and mobility which will be monitored through quarterly reports.

[62] Data from District Report

⇒ PRIORITY 5: IMPLEMENTATION OF A STRATEGY TO PREVENT DISABILITY

Implementation of the strategy has been postponed due to a lack of funding.

The HIV and AIDS Programme were unable to develop Braille information material due to financial constraints. This will be pursued in 2009/10 pending allocation of funding.

PROVINCIAL PERFORMANCE INDICATORS

Data completeness: 95%

Table 30: Provincial Objectives and Performance Indicators for Communicable & Non-Communicable Diseases (Disability and Rehabilitation)

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Strategic Objective: To ensure the effective implementation of programmes to reduce Non-Communicable & Communicable Diseases and diseases of lifestyle.					
Measurable Objective: To implement and sustain an integrated disability and rehabilitation strategy.					
1. Number of diagnostic Audiology clinics.	12	12	19	24	24
2. Percentage of facilities with appropriate access for persons with disabilities.	20%	20%	60%[63]	80%	60%
3. Percentage of PHC facilities with health promotion materials in Braille and audiotape.	10%	10%	40%	60%	40%
4. Service Level Agreements with external support organisations approved and operational.	3	3	3	3	3
5. Number of Health Workers trained to use sign language to communicate with the deaf.	0	30	50[64]	300	300
6. Percentage of Therapists trained to identify and administer the "Free Health Service System".	0	0	0%[65]	75%	0%

Table 31: Reasons for under- over achievement against targets

Indicator	Explanation
Percentage of facilities with appropriate access for persons with disabilities.	Status did not change since the 2006/07 audit as a result of limited financial support to effect change.
Percentage of PHC facilities with health promotion materials in Braille and audiotape.	No progress has been made due to financial constraints. The available material has been provided by NGO's.
Service Level Agreements with external support organisations approved and operational.	Still at 3 SLA's as all new agreements relating to service delivery will be done at a district level.
Number of Health Workers trained to use sign language to communicate with the deaf. Percentage of Therapists trained to identify and administer the "Free Health Service System".	Unable to conduct any training in 2008/09 due to financial constraints and cost saving measures. Training that has been done was through NGO's.

[63] 2007 Audit results
[64] All training cancelled due to shortage of funds
[65] All training cancelled due to shortage of funds

ORAL HEALTH

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities 2006-2008/09

Priority 4: Improve management of communicable diseases and non-communicable illnesses

↓

Provincial Strategic Plan 2005-2009/10

Goal 2: Strengthen PHC and provide caring, responsive and quality health services at all levels

↓

Annual Performance Plan 2008/09

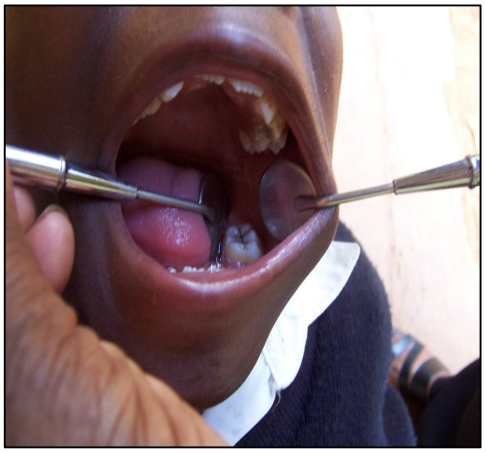
Goal 5

Strategic Objective: To ensure the effective implementation of programmes to reduce communicable and non-communicable diseases and diseases of lifestyle

↓

Oral Health Priorities 2008/09

1. Implementation of strategies to promote drinking water fluoridation.
2. Facilitate and monitor the implementation of mechanisms to reduce the extraction to restoration ratio.



Oral health screening programmes are an integral part of oral health services. The shortage of Oral Hygienists however impacts on this service, especially in school screening services.

EXECUTIVE SUMMARY

Access to Oral Health services improved slightly with the establishment of 5 new dental clinics at Nkandla, Kingsburg, Weenen, Pinetown and Assisi where primary Oral Health services were commissioned. The Children's Oral Health Centre at Imbalenhle (Umgungundlovu District) was commissioned in February 2009 where a pilot project, in collaboration with the University of Witwatersrand, will inform service delivery before roll-out to other centres. The centre is fully equipped and clinical staff appointed although the optimal number of chair side assistants was not appointed.

The extraction to restoration ratio increased from 25:1 in 2007/08 to 28:1 in 2008/09. Financial constraints, delays in the procurement of equipment and consumables and the inability to recruit and appoint staff impacted negatively on service delivery and the achievement of targets.

High turnover and vacancy rates for dental health practitioners impacted negatively on service delivery and performance - as can be seen with increased extraction versus restoration ratio. The vacancy rate for Dental Practitioners increased to 37.3% (34.9% in 2007/08) and the turnover rate increased from 25.4% to 27.7% in 2008/09. The vacancy rate for Oral Hygienists is high at 51.9% with an annual turnover rate of 7.7%.

POLICIES

Table 32: Acts, Policies, Protocols and Guidelines

New Acts, Policies, Protocols & Guidelines	Comments
1. National Oral Health Strategy.	Review of strategy will be completed in 2010.
2. District Oral Health Plans.	District Plans have been developed in 9 Districts - eThekwini and Umgungundlovu Districts are still outstanding.
3. Provincial Guideline for Provision of Dentures at District and Provincial Hospitals.	The Guidelines must still be approved.

PROGRAMME PERFORMANCE

The vacancy rate of 51.9% for Oral Hygienists is high and recruitment and retention is a challenge which impacted negatively on service delivery. Oral health promotion, education and school screening programmes, considered high priority in the Province, were jeopardised as a result of the high vacancy rate. According to the Children's Oral Health Survey the high vacancy rate is also considered to

be one of the leading causes for backlogs in treatment referrals.

The Primary School Brushing Programme, aimed at improving oral hygiene, remained static due to inadequate human resources and the lack of funding. The 2008/09 target was unrealistic and could not be achieved.

The number of Dentists employed in the Department remains fairly constant although the vacancy rate increased from 34.9% to 37.3% and the turnover rate increased from 25.4% to 27.7%. The delay with the implementation of OSD and the lack of career pathing impacted negatively on the retention of Dentists, Dental Therapists and Oral Hygienists. The number of Community Service Dentists increased from 25 – 30 (20%) for 2010.

Monitoring and evaluation of Oral Health services was improved in 2008/09 through inclusion of core indicators in the Provincial Monitoring & Evaluation Framework.

⇒ PRIORITY 1: DRINKING WATER FLUORIDATION

Regulations on water fluoridation were not Gazetted in 2008/09, and the implementation of strategies for drinking water fluoridation has been delayed due to unresolved disputes between the Departments of Health, Water Affairs and KwaNaLoGa.

The Municipalities of Matubatuba (Umkhanyakude), Underberg (Sisonke) and Dannhauser (Amajuba), all with a high poverty and deprivation index, have no Oral Health services. Services will be established as part of the package of services for Community Health Centres once these are established.

⇒ PRIORITY 2: IMPLEMENTATION OF MECHANISMS TO REDUCE THE EXTRACTION TO RESTORATION RATIO

Delays in the finalisation of the tender for dental equipment have significant cost implications for the Department and impacted negatively on service delivery including the availability and expansion of restoration services. Districts, except eThekwini and Sisonke, successfully standardised dental equipment and Umgungundlovu procured video digital imaging to replace x-ray films - which is a first for the Province. The lack of ring-fenced budgets delayed facility upgrades that are required for rendering of the oral health package of services. Funding is generally provided for extraction services only, hence defeating the goal to improve restoration services.

District and Provincial Hospitals continued to provide Oral Health services at the prescribed tariff, and resisted change in lieu of loss of revenue. Addington, Murchison and Madadeni Hospitals relocated services to Gateway clinics in line with Provincial directive.

PROVINCIAL PERFORMANCE INDICATORS

Data completeness: 95%

Table 33: Provincial Objectives and Performance Indicators for Communicable & Non-Communicable Diseases (Oral Health)

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Strategic Objective: To ensure the effective implementation of programmes to reduce Non-Communicable & Communicable Diseases and diseases of lifestyle.					
Measurable Objective: To re-orientate Oral Health services from a curative to a preventive approach.					
1. Number of Municipalities with Oral Health services.	80%	85%	90%	95%	97%
2. Extraction to Restoration ratio.	30:1	31:1	25:1	25:1	28:1
3. Number of schools with a 'Brushing" programme.	10%	15%	20%	100%	18%
4. Percentages of facilities with the standard package of dental equipment.	20%	30%	63%	75%	80%

ENVIRONMENTAL HEALTH

NATIONAL & PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Strategic Priorities 2006-2008/09

Priority 4: Improve management of communicable and non-communicable illnesses

Priority 6: Strengthen support services

↓

Provincial Strategic Plan 2005-2009/10

Goal 2: Strengthen PHC and provide caring, responsive and quality health services at all levels

↓

Annual Performance Plan 2008/09

Goal 5

Strategic Objective 20: To ensure the effective implementation of programmes to reduce communicable and non-communicable diseases and diseases of lifestyle

↓

Environmental Health Priorities 2008/09

1. Develop and facilitate the implementation of a policy framework enabling the monitoring and evaluation of Environmental Health service delivery by Local Municipalities.
2. Establish mechanisms for the development of Hazardous Substance Control Programmes.
3. Provide technical support to districts to strengthen Vector Control Programmes.
4. Develop and maintain an Environmental Health Management Information System.
5. Develop a Readiness Plan for the provisioning of Port Health services during the 2010 Soccer World Cup.
6. Develop and facilitate the adoption of a policy framework to regulate the provisioning of services by private entities such as Funeral Undertakers.

The reduction in the Provincial malaria incidence is largely attributed to the successful indoor spraying programme using DDT and Coartem.

EXECUTIVE SUMMARY

The Province successfully sustained control measures towards achieving malaria elimination as prescribed in the SADC Strategy for the Africa Malaria Elimination Campaign, and achievements exceed the Millennium Development Goal to halve malaria morbidity and mortality by 2015. The Province reported a malaria incidence of below 1/1000 population in 2008/09 and a reduction of reported cases from 606 cases in 2007/08 to 429 cases in 2008/09.

Achievements are attributed to the successful implementation of focused intervention strategies including a 93% indoor residual spraying coverage, intensive health education and promotion programmes and behaviour change interventions to improve prevention, care seeking and early treatment of malaria. Current budgetary constraints however challenge the sustainability of the programme which could reverse the current impact.

Challenges with the transfer of municipal health services to District and Metropolitan Municipalities were not resolved, and the Premiers' Technical Coordinating

Forum, in collaboration with the Department of Health, Provincial Treasury and Local Government and Traditional Affairs, is still dealing with issues pertaining to inadequate funding allocation to municipalities.

High staff turnover and vacancy rates (34.2% and 32.3% in 2008/09), without replacement of staff due to financial constraints and the moratorium on the filling of posts have a serious impact on the sustainability and quality of environmental health services. This will undoubtedly have an impact on the effective management and containment of outbreaks and epidemics as well as routine disease surveillance.

Financial constraints in 2008/09 impacted negatively on water quality monitoring due to inadequate laboratory capacity for laboratory analysis; monitoring of implementation of legislation related to undertakers and mortuaries; roll-out of the Health Care Risk Waste Management Plan to all districts; and the implementation and monitoring of the Environmental Management Plan.

POLICIES

Table 34: Acts, Policies, Protocols and Guidelines

New Acts, Policies, Protocols & Guidelines	Comments
1. Draft Environmental Health Regulations.	• Promulgation of the Draft Health Regulations is expected soon as part of the KZN Health Care Act No 1 of 2009.
2. Regulations for Funeral Undertakers Premises - published in the Government Notice No 237 dated 8 February 1985.	• Regulations regulate the provision of services by funeral undertakers. No Policy Framework has been developed.
3. Framework for the Control of Hazardous Substances.	• Prioritisation of resources and phased in implementation of the approved Framework will be pursued in 2009/10.
4. Approved Health Care Risk Waste Management Policy.	• External funding was mobilised for roll-out and implementation of the Policy to district and institutional structures in 2009/10. *Access and/or use of these external funds depend on co-funding by the Department, which might not be possible.*
5. Guidelines on Vectors and Pests and Transmission and Prevention of Vector Borne Diseases.	• Implemented and strengthened vector control.
6. KZN Department of Health Environmental Management Plan.	• The Environmental Management Plan's action plans were incorporated into the Environmental Implementation Plan of Provincial Government to ensure enhanced integration of environmental management processes and cooperative governance in the Province and between spheres of government. The transfer to Municipalities was not resolved in 2008/09 and the Technical Premiers' Coordinating Forum, in collaboration with the Department of Health, Provincial Treasury and Local Government and Traditional Affairs, is currently dealing with issues pertaining to inadequate funding allocation to municipalities. • Monitoring and coordination will be facilitated through the Provincial Committee on Environmental Coordination.

PROGRAMME PERFORMANCE

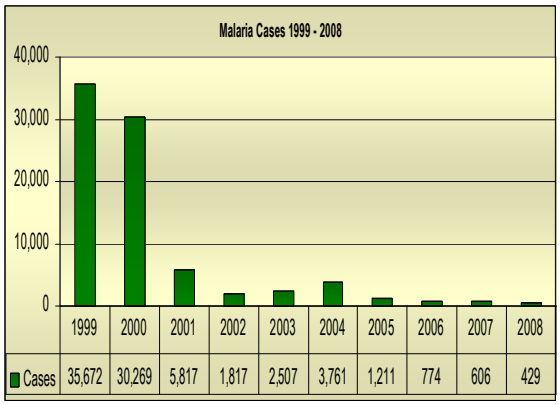
Malaria Control Programme

The Province prides itself on a highly effective Malaria Control Programme and currently exceeds the Millennium Development Goal for Malaria control ('*…have halted by 2015, and begin to reverse the incidence of malaria*'). The Provincial malaria incidence is currently below 1/1000 population and the case fatality rate 1.1% compared to the national case fatality rate target of 0.5%.

The Indoor Residual Spraying coverage of 93% (compared to 86% in 2007/08) ensured that more than 280,000 people in malaria risk areas were protected from malaria in 2008/09. More than 30,000 community members, including Traditional Leaders and Healers, were reached with information and health education/promotion on malaria transmission and prevention, and a total of 121 health professionals were trained on malaria case management.

The Province reported a decrease of 90% in notified malaria cases and 95% in malaria deaths from 293/35,672 cases in 1999 to 17/1,211 cases in 2005/06 (1st year of 5-year planning cycle) and 5/429 cases in 2008/09.

Graph 12: Number of Malaria Cases for the period 1999/2000 to 2008/09



The bulk of reported cases were from eThekwini, Umkhanyakude, Uthungulu and Zululand, although cases have also been reported from other 'risk free' areas i.e. Umgungundlovu, Uthukela, Amajuba and Sisonke Districts.

! CHALLENGES

The sustainability and positive outcome of the Malaria Control Programme is severely compromised as a result of:

- Financial constraints which adversely affect the urgent consolidation of the Malaria Control Programme to the pre-elimination phase of the SADC Malaria Elimination Framework.
- Financial constraints compromising the implementation of the approved organisational structure for the Malaria Control Programme, with a direct impact on service delivery and health outcomes.
- The high staff attrition and vacancy rates (without replacement) effectively erode the essential skills base, negatively impacting on sustainability of achievements to date.
- Increasing numbers of malaria cases reported outside malaria risk areas is a concern which should be investigated to institute the necessary pro-active strategies.

Water and Sanitation

The impact of inadequate water and sanitation on health was highlighted in the 2003 South African Demographic and Health Survey Report which indicated that child mortality more than doubled where the source of drinking water was any other source than piped water, and the mortality rate increased from 7.7/1000 (where there was a flush toilet) to 34.9/1000 where there were none.[66]

The National Burden of Disease Study reported that 13,434 of the total deaths were attributed to unsafe water and a lack of sanitation and hygiene – representing 2.6% of the total deaths. The greatest burden was in children <5 years who accounted for 9.3% of all deaths in this age group. It was estimated that 84% of all deaths due to diarrhoea were as a result of unsafe water and lack of sanitation - 66.4% of these deaths were children <5 years.

Backlogs in the supply of potable water and sanitation are still a serious challenge in the Province, and in spite of various health programmes targeting vulnerable groups, the lack of basic services continues to jeopardise health outcomes. Focussed and pro-active partnerships are therefore essential to address these backlogs.

Maps 10 and 11 illustrate access to water and sanitation per sub-district and Map 12 the diarrhoea incidence per sub-district. Data for the development of maps has been obtained from the Household Survey conducted by Stats SA in 2007.

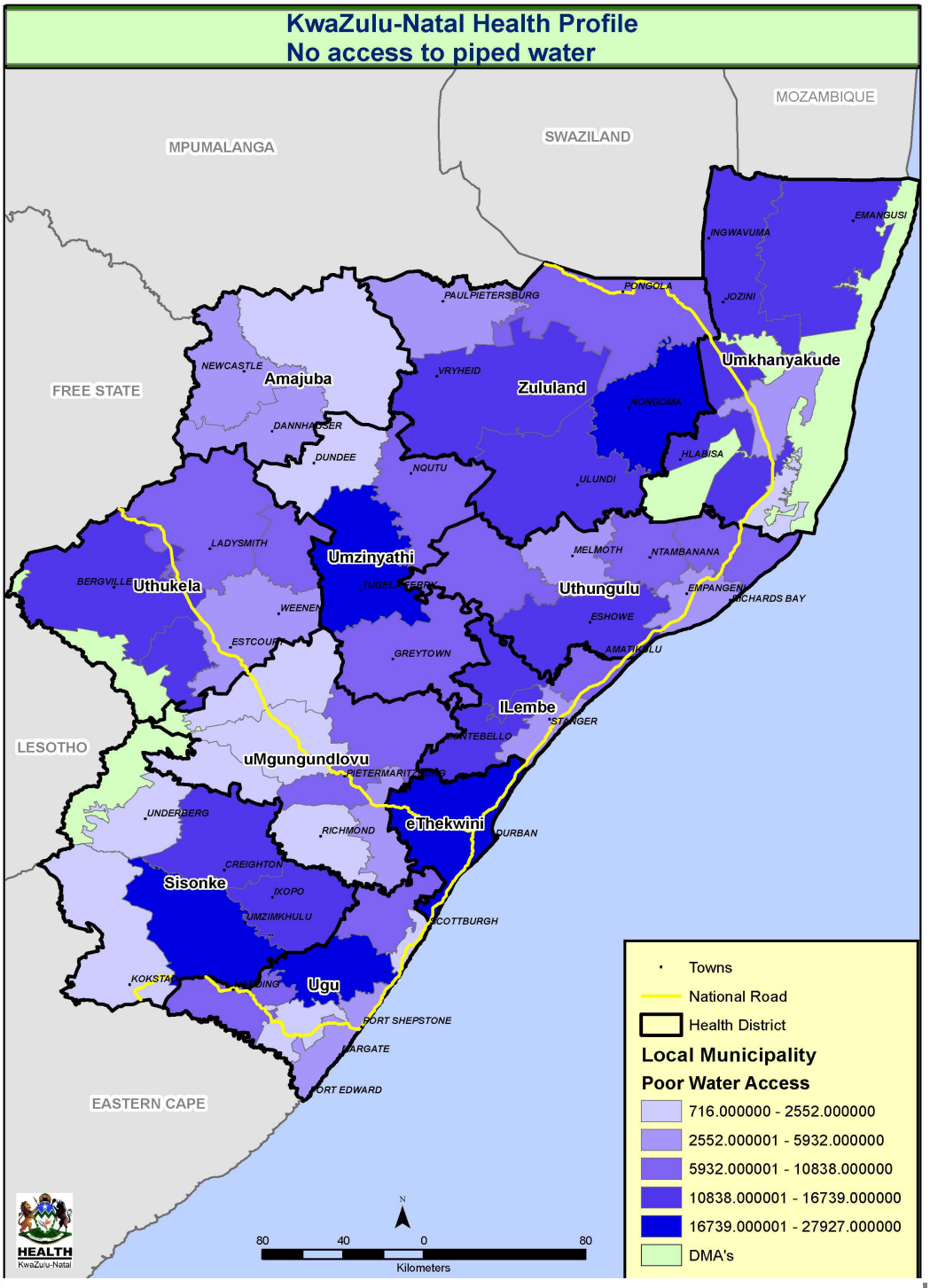
.

[66] SA Demographic and Health Survey 2003

Map 10: Access to Sanitation per Sub-District

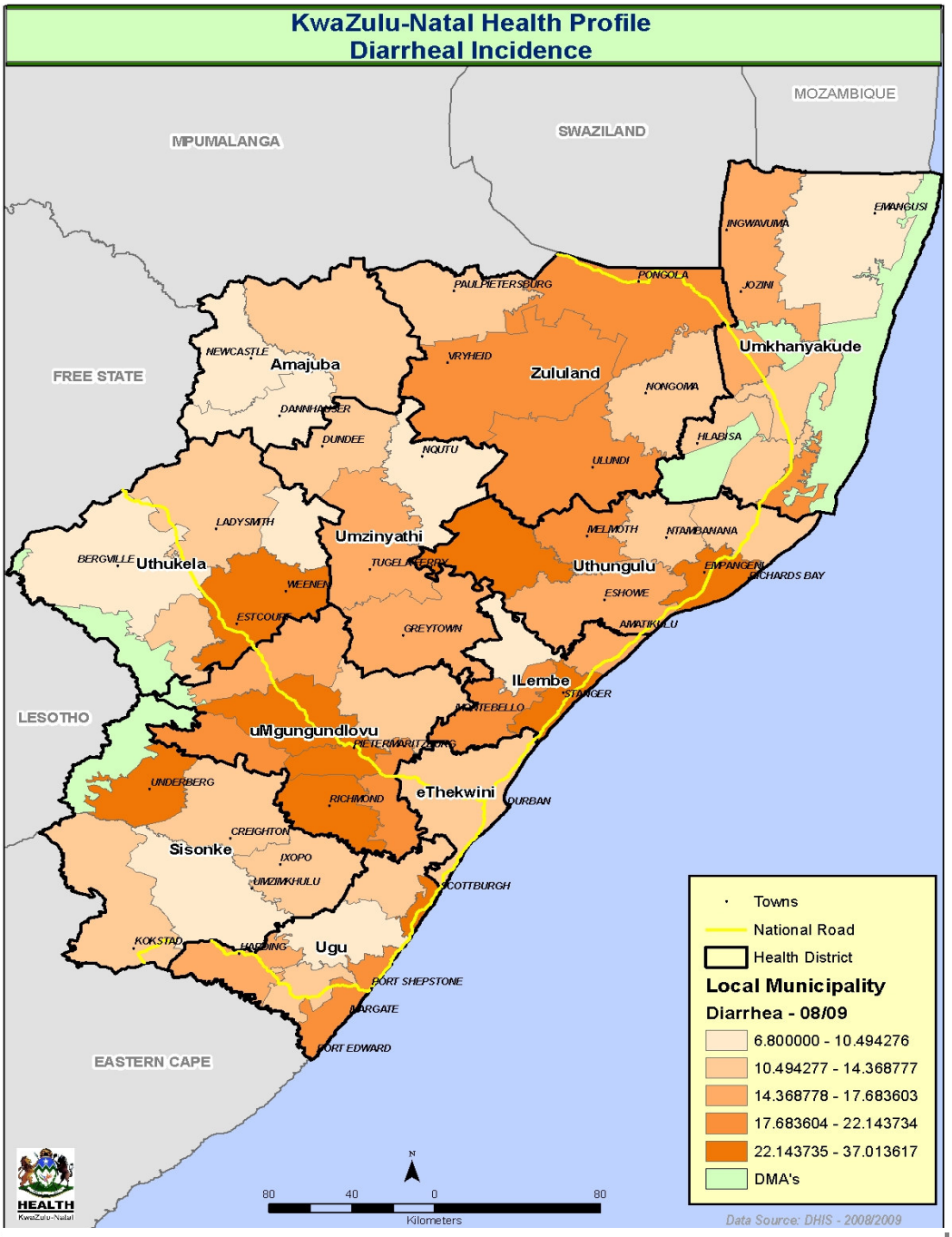
The map depicts the level of access to sanitation per household per sub-district. The lightest shades of brown indicate the municipalities that have <10,646 households within the municipality with poor access to sanitation. Darkest shades of brown indicate municipalities that have >46,455 households with poor access to sanitation. Poor levels of sanitation are measured using: *Households that do not have a flush or chemical toilet.*

Map 11: Access to Water per Sub-District



The map depicts the level of access to piped water per household per sub-district. The lightest shades of blue indicate municipalities that have <2,552 households within the municipality with little or no access to piped water. The darkest shades of blue indicate the municipalities that have >16,739 households with little or no access to piped water. Access to piped water is measured using: *Households not receiving piped water to dwellings.*

Map 12: Diarrhoea Incidence per Sub-District



The map depicts the incidence of diarrhoea per sub-district. The lightest shades of orange indicate municipalities that have an incidence of <10.4/1000 within the municipality. The darkest shades of orange indicate the municipalities with an incidence of >37/1000 within the municipality.
Data obtained from District Health Information System (DHIS).

The Province continued to monitor water quality in all districts during 2008/09. Water sampling for laboratory analysis was however severely compromised as a result of financial restrictions and inadequate laboratory capacity to cope with the increased workload. Although specific data is not available to determine the direct impact of these limitations, the table below clearly indicates the challenges faced by communities without access to safe water supply.

Table 35: Water Samples for Microbiological and Chemical Analysis per District

District	Micro-Biological Analysis	Samples Compliant		Chemical Analysis	Samples Compliant	
Ugu	377	264	70%	20	20	100 %
Sisonke	253	128	51%	9	5	56%
Umgungun-dlovu	237	181	76%	65	5	8%
Uthukela	842	609	72%	767	433	56%
Umzinyathi	171	96	56%	14	5	36%
Amajuba	146	78	53%	0	0	0%
Zululand	187	145	78%	231	139	60%
Umkhanya-kude	124	108	87%	3	0	0%
Uthungulu	374	220	59%	9	4	44%
Ilembe	248	165	67%	59	49	83%
eThekwini	59	24	41%	20	14	70%
Total	**3,018**	**2,018**	**67%**	**1,197**	**674**	**56%**

The Khanyisa Project, focusing on health and hygiene education as an integral part of water and sanitation improvement programmes, facilitated 451 training sessions reaching a total of 19,613 people as indicated in the table below.

Table 36: Khanyisa Project Training per District

District	Sessions	Participants
Ugu	6	166
Sisonke	31	1,951
Umgungundlovu	43	1,969
Uthukela	26	1,359
Umzinyathi	59	2,232
Amajuba	28	1,268
Zululand	42	1,431
Umkhanyakude	27	959
Uthungulu	40	2,295
Ilembe	9	561
eThekwini	140	5,422
Total	**451**	**19,613**

A total number of 163 staff members were trained on the PHAST methodology (table below), limited by financial constraints during 2008/09. The practical skills gained during the PHAST training ensured integration of relevant health concepts into water and sanitation projects, increased community participation in health, improved the analysis, design and implementation of water initiatives and enhanced the potential for project sustainability. Implementation of the methodology further contributed to the hygienic use and improved maintenance of water and sanitation facilities in communities.

Table 37: PHAST Training per District

District	Participants
Ugu	0
Sisonke	3
Umgungundlovu	27
Uthukela	21
Umzinyathi	39
Amajuba	30
Zululand	1
Umkhanyakude	36
Uthungulu	0
Ilembe	8
eThekwini	1
Total	**163**

⇒ PRIORITY 1: MONITORING AND EVALUATION OF ENVIRONMENTAL HEALTH SERVICES

Monitoring and evaluation improved with the incorporation of the Environmental Health National Indicator Dataset into the draft Provincial Monitoring & Evaluation Framework. Reporting arrangements between the Local

Municipalities and Department included quarterly collection and reporting of routine core indicators and submission through the provincial monitoring & evaluation system. This arrangement ensures non-duplication and availability of data to track performance against targets as well as performance management through evidence-based decision-making and planning. The module for Environmental Health is included in the official data information system of the Department (DHIS version 1.4) which will be rolled out to all services in 2009/10.

⇒ PRIORITY 2: HAZARDOUS SUBSTANCES CONTROL PROGRAMMES

Implementation of the Control of Hazardous Substances Framework could not commence in 2008/09 as planned due to severe budgetary constraints which delayed the development of district capacity and thus prevented the effective roll-out and implementation. This will again be pursued in 2009/10 pending availability of funds.

Training for the implementation of the Health Care Risk Waste Management Policy did not commence in 2008/09 due to financial constraints, this impacted on compliance to policy imperatives. The majority of districts succeeded in establishing the prescribed structures to fulfil a decentralised training and monitoring function, although most Districts could not commence with the development and implementation of a Health Care Risk Waste Management Plan due to financial constraints.

! CHALLENGE

- District reports referred to incidents of non-compliance to the Health Care Risk Waste Management Policy especially with relation to waste separation and the lack of a designated storage area.

⇒ PRIORITY 3: STRENGTHENING VECTOR CONTROL

Vector Control was strengthened through the implementation of Guidelines on vectors and pests and transmission and prevention of vector borne diseases.

⇒ PRIORITY 4: ENVIRONMENTAL HEALTH MANAGEMENT INFORMATION SYSTEM

The Environmental Management Plan (EMP) has been incorporated into the Environmental Implementation Plan of Provincial Government to enhance integration of environmental management processes and cooperative governance in the Province and between spheres of government. Monitoring and coordination of the EMP will be facilitated through the Provincial Committee on Environmental Coordination.

⇒ PRIORITY 5: READINESS PLAN FOR PORT HEALTH SERVICES DURING THE 2010 SOCCER WORLD CUP

Although the 2010 Port Health Framework was approved, the budget allocation for 2009/10 has not been confirmed and the required posts could not be filled to strengthen capacity. Apart from the work study conducted by the Organisational Improvement Services in August 2008, no further progress has been made to ensure required staffing for the new ports of entry.

Strengthen Port and Marine Health and food outlets, and accreditation of formal & informal food vendors & outlets

The training programme on the Food Safety Protocol commenced in October 2008, and a total of 68 Environmental Health Professionals (EHP's) were trained in the Umkhanyakude, Ilembe, Ugu and Umgungundlovu Districts. Training will be rolled out to the remaining districts in 2009/10. Arrangements for the orientation of Supply Chain Management Units of Provincial Departments on the health requirements for caterers commenced in 2008/09, and trained EHP's will be rolling it out to the formal and informal food sector. Districts noted that a great number of caterers do not have certificates of acceptability and as a result do not comply with the imperatives set in Regulation R918.

Food poisoning in schools is a concern, with Zululand reporting a total of 265 cases of food poisoning in 2008/09. Targeted health education and follow-up is conducted through integrated and multi-disciplinary school health teams as well as community-based out-reach programmes. See Communicable Diseases Control Programme for further details.

⇒ PRIORITY 6: POLICY FRAMEWORK TO REGULATE SERVICES BY PRIVATE ENTITIES SUCH AS FUNERAL UNDERTAKERS

A draft Handbook and Inspection Guide has been developed to regulate the inspection and control of Undertakers and Mortuaries, and consultation commenced with key role-players in 2008/09. Districts however reported numerous challenges with regards to regulation of undertakers. Lack of resources challenge the regulation of these services at district level.

COMMUNICABLE DISEASES CONTROL

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities 2006-2008/09

Priority 4: Improve management of communicable diseases and non-communicable illnesses

↓

Provincial Strategic Plan 2005-2009/10

Goal 3: Promote health, prevent and manage illnesses with emphasis on poverty, lifestyle, trauma and violence

↓

Annual Performance Plan 2008/09

Goal 5

Strategic Objective 20: To ensure the effective implementation of programmes to reduce communicable and non-communicable diseases and diseases of lifestyle

↓

CDC Priorities 2008/09

1. Improve the communicable disease surveillance and information system.
2. Improve and expand the facility for communicable diseases reporting on the 24-hour Disaster Management Flash Reporting System.
3. Improve capacity at district level to facilitate and monitor the implementation of Provincial plans for Influenza Epidemic and the 2010 Soccer World Cup.
4. Develop and facilitate the implementation of the Provincial Influenza Epidemic Plan and planning for the 2010 Soccer World Cup.
5. Expand and develop capacity for research on communicable diseases control.

Patients at Mosvold Hospital

EXECUTIVE SUMMARY

The Cholera and H1N1 outbreaks in 2008/09 stimulated more focused disease vigilance. Surveillance systems were critically assessed to ensure readiness for identifying early warning signs of outbreaks and the appropriate response thereafter. The notifiable data management system was updated and the daily zero reporting system revived for the duration of the cholera outbreak. The outbreaks highlighted the importance of inter alia:

- Integrated strategies and action, not only during times of crisis, but as an integral part of the Department's Strategic Statement;
- Increased focus (with budget) on health promotion and education to reduce preventable causes of morbidity and mortality;
- Community involvement, including feedback with regards to health issues pertinent to specific communities; and
- Improved evaluation of the impact of health promotion and education strategies.

The National database is not yet implemented and the current vertical reporting systems result in duplication and data timeliness, inconsistencies and inaccuracies. Examples of this are evident in the current dual reporting of malaria (Environmental Health & CDC), Acute Flaccid Paralysis and measles (MC&WH & CDC) and diarrhoea (CDC and DHIS). Implementation of the Master Systems

Plan needs to be prioritised in order to improve integrated information systems and data quality.

Two confirmed cholera cases (one death) were reported in the Province during the outbreak in 2008/09. Other notifiable diseases over the same reporting period are reflected in table 38.

POLICIES

Table 38: Acts, Policies, Protocols and Guidelines

New Acts, Policies, Protocols & Guidelines	Comments
1. Meningococcal Meningitis Protocol/ Guidelines.	• Development of this policy followed the death of a 12 year old in eThekwini and the outbreak in Nigeria. • The Province had 36 cases in 2008 and 7 cases (including 2 deaths) from January to March 2009 (sporadic cases and not an outbreak). • The Policy & Guidelines were disseminated to all health care workers followed with regular feedback on statistics and appropriate management of the disease.
2. Hand, Foot & Mouth Disease Protocol/ Guidelines.	• A suspected outbreak was reported in Kwadukuza Municipality (Ilembe District) in February 2009. A total of 389 (383 Grade 1 learners and 6 educators) were affected. • The Province obtained technical support from the National Department of Health (NICD) who sent two Field Epidemiology Residents to provide support to the Ilembe District during the suspected outbreak.
3. Rift Valley Fever Protocol/ Guidelines.	• An outbreak was reported in the Creigton area (Sisonke District) and successfully managed.

PROGRAMME PERFORMANCE

Cholera

The Province implemented immediate emergency measures following the cholera outbreak alert in 2008 and was able to successfully respond to the impending outbreak. Two confirmed cholera cases were reported in the Province during the outbreak. The patient in the Zululand District (a construction worker from Ethiopia) was successfully treated but the patient in eThekwini (a truck driver from Zimbabwe) died.

Cholera Management Guidelines have been re-introduced in all districts and the cholera database was updated and downloaded in all districts. Other measures put in place during the outbreak will continue to strengthen outbreak response and improve response to early warning signs and appropriate action thereafter.

Diarrhoea Programme

The Department has not yet developed an integrated strategy for the Diarrhoeal Control Programme although vertical initiatives are implemented through the MC&WH, Environmental Health and CDC Directorates. The incidence of diarrhoea in children under-5 years ranges between 114/1000 and 215/1000, and the implementation of an integrated intra- and inter-sectoral strategy is therefore imperative to manage this leading cause of morbidity and mortality more effectively. Map 13 illustrates the diarrhoea with dehydration per sub-district in 2008/09.[67]

All districts participated in a training programme to up-scale the Diarrhoea Control Programme and a TB Surveillance Officer was appointed to track diarrhoeal data and to investigate trends. Current data is questionable and inconsistent with rain patterns, poverty profiles, access to water and sanitation and results of water sample analysis.

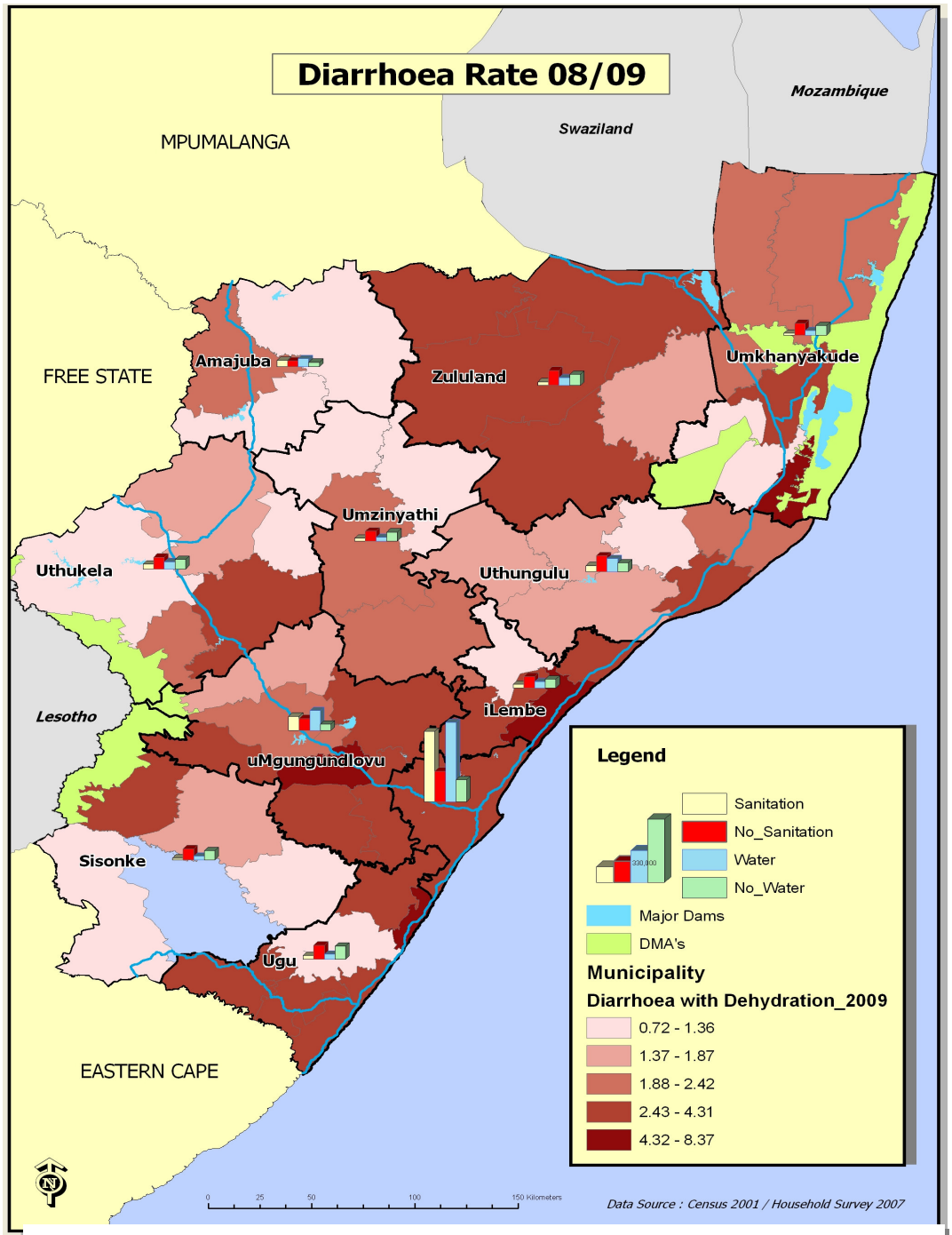
The Department will be introducing the Rotavirus (diarrhoea) vaccine (as part of the immunisation schedule) in 2009/10, hoping to reduce morbidity and mortality from diarrhoeal disease. This will be managed through the MC&WH Programme.

[67] Data for maps obtained from the Household Survey conducted by Stats SA in 2007

! CHALLENGES

- Data on diarrhoea is incomplete and currently jeopardises the analysis of trends and profiles which must inform planning.
- Surveillance (including collection of specimens and the collection and reporting of data) is still a challenge in most districts.
- The lack of an integrated strategy results in duplication, missed opportunities and ineffective utilisation of resources.

Map 13: Diarrhoea with Dehydration 2008/09



The map depicts the incidence of diarrhoea with dehydration per sub-district for the period 2008/09. The lightest shades of brown indicate municipalities that have an incidence of <1.36/1000 within the municipality. The darkest shades of brown indicate municipalities that have an incidence of >4.32/1000 within that municipality. The bar graph attached to each centroid of the districts give an indication of the levels of sanitation and water within the respective districts, which assist with the linkage between the availability of water and sanitation and diarrhoea.

Poor levels of sanitation are measured using *Households that do not have flush or chemical toilets,* and poor access to piped water is measured using *Households that do not receive piped water to the dwelling.*

Rabies

A total of 178 rabies cases were reported through the notifiable system in 2008/09 (see table 39) and Districts started District Rabies Action Groups to improve the comprehensive management of rabies at district level.

! CHALLENGES

- Compliance to treatment due to inadequate communication between hospital and PHC clinic levels, inadequate follow-up and information at community level.
- Community awareness regarding rabies is still lacking resulting in exposure to rabies due to ignorance.

Training

Although financial constraints impacted negatively on planned training programmes, training was conducted on Cholera, Typhoid, Shigella, Acute Flaccid Paralysis, Avian Influenza, Rabies, Meningitis, 2010 preparedness and the Notifiable Medical Conditions Database. Output will be monitored in 2009/10.

⇒ PRIORITY 1: IMPROVE THE COMMUNICABLE DISEASE SURVEILLANCE AND INFORMATION SYSTEM

The National Notifiable Medical Database is not yet functional and the Department is still using an excel spreadsheet provided by the National Department of Health. The lack of an integrated computerised system negatively affects monitoring and evaluation as well as submission of data (timeliness and completeness). The Department employed 2 experiential learners to capture relevant data to improve data quality and management of data. This process commenced in March 2009.

! CHALLENGES

- Inconsistencies in data between various vertical systems e.g. DHIS and Environmental Health are a serious concern because it affects pro-active and timely response to outbreaks and threats.
- The delay in implementation of the National Notifiable Medical Database affects surveillance and delays Provincial processes to improve the system.
- The CDC information system is not yet linked with the Provincial M&E Framework which jeopardises monitoring & evaluation at different levels of care.

Part B - Programme 2: District Health Services

Table 39: Provincial Notifiable Conditions Statistics for 2008

District	Hepatitis A	Hepatitis B	Cholera	Typhoid	Exposure to Rabies	Malaria	Food Poisoning	Chicken Pox	Bilharzia	Meningococcal Meningitis	Tetanus	Animal Rabies	Congenital Syphilis	Pertussis
eThekwini	27	100	1	2	3	90	18			20			1	1
Ugu	11	59			12	1	8					3		
Umgungundlovu	1	7		2		3	53			1	2			
Uthukela		1				2	1			1				
Umzinyathi	2	14		1	150	1	24		21	2	1			
Amajuba	6	28		1		7	47		29	3				
Zululand		23	1		7	4	265	7	17					
Umkhanyakude		4			1	4	0			3				
Uthungulu	1	25			2	29	8	15	221	3				1
Ilembe		4			2	13				2				
Sisonke		3			1	1	62			1				
Total	**48**	**268**	**2**	**6**	**178**	**155**[68]	**486**	**22**	**288**	**36**	**3**	**3**	**1**	**2**

[68] Data is incomplete and will be updated

The Communicable Disease Control (CDC) Directorate is facilitating integrated meetings to improve the reporting of notifiable conditions. Regular meetings with the MC&WH Programme to improve reporting of AFP and measles, Vetinary Services to improve the treatment and management of both animal & human rabies, and Leprosy Mission (new project).

The CDC Directorate is publishing a monthly CDC newsletter to ensure that all staff are informed and updated with the latest disease trends/ patterns. Regular alerts on seasonal diseases are also sent out via the intranet to ensure a timely response if needed. Current disease information, CDC Guidelines, Treatment Protocols, statistics, etc. are available on the updated CDC website to ensure easy access to relevant information.

⇒ PRIORITY 2: 24-HOUR DISASTER MANAGEMENT FLASH REPORTING SYSTEM

Although the system is in place via phone, SMS, and fax there are still gaps that must be attended to. Some districts reported poor reporting through the system which will impact negatively on response times.

! CHALLENGE

- Some facilities still experience challenges with regards to effective communication e.g. lack of phones and faxes jeopardises reporting.

⇒ PRIORITY 3: IMPLEMENTATION OF THE PROVINCIAL INFLUENZA EPIDEMIC AND THE 2010 FIFA SOCCER WORLD CUP PLANS

The National Department of Health conducted a train-the-trainer course from the 24th to 26th of June 2008 targeting all CDC Coordinators and representatives from Port Health and Quality Assurance (TB laboratory). All districts (except Zululand) were represented at the training. Uthukela, Umzinyathi, Uthungulu, Ugu and Amajuba Districts successfully cascaded the training to service providers at district level, while the remaining 6 districts are expected to complete the decentralised training in 2009/10. The delivery of training manuals (from the National Department of Health) was delayed but are expected in 2009/10.

Participation in 2010 preparation is ongoing and the CDC representative attended the Project Portfolio Office training from the 16th to 17th of March 2009. The training was aimed at the management of activities during the 2010 World Cup.

The Zululand District profiled illegal border posts in the district i.e. Swaziland/ SA and Mozambique/ SA that are expected to carry high numbers of people during the 2010 World Cup. The aim of the profiling is to set up adequate screening facilities during this peak period.

Institutional and District Infection Control Committees assisted in minimizing infections and cross infections in institutions and National and Provincial guidelines are provided to all facilities.

! CHALLENGE

- The availability of isolation facilities is currently inadequate in the Province and poses a serious challenge for the effective management of CDC emergencies. Answers should be sought to address challenges pertaining to infrastructure, human resources and serious financial limitations.

⇒ PRIORITY 4: EXPAND RESEARCH ON COMMUNICABLE DISEASES AND DEVELOP CAPACITY IN RESEARCH

Due to severe financial and human resource constraints the CDC Directorate was unable to pursue telemedicine as means to fast track staff development. The National Department of Health has however been running weekly telemedicine sessions nationally including topics on Cholera and Influenza A (H1N1). No in-house research on CDC has been undertaken in 2008/09.

! CHALLENGES

- Delegation of two portfolios to District CDC Coordinators (TB and CDC) and partaking in surveillance activities with MC&WH and Environmental Health impacts on compliance to CDC Programme imperatives. Districts started to split TB and CDC posts due to the volume of work.
- There is no vaccine prevention strategy for Yellow Fever in public health services - this service is available in the private sector at cost. Currently the 1 week course is only offered by Travel Medicine via the Wits University at a cost of R 7,150.

Part B – Programme 2: District Health Services

PROVINCIAL PERFORMANCE INDICATORS

Data completeness: 95%

Table 40: Provincial Objectives and Performance Indicators for Communicable & Non-Communicable Diseases (Communicable Diseases Control)

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Strategic Objective: To ensure the effective implementation of programmes to reduce Non-Communicable & Communicable Diseases and diseases of lifestyle.					
Measurable Objective: To reduce morbidity and mortality due to Communicable Diseases.					
1. Outbreak response time.	<1 Day	<1 Day	<1 Day	<1 Day	<1 Day
2. Malaria fatality rate.	<1%	0.6%	1.5% (DHIS) 0.8% (EH)	0.5%	1% (5/429)
3. Cholera fatality rate.	0%	<1%	0%	<1%	50%[69]
4. Percentage of Districts implementing the Surveillance System.	100%	100%	100%	100%	100%
5. Number of facilities implementing the Diarrhoea Programme.	Implemented in 4 sentinel sites in each district	Implemented in 4 sentinel sites in each district	Implemented in 4 sentinel sites in each district[70]	442 (80%)	508 (92%)[71]
6. Number of Districts implementing the Disaster Management Flash Reporting System.	11	11	11	11	11

[69] 2 confirmed Cholera cases and 1 fatality
[70] Implementation still fragmented and not monitored adequately. Increased staff component will improve implementation and monitoring
[71] Based on Annual District Reports

HIV AND AIDS PROGRAMMES

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities 2006-2008/09

Priority 4: Improve management of communicable diseases and non-communicable illnesses

↓

Provincial Strategic Plan 2005-2009/10

Goal 1: Effective implementation of the Comprehensive HIV and AIDS Strategy

↓

Annual Performance Plan 2008/09

Goal 4

Strategic Objective 17: To continue to accelerate and sustain the implementation of the Comprehensive HIV and AIDS Management Plan

↓

HIV & AIDS Priorities 2008/09

ART

1. Strengthen the ART Programme by expanding accredited ART sites to ensure that all qualifying HIV+ persons receive ART.
2. Strengthen the monitoring & evaluation of the ART Programme including active monitoring of viral loads to determine adherence and effectiveness of ART.
3. Increase the uptake of HAST services by children.
4. Strengthen the implementation of integrated strategies and services targeting vulnerable children to increase uptake of HAST services.
5. Test and implement an electronic monitoring & evaluation data system to improve monitoring of adherence to treatment, viral loads and Pharmaco-vigilance.
6. Expand accredited ART sites to PHC level including TB facilities.

Home-Based Care

1. Standardise the Home and Community-Based Care Programmes and develop a Provincial database to determine and monitor coverage.

High Transmission Areas

1. Expand sites to strengthen prevention and treatment services for STI and HIV and AIDS.

Step-Down Care

1. Implement the STP in collaboration with District Services.

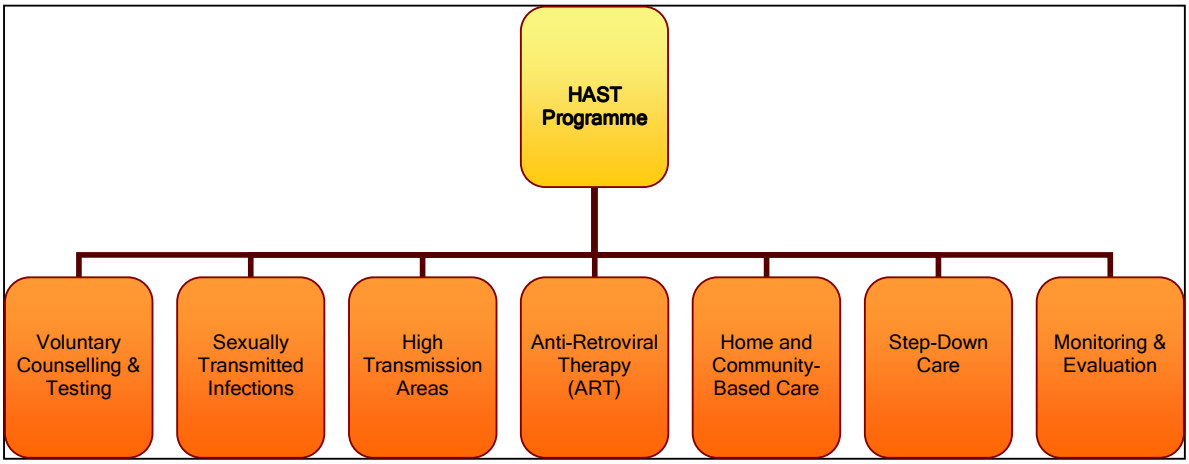
Sexually Transmitted Infections

1. Improve the implementation of the Syndromic Management of STI's.

HIV testing is vigorously encouraged and supported in all health services and is in line with the Departments vision to improve health of all citizens living in KwaZulu-Natal.

Part B – Programme 2: District Health Services

Figure 2: HIV and AIDS (HAST) Programme



EXECUTIVE SUMMARY

In spite of the high HIV prevalence in the Province that places a major strain on resources and capacity, the Province made significant progress in 2008/09 as evident in the increased number of patients accessing HIV and AIDS services. To address the increasing numbers of patients on waiting lists, the Department introduced community based screening, clinical staging, ART literacy training and the introduction of mobile service to address issues of access for high risk communities who are normally unable to access ART services. To address overcrowding in facilities, initiatives such as two months supply of ARV's to ART stable patients are in the development phase.

Fiscal management improved with the introduction of a facility based budget system that is based on patient load and year projections. This has enabled District Offices to allocate appropriate budgets per facility to reflect the needs of individual facilities in the programme.

Mobilisation of additional funding to bridge the gap in traditional funding i.e. Conditional Grant and Equitable Share safeguarded the continuous functioning of services which could have been jeopardised due to inadequate funding.

Contractual obligations for various funded NGO's providing Home and Community Based services for the Province have been revised, guidelines for NGO funding have been developed and integrated monitoring and evaluation have been revised to ensure adequate support for the programme.

To improve access and service delivery, a total of 2,800 Traditional Health Practitioners and Traditional Leaders have been trained on HIV and AIDS issues and clinics at Truck Stops have been expanded. The monitoring of adverse drug reactions has been improved with the implementation of a Pharmacovigilance system and a learnership programme for Youth Ambassadors has been implemented.

POLICIES

Table 41: Acts, Policies, Protocols and Guidelines

New Acts, Policies, Protocols & Guidelines	Comments
1. First Line Comprehensive Management and Control of Sexually Transmitted Infections.	• The revised edition was released in May 2008. District Trainers and HAST Coordinators were trained in June 2008 to cascade training at district level. All health facilities started implementation of the revised Protocols by August 2008.
2. Updated VCT Guidelines.	• Awaits approval from the National Minister of Health.
3. Updated Mentorship Guidelines.	• Updated Guidelines approved and disseminated to all the Provinces for implementation.
4. HTA[72] Guidelines (1st Draft).	• The Province developed the 1st draft document and submitted it to the National Department of Health and other provinces for comments.
5. HBC[73] NGO[74] Funding Guidelines (1st Draft).	• Guidelines circulated to external stakeholders for comments. The final guidelines are expected in 2009/10.

[72] High Transmission Areas
[73] Home Based Care
[74] Non Governmental Organisation

Part B - Programme 2: District Health Services

PROGRAMME PERFORMANCE

The ANC Sero-Prevalence Study is used as a marker in the development of strategies for HIV and AIDS services. According to the 2007 Study, the HIV prevalence in pregnant women decreased slightly from 39.1% to 37.4% with eThekwini (currently at 41.1%) having the highest prevalence.

The Comprehensive Care Management and Treatment (CCMT) Programme is supported by PEPFAR funded NGO's, the Global Fund, other funding agencies and supporting NGO's that are fairly distributed throughout the Province to facilitate improved and equal access to services. NGO's support mainly ART rollout programmes, VCT, STI, HTA and HBC by providing human resources, infrastructure, equipment and systems improvement and capacity building. Monitoring is done through bi-annual meetings and routine ART post-accreditation support visits. Through this support and contributions (including park homes and renovations to existing structures) the Department was able to exceed the target of patients on ART by more than 30,000 patients in 2008/09.

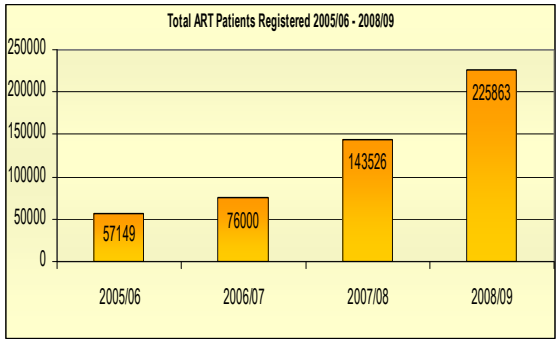
Broadreach is funding 11 park homes (valued at R6.9 million) in the Ugu District, and ARK will fund some of the posts for planned roving teams in the Amajuba District.

The integration of programmes is strengthened through integrated business planning meetings with MC&WH, TB and Nutrition. The Department commenced with training programmes on the integrated management of adulthood illnesses (IMAI) in 2008/09 to improve the integrated management of illness at operational levels. The accreditation of TB Specialised Hospitals as CCMT Service Points commenced in 2008/09.

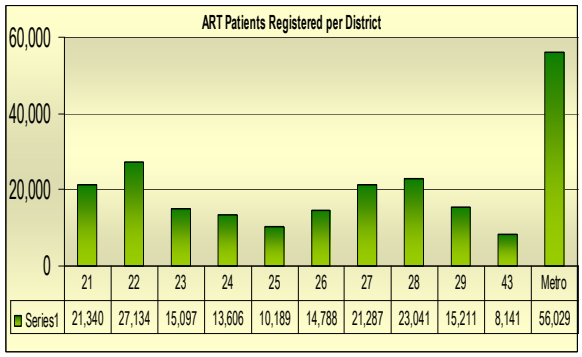
⇒ PRIORITY 1: STRENGTHEN THE ART PROGRAMME

The Province has 86 ART service points (6 accredited in 2008/09) and 3 NGO's with clinical capacity (2 in eThekwini and 1 in Umgungundlovu Districts) providing services for the initiation and referral of ART patients. A total of 225,863 patients were on ART by the end of 2008/09, exceeding the target of 195,312 with 15%. The patients on treatment included 21,329 children, 139,286 women and 65,248 men.

Graph 13: Total Number of ART Patients Registered - 2005/06 to 2008/09



Graph 14: ART Registered Patients per District[75]



Elizabeth Glaser Paediatric AIDS Foundation (EGPAF) has provided human resources (2 Doctors, 4 Professional Nurses and 2 data capturers) to improve service delivery in the Umgungundlovu District, and provided financial assistance with infrastructure improvements at Doris Goodwin Hospital. The Hospital is ready for accreditation as an in-patient facility pending national accreditation.

St. Margaret TB Hospital is in the process of being accredited as an ARV site which is in line with the intention to improve management of co-infection through integration of TB and HIV and AIDS services.

The accreditation of PHC facilities is prioritised in direct response to the National Strategic Plan (NSP) Goal to expand the appropriate package of treatment, care and support services to 80% of all patients diagnosed with HIV. There are currently 322 PHC clinics serving as down referral sites for stable ART patients where active HIV screening and literacy education for HIV+ clients are prioritised.

[75] 21=Ugu; 22=Umgungundlovu; 23=Uthukela; 24=Umzinyathi; 25=Amajuba; 26=Zululand; 27=Umkhanyakude; 28=Uthungulu; 29-Ilembe; 43=Sisonke; Metro=eThekwini

The unexpected increase in patient numbers and associated costs impacted dramatically on expenditure against the initial budget allocation of R630 million, with the major cost drivers being ARV drugs, laboratory services and compensation of staff (*indicated in table 42*). An additional R127million was allocated to the Programme in October 2008.

Table 42: HIV and AIDS budget allocation versus expenditure

Budget Item	Allocation	Expenditure	Variance
Compensation of Staff.	R 173,919,000.00	R 180,244,271.59	R -6,325,271.59
Procurement of Antiretroviral Drugs.	R 495,377,200.00	R 403,811,872.61	R 91,565,327.39
Procurement of Laboratory Services.	R 69,066,000.00	R 64,839,650.32	R 4,226,349.68

The CD_4 turn-around time improved with most facilities accessing results within 6 days. Transporting of emailed and faxed laboratory copies to facilities in deep rural areas is still a challenge, although turn-around times in these areas have improved to ±8 days. All virology results are emailed daily by the NHLS to the Department and are available on the Departmental intranet. Hard copies are posted daily to all institutions and can be accessed through the respective Laboratory Managers. In some instances (on request) results are posted directly to PHC and CHC's. The Dry Blood Spot (DBS) HIV PCR results are emailed to all Laboratory Managers monthly.

The Department was not able to implement a Provincial Electronic System in 2008/09 to monitor defaulter rates, and the patient booking system was used to monitor defaulters.

! CHALLENGES

- The shortage of staff seriously affected service delivery at all levels of care. The moratorium on the appointment of staff affected grant funded activities including appointment of staff.
- The lack of space due to infrastructure inadequacies and high volumes of staff attending ART clinics led to congestion and overcrowding and affected accreditation of facilities as ART service points.
- The insufficient budget (based on the projected number of patients to be initiated on ART) impacted negatively on planning and service delivery. ART service points were forced to slow down on ART initiations to avoid over expenditure and in so doing jeopardised programme outcomes.
- Late allocation of facility budgets delayed planning for example, filling of essential posts.
- The challenges mentioned above contributed to an increase in patients on ART waiting lists which in turn impacted negatively on morbidity, mortality and costs.
- More rural districts e.g. Sisonke District noticed an increase in the use of traditional medication which impacted on treatment outcomes.
- Inadequate de-briefing opportunities for staff working in ART services - staff wellness should be prioritised.

Voluntary Counselling and Testing (VCT) Services

VCT, being the entry point for all HIV and AIDS Programmes, is still challenged by missed opportunities as a result of infrastructural challenges, inadequate counselling space, high staff turn-over rates, fragmented services and the high demand for HIV and AIDS services.

To improve access and utilisation of VCT services the Department upgraded 28 PHC facilities to accommodate VCT services and sustained VCT at 63 non-medical sites. Four mobile service units were launched in the Umzinyathi, Amajuba and Zululand Districts to expand services to high risk areas. VCT services are routinely offered at health entry points, hours of operation have been extended in some facilities to accommodate more clients and community based screening has been expanded. As a result, VCT uptake improved from 2% in 2007/08 to 3% in 2008/09 (national target 4%).

Part B - Programme 2: District Health Services

In 2008/09, a total of 681,017 clients were pre-test counselled and 635,814 (95.5%) clients were tested for HIV which exceeded the national target of 70%. A total of 246,071 clients tested positive (38.7%).

The Provider Initiated Testing and Counselling (PITC) Pilot that commenced in the Ugu District in 2007/08 increased the VCT uptake in Ugu from 2% (baseline) to 5% in 2008/09. Both Health Systems Trust and Broadreach continue to train counsellors and nurses on PITC.

As a direct outcome of the pilot the Province commenced with the following projects:

- Rollout of the routinely offered VCT in all facilities targeting high risk clients i.e. clients with STI's and TB, as well as ANC and Family Planning clients.
- The "Men Knows Campaign" which aims to increase VCT uptake by men. Immediately following the initial media campaign, more than 5,000 men tested for HIV. Negotiations are currently underway to include this event in the Health Calendar as an annual event.

The VCT Programme is supported by 1,904 Lay Counsellors (LC) and 95 Site Mentors who contributed to the increase in the number of people tested from 288,536 in 2005/06 to 635,814 in 2008/09 (120% increase). A total of 1,509 LC were trained on ART adherence, infant and young child feeding and dual therapy. Table 43 reflects a breakdown of LC and Site Mentors per district.

Table 43: Lay Counsellors and Site Mentors per District

District	Lay Counsellors	Site Mentors
Ugu	231	13
Umgungundlovu	162	7
Uthukela	108	7
Umzinyathi	121	11
Amajuba	123	7
Zululand	219	9
Umkhanyakude	163	9
Uthungulu	220	9
Ilembe	145	7
Sisonke	99	8
eThekwini	313	8
Total	**1,904**	**95**

Sustainability of the HIV Lay Counsellor programme is improved with the option of permanent employment of HIV counsellors and ongoing training and development. Since the HIV and AIDS counsellors are employed full time they were encouraged to enroll with formal institutions to further their careers in Psychology, Social Sciences, Pharmacy, Nursing, Phlebotomy and Medical study fields.

The Department submitted the application for accreditation of the Lay Counsellor Training Curriculum to the South African Qualifications Authority in 2007/08 and still awaits a response. The curriculum will be finalised with the Amatikulu Training Centre once SAQA approval is received.

Monitoring of the VCT programme remains a challenge due to the number of facilities providing services and the limited human resources available for monitoring. Limited site visits were conducted in 2008/09.

! CHALLENGES

- The VCT indicator definition skews actual coverage at facility level. If the denominator remains "*PHC headcount 5 years and older excluding antenatal clients*" and the numerator "*HIV clients pre-test counselled*" the indicator cannot reflect actual coverage. Headcount is beyond the VCT target and most clients attending PHC are women and children - hence more children cannot be captured.
- Insufficient space at clinics causes long waiting times and patients tend to leave without being counselled - missed opportunity.
- Inadequate skills, high staff turn-over, and poor recording of VCT data diminishes efforts and impacted on programme development.
- The lack of Professional Nurse posts at non-medical VCT sites impacted on service delivery - cannot confirm HIV tests as required.
- Lay Counsellors are employed as straight shift workers and therefore not available after hours and weekends which limit availability and access of services.
- Inadequate debriefing of Site Mentors and Lay Counsellors affects staff wellness.

⇒ PRIORITY 2: STRENGTHEN MONITORING AND EVALUATION OF THE ART PROGRAMME

Due to the lack of an electronic system the Department still experiences challenges in reporting on clients who have de-registered, transferred or defaulted which has a huge impact on the programme outcomes and cost. The Pharmacovigilance system has been introduced to monitor adverse drug reactions although it is not yet fully functional. The Integrated Electronic Patient Record System (IePRS) for HIV and AIDS that was piloted in the Ugu District (2007/08) is currently at an advanced stage of implementation in the Province. It is expected to commence provincially in 2009/10.

The HIV and AIDS Unit has been involved in producing two papers on the Economic Evaluation of the ART Programme. The full research report was published and disseminated within the Department and is available on the intranet.

! CHALLENGE

- Unnecessary repeating of laboratory tests due to patients utilising multiple service points resulted in inaccurate data to monitor clinical outcomes and increased costs.

⇒ PRIORITY 3: INCREASE THE UPTAKE OF HIV AND AIDS SERVICES BY CHILDREN

Training on the management of children has been conducted for all clinicians, and all CCMT Service Points are offering HIV and AIDS child services. The integration project with MC&WH to fast track pregnant women for initiation on ART services is functional. The number of children on ART increased from 12,972 in 2007/08 to 21,329 (+64%) in 2008/09.

⇒ PRIORITY 4: STRENGTHEN INTEGRATED STRATEGIES TARGETING VULNERABLE CHILDREN

Integrated planning meetings were prioritised in 2008/09 to ensure improved management of vulnerable children at entry points. The partnership with the Nutrition Programme to ensure nutritional support services to vulnerable groups (including children) is effective and sustained in spite of budget constraints. *See Nutrition Programme for specific information regarding supplements for vulnerable groups.*

⇒ PRIORITY 5: EXPANDING ACCREDITED ART SITES TO PHC LEVEL INCLUDING TB FACILITIES

Access is further expanded through roving teams visiting areas with poor access to services for example in Ilembe and Umkhanyakude Districts. Doris Goodwin is ready for assessment as an ART site.

⇒ PRIORITY 6: STANDARDISE THE HOME AND COMMUNITY-BASED PROGRAMMES

The Departments of Health and Social Development drafted an integrated monitoring & evaluation tool that is expected to be finalised in 2009/10. Decentralised workshops were conducted with District Coordinators to standardise the Home-Based Care (HBC) reporting tools, and a Provincial database was developed for all HBC organisations, which includes the names of HBC organisations and details of caregivers receiving stipends. HBC details are included in table 44.

Caregivers serve as a link between health facilities and communities and support comprehensive care through referrals and assisting health facilities with tracking and follow-up of patients. During 2008/09 a total of 268,165 patients were cared for by HBC's, 4,168 volunteers received a stipend of R500 per month and 148 organisations received R250,000 per annum to render HBC services in the communities. The Department trained 1,399 caregivers and distributed 33,896 HBC Kits.

To relieve pressure on acute beds in hospitals, the Department is funding 8 NGO-run step-down facilities with a total of 2,556 beds in addition to the allocated beds in Provincial facilities.

Part B – Programme 2: District Health Services

Table 44: Home-Based Care per District

Districts	Funded HBC Organisations	Active HBC Caregivers	Caregivers receiving Stipends	New HBC's Trained	Patients Served	Number of HBC Kits Purchased
Ugu	18	1,006	1,006	40	10,553	1,060
Umgungundlovu	4	1,347	80	270	25,520	1,429
Uthukela	13	800	280	310	90,900	6,800
Umzinyathi	4	700	90	350	11,000	1,680
Amajuba	5	300	100	0	8,460	1,816
Zululand	6	425	144	148	17,938	3,019
Umkhanyakude	7	1,132	175	141	33,459	2,516
Uthungulu	17	618	367	0	15,538	1,449
Ilembe	19	534	410	0	9,495	1,529
Sisonke	16	558	398	0	8,726	2,760
eThekwini	37	2,532	1,118	140	36,576	9,838
TOTAL	**146**	**9,952**	**4,168**	**1,399**	**268,165**	**33,896**

In 2008/09 the Department, in partnership with the Department of Social Development, funded 84 community organisations to provide services for Orphans and Vulnerable Children. Through this programme, the orphans and vulnerable children were provided with cooked meals, food parcels, assisted with issuing of birth certificates and those that needed health care were referred to health facilities. The following table indicated the number of National Integrated Programme (NIP) Sites per district. The Department reviewed and amended the HBC and NIP contracts.

Table 45: Functional NIP Sites per District

Districts	NIP Sites	Orphans & Vulnerable Children served	Child Headed Households served	Families (excluding Child Headed Households) served
Ugu	9	1,560	205	5,792
Umgungundlovu	9	3,768	163	622
Uthukela	5	2,000	1,000	8,000
Umzinyathi	5	1,200	650	120,000
Amajuba	2	225	328	7,883
Zululand	9	2,840	101	212,230
Umkhanyakude	7	6,073	1,973	87,356
Uthungulu	9	6,977	1,211	1,727
Ilembe	10	1,389	245	8,942
Sisonke	6	3,791	529	7,446
eThekwini	13	37,074	14,103	8,879
Total	**84**	**66,897**	**20,508**	**277,877**

! CHALLENGES

- VCT is not fully functional in all NIP Sites due to infrastructural challenges and inadequate staffing arrangements influenced by budget constraints.
- Monitoring and supervision of CHBC remained a challenge in 2008/09.
- Stipends are not standardised with ex KwaZulu workers being paid more than NPA workers, creating conflict.
- Reporting tools are not yet standardised and reporting and data quality is poor.
- Current community programmes are not yet fully integrated into PHC resulting in duplication and under utilisation of existing resources.

⇒ PRIORITY 7: EXPANDING HIGH TRANSMISSION AREA (HTA) SITES

There are currently 6 Truck Stop Clinics in the Province at Uthukela, Mooiriver, Kokstad, Marburg (in Port Shepstone), Pongola and Pinetown, where services for STI's, condom distribution and VCT are offered.

High Transmission Areas intervention sites increased from 19 in 2007/08 to 42 in 2008/09. The sites include 11 Correctional Service Centres, 10 Tertiary Institutions, 8 Hostels, 6 Taxi Ranks and 1 Mobile Unit targeting farming areas. These intervention sites offer condom distribution and HIV counselling to high risk groups. A total of 1,544 patients received STI treatment at these sites and 688,000 male and 16,442 female condoms were distributed at these sites during 2008/09.

! CHALLENGES

- Male condom shortages reported from most districts.
- Poor utilisation of HTA sites.

⇒ PRIORITY 8: IMPLEMENTATION OF STEP-DOWN CARE

The burden of palliative care is significant on hospital staff as a result of inadequate and/or under-utilised step-down facilities. This reduces the quality of care.

Genesis step-down facility is under-utilised and hospitals have been urged to utilise the facility to relieve pressure at hospital level. There are still no step-down facilities in the Umgungundlovu District due to infrastructural challenges at Kwa-Hlengabantu and Umgeni Hospital. The district is in the process to establish a step-down facility at Umgeni.

A site for a step-down facility was sourced from the Municipality while construction on the second site donated by Inkosi Mabaso did not start due to a lack of funds. The district is in the process of approving a current institution belonging to a NGO as a step-down facility for the Ladysmith area.

One NGO step-down facility (27 beds) is being maintained for palliative care in the Umzinyathi District.

The Newcastle Hospital (33 beds) is offering step-down care, but the Madadeni Hospital (48 beds identified) delayed the programme due to a lack of space and other resources.

All institutions in the Ilembe District have step down beds, however the lack of cost centres at institutions affects costing and budget allocation.

⇒ PRIORITY 9: IMPROVE THE IMPLEMENTATION OF THE SYNDROMIC MANAGEMENT OF SEXUALLY TRANSMITTED INFECTIONS

A total of 40,734,650 male and 285,504 female condoms were distributed against targets of 84 million male (based on population estimates) and 480,000 female condoms. The partnership with Prestige (placing condoms in company toilets) was sustained in eThekwini, and the Society for Family Health continues to distribute male condoms in grey areas e.g. taverns and tuck shops around Umlazi.

A mini survey to determine missed opportunities at PHC level was conducted in 2008/09. Results indicated that:

- There is a low uptake of condoms under family planning clients; and
- Condoms are introduced to clients however not distributed at the contact point. Clients are instead referred to strategic points where condoms are available.

The results of the survey were discussed with the Sexual & Reproductive Health Manager and a strategy to address the identified gaps is being planned for 2009/10.

The '*Call a Slip Campaign*' was introduced in all districts in the first quarter of 2008/09. Ilembe District monitored the

impact of the campaign and reported no change in follow-up of partners. The campaign was extended and rolled out to all facilities in the district for long-term monitoring. Results will be used for rollout to other districts. The Department is in the process to develop a Fact Sheet to assist health care workers to promote STI partner treatment.

The intended target of reducing STI incidence from 7/1000 to 5/1000 by March 2008 has not been achieved. The current incidence is 5.9 /1000.

PROVINCIAL PERFORMANCE INDICATORS

Data completeness: 95%

Table 46: (HIV 2) Provincial Objectives and Performance Indicators for HIV, AIDS, STI & TB Control (HIV, AIDS & STI)

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
ANTI-RETROVIRAL THERAPY					
Measurable Objective: To implement the Comprehensive Plan for HIV and AIDS.					
Number of accredited sites (Hospitals / Clinics/ Other).	69	72	80	79 Hospital: 62 PHC: 17	86
Total number of ART patients.	32,147	76,000	143,526	195,312	225,863
HIV testing rate.	85.3%	*92%	91%	95%	95.5%
Number of children on ART.	3,492	7,977	12,972	21,484	21,329
Number of STI treated new episode: ART patients.	*16,848	*12,240	*22,209	4,000	24,862
Proportion of HIV+ patients screened for TB.	Not reported	Not reported	Not reported	100%	100%
SEXUALLY TRANSMITTED INFECTIONS					
Measurable Objective: To support the effective implementation of the Syndromic Management of STI's.					
STI partner treatment rate.	22%	28%	21.2%	30%	21%
STI treated – new episode.	478,233	645,000	424,452	368,000	456,043
Syphilis prevalence among antenatal clients tested.	2.6%	1%	5%	2%	3%
VOLUNTARY COUNSELLING AND TESTING					
Measurable Objective: To expand and sustain the Voluntary Counselling and Testing Programme.					
Proportion clients HIV pre-test counselled (excluding ANC).	2%	2%	2%	10%	3%
Fixed facilities offering VCT.	97%	97%	100%	100%	100%
Number non-medical sites offering VCT.	Not reported	59	65	94	63
% Mobile clinics offering VCT.	Not reported	Not reported	80%*	90%	See Footnote[76]

Note:* Denotes a change in data since last reporting (complete data).

[76] HAST Programme stopped to monitor this indicator before April 2008/09 – data therefore not available

TB SERVICES

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities 2006-2008/09

Priority 4: Improve management of communicable diseases and non-communicable illnesses

↓

Provincial Strategic Plan 2005-2009/10

Goal 3: Promote health, prevent and manage illnesses with emphasis on poverty, lifestyle, trauma and violence

↓

Annual Performance Plan 2008/09

Goal 4

Strategic Objective 16: To continue to implement the TB Crisis Management Plan

↓

TB Priorities 2008/09

1. Optimise and sustain the quality of DOTS through continued commitment, increased accountability, and the allocation of adequate resources and implementation of community awareness and mobilisation programmes.
2. Align standard diagnostic protocols to include screening for TB in all instances, irrespective of the reasons for clients entering the Public Health System.
3. Improve access to quality assured TB sputum microscopy for case detection.
4. Implement standardised treatment protocols.
5. Ensure an effective and regular drug supply system (facilitate the procurement of appropriate fixed dose combination TB medication).
6. Implementation of the Electronic TB Register.
7. Collaborate with external providers to improve the efficiency of the TB Programme.
8. Implementation of the STP in relation to TB services.

MDR TB

1. Implement the National TB Crisis Management Plan and step-wise approach including:
   - Identification of the causal factors for the emergence of drug resistant TB.
   - Strengthening of surveillance of drug resistant TB.
   - Measures to prevent the development and spread of drug resistant TB.
   - Assessment and strengthening of the quality of MDR TB treatment.
   - Systematic implementation of infection control measures in MDR TB treatment centres.
   - Development of clearly defined clinical protocols enabling institutions to identify possible MDR TB cases and to manage confirmed cases appropriately.
2. Improved laboratory capacity for MDR TB diagnosis.

The Hlola Manje Campaign increased awareness about the TB and the importance of treatment compliance.

Part B – Programme 2: District Health Services

EXECUTIVE SUMMARY

In 2008/09 the TB Programme has focused on improving the management of the TB Crisis Management Plan at Provincial, District and Sub-District levels and improving case finding and case management; case retention; reporting and recording; capacity and quality of laboratory diagnostics, and the management of MDR TB.

Budget constraints severely hampered progress towards improving management of the TB Programme at both Provincial and Districts levels. At district level, 4 districts (Sisonke, Umzinyathi, Uthungulu, and Ugu) were able to separate CDC and TB coordination and were able to appoint dedicated District TB Coordinators.

Early case finding improved with 94% of facilities (that diagnose TB) implementing the suspect register for early case finding. 2.5% of patients were screened for TB, 9% tested positive for TB and 90% of those were placed on treatment. A total of 26 dedicated TB nurses were appointed at facility level in 2008/09 (total of 174 since 2006) which improved the capacity to manage patient loads adequately.

The patient treatment calendar and diary system has been developed and unpacked to facility level to improve patient tracking on a daily basis and to identify defaulters quickly. Four TB Community Officers posts were filled in 2008/09 bringing the total to 65 since 2006. Only 5 vehicles were procured in 2008/09 bringing the total number of vehicles to support TB to 129.

The updated ETR.Net system (with the built in TBHIV component) was downloaded into the Provincial system which improved data collection on co-infection. The Province appointed 243 Data Capturers/ Clerk's as part of the Data Project on a one year intern contract which drastically improved data completeness and timeliness. There are 840 TB reporting stations in the Province including hospitals, clinics (public, municipal and private), correctional services and SANDF services. The system is running at ±95% completeness compared to 85% in 2004.

The Department conducted a comprehensive SWOT analysis on laboratory skills/ processes to inform strategies. Due to financial constraints the physical and staffing capacity at laboratories could not be upgraded.

The new MDR TB reporting and recording register system has been introduced and is being implemented provincially, resulting in all patients diagnosed being registered into the system and the 2007 patients being captured in the system retrospectively. Two new decentralised MDR TB Units opened in 2008/09 i.e. Murchison MDR TB Unit, and Manguzi MDR TB Unit (temporary 15 bedded Unit while construction of the new 40 bedded dedicated Unit is in progress). FOSA, M3 Greytown and Thulasizwe MDR TB Units expanded their bed numbers and increased the MDR TB bed capacity from 240 beds in 2006 to 581 in 2008/09 (130% increase in two years). The M3 Greytown, Thulasizwe, Murchison and Manguzi MDR TB Units started to initiate treatment and management of their patients thus starting to decrease the high caseload in King George V Unit.

.

POLICIES

Table 47: **Acts, Policies, Protocols and Guidelines**

New Acts, Policies, Protocols & Guidelines	Comments
1. Guidelines for Community-Based MDR TB Management.	• Guidelines finalised in 2008/09 and Department commenced with a Community-Based Pilot Programme for MDR TB in the Msinga Sub-District in Umzinyathi District. **Project summary:** • Five mobile teams do home visits where patients receive injections in their homes 5 days a week, reducing the actual average cost to approximately 25% of the cost of the traditional hospital management of patients. • Although it is too early to measure official completed treatment outcomes the initial early outcomes are positive. Patient safety with regards to side effects is also positive with none of the initial 81 patients in the first cohort group having to be taken out the programme due to unmanageable side effects.

New Acts, Policies, Protocols & Guidelines	Comments
	• Patients themselves have a very positive response to date as they are managed at home and close to their families. • Early assessment indicates that the programme is relatively safe in terms of patient safety, transmission rates in household contacts, and dramatically reduced costs for both the Department and households.
2. Priority 2008/09: To align Standard Diagnostic Protocols to include screening for TB in all instances.	• Screening and diagnostic protocols are implemented across the Province in accordance with the NTCP Guidelines. Protocols are now part of the HAST Programme Screening and Diagnostic Protocols and Guidelines which ensures that all patients are screened at entry level.
3. Priority 2008/09: Implement Standardised Treatment Protocols.	• Standardised TB treatment regimens are now implemented across the Province, and the new seven day a week dosage regimen was introduced during 2008/09 as opposed to the old five day a week dosage regimen. This has resulted in an approximate 30% increase in TB treatment (drug) cost.
4. Priority 2008/09: Development of clearly defined Clinical Protocols enabling institutions to identify possible MDR TB cases and to manage confirmed cases appropriately.	• No new protocols have been developed. Policies are in place however implementation is poor. Focus on protocol during TB and MDR TB training shows positive results with the number of MDR TB patients registered into the programme increasing from 600 in 2006 to 1,100 in 2008/09 (±40% increase).

PROGRAMME PERFORMANCE

⇒ PRIORITY 1: OPTIMISE AND SUSTAIN THE QUALITY OF DOTS

Sustaining the DOT Supporters programme remains a challenge as indicated by the fluctuating coverage of TB patients with support, from 80% in 2005/06 to 75% in 2007/08 and 72% in 2008/09. Increased community awareness and community involvement (supported by door-to-door campaigns) should improve support and treatment adherence. At least one door-to-door campaign has been done in at least one district per month, and the Hlola Manje Campaign reached a total of 4,774 homes in one week. Although outcome has not been evaluated all districts reported an increase in TB suspects at facilities following campaigns.

Due to financial constraints, training could not be undertaken for volunteers thus affecting the DOT Supporter programme.

Case finding and retention has been strengthened with 697/740 facilities (94%) implementing and reporting on the suspect register although the quality of reporting should be evaluated which has not been possible due to limited resources.

The Department has appointed 65 TB Community Officers (Tracers) and procured 129 vehicles to support TB since the Crisis Management Plan implementation commenced in 2006. The appointment of dedicated TB staff (including TB tracer teams) resulted in improved compliance and an increase in cure rates from 35% in 2004 to 54.2% in 2008. The interruption rate decreased from 14% in 2004 to 9.9% in 2008. Umzinyathi District reported a remarkable defaulter rate of less than 2%.

! CHALLENGE

- Inadequate tracer teams to manage increased workloads directly related to the MDR TB contact surveillance programme which requires all MDR TB household contacts to be placed on a 6 monthly follow-up surveillance programme for 2 years. Inability to increase tracer teams might jeopardise treatment outcomes.

The nutritional supplementation programme for TB and HIV patients on treatment has been scaled up to improve compliance and efficacy of treatment. The number of patients that received supplements averages ±70,000 per quarter (*see details in Nutrition Programme*).

⇒ PRIORITY 2: ALIGN & IMPLEMENT STANDARDISED SCREENING & TREATMENT PROTOCOLS

All patients are screened for TB at VCT and ART service points although data collection, reporting and quality is still

a challenge. A paper-based system is being piloted in the Sisonke District while the HIV and AIDS Unit appointed district staff to improve data quality.

To improve the clinical management of TB the Department appointed 26 Staff Nurses at clinic level bringing the total to 174 since 2006. Increased capacity at clinic level improved the implementation of management protocols, and data completeness shows improvement with ±95% of data in the system.

Due to financial constraints no TB training courses could be conducted in 2008/09. In-service training was however intensified to bridge the gap and 2,117 Home and Community Based Carers have been trained in the National TB Guidelines to strengthen capacity for good patient and programme management.

⇒ PRIORITY 3: IMPROVE ACCESS TO QUALITY ASSURED TB SPUTUM MICROSCOPY FOR CASE DETECTION

No progress has been made with recruitment of laboratory staff and improvement of infrastructure (space) due to financial constraints in 2008/09. There seems to be a general increase in the turn-around times from laboratory as a result of human resource challenges.

⇒ PRIORITY 4: ENSURE AN EFFECTIVE & REGULAR DRUG SUPPLY SYSTEM

The Province reported no stock-out of 'ordinary' TB drugs. Stock-out of Streptomycin (used for re-treatment of TB patients) and MDR TB drugs were however reported as a result of the inability of registered suppliers to supply sufficient drugs which has been raised with National Health. Due to financial constraints and inadequate space at PMSC, the Department could not hold the recommended buffer stock of drugs and hence was unable to prevent some of the reported stock-outs.

⇒ PRIORITY 5: IMPLEMENTATION OF THE ELECTRONIC TB REGISTER

There are 863 reporting stations with 27 main capturing points in the Province, and although the system is fairly sound, timeliness is compromised at times due to software problems that must be resolved by the contracted Data Company in Cape Town. The TB Unit completed a district audit of the register sheet submission system to inform improvement strategies that will be implemented in 2009/10.

! CHALLENGES

- Current computers (for data collection) must be upgraded or replaced to comply with standard specs for the TB software.
- Data collection and reporting is a challenge and impacts on data quality, planning and programme management.
- Imported viruses into the ETR.Net system as a result of the use of USB's for exporting and importing data into the system. Inadequate anti virus programmes have huge cost implications.
- Delay in data capturing compromises timeliness of data (3-5 months behind) and in turn monitoring of progress. Upgraded IT systems must be considered to improve data quality.
- The TB Register accommodates capturing for chemoprophylaxis, other basis of diagnosis, culture diagnosis, DOT and patients started on treatment. The ETR.Net report however does not generate this information for planning and management purposes.
- The ETR.Net does not capture MDR patients in the case finding report and reports can therefore not be generated on MDR / XDR contacts as per ETR report.

⇒ PRIORITY 6: COLLABORATE WITH EXTERNAL PROVIDERS TO IMPROVE THE EFFICIENCY OF THE TB PROGRAMME

The TB Programme works closely with external providers to improve service delivery through implementation of relevant projects with the potential to inform programme development. Evaluation and research are supported to determine outcome and impact of interventions.

The following organisations supported the Department in 2008/09 and contributed significantly towards improving and sustaining the TB Programme:

- MRC and UKZN: MDR & XDR TB Rapid Point Prevalence Surveys;
- MRC: TB in Health Care Workers Profile Project (data collection phase);
- MRC: Proposed Data Validation Project;
- MRC: Proposed IC Implementation Evaluation Project;
- TB Free: Training and Coordination of DOT Supporters (currently being evaluated);

- TASK TB: Supervision and M&E implemented in the Ilembe and eThekwini Districts, and currently being rolled out to the Ugu and Umkhanyakude Districts. Improvement in treatment outcomes noted in both districts.

⇒ PRIORITY 7: IMPLEMENTATION OF THE STP

TB norms are included in the draft STP although it has not been updated in 2008/09. The STP is not yet implemented.

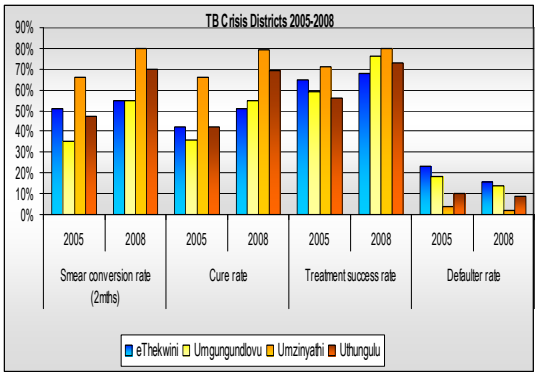
⇒ PRIORITY 8: IMPLEMENT THE NATIONAL TB CRISIS MANAGEMENT PLAN

The emergence of MDR and XDR TB resulted in the aggressive implementation of the TB Crisis Management Plan. As a result of this, an increase in the case load from 98,000 in 2005/06 to 110,000 in 2007/08 has been noted. Improved screening, implementation of the suspect register and management of TB patients improved case finding and ensured appropriate management of patients as per standard treatment guidelines.

In 2008/09, a total of 1,134 MDR TB patients (compared to 1,128 in 2007/08) and 109 XDR TB patients (compared to 168 in 2007/08) were registered in the Province in 2008/09.

Although the TB Crisis Management Plan is implemented in all districts, it specifically targeted eThekwini, Umgungundlovu, Umzinyathi and Uthungulu Districts. All four priority districts show improved outcomes since initiation of the Plan in 2005 with the cure rate improving from 31.9% (2005) to 55.2% in 2008 and the interruption rate decreased from 13.4% in 2005 to 9.9% in 2008. A comparison between the 4 priority districts is reflected in graph 15.

Graph 15: TB Crisis Districts 2005-2008



A study done by the Italian Cooperation on MDR and XDR TB patients in Church of Scotland Hospital reported that at four weeks from specimens being taken (4 weeks being the average time to get the culture and DST result), 55% of patients had already died by the time diagnosis had been confirmed in order to start treatment. Interestingly there were no significant differences between the survival rate of XDR and MDR TB patients which stresses the importance of effective management of the programme through investment of resources.

Although all TB Specialised Hospitals are not yet accredited ART sites, the screening of TB patients has improved during 2008/09 with the current TBHIV co-infection rates in TB patients ranging between 70-90% in different areas in the Province. The current data collection system is being developed to ensure more accurate recording and reporting that will inform decision-making.

The Province improved access to MDR TB management with the opening of the Murchison MDR TB Unit (Park Home) with 40 beds, and a temporary 15 bedded side ward at Manguzi Hospital. Construction of the new purpose designed 40 bedded Unit in Manguzi commenced on the 12th of January 2009. Expansion of services in 2009/10 is planned for the Catherine Booth Hospital (40 beds) and Doris Goodwin Hospital (60 beds).

Although the number of TB beds increased from 240 in 2005 to 581 in 2008 it is still inadequate to accommodate the increasing number of TB cases in the Province. The decrease in patients on waiting lists, from approximately 170 patients/ 2-4 weeks to 50 patients/ 1-2 weeks, suggests that improved screening, access and treatment outcomes have a positive effect on management of patients in the community. Funding restrictions however severely impact on the availability of infrastructure and resources which in turn have serious implications for service delivery and treatment outcomes. Table 48 reflects bed numbers per institution.

Table 48: TB Bed numbers per Institution

Institution	2005	2006	2007	2008
King George V	240	160 (FOSA opened)	160	190
FOSA		165	165	195
M3 Greytown		25	25	31
Thulasizwe			40	110

Institution	2005	2006	2007	2008
Manguzi (Temporary)			15	15 (start new unit)
Murchison				40

According to Dr K Wallengren, WHO sponsored Technical Advisor in 2007, the main reason for the increased number of MDR TB patients is poor compliance to standard treatment regimens and to a lesser degree poor implementation of standard treatment guidelines. This finding highlights the need to improve general adherence to the NTCP screening guidelines which has been done in 2008/09 with results showing an increase in registered patient numbers since 2006.

To decrease delay in results, the Province does an automatic work-up of DST for both MDR and XDR TB initially (on all culture specimens) as opposed to a work-up of MDR TB first and if positive start work-up for XDR TB which results in a 4-6 week delay in diagnosing XDR TB. The Department is continuing with the rapid point prevalence MDR / XDR TB surveys to ensure evidence-based practice.

Infection control has been done through in-service training and focused mainly on cough hygiene (reduce the initial explosive burst of bacilli into the airspace) and open window policy (improved ventilation/ air movement to move and spread thinly what bacilli are in the air). The open window policy is being implemented satisfactorily but cough hygiene needs to improve more. Districts started implementation of fast queues and triaging of TB suspects/ patients which is in line with infection control measures.

The MRC is in the prepatory phase of a Provincial study on Infection Control Implementation Strategies in MDR TB Units which will inform strategies and action.

! CHALLENGES

- Limited capacity delayed effective monitoring and evaluation of implementation of policies e.g. physical air movement assessments, etc. which challenge pro-active interventions to address implementation challenges.
- Financial constraints delayed infrastructure demands required for effective infection prevention and control interventions. This jeopardises clinical outcomes with huge implications.

⇒ PRIORITY 9: IMPROVED LABORATORY CAPACITY FOR MDR TB DIAGNOSIS

The microscopy sites increased from 55 in 2005 to 81 in 2008, to improve early diagnosis and treatment of TB.

Inadequate resources challenged programme monitoring in 2008/09. The blinded re-check Quality Improvement Programme could not be sustained due to lack of resources. Enhanced laboratory capacity was a challenge and DST testing reached the limit. The option of decentralisation and expansion needs serious consideration in order to sustain gains made in the programme. IALCH processed approximately 15,000 specimens per month compared to 13,500 in 2007/08.

Monitoring & Evaluation, Research and TB Projects

The MRC is currently conducting a drug trial on new TB drugs that will reduce the length of TB treatment from 6 to 4 months.

The Department commenced with Rapid Point Prevalence Surveys in response to the WHO 7-Point Plan to respond to MDR/ XDR TB and to determine outbreak trends linked to Church of Scotland Hospital (COSH) in the Umzinyathi District. Surveys focus on:

- Out-patient surveys where all TB suspects presenting at a facility were screened for MDR/ XDR TB. Approximately 500 suspects were screened to find 100 TB positive cases which are then calculated for MDR/ XDR TB. In spite of financial constraints surveys were completed in 5 sites reporting MDR rates ranging from 2.5% to 18%. Of concern was the unexpected high MDR rate of 18% in the Umkhanyakude District, which reported an XDR rate of <1%. Another 3 sites are currently conducting the audit - too early for results in this report.

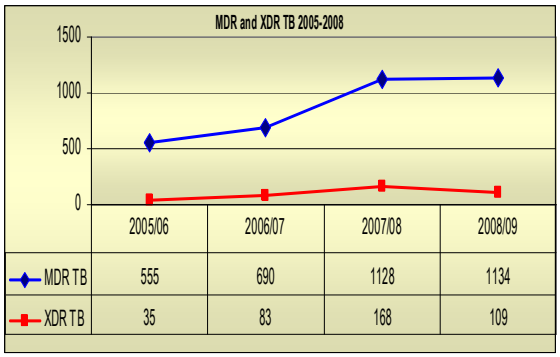
- In-patient surveys (considered a snapshot of all coughing patients in the hospital on the day of the survey) take specimens of all suspect patients in the hospital to screen for MDR/ XDR TB. Missed opportunities were suspected as indicated in the COSH out-break in 2006/07.

  The survey was completed in 18 hospitals reporting a total of 701 suspects screened and 234 of the suspects

being positive for TB. Of these, 32 (13.6%) were MDR TB, and 5 (2.1%) were XDR TB. As with out-patient surveys there were high MDR TB rates and very low XDR TB rates. The Department will repeat the survey in the 18 hospitals to observe trends.

The FIND Project has been completed and succeeded in reducing the diagnostic time from 4 - 6 weeks to 7 - 10 days. Role out of the project recommendations was however delayed due to the lack of financial support to improve laboratory resources, capacity and space.

Graph 16: MDR TB and XDR TB 2005/06 - 2008/09



There has been no progress with the Electronic Tracking System Pilot in the Amajuba District due to financial constraints, and the system has not been evaluated and rolled out to other districts. The Province instead continues to implement a paper-based system (patient treatment calendar and diary) that has been developed and rolled out to all districts. The Department will evaluate the effectiveness of this system in 2009/10.

The Data Capturers Project was well received by all districts with improved maintenance of TB records. The project will continue during 2009/10 and the Department is currently in the process to recruit new one year internship candidates.

The Community Management Strategy Pilot in the Masinga Sub-District shows real potential towards the community management of patients, especially in the resource deprived climate. Mobile teams fall under the M3 Greytown MDR TB Unit and are managed by a PHC nurse from the COSH TB DOTS office on a daily basis.

- At any point in time the teams are managing approximately 35 patients at home who are in the injection phase;
- The Department profiled the first 81 patients put on the programme during September 2008. The average home contacts between the 81 patients were 403.
- At the time of diagnosis, 6 positive MDR TB (1.5%) patients were diagnosed (transmission rate before diagnoses and treatment).
- Current results indicated that 45% of the 403 household contacts had had their 6 monthly follow-up visits and no MDR TB was found indicating 0% transmission rate.
- No deaths and only 1 defaulter has been reported to date, with most of the patients converting to negative although it is too early to quantify outcome results. Indicators are however promising at this stage.
- No patients have had to be removed from the programme at this stage due to unmanageable side effects which is promising for programme outcome.
- An outcome assessment visit is planned for further evaluation before the end of May 2009.

A Primary School Project, sponsored by the Italian Cooperation, commenced in late 2008/09. TB information books and pamphlets designed for young children with information presented in the form of puppet shows in schools. The response from children, educators and parents has been very positive to date. The outcome will be evaluated in 2009/10.

Part B – Programme 2: District Health Services

PROVINCIAL PERFORMANCE INDICATORS

Data completeness: 95%

Table 49: (HIV 2) Provincial Objectives and Performance Indicators for HIV, AIDS, STI & TB Control (TB Control)

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Measurable Objective: To improve case finding and improve clinical management.					
1. Percentage institutions implementing the Suspect Register.	Not measured	50% (319)	72% (460/639)	100%	94%
2. Number of Facilities with an effective Patient Tracking System.	Not measured	24% (153)	52% (332/639)	100%	Data not available
3. Smear conversion rate – 2 months.	48.3%	53.9%	54.9%	60%	52.1% (data incomplete)
4. Defaulter rate.	13.4%	15.3%	12.9%	10%	9.6%
Measurable Objective: To improve laboratory diagnostic capacity to handle diagnostic workload and quality assurance and control.					
5. TB sputa specimens turn-around time <48 hours.	15%	55%	68%	85%	60.3%
6. % Laboratories implementing quality assurance protocols and controls.	0%	0%	100%	100%	100%
7. Bacteriological coverage.	Not available	78%	85%	85%	Data outstanding[77]
8. % Institutions provided with transport three times per week for sputum collection.	Not available	Not available	100%	85%	Not measured
Measurable Objective: To strengthen community support and participation and improve patient adherence.					
9. TB cases with a DOTS supporter.	80%	77%	79%	90%	72%
10. Number of DOTS Supporters trained.	Not collected	Not collected	1,200	1,200	1,473
11. Number of TB door to door campaigns.	Not collected	Not collected	22	25	33
Measurable Objective: To sustain the MDR TB reporting and recording system.					
12. Number of MDR TB sites implementing the MDR Electronic Register.	Not measured	Not measured	1	5	5
Measurable Objective: To strengthen the surveillance and management of MDR and XDR TB.					
13. Number of MDR TB decentralised sites.	-	2	4	7	5

[77] Data not available from the system at time of finalising the report

NUTRITION

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities 2006-2008/09

Priority 2: Promote healthy lifestyles

Provincial Strategic Plan 2005-2009/10

Goal 1: Effective implementation of the Comprehensive HIV and AIDS Strategy

Goal 3: Promote health, prevent and manage illnesses with emphasis on poverty, lifestyle, trauma and violence

Annual Performance Plan 2008/09

Goal 4

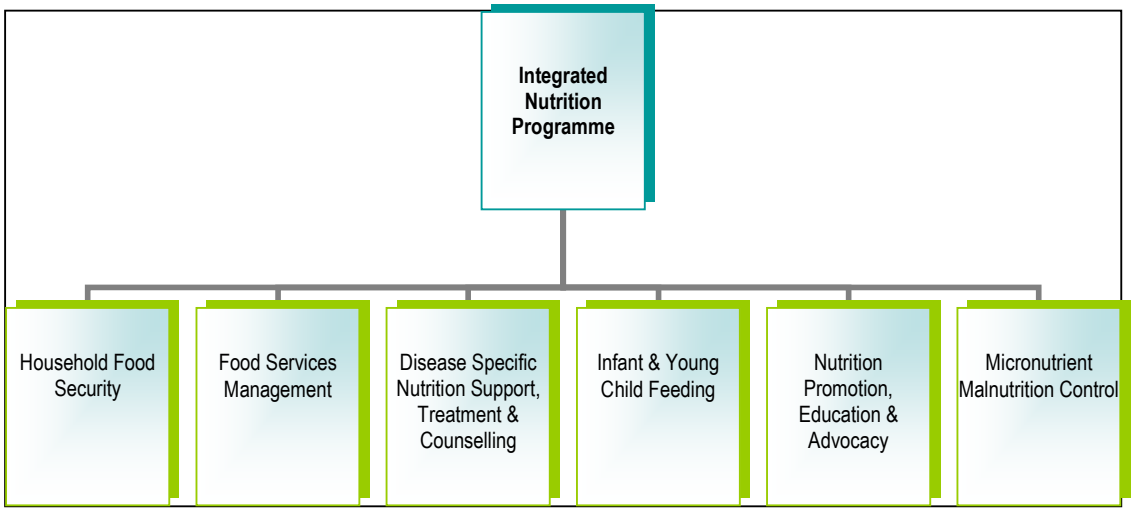
Strategic Objective 19: To sustain the integrated Nutrition Programme

Nutrition Priorities 2008/09

1. Strengthen the management of severe malnutrition in all districts.
2. Improve and sustain the coverage of Vitamin A supplementation programmes.
3. Strengthen the implementation of the Baby-Friendly Hospital initiative in all districts.
4. Contribute towards poverty reduction by providing nutritional support to vulnerable groups.
5. Ensure the inclusion of nutrition indicators in the DHIS to ensure effective monitoring.

Household food security, aimed at contributing to adequate access to food for households, forms an integral part of the Nutrition Programmes' activities and is in line with the Departments' commitment to '*Fighting Disease, Fighting Poverty, and Giving Hope'.*

Figure 3: **Nutrition Directorate**



Part B – Programme 2: District Health Services

EXECUTIVE SUMMARY

Malnutrition remains a major co-morbidity and together with HIV and AIDS contributes significantly to the under-5 mortality in the Province. According to the 2007 Saving Children Report, 31% of under-5 (in-patient) deaths in the Province were in the underweight for age category and 21.9% in the severe malnutrition category including kwashiorkor, marasmic-kwasiorkor or marasmus. The discordance between the severe malnutrition rate (0.6%) and the Provincial poverty and disease profile is a concern that will receive additional attention in the new financial year.

Improving the vitamin A status of children increases their chances of survival and can reduce child mortality by 25%. After 6 years of implementing the vitamin A supplementation programme, the coverage for children 6-11 months is 91% and for children 12-59 months a very disappointing 29.6%. To raise awareness and improve coverage, a Vitamin A campaign (targeting children 12-59 months) was held in September 2008 during which the Province achieved 82% coverage (target 80%).

A successful Child Health Week was held in Maphumulo (Ilembe District) in March 2009 focusing on vitamin A supplementation, immunisation, de-worming and other missed opportunities. 68.8% of children 12-59 months and 43% of children 6-11 months received vitamin A supplementation during the week.

During 2008/09, the Department purchased fortified porridges to the value of ±R 60m for supply to patients initiating treatment for HIV and TB. A total number of 203,771 patients starting HIV treatment and 106,155 starting TB treatment benefited from this programme.

Breastfeeding, considered one of the key survival strategies for children, and contributing to the achievement of Millennium Development Goal 4, has been included in the Accelerated Plan for PMTCT as a component of the Child Survival Strategies (preventative care). According to DHIS data, 52% of HIV+ mothers selected exclusive breastfeeding and 48% selected formula feeding as feeding choice in 2008/09. A total of 330 Lay Counsellors were trained on Infant & Young Child Feeding in the context of HIV to provide support to patients in the PMTCT programme and improve feeding practices.

Health has partnered with the Social Cluster Departments and the Department of Agriculture (lead department) in the KZN Food Security Project that is funded by the Flanders Government. Community projects and projects within health facilities that focus on food security have been established in the four targeted districts namely Umkhanyakude, Zululand, Ugu and Umgungundlovu.

The Nutrition Directorate put in place 28 new outsourced Food Service contracts in hospitals, of which 10 were given to emerging service provider.

POLICIES

Table 50: Acts, Policies, Protocols and Guidelines

New Acts, Policies, Protocols & Guidelines	Comments
1. Nutrition Guidelines for Parenteral Nutrition use in the Public Sector.	• Nutritional products that are used need to be on tender for easier implementation as delays impact on service delivery and cost. SCM has been very slow in awarding contracts for nutritional products resulting in delayed service delivery.
2. Amended KZN Protocol for in-hospital management of Severe Malnutrition in children.	• Dedicated monitoring is routinely done by Province and districts to monitor implementation of the Protocol in institutions.
3. National Vitamin Campaign Field Guide for Vitamin A campaign points.	• Assist with the planning and implementation of Vitamin A campaigns since this initiative only commenced in South Africa in 2008/09.
4. National Food Consumption Survey: Fortification Baseline.	• Study was done in 2005 and results released in 2008/09. The Survey revealed very poor improvements in most nutrition indicators especially vitamin A with recommendations informing turn-around strategies.
5. National Nutrition & HIV Guidelines & Implementation Framework.	• Guidelines adopted by the Province and disseminated to all health facilities.
6. National Infant and Young Child Feeding Policy.	• Advocacy meeting was held with District/ Facility Managers and staff and the policy

New Acts, Policies, Protocols & Guidelines	Comments
	was disseminated.
7. Obesity Guidelines - 1st draft.	• Need more Human Resources at grassroot level to effect implementation and follow up of Policy requirements.
8. Mother-Friendly Policy - 1st draft.	14. Need buy-in of all Managers in order for the policy to be effectively implemented.

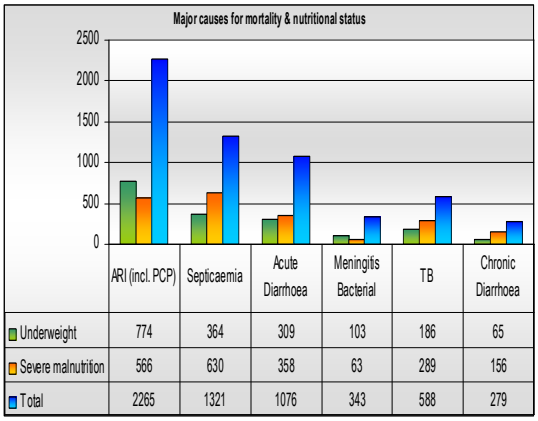
PROGRAMME PERFORMANCE

The vacancy rate for Dieticians and Nutritionists increased slightly from 76.2% in 2007/08 to 76.5% in 2008/09 whereas the turn-over rate showed a significant increase from 29.7% in 2007/08 to 39.7% in 2008/09. The increased demand for nutritional services severely challenged service delivery and planning with the current ratio of Nutritionists at 1:100000 and Dieticians at 2:100000. Criteria for nutritional support at ART accredited sites as well as the growing number of patients requiring nutritional assessment and support seriously challenged compliance and quality of care, and pro-active decentralised interventions should form part of the new 5-year Strategic Plan.

Poor management of severe malnutrition in children <5 years leads to high case fatality especially with regards to fluid overload, hypothermia and incorrect antibiotic administration. Most hospitals without a paediatric trained nurse in the Paediatric Out-Patient Department (POPD) reportedly experienced challenges implementing the 10-step Protocol for the Management of Severe Malnutrition, and the inevitable rotation of doctors and 'untrained' doctors further challenged effective management of children at facility level. Integrated strategies with MC&WH, TB, HIV & AIDS, PMTCT, etc. acknowledged the fact that malnutrition and AIDS remains significant in contributing to <5 mortality (approximately two thirds of all deaths).

According to the Saving Children Report 2005 - 2007, the highest risk of mortality associated with malnutrition was in the 1-5 year age group where one out of every two deaths was severely malnourished. Graph 17 illustrates the major causes of mortality and nutritional status for the period 2005 - 2007, which confirms the fundamental importance of addressing nutrition as an integral part of all health strategies.

Graph 17: Major Causes for Mortality and Nutritional Status 2005-2007[78]



	ARI (incl. PCP)	Septicaemia	Acute Diarrhoea	Meningitis Bacterial	TB	Chronic Diarrhoea
Underweight	774	364	309	103	186	65
Severe malnutrition	566	630	358	63	289	156
Total	2265	1321	1076	343	588	279

The Department faced numerous challenges to ensure the availability of commercial ready to use starter (F75) and catch-up (F100) formulas. Many Pharmacies reported stock-outs of trace element mixtures in spite of a circular being issued in this regard. The non-awarding of the Supplementary Feeds tender by SCM has severely limited the availability of therapeutic feeds at health facilities, and although the impact on programme and health outcomes has not been measured it is suspected to be considerable.

In an effort to contribute towards Household Food Security, more than 400 clinic gardens have been established in the Province since the inception of this initiative in 2002, and most districts have food gardens in ±80% of health facilities. Identifying garden space at clinics becomes increasingly difficult due to the erection of park homes at clinics for HIV programmes. Communal garden projects are the mandate of the Department of Agriculture with limited involvement by the Department.

An analysis of the adequacy of current micronutrients being issued to pregnant women in comparison with the recommended dietary allowances was completed in 2008/09. The Nutrition Directorate disseminated the final

[78] Saving Children 2005-2007 - A survey of child healthcare in South Africa

report to the MC&WH Directorate and the National Department of Health to inform incorporation of comprehensive micronutrient supplementation for all pregnant women into relevant policies and guidelines.

New Food Service Management (outsourced) contracts were established in 28 hospitals in the Province in 2008/09, and new specifications have been developed for use with future revised contracts. The main challenge was the lack of monitoring of Food Service Management in facilities predominantly as a result of the vacant Provincial Food Service Coordinator post.

In spite of severe financial and human resource limitations, the Department was able to respond to the 2008/09 priorities as identified in the 2008/09 Annual Performance Plan.

⇒ PRIORITY 1: STRENGTHEN THE MANAGEMENT OF SEVERE MALNUTRITION

The unemployment rate, estimated at 26.5%[79] and household food security estimated between 63% and 77%[80] are both contributing to the increased burden of malnutrition and raise the concern that the current health data on malnutrition may be deceptive and/or under-reported. Saving Children 2005 - 2007 report that almost two thirds of children who died (during the reporting period) were underweight for age and more than one half of these had severe malnutrition.

According to DHIS data, the incidence of severe malnutrition for children <5 years remained constant at 0.6% for the past 3 years. This however seems contradictory to the Provincial poverty and disease profile. In addition, district reports reflect that 79,260 malnourished children were issued with food supplements as part of the PEM Scheme in 2008/09, which in essence indicated under-reporting of malnutrition. The extent of malnutrition is therefore masked which in turn will have an impact on morbidity and mortality and ultimate achievement of Millennium Development Goal 4.

There seemed to be various plausible reasons for under-reporting including:

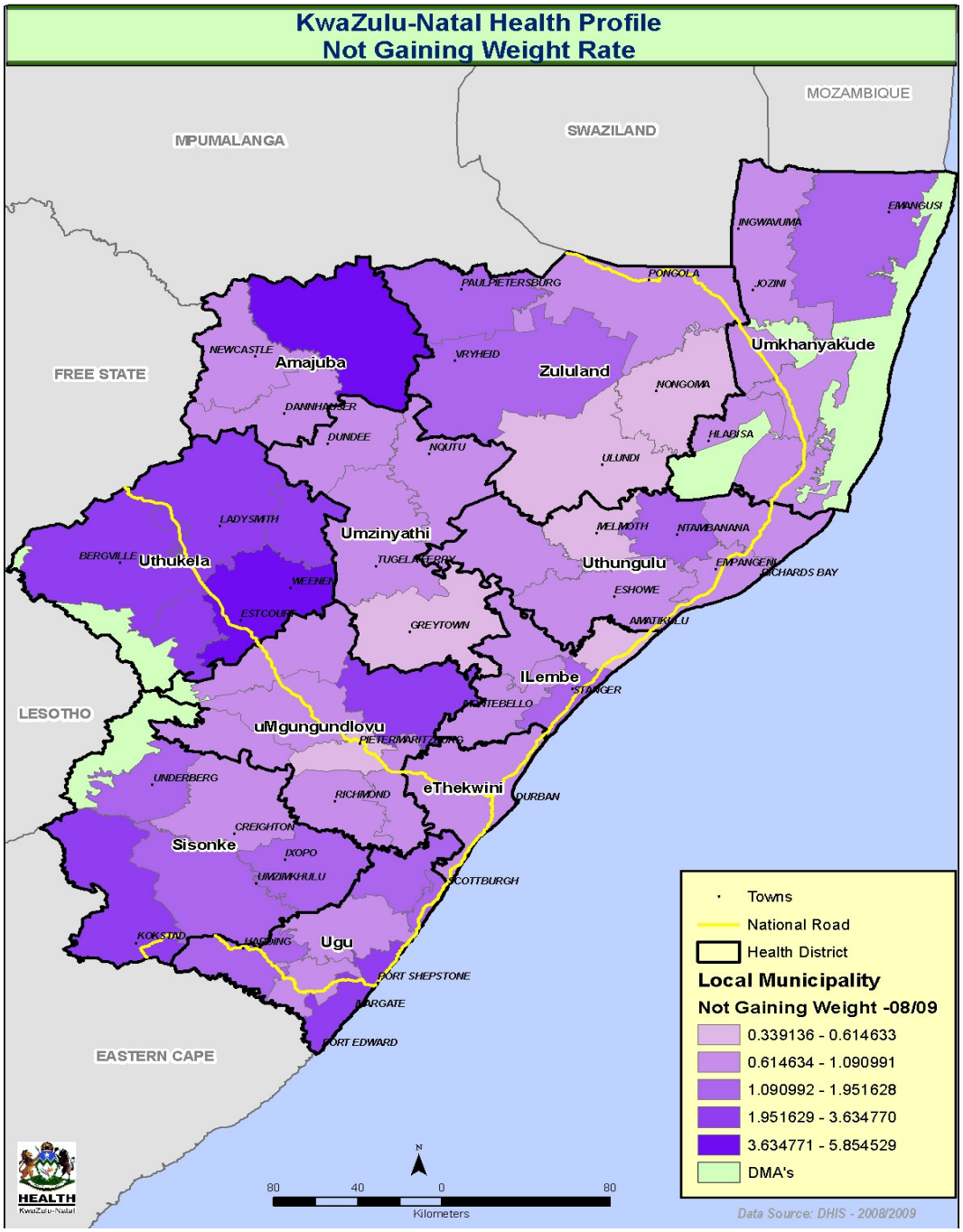
- Failure to identify children nutritionally at risk. Apart from gaps in clinical competencies that affect effective diagnoses and referral, a large number of children fail to present with Road to Health Charts (RTHC) thus making it difficult to estimate the level of malnutrition and food supplementation.
- Limitations in the DHIS to identify malnutrition as reason for admission or death as only the primary disease/ condition for admission or death (e.g. pneumonia) are captured and reported.
- Lack of appropriate nursing records and data management tools especially between Paediatric Out-Patient Department (POPD) and paediatric wards. This is expected to improve with the implementation of DHIS version 1.4.

In spite of concerted efforts to improve growth monitoring there are still gaps that are dealt with at facility and community levels. All districts have functioning scales to ensure that all children under-5 years are weighed at every visit. The weighing coverage increased from 62% in 2007/08 to 76% in 2008/09 which is still below the expected output. Assessments confirm that feedback to caregivers and interpretation of the growth curve is still very poor. It was clear during the vitamin A campaign that many caregivers do not present RTHC during visits to health facilities (which might be a general trend). There has been a sufficient supply of RTHC in facilities with no stock-out reported during 2008/09.

Progress with the community management of severe malnutrition (growth monitoring) has been very slow despite efforts by the Nutrition Directorate to procure scales for and train all Community Health Workers (CHW's) to monitor and plot weight on the RTHC.

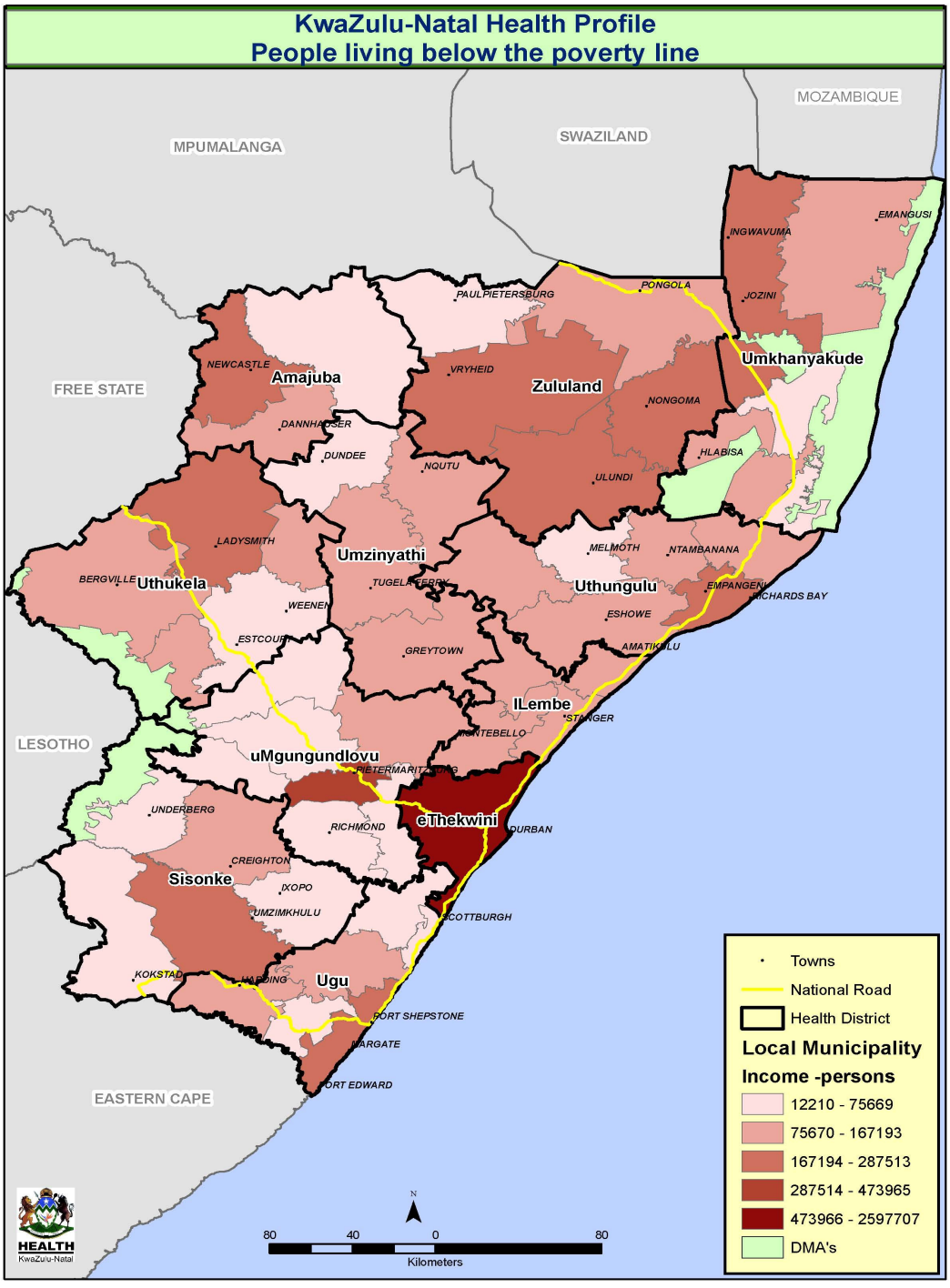
[79] Stats SA (2005)
[80] Food Fortification Baseline (2005)

Map 14: Not gaining weight rate per Sub-District



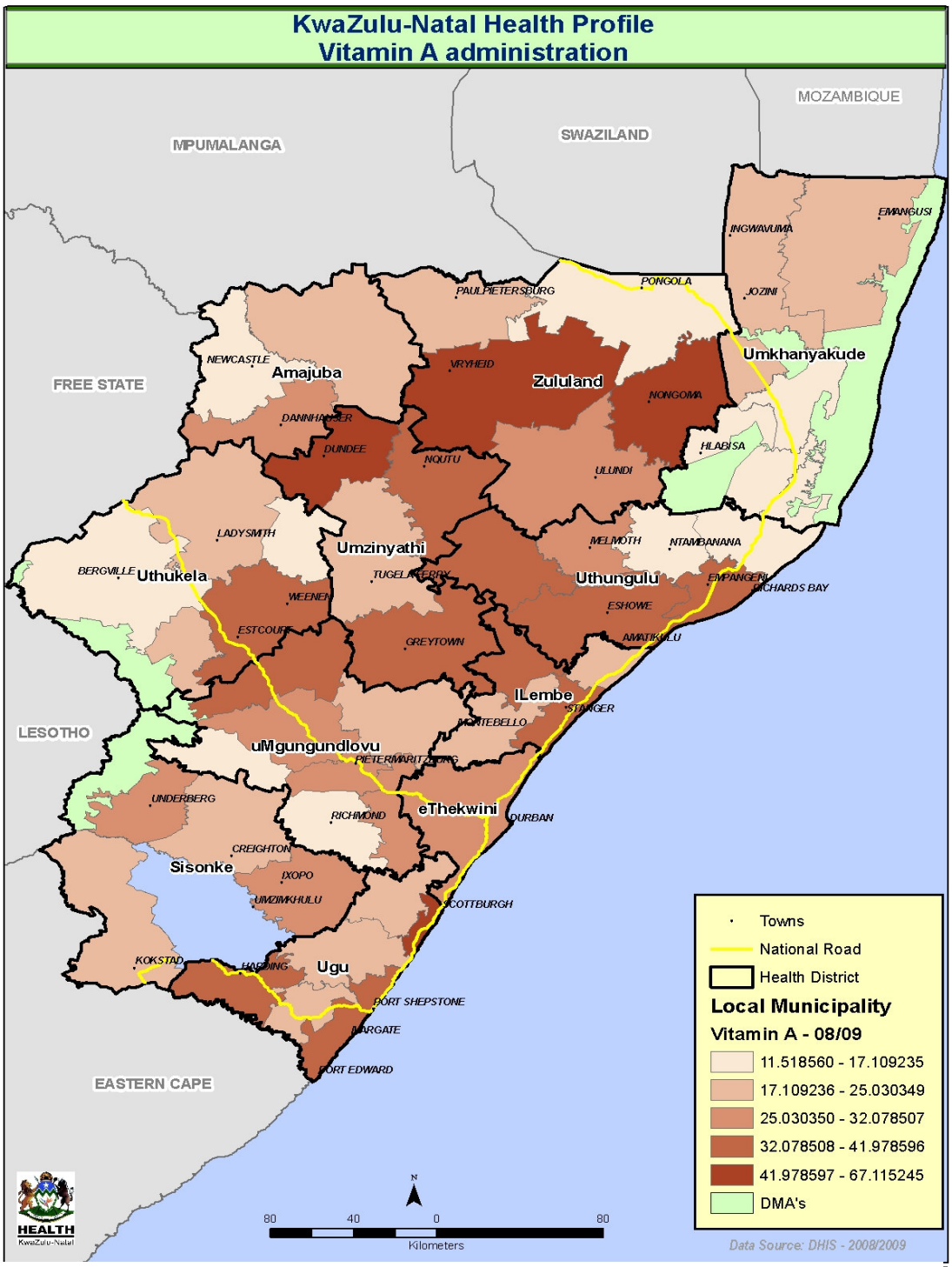
The map depicts the children not gaining weight per municipality. The lightest shades of purple indicate the children not gaining weight rate <0.6% within the municipality. The darkest shades of purple indicate the children not gaining weight rate >5.8% within the municipality.

Map 15: People living below the poverty line per Sub-District



The map depicts the number of persons living with an income below R1,600 per month per municipality. The lightest shades of brown indicate municipalities that have <75,669 persons within the municipality that receive an income below R1,600 per month. The darkest shades of brown indicate municipalities that have >473,966 persons within the municipality that receive an income below R1,600 per month.

Map 16: Vitamin A coverage per Sub-District



The map depicts the Vitamin A coverage in children under 1 year per municipality. The lightest shades of brown indicates where the coverage is <17.1% within the municipality. The darkest shades of brown indicate municipalities where the coverage is >41.9% within the municipality.

Part B – Programme 2: District Health Services

To improve community interventions, the Nutrition and Maternal, Child & Women's Health Components developed a draft document with intent to improve community activities and out-reach. The document is awaiting approval.

Although Nutrition has been integrated into the Integrated Management of Childhood Illnesses (IMCI) programme at PHC level, the integration and management of severe malnutrition should be scaled up at PHC and community level. In addition to IMCI, routine nutrition services at PHC level include nutrition supplementation and promotion, growth monitoring and promotion, breastfeeding promotion, demonstration of food gardens, etc.

An evaluation of the Integrated Nutrition Programme at PHC level was completed, the implementation of nutrition guidelines was assessed, and an assessment and evaluation of facility-based nutrition interventions to prevent and manage malnutrition at the PHC level was completed. Recommendations from these assessments/ evaluations will be actioned in 2009/10.

! CHALLENGES

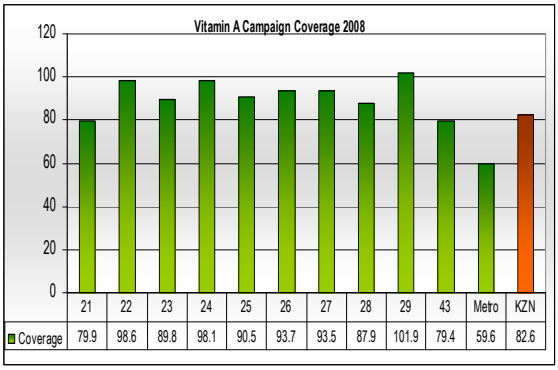
- Inter-sectoral response to the treatment of malnutrition at PHC and hospital level remains a challenge. Shortage of staff and workload increasingly affect comprehensive and seamless management of the sick child.
- The joint Business Plan, developed with the Department of Social Welfare for the distribution of food parcels to vulnerable people in the community, was unsuccessful due to appeals in the appointment of service providers.

⇒ PRIORITY 2: VITAMIN A SUPPLEMENTATION PROGRAMMES

In accordance with the Department's commitment towards achieving Millennium Development Goal 4 by reducing child mortality, vitamin A supplementation was included as one of the Child Survival Strategies in the Accelerated Plan for PMTCT. Implementation of the Plan commenced in 2008/09 and will be fast-tracked in the 4 priority sub-districts (identified by the National Department of Health). The same programme will be rolled out in the rest of the Province in 2009/10.

To improve vitamin A coverage of children 12 – 59 months, a National Vitamin A Campaign was conducted in September 2008. The Province achieved a campaign coverage of 82% which exceeded the national target by 2%. [Details available at H:\Micronutrients\VITAMIN A CAMPAIGN REPORT 2008.doc]

Graph 18: Vitamin A Campaign Coverage – September 2008[81]



During March 2008 an integrated Child Health Campaign was piloted in Maphumulo (Ilembe District) with the aim of promoting child health. Activities focused on vitamin A supplementation with 68.8% coverage for children 11-59 months and 43% for children 6-11 months; de-worming with 63% coverage; immunisation; abuse; screening; etc. to increase community awareness about child health. [Details available at H:\Micronutrients\Child Health Campaign Report 2 23-29 March 2009 (2).doc]

! CHALLENGES

- Poor utilisation of the RTHC impacted negatively on determination of vitamin supplementation, growth monitoring and vaccination.
- Lost opportunities as a result of health workers neglecting to routinely educate caregivers on the importance of vitamin A, return for follow-up supplementation and other relevant child health interventions.
- Inadequate human resources at grassroot level to ensure effective and seamless health education, promotion and support. There still seems to be a focus on treatment rather than health promotion.

[81] 21=Ugu; 22=Umgungundlovu; 23=Uthukela; 24=Umzinyathi; 25=Amajuba; 26=Zululand; 27=Umkhanyakude; 28=Uthungulu; 29=Ilembe; 43=Sisonke; Metro=eThekwini

⇒ PRIORITY 3: BABY-FRIENDLY HOSPITAL INITIATIVE

Breastfeeding, unequalled in providing the ideal nutrition for healthy growth and development of infants, also has a unique biological and emotional impact on the health of both the mother and the child. Exclusive breastfeeding, a child's first defense against malnutrition and death, is not yet implemented to the extent it is intended and the monitoring & evaluation system to monitor compliance to the criteria of exclusive breastfeeding is not yet in place. According to DHIS data, 52% of HIV+ women selected exclusive breastfeeding as feeding choice immediately after birth. It is however difficult to determine the actual compliance at 6 months.

The KZN Baby-Friendly Facility Assessors conducted internal assessments in May 2008 to support and monitor implementation of the 10 steps to successful breastfeeding before external assessments were conducted. National re-assessments were conducted in 15 facilities in August 2008, during which 10 facilities maintained their status as Baby-Friendly and 5 facilities failed to comply with the standard criteria. There are a total of 44 Baby-Friendly Facilities (42 hospitals and 2 clinics) in 2007/08. The facilities that failed compliance were visited by Provincial teams to identify challenges and provide support in pursuance of accreditation.

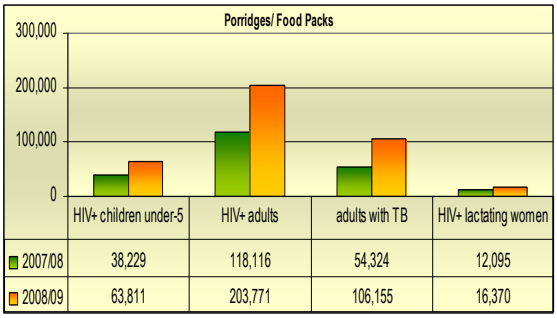
The Province conducted 2 Lactation Management training workshops to improve support for Baby-Friendly Facilities and those facilities working towards it. Facilities continue with training of staff internally, and Districts support and monitor implementation.

⇒ PRIORITY 4: NUTRITIONAL SUPPORT TO VULNERABLE GROUPS

The rapidly increasing number of HIV+ and TB patients on treatment increased the number of patients receiving porridge/ food packs significantly in 2008/09. Issues to HIV+ children under-5 increased with 66.9%; HIV+ adults with 75.5%; adults with TB with 95.4% and HIV+ lactating women with 35.3%. Financial restrictions impacted negatively on the purchase of porridge/ food packs with most districts reporting stock outs.

Graph 19 reflects the number of porridges/ food packs issued in 2008/09 as compared with 2007/08. The increase is a reflection of the output and outcome of improved screening, Voluntary Counselling and Testing, and treatment services implemented at both community and facility levels.

Graph 19: Porridge/ Food Packs issued 2007/08 - 2008/09



	HIV+ children under-5	HIV+ adults	adults with TB	HIV+ lactating women
2007/08	38,229	118,116	54,324	12,095
2008/09	63,811	203,771	106,155	16,370

⇒ PRIORITY 5: NUTRITION INDICATORS IN THE DHIS

Much progress has been made in streamlining nutrition data elements and data collection tools and aligning indicators with DHIS, District Reports and the Monitoring & Evaluation Framework. All core indicators (data elements) are included in DHIS version 1.4 which is expected to improve collection and reporting as well as timeliness and accuracy. No vertical reporting systems will be used from April 2009.

Clinical Dieticians actively monitor district performance and provide the necessary supportive supervision. The Child Health Problem Identification Programme (Child PIP) has been expanded to more hospitals in order to provide the necessary analysis and recommendations on child health indicators and interventions. *See MC&W for more information on Child PIP.*

! CHALLENGE

- The shortage of nutritional staff, including Nutritional Advisors at PHC level, has not been addressed due to delays in the finalisation of the PHC organisational structures.

Part B – Programme 2: District Health Services

PROVINCIAL PERFORMANCE INDICATORS

Data completeness: 95%

Table 51: (MC&WH 2) Provincial Objectives and Performance Indicators for Nutrition

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Strategic Objective: To sustain the Integrated Nutrition Programme.					
Measurable Objective: To expand services to reduce malnutrition in children under-5 years.					
1. Number of Baby-Friendly Hospitals.[82]	65% (37/58)	70% (40/ 58)	76% (44/ 58)	76% (44/ 58)	76% (44/ 58)
2. Children under-5 admitted with malnutrition.	Not measured	Not measured	1,840	150/1000[83]	8.5% 33/1000
3. Underweight for age rate under-5 years.	1.2%	1.2%	1.6%	1%	1%
4. Percentage of HIV+ women selecting exclusive breastfeeding.	Not collected	Not collected	37%*	65%	52%
5. Percentage of HIV+ women selecting exclusive formula feeding.	Not collected	Not collected	62%	35%	48%
6. Incidence of severe malnutrition under-5 years.	0.8%	0.6%	0.6%	0.5 %	0.6%
Measurable Objective: To eliminate micronutrient deficiencies amongst vulnerable groups.					
7. Percentage of children aged 6-11 months receiving Vitamin A capsules.	98.6%[84]	88%	75%*	75%	126%
8. Percentage of children aged 12-59 months receiving Vitamin A capsules (annualised).	20.7%	40%	45%*	50%	29.6%
9. Percentage of non-breastfed infants (0-5 months) receiving Vitamin A capsules.	Not collected	45%	50%	75%	42%
10. Percentage of postpartum women who receive Vitamin A capsules.	40%	70%	75%*	80%	105.2%
Measurable Objective: To contribute to the improvement of household food security among vulnerable groups.[85]					
11. Number of HIV+ children under-5 years receiving porridges/ food packs.	Not collected	Not collected	38,229*	18,000	63,811
12. Number of HIV+ adults receiving porridges/ food packs.	Not collected	Not collected	118,116*	75,000	203,771
13. Number of adults with TB receiving porridges/ food packs.	Not collected	Not collected	54,324*	23,000	106,155
14. Number of HIV+ lactating women receiving porridges/ food packs.	Not collected	Not collected	12,095*	2,500	16,370
Measurable Objective: To sustain disease specific nutrition support and counselling.[86]					
15. Number of underweight pregnant women receiving supplements.	Not collected	Not collected	Not collected	500	Not collected

[82] An annual indicator only considering Hospitals with Maternity Beds
[83] Target was based on an estimate in the absence of actual data - performance & trends will be monitored and target considered once baseline data is available
[84] Data unreliable and should be read with caution
[85] Monitored against HIV+ clients per catchment area - all data sourced from the collated Annual District Reports. Targets were set without actual baseline data hence the under-estimation
[86] All data sourced from the collated Annual District Reports. Targets for supplementation were estimated with actual baseline data and will be reconsidered for the next financial year

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
16. Number of underweight lactating women receiving supplements.	Not collected	Not collected	Not collected	1,000	Not collected
17. Number of underweight adults who are HIV+ receiving supplements.	Not collected	Not collected	Not collected	35,000	142,615
18. Number of underweight adults with TB receiving supplements.	Not collected	Not collected	Not collected	50,000	107,099
19. Children under-5 years weighing coverage.	55.1%	60%	62%*	100%	76%

* Reflect updated data from DHIS.

Part B – Programme 2: District Health Services

NOTES

MATERNAL CHILD & WOMEN'S HEALTH

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities 2006-2008/09

Priority 2: Promote healthy lifestyles

Priority 4: Improve management of communicable diseases and non-communicable illnesses

↓

Provincial Strategic Plan 2005-2009/10

Goal 2: Strengthen PHC and provide caring, responsive and quality health services at all levels

↓

Annual Performance Plan 2008/09

Goal 4

Strategic Objective 18: To decrease preventable causes of morbidity and mortality of women and children

↓

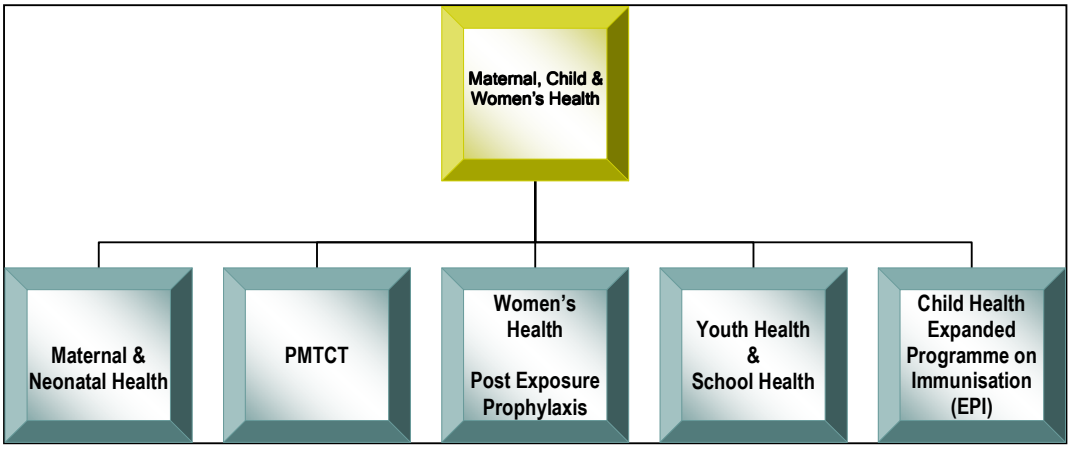
MC&WH Priorities 2008/09

1. Develop and facilitate the implementation of integrated strategies to reduce perinatal, neonatal, child, youth, maternal and women's morbidity and mortality.
2. Develop and facilitate the implementation of a policy framework to increase VCT uptake of pregnant women to improve clinical outcomes.
3. Increase the number of sites providing CTOP services as well as programmes to sensitise staff.
4. Develop and facilitate the implementation of strategies to improve the cervical cancer screening programme.
5. Develop appropriate child health services including community out-reach programmes to reduce preventable causes of morbidity and mortality.
6. Improve implementation and evaluation of the Saving Mothers Recommendations and assess the impact on preventable causes of death.

The Honorable Ambassador, Dr Mongella, President of the Pan African Parliament said "Now, reaching every woman, baby and child in Africa with essential health care will depend on us. We all have a role to play as government officials to lead, as policy makers to guarantee essential interventions and equity, as partners and donors to support programmes, as health workers to provide high quality care, and as humans to advocate for more action to Africa's newborns, mothers and children."

Part B – Programme 2: District Health Services

Figure 4: **Maternal, Child & Women's Health Directorate**



EXECUTIVE SUMMARY

The KwaZulu-Natal Department of Health remains committed to the implementation of evidence-based programmes in pursuance of the 2015 Millennium Development Goals (MDG's). Maternal, Child and Women's Health (MC&WH) services focus on goals specific to the survival and health of women and children (MDG's 1, 3, 4 and 5) by pursuing integrated and evidence-based services and interventions to ensure continuum of care and positive impact on morbidity and mortality.

Dual therapy, introduced in April 2008, is implemented in 98% of all health facilities that offer the full package of PMTCT services. Almost all facilities (95%) have at least two Professional Nurses trained in PMTCT (including dual therapy) which indicates that availability is no longer a challenge but rather access and quality of care. The 4 priority health districts (Ilembe, Zululand, Umkhanyakude and Amajuba), identified by the National Department of Health, commenced with the implementation of the National PMTCT Accelerated Plan in 2008/09. Progress will be closely monitored to assess service delivery outcomes and impact.

89% of all first time ANC clients are tested for HIV which falls short of the target of 95%. The timely access to the PMTCT Programme including HAART is limited by the low ANC attendance before 20 weeks (32%) and a coherent communication strategy that promotes early booking will be implemented as part of the Accelerated Plan. The transmission rate at 15 months has been reduced from 21% in 2007/08 to 12% in 2008/09.

Current information indicate that 77% of children younger than three months are breastfed at some stage in their lives however only 15% are exclusively breastfed at three months of age.

A total of 308 maternal deaths were reported in 2008/09 and 100% of hospitals implement at least 80% of the Saving Mothers Recommendations to reduce the preventable causes of maternal deaths. The leading causes of maternal death are still non-pregnancy related infections (49%) with AIDS contributing to 18%, hypertension (12%) and obstetric haemorrhage (8.3%).

Equal distribution of termination of pregnancy services has not been achieved and services are provided in only 22/54 designated public health facilities. An additional 5 Private Facilities are rendering 1st trimester services and 2 public health facilities are rendering 2nd trimester services. The increasing number of incomplete abortions (11,343) and septic abortions (305) is an indication that comprehensive Sexual & Reproductive Health services are not yet equal to need.

The cervical cancer screening coverage is still very low at 0.5% DHIS data and 5.2% according to Cytology reports. Staff shortages at the Cytology Department result in extended turn-around times for Pap smear results and inadequate smears have serious financial implications.

The women-year protection rate is very low at 23%, although it increased slightly from 19.2% in 2005/06. Integration strategies should be fast-tracked to ensure increased coverage especially in consideration of the changing disease profiles.

The full immunisation coverage is 85% which still falls short of the national target of 90%, and the measles coverage is 89% compared to the target of 90%. 51.8% of AFP cases were fully investigated, and 77.2% of AEFI were fully investigated and reports submitted to National Health. A total of 1,190 suspected measles cases were reported in 2008/09 with 5 cases confirmed as measles.

POLICIES

Table 52: Acts, Policies, Protocols and Guidelines

New Acts, Policies, Protocols & Guidelines	Comments
1. Provincial ANC/ PNC Policy & Guidelines.	• The policy has been approved in 2008/09. The policy is currently being piloted in 3 districts. 18 Professional Nurses, 3 District MC&WH Coordinators, PHC Supervisors and Midwifery/ PHC Trainers have been trained to facilitate implementation and monitoring.
2. Provincial Child Health Policy & Guidelines.	• Final draft.
3. Provincial Genetic Policy.	• Final draft.
4. PMTCT Policy & Guidelines.	15. Policy implemented.

PROGRAMME PERFORMANCE

In support of the commitment towards achieving the MDG's by 2015, the Department continues to create a supportive health environment that would respect the status of women and children in communities as well as health services. Programmes to improve availability, access and utilisation of health facilities, availability of trained and skilled staff, availability of commodities, and provision of high quality health care has been reviewed to ensure evidence-based programmes and services, especially cognisant of current disease profiles and financial constraints.

The Department recognises specific well developed, tested, proven and efficient interventions for the prevention and management of common causes of morbidity and mortality among women and children in renewed efforts to improve health care. Strengthening of health systems, particularly family and community oriented services and PHC services (including district hospitals) is therefore prioritised for the prevention of priority conditions such as diarrhoea, malnutrition, primary obstetric causes of death, HIV infections, etc.

The National Department of Health identified 18 Sub-Districts across the country as focus points to improve maternal and child health. Criteria for selection were based on the high levels of deprivation and low maternal and child health outcomes. Nongoma (Zululand District), Maphumulo (Ilembe District), Umhlabuyalingana (Umkhanyakude District) and Dannhauser (Amajuba District) were identified in KwaZulu-Natal, and although focus will be directed towards improving health outcomes in these sub-districts, programmes will simultaneously be implemented in all other districts.

⇒ PRIORITY 1: INTEGRATED STRATEGIES TO REDUCE PERINATAL, NEONATAL, CHILD, YOUTH, MATERNAL AND WOMEN'S MORBIDITY & MORTALITY

Strategies were reviewed in 2008/09 to ensure a strong focus on integration of interventions to ensure continuity of care, prevention of preventable causes of morbidity and mortality, and implementation of tested interventions proved to have a significant impact on morbidity and mortality of women and children (*see Figures 5 and 6*).

Figure 5: Maternal Health Strategies

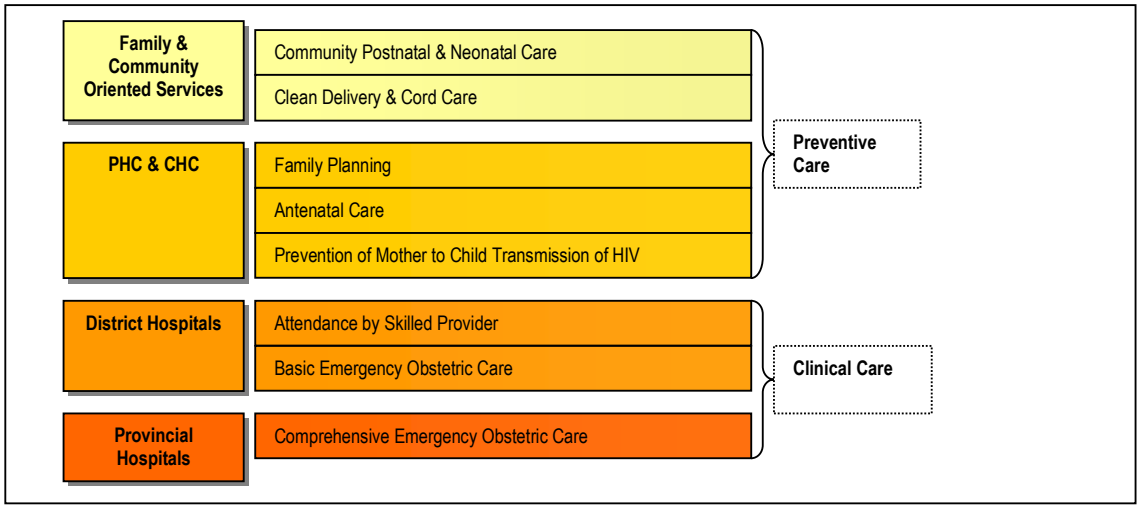
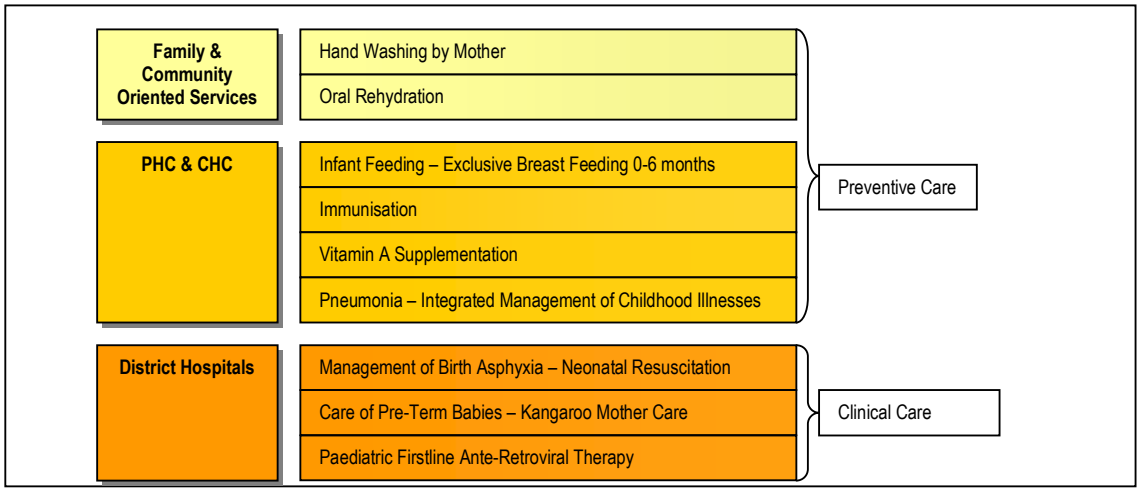


Figure 6: Child Survival Strategies



Basic Ante Natal Care (BANC) is implemented in 61% of facilities and approximately 50% of nurses have been trained in BANC classification in 2008/09. Improvement of early booking (ANC) is evident in eThekwini (from 28% to 34%) and Umgungundlovu (from 51% to 59%). Other pilot districts (Amajuba, Umkhanyakude and Zululand) will be closely monitored to determine outcomes.

According to District Reports, Kangaroo Mother Care (KMC) was implemented in 86% of facilities with 100% facilities in Ilembe, Ugu, Umgungundlovu, Uthukela, Amajuba and Sisonke Districts. Although a formal evaluation has not been undertaken to determine the impact of the programme, research suggests marked improvement in survival where the programme is implemented effectively.

The high number of maternal deaths can be partly attributed to poor intrapartum monitoring of pregnancy induced hypertension & late referral to high levels of care. The PATH Pilot Project to improve intrapartum management is implemented in the Sisonke, Ilembe and Umzinyathi Districts. Project results and the final report are expected in 2009/10.

Contraceptive uptake is still unacceptably low and integrated strategies are included in the Accelerated Plan. Changing disease profiles with high incidences of communicable, non-communicable & chronic diseases require scaled-up efforts to improve access and utilisation

of contraceptive services. The Women-Year Protection Rate increased from 22.1% in 2007/08 to 22.3% in 2008/09.

A total of 549 Professional Nurses were trained in Sexual & Reproductive Health in 2008/09 (eThekwini data outstanding). Train-the-trainer workshops on the WHO Decision-Making Tool have been conducted in November 2008 with the aim to improve education and counselling on sexual & reproductive health. Ugu, Umzinyathi, Umkhanyakude and Amajuba Districts have rolled out the training and commenced implementation of the Tool. Inadequate Tools, due to insufficient funding, unfortunately delayed the rollout of the programme.

Districts engaged in various activities to improve contraceptive services including:

- Districts secured local radio slots to promote contraceptive services (including emergency contraception) with the aim to raise awareness and prevent unwanted and unsafe pregnancies.
- Mum and Baby Edu-Shows in eThekwini reached significant numbers of mothers with information.
- SADTU PHC centre in Gale Street has been accredited for FP.
- MC&WH door-to-door campaigns were introduced in a number of districts to improve immunisation, ANC visit before 20 weeks, PMTCT and contraception.

⇒ PRIORITY 2: INCREASE VCT UPTAKE OF PREGNANT WOMEN TO IMPROVE CLINICAL OUTCOMES

The Antenatal Care/ Post Natal Care (ANC/ PNC) Policy was approved in 2008/09 and makes provision for the minimum package of services during pregnancy and post delivery and it is hoped that implementation will have an impact on routine testing for HIV. The Policy is being piloted in 3 facilities in the Umkhanyakude District (Maputa Gateway and Mseleni and Bethesda Hospitals) and will be rolled out to the rest of the Province in 2009/10.

The HIV testing rate (ANC clients) increased from 80% in 2007/08 to 96% in 2008/09 although the proportion of mothers joining the PMTCT Programme is still a challenge.

According to the Saving Babies 2006-2007 Report,[87] over half of the neonates dying in hospital were not tested for HIV and had no information about their HIV laboratory status in their records, and over one third were HIV infected or exposed to HIV.

⇒ PRIORITY 3: INCREASE ACCESS TO CHOICE ON TERMINATION OF PREGNANCY SERVICES

A total of 22 public health hospitals (22/54 accredited facilities) are currently providing choice on termination of pregnancy (CTOP) services, two of which provide both 1st and 2nd trimester terminations. Ugu and Umkhanyakude Districts entered into Service Level Agreements with private partners to improve availability, and Umzinyathi District does not provide any CTOP service. Five Private Organisations provide both 1st and 2nd trimester CTOP's.

Insufficient and unequal distribution of comprehensive CTOP services including scarce 2nd trimester services result in increased risk that will impact negatively on maternal morbidity and mortality. The 2005-2006 KZN Maternal Death Report indicated that septic abortion was responsible for 3.6% of maternal deaths as compared to 3.2% in 2002-2004.

In 2008/09, 12,528 legal terminations were performed in designated facilities compared to 14,435 in 2007/08. During the same time 305 septic abortions (201 in 2007/08) and 11,343 incomplete abortions (8,860 in 2007/08) were reported, which might indicate that services to prevent unwanted pregnancy are inadequate e.g. community-based awareness, contraceptive services, etc.

A total of 38 Professional Nurses and 2 Medical Doctors were trained as CTOP Practitioners, although only 21 Professional Nurses and 1 Doctor are actively involved in rendering services post training. This puts into question the cost benefit of training (±R 80,000 per trainee) with only 55% of the qualified Practitioners rendering the service post training. Selection criteria and commitment of Management to develop services will be reviewed to ensure effective utilisation of resources.

! CHALLENGES

- Illegal and unsafe termination of pregnancy services (not complying with the CTOP Act) is rapidly increasing and very difficult to control.
- Community mobilisation and out-reach to reduce unwanted and high risk pregnancies is still inadequate. This will form part of the Accelerated Plan.

[87] Saving Babies 2006-2007, Sixth Report on Perinatal Care in South Africa

- Non-reporting of hospitals providing CTOP services (as per CTOP Act imperatives) are still a challenge and also impact on decision-making and planning. This is being addressed.
- Sustainability of CTOP services is a challenge due to the sensitivity of the programme (conscientious objection and poor incentives to keep specialised Providers). The cost of training versus service delivery is a concern and pro-active strategies are necessary to address that.

⇒ PRIORITY 4: IMPROVE CERVICAL CANCER SCREENING

The cervical cancer screening coverage is 5.2%[88] compared to 4.2% in 2007/08. Colposcopy services, for the management of abnormal Pap smears, are provided in 14 hospitals (8 districts). A high percentage of Pap smears (used for screening for abnormal cells) are abnormal according to Cytology reports which raised concerns about the distribution of services to manage abnormalities. According to 2008/09 results, 20.15% of Pap smears were abnormal (12.95% low-grade lesions, 7.2% high-grade lesions and 0.25% invasive cancer).

The Pap smear adequacy rate is 49.05% (target 90%) which has a great impact on cost, timely diagnosis and management of abnormal Pap smears and the ultimate health outcome/ impact. Although more than 2 Professional Nurses per facility are reported to be trained on cervical cancer screening (including Pap smear procedure) the adequacy rate is a clear indication that more training is required to improve performance.

! CHALLENGES

- Routine screening for cervical cancer is still poor as indicated by Cytology reports. The increased number of diagnostic Pap smears contradicts the intention of the screening programme.
- Poor reporting (as per Policy & Guidelines) impacts on programme planning including financial forecasting to ensure an effective screening programme.
- Increased turn-around time for Pap smear results (as a result of inadequate human resources in cytology) affect the management of abnormal results and ultimate outcomes.

⇒ PRIORITY 5: DEVELOP APPROPRIATE CHILD HEALTH SERVICES

The reduction of child mortality remains a major challenge and the only data available on the common causes of death is still facility based. According to the Saving Children 2007 Report, the top five causes of death are Pneumonia (18.7%); Septicaemia (15.9%), Acute diarrhoea (14.2%), PCP (6.2%) and chronic diarrhoea (4.6%). HIV associated deaths increased from 597 in 2006 to 1,230 in 2007. Malnutrition and the lack of safe water and sanitation contributed to half the deaths. Research indicates that the majority of these deaths can be prevented by cost effective evidence-based measures such as vaccination, antibiotics, micronutrient supplementation and breastfeeding.[89]

The Child Healthcare Problem Identification Programme (Child PIP), a mortality audit tool for children's wards in health facilities, provides a structured framework to assess quality of care in the health system. KwaZulu-Natal improved coverage of this programme from 17 sites in 2007/08 to 27 sites in 2008/09. To improve the quality of data and ensure the inclusion of programme output into child health strategies that seek to improve quality of care and reduce child morbidity and mortality, a Provincial Child PIP Coordinating Structure was established in 2008/09. The structure mirrors the National Child PIP structure and was established within the framework of the District Health System framework of the Department. The KZN Child PIP Executive Committee is supported by a Provincial Technical Task Team including 11 District and/or 3 Area Coordinators. Districts will form committees to provide technical support to district and institutional Child PIP teams (Paediatric and Child Health).

The package of services for the Well Baby/ Child services has been finalised, flip charts have been developed and the training manual is in the final stage of development.

To improve the management of the sick child at facility level and reduce the preventable causes of morbidity and mortality, the Integrated Management of Childhood Illnesses (IMCI) is being implemented in 637 facilities. The Community Component, focusing on 16 household messages to improve child health, is implemented in 30 Local Municipalities i.e. Amajuba (3); eThekwini (1); Ugu

[88] Data from laboratory (Cytology) which is considered more reliable than DHIS data - this is being addressed

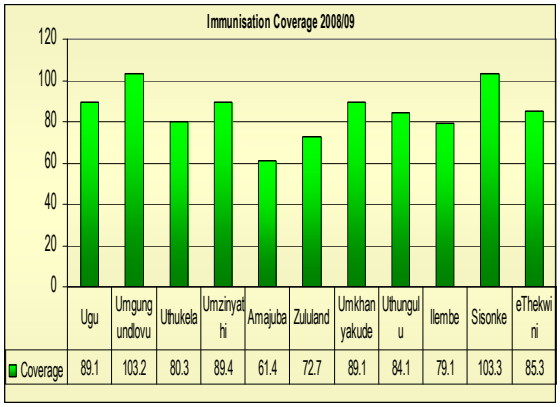
[89] Lancet series 2005

(2); Umzinyathi (4); Sisonke (1); Umkhanyakude (5); Ilembe (3); Zululand (5); Uthukela (5) and Uthungulu (1).

The immunisation coverage is 85% against the National target of 90%. Amajuba, Zululand and Ilembe Districts reported coverage below 80% which might be partly due to data quality and poor social mobilisation resulting in a higher defaulter rate after immunisation at 14 weeks. The drop-out rate between 6 weeks (1st dose) and 14 weeks (3rd dose) is below 10% however the Provincial drop-out rate between measles 1 and 2 is 12.4% with Zululand (23.4%), Uthukela (18.3%), Umkhanyakude (17%), eThekwini (14.2%) and Sisonke (11.8%) exceeding the target of <10%. The Immunisation Monitoring Chart has been introduced in all facilities to improve the calculation and monitoring of drop-out rate to inform follow-up strategies.

The Department started with preparation for the implementation of the Pneumococcal vaccine (April 2009), and the Rotavirus vaccine (August 2009). These vaccines will contribute greatly to the achievement of Millennium Development Goal 4 by reducing morbidity and mortality in children < 5years.

Graph 20: Immunisation Coverage per District - 2008/09



Community out-reach programmes to increase awareness have been improved with the introduction of the Reach Every District (RED) strategy with the aim to improve immunisation coverage and reduce vaccine preventable diseases. The strategy has been introduced in 9 districts although monitoring and evaluation is still a challenge as a result of the restrictions on traveling. Implementation of the strategy improved immunisation coverage in eThekwini and Ilembe Districts as reflected in Graph 21 and 22.

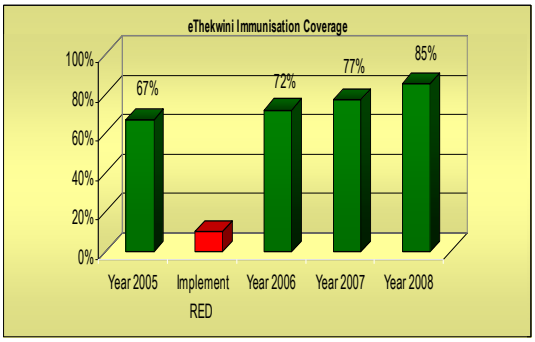
The National Quality Self Assessment Tool (DQS) has been introduced to 10 Districts to improve data quality. The one outstanding district reported transport challenges for supervision and support at facilities.

All facilities have dedicated vaccine fridges although compliance to cold chain standards is compromised in some facilities due to fridge storage capacity. Cold chain management is actively monitored and the use of stock cards is encouraged. Delays in the delivery of vaccine fridges from Biovac might compromise the cold chain especially with the intended roll-out of the new vaccines in 2009.

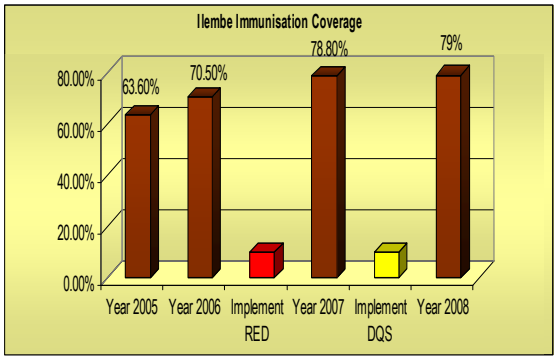
Expanded Programme on Immunisation (EPI) surveillance is actively monitored to ensure appropriate action.

- A total of 62/66 AFP cases were detected between January to December 2008 of which 51.82% were fully investigated with adequate stools (target 80%). Eleven cases were either reported late or stools were taken 14 days after the onset of paralysis or one stool instead of two was sent to NICD.
- A total of 22 adverse events following immunisation (AEFI) cases were reported between January to December 2008 of which 17 cases (77.2%) were fully investigated and reported. The 5 outstanding cases had inadequate information.
- A total of 1,198 suspected measles cases were reported between January to December 2008 and all cases were fully investigated. Only 5 cases were confirmed measles.
- No Neonatal Tetanus case has been reported during 2008/09.

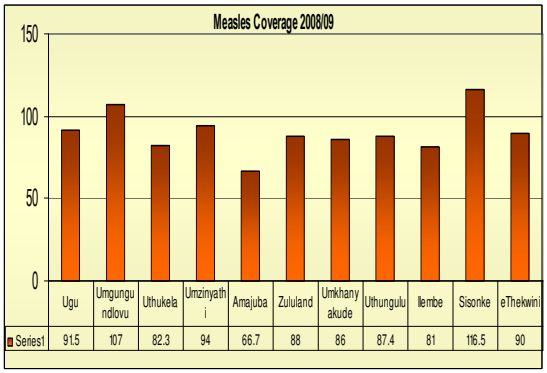
Graph 21: eThekwini Immunisation Coverage



Graph 22: **Ilembe Immunisation Coverage**



Graph 23: **Measles Coverage 2008/09**



The current Genetics Surveillance System in the Province will enable the Department to monitor trends in genetics that will ultimately inform the development of systems and services for the effective management of genetic disorders. Genetic services are costly and primary prevention and detection is therefore crucial to ensure that cost is contained and parents and patients are well informed.

There are currently 55 Genetic Surveillance Sites in the Province which include sites that refer to regional facilities and defects reporting to the same facilities. The main birth defects in the Province are Neurotube Defects, Down Syndrome, Albinism, Facial Clefts and Club Feet. Eleven Professional Nurses successfully qualified as Genetic Practitioners in the Medical Genetics Programme although this is totally inadequate to sustain the programme at an acceptable level.

School Health Services, targeting learners from Grade R/1 to Grade 12, render crucial primary care services at both community level as well as PHC level (referral). Coverage of schools increased from 57% in 2007/08 to 62% in 2008/09, although shortage of staff and other resources influenced achievements considerably. A total of 165,442 Grade R/1 learners and 244,480 Grade 2-12 received health assessments in 2008/09. A total of 27,556 of these learners were referred and received treatment at the next level of care.

A number of PHC clinics started to implement the Youth-Friendly standards and criteria to improve access to information and services to young people (10-24 years) although these services have not been formally assessed for accreditation.

! CHALLENGES

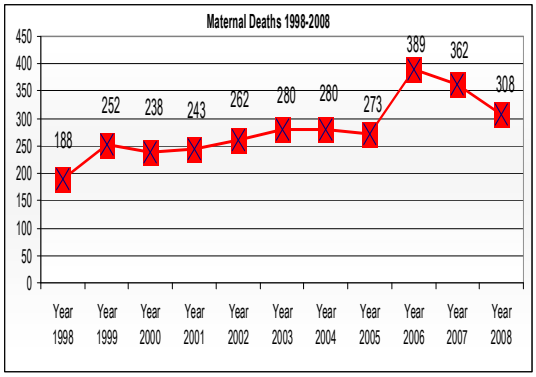
- Availability of data to determine child mortality is still a challenge and impacted negatively on planning.
- Lack of resources (including financial & human) impacted on sustainability of programmes e.g. IMCI, School Health Services, Youth-Friendly Services, etc.
- Lack of capacity to manage community out-reach programmes resulted in poor sustainability and monitoring i.e. Community Component of IMCI and RED Strategy.

⇒ PRIORITY 6: IMPLEMENT THE SAVING MOTHERS RECOMMENDATIONS AND EVALUATE OUTCOME AND IMPACT

The Provincial Maternal Mortality Ratio has shown an increase from 166 per 100,000 in 1996 to 210 per 100,000 in 2007. A total of 308 Maternal Deaths were reported in 2008/09 (confirmed May 2009 to accommodate late reporting), and 14 Provincial Assessors (from 4 districts) conduct the Provincial assessments to determine causes of death. The leading causes of death are Non-Pregnancy Related Infections (49%) with AIDS contributing to 18% of those; Hypertension (12%) and Obstetric Haemorrhage (8.3%). UNICEFF estimates that at least 80% of the burden of disease in children below the age of five is related to substandard maternal care and nutrition quality of intrapartum care, while nearly 8 million neonates die during delivery or in the first week of life globally. Fast tracking of pregnant women (in the health system) is actively promoted to ensure prompt care to treatment.

Graph 24 reflects the number of reported maternal deaths from 1998 to 2008. Current data indicates a reduction in the number of reported deaths. Caution should however be exercised as many maternal deaths are reported late and deaths for 2008 may still be reported after submission of this report.

Graph 24: **Reported Maternal Deaths 1998 - 2008**



According to quarterly district reports all districts except Uthungulu (75%), Zululand (78%) and eThekwini (76%) implement 80% of the Saving Mothers Recommendations. Implementation is not currently actively monitored at Provincial level.

The Perinatal Problem Identification Programme (PPIP), aimed at reducing perinatal mortality, was targeted in 2008/09. There are currently 50 registered and 26 active sites in the Province to provide specific data and analysis on neonatal and perinatal health. The Saving Babies 2006-2007 Report confirmed that pregnant women 17 years and younger and pregnant women 35 years and older had significantly higher perinatal mortality rates than women between 20 to 35 years. This highlights the importance of contraceptive (Family Planning) services.

⇒ PRIORITY 7: SCALE UP THE IMPLEMENTATION OF THE INTEGRATED PMTCT PROGRAMME

Being the commonest mode of HIV transmission to children, PMTCT was addressed in a more aggressive manner with the introduction of the dual therapy approach as opposed to the previously Nevirapine-based monotherapy. The dual therapy-based package of care was rolled out to 95% of health facilities from April 2008, and has since shown a 10% decline in the prevalence of HIV in babies born to HIV+ mothers tested at 6 weeks post delivery.

The HIV testing rate of ANC clients increased from 80% in 2007/08 to 96% in 2008/09, although the Nevirapine uptake rate of ANC clients decreased slightly from 76% in 2007/08 to 85% in 2008/09. It is hoped that the partnerships with the M2M2B and 20000+ projects will increase PMTCT.

Partnerships to improve the management of HIV+ pregnant women is continuing with the M2M2B project (providing motivation and support to HIV+ pregnant women to commit to PMTCT) and the 20000+ project from UKZN (assisting facilities with implementing strategies to reduce the MTCT rate).

The Accelerated Plan, developed in 2008/09, makes provision for the following strategies to improve PMTCT at all levels of care:

<u>At community level</u>

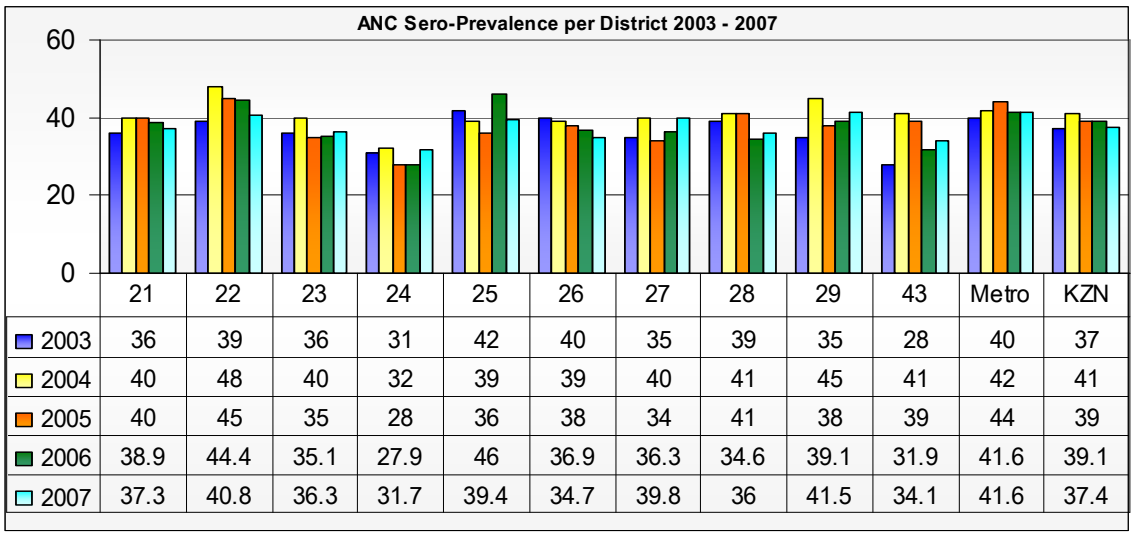
- Implement a communication strategy to de-stigmatise HIV and enhance male and family involvement and support;
- Strengthen community-based support groups and follow-up support by CHW;
- Implement the revised National Guidelines on Community-Based Support Post-Delivery; and
- Promote early booking for ANC.

<u>At PHC level</u>

- Strengthen and support provider initiated counseling and testing;
- Put a system in place to reduce the turn around time (TAT) for results (electronic access to results, via sim card) through a partnership with NHLS;
- Retrain providers to improve the quality of tests;
- Strengthen tracing mechanisms of pregnant women and children;
- Develop a system to bring HAART to ANC, single point management and synchronised repeat visits with clear follow-up;
- Strengthen the linkages between the district hospital and CHC with the feeder clinics through regular meetings;
- Ensure and improve supportive supervision; and
- Ensure identification of babies at six weeks and improve PCR testing. On discharge, the child's medication must be recorded on the immunisation card; all PCR's must be done at the well-baby clinics or IMCI; results must be available within 3 weeks.

According to the 2007 ANC Sero-Prevalence Study, the HIV prevalence in pregnant women decreased slightly from 39.1% to 37.4%. Ugu, Umgungundlovu, Amajuba, and Zululand Districts show a decreased prevalence in 2007 as compared to 2006, while eThekwini (currently stable at 41.1%) has the highest prevalence. This might be partly due to densely populated areas and 'day visitors' accessing health services.

Graph 25: ANC Sero-Prevalence per District 2003 - 2007



	21	22	23	24	25	26	27	28	29	43	Metro	KZN
2003	36	39	36	31	42	40	35	39	35	28	40	37
2004	40	48	40	32	39	39	40	41	45	41	42	41
2005	40	45	35	28	36	38	34	41	38	39	44	39
2006	38.9	44.4	35.1	27.9	46	36.9	36.3	34.6	39.1	31.9	41.6	39.1
2007	37.3	40.8	36.3	31.7	39.4	34.7	39.8	36	41.5	34.1	41.6	37.4

! CHALLENGES

- Lengthy TAT for CD_4 results and subsequent initiation of the pregnant women on HAART. This is due to quality of the specimen and completeness of forms, limited access to electronic results, and poor courier services.
- Access to HAART is limited to accredited CCMT sites, resulting in pregnant women having to travel to district hospitals or CHC's. CCMT sites may become overburdened, and fast-tracking of PMTCT mothers may be compromised.
- Identification of exposed children at well baby clinics is a major challenge. This is due to low index of suspicion of the health care workers and non-reporting by the care giver. Approximately 20% of children presented for immunisation are tested for HIV and fewer are managed appropriately due to the delay in PCR results.
- A substantially low proportion (30%) of specimens reaching the laboratory is of usable quality.
- There are still high levels of mixed feeding in spite of counseling throughout pregnancy and postnatal.

⇒ PRIORITY 8: IMPLEMENT THE NOPEP

SITUATIONAL ANALYSIS RECOMMENDATIONS

100% of hospitals and 75% of CHC's provide post exposure prophylaxis for sexual assault. During 2008/09, a total of 10,423 new sexual assault cases were reported in Public Health facilities of which 3,604 (34.5%) received ARV prophylaxis. The Population Council will assist the Department to conduct a baseline assessment of Trauma Care Centers in 2009/10 to inform decision-making and planning.

A total of 38 Health Care Practitioners were trained on caring for sexual assault and rape survivors, 45 Doctors were trained on sexual assault and 3 providers working in crisis centres received training on the management of rape and sexual assault. 2,000 Sexual Assault Examination Care Kits (adult and paediatric) were procured and distributed to districts.

! CHALLENGES

- Poor linkage with SAPS resulted in lengthy delays in the management of clients at health services.
- Shortage of Psychologists and Social Workers delayed comprehensive care of clients.
- The effectiveness of PEP is jeopardised by late reporting (after 72 hours), lack of trained staff (forensic skills), inadequate training of trauma support workers on the management of sexual assault and rape, high staff turn-over, inadequate number of district surgeons and poor partnerships with the police and other community structures to ensure timeous reporting and follow-up.
- The increase in the number of under-12 year old children reporting sexual assault is a concern and

requires urgent and integrated community interventions. Due to severe financial constraints it was not possible to engage in community awareness and social mobilisation programmes in 2008/09.

- A number of districts reported an increase in the number of needle stick injuries (although data is not available to determine trends).
- Health workers seem to be hesitant to report exposure and tend to default on the 28-day treatment. This raised a concern as far as staff wellness is concerned and must be addressed urgently.

PROVINCIAL PERFORMANCE INDICATORS

Data completeness: 95%

Table 53: Provincial Objectives and Performance Indicators for Maternal, Child and Women's Health 2008/09

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Strategic Objective: To decrease preventable causes of Maternal, Child & Women's morbidity and mortality.					
Measurable Objective: To strengthen Maternal and Neonatal health services.					
1. Maternal mortality rate.	159/100000	159/100000	159/100000	159/100000	224.4/100000[90]
2. Percentage of reported maternal deaths assessed, reported and submitted.	Not monitored	100%	100%[91]	100%	100%
3. Percentage of women attending ANC before 20 weeks.	26%	45%	37% 71,498	70%	32%
4. Peri-natal mortality rate.	25/1000[92]	30/1000	30/1000	30/1000	17/1000
5. Facilities implementing the Saving Mothers Recommendations.	Not collected	100%	100%	100%	92%[93]
6. Number of Hospitals conducting monthly maternal/ peri-natal mortality meetings.	Not monitored	100%	100%	100%	100%
7. Percentage of low birth-weight babies.	13.3%*	15%	11.3%	15%	12%
8. Number of Hospitals implementing PPIP.	29	50	53 Register 10 Active	50 Register 20 Active	50 Registered 26 Active
9. Neonatal mortality rate.	6.1/1000[94]	9.5/1000	9.5/1000	9.5/1000	10.2/1000
Measurable Objective: To improve integrated Child Health services.					
10. Number of Districts implementing the RED Strategy.	1 District	3 Districts	7 Districts	11Districts	9 Districts
11. Full immunisation coverage under-1 year.	77.2%	74.8%	82%	90%	85%
12. Measles coverage under-1 year.	82.2%	90%	86%	90%	89.3%
13. Drop-out rate DTP1 - DTP2.	3%	6.9%	4.2%	<10%	2.7%

[90] Based on reported maternal deaths (DHIS)
[91] Refers to complete records and submission to the National Department of Health
[92] Included value refers to facility mortality rate
[93] 92% of facilities implement at least 80% of the Saving Mothers Recommendations according to District Reports
[94] Value refers to facility mortality

Part B – Programme 2: District Health Services

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
14. Percentage of Adverse Events Following Immunisation cases reported and fully investigated.	100% (45)	25% (36/45)	52% (32/43)	70%	77.2% (17/22)
15. Number Acute Flaccid Paralysis (AFP) reported cases fully investigated.	53/53 (100%)	36/45 (80%)	32/43 (75%)	67/67	51.8% (32/62)
16. Number of facilities implementing the Child Health Problem Identification Programme (ChIP).	27	4	17	20	27
17. Number of functional Well Baby Clinics.	Not measured	Not measured	Not measured	12	12[95]
18. Percentage of fixed PHC facilities implementing IMCI.	75%	80%	82%	82%	82%
19. Percentage of facilities with at least 1 provider trained in IMCI.	72%	72%	72%	90%	90%
20. Number of PHC clinics implementing the IMCI Community Component.	0	0	0	11	12
21. Number of active Birth Defects Reporting Sites.	22	35	49	All Hospitals with Maternity Units	56
Measurable Objective: To improve integrated Youth Health services.					
22. School Health Services (school) coverage.	17%	48%	57%	70%	46%
23. Number of fixed PHC services accredited as Youth-Friendly.	33 (8%)	37 (8.2%)	39 (6.8%)	45	27[96]
Measurable Objective: To improve integrated Women's Health services.					
24. Number of Hospitals offering CTOP.	16/56 (28%)	22/56 (40%)	18/56 (32%)	30/56 (53%)	22[97]
25. Cervical cancer screening coverage.	2%	4.5%	4.3%[98]	5%	0.5%[99]
26. Number of Hospitals offering colposcopy services.	10	12	12	15	14
27. Women-year protection rate.	19.2%	38%	22.1%	50%	23%
28. Number of septic abortions.[100]	326	261	201	No target	305
29. Number of incomplete abortions.[101]	5,714	6,043	8,860	No target	11,343

[95] Data provided by MC&WH Programme
[96] District Quarterly data - according to Programme Manager no services are accredited as YFS
[97] Reporting (DHIS) is still a challenge with 11 Provincial and 6 Private Facilities submitting monthly data to the Provincial Office
[98] DHIS data incomplete (0.4%) - used NHLS Cytology data
[99] According to Cytology data the coverage is 5.2%
[100] Baseline targets are not available to inform targets. Numbers will be monitored for future target setting and reporting
[101] Baseline targets are not available to inform targets. Numbers will be monitored for future target setting and reporting

Table 54: (HIV 2) Provincial Objectives and Performance Indicators for HIV, AIDS, STI & TB Control (PMTCT & PEP)

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT)					
Measurable Objective: To scale up and sustain implementation of the PMTCT Programme.					
1. Nevirapine dose to baby coverage.	102%[102]	93%	98%	98%	85%
2. Nevirapine uptake - antenatal clients.	63%	70%	76%	80%	85%
3. Fixed Facilities offering PMTCT.	96%	96%	98%	98%	96%
4. Portion of ANC clients tested for HIV	63%	70%	80%	90%	96%
5. Number of PCR tests done on babies born to HIV positive mothers (at 6 weeks).	Not available	26,956	44,115	50,000	31,617
6. Number of Hospitals offering PMTCT with dual ARV prophylaxis.[103]	Not collected	Not collected	53	53	53
7. Number of fixed PHC facilities offering PMTCT with dual ARV prophylaxis.	Not collected	Not collected	565	570	573
POST EXPOSURE PROPHYLAXIS (PEP)					
Measurable Objective: To strengthen Occupational and Non-Occupational PEP services					
8. Hospitals offering PEP for Occupational HIV exposure.	100%	100%	100%	100%	100%
9. Hospitals offering PEP for sexual abuse.	87%	87%	89%	90%	100%
10. Number of Trauma Centres for victims of violence.	23	25	36	37	37
11. Number of sexual assault cases - new.	7,612	8,681	10,948	1,500	7,618
12. Number of ARV Prophylaxis to sexual assault case - new.	3,585	3,822	4,507	1,200	1,892

[102] Data is questionable
[103] New indicator starting 2008/09

Part B – Programme 2: District Health Services

NOTES

FORENSIC SERVICE & BIOETHICS

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities - 2008/09

Priority 8: Planning, budgeting and monitoring and evaluation

↓

Provincial Strategic Plan 2005 - 2009/10

Goal 3: Promote health, prevent and manage illnesses with emphasis on poverty, lifestyle, trauma and violence

↓

Annual Performance Plan 2008/09

Goal 3

Strategic Objective 15: To ensure that key support services are effectively provided

↓

Forensic and Bioethics Priorities 2008/09

1. Develop a Human Resource Plan.
2. Develop a Mortuary Infrastructure Development Plan.
3. Improving the Forensic transport system.
4. Training and development.

Lab Technician

EXECUTIVE SUMMARY

National Cabinet approved the transfer of Medico-Legal Mortuaries from the South African Police Services (SAPS) to Provincial Health Departments in May 2000, and in July 2000 approved a framework to guide the development of detailed province-specific implementation plans. In May 2005, guided by the National Health Act, 2003 (Act 61 of 2003) the KwaZulu-Natal Department of Health commenced with preparation for the take-over of the functions to '*provide and coordinate forensic pathology, forensic clinical medicines and related services including the provision of Medico-Legal Mortuaries and Medico-Legal Services'.* In April 2006, the Forensic Service and Bioethics Directorate assumed responsibility for the SAPS mortuaries, hospital mortuaries and undertaker's premises utilised for the rendering of autopsy services.

There are currently 40 Medico-Legal Mortuaries in KwaZulu-Natal. One mortuary in Richards Bay was completed in 2008/09 and another 12 are still under construction to improve aged and inadequate infrastructure.

The main cost drivers in 2008/09 were personnel (41%), infrastructure and equipment (40%), and goods and services (19%). The 2008/09 total expenditure of R149.1 million exceeded the available budget by R24.4 million mostly due to building costs, exorbitant fuel and vehicle repair costs, as well as repair and maintenance costs of the current dilapidated infrastructure, especially the archaic refrigeration equipment that was inherited from the SAPS.

POLICIES

Operational Managers use standard data collection and quality assurance tools to monitor compliance with legislation, policies, protocols and norms and standards.

Part B – Programme 2: District Health Services

Table 55: Acts, Policies, Protocols & Guidelines

Acts, Policies, Protocols & Guidelines 2008/09	Comments including strategies to strengthen policy implementation & monitoring
1. National Health Act, 2003 (Act 61 of 2003).	• Guiding the establishment and administration of mortuary facilities. A monitoring tool has been implemented to evaluate the Medico-Legal Mortuaries as part of the Quality Assurance Programme.
2. Occupational Health and Safety Act.	• Systems have been put in place to ensure safe working conditions in the Mortuaries. Infection control and training was undertaken in Health Safety & Environment, waste management, and personal protective equipment.
3. Criminal Procedures Act.	• Guiding the establishment of the chain of evidence by means of an attested statement.
4. Inquest Act	• Implementation of the investigation of deaths other than natural causes.
5. Sexual Offences Act, Children's Act, Victim's Charter	• Developed management protocols for the effective management of victims of violence and the collection and preservation of forensic evidence.

PROGRAMME PERFORMANCE

Mortuary and Forensic Pathology services have been operationally decentralised to ensure effective monitoring of operational services. Specialists are conducting clinical auditing for professional services (autopsy and clinical aspects of services) to ensure that services comply with clinical standards within the legislative frameworks.

The post mortem coverage is currently 55% (16,743 post mortems conducted from a potential 30,315) with the standardised rate of 3 unnatural deaths per 1000 population.

The exorbitant costs to improve and maintain mortuary services placed severe financial demands on the Department. The over expenditure of R7.3 million on goods and services mainly on maintenance of vehicles, dilapidated infrastructure, and antiquated refrigeration equipment that was inherited from the SAPS.

Personnel accounted for 41% of the total expenditure. The inability to fill vacant posts resulted in a marked increase in overtime and standby allowances to ensure after hour services.

Infrastructure and equipment accounted for 40% of the total expenditure. The expenditure of R59.4 million exceeded the allocated budget by R14.5 million, due to a rollover request from the 2007/08 financial year being denied. Contracts have been awarded and this cost cannot be contained. Goods and Services constituted the remaining 19% of expenditure.

! CHALLENGES

- The lack of an electronic IT system for mortuary services affected data timeliness, completeness and quality.
- Union activities undermined efforts to improve mortuary services. Regular IMLC meetings with union representatives have been fruitless to date, and a full-time HR Manager is essential to deal with HR related matters as Operational Managers are not qualified to deal with organised labour.
- Financial constraints have a limiting impact on service delivery especially maintaining and upgrading inadequate infrastructure and equipment and filling of vacant posts to ensure a 24-hour service.

⇒ PRIORITY 1: DEVELOP A HUMAN RESOURCE PLAN

The organisational structure and post establishment of the Forensic Pathology Services has been reviewed and makes provision for a total of 1,040 posts for an effective 24-hour service. The current vacancy rate is 48.9% with 531/ 1,040 posts filled.

! CHALLENGE

- Recruitment and retention of medical and technical staff due to the nature of work as well as the national shortage of these specialised professionals.

⇒ PRIORITY 2: DEVELOP A MORTUARY INFRASTRUCTURE DEVELOPMENT PLAN

A comprehensive audit of all mortuaries (previously falling under SAPS) was conducted and revealed that only 9 mortuaries were suitable for retention (for a limited period of time) until new/upgraded facilities were established. A comprehensive Mortuary Infrastructure Development Plan (MIDP) was developed (based on the audit findings) and within the national framework.

The financial shortfalls however severely affected implementation of the MIDP and resulted in considerable delays in infrastructure projects (maintenance/ upgrades/ new buildings) deemed essential for effective service delivery.

One mortuary in Richards Bay was completed in 2008/09 and the mortuary in Gale Street Durban is near completion. Eleven mortuaries are still under construction and 2 are set to start construction in 2009/10. The upgrade/construction of the remaining 23 mortuaries has not commenced due to budgetary constraints.

! CHALLENGE

- Aged infrastructure, inherited from the SAPS, is not conducive to the rendering of effective mortuary services. Inadequate financial allocation leads to extended delays in the implementation of the approved MIDP.

⇒ PRIORITY 3: IMPROVE THE FORENSIC TRANSPORT SYSTEM

Forensic pathology and mortuary services have a fleet of 135/215 vehicles to render a 24-hour service in the Province. The shortfall of 80 vehicles affected service delivery and increased maintenance costs in 2008/09. The fleet management and supervision of mortuary drivers have been devolved to the District EMRS and forms part of Disaster Management.

⇒ PRIORITY 4: TRAINING & DEVELOPMENT

The Province offers a 2-year training programme that allows student Mortuary Technicians to obtain professional registration as Mortuary Technicians with the HPCSA. The training of the 1st cohort of Mortuary Technicians (120) at the Durban University of Technology (DUT) commenced and will be completed in June 2009. The second cohort of students will commence training in the beginning of 2009.

PROVINCIAL PERFORMANCE INDICATORS

Table 56: Provincial Objectives and Performance Indicators for Forensic Service & Bioethics

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Strategic Objective 15: To ensure that key support services re effectively provided. (Goal 3)					
Measurable Objective: To ensure the effective and efficient management and provision of forensic medical pathology and mortuary services.					
1. Number of functional Mortuary Facilities in the Province.	25	39	39	40	40
2. Post mortem coverage ratio.	Not measured	Not Measured	51.17%	55.00%	55.23%

Part B – Programme 2: District Health Services

NOTES

DISTRICT HOSPITALS

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Strategic Priorities 2006-2008/09

Priority 5: Strengthen PHC, EMS and Hospital delivery Systems

↓

Provincial Strategic Plan 2005-2009/10

Goal 2: Strengthen PHC and provide caring, responsive and quality health services at all levels

↓

Annual Performance Plan 2008/09

Goal 1

Strategic Objective 1: To mainstream PHC services

Strategic Objective 2: To improve clinical governance including quality of care & infection prevention & control

↓

District Hospital Priorities 2008/09

1. Continue with the implementation of the revised organisational structures and post establishments.
2. Increase the number of step-down beds based on category A and B District Hospitals in the STP.
3. Develop & provide dedicated capacity for out-reach initiatives to strengthen PHC clinics and CHC's.
4. To improve the quality of health care.
5. To improve infection prevention & control.

Esidumbini Clinic

EXECUTIVE SUMMARY

The 41 District Hospitals in the Province, located in deep rural, peri-urban and urban areas, typically offer generalist level of services focusing on maternal and child health, basic emergency, surgery and physical medicine services. Service delivery was challenged in 2008/09 due to severe financial constraints and the non-implementation of approved hospital organisational structures and post establishments. Recruitment for critical hospital posts has been curtailed to the absolute minimum as a result of over-expenditure in the 2007/08 and 2008/09 financial years.

In spite of critical financial and human resource and infrastructural challenges, hospital patient numbers increased considerably in 2008/09. Separations increased to 361,244 (+10%), patient day equivalent to 2,804,928 (+2%), and out-patient headcounts increased by 28%.

Bed occupancy rates decreased from 68% in 2007/08 to 62.6% in 2008/09 and the average length of stay increased from 4 days in 2007/08 to 5.6 days in 2008/09 both of which have significant cost implications.

The caesarean section rate shows a steady increase since 2005/06 from 19% to 22.7% in 2008/09 exceeding the national target of 11%. The case fatality rate for surgical separations increased from 4% in 2005/06 to 4.5% in 2008/09 which is a serious concern.

Expenditure per patient day equivalent increased from R 1,351 in 2007/08 to R 1,441 in 2008/09 against a national target of R814.

POLICIES

The KwaZulu-Natal Provincial Health Act was enacted late in 2008/09 and provides the legal framework for the development and delivery of public health services in the

Province. The Act enables the Department to constitute and appoint Hospital Boards, establish a constituted Licensing Committee to consider applications for private health establishments and for the establishment of an Inspectorate of Health Establishments. The establishment of the Inspectorate will make an important contribution to improved monitoring and evaluation of all aspects of service delivery at all levels of care. There is no doubt that the new legislation will be an important milestone in the development of health services in this Province.

A number of policies which have been drafted in 2008/09 will be considered for approval by the new administration.

Table 57: Acts, Policies, Protocols and Guidelines

New Acts, Policies, Protocols & Guidelines	Comments
1. Generic Policy on Clinical Governance.	• A Framework for Clinical Governance has been approved. Implementation is delayed due to budget constraints. • The National CORE Evaluation Document will be used to evaluate hospital compliance to the policy.
2. Clinical Governance Policy for Accident and Emergency Units.	• The clinical document on trauma has been finalised and is aimed as a reference guide in rural areas where no specialists are available. The policy will also assist with the standardisation of emergency procedures during the 2010 Soccer World Cup. • It is envisaged that the policy will be finalised and implemented in January 2010.
3. Development of a Policy on Patient Escorts.	• The draft policy has been completed and finalisation envisaged in 2009/10. • This policy aims to limit the number of patient escorts; improve the repatriation of discharged patients from Tertiary and Provincial Hospitals (reducing ALOS); reduce the need for overtime; prevent unauthorised passengers and ensure adequate care of patients during transit.
4. Policy on Adverse Events.	• A review on litigation on medical adverse events against the Department revealed that certain adverse events are more prevalent than other i.e. issuing of incorrect medication. • The current policy is in place to monitor and alert hospitals to possible medico legal hazards.
5. Development of a Policy on private wards and admission of patients by Private Practitioners.	• A draft policy has been submitted for approval. • It is envisaged that the 'Designated Service Provider Agreement' with Medical Aids will address this challenge.

PROGRAMME PERFORMANCE

District Hospitals play a pivotal role in the provision of health services in a defined catchment area where catchment populations vary significantly from national planning norms and from hospital to hospital due to geographical locations. Hospitals provide both clinical and non-clinical support services to PHC services functioning in their catchment area. The role of hospitals becomes more crucial outside of the eThekwini Metro where there is almost a complete absence of Community Health Centres.

Hospitals face significant resource challenges varying from hospital to hospital including:

- Ageing and sometimes inappropriate and inadequate infrastructure.
- Serious maintenance backlogs.
- Varying levels of staff and skills shortages.

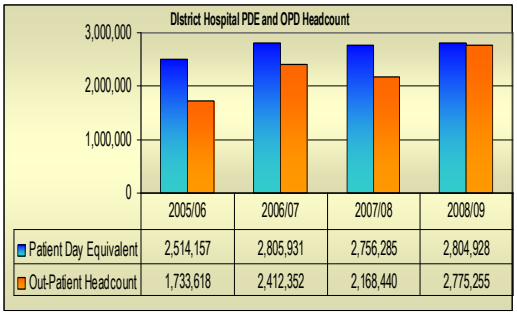
The average performance of District Hospitals (as a sector) is a cause of concern. There are obvious differences between hospitals however Provincial averages present a picture of significant inefficiencies. Table 58 reflects important measures of district hospital efficiency compared with national norms. The data indicates a negative trend in respect of all the indicators as compared to national targets. These inefficiencies clearly contributed to the current financial crisis and will be addressed in 2009/10.

Table 58: District Hospital Efficiency Indicators

Indicator	2007/08	2008/09	National Norm
Average length of stay.	4 Days	5,6 Days	4,2 Days
Bed occupancy rate.	68%	62,5%	72%
Caesarian section rate.	21%	22,7%	11%
Cost per Patient day equivalent.	R 1,351	R 1,441	R 814

The decrease in patient numbers in 2007/08 (Graph 26) is suspected to be as a result of the national nurses strike in 2007. Although more data is needed for trend analysis, it does not seem as if the increased availability and utilisation of PHC services has had an impact on the reduction of out-patient department (OPD) numbers as illustrated in Graph 26. Increased in-patient numbers can probably be attributed to changing disease profiles, improved availability of services at PHC level with appropriate management and referral.

Graph 26: District Hospital Patient Day Equivalent and Out-Patient Headcount



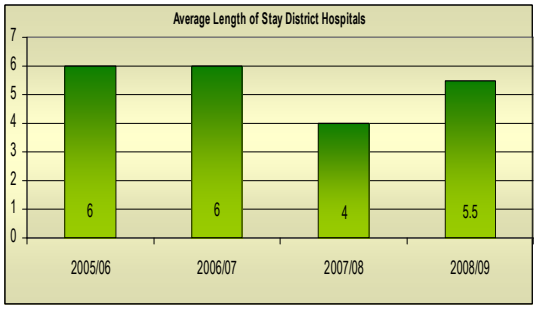
The average length of stay in District Hospitals (5.6 days) still exceeds the national target of 4.2 days although there is a slight decrease from 2006/07 (2007/08 affected by the nurses strike). The quadruple disease burden, including the HIV pandemic, has significantly changed the spectrum of diseases managed at District Hospital level. Many patients are still reporting late to health services and/or presenting with multiple pathologies that may require extensive investigation and/or admission. Many patients admitted with HIV related conditions are severely ill e.g. meningitis and pneumonia, hence requiring 7-14 days induction therapy for the initial care regimen.

The Provincial Referral Protocols were strictly adhered to and cases were discussed with consultants prior to referral, hence ensuring compliance. Inadequate availability of package of services, inadequate equipment and resources however impacted negatively in referral adherence.

The lack of adequate step-down facilities also negatively impacted on the average length of stay and subsequent costs. This is expected to get worse as chronic and communicable disease patient numbers escalates as is evident and expected with the current trends. Improving access through partnerships with NGO's and other partners is becoming increasingly important as financial constraints are expected to continue for the next financial year.

The Sisonke District was able to reduce average length of stay from 7 to 5 days in 2008/09. District Management attributed the decrease to strict adherence to admission and discharge criteria and improved utilisation of Home and Community Based Care Givers in caring for long term illness that does not require active and high level care.

Graph 27: District Hospital Average Length of Stay

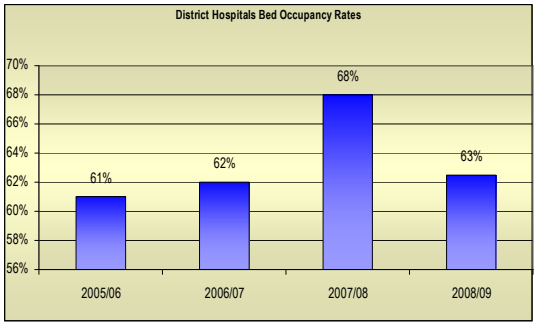


The bed occupancy rate (BOR) decreased slightly although there was significant variance between hospitals. Nine hospitals (McCords 47.8%; Appelsbosch 49.4%; Catherine Booth 47.9%; Ekhombe 37.5%; Mbongolwane 46.1%; Nkandla 45.9%; Benedictine 45.1%; Ceza 47.3% and Nkonjeni 48.1%) reported BOR's below 50% in 2008/09 which is a serious concern that must be investigated to ensure effective utilisation of resources.

Seven hospitals exceeded the national target of 72% i.e. St Mary's 107.1%; GJ Crookes 74.5%; Murchison 72.1%; Northdale 77%; Manguzi 73.8%; Greytown 72.1% and Vryheid 72.5%. Of extreme concern is the overburdened St Mary's Hospital (eThekwini) that consistently reports

BOR's of between 90% and 104% over the last three years. Medical and maternity wards mostly exceeds 100% occupancy while others such as surgery and paediatrics were between 89% and 90% full. The hospital had a 69% shortage of doctors for both 2007/08 and 2008/09 financial years.

Graph 28: District Hospital Bed Occupancy Rate



Health Research & Knowledge Management conducted a 3-year review of BOR and ALOS in an attempt to identify the reasons for the low BOR and extended ALOS in the Province. The report highlighted the following:

- Bed allocation per category e.g. medical, maternity, etc. should be reviewed based on consistent BOR trends per category.
- Step-down facilities are inadequate to accommodate down referral of stabilised patients hence 'blocking' beds for admission of new patients and extending ALOS. This is relevant specifically to medical beds with consistently high occupancy.
- The burden of HIV, AIDS, TB and other chronic conditions impacted on ALOS - patients reporting late at health facilities resulting in an extended stay to manage illnesses.
- Non-separation of wards in calculation of indicator (e.g. TB and psychiatric) impact on average ALOS.
- Lack of transport for down or up referral of patients is a challenge in some districts leading to increased ALOS.
- The argument that a shortage of doctors is responsible for extended ALOS was not fully supported in the review and further analysis is necessary to determine the real impact of shortages of staff on ALOS and BOR.

⇒ PRIORITY 1: IMPLEMENTATION OF THE REVISED ORGANISATIONAL STRUCTURES AND POST ESTABLISHMENTS

Hospital organisational structures and post establishments have been approved in 2007/08 however have not been implemented which has serious implications for effective management of hospital services. Recruitment of staff in critical hospital posts has been curtailed to the absolute minimum as a result of over-expenditure in 2007/08 and 2008/09, and critical criteria and norms and standards for the identification of 'critical' posts have not been finalised resulting in delays with motivations for filling of posts.

The inability to fill critical posts has had a negative impact on equity and availability of services. Service quality has also been affected as a result of increased workloads of already overburdened staff with concomitant increase in sick leave and absenteeism. District Human Resource Plans, aligned to the 10-year Provincial Plan have not been finalised which may have had an impact on allocation of resources. This will be addressed in 2009/10.

! CHALLENGE

- Delays with implementation of hospital organisational structure and post establishment affected service delivery.

⇒ PRIORITY 2: INCREASE STEP-DOWN BEDS BASED ON CATEGORY A AND B DISTRICT HOSPITALS IN THE STP

The Service Transformation Plan has not been approved and implementation has not commenced as planned in the 2008/09 Annual Performance Plan.

Step-Down facilities and beds increased from 8 facilities (483 beds) in 2007/08 to 14 facilities (781 beds) in 2008/09. The demand for step-down care steadily increased due to the quadruple burden of disease including an increase in non-communicable and communicable diseases, chronic conditions requiring long-term care, TB, HIV and AIDS, etc. As a result of severe financial constraints these patients do not always receive the long-term care they require which negatively impacts on ultimate health outcomes. The average length of stay remains high due to the limited number of step down facilities, further adding to increased cost per patient day at District Hospitals.

District Hospitals have been encouraged to utilise step-down facilities in the private sector (as an interim arrangement) with the understanding that costs at these facilities will be reduced. Improved community awareness and participation in caring for chronically ill patients,

improved integrated strategies to link community out-reach programmes, partnerships with NGO's/ CBO's and active healthy lifestyle initiatives should contribute towards addressing this in the interim.

⇒ PRIORITY 3: PROVIDING DEDICATED CAPACITY FOR OUT-REACH ACTIVITIES TO STRENGTHEN PHC

District Hospitals are dependant on Community Service Officers for the provisioning of medical, dental and rehabilitation services. The maintenance of standards and continuity of services is a challenge due to rotation and uncertainty of availability of these categories of staff. The unpredictability of community service allocations impacts directly on resourcing of services, in particular dental and rehabilitation services. Equipping these services is very costly and may be wasteful if there is no continuity in service provision.

Regional Hospitals provide out-reach programmes to District Hospitals, and District Hospitals provide services to PHC clinics and CHC's despite the high vacancy rates in some institutions. There has been an increase in community service programmes since the induction of the Community Services Programme with more Therapists, Dentists, and Medical Officers doing duty in PHC clinics and CHC.

⇒ PRIORITY 4: IMPROVE THE QUALITY OF HEALTH CARE

According to district reports 95% (39/41) of District Hospitals offer the full package of District Hospital services, although over-expenditure has had a limiting effect on quality of care.

A number of District Hospitals render partial regional services e.g. Radiology, Audiometer and Cataract surgery services at Dundee Hospital and Orthopaedic services at Benedictine Hospital. Cost centres have not been established at 'Combo'[104] hospitals and itemised billing for pharmacy and inpatients has not been introduced to determine cost per level of care in these hospitals. This has significant implications for budget forecasting and allocation and may be one of the reasons for over-expenditure.

! CHALLENGES

Financial challenges that impacted on expenditure and service delivery during 2008/09 included:

- Late allocation of budget impacted negatively on planning and decision-making and jeopardised service delivery.
- Hospital organisational and post structures not being implemented resulted in inability of managers to appoint critical skill personnel including critical medical and nursing posts.
- Insufficient funds to meet the urgent infrastructural demands, and initial budgets not aligned to Business Plans leading to core business not being attended to. Unfinished projects as a result of co-operatives abandoning work because of inadequate funding (e.g. EG and Usher Memorial Hospital).
- Increased migration of staff to economically viable positions resulted in increased pressure on health systems in already challenged areas.
- Inflation and price risk (including manipulation by suppliers) impacting on the Department's ability to contain costs for essential sundries.

The Department did not participate in the COHSASA Programme this year and no hospital has received accreditation. Norms and standards are however sustained as far as possible and are being monitored by Quality Assurance. Escort Hospital received the Premier's Gold Award for Service Excellence in 2008/09.

According to District Reports, 93% of institutions conduct monthly clinical audit meetings and 100% conduct morbidity and mortality meetings which should impact positively on quality of care. Formal evaluations have not been done to determine how these meetings contribute towards quality and service delivery outcomes.

There are various challenges affecting service delivery at hospital level mainly attributed to cost containment (due to over-expenditure in 2007/08 and 2008/09) and inadequate budgets allocated for district health services. Supervision must be improved in spite of cost containment measures.

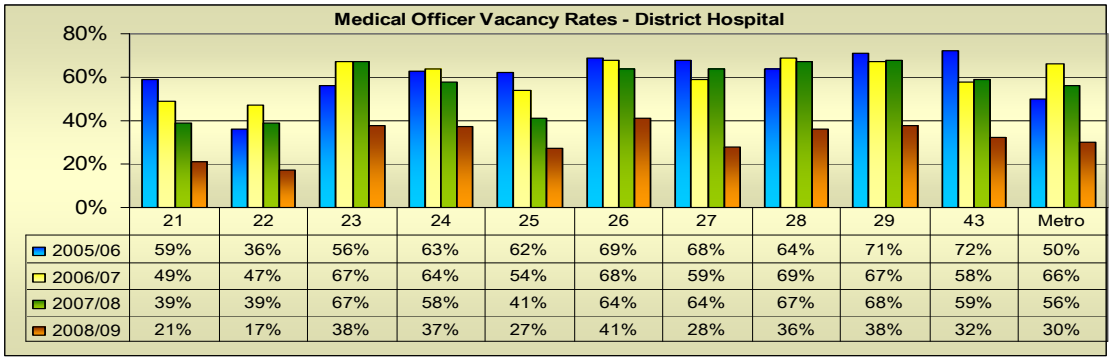
Early reports indicated that OSD had a negative impact on staff retention in hospitals i.e. Infection Control and Quality Assurance Practitioners returned to their respective areas of specialty as they did not receive OSD recognition. This seriously jeopardised service delivery. The Human Resource Planning Component is currently assessing the impact of OSD on services.

[104] Referred to as hospitals rendering part of the level 2 package of services

Service delivery is still plagued by high vacancy rates of core personnel e.g. professional nurses and medical officers. Although there may be great variance in vacancy rates between hospitals, the need is great and definitely impacted negatively on delivery of the core package of services and maintaining quality. Staff wellness also suffers as a result with an increase in sick leave, absenteeism, etc. The next 2 graphs illustrate the vacancy rates for Medical Officers (for District Hospitals) and Professional Nurses over the last 4 years.

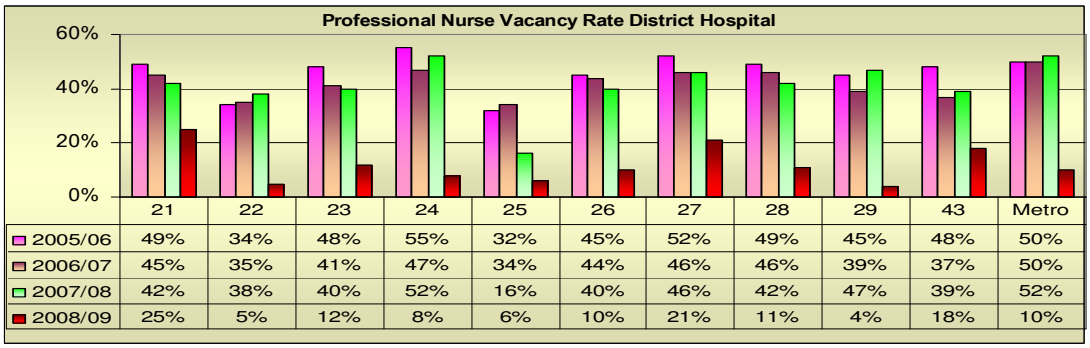
The significant drop in the 2008/09 vacancy rates for both Medical Officers (Graph 29) and Professional Nurses (Graph 30) is as a result of the abolishment of unfunded vacant posts at the end of July 2008 as per Cabinet instruction.

Graph 29: Medical Officer Vacancy Rates in District Hospitals 2005/06 - 2008/09[105]



	21	22	23	24	25	26	27	28	29	43	Metro
2005/06	59%	36%	56%	63%	62%	69%	68%	64%	71%	72%	50%
2006/07	49%	47%	67%	64%	54%	68%	59%	69%	67%	58%	66%
2007/08	39%	39%	67%	58%	41%	64%	64%	67%	68%	59%	56%
2008/09	21%	17%	38%	37%	27%	41%	28%	36%	38%	32%	30%

Graph 30: Professional Nurse Vacancy Rate in District Hospitals 2005/06 - 2007/09[106]



	21	22	23	24	25	26	27	28	29	43	Metro
2005/06	49%	34%	48%	55%	32%	45%	52%	49%	45%	48%	50%
2006/07	45%	35%	41%	47%	34%	44%	46%	46%	39%	37%	50%
2007/08	42%	38%	40%	52%	16%	40%	46%	42%	47%	39%	52%
2008/09	25%	5%	12%	8%	6%	10%	21%	11%	4%	18%	10%

⇒ PRIORITY 5: IMPROVE INFECTION PREVENTION & CONTROL

Infection Prevention and Control management has improved and is actively monitored.

[105] Data obtained from Persal. 21=Ugu; 22=Umgungundlovu; 23=Uthukela; 24=Umzinyathi; 25=Amajuba; 26=Zululand; 27=Umkhanyakude; 28=Uthungulu; 29=Ilembe; 43=Sisonke; Metro=eThekwini

[106] Data obtained from Persal

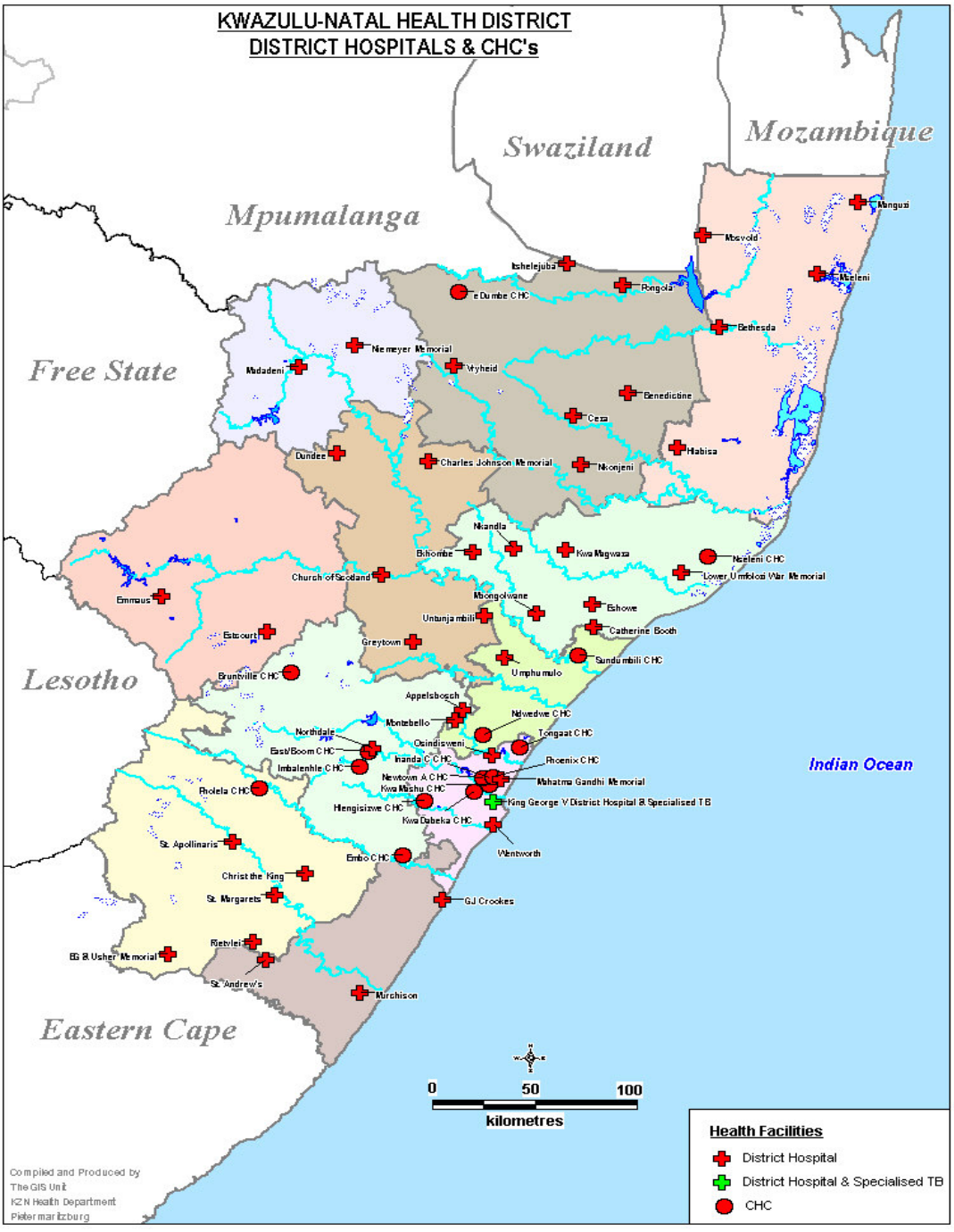
PROVINCIAL PERFORMANCE INDICATORS

Data completeness: 95%

Table 59: (DHS 5) Provincial Objectives and Performance Indicators for District Hospital Services 2008/09

Performance Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Measurable Objective: To ensure that all District Hospitals provide quality care to all patients based on the defined package of services as per STP.					
1. Caesarean section rate.	19%	20%	21%	20%	22.7%
2. Average length of stay.	6 Days	6 Days	4 Days	5.6 Days	5.6 Days
3. Bed utilisation rate.	61%	62.1%	68%	64%	62.6%
4. Case fatality rate.	4%	4%	4.5%	4%	4.5%
5. Number of District Hospitals implementing the Infection Prevention and Control Policy.	Nor collected	Not collected	Policy approved	41 (100%)	41 (100%)
Measurable Objective: To develop and implement a framework to improve clinical governance at Health Facilities.					
6. Number of District Hospitals conducting monthly clinical audit meetings.	16 (39%)	16 (39%)	17 (42%)	30 (73%)	36 (88%)
7. Integrated Quality Assurance implemented in all District Hospitals.	Not collected	Not collected	Not collected	41 (100%)	36 (88%)
8. Number of District Hospitals implementing strategies to reduce preventable causes of morbidity and mortality.	Not collected	Not collected	16 (39%)	30 (73%)	41 (100%)

Map 17: District Hospitals and Community Health Centres



Map illustrating the spatial distribution of District Hospitals and Community Health Centres in KwaZulu-Natal.

Table 60: (DHS 1) District Health Service Facilities per Health District – MTEF 2007/08 – MTEF 2008/09

Health District	Facility Type	Number 2007/08	Number 2008/09	Total Population	Average Catchment Population 2008/09	Per Capita Utilisation Rate 2007/08	Per Capita Utilisation Rate 2008/09
Amajuba	Health Posts	0	0	593,268	593,268	2.2	2.0
	Mobiles	7	7				
	Fixed Clinics	24	26				
	CHC's	0	0				
	District Hospitals	3	3				
eThekwini	Health Posts	35	35	3,246,991	3,246,991	2,3*	2,6
	Mobiles	19	21				
	Fixed Clinics	117	116				
	CHC's	8	8				
	District Hospitals	4	4				
Ilembe	Health Posts	06	06	589,841	589,841	2.4*	2.6
	Mobiles	10	10				
	Fixed Clinics	30	30				
	CHC's	2	2				
	District Hospitals	3	3				
Sisonke	Health Posts	2	2	499,954	499,954	1.7*	2.1
	Mobiles	12	12				
	Fixed Clinics	36	36				
	CHC's	1	1				
	District Hospitals	4	4				
Ugu	Health Posts	0	1	710,847	710,847	2.4*	2.5
	Mobiles	14	15				
	Fixed Clinics	48	52				
	CHC's	0	0				
	District Hospitals	3	3				
Umgungundlovu	Health Posts	0	0	2,762,145	2,762,145	2.2	3.1
	Mobiles	17	17				
	Fixed Clinics	50	51				
	CHC's	4	3				
	District Hospitals	2	2				
Umkhanyakude	Health Posts	0	0	600,838	600,838	2.2	2.7
	Mobiles	14	14				
	Fixed Clinics	51	52				

Part B - Programme 2: District Health Services

Health District	Facility Type	Number 2007/08	Number 2008/09	Total Population	Average Catchment Population 2008/09	Per Capita Utilisation Rate 2007/08	Per Capita Utilisation Rate 2008/09
	CHC's	0	0				
	District Hospitals	5	5				
Umzinyathi	Health Posts	0	0				
	Mobiles	11	11				
	Fixed Clinics	42	44	473,967	473,967	2.2	3
	CHC's	0	0				
	District Hospitals	4	4				
Uthukela	Health Posts	0	0				
	Mobiles	13	14				
	Fixed Clinics	36	36	690,333	690,333	2.2	2.1
	CHC's	0	0				
	District Hospitals	2	2				
Uthungulu	Health Posts	1	2				
	Mobiles	15	15				
	Fixed Clinics	53	54	930,943	930,943	2.2	2.3
	CHC's	1	1				
	District Hospitals	6	6				
Zululand	Health Posts	0	1				
	Mobiles	14	16				
	Fixed Clinics	55	56	845,295	845,295	2.2	2.3
	CHC's	1	1				
	District Hospitals	5	5				
Total	**Health Posts**	**44**	**47**				
	Mobiles	**146**	**152**				
	Fixed Clinics	**542**	**553**	**10,070,677**[107]	**10,070,677**	**2.3**	**2.5**
	CHC's	**17**	**16**				
	District Hospitals	**41**	**41**				

[107] The 2008 Mid-Year estimates for 2008: 10,105,500 (Statistics SA Mid-Year Estimates)

Table 61: (DHS 2) Personnel in District Health Services by Health District – MTEF 2008/09

Health District	Personnel Category	Posts Filled 2008/09	Posts Approved 2008/09	Vacancy Rate (%)	Number in post per 100,000 Uninsured People
Ugu	**PHC facilities**				
	Medical Officers	0	0	0	0
Uninsured Population	Professional Nurses	140	157	10.8%	21.51
650,996	Pharmacists	0	0	0	0
	CHW's	521[108]			
	District Hospitals				
	Medical Officers	59	101	41.5%	9.063
	Professional Nurses	255	286	10.83%	39.171
	Pharmacists	17	96	82%	2.611
uMgungundlovu	**PHC facilities**				
	Medical Officers	20	25	20%	2.33
Uninsured Population	Professional Nurses	231	273	15.38%	26.92
857,956	Pharmacists	2	9	77.7%	0.233
	CHW's	487[108]			
	District Hospitals				
	Medical Officers	199	323	38.39%	23.1
	Professional Nurses	1371	1684	18.59%	159.79
	Pharmacists	43	110	60.90%	5.012
Uthukela	**PHC facilities**				
	Medical Officers	0	0	0	0
Uninsured Population	Professional Nurses	135	142	4.92%	22.22
607,493	Pharmacists	0	0	0	0
	CHW's	470[108]			
	District Hospitals				
	Medical Officers	27	86	68.60%	4.11
	Professional Nurses	156	170	8.213%	25.679
	Pharmacists	9	90	90%	1.481
Umzinyathi	**PHC facilities**				
	Medical Officers	0	0	0	0
Uninsured Population	Professional Nurses	160	181	11.6%	37.91
422,072	Pharmacists	0	0	0	0
	CHW's	343[108]			

[108] CHW not employed by the Department - information provided by CHW Programme Manager

Part B - Programme 2: District Health Services

Health District	Personnel Category	Posts Filled 2008/09	Posts Approved 2008/09	Vacancy Rate (%)	Number in post per 100,000 Uninsured People
	District Hospitals				
	Medical Officers	48	102	52.9%	11.372
	Professional Nurses	333	565	41%	78.896
	Pharmacists	15	99	84.8	3.553
Amajuba	**PHC facilities**				
	Medical Officers	0	0	0	0
Uninsured Population	Professional Nurses	132	146	9.58%	030.5
432,780	Pharmacists	0	0	0	0
	CHW's	261[108]			
	District Hospitals				
	Medical Officers	46	68	32.35%	10.62
	Professional Nurses	185	197	6.09%	42.74
	Pharmacists	7	84	91.66%	1.617
Zululand	**PHC facilities**				
	Medical Officers	0	0	0	0
Uninsured Population	Professional Nurses	185	212	12.73%	24.87
743,850	Pharmacists	0	0	0	0
	CHW's	547[108]			
	District Hospitals				
	Medical Officers	48	117	58.97%	6.45
	Professional Nurses	541	562	3.73%	72.729
	Pharmacists	11	102	89.2%	1.478
Umkhanyakude	**PHC facilities**				
	Medical Officers	0	0	0%	0%
Uninsured Population	Professional Nurses	181	206	12.13%	34.141
530,152	Pharmacists	5	63	92.06%	0.943
	CHW's	457[108]			
	District Hospitals				
	Medical Officers	51	120	57.5%	9.619
	Professional Nurses	355	382	7.06%	66.96
	Pharmacists	8	102	92.15%	1.509
Uthungulu	**PHC facilities** Correct				
	Medical Officers	0	0	0	0
Uninsured Population	Professional Nurses	120	145	17.24%	14.647
819,230	Pharmacists	0	0	0	0

Health District	Personnel Category	Posts Filled 2008/09	Posts Approved 2008/09	Vacancy Rate (%)	Number in post per 100,000 Uninsured People
	CHW's	400[108]			
	District Hospitals				
	Medical Officers	76	143	46.8%	9.277
	Professional Nurses	547	561	2.49%	66.77
	Pharmacists	15	106	85.84%	1.83
Ilembe	**PHC facilities**				
	Medical Officers	7	14	50%	1.35
Uninsured Population	Professional Nurses	199	251	20.71%	38.40
518,180	Pharmacists	2	5	60%	0.38
	CHW's	423[108]			
	District Hospitals				
	Medical Officers	95	177	48%	17.92
	Professional Nurses	288	476	39%	54.32
	Pharmacists	11	96	89%	2.07
Sisonke	**PHC facilities**				
	Medical Officers	0	5	100%	0
Uninsured Population	Professional Nurses	117	156	25%	27.716
422,125	Pharmacists	2	4	50%	0.473
	CHW's	483[108]			
	District Hospitals				
	Medical Officers	24	66	63.63%	5.685
	Professional Nurses	283	371	23.72%	67.04
	Pharmacists	4	43	90.96%	0.947
eThekwini	**PHC facilities**				
	Medical Officers	73	Not confirmed	47%	5.4
Uninsured Population	Professional Nurses	201	211	4.7%	7.034
2,857,352	Pharmacists	31	Not confirmed	55%	1.084
	CHW's	960[108]			
	District Hospitals				
	Medical Officers	97	159	38.99%	3.394
	Professional Nurses	723	741	2.42%	25.303
	Pharmacists	57	127	55.11%	01.994
KwaZulu-Natal Province	**PHC facilities**				
	Medical Officers	100	44	-127.27%	1.128
Uninsured Population	Professional Nurses	1,801	2,080	13.41%	20.325

Part B - Programme 2: District Health Services

Health District	Personnel Category	Posts Filled 2008/09	Posts Approved 2008/09	Vacancy Rate (%)	Number in post per 100,000 Uninsured People
8,862,198	Pharmacists	42	81	48.14%	0.473
	CHW's	5,352			
	District Hospitals				
	Medical Officers	955	1,462	34.67%	10.776
	Professional Nurses	5,037	5,995	15.97%	56.83
	Pharmacists	197	1,055	81.32%	2.222

Table 62: (DHS 6) Situational Analysis and Performance Indicators for District Health Services

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Input					
1. Provincial PHC expenditure per uninsured person. (R)	R 251.41	R 297.28	R 184.39[109] R406.78	R 419.07	R 232.29
2. Sub-Districts offering full package of PHC services. (%)[110]	87%	100%	100%	100%	100%
Output					
3. PHC total headcount.[111] (No)	19,210,359	20,548,203	21,260,261	22,350,000	23,838,854
4. Utilisation rate - PHC. (No)	2.0	1.7	2.3	2.4	2.5
5. Utilisation rate - PHC under-5 years. (No)	4.0	3.2	4.2	4.0	4.4
Quality					
6. Supervision rate. (%)	93%	50%	54%	100%	60%
7. Fixed PHC facilities supported by a doctor at least once a week. (%)	Not collected	Not collected	73%	40%	53%[112]
Efficiency					
8. Provincial PHC expenditure per headcount at Provincial PHC facilities. (R)	R 92	R 64	R 97.46	R 74	R 89

[109] R 184.39 according to DHIS and R 406.78 from Finance
[110] Poorly defined indicator (non-specific) - not indicative of number of facilities implementing the full package of services (National to review)
[111] Targets calculated using a 5% increase - trends will be monitored
[112] 61% facilities visited by a Medical Officer at least once a month

Table 63: Performance Indicators for Communicable & Non-Communicable Diseases

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Input					
1. Number of Trauma Centres for victims of violence.	23	25	36	37	37
Output					
2. Health Districts with Health Care Waste Management Plan implemented.	11	11	11	11	8[113]
3. Hospitals providing Occupational Health Programmes.	100%	100%	100%	100%	100%
4. Schools implementing the Health Promoting Schools (HPS) Programme.	132	132	165[114]	200	1,032[115]
5. Integrated Epidemic Preparedness and Response Plans.	Yes	Yes	Yes	Yes	Yes
Quality					
6. Outbreak response time.	1 Day	1 Day	1 Day	1 Day	1 Day
Outcome					
7. Malaria fatality rate.	<1%	0.6%	1.5% DHIS 0.8% EH	0.5%	1,1% (5/429)
8. Cholera fatality rate.	0%	<1%	0%	<1%	50%[116]
9. Cataract surgery rate.	8,286	6,188	7,715	13,000	9,315[117]

[113] Budget constraints impacted on training and implementation
[114] 85 Schools applied for assessment and were accredited
[115] 131 Schools are accredited as Health Promoting Schools
[116] 2 Confirmed cases in KZN (Zululand and eThekwini) and 1 patient died - see narrative on Cholera
[117] Data inconsistencies between DHIS & vertical reporting to include partnership surgeries - DHIS data reflected a cataract surgery rate of 7,085

Part B – Programme 2: District Health Services

Table 64: Situation Analysis Indicators for Non-Communicable and Communicable Disease Control per Health District

Indicator	Ugu 2008/09	Umgungundlovu 2008/09	Uthukela 2008/09	Umzinyathi 2008/09	Amajuba 2008/09	Zululand 2008/09	Umkhanyakude 2008/09	Uthungulu 2008/09	Ilembe 2008/09	Sisonke 2008/09	eThekwini 2008/09
Input											
1. Trauma Centres for victims of violence. (No)	4	3	3	3	3	2	2	5	2	5	3
2. Health Districts with Health Care Waste Management Plan implemented. (No)	No	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes
3. Hospitals providing Occupational Health programmes. (No)	5	10	3	4	3	7	5	8	3	7	15
4. Schools implementing the Health Promoting Schools (HPS) Programme. (No)	86	16	54	59	150	293	110	197	17	44	6
5. Integrated Epidemic Preparedness and Response Plans implemented. (Y/N)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Quality											
6. Outbreak response time. (Days).	1 Day	1 Day	1 Day	1 Day	1 Day	1 Day	1 Day	1 Day	1 Day	1 Day	1 Day
Outcome											
7. Malaria fatality rate. (%)	0%	0%	0%	0%	0%	10% (1/10)	2.0% (2/96)	1.5% (1/63)	0%	0%	1.1% (1/90)
8. Cholera fatality rate. (%)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100% (1/1)[118]
9. Cataract surgery rate. (No)	265	1,717	195	562	516	184	439	1,114	456	714	3,153

[118] 1 Case reported (truck driver from Zimbabwe) and 1 person died

Table 65: (HIV 3) Performance Indicators for HIV, AIDS, STI and TB Control

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Input					
1. Fixed PHC facilities offering PMTCT. (%)	96%	96%	96%	98%	96%
2. Fixed PHC facilities offering Voluntary Counselling and Testing (VCT). (%)	97%	97%	100%	100%	100%
3. Hospitals offering PEP for occupational HIV exposure. (%)	100%	100%	100%	100%	100%
4. Hospitals offering PEP for sexual abuse. (%)	57%	87%	88% (51/58)	90%	100%
5. ART service points registered. (No)	55	72	80	79	86
6. ART patients - total registered. (No)	57,149	76,000	143,526[119]	195,312	225,863
Process					
7. TB cases with a DOTS Supporter. (%)	80%	77%	79%	90%	72%
8. Male condom distribution rate from Public Sector health facilities. (No)	7	7	7	9	7
9. Fixed facilities with any ARV drug stock-out. (%)	0%	0%	2.7%	0%	0%
10. Fixed facilities referring patients to ARV treatment points for assessment. (%)	100%	100%	100%	100%	100%
Output					
11. STI partner treatment rate. (%)	22%	28%	21.2%	30%	21%
12. Nevirapine dose to baby coverage rate. (%)	39%	102%[120]	72%	98%	85%
13. Nevirapine uptake - antenatal clients. (%)	25%	63%	67%	76%	85%
14. Clients HIV pre-test counselled rate in fixed PHC facilities. (%)	100%	100%	100%	100%	100%
15. HIV testing rate (excluding antenatal). (%)	91%	91%	88%	95%	95.5%
16. TB treatment interruption rate. (%)	13.4%*	15.3%*	12.9%*	10%*	9.9%
Quality					
17. CD_4 test at ARV treatment service points with turn-around time >6 days. (%)	0%	0%	0%	0%	Roger
18. TB sputa specimens with turn-around time <48 hours. (%)	15%	55%	68%	85%	60.3%
Efficiency					
19. Dedicated HIV and AIDS budget spent. (%)	97% R 528,093m	98% R 703,970m	105% R 1,058,570	100%	100% R758,587,347.71
Outcome					

[119] DORA Report
[120] Incorrect data due to system changes

Part B - Programme 2: District Health Services

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
20. New smear positive PTB cases cured at first attempt. (%)	31.9%*	40.1%*	47.8%*	50%	54.2%
21. New MDR TB cases reported - % annual change. (%)	555 cases*	690 (+24%)*	1128 (+63%)	60 cases	1134 (+0.5%)
22. New XDR TB cases reported - annual % change. (%)	35 cases*	83 (+137%)*	168 (+102%)	69 cases	109 (+35%)

Table 66: (NHS Priority 4) Priority Health Programmes

Activity	Indicators	Targets 2008/09	Progress
Implementation of the National Strategic Plan for HIV and AIDS.	Increase the proportion of health facilities providing comprehensive HIV care including ART.	25%	• Accredited services increased from 80 to 86 with 322 clinics providing down-referral HIV and AIDS care.
Implementation of the TB Crisis Management Plan.	Increase in smear conversion rate in selected Districts.	10% above baseline.	• 2005 - 48% • Current - 54% (+6%)
	Increase in cure rate in selected Districts.	10% above baseline.	• 2005 - 40% • Current - 53% (+13%)

Table 67: (HIV 1) Situation Analysis Indicators for HIV & AIDS, STI & TB Control per Health District[121]

Indicator	Ugu 2008/09	Umgungundlovu 2008/09	Uthukela 2008/09	Umzinyathi 2008/09	Amajuba 2008/09	Zululand 2008/09	Umkhanyakude 2008/09	Uthungulu 2008/09	Ilembe 2008/09	Sisonke 2008/09	eThekwini 2008/09
Input											
1. Fixed PHC facilities offering PMTCT.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%
2. Fixed PHC facilities offering VCT.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
3. Hospitals offering PEP for occupational HIV exposure.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
4. Hospitals offering PEP for sexual abuse.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
5. ART service points registered.	4	10	3	4	4	9	5	10	8	6	23
6. ART patients - total registered.	21,340	27,134	15,097	13,606	10,189	14,788	21,287	23,041	15,211	8,141	56,029
Process											
7. TB cases with a DOTS Supporter.	78%	62%	73%	71%	94%	69%	90%	-[122]	47%	65%	62%
8. Male condom distribution rate from Public Sector health facilities.	5	5	10	8	11	8	7	5	6	9	8
9. Fixed facilities with any ARV drug stock-out.	0	0	0	0	0	0	0	0	0	0	0
10. Fixed facilities referring patients to ARV treatment points for assessment.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Output											

[121] Data from Annual District Reports (collated by the M&E Component) unless otherwise indicated
[122] TB Data not available due to challenges with the Electronic Register

Part B – Programme 2: District Health Services

Indicator	Ugu 2008/09	Umgungundlovu 2008/09	Uthukela 2008/09	Umzinyathi 2008/09	Amajuba 2008/09	Zululand 2008/09	Umkhanyakude 2008/09	Uthungulu 2008/09	Ilembe 2008/09	Sisonke 2008/09	eThekwini 2008/09
11. STI partner treatment rate.	18%	24%	20%	24%	26%	20%	23%	29%	19%	15%	17%
12. Nevirapine dose to baby coverage rate.	99%	92%	86%	71%	100%	57%	81%	81%	93%	62%	91%
13. Nevirapine uptake - antenatal clients.[123]	63%	92%	126%	91%	125%	59%	98%	96%	125%	88%	96%
14. Clients HIV pre-test counselled rate in fixed PHC facilities.	5.6	1.9	3.5	3.6	5.9	3.7	3.3	1.1	3.1	7.4	1.9
15. HIV testing rate (excluding antenatal).	91%	97%	98%	94%	96%	86%	95%	91%	97%	81%	92%
16. TB treatment interruption rate.	9%	11%	10%	2%	1%	8%	4%	-[124]	7%	7%	14%
Quality											
17. CD_4 test at ARV treatment service points with turnaround time >6 days.	-	-	-	-	-	-	-	-	-	-	-
18. TB sputa specimens with turnaround time > 48 hours.	52%	48%	74%	77%	83%	28%	26%	-	100%	44%	96%
Efficiency											
19. Dedicated HIV & AIDS budget spent.	*[125]	*	*	*	*	*	*	*	*	*	*
Outcome											
20. New smear positive PTB cases cured at first attempt. .	71%	75%	69%	81%	72%	69%	69%	-	76%	74%	63%
21. New MDR TB cases reported - annual % change.	26 cases	109 cases	62 cases	113 cases	0 cases	619 cases	313 cases	-	-	36 cases	131 cases

[123] This indicator is using NVP dose issued in labour or at ANC. Double counting is therefore very possible - the indicator will be improved/ reviewed for 2009/10
[124] TB data not available due to challenges with the Electronic Register
[125] Data from HAST Finance Section still outstanding - currently sourcing the data

Table 68: (MC&WH 3) Situational Analysis Indicators for Nutrition and Maternal, Child and Women's Health

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Input					
1. Number of Hospitals offering CTOP services.	16/56 (28%)	22/56 (40%)	18/56 (32%)	30/56 (53%)	22[126]
2. Number of CHC's offering CTOP services.	0	0	0	2	0
Process					
3. Fixed PHC facilities with DTP Hib vaccine stock out.	2%	0%	1.2%	0%	3,8%
Output					
4. (Full) Immunisation coverage under-1 year.	76.4%	74.8%	81.1%	90%	85%
5. Vitamin A coverage under-1 year.	116%	100%	111.6%	75%	126%
6. Measles coverage under-1 year.	79%	90%	84.5%	90%	89.3%
7. Cervical cancer screening coverage.	2%	4.5%	4.3%[127]	5%	0.5%
8. Deliveries in facilities.	169,621	188,080	193,564	No target	202,685
Quality					
9. Facilities certified as Baby-Friendly.	65%	70%	76%[128]	75%	76% (44/58)
10. Fixed PHC clinics certified as Youth-Friendly.	33 (8%)	37 (8.2%)	39 (6.8%)	40 (6.9%)	27[129]
11. Fixed PHC facilities implementing IMCI.	75%	80%	82%	82%	82%
Outcome					
12. Institutional delivery rate for women under-18 years.	8%	8%	8.4%	8%	9.4%

[126] Reporting is still a challenge with 11 Public and 6 Private facilities reporting through DHIS
[127] DHIS data is incomplete (0.4%) - data used from NHLS Cytology
[128] 44/58 Hospitals, as well as 1 CHC and 3 PHC Clinics certified as Baby-Friendly
[129] Data from District Annual Report (collated by the M&E Component) - according to the MC&WH Programme Manager no PHC clinic is accredited as Youth-Friendly

Part B - Programme 2: District Health Services

Table 69: (MC&WH 1): Situational Analysis Indicators for Nutrition, Maternal, Child & Women's Health per Health District

Indicator	Ugu 2008/09	Umgungundlovu 2008/09	Uthukela 2008/09	Umzinyathi 2008/09	Amajuba 2008/09	Zululand 2008/09	Umkhanyakude 2008/09	Uthungulu 2008/09	Ilembe 2008/09	Sisonke 2008/09	eThekwini 2008/09
Incidence											
1. Hospitals offering CTOP services.[130]	0	4	2	0	1	6	1	3	1	4	4
2. CHC's offering CTOP services.	0	0	0	0	0	0	0	0	0	0	0
Process											
3. Fixed PHC facilities with DTP Hib vaccine stock out.	2.7	1.4	0.7	2.3	2.4	18.0	3.1	4.0	1.7	1.9	1.4
Output											
4. (Full) Immunisation coverage under-1 year.	89.1%	103.2%	80.3%	89.4%	61.4%	72.7%	89.1%	84.1%	79.1%	110.3%	85.3%
5. Vitamin A coverage under-1 year.	128.3%	128.1%	104.5%	104.6%	103.3%	162%	111.3%	110.5%	106.5%	125.8%	141.4%
6. Measles coverage under-1 year.	91.5%	107%	82.3%	94%	66.7%	88%	86%	87.4%	81%	117%	90%
7. Cervical cancer screening coverage.	1.2%	0.5%	0.5%	0.7%	0.5%	0.8%	0.6%	0.4%	0.5%	0.6%	0.4%
8. Deliveries in facilities.	14,717	18,839	13,557	12,482	8,450	16,442	14,355	20,231	11,262	9,200	63,150
Quality											
9. Facilities certified as Baby-Friendly.	4	4	3	4	3	6	5	5	3	2	5
10. Fixed PHC facilities certified as Youth-Friendly.	4	0	1	0	6	0	0	5	1	2	8
11. Fixed PHC facilities implementing IMCI.	67	69	39	48	34	84	54	62	46	41	101
Outcome											
12. Institutional delivery rate for women under-18 years.	10.2%	7.5%	9.6%	7.4%	10.2%	10.1%	12.6%	8.2%	9.2%	11.2%	9.4%

[130] District data (Annual District Report) does not correspond with MC&WH Programme Manager report (refer to MC&WH narrative) - data will be verified

Table 70: (DHS 7) Performance Indicators for District Hospitals Sub-Programme

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Output					
1. Caesarean section rate for District Hospitals.(%)	19%	20%	21%	19%	22.7%
2. Separations - total. (No)	316,889	349,624	329,406	371,300	361,244
3. Patient day equivalents. (No)	2,514,157*	2,805,931*	2,756,285*[131]	5,600,000	2,804,928
4. OPD total headcounts.[132] (No)	1,733,618	2,412,352	2,168,440	2,545,000	2,775,255
Quality					
5. District Hospitals with Patient Satisfaction Survey using DOH template. (%)	100%	95%	88% (36)	100%	87% (36)
6. District Hospitals with mortality and morbidity meetings every month. (No)	40%	16 (40%)	16 (40%)	30 (75%)	100% (40)
7. District Hospitals with monthly clinical audit meetings every month.[133] (No)	40%	16 (40%)	17 (42%)	30 (75%)	95% (37)
8. Complaints resolved within 25 days. (%)	Not collected	Not collected	Not collected	40%	72.5%
Efficiency					
9. Average length of stay in District Hospitals. (Days)	6 Days	6 Days	4 Days	5.6 Days	5.6 Days
10. Bed utilisation rate (based on usable beds) in District Hospitals. (%)	61%	62.1%	68%	64%	62.6%
11. Expenditure per patient day equivalent in District Hospitals. (R)	R 984	R 949	R 1,351	R 1,436	R 1,441
Outcome					
12. Case fatality rate in District Hospitals for surgery separations. (%)	4%	4%	4.5%	4%	4.5%

Table 71: (NHS 3) Quality of Care

Activity	Indicators	2008/09 Targets	2008/09 Progress
Hospital Improvement Plans.	Clinical audits.	Clinical audits routinely monitored in 75% of District Hospitals (30).	• Clinical audits routinely monitored in 87% (36) District Hospitals. • The Hospital improvement plans are in line with the Audit tool that the National Department of Health piloted and if implemented will contribute to the improvement of the quality of care in hospitals. The improvement plans have target dates. • A proforma has been developed for hospital improvement plans, but will be realigned to the new CORE document.

[131] * Denotes data that has been verified since reporting. It is not clear why the huge discrepancies in previously reported data. That will also account for the unrealistic target that were based on previously reported data
[132] Targets calculated using a 5% increase - trends will be motivated
[133] 100% of District Hospitals conduct quarterly meetings

Part B - Programme 2: District Health Services

Activity	Indicators	2008/09 Targets	2008/09 Progress
	Complaints Mechanisms.	Complaints mechanisms routinely managed in all Districts (Level 1) Hospitals and PHC facilities.	• Complaints were resolved within 25 days in 72% (Q1), 71% (Q2), 65% (Q3) and 82% (Q4) - Annual average 72.5% • 100% of hospitals are reporting on this indicator.
	Infection Prevention & Control.	Infection Prevention and Control management effected in all Hospitals and CHC's and 100 PHC clinics.	• Infection Prevention and Control management effected in 100% Hospitals and CHC's and 100 PHC clinics compliant (achieved 80% and above).
	Telemedicine.	Hub & spoke systems developed in accordance with the STP.	• Telemedicine Plan not implemented due to financial constraints.
Supervision	Supervision rate for PHC.	100% Supervision rate.	• On average 60% of clinics are receiving monthly supervision. This has fluctuated throughout the year, and there has been a change in how it is calculated by DHIS. • Supervisors are using the new checklists.

Table 72: (DHS 9) Trends in Provincial Public Health Expenditure for District Health Services (R million)

Expenditure (R'000)	2004/05 Actual	2005/06 Actual	200607 Actual	Average Annual Change	2007/08 Actual	2008/09 Actual	2009/10 MTEF Projection	2010/11 MTEF Projection
Current prices.								
Total	R4 253,689	R4 924,947	R5 370,301	12.36%	R6 834,483	R6 915,052	R7 736,926	R8 922,508
Total per person	R434.96	R499.92	R541.14	11.54%	R683.45	R686.39	R762.29	R872.60
Total per uninsured person[134]	R494.27	R568.09	R614.93	11.54%	R776.65	R779.99	R866.24	R991.59
Total capital								
Constant (2007/08) prices.								
Total	R4 934,279	R5,515,941	R5,746,222	7.91%	R6,834,483	R6,500,149	R6,963,233	R7,673,357
Total per person	R504.56	R559.91	R579.02	7.13%	R683.45	R645.21	R686.06	R750.43
Total per uninsured person[135]	R573.36	R636.26	R657.98	7.13%	R776.65	R733.19	R779.61	R852.77

[134] Due to different levels of care being provided by the same Districts & Hospitals the expenditure per uninsured person is not accurate
[135] Due to different levels of care being provided by the same Districts & Hospitals the expenditure per uninsured person is not accurate

PROGRAMME 3:

EMERGENCY MEDICAL RESCUE SERVICES

Part B - Programme 3: EMRS

TABLE OF CONTENTS

PROGRAMME DESCRIPTION

Provide emergency, medical, rescue & non-emergency (elective) transport and health disaster management services in the Province

PROGRAMME STRUCTURE

Sub-Programme 3.1

Emergency Patient Transport (EPT)

Render emergency response to, stablisation and transportation of all patients involved in trauma, medical, maternal and other emergencies through the utilisation of specialised vehicles, equipment and skilled Emergency Care Practitioners (ECP)

Sub-Programme 3.2

Planned Patient Transport (PPT)

Render transport for non-emergency referrals between hospitals, from PHC Clinics to Community Health Centres and Hospitals for indigent persons with no other means of transport

Sub-Programme 3.3

Disaster Management

Pre- and in-hospital mass casualty incident management. Conducts surveillance and facilitates action in response to early warning systems for the Department and active effective response protocols – in line with the provisions of the Disaster Management Act, 2002

Part B - Programme 3: EMRS

PROGRAMME 3: EMERGENCY MEDICAL RESCUE SERVICES

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities 2006 - 2008/09

Priority 5: Strengthen PHC, Emergency Medical Rescue Services and Hospital Service delivery systems.

↓

Provincial Strategic Plan 2005 - 2009/10

Goal 2: Strengthen PHC and provide caring, responsive and quality health services at all levels.

↓

Annual Performance Plan 2008/09

Goal 1

Strategic Objective 2: To improve clinical governance including quality of care and infection prevention and control.

↓

EMRS Priorities 2008/09

1. Implementation of the Operational Plan for the 2010 FIFA Soccer World Cup.
2. Procurement of additional ambulances to comply with the norm of 1:10,000.
3. Provisioning of vehicle replacements in the annual procurement plan.
4. Expanding Planned Patient Transport to comply with District referral protocols.
5. Enhance service delivery and efficiency of the "Call Centre".
6. Expanding to a 3-rotor wing aircraft, one being a twin engine.

Disaster Management Priorities 2008/09

2. Establish Provincial & District capacity to deal with health related disaster management issues.
3. Improve disaster risk management.
4. Integrate guidelines for disaster management into service delivery plans.
5. Sustain and monitor early warning systems and emergency preparedness.

EMRS fleet display at the Royal Show Grounds

EXECUTIVE SUMMARY

The Emergency Medical Rescue Services (EMRS) structure has been centralised to improve strategic leadership and management and thus ensure well coordinated and standardised service delivery. Service delivery operates from a district level.

Financial constraints resulted in a shortage of vehicles and skilled staff, thus the Department has been unable to comply with the national norm of 1 emergency vehicle per 10,000 population, and is currently functioning at 1:44,000. The response times are still well below national and provincial targets with rural response times <40 minutes at 39% and urban response time <15 minutes at 28.1%.

To combat the shortage of skills, the Department entered into a Service Level Agreement with the Durban University of Technology (DUT) to conduct Critical Care Assistant courses on behalf of the Department. The College of Emergency Care (COEC) has secured premises to accommodate the new Emergency Care Technician course which should also assist in alleviating the skills shortage. As part of recruitment and retention of Advanced Life Support (ALS) staff, the Province increased salaries of ALS staff in 2008/09 to match national scales.

Upgrades on 4 Communication Centres have been completed and included the upgrading of computerised communication systems and reconfiguration of the floor layout to ensure a more conducive work environment. Communication Centres at Ugu, Uthukela, Umgungundlovu and Ilembe Districts are complete.

PROFILE OF EMRS FOR 2008/09

- 65% Medical cases
- 11% Motor vehicle accidents
- 21% Maternity cases
- 18% Assault cases
- 25% Other

The 2010 Committee has developed a draft Operational Plan in preparedness for the 2010 World Cup Soccer. The 2010 Soccer World Cup Plan will be implemented as soon as funds are available.

A total of 760,072 patients were transported by Planned Patient Transport (PPT) during 2008/09. The service was operational in all districts although challenges were reported in converting busses for PPT.

Disaster Management continues to be a challenge as there is no Disaster Management structure and no funding was allocated for implementation of programmes.

POLICIES

Table 73: Acts, Policies, Protocols and Guidelines

New Acts, Policies, Protocols & Guidelines	Comments
Volunteer Policy.	Managed at district level with oversight support from the Provincial Operation Manager.
Vehicle replacement Policy.	Managed at Provincial level with support from the Department's fleet office.
Standard Operating Procedure.	A pocket size booklet provided to every Emergency Care Practitioner as an operating manual.

PROGRAMME PERFORMANCE

Emergency Medical Rescue Services (EMRS) operate from the 11 district Communication Centers. Services have been centralised in 2008 to promote accessibility, strategic and supportive management and the provision of a well coordinated and standardised service.

Recruitment and retention of ALS Practitioners has been severely challenged due to a lack of financial resources. Consequent staffing/ skills gaps created additional challenges pertaining to training of the current Basic Life Support (BLS) into Intermediate Life Support (ILS). In the last 12 months, approximately 13 ALS Support Practitioners have relocated to other provinces and/or the private sector. Late in 2008/09, permission was obtained to increase ALS Practitioner salaries to align with other Provinces in an effort to stop the exit of this cadre of staff. No new Emergency Care Practitioners were recruited during 2008/09.

Response Times

Demand for EMRS services increased considerably in 2008/09 and the response times remained well below the national norms and targets. Demand increased as a result of changing disease patterns, influx of holiday makers in the Province during the Easter and December holidays as well as other sporting/cultural events that occured throughout the year. The increase in demand has not

been supported by resource allocation including financial and human resources to manage the increased workload.

The gap between supply and demand of both human and financial resources directly influenced the Department's performance against targets. Only 39% of rural calls was attended to within <40 minutes and 28.1% of urban calls within <15 minutes. According to a preliminary assessment done by EMRS it is suspected that the decrease in response times might be as a result of incident-based reports generated by the upgraded computer system as compared with previous patient-based reports. Statistics should improve during 2009/10 and will be monitored closely.

An analytical review of core indicators i.e. (1) *P1 Red Calls - Urban and Rural Areas* and (2) *Number of locally based staff with training in ALS (paramedics)* shows that there are various co-factors impacting on response times. Some of the co-factors are outside the mandate of the Department and require collaboration with relevant partners i.e. Department of Transport. Co-factors include (but are not exclusive to):

- Average kilometers ambulances travel - relates to "down time for maintenance and repairs";
- Condition of the roads - gravel roads generate more "wear and tear" on vehicles than tarred roads;
- Number of staff trained in ALS - high quality emergency care can be administrated immediately and the patient does not have to wait until arrival at the health facility;
- Increase in hospital/ clinics transfers demand;
- Number of rostered ambulances per 10,000 population - reviewed in conjunction with population density and distribution. For example, eThekwini EMRS response times are better in spite of a low ambulance per population ratio. The district has a higher population density and shorter distances to travel therefore improved response times as compared to more rural districts.

There are 5 Presidential Rural Development Nodes within KwaZulu-Natal namely Ugu, Umzinyathi, Zululand, Umkhanyakude and Umzimkhulu in Sisonke District. These Districts have a high deprivation index and great disease burden and are therefore targeted for additional allocations and support to address needs.

Ambulances in Umkhanyakude reported the highest average kilometres per ambulance per annum followed by Zululand and Umzimkhulu, directly affecting the number of ambulances with less than 200,000km on the odometer. Both Zululand (18%) and Umzimkhulu (22%) have poor rural response times that could be affected by the factors discussed above. Ambulances in Area 3 travel on average more kilometres per annum than the average of both the Presidential or Non-Presidential Nodes - with a low rural response time of 30.3%.

The grave shortage of locally based staff with training in ALS (paramedics) is evident in the table below. Ugu (5%) and to a lesser extent Umzimkhulu (2.5%) have limited support from paramedics while Umzinyathi, Zululand and Umkhanyakude have no ALS trained staff. This will have serious implications for performance and compliance to targets.

It is clear that Area 3 faces various challenges due to resources, topography, roads, etc. It is not clear what value the Aeromedical service adds to ambulance services. In-depth analysis and costing should be done to determine cost versus resource and output for further strategic planning.

In the table below, data from the 5 Presidential Nodes are compared with the average data of the Non-Presidential Nodes to reflect performance of the Rural Nodes versus rest of districts against the target.

Table 74: EMRS Performance indicators

Indicator	Average Non-Presidential Nodes	Average Area 3	Average Presidential Nodes	Presidential Nodes				
				DC 21 (Ugu)	DC 24 Umzin-yathi)	DC 26 (Zululand)	DC 27 (Uthun-gulu)	DC 43 (Sisonke)
Total Rostered ambulances.	23	19	17	17	17	17	20	15
Rostered ambulances per	0.02	0.03	0.03	0.02	0.03	0.03	0.03	0.03

Indicator	Average Non-Presidential Nodes	Average Area 3	Average Presidential Nodes	Presidential Nodes				
				DC 21 (Ugu)	DC 24 Umzin-yathi)	DC 26 (Zululand)	DC 27 (Uthun-gulu)	DC 43 (Sisonke)
10,000 population.								
Average km travelled per ambulance per annum.	39,660	96,657	69,088	23,319	38,456	73,221	156,588	53,854
Locally based staff with training in ALS (paramedics).	3.1%	0.6%	1.5%	5.0%	0.0%	0.0%	0.0%	2.5%
P1 Red call - urban area.	37.8%	11.0%	17.4%	22.0%	65.0%	0.0%	0.0%	0.0%
P1 Red call - rural areas.	45.7%	30.3%	30.4%	40.0%	40.0%	18.0%	32.0%	22.0%
Ambulances with less than 200 000km on the odometer.	5.5%	4.0%	4.1%	4.0%	3.8%	3.9%	3.8%	4.8%

EMRS Learnership/ Scholarship Programme

The anticipated intake of school leavers for the Advanced Certificate for Emergency Care Technology in 2008/09 was not possible. Although operational, the Basic Life Support Qualification Programme did not take any intakes in 2008/09. Individuals that were trained in previous years were employed with EMRS as operational Emergency Care Practitioners and others as Communications Center operators.

College of Emergency Care[136]

In 2008/09, the College of Emergency Care for KZN trained:

- 56 students towards ILS;
- 80 students towards Emergency Medical Dispatch;
- 18 students still in training for Advance Life Support (ALS); and
- 21 students still in training for Emergency Care Technicians.

It was envisaged that the EMRS College would start enrolling students at the Indumiso College of Education in 2008/09. This was however not possible due to withdrawal of the lease offer by DUT Management.

In 2008/09, the College of Emergency Care undertook 3 ECP Intermediate courses with an intake of 24 students each, and the College continues to train Emergency Care Technology students who enrolled in April 2007. In September 2008 the College signed a Service Level Agreement (SLA) with the Durban University of Technology and through that, eighteen (18) students were enrolled for Critical Care Assistance (CCA) course.

! CHALLENGES

- Ability to attract and retain tutoring staff for the College to operate at full potential.
- Salary disparities with other provinces therefore impact on recruitment and retention of staff.
- No formal organisational structure and post establishment for COEC.
- The lack of student accommodation poses a major challenge in running the full complement of courses.
- Lack of physical infrastructure for the COEC.

[136] Certain information contained under this section is contradictory. Provided by EMRS

Part B - Programme 3: EMRS

During the reporting period, the College had two (2) staff members resign i.e. The Course coordinator (non-medical) as well as the Principal.

During 2008/09, KZN had only 5% of EMRS staff with training in ALS (Paramedics) against the national target of 15%. A Service Level Agreement was entered into between the Department and DUT for training of ALS. The three intakes of 18 students are expected to be completed in the 2009/10 period.

⇒ PRIORITY 1: IMPLEMENTATION OF THE OPERATIONAL PLAN FOR THE 2010 SOCCER WORLD CUP

In 2008/09 the Department appointed a Project Coordinator for the 2010 Soccer World Cup. The project management office would be primarily responsible for the coordination of Departmental plans during the Confederation Cup in June 2009 and the World Cup in 2010.

EMRS has also appointed a 2010 Committee to develop and implement the 2010 Plan. The draft Operational Plan has been developed and is ready to be implemented subject to the availability of funds.

⇒ PRIORITY 2: PROCUREMENT OF ADDITIONAL AMBULANCES TO COMPLY WITH THE NORM OF 1:10 0000

Current performance (1:44 000) is still well below the national norm of 1:10 000. The EMRS 5-year Plan makes provision for up-scaling of EMRS services, including purchasing of ambulances and appointment of staff, although it will be dependent on an adequate funding envelope.

A total of 75 ambulances were purchased (2010 budget allocation) during 2008/09 in preparation for the 2010 Soccer World Cup. These ambulances have not been distributed for everyday use, and will only be absorbed into operations once the 2010 Soccer World Cup is over. A further 5 ambulances were purchased by the Umzimkhulu Local Government and issued to Sisonke District to accommodate take-over of areas previously under the jurisdiction of the Eastern Cape Province.

! CHALLENGES

- Due to financial constraints no operational ambulances were purchased in 2008/09.
- Poor infrastructure and long distances contribute to downtime and ultimately earlier replacement of ESV's.

Vehicles, especially ambulances, cover long distances which contribute to the downtime and early replacement of ESV's. Area 3 (Zululand, Umkhanyakude and Uthungulu) is most affected and the use of Aeromedical services therefore assists with transfers through air ambulance to decrease the use of the ground transport and time. First Auto (service provider) has been engaged to assist in reducing the ambulance down time when the ambulances are in for repair or service. The Department uses 4x4 ambulances in rural areas with poor road infrastructure.

⇒ PRIORITY 3: PROVISIONING OF VEHICLE REPLACEMENTS IN THE ANNUAL PROCUREMENT PLAN

Due to financial constrains in 2008/09, EMRS could not procure fleet vehicles for replacement or expansion.

⇒ PRIORITY 4: EXPANDING PLANNED PATIENT TRANSPORT (PPT) TO COMPLY WITH DISTRICT REFERRAL PROTOCOLS

In 2008/09 PPT operated in all districts. Existing personnel have been moved from Operations to PPT to expand services in compliance with protocols. EMRS achieved 100% coverage of hospital-to-hospital PPT service and 36% clinic-to-hospital. The 36% clinic-to-hospital coverage represents the percentage of the total number of clinics in the Province that are being serviced by PPT.

The EMRS Expansion Plan that was due for implementation in 2008/09 could not be implemented due to financial constraints. This included freezing of 600 additional posts that has been created for the 2010 Soccer World Cup.

A total of 760,072 patients were transported with PPT in 2008/09 with a monthly average of 5,758 patients per district (including hospital-to-hospital and clinic-to-hospital).

! CHALLENGES

- Incorrect utilisation of transport, staffing and inadequate infrastructure jeopardised service

delivery.

- The conversion of PPT buses to accommodate stretcher patients is a major challenge. It has been proposed that specification should include the conversion in the "ordered price" to ensure conversion at manufacture level rather than post purchase conversion.
- Inadequate number of buses to accommodate the growing number of patients from the hospitals.
- Non-emergency patients transported by ambulance are a growing concern. In most districts the Department has ambulances dedicated to PPT for stretcher cases. Operational ambulances are not used for non-emergency transfer.
- Referral system is a challenge with regional specialist services only being available at Empangeni, Durban and Pietermaritzburg.

The above challenges result in an overflow of patients to emergency services, negatively effecting service delivery. To improve coverage of PPT for clinics, a team has been appointed to review the PPT Policy in consultation with Hospital Management.

⇒ PRIORITY 5: ENHANCE SERVICE DELIVERY AND EFFICIENCY OF THE CALL CENTRE

The Operations/Call Centre has been operational for the past three years and provides operational support. In 2008/09, information and reporting mainly used the primary conduit of landlines as an entrance into the Centre, therefore the toll-free line (080 000 5133) has been the main route of information.

The centre has been supporting districts in generic fields i.e. EMRS Major Incident and Air Ambulance Coordination; Daily Status Reporting by Hospital Services including the Bed Bureau Status; District Health Services related incidents; Surveillance/monitoring and Customer Care. In 2008/09, the Centre expanded support to Forensic Pathology Services by creating a "one point" contact for all users.

Emergencies are logged on the toll free number (10177) and automatically directed to the nearest control centre (one control centre per district). During 2008/09 a total of 711,126 calls were logged with ambulances attending to a total of 705, 534 patients.

The EMRS Communication Control Centres are the backbone and nerve centre of the service. To date only four centres have been completely upgraded in Ilembe, Ugu, Uthukela and Umgungundlovu. In 2008/09 only the Umgungundlovu District Communication Centre was converted to a computerised paperless system and the staff received the necessary computer training to be able to operate efficiently.

The relocation of eThekwini Control Centre during 2008/09 posed many challenges for management with the major challenge being to find suitable premises to accommodate the Control Centre, the EMRS District Office and EMRS Base at one location. This was resolved with the decentralisation of EMRS Stores and the availability of premises at the Wentworth Base. Upgrading of the facility will be done in phases starting with upgrade of facility to house the eThekwini Communication Centre. Completion of this project is expected before the end of 2009.

! CHALLENGES

- Lack of capacity for the technical management and support with recently installed technologies.
- No budget allocation for the maintenance and upkeep of communication systems, which will have a major impact during disaster situations.
- The current analogue system needs to be upgraded to a digital system at substantial costs. No budget has been allocated to complete this task.
- Although staff in the upgraded control centres are being trained, there is no formal structure/ or career path for call takers and dispatchers resulting in constant movement of staff from control centres to the road. This puts a tremendous strain on the training and skilling of personal.

⇒ PRIORITY 6: EXPANDING TO A 3-ROTOR WING AIRCRAFT - ONE BEING A TWIN ENGINE

The Aeromedical contract expired in November 2008 and the Department is currently operating on a month to month contract pending the acceptance of the new contract.

In 2008/09, the Province's Aeromedical service comprised of a comprehensive rotor wing and fixed wing service including one fixed wing based in Durban and two rotor wings based in Durban and Richards Bay. Services are

provided throughout the Province transporting critical ill patients and ensuring that optimal care is delivered.

This service has been exceptionally valuable in Area 3 where scarce skills pose a major challenge in the pre-hospital environment. Districts in Area 3 have the majority of EMRS staff employed at a Basic Life Support level which limits the care provided. In addition, distances between facilities results in lengthy delays, making the Aeromedical service a necessity in this area.

During 2008/09, Aeromedical services actioned 1,069 inter-hospital transfers (including medical, trauma and neonatal transfers), and 121 primary calls (including major accidents, rescues as well as medical cases requiring rapid transportation to hospital ensuring patients receive optimal care within the golden hour). The service has enhanced service delivery considerably, as the response to such incidents and calls has positively impacted on service delivery.

! CHALLENGE

- Due to the high cost of the new Aeromedical tender/ contract it would be a challenge to procure the 3 helicopters as originally planned.

DISASTER MANAGEMENT

⇒ PRIORITY 1: ESTABLISH PROVINCIAL AND DISTRICT CAPACITY TO DEAL WITH HEALTH RELATED DISASTER MANAGEMENT ISSUES

The organisational structure and post establishment for Disaster Management has not been resolved during 2008/09, and Acting District Coordinators are still managing Disaster Management at district level.

In spite of these challenging circumstances, EMRS was able to provide medical support at special events within the Province, including the extensive runaway fires in the Uthungulu District in October 2008 (Melmoth/ Nkandla area) without additional budget and resources or a Disaster Management structure in place.

⇒ PRIORITY 2: IMPROVE DISASTER RISK MANAGEMENT

All districts have Disaster Management Plans as well as preparedness plans for mass casualty situations in place, and were able to respond to the demands during run up to election rallies and events.

Inadequate human resources impacted on the monitoring and evaluation of the District Disaster Management Committees - and no training has been conducted due to financial constraints.

! CHALLENGE

- Lack of human resources to monitor and evaluate the District Disaster Management Committees.

⇒ PRIORITY 3: INTEGRATE GUIDELINES FOR DISASTER MANAGEMENT INTO SERVICE DELIVERY PLANS

On-going process at institutional and district level with all institutions having a Disaster Management Plan in place.

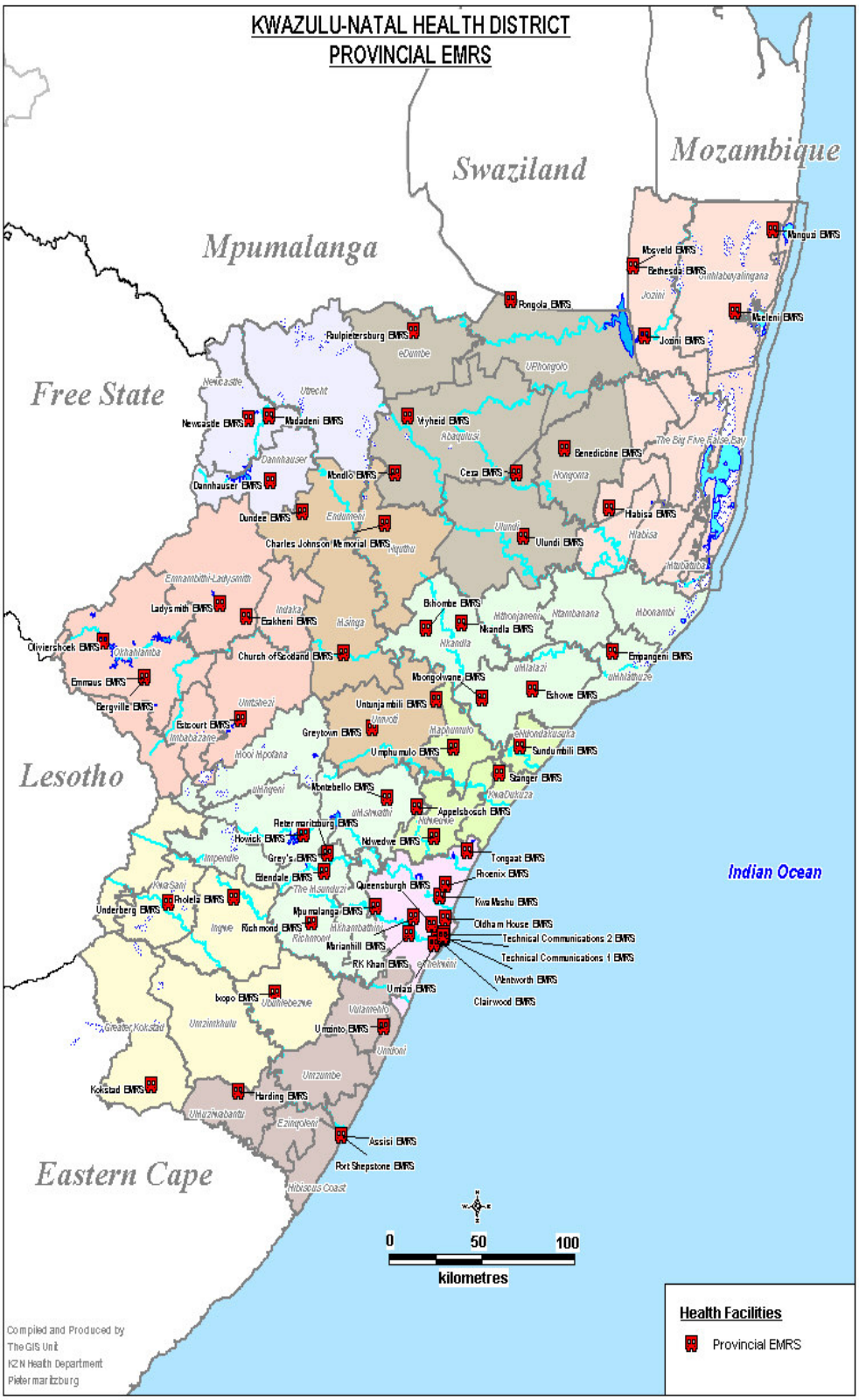
⇒ PRIORITY 4: SUSTAIN AND MONITOR EARLY WARNING SYSTEMS AND EMERGENCY PREPAREDNESS

Disaster Management is currently an added responsibility of the Communications Officers within EMRS due to inadequate human resources.

! CHALLENGES

- The proposed structure for Disaster Management was not approved during 2008/09 as anticipated.
- Disaster Management in the Department of Health is an unfunded mandate without a structure and therefore a substantial challenge to implement the mandate as per the Disaster Management Policy.

Map 18: Emergency Medical Rescue Services per District



The map depicts the Emergency Medical Rescue Services per District in KwaZulu-Natal.

Part B - Programme 3: EMRS

SERVICE DELIVERY INDICTORS

Table 75: (EMS 3) Situation Analysis Indicators for EMRS and Planned Patient Transport

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual[137]	2008/09 Target[138]	2008/09 Actual
Input					
1. Total rostered ambulances.	Not available	207	241	265[139]	226
2. Rostered ambulances per 10,000 people.[140]	Not available	0.02	0.02	0.02[141]	0.02
3. Hospitals with patient transporters.	100%	100%	100%	100%	100%
Process					
4. Kilometers travelled per ambulance (per annum).	145,320	Not available	257,183	298,626	250,849
5. Total kilometers travelled by all ambulances.	Not available	Not available	15,834,354	71,968,866	56,731,927
6. Locally based staff with training in BLS (BAA).	69%	75%	72%	80%	76%
7. Locally based staff with training in ILS (AEA).	26%	20%	25%	30%	23%
8. Locally based staff with training in ALS (Paramedics).	5%	5%	2.1%	7%	2.3%
Quality					
9. P1 (red calls) with a response of < 15 minutes in urban areas.	40.75%	50%	41%	80%[142]	28.1%
10. P1 (red Calls) with a response of < 40 minutes in rural areas.	39.25%	50%	45%	50%[143]	39%
11. All calls with a response time within 60 minutes.	Not available	27.4%	57%	75%	62.9%
12. Percentage of operational rostered ambulances.	Not available	0%	0%	0%	79%
Efficiency					
13. Ambulance journeys used for hospital transfers.	3.2%	0%	3.42%	-	3.6%
14. Green code patients transported by ambulance.	20.25%	20%	33%	10%[144]	15%
15. Cost per patient transported by ambulance (Not actual cost but tariff changed in terms of the model).	R 558	Not available	R 770	R 770	R 770
16. Ambulances with less than 200 000 km on the odometer.	526	595	255	896[145]	198
Output					
17. Patients transported (by PPT) per 10,000 separations.	60	65	Not available	-	Not available

[137] Figures for 2007/08 Actual taken from the APP 2009/10
[138] Targets for 2008/09 verified with Component inputs received for the APP 2009/10
[139] The Department is planning to purchase an additional 230 ambulances, but at least 30% of these ambulances will replace the existing number of rostered ambulances. The definition for determining the number of rostered ambulances per 1000 people needs to be clarified. The target for 2008/09 was adjusted from 399 to 265
[140] The ratio has been calculated using uninsured population. The low target for rostered ambulances per 1000 population supports the need for more ambulances to be purchased by the Province.
[141] The target for 2008/09 was adjusted from 0.04 to 0.02 as per the APP 2009/10
[142] Target for 2008/09 was adjusted from 60% to 80% as per the APP 2009/10
[143] The target for 2008/09 was adjusted from 60% to 50% as per the APP 2009/10
[144] The target for 2008/09 was adjusted from 15% to 10% as per the APP 2009/10
[145] Target was based on the expected number of ambulances - will be reviewed at the Strategic Planning Session

Table 76: (EMS 1) Situation Analysis Indicators for EMRS and Patient Transport per Health District

Indicator	Type	Ugu 2008/09	Umgungundlovu 200/09	Uthukela 2008/09	Umzinyathi 2008/09	Amajuba 2008/09	Zululand 2008/09	Umkhanyakude 2008/09	Uthungulu 2008/09	Ilembe 2008/09	Sisonke 2008/09	eThekwini 2008/09
Input												
1. Total rostered ambulances	No	17	18	16	17	21	17	20	20	14	15	51
2. Rostered Ambulances per 10,000 people[146].	No	0.02	0.02	0.02	0.03	0.03	0.03	0.03	0.03	0.02	0.03	0.01
3. Hospitals with patient transporters (refer to Hospital coverage).	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Process												
4. Kilometres travelled per ambulance (per annum).	Kms	23,319	37,788	46,778	38,456	19,138	73,221	156,588	60,163	46,027	53,854	28,067
5. Total kilometres travelled by all ambulances	Kms	396,436	680,199	748,453	653,763	401,899	1,244,769	3,131,772	1,203,268	644,389	807,821	1,431,444
6. Locally based staff with training in BLS (BAA).	%	60%	68.6%	78.2%	76.1%	88.4%	88%	92.1%	83.4%	58.6%	88.5%	58.8%
7. Locally based staff with training in ILS (AEA).	%	40.2%	36.6%	21.8%	23.9%	11.8%	12%	9.9%	15.7%	36.6%	10.3%	38.1%
8. Locally based staff with training in ALS (Paramedics).	%	5%	6.5%	0%	0%	2%	0%	0%	1.8%	4%	2.5%	4%
Quality												

[146] The ratio has been calculated using uninsured population.

Part B - Programme 3: EMRS

Indicator	Type	Ugu 2008/09	Umgungundlovu 200/09	Uthukela 2008/09	Umzinyathi 2008/09	Amajuba 2008/09	Zululand 2008/09	Umkhanyakude 2008/09	Uthungulu 2008/09	Ilembe 2008/09	Sisonke 2008/09	eThekwini 2008/09
9. (P1 Red Calls) with a response of < 15 minutes in urban areas	%	22%	31%	30%	65%	70%	0%	0%	33%	21%	0%	42%
10. (P1 Red Calls) with a response of < 40 minutes in rural areas.	%	40%	48%	37%	40%	62.9%	18%	32%	41%	55%	22%	30%
11. All calls with a response time within 60 minutes.	%	70%	75%	93%	78%	70%	40%	45%	64%	61%	47%	50%
12. Percentage of operational rostered ambulances with single person crews.	%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Efficiency												
13. Ambulance journeys used for hospital transfers.	%	1%	0.08%	0.09%	1%	0.2%	0.1%	0.2%	0.05%	0.1%	0.3%	0.3%
14. Green code patients transported by ambulance	%	2%	2.7%	3%	1.9%	2.6%	4%	3.1%	2.7%	1.7%	4.3%	5%
15. Cost per patient transported by ambulance.	R	R 770	R 770	R 770	R 770	R 770	R 770	R 770	R 770	R 770	R 770	R 770
16. Ambulances with less than 200,000 km on the odometer.	%	4%	5%	4.5%	3.8%	5.2%	3.9%	3.8%	4.4%	5.8%	4.8%	7.8%
Output												
17. Patients transported (by PTS) per 10,000 separations.	No	83.4	59.1	82.1	126	86.6	71	109	74.9	86.7	138.2	23.2

Table 77: (NHS 3) Quality of Care

Improved quality of care in the restructured service platform is essential to the delivery of the required outcomes and the Provincial Department of Health Vision and Mission.

Activity	Indicators	2008/09 Target	2008/09 Actual
Improving access to services.	Transport services.	50% Increase in Planned Patient Transport fleet deployed.	Not achieved - see narrative.
		50% Increase in EMRS road ambulance fleet deployed.	Not achieved - see narrative.
		Flying Doctor services operational.	Month to month contract.
		Air EMS service SLA signed and effected Provincially.	Contract expired 31 November 2008, however, national tender available to be used and Department in the process of procuring. No agreement in place.

Table 78: (EMS 2) Provincial Objectives and Performance Indicators for EMRS and Planned Patient Transport

Indicators	2005/06 Actual	2006/07 Actual	2007/08 Actual[147]	2008/09 Target	2008/09 Actual
Strategic Objective: To improve Clinical Governance including quality of care and Infection Prevention and Control.					
Measurable Objective: To improve access to Emergency Medical Rescue Services (EMRS) in the Province.					
1. Total rostered ambulances.	Not available	207	241	265	226
2. Rostered ambulances per 10,000 people. [148]	Not available	0.02	0.02	0.02	0.02
3. P1 calls with a response of 15 minutes (urban areas).	40.75%	50%	41%	80%	28.1%[149]
4. P1 calls with a response time <40 minutes (rural areas).	39.25%	50%	45%	50%	39%[150]
5. All calls with a response time within 60 minutes.	Not available	27.4%	57%	75%	62.9%
6. Green code patients transported by ambulance.	20.25%	20%	20%	10%	10%
7. Percentage Planned Patient Transport coverage inter-Hospital.	100%	100%	100%	100%	100%
8. Percentage Planned Patient Transport coverage Clinic-Hospital	34%	30%	55%	100%	36.3%

[147] "Actual" for 2005/06, 2006/07 and 2007/08 taken from data received from the EMRS Component for the APP 09/10
[148] The ratio has been calculated using the uninsured population
[149] This figure may be skewed as the new computerised communication centers that are in place generate data that is incident based and is not patient based which results in much lower response times reflected. This issue is being addressed with the service provider (Africon) in order to amend it
[150] This figure may be skewed as the new computerised communication centers that are in place generate data that is incident based and is not patient based which results in much lower response times reflected. This issue is being addressed with the service provider (Africon) in order to amend it

Part B - Programme 3: EMRS

Indicators	2005/06 Actual	2006/07 Actual	2007/08 Actual[147]	2008/09 Target	2008/09 Actual
Strategic Objective: To improve Clinical Governance including quality of care and Infection Prevention and Control.					
Measurable Objective: To improve access to Emergency Medical Rescue Services (EMRS) in the Province.					
9. Number of vehicles purchased.	200 ESV's 128 Support Vehicles	150 ESV's 37 Support Vehicles	180 ESV's 39 Support Vehicles	515 ESV's 79 Support Vehicles 41 PPT	75 Ambulances for 2010 preparedness and 5 ambulances for Umzimkhulu sub-district. Received 22 PPT busses
10. Number of Institutions with Disaster Management Plans.	0%	80%	70%	100%	80%

Table 79: EMRS Training Courses

Course Name	Number of Courses Held			Input			Expected Output		
	2007/08 Actual	2008/09 Target	2008/09 Actual	2007/08 Actual	2008/ 09 Target	2008/09 Actual	2007/08 Actual	2008/ 09 Target	2008/09 Actual
1. BLS (based on 93% pass rate).	3	3	0	150	150	0	140	140	0
2. BLS (based on 70% pass rate).	4	5	0	96	120	0	67	84	0
3. BLS (based on 70% pass rate).	1	1	0	24	24	0	16	16	0
4. Mid-level qualification (2 year duration)[151]	1	1	1	50	100	24	Nil	45	0
5. EMD (based on 93% pass rate).	20	20	10	240	240	120	223	223	80
6. BLS refresher.	200	220	0	80% of all BLS to attend a Course	80% of all BLS to attend a Course	0	95% - pass rate	95% - pass rate	0
7. ILS refresher.	100	120	0	80% of all ILS to attend a Course	80% of all ILS to attend a Course	0	95% - pass rate	95% - pass rate	0
8. ALS refresher.	5	10	0	80% of all ALS to attend a Course	80% of all ALS to attend a Course	0	100% - pass rate	100% - pass rate	0
9. Basic Medical Rescue (based on 90% pass rate).	10	10	0	120	120	0	108	108	0
10. Aviation Health Care provider (based on 70% pass rate).	2	2	0	30	30	0	21	21	0
11. Advanced Driver Training.	20	50	0	80	200	0	72	190	0
12. Defensive Driver training.	300	300	0	3,000	3,000	0			

[151] This is a new course therefore expect output reflected in 2008/09

Part B - Programme 3: EMRS

NOTES

PROGRAMME 4:

PROVINCIAL HOSPITAL SERVICES

Part B – Programme 4: Provincial Hospital Services

TABLE OF CONTENTS

PROGRAMME DESCRIPTION

Deliver accessible, appropriate, effective, and efficient general specialist hospital services

PROGRAMME STRUCTURE

Sub-Programme 4.1

Render hospital services at specialist level

Sub-Programme 4.2

Render hospital services for TB (including MDR TB)

Sub-Programme 4.3

Render hospital services for Mental Health

Sub-Programme 4.4

Render comprehensive Dental Health services and provide training for Oral Health personnel

Sub-Programme 4.5

Render step-Down and Rehabilitation services to the chronically ill

Part B - Programme 4: Provincial Hospital Services

PROGRAMME4: PROVINCIAL HOSPITALS

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities 2006-2008/09

Priority 3: Contribute towards human dignity by improving quality of care

Priority 5: Strengthen PHC, EMS and hospital delivery systems

↓

Provincial Strategic Plan 2005-2009/10

Goal 2: Strengthen PHC and provide caring, responsive and quality health services at all levels

↓

Annual Performance Plan 2008/09

Goal 1

Strategic Objective 2: To improve clinical governance including quality of care and infection prevention and control

↓

Provincial Hospital Priorities 2008/09

1. Improve quality of care.

Edendale Regional Hospital

EXECUTIVE SUMMARY

There are a total of 14 designated Provincial Hospitals in the Province. The hospitals are unevenly distributed with a concentration of higher levels of care in the urban districts. This distribution impacts negatively on access and increases the costs of providing this level of care as a result of the long distances patients have to be transported to access the care they require. The ripple effect is very evident in the patient transport system and Emergency and Rescue Services provided by the Province.

Provincial Hospitals provide specialist services in the five (5) basic specialities:

- Gynaecology and Obstetrics;
- Paediatrics;
- Surgery;
- Internal Medicine; and
- Orthopaedics.

Continuity in the provision of specialist services remains a challenge as specialist skills are scarce throughout the world. Provision of Orthopaedic services poses particular challenges in the Province and unacceptable backlogs have developed in this discipline.

All Provincial Hospitals provided a combination of levels of care packages of service, and in most instances provided both district and provincial levels of care. Provision of a combined package of service makes costing of the service package extremely complicated and logic would suggest that it leads to inefficiencies. Table 80 however shows that Provincial hospitals performed far closer to national norms than District Hospitals.

By virtue of the fact that the hospitals have a dual responsibility, they also play a pivotal role in the provision of health services in a defined catchment area with catchment area populations varying widely from hospital to

hospital and differing significantly from the current national planning norms. All Provincial Hospitals provide both clinical and non-clinical support services to all PHC services functioning in the catchment area of the hospital.

Hospitals face significant resource challenges varying from hospital to hospital. Challenges include:

- Aging and sometimes inappropriate infrastructure;
- Maintenance backlogs;
- Varying levels of staff and skills shortages;
- Unmanageable workloads; and
- Under funding.

Provincial Hospitals are heavily dependant on Community Service Officers for the rendering of medical, dental and rehabilitation services, and the maintenance of standards and continuity of services is very difficult under these circumstances. The unpredictability of community service allocations impacted directly on resourcing of dental and rehabilitation services in particular and equipping these services is very costly.

The competition for scarce human resources has resulted in very rapid career progression for Medical Officers in particular. The leap-frogging of normal requirements for progression has resulted in an absence of Medical Officers and Senior Medical Officers throughout the service. The absence of these categories affected the level of skills available in the service and the training of neophytes in the profession.

The average performance of Provincial Hospitals as a sector is a cause of concern, and although there are significant differences between hospitals, the provincial averages present a picture of significant inefficiencies. Table 80 highlights some important measures of hospital efficiency compared with national norms.

Table 80: Provincial Hospital Efficiency Indicators

Indicator	Actual 2007/08	Actual 2008/09	National Norm
Average length of stay	4,8 days	5,1 days	4,8 days
Bed occupancy rate	66%	71.3 %	75%
Caesarian section rate	32%	31.6 %	22 %
Cost per Patient day equivalent	R 1,119	R1,175	R1,128

The table confirmed a negative trend in respect of Provincial performance against national targets.

Improving efficiency in all spheres of operation and strengthening clinical governance were critical to improve quality of care and health outcomes. Discussions to begin the process of separating levels of care and defining packages of diagnostic services must be addressed to improve efficiencies in Provincial services. Regular auditing of core service delivery standards will enjoy priority in 2009/10.

Severe budgetary constraints negatively impacted on service delivery in 2008/09. Critical shortages of human resources, essential equipment (replacement and/or procurement), i infrastructural challenges, etc. resulted in difficulties to sustain service delivery.

The retention and recruitment of appropriately skilled medical professionals remained a challenge and the delay in the implementation of OSD has had a definite impact on staff attrition.

As expected, the OPD headcount started to show a decrease from 2,702,113 in 2007/08 to 2,752,678 in 2008/09. This may be due to increased availability and utilisation of PHC (including District Hospital) services. The patient day equivalent decreased to 2,797,350 and the cost per patient increased to R 1,175.

Severe budgetary constraints and the lack of a ring-fenced budget for the 2010 Soccer World Cup challenged preparation and implementation of essential initiatives.

POLICIES

The KwaZulu-Natal Provincial Health Act was enacted in 2008/09 and provides the legal framework for the development and delivery of health services in the Province. The Act makes provision for the establishment of an Inspectorate of Health Establishments which will make an important contribution to improved monitoring ad evaluation of all aspects of service delivery at all levels of service delivery.

A number of policies have been drafted that will be considered for approval by the new administration.

Part B - Programme 4: Provincial Hospital Services

Table 81: Acts, Policies, Protocols and Guidelines

New Acts, Policies, Protocols & Guidelines	Comments
1. Draft Provincial Hospital Governance Policy.	• Draft was piloted in Stanger Hospital and distributed to other hospitals. • Pilot results show that the Policy assisted management in assessing compliance to governance principles.
2. Comprehensive Framework for Clinical Governance.	• Framework has been approved but cannot be implemented due to financial constraints.
3. Draft Policy to regulate buying of ICU beds from Private Hospitals.	• The Draft Policy (widely consulted with Specialists from Provincial and Tertiary Hospitals) was submitted for approval.
4. Policy on Referral Pathways.	• The Task Team appointed to review the existing Referral Policy did not complete the policy.

PROGRAMME PERFORMANCE

The Service Transformation Plan has not been approved and implementation has not commenced as envisaged in the 2008/09 Annual Performance Plan.

⇒ PRIORITY 1: IMPROVE QUALITY OF CARE

The National CORE Evaluation Project aims to assist management to monitor and evaluate performance and compliance to core standards and to improve clinical governance. Four hospitals (1 Psychiatric, 1 Tertiary and 2 Provincial Hospitals) participated in a National CORE Evaluation Project. Project results showed marked improvement in: a) Updated Job Descriptions; b) Physical access and cleanliness of hospitals; c) Standard Operating Procedures for medical risk management including dispensing of prescriptions; and d) Communication and feedback of adverse events. All Districts were trained on the CORE document in preparation for rollout to ensure alignment to the relevant domains including Operational Plans and Key Result Areas.

All Provincial Hospitals render the full package of services for Provincial Hospitals except St Aidens Hospital that also offers Ophthalmology, Urology and Plastic Surgery. Port Shepstone Hospital has orthopedic facilities but is not currently rendering the service as the Orthopedic Specialist post is vacant.

A number of Provincial Hospitals render 'some' tertiary services i.e. Addington, King Edward VIII, Prince Mshiyeni Memorial, RK Khan, Edendale, Port Shepstone, Newcastle, Madadeni, St Aidens and Mahatma Ghandi Memorial. The extent of these services (rendered at Provincial Hospitals) will be determined in 2009/10 pending the availability of funding and resources. Tertiary Hospitals also render Provincial services i.e. Greys Hospital is rendering 20% Provincial services and Ngwelezana Hospital 42%.

! CHALLENGE

- Costing of services (per level of care) is not yet possible in hospitals rendering both level 1 and 2 services ('Combo' Hospitals) which impacted negatively on expenditure and budget allocation.

Provincial Hospital structures were finalised although there has been extensive delays in the filling of posts due to financial constraints. Vacancy rates, especially the shortage of certain categories of staff and critical skills shortages due to the high attrition rates, dramatically impacted on service delivery and quality of care.

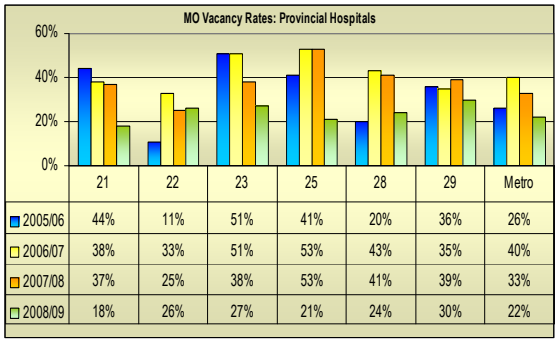
Recruitment and retention of staff was still a challenge, especially as a result of delayed implementation of OSD for Doctors. The inability and/or delay in filling of vacant posts has had a negative impact on availability of the package of services, resulting in increased clinical workload, increased sick leave, absenteeism and reduced quality of care and availability of services. Insufficient staff accommodation and lack of schools and social networks especially in rural districts further impacted on attracting health professionals to rural areas.

The overall effect of OSD is not yet clear and the Human Resource Planning Component commenced with an audit to evaluate the impact of OSD. It is evident at this stage that trained ICU and theatre nurses, previously working in Infection Control and Quality Assurance, returned to their previous areas of specialty where experience is recognised and in so doing widened the skills gap.

The following 2 graphs reflect the vacancy rates for Medical Officers and Professional Nurses for the years 2005/06 to 2008/09. The alignment between service delivery needs and Human Resource allocation has not been successfully incorporated into planning documents and strategies.

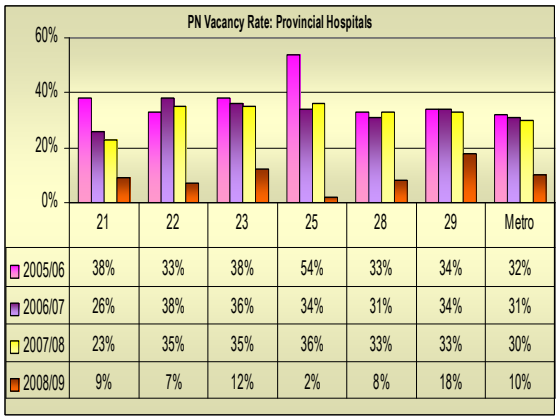
The significant drop in the 2008/09 vacancy rates (compared to 2007/08) is due to the abolishment of unfunded vacant posts at the end of July 2008 as per KZN Cabinet instruction.

Graph 31: Medical Officer Vacancy Rates - Provincial Hospitals



	21	22	23	25	28	29	Metro
2005/06	44%	11%	51%	41%	20%	36%	26%
2006/07	38%	33%	51%	53%	43%	35%	40%
2007/08	37%	25%	38%	53%	41%	39%	33%
2008/09	18%	26%	27%	21%	24%	30%	22%

Graph 32: Professional Nurse Vacancy Rates - Provincial Hospitals



	21	22	23	25	28	29	Metro
2005/06	38%	33%	38%	54%	33%	34%	32%
2006/07	26%	38%	36%	34%	31%	34%	31%
2007/08	23%	35%	35%	36%	33%	33%	30%
2008/09	9%	7%	12%	2%	8%	18%	10%

It was generally expected that the out-patient headcounts at Provincial Hospitals would decrease once access to PHC services (including District Hospitals) increased. The out-patient (OPD) headcount indeed decreased from 2,702,113 to 2,752,678 in 2008/09 and the separations from 351,169 to 355,778 in 2008/09 (Graph 33). The current disease profile may increase the number of clinical referrals to level 2 services which will have an impact on patient numbers as well as cost. In addition, clients still enter the health system at inappropriate levels which highlights the need for an effective communication strategy to promote utilisation of PHC services.

Graph 33: Patient Day Equivalent and Out-Patient Headcounts - Provincial Hospitals

	2005/06	2006/07	2007/08	2008/09
Patient Day Equivalent	2,210,171	2,783,246	2,663,297	2,529,202
Out-Patient Headcount	2,392,992	3,074,707	2,702,113	2,553,503

The Accident & Emergency Unit at Stanger Hospital (established in 2007/08) is too small for the current needs. The unit consists of a medical emergency section (9 beds) and trauma section (5 beds) and has access to 3 ICU beds but no high care facility due to limited staff and inadequate space. Due to severe financial constraints that delayed upgrading and purchasing of equipment the functionality of the unit is limited. Challenges include infrastructural shortcomings (lack of a dedicated triage area, X-ray facilities and emergency theatre, hot lab in the unit, dedicated helipad area and crisis centre), equipment (casualty equipment requires upgrading for 2010), Human Resource (CT-scan 24 hour services not operational due to limited staff, no Radiologist and no Specialist for Internal Medicine).

Referral pathways have been established and are subscribed to by EMRS and Planned Patient Transport (PPT) to ensure seamless service delivery. PPT covers 100% hospital-to-hospital transfers and 47% clinic-to-hospital transport routes.

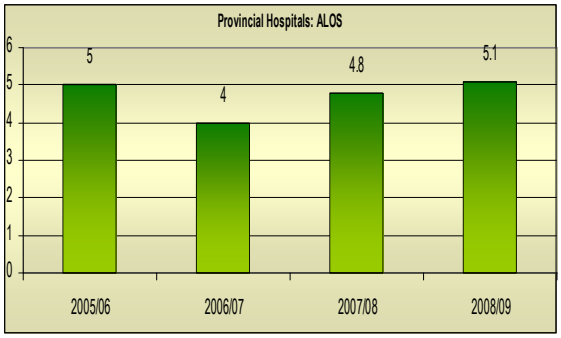
Repatriation of patients after discharge from Provincial Hospitals was still delayed and the Department commenced with the development of a Patient Escort

Policy including PPT and Repatriation Procedures to address the delays. This will be monitored in 2009/10.

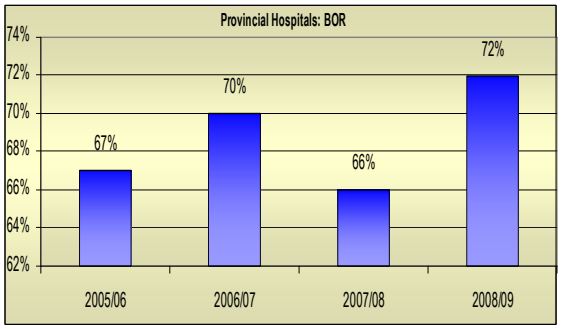
The BOR increased from 66% in 2007/08 to 71.3% in 2008/09 . Although considered an efficiency indicator the increase in the BOR is also ascribed to the lack of public transport and communication which effectively increases cost unnecessarily.

The ALOS increased from 4.8 days in 2007/08 to 5.3 in 2008/09 which exceeds the national target of 4.8 days. The increase in the ALOS can be attributed to the disease profile, insufficient step-down facilities (beds), etc. It is evident that the emerging disease patterns necessitate an urgent re-orientation of health services to expand chronic long-term care while at the same time maintaining the capacity for acute care.

Graph 34: Average Length of Stay – Provincial Hospitals



Graph 35: Bed Occupancy Rate – Provincial Hospitals



Although the Provincial caesarean section rate decreased from 32% in 2007/08 to 31.6% in 2008/09 it still exceeded the National target of 19% which is considered unrealistic taking into consideration the current and emerging disease profile e.g. high HIV prevalence. An in-house research study to determine the reasons for the high caesarean section rate commenced in the 4th quarter of 2008/09 and final results are expected in 2009/10. Results will inform the re-evaluation of services.

The case fatality rate for surgical separations was still a concern although it decreased slightly from 5.8% to 5.6% in 2008/09. The high vacancy rate of Surgical and Anaesthetic Specialists might be a contributing factor, while interpretation of the indicator at facility level still needs to be investigated. According to District Reports, 100% of hospitals conduct morbidity and mortality and clinical audit meetings which should ideally improve quality if linked with quality improvement programmes.

The KwaZulu-Natal Health Act (Act 01 of 2009), promulgated on the 5th of March 2009, regulates the appointment of Hospital Boards. Previously the Boards were appointed on an interim basis and interim structures were not always able to add value to community involvement and communication. Common challenges affecting the effectiveness of Boards include financial constraints affecting attendance of meetings and poor feedback on health status and service delivery. All Boards were not able to serve as an effective link between the community and health services.

Only Addington Hospital currently complies with the standards for implementation of the ICD 10 system. Although other hospitals comply with ICD 10 billing for insured patients, they are not compliant with the requirements for ICD 10 implementation due to inadequate IT infrastructure. Completion of the codes on diseases remains problematic i.e. Medical Practitioners being reluctant to comply with requirements, shortage of computers and universal access to computers by all practitioners. All hospitals have at least one Manual for Codes which is totally insufficient, and the ICD 10 programme on the Departmental Intranet is not easily accessible to all practitioners. ICD 10 training was not conducted in 2008/09 due to insufficient funding as well as incomplete system for ICD 10.

No hospitals were COHSASA accredited in 2008/09. Previously accredited hospitals reported improved quality of care however, compliance has not been adequately monitored to measure improvement in patient care. Documentation on policies and improvement plans are available but implementation requires direct support and monitoring to ensure sustainability.

Preparation for 2010 World Cup

FIFA designated hospitals were identified in 2008/09 and preparation for the 2010 Soccer World Cup commenced in spite of severe financial constraints. Isolation facilities have been identified and assessed, and the Hospital Improvement Plan developed in consultation with the Infrastructure Development Unit. Arrangements were made for Private Hospitals to assist and participate in the planning and implementation of 2010 Hospital Preparedness.

Training needs have been identified and were incorporated in the Skills Development Programme to ensure coordinated needs-based training as well as a comprehensive Provincial database for record purposes. The KwaZulu-Natal College of Nursing commenced with the development of a package for in-service training for nursing personnel to enable Nurse Managers to update employees on basic emergency and disaster procedures. The training package is not aimed at front line employees, but employees that may have to be deployed in case of shortages.

The Department commenced with the Emergency Medicine training programme which focus on ATLS and MIMMS. An integrated working group has been established in partnership with the Military Health Services for training of hospital and EMRS personnel on the handling of chemical and biological warfare. This requires further strengthening.

Staffing norms and equipment needs have been determined, and staffing requirements in designated service areas have been assessed and costed. It is however not clear if there will be adequate funding to realise all these goals. Equipment requirements have been standardised and requirements of each designated hospital has been finalised and costed. Additional procured equipment will be decanted to institutions with the greatest need which will assist with the sustainability of hospital improvements after 2010.

The assessment of accident and emergency units, ICU facilities, theatres and receiving units in target hospitals has been completed and will be re-assessed from January to March 2010. Standardisation is having a positive effect on service delivery as standard equipment and medication lists for hospitals have been finalised thus improving monitoring and compliance to standards.

Disaster plans, in preparation of mass casualties, have been assessed in target hospitals and plans will be updated in 2009/10. The database for accident and emergency facilities has been updated to ensure effective referral of emergency cases. (This includes GIS locations).

! CHALLENGES

- Financial constraints had a huge impact on preparation for 2010. No additional budget was made available for the procurement of equipment, pharmaceuticals or filling of critical vacant posts.
- Severe shortage of medical professionals and professional nurses in Accident and Emergency Units and ICU.
- Inadequate equipment (as per equipment list) or old equipment that needs replacement. Delays in procurement of equipment resulted in delayed delivery as well as increase in cost.
- Port Shepstone Hospital will be near a training camp. This is a major concern as the facility cannot provide adequate care currently. The new wing that will include an accident and emergency care unit may not be completed in time for 2010.

Part B - Programme 4: Provincial Hospital Services

SERVICE DELIVERY INDICATORS

Data completeness: 90%

Table 82: (NHS 3) Quality of Care

Activity	Indicators	2008/09 Targets	2008/09 Progress
Hospital Improvement Plans.	Clinical audits.	Clinical audits routinely monitored in all Provincial Hospitals.	• All hospitals have developed Hospital Improvement Plans according to the National document on the Core Standards for assessment of hospitals. All the plans are aligned to the seven domains and the performance plans. • The Core Document will be used to assess hospitals in future. • District Offices routinely monitor whether clinic audits are undertaken by hospitals.
	Complaints mechanisms.	Complaints mechanisms routinely managed in all Provincial Hospitals.	• Complaints resolved within 25 days.
	Infection Control Audits.	Infection control management in place in all Provincial Hospitals.	• Infection Control measures are in place and implemented in 100% hospitals.
	Telemedicine.	Hub and spoke systems developed in accordance with the STP in all Provincial Hospitals.	• The Telemedicine Plan has not been implemented due to budget restrictions.

Table 83: (PHS 1) Public Hospitals by Hospital Type

Hospital Type	Number of Hospitals	Number of Beds	Beds per 1,000 Uninsured People		
			Provincial Average	Highest District	Lowest District
District Hospitals.	41	8,708	0.9/1000	Umzinyathi 2.6/1000	Amajuba 0.12/1000
Provincial Hospitals.	12	7,145	0.9/1000	Amajuba 28/1000	0.4/1000 - Ugu
Tertiary and Central Hospitals.	4	1,106	0.2/1000	Uthungulu 0.97/1000	eThekwini
Sub-Total: Acute Hospitals	57	17,959	1.9/1000		
Tuberculosis.	10	2,248	0.25/1000[152]	Umgungundlovu 0.75/1000	0.04/1000 - Uthukela
Specialised Psychiatric.	5	2,839	0.32/1000[153]	Umgungundlovu 1.65/1000	0.05/1000 - Zululand
Other Specialist.	2	633	0.07/1000	0.07/1000 - eThekwini	
Total Public	75	23,723	-		
Private Sector (including Step-Down).	40	3,381	0.002/1000		

[152] Includes all hospitals that provide Specialised TB, TB MDR, TB XDR and step down beds are included
[153] Ratio's do not include Districts that do not have Specialised Psychiatric beds

Table 84: (PHS 4) Provincial Objectives and Performance Indicators for Provincial Hospitals

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Strategic Objective: To improve Clinical Governance including quality of care and Infection Prevention and Control.					
Measurable Objective: To ensure that all Regional Hospitals provide quality health care to all patients based on the defined package of service as prescribed in the STP.					
1. Caesarean section rate.	35%	34%	32% 22,505	31%	31.6%
2. Average length of stay.	5 Days	4 Days	4.8 Days	4.1 Days	5.3 Days
3. Bed utilisation rate.	67%	70%	66%	72%	71.3%
4. Case fatality rate for surgical separations.	4.2%	*5.1% 6,355	5.8% 5,942	5%	5.6% 5,683
Measurable Objective: To develop and implement a framework to improve clinical governance at all Health Facilities.					
5. Percentage of Hospitals conducting morbidity & mortality meetings every month.	40%	74%	43% (5)	100%	93%
Measurable Objective: To guide and assess the implementation of Infection Prevention and Control.					
6. Percentage of Hospitals conducting monthly clinical audit meetings.	100%	100%	75% (9)	100%	93%
7. Percentage of Hospitals implementing the Infection Prevention & Control Policy.	Not measured	80%	80%	100%	100%
Measurable Objective: To guide and assess health services against norms and standards of the Quality Improvement Plan.					
8. Percentage Hospitals implementing the Integrated Quality Assurance Tool.	Not measured	Not measured	100%	100%	100%

Table 85: (PHS 5) Performance Indicators for Provincial Hospitals

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Output					
1. Caesarean section rate.	35%	34%	32%	31%	31.6%
2. Separations - total.	288,610	372,597	351,169[154]	382,000	355,778
3. Patient day equivalents.	2,210,171	2,783,246	2,663,297	3,059,425	2,797,350
4. OPD total headcounts.	2,392,992	3,074,707	2,702,113	3,385,000	2,752,678
Quality					
5. Percentage Hospitals with a Patient Satisfaction Survey using the DOH template.	88%	100%	57% (8)	100%	78%
6. Percentage Hospitals conducting morbidity and mortality meetings every month.	40%	74%	43% (5)	100%	93%
7. Percentage Hospitals conducting clinical audit meetings every month.	100%	100%	75% (9)	100%	93%
8. Complaints resolved within 25 days.	Not collected	Not collected	Not collected	100%	59%

[154] Data is lower than previous year due to Ngwelezana being included under Tertiary Hospitals

Part B - Programme 4: Provincial Hospital Services

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Efficiency					
9. Average length of stay.	5 Days	4 Days	4.8 Days	4.1 Days	5.3 Days
10. Bed utilisation rate (based on usable beds).	67%	70%	66%	72%	71.3%
11. Expenditure per patient day equivalent.	Not available	R 748	R 1,119	R 1,128	R 1,175
Outcome					
12. Case fatality rate for surgery separations.	4.2%	6.4%	5.8% 3,120	5%	5.6%

Table 86: (PHS 3) Situation Analysis Indicators for Provincial Hospitals per Health District - 2008/09

Indicator	eThekwini	Ugu	Umgungundlovu	Amajuba	Uthungulu	Ilembe	Uthukela
Output							
1. Caesarean section rate. (%)	32%	43%	36%	21%	39%	28%	20%
2. Separations - total. (No)	164,327	15,430	52,179	42,502	37,025	26,157	25,674
3. Patient day equivalents. (No)	1,378,659	195,525	264,329	290,384	252,005	201,061	199,243
4. OPD total headcounts. (No)	1,468,733	260,816	352,535	103,452	168,863	138,670	229,297
Quality							
5. Percentage Hospitals with a patient satisfaction survey using the DOH template.[155] (%)	0%	100%	100%	100%	100%	100%	0%
6. Percentage Hospitals conducting mortality and morbidity meetings every month.[156] (%)	100%	100%	100%	100%	100%	100%	100%
7. Percentage Hospitals with clinical audit meetings every month.[157] (%)	33%	100%	100%	100%	100%	100%	100%
8. Complaints resolved within 25 days. (%)	90%	71%	81%	0%	47%	86%	66%
Efficiency							
9. Average length of stay. (Days)	4.9 Days	6.5 Days	4.6 Days	5.9 Days	5.3 Days	5.5 Days	4.5 Days
10. Bed utilisation rate (based on usable beds). (%)	78%	83%	76%	51%	73%	78%	71%
11. Expenditure per patient day equivalent. (R) [158]	R 1,268	R 1,271	R 1,202	R 2,685	R 2,125	R 876	R 1,124

[155] This is a Head office initiative. Due to delays by SCM to award the tender, the survey was not conducted
[156] These are meetings to discuss all deaths at facilities (avoidable and unavoidable)
[157] These are meetings to discuss clinical audits for specific disciplines in relation to morbidity & mortality, disease surveillance, nursing/patient audits and disease specific conditions
[158] Cost per PDE quoted from the District Reports

Indicator	eThekwini	Ugu	Umgungundlovu	Amajuba	Uthungulu	Ilembe	Uthukela
Outcome							
12. Case fatality rate for surgery separations. (%)	6.3%	6.3%	6.1%	3.1%	4.2%	4%	4%

Map 19: KwaZulu-Natal Regional and Specialised Hospitals

Map illustrates the spatial location of Provincial (Regional), Tertiary, Central and Specialised Hospitals in KwaZulu-Natal.

PROGRAMME 5:

TERTIARY & CENTRAL HOSPITAL SERVICES

Part B – Programme 5: Tertiary & Central Hospital Services

TABLE OF CONTENTS

PROGRAMME DESCRIPTION

Rendering quaternary and other Tertiary health services

PROGRAMME STRUCTURE

Sub-Programme 5.1

Rendering of Central and Quaternary Hospital services

Sub-Programme 5.2

Rendering Tertiary Hospital Services

PROGRAMME 5: TERTIARY & CENTRAL HOSPITALS

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities 2006-2008/09

Priority 3: Contribute towards human dignity by improving quality of care.

Priority 5: Strengthen PHC, EMS and hospital delivery systems.

↓

Provincial Strategic Plan 2005-2009/10

Goal 2: Strengthen PHC and provide caring, responsive and quality health services at all levels.

↓

Annual Performance Plan 2008/09

Goal 1

Strategic Objective 2: To improve clinical governance including quality of care and infection prevention and control.

↓

Tertiary & Central Hospital Priorities 2008/09

1. Strengthen Tertiary services.
2. Define Tertiary package of services.
3. Conduct an audit of existing Tertiary services.
4. Utilisation of Conditional Grant - development and monitoring of the Business Plan.
5. Develop a service delivery platform for Tertiary services.

Inkosi Albert Luthuli Central Hospital, located in Durban eThekwini, is rendering Central Hospital services to the Province.

Greys Hospital is rendering 80% Tertiary services, Ngwelezane Hospital 33% Tertiary and Lower Umfolozi War Memorial Hospital 37% Tertiary services.

EXECUTIVE SUMMARY

There are four (4) designated Tertiary Hospitals in the Province providing highly specialised care to a total population of 9,426,003 (2001 census) and 8,294,895 uninsured population. These hospitals, with the exception of Inkosi Albert Luthuli Central Hospital (IALCH), also provide some Level 2 (Provincial) and Level 1 (District) services as indicated below.

- Inkosi Albert Luthuli Central Hospital in eThekwini - 100% Tertiary package of services.
- Greys Hospital in Pietermaritzburg - 80% Tertiary and 20% Provincial package of services.
- Ngwelezane Hospital in Empangeni - 33% Tertiary, 42% Provincial and 25% District package of services.
- Lower Umfolozi War Memorial Hospital in Empangeni - 37% Tertiary, 36% Regional and 27% District package of services.

The Province is divided into three service delivery areas, and the intention is to provide a tertiary service in each area. Ngwelezane and Lower Umfolozi War Memorial Hospitals are in the early stages of development as tertiary services with the greatest obstacles to the development of the services related to inadequate infrastructure. Current infrastructure does not allow for further expansion of services which has forced the Province to consider building a new Tertiary Hospital in the area (Area 3).

Provision of three levels of care in these institutions complicates service delivery. In addition to providing specialist services, Ngwelezane Hospital is also responsible for the clinical and non-clinical support of all Primary Health Care services in the catchment area of the District Hospital component of the hospital. A new Tertiary Hospital would allow unbundling of this very complex configuration of services in one institution.

Greys Hospital has progressed well in establishing tertiary services and establishing outreach services in the five districts served by the hospital. Specialists in the major disciplines travel to lower levels of services throughout the area where they run specialist clinics and participate in clinical auditing and teaching activities at the lower level institutions. The outreach services have enhanced the referral systems in the area by supporting the creation of a seamless system of service delivery.

Access to specialist services at IALCH remains a challenge that must be addressed urgently. Limitations placed on access to services, by the Public Private Partnership, are creating severe backlogs in particular disciplines.

The process of revitalising Oncology Services in the Province was moved to eThekwini. Procurement of equipment that will be placed at Addington Hospital and eventually moved to the revitalised King Edward VIII Hospital has advanced well. Development of discipline specific service packages for each area is progressing, but progress is being slowed down by financial constraints and serious deterioration of infrastructure at King Edward VIII Hospital.

Tables 88 and 89 highlight some important measures of hospital efficiency compared with national norms. The caesarian section rates are still exceeding national targets by far. An in-house study on high caesarean section rates commenced in 2008/09 and results are expected in 2009/10 to inform review of policies and strategies.

The average length of stay continues to exceed the national target and might be due to the burden of disease. These inefficiencies clearly contributed to the current financial crisis and must be addressed urgently.

The cost per patient day equivalent in both hospitals is far above national targets. These costs point to serious inefficiencies in the systems at these hospitals.

Table 87: Efficiency Indicators - Greys Hospital

Indicator	2007/08	2008/09	National Norm
Average length of stay	10 days	9,9 days	5.3 days
Bed occupancy rate	76%	70.5%	75%
Caesarean section rate	61%	45.4%	25%
Cost per patient day equivalent	R 1,899[159]	R 2,292[160]	R 1,877

[159] Submitted by Hospital
[160] Submitted by Hospital

Table 88: Efficiency Indicators - Inkosi Albert Luthuli Central Hospital

Indicator	2007/08	2008/09	National Norm
Average length of stay	9,5 days	8,8 days	5,3 days
Bed occupancy rate	42%	62.8%	75%
Caesarean section rate	78%	81.5%	25%
Cost per patient day equivalent	R 5,300	R 6,307[161]	R 1,877

POLICIES

The KwaZulu-Natal Provincial Health Act was enacted in 2008/09. The Act provides the legal framework and will enhance the development and delivery of health services in the Province and there is no doubt that the new legislation will be an important milestone in the development of Health Services in KwaZulu-Natal.

The Act makes provision for the establishment of an Inspectorate of Health Establishments which will make an important contribution to improving monitoring and evaluation of all aspects of service delivery at all levels of care.

A number of policies relevant to hospital services have been drafted and will be considered for approval by the new administration.

[161] Submitted by Hospital

Table 89: Acts, Policies, Protocols and Guidelines

New Acts, Policies, Protocols & Guidelines	Comments
1. Hospital Governance Policy.	• Policy fully implemented in all 4 Tertiary Hospitals. Governance structures are fully functional and meetings are held as prescribed. The policy is monitored quarterly and will be reviewed annually.
2. Tertiary Services Definitions Policy.	• A Provincial Project Team completed the Policy which is benchmarked by the National Department of Health. • This document is accessible on the Provincial website for ease of reference. • Tertiary Institutions are utilising the Policy to define the package of services and to complete commissioning of tertiary services.
3. Tertiary Services Performance Indicators.	• Performance indicators have been developed to ensure objective measuring of performance in the Tertiary Hospitals.
4. National Tertiary Services Grant Business Plan (NTSG).	• The NTSG Business Plan was designed in consultation with Tertiary Hospital Management teams and aligned to service needs. • The reporting process occurs quarterly between Tertiary Hospitals, Provincial Programme Manager and the National Department of Health.

PROGRAMME PERFORMANCE

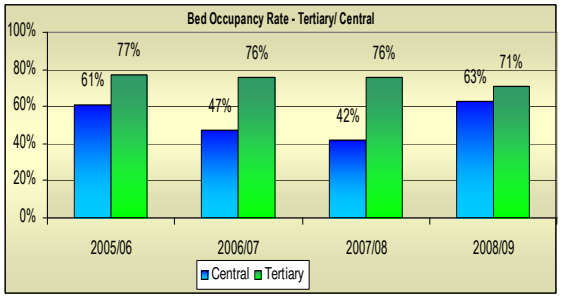
Budgetary constraints severely affected service delivery and planning in 2008/09 with the filling of critical posts, rendering of the package of services, etc. having a major impact on maintaining service delivery standards. Planning for the separation of levels of care (service package) has to begin as a matter of urgency. The Province has progressed in reaching agreement on packages of care and referral criteria, however further discussion is necessary especially with consideration of the current financial envelope. Discussion on the package of diagnostic procedures appropriate to each level requires urgent attention.

Improving efficiency in all spheres of operation and strengthening clinical governance are critical objectives that will guide most efforts to improve the quality of care, outcomes and impact of services provided by Central/ Tertiary Hospitals over the next 5 years.

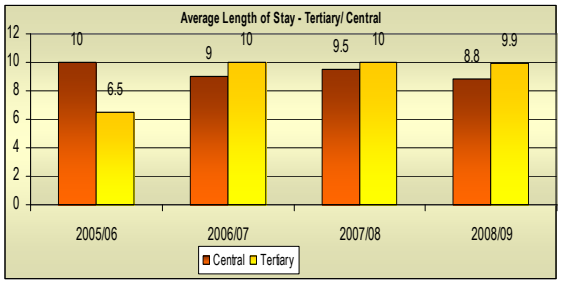
Patient day equivalents decreased from 687,403 in 2007/08 to 657,084 in 2008/09 and the OPD headcounts slightly increased from 533,110 in 2007/08 to 537,913 in 2008/09. The bed occupancy rates in ILACH increased significantly while Greys Hospital reported a slight decrease. The average length of stay decreased slightly in both Tertiary and Central Hospitals.

The case fatality rates for surgery separations were still unacceptably high especially in Ngwelezana/ LUWM and Greys Hospitals (5.8%) with a slight decrease in IALCH (3.2%).

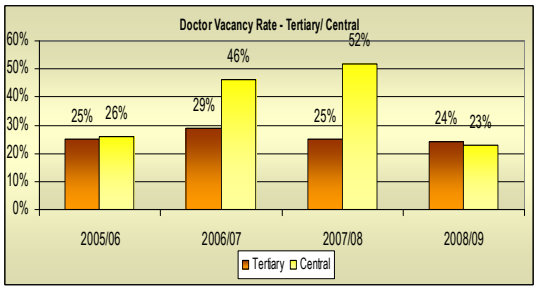
Graph 36: Bed Occupancy Rates - Tertiary and Central Hospitals



Graph 37: Average Length of Stay – Tertiary and Central Hospitals



Graph 38: Doctor Vacancy Rate – Tertiary and Central Hospitals



⇒ PRIORITY 1: STRENGTHEN TERTIARY HOSPITAL SERVICES

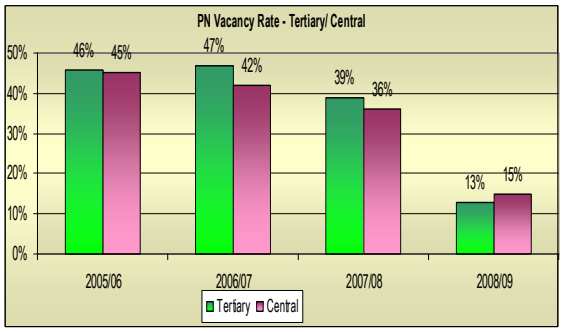
The organisational structures for Tertiary Hospitals have not been finalised except for IALCH. This impacted negatively on budget allocation and the filling of posts, as critical staff appointments were being motivated for on an individual basis depending on service priority needs. Appointment of specialist staff has been delayed due to financial constraints and expansion of services had to be curtailed as per directive of the Acting Head of Department due to over expenditure in the Department. The Human Resource expenditure varied between 70% - 75% of the total budget amongst the 4 Tertiary Hospitals.

High vacancy rates and concomitant skills gaps severely affected service delivery and costs. Expansion of services, as necessitated by the increased burden of disease, has not been possible as a result of inadequate financial and human resources. Failure to develop services will have an impact on eventual long-term cost as well as ability to respond appropriately to the health needs of beneficiaries in the Province.

The following 2 graphs reflect the vacancy rates for Medical Officers and Professional Nurses in Tertiary and Central Hospitals. The graphs do not reflect vacancies for Specialists which should however be monitored as level 3 services are dependent on adequate numbers of specialised professionals.

The drop in the 2008/09 vacancy rates (compared to 2007/08) is due to the abolishment of unfunded vacant posts on Persal at the end of July 2008 as per KZN Cabinet instruction.

Graph 39: Professional Nurse Vacancy Rate - Tertiary and Central Hospitals



Medical & Allied equipment, ICU (neonatal, paediatric, adult and anaesthetic) and radiology and oncology equipment had been prioritised during 2008/09 especially in sub-disciplines. Telemedicine and equipment used by visiting specialists enhanced the skills and competencies of Medical Officers, Community Service Doctors, Registrars and Generalist Doctors in Provincial Hospitals, which is in line with the aim to ensure that patients in rural and peripheral areas receive equal access to medical treatment and care.

The cost of medicines increased in 2008/09 due to the increased number of prescriptions per patient as a result of co-morbidities. The timeous prescription of non-EDL medication proved to be more effective and decreased patient waiting times.

⇒ PRIORITY 2: DEFINE THE TERTIARY PACKAGE OF SERVICES

Although progress has been made with defining the packages of care, referral criteria and package of diagnostic procedures appropriate to each level of care, further consultation is necessary to accommodate existing

challenges with implementation and sustained service delivery.

Due to inadequate capacity and resources, all Tertiary Hospitals continue to render additional provincial and district level services i.e. Greys Hospital 20% Provincial services, Ngwelezana Hospital 42% Regional and 25% District services and Lower Umfolozi War Memorial Hospital 36% Regional and 27% District services.

Costing of these services is still a challenge and impacts on planning, budget allocation and expenditure.

⇒ PRIORITY 3: CONDUCT AN AUDIT OF EXISTING TERTIARY SERVICES

The audit on Tertiary services was not conducted in 2008/09 due to inadequate resources. This will be pursued in 2009/10 pending availability of resources. The audit will inform decision-making and planning. A study has been completed to assess value for money at Inkosi Albert Luthuli Central Hospital. The findings will guide decisions regarding management of the PPP contract.

⇒ PRIORITY 4: CONDITIONAL GRANT - DEVELOPMENT, UTILISATION AND MONITORING OF THE BUSINESS PLAN

Strategic and Operational Plans for Tertiary services were developed and implemented in 2008/09. The National Tertiary Services Grant (NTSG) allocations were: IALCH: R 541,978.20 (60%); Greys Hospital: R 270,989.10 (30%); and Ngwelezana Hospital: R 90,329.70 (10%). The budget was fully utilised.

The appointment of specialist staff was delayed due to the moratorium on the filling of posts and the expansion of services had to be curtailed as per directive of the Acting Head of Department as a result of over-expenditure in the Department.

Telemedicine and equipment used by visiting specialists enhanced the skills and competencies of Medical Officers, Community Service Doctors, Registrars and Generalist Doctors in Provincial Hospitals.

⇒ PRIORITY 5: DEVELOP A SERVICE DELIVERY PLATFORM FOR TERTIARY SERVICES

Layered service delivery (providing limited Tertiary services at Provincial Hospitals) offers the highest level of access to health care as patients can walk in with appropriate referral. Benefits of these services are that patients are diagnosed earlier due to better diagnostics measurements and effective treatment can thus delay the onset of complications. The *MTS Model A* makes provision for sufficient funds and skills to deepen specialist services at Provincial Hospitals with consequential fewer tertiary institutions required to render services.

! CHALLENGES

- The functioning of all systems related to service delivery suffered severely as a result of the extreme financial crisis in the Department. Services have not been cut, but they are severely under-resourced in terms of personnel, equipment and supplies. Inefficiencies in supply chain management are adding to shortages of resources.
- The Service Transformation Plan has not been signed off and is not yet implemented as envisaged in 2008/09. This has become a serious obstacle in effective planning and development of the hospital sector as a whole.

Part B - Programme 5: Tertiary & Central Hospital Services

SERVICE DELIVERY INDICATORS

Data completeness: 95%

Table 90: (CHS 1) Number of Beds in Tertiary/ Central Hospitals

Hospital	Medical Beds	Surgical Beds	Maternity Beds	Paediatric Beds	Orthopaedic Beds	Gynaecology Beds	High Care/ ICU Beds	Specialised Psychiatric Beds
Inkosi Albert Luthuli Central Hospital	208	302	64	217	0	0	74	0
Grey's Hospital	99	140	80	94	54	22	5	0

Table 91: (CHS 2) Performance Indicators for Tertiary Hospitals [162]

Indicator	2005/06 Actual[163]	2006/07 Actual[164]	2007/08 Actual[165]	2008/09 Target	2008/09 Actual
Output					
1. Caesarean section rate.	73%	67%	61%(1,204)	55%	45.4%
2. Separations - total.	15,486	12,305	12,049	12,650	52,117
3. Patient day equivalents.	139,844	189,402	193,913	202,524	459,149
4. OPD total headcounts.	178,493	181,595	196,857	207,314	441,012
Quality					
5. Patient Satisfaction Survey completed.[166]	0	0	Yes (100%)	100%	Yes (100%)
6. Morbidity and mortality meetings conducted at least once a month.	Yes	Yes	Yes Quarterly	100%	Yes Quarterly
7. Clinical audit meetings conducted at least once a month.	Yes	Yes	Yes Quarterly	100%	Yes Quarterly
8. Complaints resolved within 25 days.[167]	Not collected	Not collected	Not collected	100%	100%
Efficiency					
9. Average length of stay.	6.53 Days	10 Days	10 Days	5.5 days	6.1 Days
10. Bed utilisation rate.	77%	76.4%	76%	85%	70.5%
11. Expenditure per patient day equivalent.	R 1,273	R 1,336	R 1,899*	R 1,472	R 2,947
Outcome					
12. Case fatality rate for surgery separations.	Not collected	7%	6.6% (258)	6%	5.8%

[162] This includes Grey's, Lower Umfolozi War Memorial and Ngwelezane Hospitals
[163] The figures for 2005/06 Actual are for Grey's Hospital only
[164] The figures for 2006/07 Actual are for Grey's Hospital only
[165] The figures for 2007/08 Actual are for Grey's Hospital only
[166] SCM delays in award of tender resulted in survey not completed in 2006/07 and 2007/08
[167] New Indicator added for 2008/09. The Department has reported against this indicator as being 60 days until MTEF 2007/08. As from MTEF 2008/09 the Department will report against this indicator as being 25 days

Table 92: (CHS 2) Performance Indicators for Inkosi Albert Luthuli Hospital

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Output					
1. Caesarean section rate.	74%	79%	78% (318)	75%	81.5%
2. Separations - total.	14,733	17,522	14,405	17,500	20,886
3. Patient day equivalents.	191,673	157,954	190,245	160,000	242,334
4. OPD total headcounts.	145,768	154,072	159,459	158,000	174,704
Quality					
5. Patient Satisfaction Survey completed.[168]	Yes	No	No	Yes	Yes
6. Morbidity and mortality meetings conducted at least once a month.	Quarterly	Quarterly	Quarterly	100%	Yes (100%)
7. Clinical audit meetings conducted at least once a month.	Quarterly	Quarterly	Quarterly	100%	Yes (100%)
8. Complaints resolved within 25 days.[169]	Not available	Not available	100%	100%	100%
Efficiency					
9. Average length of stay.	10 Days	9 Days	9.5 Days	8 Days	8.8 Days
10. Bed utilisation rate.	61%	47%	42%	48%	62.8%
11. Expenditure per patient day equivalent.	R 3,855	R 2,230	R 5,300	R 3,286	R6,3077
Outcome					
12. Case fatality rate for surgery separations.	6%	6%	4.5%	4%	3.2%

Table 93: (NHS) Performance Indicators

Activity	Indicators	2008/09 Target	2008/09 Progress
Hospital Improvement Plans.	Clinical Audits.	Clinical audits routinely monitored in all Tertiary and Central Hospitals.	• Quarterly Clinical Audit meetings are conducted in Tertiary & Central Hospitals.
	Complaints Mechanisms.	Complaints mechanisms routinely managed in all Tertiary and Central Hospitals.	• Complaints mechanism routinely managed and monitored at Tertiary and Central Hospitals.
	Infection Control.	Infection control management effected in all Tertiary and Central Hospitals.	• 100% Hospitals are implementing the Infection Prevention and Control Policy.
	Telemedicine.	Hub and spoke system developed in accordance with the STP.	• Telemedicine Plan not implemented due to financial constraints.

[168] SCM delays in award of tender resulted in survey not completed in 2006/07 and 2007/08
[169] New Indicator added for 2008/09. The Department has reported against this Indicator as being 60 days until MTEF 2007/08. As from MTEF 2008/09 the Department will report against this Indicator as being 25 days

Table 94: (CHS 3) Provincial Objectives and Performance Indicators for Tertiary and Central Hospitals

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Strategic Objective: To improve Clinical Governance including quality of care and Infection Prevention and Control.					
Measurable Objective: To ensure that all Central and Tertiary Hospitals provide quality care to all patients based on the defined package of services in the STP.					
1. Caesarean section rate.	T: 73%	T: 67%	T: 61%	T: 35%	T: 45.4%
	C: 74%	C: 79%	C: 78%	C: 75%	C: 81.5%
2. Average length of stay.	T: 6.53 Days	T: 10 Days	T: 10 Days	T: 8 Days	T: 6.1 Days
	C: 10 Days	C: 9 Days	C: 9.5 Days	C: 8 Days	C: 8.8 Days
3. Bed utilisation rate.	T: 77%	T: 76.4%	T: 76%	T: 82%	T: 70.5%
	C: 61%	C: 47%	C: 42%	C: 70%[170]	C: 62.8%
4. Case fatality rate.	T: 5.2%	T: 7%	T: 6.6%	T: 6%	T: 5,8%
	C: 6%	C: 6%	C: 4.5%	C: 4%	C: 3.2%
Measurable Objective: To guide and assess the implementation of Infection Prevention and Control.					
5. Implementing the Infection Prevention and Control Policy.	T: Not collected	T: Yes	T: Yes	T: 2 hospitals	T: Yes
	C: Not collected	C: Yes	C: Yes	C: 1 hospital	C: Yes
6. Conducting monthly clinical audit meetings.	T: Quarterly	T: Quarterly	T: Quarterly	T: 2 hospitals	T: Yes
	C: Quarterly	C: Quarterly	C: Quarterly	C: 1 hospital	C: Yes
Measurable Objective: To develop and implement a framework to improve clinical governance at all health facilities.					
7. Implementing strategies to reduce preventable causes of morbidity and mortality (emanating from morbidity and mortality meetings).	T: Not collected	T: Yes	T: Yes	T: 1 hospital	T: Yes
	C: Not collected	C: Yes	C: Yes	C: 1 hospital	C: Yes

T = Tertiary Hospitals

C = Central Hospitals

Table 95: Performance Indicators for all Central/ Tertiary Hospitals

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Actual	2008/09 Target
INKOSI ALBERT LUTHULI CENTRAL HOSPITAL					
1. Expenditure on hospital staff as % of hospital expenditure.	27.93%	27.82%	35.33%	33.54%	43.47%
2. Expenditure on drugs for hospital use as % of hospital expenditure.	3.86%	4.20%	6.81%	5.64%	5.63%
GREY'S HOSPITAL					
3. Expenditure on hospital staff as % of hospital expenditure.	64.96%	60.22%	58.91%	63.15%	63.62%

[170] The bed occupancy rate for IALH is very low. However the caesarean section rate is very high. The hospital will urgently review the situation and implement measures to improve the occupancy rate/validate if the data is correct during MTEF 2008/09 in order to meet the required target

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Actual	2008/09 Target
4. Expenditure on drugs for hospital use as % of hospital expenditure.	9.21%	9.36%	7.98%	6.79%	6.13%
NGWLEZANE HOSPITAL					
5. Expenditure on hospital staff as % of hospital expenditure.	Not available	76.87%	54.05%	62.02%	89.48%
6. Expenditure on drugs for hospital use as % of hospital expenditure.	Not available	3.75%	Not available	17.95%	11.00%
LOWER UMFOLOZI WAR MEMORIAL HOSPITAL					
7. Expenditure on hospital staff as % of hospital expenditure.	Not available	59.20%	47.08%	51.86%	54.78%
8. Expenditure on drugs for hospital use as % of hospital expenditure.	Not available	11%	8.62%	6.43%	2.42%

NOTES

PROGRAMME 6:

HEALTH SCIENCES AND TRAINING

Part B – Programme 6: Health Sciences & Training

TABLE OF CONTENTS

The provisioning of training and development opportunities for existing and potential employees of the Department

PROGRAMME STRUCTURE

Sub-Programme 6.1
Nurse Training College
Training of Nurses at both undergraduate and postgraduate level

Sub-Programme 6.2
EMRS Training College
Training of Emergency Care Practitioners

Sub-Programme 6.3
Bursaries
Provision of bursaries for students studying in health science programmes at undergraduate levels

Sub-Programme 6.4
PHC Training
Provision of PHC related training for Professional Nurses working in a PHC setting

Sub-Programme 6.5
Training (Other)
Provision of skills development interventions for all occupational categories

PROGRAMME 6: HEALTH SCIENCE AND TRAINING

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities 2006/07 - 2008/09

Priority 7: Human resource planning, development and management.

↓

Provincial Strategic Plan 2005 - 2009/10

Goal 4: Human Resource Management for Public Health

↓

Annual Performance Plan 2008/09

Goal 1

Strategic Objective 14: To align Human Resource Planning and consolidate Human Resource Management Services (HRMS) Reports

Goal 3

Strategic Objective 1: To sustain and expand the health workforce through implementation of innovative Human Resources Management strategies.

Strategic Objective 11: To implement performance management and coaching programmes

Strategic Objective 12: To design and implement a seamless quality service delivery system for the Department.

↓

Health Science & Training Priorities 2008/09

1. Effective recruitment and placement of graduating nurses.
2. Develop and implement an effective recruitment and retention strategy to halt migration of staff.
3. Align human resource demand and supply in targeted occupational categories.
4. Increase the number of nurses trained in the Province.
5. Increase the number of nurses trained by the Province.
6. Effective recruitment and placement of graduating bursary holders.
7. Strengthen the training of post graduate PHC nurses.
8. Develop skills and competencies of middle management through talent management and mentoring.

Nurses' graduation

EXECUTIVE SUMMARY

The doubling of nurse training commenced in 2002 on instruction from the National Department of Health (NDOH) with the KwaZulu-Natal College of Nursing (KZNCN) producing a sustainable average output of 1,200 nurses per annum.

There is a shortage of Professional Nurses (PN's) in KwaZulu-Natal (KZN) as indicated in the Human Resource Plan. During 2008/09, a total of 399 nursing students completed their bridging course from Staff Nurse to Professional Nurse and a further 419 Professional Nurses qualified during the same reporting period bringing the total of Professional Nurses trained by the KwaZulu-Natal Department of Health to 818. The number of post basic nursing graduates remained constant at 427 with 192 post graduate PHC nurses trained.

The KwaZulu-Natal Department of Health awarded a total of 708 bursaries of which 412 were for medical students and the remaining 296 for related studies excluding nursing. The Cuban Exchange Programme is progressing well, with 31 KZN students currently studying in Cuba, 17 are completing their final year at a local South African tertiary institution with 69 KZN students having completed the Cuban Programme.

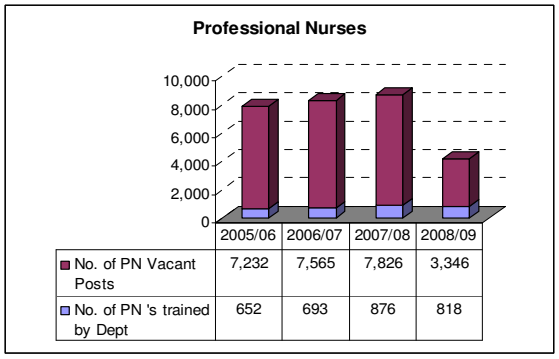
The Adult Basic Education and Training (ABET) Programme contract with Vega Business Services expired with ABET tutors being appointed and 200 ABET learnerships commencing in January 2009. The Health and Welfare Sector Education and Training Association (HWSETA) issued 5 learnerships for this reporting period, with Presidential Emergency Plan for AIDS Relief (PEPFAR) funding the Pharmacy Assistants training which commenced in January 2008. Fifteen PHC nursing learnerships started at Prince Mshiyeni Memorial Hospital in September 2008. The Auxiliary Nursing Learnerships which commenced in April 2009 were concluded in March 2009. The Youth Ambassador Programme has been implemented although a few challenges were experienced.

PERFORMANCE

Multiple post establishments and out-of-adjustments reflect an inflated structure and incorrect vacancy rate. The results of which is evident in the 2008/09 data indicating that vacancy rates for Professional Nurses' has decreased by 4,480 posts. The vacancy rate, especially with regards to Professional Nurses and Medical Practitioners (MP's), has often been cited as the reason for failure and/or lack of service delivery. Although this is valid, the Department should investigate other contributory factors such as distribution and placement of staff, the geographical location of services and the package of health services offered by the clinics in relation to the needs of the community that they serve.

The main function of the KZNCN and the Human Resource Development Units is to identify the employment and training gaps/ needs in the critical health professions occupations and ensure that these demands are met. KZNCN has steadily increased the production of Professional Nurses from 652 in 2005/06 to 818 in 2008/09, an increase of 25% in the past 4 years. The number of Professional Nurse's posts vacant within the Department in 2005/06 has decreased from 7,232 to 3,346 in 2008/09 due to the clean-up of Persal data that occurred during the reporting period. Data therefore indicates that in 2005/06 the KZNCN was only meeting 9% of the Department's requirements for Professional Nurses compared with 2008/09 when it escalated to 24.4%.

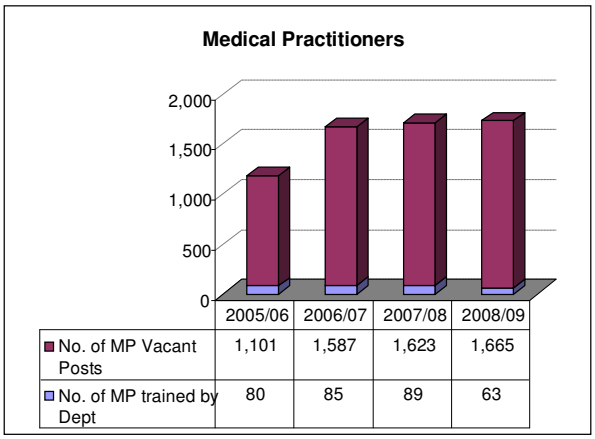
Graph 40: Number of Professional Nurses trained by the KZNCN versus the number of vacant Professional Nurse Posts



In 2005/06 there were 1,101 vacant Medical Practitioner posts compared with 1,665 in 2008/09. In 2005/06, 80 Medical Practitioners were trained decreasing to 63 in 2008/09. Of concern is that fewer doctors are graduating through the Department of Health's bursary system. Currently, approximately 1,200 Medical Practitioners graduate annually throughout South Africa with a large proportion of graduates emigrating, leaving a huge shortfall in the public sector.

An earlier study by Johnson L indicated that a third of Medical Practitioners graduating through the KZN bursary programme renegade on their bursary obligations choosing to repay their commitments in monetary value and not in time served. Should this same apply for the 2008/09 reporting period, 19 graduating bursary holders will default leaving 44 bursary graduates to enter the public sector, a shortfall of 1,621.

Graph 41: Medical Practitioner vacancies versus the Number of Medical Practitioners graduating through the KZN DOH Bursary Programme



	2005/06	2006/07	2007/08	2008/09
No. of MP Vacant Posts	1,101	1,587	1,623	1,665
No. of MP trained by Dept	80	85	89	63

Due to overspending and consequent cost saving measures all short and long-term training has been cancelled for the reporting period. Although the direct impact of this lack of training has not been measured, it can be assumed that the lack of training, linked with high vacancy rates and consequent skills gaps, will have a profound impact on service delivery and quality. The value of ongoing training and support is evident in the Umzinyathi District where training and support for MDR and XDR TB has been up-scaled and sustained in 2008/09. *See Programme 2: Tuberculosis*

To improve monitoring and evaluation (M&E) post training, a standard set of M&E indicators (developed by the National Department of Health with the relevant SETA's) will be implemented to inform decision-making. The lack of an effective province-wide system for the identification of training needs and related training programmes impact on value added (input versus output/ outcome) and will be reviewed to make provision for needs-based training as opposed to pre-determined training schedules. The alignment of the Human Resource and District Health Plans will create the opportunity to identify training needs based on service delivery imperatives.

⇒ PRIORITY 1: EFFECTIVE RECRUITMENT AND PLACEMENT OF GRADUATING NURSES

The recruitment of student nurses is faced with various challenges i.e. applicants falsifying addresses or information, lack of accommodation at institutions, unsuitable candidates enrolling due to an ineffective screening programme, and the increased burden of disease impacting on the resource pool.

The high unemployment rate contributes towards an increasing number of 'unsuitable' applicants applying for student nursing posts as remuneration is received whilst studying unlike in the private sector. More effective screening programmes, verification of qualifications as well as medical screening has been instituted to address the challenges.

! CHALLENGES

- Verification of addresses is complex and remains a challenge. *It is intended that the voter role will be used to verify addresses.*
- The new Housing Policy at institutions does not prioritise student nurses - leading to an increase in absenteeism and learners being exposed to crime. Lack of accommodation for lecturers is a serious challenge that is impacting on recruitment and retention especially in the rural areas.
- The burden of disease resulted in an increase in sick leave taken which negatively impacted on students meeting their training requirements of 80% clinical and academic attendance.
- A decrease in white applications for nursing training and the fact that many rural sub/campuses train mainly black nurses leads to a skewed equity profile provincially.

⇒ PRIORITY 2: INCREASE THE NUMBER OF NURSES TRAINED BY THE PROVINCE

The production of nurses is critical to the effectiveness of the public health system. Evidence from a study conducted by the Trade Union Solidarity[171] indicated that nursing is a "dying" profession with only 3% of nurses under the age of 30 years and 40% 50 years and older.

[171] Article appeared in the Sowetan on 12 may 2009 entitled "The Nursing Profession is dying"

In 2008, the KZNCN produced the largest number of Enrolled Nurses (EN's) and post-registration courses nationally and was equal to Gauteng in the training of Professional Nurses. Three (3) new campuses will produce an additional 50 Professional Nurses in July 2009.

KZNCN planned to increase lecturer posts to include clinical mentoring and teaching and for that purpose additional funds have been requested to create and fill the required posts. Due to financial constraints in the Department, this could not be pursued in 2008/09.

! CHALLENGE

- The funding and filling of clinical mentoring lecturer posts to ensure that standards are maintained when the students do their practical training at the hospitals.

Nursing education in South Africa is undergoing a reform as a result of the introduction of the SAQA (South Africa Qualifications Association) registered nursing qualifications which requires that nursing programmes be offered at a higher education level. This will impact on KZNCN who will be required to register as a Higher Education Institution (HEI) by July 2010 in order to continue nursing training. This will ultimately affect nurse production and in turn service delivery in KwaZulu-Natal should the registration with SAQA not be successful.

! CHALLENGE

- KZNCN to meet SAQA's requirements for nursing training to be presented at a Higher Education Institutional level.

⇒ PRIORITY 3: RECRUITMENT AND PLACEMENT OF GRADUATING BURSARY HOLDERS

Several challenges have been identified with regards to the recruitment of bursary holders' e.g. poor matric results thereby limiting the pool of applicants; quota intakes allocated by tertiary institutions resulted in limited places; strict academic admission criteria; etc. Posters advertising the KZN Department of Health (DOH) bursaries have been placed at all high schools, municipal offices, tertiary institutions and health institutions to target the broader community and increase intake of students.

Tertiary Institutions, like the University of the Witwatersrand and the University of Cape Town (UCT), have introduced Intervention or Extended Programmes in order to assist students to complete their 1st year over a period of two years with additional support modules. The repercussions at a service delivery level are minimal because more bursaries are allocated to senior students with shorter obligation time frames. Concession planning is in place throughout KZN.

! CHALLENGES

- Poor matric results impacted on intake of students.
- Quota system for intake of students and strict admission criteria at tertiary institutions limit opportunities for prospective students.

⇒ PRIORITY 4: STRENGTHEN THE TRAINING OF POST GRADUATE PHC NURSES

The University of KwaZulu-Natal (UKZN) is providing post graduate training for PHC nurses. Due to budget constraints the training through the Durban Institute of Technology (DUT) was not sourced and other Provincial campuses will instead offer the PHC course. The KZNCN and the People Development Component have embarked on PHC learnerships which commenced at Prince Mshiyeni Memorial Hospital in September 2008.

During 2008 there was an increase in applications for nurse training especially in the specialty areas. It is however still too early to identify trends and evaluate the impact of OSD on this increase.

The KZNCN has entered into a partnership with the UKZN with regards to training of Advanced Midwives to strengthen expertise and skills in areas which are lacking. To date, a total of 5 learning centers have been initiated with a total number of 56 Midwives commencing training.

⇒ PRIORITY 5: DEVELOP THE SKILLS AND CAPABILITIES OF MIDDLE MANAGEMENT THROUGH TALENT MANAGEMENT AND MENTORING

Mentorship and coaching internship programmes was put on hold in 2008/09 due to financial constraints. The Department participates in the Khaedu Programme (funded by the Office of the Premier) for Middle Management Services (MMS) and a total of 21 Managers have been enrolled in the Master of Public Health (MPH)

for Hospital Management Programme which is a National Department of Health initiative.

Talent management has been prioritised in the Human Resource Development Strategic Implementation Plan for 2009/10. The step-by-step mentorship guide for Public Service is readily available for managers.

! CHALLENGES

- Financial constraints impede on intensifying talent management and mentoring of the MMS.
- Limited allocation of spaces for MMS members to participate in the Khaedu Programme.
- Not all managers qualify to be enrolled in the MPH due to academic requirements/admission criteria of the University of KwaZulu-Natal.
- Allocation of skills development budget is insufficient.

HUMAN RESOURCE DEVELOPMENT

The contract with Vega Business Services to provide ABET to the Department, ended on 30 November 2008. The Department developed and implemented a strategy to appoint ABET tutors on one renewable contract, however ABET classes did not commenced in January 2009 due to financial constraints.

The learnership project is a National Department of Health initiative. HWSETA funded 5 learnerships which commenced in January 2009; PEPFAR is funding 150 Pharmacy Assistant learnerships which started in January 2009; and 15 Primary Health Care learnerships commenced at Prince Mshiyeni Memorial Hospital in September 2008. The Nursing Auxiliary learnerships which commenced in April 2008 reached conclusion on 31 March 2009 and the 200 ABET learnerships were awarded in January 2009.

The Department is negotiating with Higher Education Institutions for the development of mid-level worker training programmes which include mortuary technicians, occupational therapy assistants, and physiotherapy assistants.

The Youth Ambassador Programme is progressing well and will end in August 2009. A few Ambassadors experienced learning difficulties as their education level was very low and 2 Ambassadors were withdrawn from the programme due to gross misconduct. Pre-assessment should be conducted prior to future appointments to ensure that ambassadors meet the minimum requirement for enrollment to the programme.

The internship programme continues with 205 interns contracted from 01 April 2008 to 31 March 2009. Interns receive a stipend to assist with transport and other costs related to their internship. The combined accumulative total of the stipends was R 8 million for the duration of the contract. 5% or 10/205 contracted interns managed to secure permanent employment before expiry of their contracts.

To make provision for students not complying with the strict academic admission criteria of Higher Education Institutions (HEI's) the Department partnered with the Further Education and Training (FET) Colleges to ensure that those employees who would like to study further but do not meet the criteria of the HEI's are able to be catered for at the FET Colleges. The Department is also liaising with Higher Education Institutions to establish future partnerships to ensure that employees can be accommodated at the HEI's.

BURSARIES

The Cuban Medical Training Programme is ongoing, with 31 students (10 first year and 19 second year students) currently studying in Cuba.[172] Two 5th year students will return in July 2009 to complete their final year at a local Tertiary Institution in SA and 17 students are completing their final year of study at a medical school in SA. To date, 69 students have graduated through this programme. Three former students are serving back their obligation, 20 students are doing their community service and 46 are busy with their internship. Eastern Cape and Mphumalanga used the KZN Bursary Allocations process as a benchmark for the allocation of their bursaries.

In-service bursaries will be awarded to employees in rural areas for distance learning/ correspondence studies. There is also a plan to promote the use of e-learning and correspondence/ distance learning to mitigate inadequate numbers of training facilities in rural areas.

[172] Information to be verified by the Bursaries Component

! CHALLENGES

- Non-availability of funded posts to accommodate bursary holders after completion of community service.
- Bursary holders entering the registrar programme without completing their initial bursary obligation.
- Bursary holders wanting to transfer to other districts due to promotion posts.
- Financial constraints limit the district allocation of bursaries.
- Delay in raising debts delays the recovery of bursaries when bursary holders have breached their contractual obligation.
- No debt collection section to fast track recovery resulting from breach of contract.

Part B - Programme 6: Health Sciences & Training

PERFORMANCE INDICATORS

Table 96: Specification of Measurable Objectives and Performance Indicators of the Health Sciences and Training Programme

Sub-Programme	Objectives Outputs	Indicator	Performance				
			2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Actual	2008/09 Actual
Health Sciences and Training Programme.	To provide cost effective Training of Nurses.	Number of ENA's trained	76	66	29	60	66
		Number of EN's trained	600	689	543	670	415[173]
Nurse training colleges.	To provide cost effective Training of Nurses.	Number of Bridging students trained	334	349	333	350[174]	399
		Number of RN's trained	318	344	392	350[175]	419
PHC Training.	To provide cost effective Training of Nurses.	Number of post basic graduates	457	499	434	510	427
		PHC nurses trained	230	256	220	260	192
Bursaries.	Ensure appropriate development of HR via bursaries.	Students in tertiary institutions	571	645	697	890	770
EMRS training college.	To increase ILS (Intermediate Life Support) training.	Number of ILS trained	47	71	96	120	56
	Provide Emergency Care Technician (ECT) training.	Number of ECT's trained[176]	16	8	50	100	0[177]
Human Resource Management Services.	Development of Human Resource Plan (HRP).	Finalised HRP	Implemen-tation Plan	HR norms developed	100%	100%	100%
	Finalisation of post established.	N/A	Restructuring	Restructuring	100%	100%	80%

[173] The demand for enrolled nurses has slowed down. This category of nurse is also being produced in large numbers by the private nursing schools. The intake of enrolled nurses has therefore also been decreased
[174] Target for No. of Bridging students trained and No. of RN's trained was duplicated in the APP 2008/09. The target should read as 350 per category with a total target of 700 for both indicators
[175] Target for No. of Bridging students trained and No. of RN's trained was duplicated in the APP 2008/09. It should target should read as 350 per category with a total target of 700 for both indicators
[176] Data prior to 2007/08 is for ALS (Advance Life Support) training
[177] 21 to write final examinations in June 2009

Sub-Programme	Objectives Outputs	Indicator	Performance				
			2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Actual	2008/09 Actual
	Implement Employee Performance Management and Development (EPMDS).	N/A	100%	Not available	100%	100%	100%
	Consolidation of recruitment & retention strategy.	Implemen-tation of policy	100% Implemen-tation	Policy being revised	100%	100%	100%
	Realignment of HR portfolio.	HR posts decentralised	80%	100%	100%	100%	100%
	Decentralise HR delegations.	Decentralised delegations effected by institutions	80%	100%	100%	100%	100%
	Management capacity building.	Training received	100%	100%	100%	100%	66%
	Effective management of misconduct cases.	Backlogs cleared	80%	80%	100%	100%	80%
	Compliance with National Minimum Information Requirements (NMIR) on Persal.	Updating information	70%	70%	75%	75%	85%
	Persal training needs established.	Database updated	11 Districts	100%	100%	100%	0%

Table 97: (HR 2) Provincial Objectives and Performance Indicators for Human Resources

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Strategic Objective: To design and implement a total seamless quality service delivery system for the Department.					
Measurable Objective: To enhance management capacity through a variety of management Programmes.					
1. Number of Managers, Level 13 and above, being trained in Khaedu Programme.	Not collected	10	15	20	10
2. Number of middle Managers, Level 7 to 12, who attended Management Programmes.	Not collected	150	110	795	86
3. Number of Hospital Managers / CEOs that have been enrolled on an accredited Hospitals Management training programme.	Not collected	10	24	16	14
Measurable Objective: To align the training and deployment of health workers to the Human Resources Plan.					
4. Number of Dental Technicians trained.		Nil	Nil	Nil	0
5. Number of Advanced Midwives trained.	Not available	70	70	100	43
6. Number of Physiotherapists trained.	Not available	7	7	Targets to be informed by HRP	5
7. Number of Occupational Therapists trained.	Not available	3	3	Targets to be informed by HRP	2
8. Number of Dentists trained.	Not available	2	2	Targets to be informed by HRP	0
9. Number of Pharmacists trained.	Not available	24	24	Targets to be informed by HRP	24

Table 98: Situation Analysis and Projected Performance for Health Sciences and Training

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Input					
1. Intake of medical students (provided with provincial bursaries).	365	367	402	396	412
2. Intake of nurse students (student nurses and bursary holders).	2,455	2,475	2,485	2,495	2,402
3. Students with bursaries from the province (excluding nursing and medicine).	571	645	697	590	296
Process					
4. Attrition rates of bursary holders in first year of medical school.	0,7%	0%	0%	0%	0%
5. Attrition rates of bursary holders and student nurses in first year of nursing school.	0.4%	0.4%	0.4%	0.4%	0%
Output					
6. Basic medical students graduating.	80	85	89	93	63
7. Basic nurse students graduating.	1,152	1,160	1,170	1,180	1,508
8. Medical registrars graduating.	0	0	0	0	0
9. Advanced nurse students graduating.	450	510	540	570	467
Efficiency					
10. Average training cost per basic nursing graduate.	R72,000	R80,000	R85,000	R90,000	R90,000
11. Development component of Health Professionals Training and Development grant spent.	N/A	N/A	N/A	N/A	N/A

NOTES

PROGRAMME 7:

HEALTH CARE SUPPORT SERVICES

Part B – Programme 7: Health Care Support Services

TABLE OF CONTENTS

PROGRAMME DESCRIPTION

Render support services as required by the Department of Health

PROGRAMME STRUCTURE

Sub-Programme 7.1

Medicine Trading Account

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities 2006 - 2008/09

Priority 6: Strengthening Support Services

↓

Provincial Strategic Plan 2005 - 2009/10

Goal 2: Strengthen PHC and provide caring, responsive and quality health services at all levels.

↓

Annual Performance Plan 2008/09

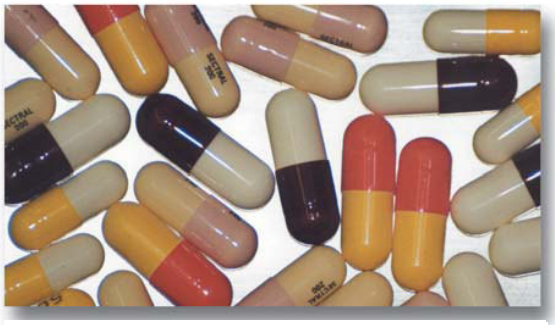
Goal 3

Strategic Objective 15: To ensure that key support services are effectively provided.

↓

Pharmacy Priorities 2008/09

1. Ensure compliance with the registration requirements of the South African Pharmacy Council and the Medicines Control Council for a Pharmaceutical Warehousing Facility (Provincial Pharmaceutical Supply Depot (PPSD).
2. Improve operational efficiency through the implementation of an electronic warehouse management system to progressively replace manual systems.
3. Develop mechanisms, within the limitation set by the Standard Stock Account, to develop a "stock holding stock" capacity for critical pharmaceutical items.
4. Streamline acquisition processes and practices ("orders" from Institutions / PHC Clinics are currently faxed to PPSD creating a high margin of error).
5. Relocation of PPSD to new premises to create extra capacity and improve storage conditions.
6. Improve the coordination between Pharmaceutical Policy and Systems Development and PPSD.



Compliance to prescribed medication will determine the outcome of treatment.

EXECUTIVE SUMMARY

Health Care Support Services provided and supplied essential medication to 75 hospitals, 17 CHC's, 400 provincial clinics, 120 municipal clinics and 40 NGO's via the Provincial Pharmaceutical Supply Depot (PPSD). A stockholding of R135 million is held by the PPSD Standard Stock Account to cater for sufficient stock of essential drugs. Alternative sources were used to procure required medicine where suppliers with contracts had difficulty in meeting the PPSD demand.

PPSD has reached full capacity and cannot extend the warehousing capacity or expand services to include more facilities. A motivation for a new depot has been submitted to address the present capacity constraints and to allow for further expansion. In 2008/09, a team of consultants was to be appointed to prioritise this project with the anticipated

start of construction in May 2009. The Medicines Control Council has declined the Department's application to operate as a wholesaler, and until such time as the new premises are secured/ built the status quo will remain.

A new organisational structure was developed in 2007/08 to address severe staff shortages. The structure has not been implemented and should receive urgent attention to alleviate the current bottlenecks.

The Provincial Pharmaceutical Committees i.e. KwaZulu-Natal Pharmacy and Therapeutics Committee (KZN PTC) and KwaZulu-Natal Pharmacovigilance Committee were functional and effective in providing technical guidance with regards to the utilisation of medicines and adherence to Standard Treatment Guidelines.

POLICIES

Table 99: New Acts, Policies, Protocols and Guidelines

New Acts, Policies, Protocols & Guidelines	Comments
1. Supply of Contraceptive Medicines to Private Sector Service Providers.	• Implemented with difficulty relating to the logistics of processing the applications, however Pharmaceutical Policy and System Development has strengthened liaison with Maternal, Child and Women's Health (MC&WH) Programme to ensure successful implementation and monitoring of the policy deliverables. The private sector service providers are keen to partner with the Department in this essential service.
2. Disposal of Pharmaceutical Waste.	• Currently working well. The new contract for management of Health Care Risk Waste Management is to be undertaken in 2009/10.
3. Approval of non-EDL medicines on named patient basis.	• A Standard Operations Procedure for renewal of motivations for chronic conditions has been developed with the aim of delegating some of the functions to service delivery points in order to expedite the process.
4. The Prescribing and Dispensing of Medicines in KwaZulu-Natal Department of Health Institutions.	• Reviewed and is due for implementation in 2009/10.
5. Placement and Training of Pharmacy Assistants.	• Reviewed and is due for implementation in 2009/10.
6. Control of Schedule 5 and 6 Medicines and Substances.	• Reviewed and is due for implementation in 2009/10.
7. Access to Pharmacy Departments.	• Reviewed and is due for implementation in 2009/10.

PROGRAMME PERFORMANCE

⇒ PRIORITY 1: ENSURE COMPLIANCE WITH LEGISLATIVE REQUIREMENTS

PPSD has reached full capacity and cannot extend services to more facilities. The current premises are not compliant with extended warehousing requirements and regulations for storage of medicines in terms of temperature control, and the pre-packing unit requires infrastructural changes to ensure compliance with Good Manufacturing Practice.

In 2008/09, a team of consultants was to be appointed to prioritise this project with the anticipated start of construction in May 2009. The Medicines Control Council (MCC) inspected the premises in August 2007 and has turned down the Department's application for a license to operate as a wholesaler. As a result, PPSD premises are not licensed with the Department of Health, and are thus not recorded with the SA Pharmacy Council - this status remains to date. The MCC will be conducting annual inspections of the premises to monitor progress.

Due to a lack of capacity at district level, the electronic RDM (Remote Demand Module) system, recommended

for processing of orders, has not been successful and a large volume of orders are still being processed via fax. The system of direct delivery of supplies from suppliers to hospitals has been extended but is limited by the:

- Location of institutions;
- Size of orders;
- Value of orders; and
- Additional staff required for administration of the process.

! CHALLENGES

- Non-compliance with legislation - PPSD and institutional pharmacies.
- Inadequate infrastructure - *Pharmaceutical Policy and System Development Unit is liaising with the Infrastructure Development Unit to address the challenge*.
- Shortage of Pharmacists at service delivery points severely jeopardised service delivery including waiting times. The number of graduates from universities does not match the demand severely challenging recruitment processes.
- Delays with implementation of OSD for Pharmacists challenge recruitment and retention of Pharmacists.

⇒ PRIORITY 2: IMPLEMENT AN ELECTRONIC WAREHOUSE MANAGEMENT SYSTEM

A new computerised stock management system has been piloted in the Gauteng Province in 2008/09 with the intention of rolling it out to the rest of provinces. Rollout of the system has however been delayed due to system challenges that must be addressed before rollout.

⇒ PRIORITY 3: DEVELOP BUFFER STOCK CAPACITY FOR CRITICAL PHARMACEUTICAL ITEMS

The PPSD Standard Stock Account for 2008/09 was R134,93 million with an average monthly turnover of R 91,7 million. Sufficient buffer stock on all items i.e. six weeks for ARV's and two weeks for other stock would require a Standard Stock Account of R150 million.

Procurement parameters are routinely checked and reset according to supplier's current performance in terms of delivery lead times to establish minimum quantities that can be ordered. The amount of buffer stock for critical items e.g. ARV's, TB drugs and vaccines is set at 4 weeks, but other items vary according to supplier performance. Replenishment and stockholding is done daily. Direct deliveries have increased from R30-40 million per annum to R133 million per annum.

Adequate buffer stock is crucial to counteract non-availability of drugs due to suppliers being closed down; suppliers not being able to supply according to demand; or when suppliers are unable to source adequate quantities of raw materials for production of drugs. The repercussions of drug stock-out are far-reaching and have definite consequence for health outcomes.

A total of 560 clinics are being supplied from PPSD:

- 400 Provincial Clinics
- 120 Municipal Clinics
- 40 NGO's

⇒ PRIORITY 4: STREAMLINE ACQUISITION PROCESSES AND PRACTICES

RDM has been installed at 94 sites (hospitals and CHC's), and clinics are expected to send their orders to their mother hospitals for processing on RDM on their behalf. Large numbers of faxes are however still increasing the margin for error.

⇒ PRIORITY 5: RELOCATION OF PPSD TO NEW PREMISES

PPSD was built 26 years ago with inadequate space to accommodate current needs. Maximum capacity has been reached and no additional clinics can be accommodated. Additional clinics are serviced by their "mother" hospitals although it seems that service delivery is negatively affected by this arrangement. Clinics that receive direct delivery from PPSD seem to have fewer challenges with obtaining stock and it appears that the level of key indicator drugs available at these clinics is higher than those serviced from hospitals.

At the moment there is a waiting list of more than 100 clinics that have requested direct delivery from PPSD. The Department has extended the section for deliveries that are sent directly from the supplier to the hospital but this is only possible with large orders and expensive items. There is also an enormous increase in administration of these direct delivery orders which place additional strain on an already short staffed service.

A new organisational structure was created 18 months ago to address staff shortages and improve efficiency. It is a matter of urgency that these posts are created on the

Persal system and the posts filled to alleviate workload and improve service delivery.

A new ARV store was created in the old manufacturing department to address shortage of space for the ever increasing stockholding of ARV's. Unfortunately, some stock still needs to be stored in the main warehouse.

⇒ PRIORITY 6: IMPROVE COORDINATION BETWEEN PHARMACEUTICAL POLICY AND SYSTEMS DEVELOPMENT AND PMSC

There is telephonic and email communication between Head Office and PPSD almost daily, however it may be beneficial to have regular scheduled meetings at PPSD to address both management and service delivery challenges and action. This will receive attention in 2009/10.

Special Pharmacy Projects

A pilot project to develop a **Central Chronic Medication Dispensing Unit (CCMDU)** was initiated in 2008/09. The objectives of this project were to decongest pharmacies in hospitals, reduce waiting times at pharmacies, and provide a better service to patients who receive regular monthly medicines. The project lifespan is six months and the evaluation is expected to be completed in 2009/10.

Implementation of a **Computerised Dispensing Programme** has been implemented in 8 pharmacies and has improved efficiency and speed of dispensing chronic prescriptions. Management information is also available from the system.

Pharmacovigilance

Fourteen facilities were chosen as **Sentinel Surveillance Sites** to monitor the adverse events in patients on Antiretroviral Therapy (ART), and 8 facilities were selected for the **Research Project, Antiretroviral Cohort Adverse Event Monitoring in KwaZulu-Natal (ACADEMIK)**. The protocol for the study has been submitted for ethics approval at UKZN. The ART clinic teams from Sentinel Surveillance sites and Cohort Event Monitoring sites were trained on the principles of Pharmacovigilance. The software for facilitating the collection and management of clinical data is being developed to improve processes at the ART sites.

Training of Pharmacist's Assistants

The Department entered into a Service Level Agreement with Health Science Academy (Pty) Ltd for the training of Pharmacist's Assistants on Pharmacist's Assistant Basic and Post-basic Courses. The Health Science Academy would use United States President's Emergency Plan for Aids Relief (PEPFAR) funds for this project. The training is in progress and the first group is expected to complete the course(s) in the last quarter of 2009/10.

A monitoring and evaluation framework has been initiated and is expected to be completed in 2009/10.

Part B – Programme 7: Health Care Support Services

SERVICE DELIVERY INDICATORS

Table 100: Provincial Objective and Performance Indicators for Support Services

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Strategic Objective 15: To ensure that key support services are effectively provided. (Goal 3)					
Measurable Objective: To procure, store and distribute EDL and approved medicines.					
1. Un-interrupted supply of ARV medication for patients initiated on HAART.	-	100%	100%	100%	85%[178]
2. Stock-out rate of EDL medicines.	5%	3%	3%	<2%	20%[179]
3. Compliance with legislation of Institutional Pharmacies.	-	-	60%	75%	PPSD non compliant
4. "Buffer" stock maintained for critical pharmacy items.	-	-	Not measured	100%	30%[180]

NOTES

[178] 85% indicates approximate number of ARV orders supplied in full by the depot. Supply to patients would need to be estimated at hospital level as they should be keeping 6 weeks buffer stock
[179] This is based on an average service level of 80%
[180] Buffer stock is not kept on all items as it is not possible due to SSA and space constraints

PROGRAMME 8:

INFRASTRUCTURE DEVELOPMENT

Part B – Programme 8: Infrastructure Development

TABLE OF CONTENTS

.

To provide new health facilities and upgrade and maintain existing health facilities, including the management of the Hospital Revitalisation Programme and concomitant Conditional Grant

PROGRAMME STRUCTURE

Sub-Programme 8.1
Community Health Services including Primary Health Care clinics and Community Health Centres

Sub-Programme 8.2
District Hospitals

Sub-Programme 8.3
Emergency Medical Rescue Services

Sub-Programme 8.4
Provincial Hospital Services

Sub-Programme 8.5
Tertiary and Central Hospital Services

Sub-Programme 8.6
Other Facilities

Part B – Programme 8: Infrastructure Development

PROGRAMME 8: FACILITIES MANAGEMENT

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities 2006/07 - 2008/09

Priority 6: Strengthen support services.

Provincial Strategic Plan 2005 - 2009/10

Goal 5: Infrastructure investment in health technology, communication, management information systems and buildings.

Annual Performance Plan 2008/09

Goal 1

Strategic Objective 5: To accelerate infrastructure development and purchase of medical equipment.

Facilities Management Priorities 2008/09

1. Institutions are encouraged to undertake maintenance initiatives under R 200,000 by utilising centrally prepared specifications.
2. Implementation of a more flexible procurement service by using Fixed Term Contacts to eliminate procurement delays.
3. Institutions are encouraged to fill vacant posts within the Technician/Artisan Occupational Categories.
4. With the introduction of the VCT and PMTCT Programmes steps have been taken to supply Mobile Homes as interim facilities for these services.
5. Compliance with statutory obligations (for example mortuaries, pharmacies etc.). A detailed investigation has been undertaken into both the Forensic and Hospital Mortuaries to establish compliance and to identify the extent of upgrade work requirements.
6. A survey is currently being conducted to identify and list upgrade requirements in order for all Pharmacies to comply with the provisions of The Pharmacy Act, 2003.
7. Alignment of projects to the imperatives set by the STP for MTEF 2007/08 - 2008/09.
8. Compliance with the STP categorisation of PHC facilities and minimum structural requirements.
9. The Department is, as part of its stated objective to assist with the reduction of poverty in the Province, exploring options to "outsource" the washing of "non critical" items to Cooperatives. This approach will reduce the pressure on the laundries and assist with initiatives to properly maintain/upgrade the "ageing" laundry equipment.
10. Additional funding / re-prioritising will have to be done to prevent a situation where hospitals will not be able to perform procedures due to the unavailability of clean theatre garments and linen.

Hlengimpilo Clinic

EXECUTIVE SUMMARY

The Department is falling behind with maintenance work on facilities and the alternative to alleviate this crisis would be to drastically reduce construction of new buildings given the deteriorating state of some of the existing facilities.

A budget cut of R 36 million has been affected and an accrual expenditure of R134 million will be paid for in 2009/10 financial year as a result of cost savings to mitigate the overall expenditure in 2008/09. 100% of the Conditional Grant for Hospital Revitalisation, Coroner services and Infrastructure was spent during 2008/09.

In 2008/09 a total of 57 projects have been completed including upgrades, new facilities and renovations at a cost of R 272,271,793 million, and 42 PHC clinic projects were completed at a cost of R 117,702,793 million. A total of 7 projects were completed at District Hospital level at a total cost of R 141,378,000 million. The Regional Hospitals spent R 9,844,00 million on 4 infrastructure projects with Psychiatric and Tertiary Hospitals having spent R 138,00 million and R 2,651,000 million respectively on their projects. At PHC level, 10 PHC clinics were completed during 2008/09 with a further 18 PHC clinics in various stages of construction.

In an effort to contain costs, especially with the building of new facilities, alternative methods of construction such as Lightweight Steel Framework (LSF) and Modular Construction were being piloted during 2008/09 to improve service delivery turn-around times in respect of time, cost and quality. The Technical Management Committee ensured the coordination of planning and the maintenance and integration of standards.

Building inflation costs is one of the biggest cost drivers for Facilities Management with regards to current projects, varying from between 20% to 40% of total cost. The Department therefore has developed a Project Progress Monitoring Tool which will assist in curbing unwarranted escalation costs that are associated with project duration overruns.

Infrastructure Plans have been developed together with revised Service Delivery Agreements (SDA's), and feedback on planning and implementation of these plans has been given to the Districts. The Infrastructure Programme Management Plan and the Infrastructure Implementation Plan are aligned to the Service Transformation Plan and have been updated although the continuous reduction of the infrastructure budget allocations made it difficult to implement projects as planned. Priority projects had to be cancelled and maintenance budgets reduced.

There are currently no broad-based strategies in place as Facilities Management is under-funded and there has been a continuous forced under-expenditure on a yearly basis, however the maintenance backlog will be quantified properly in the 2010/11 Infrastructure Plan.

POLICIES

Table 101: New Acts, Policies, Protocols and Guidelines

New Acts, Policies, Protocols & Guidelines	Comments
1. Construction Industry Development Board (CIDB) Prescripts.	• Supply Chain Management (SCM) officials were trained in various Construction Procurement legal requirements. The Department has been registered with the CIDB as an employer and relevant officials trained towards the use of the Register of Projects 1-tender system. • Compliant documentation was developed for various tenders that were advertised in-house.
2. Department of Health Standards and Guidelines Policy.	• The policy document for health standards was revised in-house in line with Council for Scientific and Industrial Research (CSIR) recommendations in order to update the requirements that seek to ensure compliance of infrastructure facilities with various Health Regulations, norms and standards. This document has been made available internally as well as externally for use by the Implementing Agents.

PROGRAMME PERFORMANCE

The biggest challenge faced by Infrastructure during the 2008/09 reporting period has been the drastic reduction in budget as part of the cost-saving measures that were implemented due to the over-expenditure within the Department. This affected progress against the previously determined targets and in addition also affected service delivery at a grass roots level as clinics and PHC's designated for construction/ upgrading had to be placed on hold. Infrastructural challenges e.g. lack of adequate space to render the package of services may have a profound impact on availability, access and utilisation hence impacting negatively on health outcomes.

The recruitment and retention of skilled professional staff continued to be a challenge both during the construction phase (engineers) and upon completion of new projects (professional medical staff). Alignment of planning processes and systems is therefore paramount to ensure the effective utilisation of resources.

Another epic challenge for the Infrastructure Unit is the unavailability of accommodation for priority programmes e.g. VCT, PMTCT, etc. at a Primary Health Care level. The social stigma still necessitates the utmost sensitivity in rendering these services and planning should therefore accommodate this need. In a study conducted by the Centre for Rural Health (CRH) and the UKZN, titled "The Evaluation of the integration of PMTCT into Maternal and Child Health Services in two Districts of KwaZulu-Natal"[181], an example is made of patients accessing PMTCT treatment at a PHC level. A few PMTCT patients want a facility / consultation room specifically for PMTCT to ensure shorter queues and waiting times and specialised advice from a professional nurse who has had training / experience in PMTCT. Alternatively, some patients feel that this is an invasion of privacy as they can then be identified as being HIV+ should they visit the PMTCT facility. This is especially noticeable if this service has not been integrated into other PHC services and operates as a "stand-alone" service. Both options have merit although; the physical layout of the facility can determine the behaviour of patients.

Revitalisation Projects

King George V Hospital

The anticipated completion date for the upgrading of the District Hospital, TB surgical ward and mortuary at King George V Hospital was December 2008. Construction has however been delayed due to changes in the scope of work that had to be accommodated and the new anticipated completion dates are now August and December 2009 respectively.

Psychiatric services took occupation of the Psychiatric Unit and the 130 beds for Psychiatric services during 2008.

The TB surgical wards and mortuary are in the process of being commissioned and are due for completion in September 2009. IDT (Independent Development Trust) is currently in the planning phase for equipping of the facilities in the 2009/10 financial year. The staffing structure has still not been approved and is expected to be finalised in 2009/10.

The TB star wards were handed over in 2008 although it is not yet occupied due to the shortage of doctors and other medical/ nursing staff. This matter will be pursued in 2009/10.

! CHALLENGE

- Shortage of staff to fulfill staffing requirements of the TB star wards in King George V Hospital.

Rietvlei Hospital

Planning for Phase 3A and 3B of this project commenced in 2007/08. Phase 3A is behind schedule due to delays by the contractor, and the expected completion date has been extended from November 2009 to August 2010. Phase 3B is in the preliminary planning stage.

! CHALLENGE

- Delays and slow construction result in over-expenditure due to an overrun of the project and increased inflation costs.

Lower Umfolozi War Memorial Hospital

During 2008/09 it was reported that attention would be given to further upgrading of the water supply, air handlers, replacement of kitchen equipment with conversion to electricity, and conversion of the autoclave from steam to electricity. To date the water supply and air handlers are 100% complete and awaiting as-build drawings, manuals and compliance certificate. The

[181] "An Evaluation of the Integration of PMTCT into Maternal and Child Health Services in Two Districts in KwaZulu-Natal" by the CRH and UKZN in 2008

conversion of electricity and the autoclaves forms part of the new 4 storey project which is due for completion at the end of May 2009.

Ngwelezana Hospital

The pharmacy was completed at the end of July 2008. In 2008/09 construction commenced on the Mental Health Unit and helipad and is approximately 65% complete.

Dr Pixley Seme Hospital

A peer review has been conducted and the IPIP submitted to the National Department of Health in August 2008 for approval. The process has therefore been delayed and the reviewed completion date for this project is now 2011 bar no further financial constraints. The current facilities will be utilised until such a time that the new facility is complete.

Dr John Dube District Hospital

During 2008/09 an initial study was completed and received by the Department of Health from the Provincial Department of Works. This project has been re-allocated to IDT as the implementing agent and the Service Delivery Agreement (SDA) was signed in April 2009. Design will now commence and programme dates will be set.

Madadeni Regional Hospital

The Master Plan has been completed and JOPAC approval received. Priority has been given to the Psychiatric Hospital with the commencement of a detailed design - therefore nothing will be done on the District and Regional Hospital at this stage. A detailed brief and operational narrative was submitted to the National Department of Health in March 2009, and Facilities Management is currently busy with finalising the administrative and contractual issues with IDT. At this stage there have been no funding constraints but funding constraints are anticipated as several mega projects will soon be implemented.

! CHALLENGE

- Funding constraints anticipated.

Hlabisa Hospital

The extensive renovations at the hospital form part of a Presidential Lead Project with the design of Phase 2 (incorporating the Pharmacy and out-patient section) completed in 2008/09. Phase 2A is a tender for a civil contact which has been advertised, however the tender process still has to be concluded. The anticipated completion date is March 2012.

Other Infrastructure Projects Not Part Of The Hospital Revitalisation Grant

King Edward VIII Hospital

A business case for the total re-commissioning of King Edward VIII has been submitted to the National Department of Health in 2008/09 to make provision for R30 million being required to repair the roof at the hospital.

Addington Hospital

The lifts at Addington Hospital require upgrading to comply with fire regulations. Funding was secured in 2008/09 and R 2,710,000 has been allocated in the 2009/10 financial year for this upgrade.

Edendale Hospital

A business case for Edendale Hospital was submitted and funding has been secured under the Hospital Revitalisation Grant. The Master Plan has been completed, with the appointment of consultants expected to be finalised in July 2009. Plans have been formulated to continue using the existing facilities while staged construction is in progress.

Tertiary Hospital For Area 3

There has been a delay with the tender process for the appointment of consultants to develop the business plan and the brief was finalised and approved in May 2008. A suitable site has been identified and the Department of Public Works has been instructed as per the Department's requirements. The Provincial Treasury needs to be lobbied for funding. In the short/ medium term, Ngwelezane Regional Hospital will continue to provide a proportion of the tertiary package of services.

Mental Health

In order for health facilities to comply with the minimum infrastructure requirements enshrined in the Mental Health Act, 2002 the Department is putting up 72-hour facilities in District Hospitals with the national standardised seclusion rooms. Establishment of Psychiatric Units in Regional Hospitals (with seclusion rooms) will serve as the second level of referral from districts. This is being implemented at a slow pace due to budgetary constraints. Total cost

required for implementation will be finalised as part of the 2009/10 Infrastructure Plan.

Additional MDR And XDR Wards

The construction of MDR and XDR projects at Manguzi with CSIR intervention is underway. Construction at Catherine Booth Hospital will follow on completion of this project.

Appropriate Residential Accommodation To Attract And Retain Staff

Residential accommodation is still a challenge as budgetary constraints do not allow prioritisation of these facilities.

! CHALLENGE

- Budgetary constraints do not allow for prioritisation of residential/ staff accommodation which have a direct bearing on staff recruitment and retention.

Essential Building Upgrades to Provide Infrastructure for Psychiatric and TB Facilities

Infrastructure for Psychiatric facilities has seen the commissioning of the Psychiatric unit at King George V Hospital during 2008. The Psychiatric Hospital in Madadeni will be designed in 2009/10. Infrastructure for TB facilities is currently provided through WHO Donor funding.

Trauma Bed Facilities, Isolation Wards, And EMRS Communication Centers In Preparation For The 2010 Soccer World Cup

The preferred alternative construction method (Light Steel Framework) is being used in relation to trauma bed facilities, isolation wards and EMRS Communication Centres due to the shorter construction period compared to the conversional building method.

⇒ PRIORITY 1: UNDERTAKE MAINTENANCE INITIATIVES UNDER R 200,000 BY UTILISING CENTRALLY PREPARED SPECIFICATIONS

This is ongoing.

⇒ PRIORITY 2: MORE FLEXIBLE PROCUREMENT SERVICE BY USING FIXED TERM CONTACTS TO ELIMINATE PROCUREMENT DELAYS

No procurement delays were experienced as the working relationship with the SCM Unit has improved. There were two fixed term contracts that were available for use by the districts without having to undertake the full procurement process through the Central Supply Chain Management Committees. The internal contract ZNB7198 for building work allowed districts to select pre-approved contractors from the Roster Database and scheduled rates were used to determine the cost of the work. The districts also had access to a 55G contract for mechanical work, and the same process applied in terms of its utilisation.

Three (3) interventions were implemented during 2008/09 to alleviate the challenge of managing projects and capacity for procurement.

1. Outsourcing of contracts to alleviate the inadequate capacity of the Department of Works, with Service Level Agreements (SLA's) established to expedite infrastructure development. This challenge is currently being addressed through the appointment of additional Project Management firms to undertake specific Programmes within the Infrastructure Programmes.

2. Implementation of period contracts to overcome time consuming Provincial procurement procedures. In 2008/09, an agreement was reached with the Department of Works for the appointment of additional Project Managers to ensure that Health Projects receive the necessary urgent attention.

3. Utilisation of Ithala and IDT to assist in the roll-out of urgent projects i.e. clinics, VCT Centres and Hlabisa Hospital. During 2008/09, Ithala had not performed as anticipated, therefore most new projects have been moved across to IDT.

⇒ PRIORITY 3: FILLING OF VACANT POSTS WITHIN THE TECHNICIAN/ ARTISAN OCCUPATIONAL CATEGORIES

Posts were frozen in order to curtail over-expenditure within the Department. Where approval for filling of posts was granted, it was difficult to recruit appropriately qualified staff due to low salary entry levels as compared to the other institutions/ organisations. The evaluation of posts will be undertaken when the capacity review of the infrastructure delivery within the regions is undertaken.

There has been difficulty in recruiting and retaining staff with engineering and related technical skills. During 2008/09 Infrastructure Development liaised with the Human Resource Management Services to develop and

implement a recruitment and retention strategy for engineering and other relevant skills for the Department. Seven (7) posts were advertised and 2 Project Management posts filled. More appointments are expected in 2009/10.

! CHALLENGE

- Difficulty in recruiting and retaining staff with the required engineering skills.

⇒ PRIORITY 4: SUPPLY OF MOBILE HOMES FOR VCT AND PMTCT AS INTERIM ARRANGEMENT

The Department resolved not to provide mobile accommodation any more. Various other alternative building methods, which are more cost effective with a shorter construction time, were investigated by the Department, and the Department has approved two other alternative building methods namely Plastic Shutter Foam and Light Steel Frame Construction. The Mseleni and Kwa Dukuza PMTCT projects have been tendered under the Light Steel Frame Construction and the building of these units will take approximately 5 months as compared to 12 months if conventional construction methods had been employed.

Broadreach Health Care is sponsoring 7 Park Homes for VCT and PMTCT in the Ugu District in support of the Massification Programme in the district.[182]

⇒ PRIORITY 5: COMPLIANCE WITH STATUTORY OBLIGATIONS (FOR EXAMPLE MORTUARIES, PHARMACIES, ETC.)

Two mortuary upgrades were completed in 2008/09 namely New Hanover and Richards Bay Mortuaries. Three other mortuary upgrades went through the tender process with Gale Street Mortuary 75% complete and due for completion in 2009/10 and Newcastle and Port Shepstone Mortuary sites due for hand-over in June 2009.

During 2008/09 it was reported that a further 9 new facilities were required to meet the demand for services and a further 6 facilities required upgrading. Due to funding constraints only 7 facilities are on-site, the Pietermaritzburg M6 Mortuary site is due for hand-over in May 2009 and the Phoenix Mortuary project awaits funding before being awarded. The design process for the other identified mortuaries will only start in 2011/12 due to funding limitations. To address the unmet need for suitable facilities, the Department is utilising private mortuaries which impact on ultimate cost of rendering the service.

! CHALLENGE

- Lack of funding for the building of new mortuary facilities is negatively hampering pathology services forcing Pathology Services to utilise private mortuaries.

⇒ PRIORITY 6: PHARMACIES TO COMPLY WITH THE PROVISIONS OF THE PHARMACY ACT, 2003

A survey was conducted in 2006 to identify pharmacies that do not meet the infrastructural requirements as prescribed in the Pharmacy Act, 2003. The survey identified approximately 30 new or upgrades projects for pharmacies that did not meet the provisions of the Act.

Construction for some pharmacies is in progress with 3 projects completed during 2008/09. The building process is slow and the Department of Public Works has been instructed to appoint a consultant who will be responsible for the design and supervision of the work in the Provincial Pharmaceutical Supply Depot (PPSD). It is envisaged that the construction work will start late in the 2009/10 financial year.

! CHALLENGE

- Budget constraints have impacted significantly on pharmacy projects - and resulted in the PPSD facility not meeting the requirements of the Pharmacy Act, 2003.

⇒ PRIORITY 7: ALIGNMENT WITH THE SERVICE TRANSFORMATION PLAN (STP)

The 10-year Infrastructure Plan for 2008/09 and 2009/10 has been aligned with the STP. In terms of the 2007/08 - 2008/09 MTEF years, the alignment was poor due to a huge number of projects that were already in the planning and construction phase but were not included in the STP. The Department had to find ways to align its budgeting process with the planning and implementation of these projects that had already been approved by the Department. The other challenge was that the STP has not been implemented or costed and in most of the Districts projects that had been prioritised could not be funded from the normal annual budgets. There is now a

[182] Information taken from the narrative of the District ¼ Reports for 2008/09

better planning process developed and the alignment of Annual Plans to the STP should improve.

The formalisation of the MTEF and Long Term Planning within the Department led to the development of the Terms of Reference for both the Provincial and District Prioritisation Committees. It is envisaged that District Committees would assist in ensuring a credible process in the review/ updating of Infrastructure Plans on an annual basis. The Committees will also deal with all facilities that the STP does not currently deal with i.e. EMRS, Forensic Mortuaries, pharmacies, office and residential accommodation, MDR and XDR facilities, seclusion and isolation wards, upgrading and maintenance of all health facilities, etc. Unfortunately this did not happen during 2008/09 due to a shortage of staff in the Infrastructure Unit. An Infrastructure Manager and two Technical Advisors were appointed in 2008/09 and this process should therefore be implemented during the course of 2009/10.

The current challenge is that even if facilities have been prioritised in the STP, a decision still needs to be made at a management level as to how much of the annual budget will be allocated for maintenance, new construction, upgrades and additions, new PHC facilities, etc. Therefore there is merit in the proposed Prioritisation Committees in order to align the planning, budgeting and the implementation processes for health infrastructure for the Province. As part of this process the integration with the PGDS, PSEDS and other Provincial needs will be facilitated.

! CHALLENGES

- No funding to implement the STP as it has not been signed off.
- There is an identified gap in planning as it is done at a Provincial level with little or no input from districts. Each district has unique needs and requirements and these should be incorporated into planning for facilities.

⇒ PRIORITY 8: COMPLIANCE WITH THE STP CATEGORISATION OF PHC FACILITIES AND MINIMUM STRUCTURAL REQUIREMENTS

Construction on 3 new CHC's commenced during 2008/09. The two projects at KwaMashu Replacement CHC and St Chads CHC at Ezakheni are 70% complete, and the project at Turton CHC in the Ugu District is 50% complete with an expected opening date middle 2009/10. The Umzimkhulu CHC is still at the tender phase and completion has been estimated at 2011/12.

During 2008/09, 18 new construction projects for CHC's and PHC clinics were underway. Six projects are due for completion in 2010, 8 will be opened to the public in 2011 and a further 4 are due for completion in 2012.

There are still 8 PHC clinics in the Umzimkhulu Sub-District that are not connected to the electricity grid. During 2008/09 negotiations commenced with ESKOM for the clinics to be connected to the electricity grid in March 2010. Alternative power supplies are also being investigated by Facilities Management.

Telecommunications was not available at 21 PHC clinics within KwaZulu-Natal during 2008/09, including 8 from the Umzimkhulu Sub-District. This is deemed a priority by the Department and will be rectified in 2009/10.

⇒ PRIORITY 9: OUTSOURCING WASHING OF "NON CRITICAL" ITEMS TO COOPERATIVES

There has been no progress in this area. The Department is currently restructuring its services in order to maximize the productivity especially in laundries within the eThekwini District.

⇒ PRIORITY 10: ADDITIONAL FUNDING / RE-PRIORITISING TO ENSURE AVAILABILITY OF CLEAN THEATRE GARMENTS AND LINEN

Apart from the Cato Manor Laundry, the Department is facing a challenge as infrastructure, equipment upgrading and maintenance was neglected over a substantial period of time resulting in an increase in "down time" and in some instances a concern that the plant is not compliant with legislative imperatives. In 2008/09 laundries were streamlined with proposed changes i.e. Sea Cow Lake to close down, Prince Mshiyeni to function at full capacity and upgrading of equipment at the Dundee Laundry. It was ultimately resolved that the Regional Laundries will assist each other in the Durban Region and the Regional Laundries in the Durban Region will also assist the laundry in Northern Natal as and when required. Review of the organogram commenced in 2008/09 with approval for advertising of posts in 2009/10.

The issue of machinery needs to be addressed as machinery has not been upgraded for 20 years. Due to financial constraints plans to replace machinery in 2008/09 have been put on hold until 2010/11. Upgrading and

replacing of the older machines would in fact save money as the maintenance costs and downtime of machinery would decrease. The production would increase and the costs of overtime for staff will drastically decrease.

PERFORMANCE INDICATORS

Table 102: Summary of Projects Completed in MTEF 2008/09

Facilities Type	Nature of Project(s)	Number of Projects	Spent 2008/09 R (Million)	Total Projects per Facility Type	Total Spent Per Facilities Type R (Mil)
Step-down and Rehabilitation Hospitals	New Facility	-	-	-	-
CHC's	New Facility	-	-	-	-
	Rehabilitation/Renovation	-	-		
	Upgrading	-	-		
PHC Clinics	New Facility	10	R 60,680,009	42	R 117,702,793
	Replacement	-	-		
	Upgrading	28	R 45,967,770		
	Maintenance	3	R 11,055,014		
	Mobile Clinics	-	-		
District Hospitals	New Facility	5	R 11,687,000	7	R 14,1378,000
	Rehabilitation/ Renovation	1	R 1,455,000		
	Upgrading	1	R 995,000		
	Maintenance	-	-		
	Replacement	-	-		
EMRS	New Facility	-	-	-	-
	Upgrading	-	-		
Regional Hospitals	New Facility	1	R 1,492,000	4	R 9,844,000
	Rehabilitation/ Renovation	2	R 7,992000		
	Upgrading	1	R 360,000		
	Replacement	-	-		
Other Services	Upgrading	1	R 558,000	1	R 558,000
	Replacement	-	-		

Part B – Programme 8: Infrastructure Development

Facilities Type	Nature of Project(s)	Number of Projects	Spent 2008/09 R (Million)	Total Projects per Facility Type	Total Spent Per Facilities Type R (Mil)
Psychiatric Hospitals	Upgrading	2	R 138,000	2	R138,000
	New facilities				
TB Hospitals	New Facility	-	-	-	-
	Upgrading	-	-		
	Replacement	-	-		
Tertiary Hospitals	Upgrading	-	-	1	R 2,651,000
	New Facility	1	R 2,651,000		
Mortuary Services	New Facility	-	-	-	-
	Upgrading	-	-		
Training Complexes	Upgrading	-	-	-	-
Total				**57**	**R 272,271,793**

Table 103: Historic and Planned Infrastructure Projects

Projects	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Projection	2008/09 Actual
New PHC facilities (Clinics and CHC's) and upgrading of PHC facilities	209 (Including upgrading)	296 (Including upgrading)	143 New 13 Upgrade	30 (Including upgrading)	30 (including 1 HAART Unit)
New District Hospitals.	-	-	-	1	0
Upgrading District Hospitals.	38 Projects	42 Projects	11 Hospitals 20 Projects	15 Projects	15
New Regional Hospitals.	-	-	-	-	-
Upgrading Regional Hospitals.	15 Projects	30 Projects	6 Hospitals 14 Projects	13 Projects	1
Upgrading Tertiary Hospitals.	-	-	-	-	-

Table 104: (HFM 1) Historic and Planned Capital Expenditure by Type

	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Projection	2008/09 Actual
Major capital	R 402,445	R 551,037	R 621,725	R 713,305	R 342,898
Minor capital	R 19,972	R 99,517	R 240,557	R 125,000	R 298,817
Maintenance	-	R 72,694	R 132,742	R 182,522	R 332,496
Equipment	R 118,505	R 89,930	R 97,783	R 110,000	R 129,447
Equip maintenance	-	-	-	-	-
Total capital	**R 540,922**	**R 813,178**	**R 1,092,807**	**R 1,130,827**	**R 1,103,658**

Table 105: (HFM 2) Summary of Sources of Funding for Capital Expenditure

	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Projection	2008/09 Actual
Infrastructure grant	R 157,561	R 174,098	R259,758	R 288,193	R 294,832
Equitable share	R 237,432	R 413,552	R 474,520	R 640,841	R 425,819
Revitalisation grant	R 145,929	R 225,528	R 333,523	R 201,793	R 330,404
Donor funding	-	-	-	-	-
Other (Coroner)	-	-	R 25,006	-	R 52,503
Total capital	**R 540,922**	**R 813,178**	**R 1,092,807**	**R 1,130,827**	**R 1,103,558**

Table 106: (HFM 3) Historic and Planned Major Project Completions by Type

	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Projection	2008/09 Actual
New Hospitals	-	-	-	1[183]	0
New Clinics / CHC's	6	9[184]	12	43[185]	10
Upgraded Hospitals	53	-	-	28	15
Upgraded Clinics / CHC's	11[186]	24[187]	16	8[188]	19

[183] Target changed by Infrastructure in APP 09/10. Motivation to be provided
[184] Information verified since printing of APP 2008/09 with Infrastructure. See APP 2009/10
[185] Target changed by Infrastructure in APP 09/10. Motivation to be provided
[186] Information verified since printing of APP 2008/09 with Infrastructure. See APP 2009/10
[187] Information verified since printing of APP 2008/09 with Infrastructure. See APP 2009/10
[188] Target changed by Infrastructure in APP 09/10. Motivation to be provided

Part B - Programme 8: Infrastructure Development

Table 107: Total Projected Long Term Capital Demand for Infrastructure Development[189] (R million)

Programme	Planning Horizon 2007/08 - 2012/13	Province Total Annualised 2008/09	Ugu	Umgungundlovu	Uthukela	Umzinyathi	Amajuba	Zululand	Umkhanyakude	Uthungulu	Ilembe	Sisonke	Ethekwini
Programme 1													
MEC's Office and Administration	-	-	-	-	-	-	-	-	-	-	-	-	-
Programme 2													
Clinics and CHC's	R2,196,576	R237,969,391	R53,764,478	R13,626,636	R 18,652,695	R30,484,982	R15,884,732	R14,793,154	R37,996,186	R21,373,699	R4,342,429	R11,000,544	R16,049,856
Mortuaries	R131,406	R131,965,132	R33,030,557	R22,241,428	R 27,000,000	R21,000,000	R13,000,000	R2,600,000	-	R 6,604,686	R4,000,000	R 507,329	R1,981,132
District Hospitals	R1,880,172	R210,989,935	R8,400,748	R5,634,312	R 16,120,149	R7,892,213	R5,211,369	R31,054,536	R41,618,706	R29,913,397	R7,006,970	R19,740,000	R38,397,535
Programme 3													
EMS Infrastructure	R 46,782	-	R3,007,742	-	-	-	-	-	-	-	-	-	R1,363,372
Programme 4													
Regional Hospitals	R758,022	R246,902,753	R39,219,176	R8,972,728	R11,501,266	-	R80,624,158	R969,664	-	R24,961,197	R6,377,966	-	R74,276,598
Psychiatric Hospitals	R85,314	-	-	-	-	-	-	-	-	-	-	-	-
TB Hospitals	R1,224,516	-	-	-	-	-	-	-	-	-	-	-	-
Other Specialised Hospitals	R7,332	R424,500	-	-	-	-	-	-	-	-	-	-	R424,500
Programme 5													
Provincial Tertiary and National Tertiary Hospitals	R108,384	R45,531,683	-	R45,531,683	-	-	-	-	-	-	-	-	-

[189] Information as per 2008/09 MTEF Infrastructure Programme Management Plan

Programme	Planning Horizon 2007/08 - 2012/13	Province Total Annualised 2008/09	Ugu	Umgungundlovu	Uthukela	Umzinyathi	Amajuba	Zululand	Umkhanyakude	Uthungulu	Ilembe	Sisonke	Ethekwini
Other Programmes													
Nursing, EMS etc Colleges	R68,292	R4,371,114	R3,007,742	-	-	-	-	-	-	-	-	-	R1,363,372
Total all programmes	**R6,506,796**	**R878,154,508**	**R134,414,959**	**R99,014,529**	**R73,274,110**	**R59,377,195**	**R114,720,259**	**R 49,417,354**	**R 79,614,892**	**R82,852,979**	**R21,727,365**	**R31,247,873**	**R132,492,993**

Part B - Programme 8: Infrastructure Development

Table 108: Situation Analysis Indicators for Infrastructure Development[190]

Indicator	Actual Provincial Value 2005/06	Actual Provincial Value 2006/07	Actual Provincial Value 2007/08	Actual Provincial Value 2008/09	Ugu 2008/09	Umgungundlovu 2008/09	Uthukela 2008/09	Umzinyathi 2008/09	Amajuba 2008/09	Zululand 2008/09	Umkhanyakude 2008/09	Uthungulu 2008/09	Ilembe 2008/09	Sisonke 2008/09	Ethekwini 2008/09	National Target 2008/09
Input																
1. Equitable share capital programme as % of total health expenditure.[191]	4.06%	6.97%	4.9%	3.28%	1.56%	0.56%	0.09%	0.07%	0.05%	0.11%	0.10%	0.13%	0.10%	0.11%	0.42%	-
2. Hospitals funded on revitalisation programme as % of total health expenditure.[192]	9.5%	1.93%	2.7%	1.88%	-	-	-	-	-	-	0.06%	0.48%	-	0.08%	1.27%	-
3. Expenditure on facility maintenance as % of total health expenditure.[193]	1.36%	1.39%	1.6%	1.51%	0.19%	0.18%	0.05%	0.06%	0.06%	0.13%	0.13%	0.14%	0.06%	0.11%	0.40%	
4. Expenditure on medical equipment maintenance as % of total health expenditure.	-	0.02%	0.07%	0.07%	0.04%	0.07%	0.02%	0.03%	0.03%	0.03%	0.01%	0.01%	0.01%	0.03%	0.20%	
Quality																
5. Fixed PHC facilities with access to piped	86%	86%	98%	95.2%	99.8%	100%	99.5%	99.8%	100%	99%	99.3%	98.5%	100%	99.3%	100%	100%

[190] All data for this table taken form the estimated values in the APP 2009/10 as no data supplied by Unit, unless otherwise stipulated
[191] Data supplied by the Infrastructure Unit for 2008/09
[192] Data supplied by the Infrastructure Unit for 2008/09
[193] Data supplied by the Infrastructure Unit for 2008/09

Indicator	Actual Provincial Value 2005/06	Actual Provincial Value 2006/07	Actual Provincial Value 2007/08	Actual Provincial Value 2008/09	Ugu 2008/09	Umgungundlovu 2008/09	Uthukela 2008/09	Umzinyathi 2008/09	Amajuba 2008/09	Zululand 2008/09	Umkhanyakude 2008/09	Uthungulu 2008/09	Ilembe 2008/09	Sisonke 2008/09	Ethekwini 2008/09	National Target 2008/09
water.																
6. Fixed PHC facilities with access to mains electricity.	100%	100%	98%	97.6%	99.8%	100%	100%	100%	100%	100%	99.8%	100%	100%	98.1%	100%	100%
7. Fixed PHC facilities with access to fixed line telephone.	98%	98%	96%	93.5%	99.3%	100%	99.8%	99%	99.8%	99.8%	98.8%	99%	100%	98.1%	100%	100%
8. Average backlog of service platform in fixed PHC facilities. (R'000,000)	R 252	R 302	R 361	R2,142	15%	5%	8%	8%	9%	16%	9%	11%	3%	2%	14%	-
9. Average backlog of service platform in District Hospitals. (R'000,000)	R 731	R 874	R 1,045	R4,050	13%	2%	2%	17%	4%	13%	13%	9%	11%	14%	2%	-
10. Average backlog of service platform in Regional Hospitals. (R'000,000)	R 690	R 825	R 987	R3,434	7%	5%	1%	-	3%	-	-	10%	4%	-	70%	-
11. Average backlog of service platform in Specialised Hospitals. (R'000,000)	R 409	R 489	R 585	R1,806	10%	75%	-	3%	-	2%	-	10%	-	-	-	-

Part B - Programme 8: Infrastructure Development

Indicator	Actual Provincial Value 2005/06	Actual Provincial Value 2006/07	Actual Provincial Value 2007/08	Actual Provincial Value 2008/09	Ugu 2008/09	Umgungundlovu 2008/09	Uthukela 2008/09	Umzinyathi 2008/09	Amajuba 2008/09	Zululand 2008/09	Umkhanyakude 2008/09	Uthungulu 2008/09	Ilembe 2008/09	Sisonke 2008/09	Ethekwini 2008/09	National Target 2008/09
12. Average backlog of service platform in Tertiary and Central Hospitals. (R'000,000)	R 1,727	R 2,066	R 2,467	R 62	-	100%	-	-	-	-	-	-	-	-	-	-
13. Average backlog of service platform in Provincially Aided Hospitals.[194]	-	-	-	R 557	-	-	-	-	-	-	-	-	-	-	-	-
Efficiency																
14. Projects completed on time.	-	-	21%	39%	3%	0%	4%	2%	1%	2%	2%	6%	0%	0%	4%	-
15. Project budget over run.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Outcome																
16. Level 1 beds per 10 000 uninsured population	10	10	10	-	13	6	6	26	1	19	21	16	7	20	3	90
17. Level 2 beds per 10 000 uninsured population.	8	8	8	-	5	10	7	-	31	-	-	-	9	-	13	60
18. Population within 5 km of fixed PHC facility	-	-	6,279,899	-	481,629	709,517	252,374	231,294	307,877	257,938	231,708	343,729	420,166	252,318	2,423,704	95%

[194] Data not available

Table 109: Revitalisation Projects (2008/09 Expenditure)

Hospitals	Amount (R'000)
King George V Hospital	R 192,725
Empangeni Hospitals Project	R 89,791
Dr Pixley Seme Hospital	R 3,431
Dr John Dube Hospital	R 0
Hlabisa Hospital	R 15,422
Madadeni Hospital	R 1,556
Ngwelezane Hospital	Falls under Empangeni Hospital.
Total	R 302,925

Table 110: (NHS 5) Physical Infrastructure[195]

Activity	Indicators	2006/07 Target	2007/08 Target	2008/09 Target	2008/09 Progress
Hospital revitalisation.	Funded hospitals in plan.	36 hospitals started on site, in progress or completed.	42 hospitals started on site, in progress or completed.	42 hospitals started on site, in progress or completed.	KZN has 8 funded Hospitals in the Plan, 5 of which are on site & under construction (6 actually because the Empangeni business case is Two hospital - i.e. Lower Umfolozi and Ngwelezane), and 4 are in Planning
	Approved business cases, including MTS hospitals.	At least 2 new business cases completed and approved by May 2006.	At least 1 new business case completed and approved by May 2007.	At least 1 new business case completed and approved by May 2008.	8 Business Cases approved, 1 submitted (3 years ago - still awaiting approval) and 1 Business case to be compiled
Forensic Mortuaries/ Coroners Grant	Forensic mortuaries re-built /upgraded.	20% of forensic mortuaries.	30% of forensic mortuaries.	50% of forensic mortuaries.	11% of prioritised mortuaries are under design and 24% are on construction.

[195] Information in this table to still be verified

Part B – Programme 8: Infrastructure Development

Activity	Indicators	2006/07 Target	2007/08 Target	2008/09 Target	2008/09 Progress
Hospital Maintenance.	Maintenance increased.	Worst 10% of non-revitalisation hospitals receiving essential upgrades.	Worst 18% of non-revitalisation hospitals with completed essential upgrades.	Worst 22% of non-revitalisation hospitals with completed essential upgrades.	Maintenance budget held at facility level.
		Maintenance expenditure increased to 1.4% of budget in all provinces.	Maintenance expenditure increased to 1.6% in all provinces.	Maintenance expenditure increased to 1.9% in all provinces.	1%, decreased due to forced budget savings.
EHTP Essential Health Technology Programme.	Essential equipment provision.	Agreement on essential equipment packages (EQL) for all levels of care.	Vision: to focus on replacing redundant and absolute X-Ray equipment in all levels of care for 3 year MTEF Plan i.e. 2007-2010.	15% of the prioritized has been addressed. Challenges: CSCM changes in Technology and the lack of skills.	Progress - 80% of the priorities has been addressed. Challenges: CSCM, changes in Technology and the lack of skills.
			Worst 20% of hospitals with full EQL.	Worst 50% of hospitals with full EQL.	No budget available.
			Worst 30% of PHC facilities with full EQL.	60% of PHC facilities with full EQL.	No budget available.
PHC.	Designated staff accommodated.	Audit of required accommodation and business plan by the Department by June 2006.	Accommodation provided in accordance with business plan.	Accommodation provided in accordance with business plan.	Current leases have been retained. All new CHC's are designed with provision for staff accommodation as identified in the Management Plan.
	Inter-sectoral infrastructure provision.	Agreement on gaps in inter-sectoral infrastructure.	25% of facilities with infrastructure gaps addressed.	50% of facilities with infrastructure gaps addressed.	Indicator unclear.
	Facilities audited.	Audit of size and condition of all PHC facilities completed.	Worst 18% of facilities receiving essential upgrades.	Worst 22% of facilities receiving essential upgrades.	Facilities have been audited as planned. There was a challenge with the provision newly identified essential upgrades due to the backlog that had to be funded.

Activity	Indicators	2006/07 Target	2007/08 Target	2008/09 Target	2008/09 Progress
	CHC's development.	STP for CHC restructuring implemented.	STP for CHC restructuring implemented.	STP for CHC restructuring implemented.	Construction is slow due to poor performance by Ithala. Identified projects still in construction due to delays experienced.

Table 111: Provincial Objective and Performance Indicators for Infrastructure Development

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
Strategic Objective 5: To accelerate infrastructure development and purchase of medical equipment. (Goal 1)					
Measurable Objective: To facilitate the provisioning of basic enabling services.					
1. Fixed PHC facilities with access to piped water.	Not measured	100%	97%	100%	98%
2. Fixed PHC facilities with access to mains electricity.	Not measured	99%	100%	100%	99%
3. Fixed PHC facilities with access to fixed line telephones.	Not measured	96%	96%	100%	95%
Measurable Objective: To oversee the implementation of capital Maintenance and Equipment.					
4. Expenditure on facility maintenance as % of total health expenditure.	Not measured	1.4%	1.6%	1.9%	1.7%
5. Expenditure on equipment maintenance as % of total health expenditure.	Not measured	0.08%	0.07%	0.08%	0.07%
Measurable Objective: To facilitate the provision of new infrastructure projects.					
6. New/upgraded PHC facilities/projects.	Not measured	-	30	30	30
7. New/upgraded Hospitals/projects.	Not measured	-	1	1	1
Measurable Objective: To appropriately manage and monitor infrastructure projects.					
8. New Hospital completed.	Not measured	0	0	0	0
9. New PHC Clinics / CHC's completed.	Not measured	14	11	43	10
10. Upgraded Hospitals (Number of projects).	Not measured	76	92	59	15
11. Upgraded PHC Clinics / CHC's (Number of projects).	Not measured	147	52	47	19
12. Upgraded District Hospitals (Number of projects).	Not measured	22	28	22	7
Measurable Objective: To quantify infrastructure backlogs and fast track implementation [196]					
13. Average backlog of fixed PHC facilities (R'000).	R 252,356	R 303,818	R 361,9000	R 423,000	R 2,142
14. Average backlog District Hospitals (R'000).	R 730,756	R 873,984	R 1,045,285	R 1,232,000	R 4,050
15. Average backlog Regional Hospitals (R'000).	R 690,092	R 825,350	R 987,119	R 1,163,000	R 3,434

[196] Implementation not fast-tracked as no budget available, as budget is decreasing annually in real value - Information as per three year MTEF Infrastructure Programme Management Plan

Part B – Programme 8: Infrastructure Development

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	2008/09 Actual
16. Average backlog Specialised Hospitals (R'000).	R 409,032	R 489,202	R 585,086	R 689,000	R 1,806
17. Average backlog Tertiary Hospitals (R'000).	R 1,727,024	R 2,065,521	R 2,466,972	R 2,913,000	R 62
18. Average backlog Auxiliary Services (R'000).	-	-	-	-	R 1,947
Total average backlog (R'000).	**R 3,809,260**	**R 4,555,875**	**R 5,445,436**	**R 6,420,000**	**R 13,441**

PART C:

HUMAN RESOURCE MANAGEMENT OVERSIGHT REPORT

Part C - HRMS Oversight Report

TABLE OF CONTENTS

HUMAN RESOURCE MANAGEMENT

NATIONAL AND PROVINCIAL GOALS, OBJECTIVES AND PRIORITIES

National Health Priorities 2006/07 - 2008/09

Priority 7: Human Resource Planning, Development and Management.

↓

Provincial Strategic Plan 2005 - 2009/10

Goal 4: Human Resource Management for Public Health

↓

Annual Performance Plan 2008/09

Goal 3

Strategic Objective 10: To sustain and expand the health workforce through implementation of innovative human resources management strategies.

↓

HRMS Priorities 2008/09

1. Align the Human Resource Development Strategies of the Department with the service delivery imperatives in the STP.
2. Align the business of HRM and HRD to support the core business of the Department.
3. Implement the Performance Management and Development System.
4. Develop and implement an effective Human Resource Recruitment and Retention Strategy.
5. Implement the HRP of the Department in close consultation with Universities, Colleges and other key roleplayers.
6. Fast track the implementation of an effective and efficient employee well-being programme including special focus on health workers.

PERFORMANCE

⇒ PRIORITY 1: ALIGN HUMAN RESOURCE DEVELOPMENT STRATEGIES WITH IMPERATIVES IN THE STP

The Human Resource Plan (HRP) is fully aligned with the imperatives set in the STP, and makes provision for alignment of human resources with expansion of package of services projected over a 10 year period. The HRP was approved by the Acting Head of Department and the DPSA in the first quarter of 2008/09.

⇒ PRIORITY 2: ALIGN THE BUSINESS OF HRM AND HRD TO SUPPORT THE CORE BUSINESS OF THE DEPARTMENT

Human Resource Development (HRD) and Human Resource Management (HRM) are aligned to support the core business of the Department. Part of the support required was the development and approval of organisational structures to ensure the service delivery within the organisation is improved. Organisational structures for Head Office, District Offices, Specialised Hospitals and Tertiary Hospitals were approved in 2007/8. PHC structures were developed and are awaiting final approval. Structures for the Central Hospital, EMRS, Regional and District Hospitals have been developed during 2008/09 and require finalisation and approval from both the Department and the DPSA prior to implementation.

⇒ PRIORITY 3: IMPLEMENT THE PERFORMANCE MANAGEMENT AND DEVELOPMENT SYSTEM (PMDS)

PMDS has been implemented as the preferred Performance Management System for the Department. Training was given to Head Office staff during 2008/09 and rollout to Districts and Institutions commenced. It is anticipated that this will result in the system becoming effective as an employee performance management system. The approved post structure for EMPDS has not been filled due to budgetary constraints in 2008/09, which has led to gaps within the key result areas.

All Senior Management Services have been assessed for competency in terms of the DPSA directive.

! CHALLENGES

- Non-compliance to the PMDS reporting requirements.
- Non-payment of performance bonuses to qualifying personnel had a negative effect on the staff morale.
- Due to budget constraints posts were not filled resulting in certain functions not being performed effectively.

⇒ PRIORITY 4: STRATEGIES FOR RECRUITMENT AND RETENTION OF HUMAN RESOURCES

The strategies for recruitment and retention of human resources were not reviewed in 2008/09 and have been prioritised for 2009/10. The HRM Policy Development Sub-Component was dismantled during the reporting period, hindering the development and reviewing of policies.

The Scarce Skills Recruitment Policy came into effect in January 2009. This has been instrumental in retaining staff that have been offered posts in other Departments, with particular reference to Emergency Service Personnel with Advanced Life Support qualifications. It is still too early to assess the true impact that this policy will have on retention and human resource trends especially in the medical and nursing fields.

Occupational Specific Dispensation (OSD) was implemented during 2007/08 as a means to retain critical staff within government structures. OSD for nursing, implemented in 2007/08, contributed significantly to the Department's over-expenditure in the same reporting period. The medical OSD was due for implementation on 01 July 2008, however due to over-expenditure in 2007/08 and 2008/09 implementation has been postponed and was not implemented during 2008/09. The delay in implementation has caused concern in the medical field with medical practitioners and EMRS expressing their dissatisfaction regarding their remuneration packages and working conditions.

⇒ PRIORITY 5: IMPLEMENTATION OF THE HRP IN CONSULTATION WITH UNIVERSITIES, COLLEGES, ETC.

The HRP has been developed in consultation with internal stakeholders. Universities and Colleges have not yet been included in this process.

⇒ PRIORITY 6: IMPLEMENTATION OF AN EMPLOYEE WELL-BEING PROGRAMME

The Employee Wellness Programme is fully functional with all Districts and Institutions reporting their activities to Head Office. Dedicated health worker clinics have been established in Head Office and Institutions.

Table 112: (HR 3) Situational Analysis and Projected Performance for Human Resources (excluding Health Sciences and Training)

Indicator	Type	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Target	*2008/09 Actual*
Input						
1. Medical Officers per 100,000 people.	No	14	16	14.5	22	*28*
2. Medical Officers per 100,000 people in rural districts.	No	9	10.5	10.7	11	*12*
3. Professional Nurses per 100,000 people.	No	101	103	100.5	115	*111*
4. Professional Nurses per 100,000 people in rural Districts.	No	84	88	95.2	100	*50*
5. Pharmacists per 100,000 people.	No	10	15	13	21	*5*
6. Pharmacists per 100,000 people in rural Districts.	No	5	8	2.6	12	*2*
Process						
7. Vacancy rate for Professional Nurses.	%	19%	17%	20.75%	16%	*21.3%*
8. Attrition rate for Doctors.	%	90%	13.8%	10.30%	9%	*Not available*
9. Attrition rate for Professional Nurses.	%	12%	13%	12.80%	12%	*Not available*
10. Absenteeism for Professional Nurses.	%	10%	50%	49.70%	30%	*Not available*
Quality						
11. Hospitals with employee satisfaction survey.	%	67%	71%	56%	67%	-
Efficiency						
12. Nurse clinical workload (PHC).	No	-	1:40	1:37	1:36	*1:23 (Nurse) 1:40 (PN)*
13. Doctor clinical workload (PHC).	No	-	1:23	1:23	1:24	*1:25*
Outcome						
14. Supernumerary staff as percentage of establishment.[197]	%	Not available	Not available	Not available	Not available	*Not available*
Indicators removed from this table: Clinical audit rate and complaints resolved within 25 days.						

[197] The Department has supernumerary staff however the exact number has not been determined.

SERVICE DELIVERY

All departments are required to develop a Service Delivery Improvement (SDI) Plan. The following tables reflect the components of the SDI Plan as well as progress made in the implementation of the plans.

Table 113: Main Services Provided and Standards

Main Service	Actual Customers	Potential Customers	Standard of Service	2008/09 Actual Achievements Against Standards
Creation of posts	Line function and support personnel of the Department	Members of the population attracted to work in the Department	Efficient workforce	The organogram was rationalized and aligned with Departmental imperatives and requirements.
Human Resource Development	All employees of the Department	Students in Tertiary Institutions	Efficient employees	Training and development programmes were implemented to enhance personnel competencies in line with requirements in job descriptions and work place.
Human Resource Provisioning	All employees of the Department	New applicants	Number of appointments	Appropriately placed personnel.
Labour Relations	All employees of the Department	None	Knowledge of Conditions of Service and Labour Relations prescripts	Competencies developed at District/Institutional levels to manage labour relations cases.
Evaluation of posts	All employees of the Department	None	Appropriate level of posts determined	Appropriate skills mix and competence identified to compliment the Department's organogram and service delivery responsibilities

Source: HRMS

Table 114: Consultation Arrangements with Customers

Type of Arrangement	Actual Customers	Potential Customers	2008/09 Actual Achievements
Institutional Management and Labour Committees	Employees, Organised Labour and Management	None	Institutional Committees provide first level intervention on transversal issues.
Bargaining Chamber	Employees, Organised Labour and Management	None	Chamber provides an appropriate forum to resolve disputes emanating from Institutional Management and Labour Committees (IMLC's) and reach agreement on sector specific conditions.
Human Resource Management Forum	Human Resource Managers, employees and Head Office Management	Organised Labour	Allows for first level contact with Districts and sharing of best practices amongst institutions.

Source: HRMS

Table 115: Service Delivery Access Strategies

Access Strategy	2008/09 Actual Achievements
Batho Pele Principles	These training programmes have been devolved to a District and Institutional level targeting Public Relation Officers in these institutions. The DPSA has been engaged to assist with these initiatives and has already commenced.
Patients' Rights Charter	

Source: HRMS

Table 116: Service Information Tools

Types of Information Tools	2008/09 Actual Achievements
Information Kiosks	63 of the existing 90 Kiosks were operational in 2008/09
Departmental Website	The Departmental Website is fully functional
Telemedicine	The implementation of Telemedicine has been hampered by numerous challenges both internal and external. The lack of a dedicated post within the Department to drive Telemedicine has exacerbated the situation further. One of the main reasons for non-implementation of this programme is the bandwidth and connectivity to rural areas. Other factors include the lack of IT support at peripheral hospitals, lack of diagnostic instruments and insufficient training of medical staff in telemedicine - all directly attributed to budget constraints.
Teleconferencing	The above applies

Source: Informatics

Table 117: Complaints Mechanism

Complaints Mechanism	Actual Achievements
Grievance Procedure	PSCBC Resolution No. 2 of 1999 is followed for grievances and dispute resolution
Dispute Resolution Mechanism	PSCBC Resolution No. 2 of 1999 is followed for grievances and dispute resolution

Source: HRMS

EXPENDITURE

The following tables summarise the final audited expenditure by Programme (Table 198) and salary bands (Table 199) of the Departments' budget in terms of clearly defined Programmes. It provides an indication of the amount spent on personnel costs in terms of each of the Programmes or salary bands within the Department.

Table 118: Personnel Costs by Programme - 2008/09

Programme	Total Voted Expenditure (R'000)	Compensation of Employees Expenditure (R'000)	Training Expenditure (R'000)	Professional and Special Services (R'000)	Compensation of Employees as % of Total Expenditure	Average Compensation of Employees Cost per Employee (R'000)	Total Employment
Department of Health	-	R 0	R 0	R 0	0%	R 0	-
(P1) Administration	R 284,066	R 163,648	R 0	R 0	57.61%	R 3	-
(P2) District Health Services	R 8,132,272	R 5,264,489	R 0	R 0	64.74%	R 11	-
(P3) Emergency Medical Service	R 672,360	R 381,733	R 0	R 0	56.78%	R 6	-
(P4) Provincial Hospital Services	R 4,378,814	R 3,015,350	R 0	R 0	68.86%	R 46	-
(P5) Central Hospital	R 1,821,221	R 717,372	R 0	R 0	39.39%	R 11	-
(P6) Health Sciences & Training	R 676,601	R 528,940	R 0	R 0	78.18%	R 8	-
(P7) Health Care Support	R 34,209	R 0	R 0	R 0	0.00%	R 0	-
(P8) Health Facilities Management	R 1,103,558	R 5,510	R 0	R 0	0.50%	R 0	-
Total on Financial System (BAS)	**R 17,103,101**	**R 10,077,044**	**R 0**	**R 0**	**58.9%%**	**R 85**	**66,205**

Source: Vulindlela and Annual Financial Statements for 2008/09

Table 119: Personnel Costs by Salary Bands - 2008/09

Salary Bands	Compensation of Employees Cost (r'000)	% of Total Personnel Cost for Department	Average Compensation Cost per employee	Total Personnel Cost for Department [198] (R'000)	Number of Employees
Lower Skilled (Levels 1-2)	R 636,661	6.27%	R 71,890	-	8,856
Skilled (Levels 3-5)	R 3,111,280	30.66%	R 97,554	-	31,893
Highly Skilled Production (Levels 6-8)	R 20,16,065	19.87%	R 175,600	-	11,481
Highly Skilled Supervision (Levels 9-12)	R 3,613,933	35.62%	R 329,738	-	10,960
Senior Management (Levels 13-16)	R 187,533	1.85%	R 750,132	-	250
Other	R 45,701	0.45%	R 0	-	0
Contract (Levels 1-2)	R 11,190	0.11%	R 21,437	-	522
Contract (Levels 3-5)	R 27,783	0.27%	R 69,982	-	397
Contract (Levels 6-8)	R 208,473	2.05%	R 165,324	-	1,261
Contract (Levels 9-12)	R 164,847	1.62%	R 288,699	-	571
Contract (Levels 13-16)	R 10,018	0.10%	R 715,571	-	14
Periodical Remuneration	R 22,388	0.22%	R 32,779	-	683
Abnormal Appointment	R 21,172	0.21%	R 29,989	-	706
TOTAL	**R 10,077,044**	**100%**	**R 148,406**	**R 10,146,317**	**67,594**[199]

Source: Vulindlela

Table 120 provides a summary, per Programme, of expenditure incurred as a result of salaries, overtime, home owners allowance and medical assistance. In each case, the table provides an indication of the percentage of the personnel budget that was used for these items.

[198] Including Goods and Transfers
[199] Periodical Remuneration and Abnormal Appointments account for the different of 1,389 in the total number of employees

Part C - HRMS Oversight Report

Table 120: Salaries, Overtime, Home Owners Allowance (HOA) and Medical Assistance by Programme - 2008/09

Programme	Salaries (R'000)	Salaries as % of Personnel Cost	Overtime (R'000)	Overtime as % of Personnel Cost	HOA (R'000)	HOA as % of Personnel Cost	Medical Association (R'000)	Medical Association as % of Personnel Cost	Total Personnel Cost per Programme (R'000)
(P1) Administration	R 126,483	73.2%	R 721	0.4%	R 3,336	1.9%	R 7,121	4.1%	R 163,648
(P2) District Health Services	R 3,727,035	69.6%	R 150,620	2.8%	R 187,957	3.5%	R 245,151	4.6%	R 5,264,489
(P3) Emergency Medical Services	R 239,769	63.2%	R 43,771	11.5%	R 16,211	4.3%	R 23,269	6.1%	R 381,733
(P4) Provincial Hospital Services	R 2,044,427	68.2%	R 161,904	5.4%	R 93,255	3.1%	R 135,839	4.5%	R 3,015,350
(P5) Central Hospitals	R 474,610	70.5%	R 40,760	6.1%	R 16,572	2.5%	R 29,785	4.4%	R 717,372
(P6) Health Sciences & Training	R 375,117	70.3%	R 46,831	8.8%	R 21,783	4.1%	R 14,960	2.8%	R 528,940
(P8) Health Facilities Management	R 2,311	72.6%	R 0	0%	R 19	0.6%	R 33	1%	R 5,510
TOTAL	**R 7,009,225**	**69.1%**	**R 446,718**	**4.4%**	**R 339,855**	**3.3%**	**R 457,309**	**4.5%**	**R 10,077,044**

Source: Vulindlela

EMPLOYMENT AND VACANCIES

The following tables summarise the number of posts on the establishment, the number of employees, the vacancy rate, and whether there are any staff that are additional to the establishment. This information is presented in terms of three key variables namely Programme (121), Salary Band (Table 122) and Critical Occupations (Table 123). Departments have identified critical occupations that need to be monitored. Table 123 provides establishment and vacancy information for the key critical occupations of the Department. The vacancy rate reflects the percentage of posts that are not filled.

Table 121: Employment and Vacancies by Programme - 31 March 2009

Programme	Number of Posts	Number of Posts Filled	Vacancy Rate	Number of Posts Filled Additional to Establishment[200]
(P1) Administration	968	688	28.93%	8
(P2) District Health Services	45,420	35,719	21.36%	3
(P3) Emergency Medical Service	3,816	3,059	19.84%	0
(P4) Provincial Hospital Services	24,659	18,730	24.04%	10
(P5) Central Hospital	4,479	3,665	18.14%	00
(P6) Health Sciences & Training	5,617	4,199	25.24%	0
(P8) Health Facilities Management	12	9	25.00%	0
Donor funds	0	0	52.63%	0
Persal agencies	19	9	6.57%	1
Trading Accounts - Permanent	137	128	100%	0
TOTAL	**85,124**	**66,205**	**22.86%**	**13**

Source: Vulindlela

[200] Abnormal appointments have not bee included in these figures

Table 122: Employment and Vacancies by Salary Bands - 31 March 2009

Salary Band	Number of Posts	Number of Posts Filled	Vacancy Rate	No. of Posts Filled Additional to Establishment
Lower Skilled (Levels 1-2)	11,005	8,856	19.53%	0
Skilled (Levels 3-5)	38,391	31,893	16.93%	1
Highly Skilled Production (Levels 6-8)	16,604	11,481	30.85%	8
Highly Skilled Supervision (Levels 9-12)	15,817	10,960	30.71%	3
Senior Management (Levels 13-16)	534	250	53.18%	1
Other - (Temporary)	8	0	100%	0
Contract (Levels 1-2)	522	522	0%	0
Contract (Levels 3-5)	389	397	-2.06%	0
Contract (Levels 6-8)	1,270	1,261	0.71%	0
Contract (Levels 9-12)	570	571	-0.18%	0
Contract (Levels 13-16)	14	14	0%	0
Periodical Remuneration	-	683	-	-
Abnormal Appointment	-	706	-	-
TOTAL	**85,124**	**67,594**[201]	**20.59%**	**13**

Source: Vulindlela

Table 123: Employment and Vacancies by Critical Occupation - 31 March 2009

Critical Occupations	Number of Posts	Number of Posts Filled	Vacancy Rate	No. of Posts Filled Additional to Establishment
Ambulance and related workers	3,712	2,878	22.5%	0
Chiropodists and other related workers	2	1	50%	0
Community development workers	2	1	50%	0
Dental Practitioners				
Permanent	110	69	37.3%	0
Temporary	2	4	-100%	0
Dental Specialists	8	8	0%	0
Dental Technicians	1	0	100%	0
Dental Therapy	70	26	62.9%	0
Dieticians and Nutritionists				
Permanent	366	86	76.5%	0
Temporary	1	1	0%	0
Emergency services related	36	19	47.2%	0

[201] Periodical Remuneration and Abnormal Appointments account for the different of 1,389 in the total number of employees

Critical Occupations	Number of Posts	Number of Posts Filled	Vacancy Rate	No. of Posts Filled Additional to Establishment
Environmental Health	257	174	32.3%	0
Health Sciences related	1,120	963	14%	2
Life Sciences professionals	4	4	0%	0
Life Sciences related	7	4	42.9%	0
Medical Practitioners				
Permanent	4,308	2,643	38.6%	0
Temporary	278	399	-43.5%	0
Medical Research and related professionals				
Permanent	21	8	61.9%	0
Temporary	1	3	-200%	0
Medical Specialists				
Permanent	1,513	461	69.5%	0
Temporary	102	159	-55.9%	0
Medical Technicians/ Technologists	130	78	40%	0
Nursing Assistants	7,847	6,563	16.4%	0
Occupational Therapy	318	131	58.8%	0
Optometrists and Opticians	41	14	65.9%	0
Oral Hygienists	52	25	51.9%	0
Pharmaceutical Assistants	1,034	679	34.3%	0
Pharmacists				
Permanent	1,681	414	75.4%	0
Temporary	4	3	25%	0
Pharmacologists Pathologists & related professionals	1	1	0%	0
Physicists	10	4	60%	0
Physiotherapy				
Permanent	588	235	60%%	0
Temporary	3	3	0	0
Professional Nurse				
Permanent	15,646	12,300	21.4%	0
Temporary	26	28	-7.7%	0
Psychologists and Vocational Counsellors				
Permanent	165	60	63.6%	0
Temporary	4	10	-150%	0
Radiography				

Part C - HRMS Oversight Report

Critical Occupations	Number of Posts	Number of Posts Filled	Vacancy Rate	No. of Posts Filled Additional to Establishment
Permanent	882	456	48.3%	0
Temporary	7	7	0%	0
Assistant Manager Nursing (specialty unit)	1	1	0%	0
Clinical Nurse Practitioner (primary health care)	1	1	0%	0
Lecturer - (t) Permanent	10	6	40%	1
Lecturer: Senior - (t) Permanent	4	4	0%	1
Operational Manager Nursing (general)	1	1	0%	0
Social Sciences related	5	3	40%	0
Social Sciences supplementary workers	8	5	37.5%	0
Social Work and related professionals	512	215	58%	0
Speech Therapy and Audiology				
Permanent	134	79	41%	0
Temporary	1	1	0%	0
Staff Nurses and Pupil Nurses -				
Permanent	11,443	9,478	17.2%	0
Temporary	1	1	0%	0
Student Nurse	2,491	2,044	17.9%	0
Supplementary Diagnostic Radiographers	17	12	29.4%	0
TOTAL	**54,989**	**40,773**	**25.85%**	**4**

Source: Vulindlela

The information in each case reflects the situation as at 31 March 2009. For an indication of changes in staffing patterns over the year under review, please refer to section 5 of this report.

JOB EVALUATION

The Public Service Regulations, 1999 introduced job evaluation as a way of ensuring that work of equal value is remunerated equally. Within a nationally determined framework, executing authorities may evaluate or re-evaluate any job in his or her organisation. In terms of the Regulations all vacancies on salary levels 9 and higher must be evaluated before they are filled. This was complemented by a decision by the Minister for the Public Service and Administration that all SMS jobs must be evaluated before 31 December 2002.

Table 124 summarises the number of jobs that were evaluated during the year under review. The table also provides statistics on the number of posts that were upgraded or downgraded.

Table 124: Job Evaluation - 1 April 2008 to 31 March 2009

Salary Band	Number of Posts	Number of Jobs Evaluated	% of Posts Evaluated	No. of Posts Upgraded	% of Upgraded Posts Evaluated	No. of Posts Down-Graded	% of Downgraded Posts Evaluated
Lower skilled (Levels 1-2)	11,005	0	0%	1	0%	0	0%
Skilled (Levels 3-5)	38,391	3	0%	0	0%	0	0%
Highly skilled production (Levels 6-8)	16,604	25	0.2%	0	0%	0	0
Highly skilled Supervision (Levels 9-12)	15,817	1	0%	0	0%	2	200%
Senior Management Service Band A	258	0	0%	0	0%	0	0%
Senior Management Service Band B	232	0	0%	0	0%	0	0%
Senior Management Service Band C	41	0	0%	0	0%	0	0%
Senior Management Service Band D	3	0	0%	0	0%	0	0%
Contract (Levels 1-2)	522	0	0%	0	0%	0	0%
Contract (Levels 3-5)	389	0	0%	0	0%	0	0%
Contract (Levels 6-8)	1,270	0	0%	0	0%	0	0%
Contract (Levels 9-12)	570	0	0%	0	0%	0	0%
Contract (Management Band A & B)	10	0	0%	0	0%	0	0%
Contract (Management Band C & D)	4	0	0%	0	0%	0	0%

Part C - HRMS Oversight Report

Salary Band	Number of Posts	Number of Jobs Evaluated	% of Posts Evaluated	No. of Posts Upgraded	% of Upgraded Posts Evaluated	No. of Posts Down-Graded	% of Downgraded Posts Evaluated
Other	8	0	0%	0	0%	0	0%
TOTAL	**85,124**	**29**	**0.2%**	**1**	**3.4%**	**2**	**6.9%**

Source: Vulindlela

The following table provides a summary of the number of employees whose salary positions were upgraded due to their posts being upgraded. The number of employees might differ from the number of posts upgraded since not all employees are automatically absorbed into the new posts and some of the posts upgraded could also be vacant.

Table 125: Profile of Employees whose Salary Positions were upgraded due to their Posts being Upgraded - 1 April 2008 to 31 March 2009

Beneficiaries	African	Asian	Coloured	White	Total
Female	0	0	0	0	0
Male	0	0	0	0	0
Total	0	0	0	0	0
Employees with a Disability	0	0	0	0	0

Source: OIS

The following table summarises the number of cases where remuneration levels exceeded the grade determined by job evaluation. Reasons for the deviation are provided in each case.

Table 126: Employees whose Salary Level exceed the Grade determined by Job Evaluation: 1 April 2008 to 31 March 2009 (in terms of PSR 1.V.C.3)

Occupation	Number of Employees	Job Evaluation Level	Remuneration Level	Reason for Deviation	Number of Employees in Department
Employees whose salary level exceeds the grade determined by job evaluation	0	0	0	0	0
Total	0	0	0	0	0
Percentage of Total Employment	0	0	0	0	0

Source: OIS

Table 127 summarises the beneficiaries of the above in terms of race, gender, and disability.

Table 127: Profile of Employees whose Salary Level exceeds the Grade determined by Job Evaluation - 1 April 2008 to 31 March 2009 (in terms of PSR 1.V.C.3)

Beneficiaries	African	Asian	Coloured	White	Total
Female	0	0	0	0	0
Male	0	0	0	0	0
Total	0	0	0	0	0
Employees with a Disability	0	0	0	0	0

Total Number of Employees whose salaries exceeded the grades determined by job evaluation in 2008/ 09	**Nil**

Source: OIS

EMPLOYMENT CHANGES

This section provides information on changes in employment over the financial year. Turnover rates provide an indication of trends in the employment profile of the Department. The following tables provide a summary of turnover rates by Salary Band (Table 128) and by Critical Occupations (Table 129).

Table 128: Annual turnover rates by Salary Band for the Period 1 April 2008 to 31 March 2009

Salary Band	Employment at Beginning of Period (April 2008)	Appointments and Transfers into the Department	Terminations and Transfers out of the Department	Turnover Rate
Lower skilled (Levels 1-2)	9,213	416	677	7.35%
Skilled (Levels 3-5)	32,219	1,548	1,468	4.56%
Highly skilled production (Levels 6-8)	11,583	513	1,215	10.49%
Highly skilled Supervision (Levels 9-12)	11,307	388	749	6.62%
Senior Management Service Band A	205	8	19	9.27%
Senior Management Service Band B	40	1	3	7.5%
Senior Management Service Band C	1	0	1	100%
Other,	538	119	26	4.83%
Contract (Levels 1-2)	62	207	290	467.74%
Contract (Levels 3-5)	315	245	146	46.35%
Contract (Levels 6-8)	1,020	824	699	68.53%
Contract (9-12)	428	272	276	64.49%
Contract (Band A)	7	3	1	14.29%
Contract (Band B)	1	1	1	100%
Contract (Band D)	2	0	2	100%
TOTAL	**67,241**	**4,545**	**5,573**	**8.29%**

Source: Vulindlela

Table 129: Annual turnover rates by Critical Occupation for the Period 1 April 2008 to 31 March 2009

Occupation	Employment at Beginning of Period (April 2008)	Appointments and Transfers into the Department	Terminations and Transfers out of the Department	Turnover Rate
Ambulance and related workers	2,866	91	87	3%
Chiropodists and other related workers	1	0	0	0%
Community Development Workers	1	0	0	0%
Dental Practitioners -				
Permanent	65	21	18	27.7%
Temporary	3	0	0	0%
Dental Specialists	5	4	1	20%
Dental Therapy	34	5	8	23.5%
Dieticians and Nutritionists -				
Permanent	78	36	31	39.7%
Temporary	1	0	1	100%
Emergency Services related	46	0	3	6.5%
Environmental Health	184	66	63	34.2%
Health Sciences related	869	16	39	4.5%
Life Sciences related	14	0	1	7.1%
Medical Practitioners -				
Permanent	2,619	766	559	21.34%
Temporary	463	161	228	49.2%
Medical Research and related professionals	13	0	2	15.4%
Medical Specialists -				
Permanent	399	35	59	14.8%
Temporary	143	34	42	29.4%
Medical Technicians/ Technologists -				
Permanent	83	5	16	19.3%
Temporary	2	0	2	100%
Nursing Assistants -				
Permanent	6,780	321	330	4.9%
Temporary	0	1	2	0%
Occupational therapy	132	64	71	53.8%
Optometrists and Opticians	14	2	1	7.1%
Oral Hygienists	26	0	2	7.7%
Pharmaceutical Assistants	619	21	29	4.7%
Pharmacists -				

Occupation	Employment at Beginning of Period (April 2008)	Appointments and Transfers into the Department	Terminations and Transfers out of the Department	Turnover Rate
Permanent	432	153	166	38.4%
Temporary	4	0	0	0%
Pharmacologists Pathologists & related professionals	0	1	1	0%
Physicists	4	1	0	0%
Physiotherapy -				
Permanent	253	75	93	36.8
Temporary	3	0	0	0%
Professional Nurse -				
Permanent	11,961	452	1,029	8.6%
Temporary	29	9	9	31%
Psychologists and Vocational Counsellors -				
Permanent	59	30	28	47.5%
Temporary	10	4	3	30%
Radiography -				
Permanent	475	81	98	20.6%
Temporary	8	3	2	25%
Social Sciences related	6	0	0	0%
Social Sciences supplementary workers	5	0	0	0%
Social Work and related professionals	212	14	9	4.2%
Speech Therapy and Audiology -				
Permanent	81	42	42	51.9%
Temporary	1	0	0	0%
Staff Nurses and Pupil Nurses -				
Permanent	9,759	531	710	7.3%
Temporary	1	0	0	0%
Student Nurse	2,104	563	106	5%
Supplementary Diagnostic Radiographers	17	1	4	23.5%
TOTAL	**40,884**	**3,610**	**3,895**	**9.5%**

Source: Vulindlela

Table 130 identifies the major reasons why staff left the Department.

Table 130: Reasons why Staff are leaving the Department

Termination Type	Number	% of Total Resignations	% of Total Employment	Total Resignations	Total Employment[202]
Death	656	11.77%	0.97%	-	-
Resignation	2,772	49.74%	4.10%	-	-
Transfers	5	0.1%	0%	-	-
Expiry of contract	1,239	22.23%	1.83%	-	-
Dismissal-operational changes	4	0.07%	0.01%	-	-
Discharged due to ill health	54	1%	0.1%	-	-
Dismissal-misconduct	183	3.28%	0.27%	-	-
Dismissal - inefficiency	1	0.02%	0%	-	-
Retirement	634	11.38%	0.01%	-	-
Other	26	0.46%	0.04%	-	-
TOTAL	**5,573**	**100%**	**8.24%**	**5,573**	**67,594**

Resignations as % of Employment
8.24%

Source: Vulindlela

Table 131: Promotions by Critical Occupation

Occupation	Employment at Beginning of Period (April 2008)	Promotions to another Salary Level	Salary Level Promotions as a % of Employment	Progressions to another Notch within Salary Level	Notch Progressions as a % of Employment
Ambulance and related workers	2,866	14	0.5%	1,915	66.8%
Chiropodists and other related workers	1	0	0%	1	100%
Community Development Workers	1	0	0%	1	100%
Dental Practitioners	68	1	1.5%	13	19.1 %
Dental Specialists	5	0	0%	3	60%
Dental Therapy	34	1	2.9%	5	14.7%
Dieticians and Nutritionists - Permanent	79	16	20.3%	10	12.7%
Emergency Services related	46	0	0%	32	69.6%
Environmental Health	184	3	1.6%	49	26.6%
Health Sciences related	869	27	3.1%	44	5.1%
Life Sciences related	14	0	0%	5	35.7%
Medical Practitioners - Permanent	3,082	239	7.8%	264	8.6%

[202] Total employment figure used by Vulindlela is the total employment at April 2008.

Part C - HRMS Oversight Report

Occupation	Employment at Beginning of Period (April 2008)	Promotions to another Salary Level	Salary Level Promotions as a % of Employment	Progressions to another Notch within Salary Level	Notch Progressions as a % of Employment
Medical Research and related professionals	13	3	23.1%	5	38.5%
Medical Specialists	542	71	13.1%	79	14.6%
Medical Technicians/ Technologists	85	7	8.2%	35	41.2%
Nursing Assistants	6,780	5	0.1%	15	0.2%
Occupational Therapy	132	8	6.1%	17	12.9%
Optometrists and Opticians	14	1	7.1%	5	35.7%
Oral Hygienists	26	0	0%	8	30.8%
Pharmaceutical Assistants	619	12	1.9%	292	47.2%
Pharmacists	436	43	9.9%	132	30.3%
Pharmacologists Pathologists & related professionals	0	0	0%	0	0%
Physicists	4	1	25%	0	0%
Physiotherapy	256	19	7.4%	64	25%
Professional Nurse	11,990	202	1.7%	90	0.8%
Psychologists and Vocational Counsellors	69	3	4.3%	12	17.4%
Radiography	483	42	8.7%	153	31.7%
Social Sciences related	6	1	16.7%	1	16.7%
Social Sciences supplementary workers	5	0	0%	4	80%
Social Work and related professionals	212	14	6.6%	83	39.2%
Speech Therapy and Audiology	82	7	8.5%	16	19.5%
Staff Nurses and Pupil Nurses	9,760	52	0.5%	63	0.6%
Student Nurse	2,104	2	0.1%	669	31.8%
Supplementary Diagnostic Radiographers	17	0	0%	3	17.6%
TOTAL	**40,884**	**794**	**1.9%**	**4,088**	**10%**

Source: Vulindlela

Table 132: Promotions by Salary Band

Salary Band	Employment at Beginning of Period (April 2008)	Promotions to another Salary Level	Salary Level Promotions as a % of Employment	Progressions to another Notch within Salary Level	Notch Progressions as a % of Employment
Lower skilled (Levels 1-2)					
Permanent	9,194	6	0.4%	2,645	28.8%
Temporary	19	0	0%	2	10.5%
Skilled (Levels 3-5) -					
Permanent	32,395	254	0.8%	9,860	30.4%
Temporary	124	0	0%	5	4%
Highly skilled production (Levels 6-8)					
Permanent	11,241	335	3%	1,557	13.9%
Temporary	342	0	0%	16	4.7%
Highly skilled Supervision (Levels 9-12)					
Permanent	11,217	476	4.2%	833	7.4%
Temporary	90	0	0%	2	2.2%
Senior Management (Levels 13-16)	246	46	18.7%	55	22.4%
Other					
Permanent	444	0	0%	2	0.5%
Temporary	94	0	0%	0	0%
Contract (Levels 1-2)	62	0	0%	1	1.6%
Contract (Levels 3-5)	315	0	0%	0	0%
Contract (Levels 6-8)	1,020	7	0.7%	2	0.2%
Contract (Levels 9-12)	428	25	5.8%	18	4.2%
Contract (Levels 13-1)	10	2	20%	4	40%
TOTAL	**67,241**	**1,181**	**1.8%**	**15,002**	**22.3%**

Source: Vulindlela

Part C - HRMS Oversight Report

EMPLOYMENT EQUITY

The tables in this section are based on the formats prescribed by the Employment Equity Act, 55 of 1998.

Table 133: Total number of employees (including Employees with Disabilities) in each of the following Occupational Categories as on 31 March 2009

Occupational Categories	Male African	Male Coloured	Male Indian	Male Total Blacks	Male White	Female African	Female Coloured	Female Indian	Female Total Blacks	Female White	Total
Legislators, Senior Officials and Managers											
Permanent	37	0	9	46	6	35	4	5	44	6	102
Temporary	0	0	0	0	0	0	0	0	0	1	1
Professionals											
Permanent	4,026	88	1,174	5,288	513	16,268	532	2,777	19,577	920	26,298
Temporary	163	3	180	346	100	69	0	54	123	48	617
Clerks											
Permanent	1,865	43	457	2,365	42	3,178	138	489	3,805	210	6,422
Temporary	0	0	0	0	0	0	0	0	0	1	1
Service and Sales Workers											
Permanent	4,609	48	573	5,230	40	13,919	258	660	14,837	155	20,262
Temporary	0	0	0	0	0	0	0	1	1	0	1
Craft and related Trades Workers,	244	40	88	372	106	18	1	1	20	0	498
Plant and Machine Operators and Assemblers	751	18	99	868	1	140	5	4	149	2	1,020
Elementary occupations	3,144	41	350	3,535	38	6,868	116	315	7,299	87	10,959
Other	2	0	3	5	0	18	0	1	19	0	24
TOTAL	**14,841**	**281**	**2,933**	**18,055**	**846**	**40,513**	**1,054**	**4,307**	**45,874**	**1,430**	**66,205**
Employees with Disabilities	61	7	22	90	1	45	0	8	53	4	148

Source: Vulindlela

Table 134: Total number of employees (including Employees with Disabilities) in each of the following Occupational Bands as on 31 March 2009

Occupational Bands	Male African	Male Coloured	Male Indian	Male Total Blacks	Male White	Female African	Female Coloured	Female Indian	Female Total Blacks	Female White	Total
Top Management	12	0	9	21	10	5	0	3	8	3	42
Senior Management											
Permanent	35	1	65	101	43	21	3	25	49	14	207
Temporary	0	0	1	1	0	0	0	0	0	0	1
Professionally qualified and experienced Specialists and Mid-Management											
Permanent	1,080	30	663	1,773	274	6,847	224	1,295	8,366	450	10,863
Temporary	10	1	29	40	22	5	0	9	14	17	93
Skilled technical and academically qualified workers, Junior Management, Supervisors, Foremen											
Permanent	1,752	79	657	2,488	155	6,660	270	1,191	8,121	395	11,159
Temporary	115	2	77	194	38	44	0	26	70	16	318
Semi-skilled and discretionary decision making											
Permanent	8,275	119	996	9,390	78	20,330	437	1,268	22,035	252	31,755
Temporary	25	0	40	65	20	13	0	13	26	9	120
Unskilled and defined decision making											
Permanent	2,997	31	223	3,251	18	5,240	74	189	5,503	22	8,794
Temporary	13	0	33	46	20	7	0	7	14	8	88
Contract (Top Management)	2	0	0	2	2	0	0	0	0	0	4
Contract (Senior Management)	3	0	2	5	3	1	0	0	1	1	10
Contract (Professionally Qualified)	113	5	35	153	58	245	8	46	299	61	571

Part C - HRMS Oversight Report

Occupational Bands	Male African	Male Coloured	Male Indian	Male Total Blacks	Male White	Female African	Female Coloured	Female Indian	Female Total Blacks	Female White	Total
Contract (Skilled technical)	197	11	86	294	102	448	32	205	685	180	1,261
Contract (Semi-skilled)	91	1	17	109	3	248	5	30	283	2	397
Contract (Unskilled)	121	1	0	122	0	399	1	0	400	0	522
TOTAL	**14,841**	**281**	**2,933**	**18,055**	**846**	**40,513**	**1,054**	**4,307**	**45,874**	**1,430**	**66,205**

Source: Vulindlela

Table 135: Recruitment for the Period 1 April 2008 to 31 March 2009

Occupational Bands	Male African	Male Coloured	Male Indian	Male Total Blacks	Male White	Female African	Female Coloured	Female Indian	Female Total Blacks	Female White	Total
Senior Management	3	0	1	4	4	0	0	1	1	0	9
Professionally qualified and experienced Specialists and Mid-Management											
Permanent	39	4	39	82	24	157	8	67	232	30	368
Temporary	1	0	0	11	3	3	0	2	5	1	20
Skilled technical and academically qualified workers, Junior Management, Supervisors, Foremen											
Permanent	48	1	10	59	3	232	17	62	311	27	400
Temporary	46	2	14	62	8	21	1	15	37	6	113
Semi-skilled and discretionary decision making											
Permanent	357	5	18	380	3	1,030	18	68	1,116	8	1,507
Temporary	7	0	11	18	7	7	0	4	11	5	41
Unskilled and defined decision making											
Permanent	130	1	8	139	1	232	5	9	246	0	386

Occupational Bands	Male African	Male Coloured	Male Indian	Male Total Blacks	Male White	Female African	Female Coloured	Female Indian	Female Total Blacks	Female White	Total
Temporary	9	0	7	16	5	4	0	1	5	4	30
Not Available											
Permanent	41	0	1	42	0	66	2	0	68	0	110
Temporary	1	0	4	5	2	1	0	1	2	0	9
Contract (Senior Management)	0	0	2	2	2	0	0	0	0	0	4
Contract (Professionally Qualified)	36	3	29	68	36	79	4	36	119	49	272
Contract (Skilled technical)	125	8	67	200	59	248	15	163	426	139	824
Contract (Semi-skilled) -	58	1	13	72	3	144	4	19	167	3	245
Contract (Unskilled) -	42	0	0	42	1	162	1	1	164	0	207
TOTAL	**943**	**25**	**234**	**1,202**	**161**	**2,386**	**75**	**449**	**2,910**	**272**	**4,545**
Employees with Disabilities	2	0	0	2	0	3	0	1	4	0	6

Source: Vulindlela

Table 136: Promotions for the Period 1 April 2008 to 31 March 2009

Occupational Bands	Male African	Male Coloured	Male Indian	Male Total Blacks	Male White	Female African	Female Coloured	Female Indian	Female Total Blacks	Female White	Total
Top Management	4	0	1	5	3	0	0	0	0	1	9
Senior Management	14	0	31	45	17	11	1	10	22	8	92
Professionally qualified and experienced Specialists and Mid-Management											
Permanent	303	9	185	497	102	348	14	246	608	102	1,309
Temporary	2	0	0	2	0	0	0	0	0	0	2
Skilled technical and academically qualified workers, Junior Management, Supervisors, Foremen											
Permanent	553	21	183	757	47	693	46	265	1,004	84	1,892
Temporary	5	0	2	7	0	6	0	2	8	1	16
Semi-skilled and discretionary decision making											
Permanent	3,844	58	760	4,662	46	4,580	157	556	5,293	113	10,114
Temporary	1	0	1	2	0	1	0	0	1	2	5
Unskilled and defined decision making											
Permanent	956	9	109	1,074	5	1,488	27	82	1,597	5	2,681
Temporary	0	0	0	0	0	1	1	0	2	0	2
Not Available	1	0	0	1	0	1	0	0	1	0	2
Contract (Senior Management)	1	0	1	2	3	0	0	0	0	1	6
Contract (Professionally Qualified)	15	0	2	17	10	11	0	2	13	3	43
Contract (Skilled technical)	0	0	0	0	0	8	0	1	9	0	9

Occupational Bands	Male African	Male Coloured	Male Indian	Male Total Blacks	Male White	Female African	Female Coloured	Female Indian	Female Total Blacks	Female White	Total
Contract (Unskilled)	0	0	0	0	0	1	0	0	1	0	1
TOTAL	**5,699**	**97**	**1,275**	**7,071**	**233**	**7,149**	**246**	**1,164**	**8,559**	**320**	**16,183**
Employees with Disabilities	30	2	10	42	1	22	0	3	25	4	72

Source: Vulindlela

Table 137: Terminations for the Period 1 April 2008 to 31 March 2009

Occupational Bands	Male African	Male Coloured	Male Indian	Male Total Blacks	Male White	Female African	Female Coloured	Female Indian	Female Total Blacks	Female White	Total
Top Management	0	0	0	0	0	0	1	0	1	0	1
Senior Management	3	0	5	8	6	2	0	1	3	5	22
Professionally qualified and experienced Specialists and Mid-Management											
Permanent	80	3	70	153	61	314	13	109	436	88	738
Temporary	2	0	4	6	2	2	0	0	3	0	11
Skilled technical and academically qualified workers, Junior Management, Supervisors, Foremen -											
Permanent	117	7	52	176	29	558	35	176	769	95	1,069
Temporary	49	1	22	72	15	32	0	15	47	12	146
Semi-skilled and discretionary decision making											
Permanent	461	9	62	532	10	730	33	56	819	38	1,399
Temporary	13	0	16	29	17	12	1	4	17	6	69
Unskilled and defined decision making											

Part C - HRMS Oversight Report

Occupational Bands	Male African	Male Coloured	Male Indian	Male Total Blacks	Male White	Female African	Female Coloured	Female Indian	Female Total Blacks	Female White	Total
Permanent	212	2	9	223	1	378	4	13	395	2	621
Temporary	13	0	8	31	8	8	0	4	12	5	56
Not Available -											
Permanent	4	0	0	4	0	13	1	0	14	0	18
Temporary	2	0	2	4	2	2	0	0	2	0	8
Contract (Top Management)	1	0	0	1	0	1	0	0	1	0	2
Contract (Senior Management)	0	0	2	2	0	0	0	0	0	0	2
Contract (Professionally Qualified)	16	1	11	28	16	200	2	16	218	14	276
Contract (Skilled technical)	65	7	44	116	33	312	6	110	428	122	699
Contract (Semi-skilled)	40	1	17	58	3	71	4	8	83	2	146
Contract (Unskilled)	76	0	1	77	1	208	3	21	212	0	290
TOTAL	**1,154**	**31**	**335**	**1,520**	**204**	**2,842**	**103**	**515**	**3,460**	**389**	**5,573**
Employees with Disabilities	6	1	0	7	0	3	0	0	3	1	11

Source: Vulindlela

Table 138: Disciplinary Action for the Period 1 April 2008 to 31 March 2009

Disciplinary Action	Male African	Male Coloured	Male Indian	Male Total Blacks	Male White	Female African	Female Coloured	Female Indian	Female Total Blacks	Female White	Total
Correctional counseling	1	0	0	1	0	0	0	0	0	0	1
Demotion	2	0	0	2	0	0	0	0	0	0	2
Written warning	0	0	0	0	0	1	0	0	1	0	1
Dismissal	2	0	0	2	0	0	0	0	0	0	2
Final written warning	7	0	1	8	0	1	1	1	3	0	11
No outcome	0	0	3	3	0	2	0	1	3	0	6
Suspended without payment	1	0	0	1	0	1	0	1	2	0	3
TOTAL	**13**	**0**	**4**	**17**	**0**	**5**	**1**	**3**	**9**	**0**	**26**

Source: Vulindlela

SKILLS DEVELOPMENT FOR THE PERIOD 1 APRIL 2008 TO 31 MARCH 2009

Table 139: Training needs identified

Occupational Categories	Gender	Employment	Learnerships	Skills Programmes & Other Short Courses	Other Forms of Training	Total of Skills Programmes & Other Short Courses
Managers	Female	2,209	0	387	0	387
	Male	564	0	707	0	707
Professionals	Female	12,304	0	1,378	0	1,378
	Male	2,750	0	3,843	0	3843
Technicians and Trades Workers	Female	128	0	489	0	489
	Male	1,285	0	304	0	304
Community and Personal Service Workers	Female	20,371	396	389	0	785
	Male	7,532	121	3,402	0	3,523
Clerical and Administrative Workers	Female	4,016	0	1,175	0	1,175
	Male	2,519	0	1,193	0	1,193
Sales Workers	Female	0	0	0	0	0
	Male	0	0	0	0	0
Machinery Operators and Drivers	Female	589	0	205	0	205
	Male	1,138	0	55	0	55
Labourers	Female	7,001	146	1,154	0	1,300
	Male	2,733	54	1,905	0	1,959
Gender sub-totals	Female	46,618	542	5,177	0	5,719
	Male	18,521	175	11,409	0	11,584
Total		**65,139**[203]	**717**	**16,586**	0	**17,303**

Source: Human Resource Development

[203] Figure taken from Persal as at 31 March 2008 as this is when planning commenced

Table 140: Training Provided

Occupational Categories	Gender	Employment	Learnerships	Skills Programmes & Other Short Courses	Other Forms of Training	Total of Skills Programmes & Other Short Courses
Managers	Female	2,209	0	217	0	217
	Male	564	0	494	0	494
Professionals	Female	12,304	0	472	0	472
	Male	2,750	0	1,791	0	1,791
Technicians and Trades Workers	Female	128	0	124	0	124
	Male	1,285	0	42	0	42
Community and personal Service Workers	Female	20,371	396	728	0	1,124
	Male	7,532	121	1,025	0	1,146
Clerical and Administrative Workers	Female	4,016	0	797	0	797
	Male	2,519	0	1,548	0	1,548
Sales Workers	Female	0	0	0	0	0
	Male	0	0	0	0	0
Machinery Operators and Drivers	Female	589	0	71	0	71
	Male	1,138	0	21	0	21
Labourers	Female	7,001	146	417	0	563
	Male	2,733	54	674	0	728
Gender sub-totals	Female	46,618	542	2,826	0	3,368
	Male	18,521	175	5,595	0	5,770
Total		**65,139**[204]	**717**	**8,421**	**0**	**9,138**

Source: Human Resource Development

[204] Figure taken from Persal as at 31 March 2008 as this is when planning commenced

PERFORMANCE REWARDS

To encourage good performance, the Department has granted the following performance rewards during the year under review. The information is presented in terms of race, gender, and disability (Table 141), salary bands (Table 142) and critical occupations (Table 143).

Table 141: Performance Rewards by Race, Gender and Disability - 1 April 2008 to 31 March 2009

Demographics	Number of Beneficiaries	Total Employment	Percentage of Total Employment	Cost (R'000)	Average Cost per Beneficiary (R)
African, Female	24	40,468	0.1%	R 50	R 2,100
African, Male	11	14,780	0.1%	R 28	R 2,577
Asian, Female	2	4,299	0%	R 10	R 4,822
Asian, Male	10	2,911	0.3%	R 41	R 4,114
Coloured, Female	2	1,054	0.2%	R 7	R 3,624
Coloured, Male	0	274	0%	R 0	R 0
Total Blacks, Female	28	45,821	0.1%	R 67	R 2,403
Total Blacks, Male	21	17,965	0.1%	R 69	R 3,309
White, Female	5	1,426	0.4%	R 18	R 3,533
White, Male	1	845	0.1%	R 16	R 16,371
Employees with a disability	0	148	0%	R 0	R 0
TOTAL	**104**	**66,205**	**0.1%**	**R 171**	**R 3,106**

Source: Vulindlela

Table 142: Performance Rewards by Salary Bands for Personnel below Senior Management Service - 1 April 2008 to 31 March 2009

Salary Band	Number of Beneficiaries	Total Employment	Percentage of Total Employment	Cost (R'000)	Average Cost per Beneficiary (R)
Lower skilled (Levels 1-2)	3	8,856	0%	R 2	R 667
Skilled (Levels 3-5)	22	31,893	0.1%	R 34	R ,1545
Highly skilled production (Levels 6-8)	8	11,481	0.1%	R 18	R 2,250
Highly skilled supervision (Levels 9-12)	21	10,960	0.2%	R 110	R 5,238
Periodical Remuneration	0	683	0%	R 0	R 0
Abnormal Appointment	0	706	0%	R 0	R 0
Contracts (1-2)	0	522	0%	R 0	R 0
Contracts (3-5)	0	397	0%	R 0	R 0
Contracts (6-8)	0	1,261	0%	R 0	R 0
Contracts (9-12)	0	571	0%	R 0	R 0
TOTAL	**54**	**67,330**	**1%**	**R 164**	**R3,037**

Source: Vulindlela

Table 143: Performance Rewards by Critical Occupations - 1 April 2008 to 31 March 2009

Critical Occupations	Number of Beneficiaries	Total Employment	% of Total Employment	Cost (R'000)	Average Cost per Beneficiary (R)
Ambulance and related workers	3	2,847	0.1%	R 10	R 3,333
Chiropodists and other related workers	0	1	0%	R 0	R 0
Community Development Workers	0	1	0%	R 0	R 0
Dental Practitioners	0	72	0%	R 0	R 0
Dental Specialists	0	8	0%	R 0	R 0
Dental Therapy	0	29	0%	R 0	R 0
Dieticians and Nutritionists	0	84	0%	R 0	R 0
Emergency Services related	0	44	0%	R 0	R 0
Environmental Health	0	175	0%	R 0	R 0
Health Sciences related	2	867	0.2%	R 7	R 3,500
Life Sciences related	0	13	0%	R 0	R 0
Medical Practitioners	11	3,111	0.4%	R 54	R 4,909
Medical Research and related professionals	0	13	0%	R 0	R 0
Medical Specialists	1	553	0.2%	R 6	R 6,000
Medical Technicians/ Technologists	0	76	0%	R 0	R 0
Nursing Assistants	4	6,523	0.1%	R 6	R 1,500
Occupational Therapy	0	127	0%	R 0	R 0
Optometrists and Opticians	0	14	0%	R 0	R 0
Oral Hygienists	0	24	0%	R 0	R 0
Pharmaceutical Assistants	1	631	0.2%	R 1	R 1,000
Pharmacists	0	418	0%	R 0	R 0
Physicists	0	6	0%	R 0	R 0
Physiotherapy	0	236	0%	R 0	R 0
Professional Nurse	4	12,292	0%	R 7	R 1,750
Psychologists and Vocational Counsellors	0	70	0%	R 0	R 0
Radiography	0	458	0%	R 0	R 0
Social Sciences related	0	6	0%	R 0	R 0
Social Sciences supplementary workers	0	7	0%	R 0	R 0
Social Work and related professionals	0	214	0%	R 0	R 0
Speech Therapy and Audiology	0	82	0%	R 0	R 0
Staff Nurses and Pupil Nurses	9	9,440	0.1%	R 12	R 1,333
Student Nurse	1	2,201	0%	R 1	R 1,000
Supplementary Diagnostic Radiographers	0	14	0%	R 0	R 0
TOTAL	**36**	**40,657**	**1.3%**	**R 104**	**R24,325**

Source: Vulindlela

Table 144: Performance Related Rewards (Cash Bonus), by Salary Band for Senior Management Service

SMS Band	Number of Beneficiaries	Total Employment	% of Total Employment	Cost (R'000)	Average Cost per Beneficiary (R)	% of SMS Wage Bill	Personnel Cost SMS (R'000)
Band A	1	12	8.3%	R 6	R 600	0%	R 130,883
Band B	0	206	0%	R 0	R 0	0%	R 0
Band C	0	42	0%	R 0	R 0	0%	R 0
Band D	0	4	0%	R 0	R 0	0%	R 0
TOTAL	**1**	**264**	**0.4%**	**R 6**	**R 600**	**0%**	**R 130,883**

Source: Vulindlela

FOREIGN WORKERS

The tables below summarise the employment of foreign nationals in the Department in terms of salary bands and by major occupation. The tables also summarise changes in the total number of foreign workers in each salary band and by each major occupation.

Table 145: Foreign Workers - 1 April 2008 to 31 March 2009 (by Salary Band)

Salary Band	Employment at Beginning Period	% of Total	Employment at end of Period	% of Total	Change in Employment	% of Total	Total Employment at Beginning of Period	Total Employment at end of Period	Total Change in Employment
Lower skilled (Levels 1-2)	1	0.2%	4	0.7%	3	16.7%	-	-	-
Skilled (Levels 3-5)	16	2.7%	15	2.4%	-1	-5.6%	-	-	-
Highly skilled production (Levels 6-8)	45	7.6%	39	6.4%	-6	-33.3%	-	-	-
Highly skilled supervision (Levels 9-12)	349	58.6%	290	47.2%	-59	-327.8%	-	-	-
Senior Management (Levels 13-16)	20	3.4%	20	3.3%	0	0%	-	-	-
Other	2	0.3%	0	0%	-2	-11.1%	-	-	-
Contract (Levels 6-8)	45	7.6%	83	13.5%	38	211.1%	-	-	-
Contract (Levels 9-12)	109	18.3%	154	25.1%	45	250%	-	-	-
Contract (Levels 13-16)	5	0.8%	6	1%	1	5.6%	-	-	-
Periodical Remuneration	3	0.5%	3	0.5%	0	0%	-	-	-
Abnormal Appointment	1	0.2%	0	0%	-1	-5.6%	-	-	-
TOTAL	**596**	**100%**	**614**	**100%**	**18**	**100%**	**596**	**614**	**18**

Source: Vulindlela

Table 146: Foreign Worker - 1 April 2008 to 31 March 2009 (By Major Occupation)

Major Occupation	Employment at Beginning Period	% of Total	Employment at end of Period	Percentage of Total	Change in Employment	% of Total	Total Employment at Beginning of Period	Total Employment at end of Period	Total Change in Employment
Administrative office workers	3	0.5%	3	0.5%	0	0%	-	-	-
Craft and related trades workers	1	0.2%	1	0.2%	0	0%	-	-	-
Drivers operators and ships crew	1	0.2%	1	0.2%	0	0%	-	-	-
Elementary occupations	4	0.7%	5	0.8%	1	5.6%	-	-	-
Professionals and Managers	582	97.7%	600	97.7%	18	100%	-	-	-
Social natural technical and medical sciences + support	3	0.5%	3	0.5%	0	0%	-	-	-
Technicians and associated professionals	2	0.3%	1	0.2%	-1	-5.6%	-	-	-
TOTAL	**596**	**100%**	**614**	**100%**	**18**	**100%**	**596**	**614**	**18**

Source: Vulindlela

LEAVE UTILISATION FOR THE PERIOD 1 JANUARY 2007 TO 31 DECEMBER 2007

The Public Service Commission identified the need for careful monitoring of sick leave within the public service. The following tables provide an indication of the use of sick leave (Table 147) and disability leave (Table 148). In both cases, the estimated cost of the leave is also provided.

Table 147: Sick leave - 1 January 2007 to 31 December 2007

Salary Band	Total Days	% Days with Medical Certification	Number of Employees using Sick Leave	% of Total Employees using Sick Leave[205]	Average Days per Employee	Estimated Cost (R'000)	Total Number of Employees using Sick Leave	Total Number of Days with Medical Certification
Lower skilled (Levels 1-2)	39,109.5	89.3%	4,923	7.28%	8	R 7,093	-	34,924
Skilled (Levels 3-5)	169,289.5	88%	21,102	31.22%	8	R 41,603	-	149,018
Highly skilled production (Levels 6-8)	68,663	85.5%	8,519	12.6%	8	R 29,837	-	58,731
Highly skilled supervision (Levels 9-12)	52,876	86.1%	7,046	10.42%	8	R 41,889	-	45,503
Senior management (Levels 13-16)	618	82.8%	81	0.12%	8	R 1,347	-	512
Contract (Levels 1-2)	227	78.4%	62	0.09%	4	R 25	-	178
Contract (Levels 3-5)	692.5	82%	104	0.15%	7	R 168	-	568
Contract (Level 6-8)	2,853	72.8%	502	0.74%	6	R 1,116	-	2,078
Contract (Levels 9-12)	1,843	85.7%	287	0.42%	6	R 1,419	-	1,579
Contract (Levels 13-16)	12	91.7%	3	0%	4	R 24	-	11
Not Available	5	100%	1	0%	5	R 1	-	5
TOTAL	**336,188.5**	**87.2%**	**42,630**	**63.07%**	**8**	**R 124,522**	**42,630**	**293,107**

Source: Vulindlela

[205] The figure of 67,594 was utilised to include abnormal appointments and periodic remuneration employees

Part C - HRMS Oversight Report

Table 148: Disability Leave (Temporary and Permanent) - 1 January 2007 to 31 December 2007

Salary Band	Total Days	% Days with Medical Certification	No. of Employees using Disability Leave	% of Total Employees using Disability Leave	Average Days per Employee	Estimated Cost (R'000)	Total No. of Days with Medical Certification	Total Number of Employees using Disability Leave
Lower skilled (Levels 1-2)	4,267	99.9%	184	13.6%	23	R 778	4,263	-
Skilled (Levels 3-5)	17,258	99.9%	673	0.99%	26	R 4,367	17,242	-
Highly skilled production (Levels 6-8)	8,302	99.6%	284	0.42%	29	R 3,522	8,272	-
Highly skilled supervision (Levels 9-12)	6,490	99.9%	198	0.29%	33	R 5,095	6,484	-
Senior management (Levels 13-16)	103	100%	4	0%	26	R 216	103	-
Contract (Levels 3-5)	17	100%	3	0%	6	R 3	17	-
Contract (Levels 6-8)	48	100%	4	0%	12	R 21	48	-
Contract (Levels 9-12)	18	100%	2	0%	9	R 12	18	-
TOTAL	**36,503**	**99.8%**	**1,352**	**2%**	**27**	**R 14,014**	**36,447**	**1,352**

Source: Vulindlela

Table 149 summarises the utilisation of annual leave. The wage agreement concluded with trade unions in the PSCBC in 2000 requires management of annual leave to prevent high levels of accrued leave being paid at the time of termination of service.

Table 149: Annual Leave - 1 January 2008 to 31 December 2008

Salary Band	Total Days Taken	Average Days per Employee	No. of Employees who took Leave
Lower skilled (Levels 1-2)	166,021.88	22	7,675
Skilled (Levels 3-5)	594,647.2	22	27,590
Highly skilled production (Levels 6-8)	249,675.96	23	10,790
Highly skilled supervision (Levels 9-12)	231,077.68	23	10,092
Senior Management (Levels 13-16)	4,240.48	20	215
Contract (Levels 1-2)	1,245.84	10	131
Contract (Levels 3-5)	1,672.92	13	127
Contract(Levels 6-8)	11,333.84	15	732
Contract (Levels 9-12)	6,715.76	15	437
Contract (Levels 13-16	170.92	16	11
Not Available	12.96	13	1
TOTAL	**1,266,815.44**	**22**	**57,801**

Source: Vulindlela

Table 150: Capped Leave - 1 January 2008 to 31 December 2008

Salary Band	Total Days of Capped Leave Taken	Average No. of Days Taken per Employee	Average Capped Leave per Employee as at 31 December 2008	No. of Employees who took Capped Leave	Total No. of Capped Leave available at 31 December 2008	No. of Employees as at 31 December 2008
Lower skilled (Levels 1-2)	974	4	39	255	147,354	3,760
Skilled (Levels 3-5)	4,300	6	54	736	487,185	9,035
Highly skilled production (Levels 6-8)	4,198	7	69	637	407,453	5,932
Highly skilled supervision (Levels 9-12)	3,827	7	71	579	417,722	5,882
Senior Management (Levels 13-16)	122	11	68	11	10,487	155
TOTAL	**13,421**	**6**	**59**	**2,218**	**1,470,201**	**24,764**

Source: Vulindlela

The following table summarises payments made to employees as a result of leave that was not taken.

Table 151: Leave Payouts for the Period 1 April 2008 to 31 March 2009

Reason	Total Amount (R'000)	Number of Employees	Average Payment er Employee (R)
Leave payout for 2008/09 due to non-utilisation of leave for the previous cycle	168	24	7,000
Capped leave payouts on termination of service for 2008/09	14,037	2,604	5,391
Current leave payout on termination of service for 2008/09	4,765	933	5,107
TOTAL	**18,970**	**3,561**	**5,327**

Source: Vulindlela

HIV, AIDS & HEALTH PROMOTION PROGRAMMES

Table 152: Steps taken to reduce the risk of Occupational Exposure

Units/ Categories of Employees Identified to be at High Risk of Contracting HIV and Related Diseases (If Any)	Key Steps Taken to Reduce the Risk
Medical Officers	Induction and Orientation of Newly Recruited Doctors.
Nurses	Induction and orientation of staff
General Assistants	Induction and orientation of staff.
Laundry personnel	Induction and orientation of staff
Grounds personnel	Induction and orientation of staff
Laboratory personnel	Induction and orientation of staff
EMRS personnel	Induction and orientation of staff

Table 153: Details of Health Promotion and HIV and AIDS Programmes

Question	Yes	No	Details, if Yes
1. Has the Department designated a member of the SMS to implement the provisions contained in Part VI E of Chapter 1 of the Public Service Regulations, 2001? If so, provide her/ his name and position.	Yes		• The appointed employee is not part of the SMS but is a Principal Human Resource Management Practitioner (ISR12) for EAP. Details are Mrs K. Naidoo: Principal Human Resource Management Practitioner: EAP.
2. Does the department have a dedicated unit or has it designated specific staff members to promote the health and well being of your employees? If so, indicate the number of employees who are involved in this task and the annual budget that is available for this purpose.	Yes		• The complete structure for the wellness component at Head Office level has not been approved at this stage. The Department currently has one appointed Occupational Health Nurse and a Safety Officer at Head Office level who offers the following services: - HIV and AIDS - EAP - Occupational Health - Occupational and Employee Health and Safety • At institutional level there are Employee Assistance Practitioners; Safety Officers and Occupational Health Nurses appointed that offer the above services as well. • The Unit does not have a dedicated budget for this purpose however funding is sourced from the budget of the Corporate Services component.
3. Has the department introduced an Employee Assistance or Health Promotion Programme for your employees? If so, indicate the key elements/ services of this Programme.	Yes		• Available at Head Office and at Institutional Level. • To play an effective and meaningful role in helping both the organisation and employees , the EAP provides a programme that:

Part C - HRMS Oversight Report

Question	Yes	No	Details, if Yes
			- Facilitates lifestyle change and wellness promotion in the context of improved productivity and performance - Provides simple, quick access to help and information - Attracts, motivates and retains the best people - Incorporates assistance on a broad range of issues - Meeting the specific changes facing the organisation, country and the economy - Evaluates itself and add value to the organisation - • At Head Office level an Employee Health and Wellness Committee comprising of representatives from units has been established. The purpose of the committee is to: - Ensure all components to join forces so as not to work in silos; - To share information; - Address concerns and policy issues and - To market and evaluate all programmes.
4. Has the department established (a) committee(s) as contemplated in Part VI E.5 (e) of Chapter 1 of the Public Service Regulations, 2001? If so, please provide the names of the members of the committee and the stakeholder(s) that they represent.		No	
5. Has the department reviewed its employment policies and practices to ensure that these do not unfairly discriminate against employees on the basis of their HIV status? If so, list the employment policies/ practices so reviewed.	Yes		• The HIV status of prospective employees is not requested at any stage of the recruitment process.
6. Has the department introduced measures to protect HIV-positive employees or those perceived to be HIV-positive from discrimination? If so, list the key elements of these measures.	Yes		• HIV results are confidential. Employees have access to VCT and PEP for occupational exposure.
7. Does the department encourage its employees to undergo Voluntary Counselling and Testing? If so, list the results that you have you achieved.	Yes		• Results are confidential.
8. Has the department developed measures/ indicators to monitor & evaluate the impact of its health promotion programme? If so, list these measures/indicators.		No.	

LABOUR RELATIONS

The following collective agreements were entered into with Trade Unions within the Department.

Table 154: Collective Agreements - 1 April 2008 to 31 March 2009

Subject Matter	Date
Resolution 3 of 2008: Agreement on the implementation of an Occupation Specific Dispensation	01 April 2008
Resolution 4 of 2008: Amendment to resolution 1 of 2007: OSD negotiations at Sectoral level	23 May 2008
Resolution 5 of 2008: Amendment to the constitution: Secretary to General Secretary	23 May 2008
Resolution 6 of 2008: Amendment to resolution 2 of 2008: OSD negotiations at Sectoral level	18 June 2008
Resolution 7 of 2008: Amendments to resolution 4 of 2007 (extension of timeframes)	02 July 2008
Resolution 8 of 2008: The appointment of a panel of conciliators and arbitrators	04 August 2008
Resolution 9 of 2008: Extension of timeframes: OSD for negotiations at Sectoral level and proceed to develop minimum service level agreement	19 August 2008
Resolution 10 of 2008: Extension of timeframes on review of housing allowances	26 November 2008
Resolution 1 of 2009: Extension of timeframes: OSD for negotiations at Sectoral level	19 January 2009
Total collective agreements	**9**

Source: DPSA Website

The following table summarises the outcome of disciplinary hearings conducted within the department for the year under review.

Table 155: Misconduct and Disciplinary Hearings finalised - 1 April 2008 to 31 March 2009

Outcomes of Disciplinary Hearings	Number	% of Total	Total
Dismissal	19	5.2	-
Final written warning	325	89.8	-
No outcome	0	0	-
Suspended without payment	18	5	-
TOTAL	**362**	**100**	**362**

Source: Vulindlela

Table 156: Types of Misconduct addressed at Disciplinary Hearings

Type of Misconduct	Number	% of Total	Total
Absent from work without reason or permission	70	23.3	-
Endangers lives by disregarding safety rules	65	21.6	-
Fails to carry out order or instruction	36	12	-
Fails to comply with or contravenes an act	57	18.9	-
Falsifies records or any documents	15	5	-
Steals bribes or commits fraud	57	18.9	-
Wilfully or negligently mismanages finances	1	0.3	-
TOTAL	**301**	**100**	**301**

Source: Vulindlela

Table 157: Grievances lodged for the Period 1 April 2008 to 31 March 2009

Number of Grievances Addressed	Number	Percentage of Total	Total
Not resolved	90	63.38	142
Resolved	52	36.62	142
TOTAL	**142**	**100**	**142**

Source: Vulindlela

Table 158: Disputes Lodged with Councils for the Period 1 April 2008 to 31 March 2009

Number of Disputes Addressed	Number	% of Total
Upheld	4	80
Dismissed	1	20
Total	**5**	**100**

Source: Vulindlela

Table 159: Strike Actions for the Period 1 April 2008 to 31 March 2009

Strike Actions	
Total number of person working days lost	0
Total cost (R'000) of working days lost	0
Amount (R'000) recovered as a result of no work no pay	0

Source: Vulindlela

Table 160: Precautionary suspensions for the period 1 April 2008 to 31 March 2009

Precautionary Suspensions	_
Number of people suspended	12
Number of people whose suspension exceeded 30 days	3
Average number of days suspended	30
Cost (R'000) of suspensions	1,400

Source: Vulindlela

SKILLS DEVELOPMENT

Table 161: Training needs identified 1 April 2008 to 31 March 2009

Occupational Categories	Gender	Employment	Learnerships	Skills Programmes & other Short Courses	Other Forms of Training	Total
Legislators, Senior Officials and Managers	Female	2,209		387		387
	Male	564		707		707
Professionals	Female	12,304		1,378		1,378
	Male	2,750		3,843		3,843
Technicians and Associate Professionals	Female	128		489		489
	Male	1,285		304		304
Clerks	Female	20,371	396	389		785
	Male	7,532	121	3,402		3,523
Service and Sales Workers	Female	4,016		1,175		1,175
	Male	2,519		1,193		1,193
Skilled Agriculture and Fishery Workers	Female	0		0		0
	Male	0		0		0
Craft and related Trades Workers	Female	0		0		0
	Male	0		0		0
Plant and Machine Operators and Assemblers	Female	589		205		205
	Male	1,138		55		55
Elementary Occupations	Female	7,001	146	1,154		1,300
	Male	2,733	54	1,905		1,959
Gender sub totals	Female	46,618	542	5,177		5,719
	Male	18,521	175	11,409		11,584
Total		**65,139**[206]	**717**	**16,586**		**17,303**

Source: Human Resource Development

[206] Figure taken from Persal as at 31 March 2008 as this is when planning commenced

Table 162: Training Provided 1 April 2008 to 31 March 2009

Occupational Categories	Gender	Employment	Learnerships	Skills Programmes & other Short Courses	Other Forms of Training	Total
Legislators, Senior Officials and Managers	Female	2,209		387		387
	Male	564		707		707
Professionals	Female	12,304		1,378		1,378
	Male	2,750		3,843		3843
Technicians and Associate Professionals	Female	128		489		489
	Male	1,285		304		304
Clerks	Female	20,371	396	389		785
	Male	7,532	121	3,402		3,523
Service and Sales Workers	Female	4,016		1,175		1,175
	Male	2,519		1,193		1,193
Skilled Agriculture and Fishery Workers	Female	0		0		0
	Male	0		0		0
Craft and related Trades Workers	Female	0		0		0
	Male	0		0		0
Plant and Machine Operators and Assemblers	Female	589		71		71
	Male	1,138		21		21
Elementary occupations	Female	7,001	146	417		563
	Male	2,733	54	674		728
Gender sub totals	Female	46,618	542	2,826	0	3,368
	Male	18,521	175	5,595	0	5,770
Total		**65,139**[207]	**717**	**8,421**	**0**	**9,138**

Source: Human Resource Development

[207] Figure taken from Persal as at 31 March 2008 as this is when planning commenced

INJURED-ON-DUTY

The following tables provide basic information on injury on duty.

Table 163: Injured On Duty: 1 April 2008 to 31 March 2009

Nature of Injury on Duty	Number	% of Total
Required basic medical attention only	573	67.65%
Temporary Total Disablement	259	30.58%
Permanent Disablement	14	1.65%
Fatal	1	0.12%
Total	**847**	**100%**

Source: HRMS

NOTES

PART D:

FINANCIAL STATEMENTS

Part D - Financial Statements

TABLE OF CONTENTS

LIST OF ANNEXURES

REPORT OF THE ACCOUNTING OFFICER
For the year ended 31 March 2009

Report of the Accounting Officer to the Executive Authority and Provincial Legislature of the Province of KwaZulu-Natal

1. General review of the state of financial affairs

The main purpose for the existence of the Department of Health is to develop and implement a sustainable, coordinated, integrated and comprehensive health system through the primary health care approach which is based on accessibility, equity, community participation, use of appropriate technology and inter-sectoral collaboration.

The 2008/09 financial year represented the last year in the 2004/05 to 2008/09 strategic planning cycle. Therefore, the programmes for the year, with certain adjustments for new developments during the five year period, represented the final year of the plan. Achievements attained during the period are detailed in the annual report however these were impacted upon by the decrease in allocations, in real terms, during the last two years of the period. This however, did not impact on the programmes significantly as alternative courses of action were implemented to ensure sustainable delivery of services.

The 2008/09 financial year presented various challenges to the Department due to the shortage of funds and the forever changing disease patterns. The increase in prices, especially for imported items, has resulted in a decrease in the allocated resources in real terms. This has also resulted in a decrease in real per capita funding for the services offered.

The Department is increasingly faced with the need for tough choices to be made in the prioritization of services in light of an increased demand on health services owing to an ever increasing number of patients presenting themselves to our institutions coupled with the decrease in resources available. In this regard, the Department has developed a three-year turnaround strategy together with the Provincial Treasury which is aimed at addressing the funding constraints currently faced by the Department. The strategy focuses on cutting back on less essential costs thereby promoting efficiency in the utilization of allocated resources. A policy framework has been put in place to support the implementation of the framework and all components within the Department have attended workshops which included the communication of the framework. The circulars forming part of the framework have also been published on the intranet. In implementing the turnaround strategy it has been emphasised that the measures being implemented should not have an adverse effect on the delivery of health services.

The strategy also focuses on ensuring that the Department derives maximum benefit out of expenditure in health care services and that wastage and abuse of resources is eliminated. Current areas of focus include key cost drivers such as the Public Private Partnership, laboratory services, blood services, pharmaceuticals, patient catering services, waste management services, the utilization of nursing agencies, the utilization of private medical beds and medical sundries. Strategies for the enhancement of these services are currently being developed or implemented. A value for money study has been completed on the PPP by the Auditor General of SA, the results of which are being discussed and the implementation of recommendations will be effected immediately thereafter.

REPORT OF THE ACCOUNTING OFFICER
For the year ended 31 March 2009

Programme	Final Allocation R'000	Actual Expenditure R'000	Under/ (Over) Spending R'000
1. Administration	289,484	284,066	5,418
2. District Health Services	7,390,276	8,132,272	-741,996
3. Emergency Medical Services	672,360	672,360	-
4. Provincial Hospital Services	4,085,278	4,378,814	-293,536
5. Central Health Services	1,538,406	1,821,221	-282,815
6. Health Sciences and Training	592,875	676,601	-83,726
7. Health Care Support Services	34,130	34,209	-79
8. Health Facilities Management	1,180,176	1,103,558	76,618
TOTAL	**15,782,985**	**17,103,101**	**-1,320,116**

The Department was allocated a total of R15, 782,985,000 for the financial year. A total of R17, 103,101,000 was spent, resulting in over expenditure of R1, 320,116,000 or 8% of the allocated budget for the year. It is worth noting that the carry through effects related to funding of the 2007/08 salary increases and the funding of interventions against MDR/XDR TB, amounting to R323,123m, were not provided for in the 2008/09 MTEF allocations. These funds were earmarked for ongoing activities, therefore the under funding contributed significantly to the budget pressures faced by the Department.

The Department continued with the implementation of measures to combat MDR/ XDR TB, resulting in an internationally recognized programme as a result of the turnaround in the treatment of the disease within a short period of time. This was achieved despite the constraints mentioned above, mainly through the optimal utilisation of allocated resources and through contributions from donor organisations.

In addition, the Department was under funded by R97, 000,000 in the implementation of the 2007/08 salary adjustments that followed the June 2007 public sector strike. The carry through effects of this under funding has contributed to budgetary constraints in 2008/09, with the amount of under funding growing to R107, 185,000 when the 2008/09 cost of living adjustment is taken into account. Furthermore, the implementation of OSD was under funded by R441, 000,000 in the 2007/08 financial year. This gap was projected to grow to R487, 305,000 in 2008/09. An amount of R127, 000,000 was included in the 2008/09 for the adjustment budget to address the OSD under funding, resulting in the funding deficit being reduced to R360, 305, 000.

The above trends in allocations have contributed to the current budgetary constraints, especially when considering the fact that, over the last five years the Department has experienced a consistent trend of over spending as a result of ever changing patterns of morbidity and mortality. The carry through effects of the takeover of services such as Forensic Pathology Services and the facilities from Santa Centres have added to budgetary constraints, as these invariably required some level of upgrade as part of the multi-year programme for the development of these services.

The Department had undertaken a review of the OSD payments and it has been ascertained that the contingent asset amounted to R20,209 million. The OSD outcome mainly indicates to a difference of interpretation and documentation that was not found on the personnel files during the AGSA audit. Based on the court case uncertainty still exists on whether the overpayments can actually be recovered and as a result no corresponding debtor could be raised in the financial statements. Possible irregular expenditure could be incurred depending on the outcomes or resolutions reached on OSD payments. (Refer to note 25: This amount has been disclosed as a contingent asset as per National Treasury guideline on the disclosure).

REPORT OF THE ACCOUNTING OFFICER
For the year ended 31 March 2009

The Department finalised the KwaZulu-Natal Health Bill during the 2008/09 financial year. The Bill was approved by the Provincial Legislature and signed into law by the Premier during the financial year. Regulations emanating from the Act are expected to be finalised during the 2009/10 financial year.

The following factors led to material variances from voted funds, after considering the shifting and the virement of funds.

Programme 1: Administration

Spending on this programme matched the allocated budget. This was achieved mainly through stringent measures being put in place to prevent over expenditure.

Programme 2: District Health Services

A total of R7, 390,276,000 was allocated to the Programme and a total of R8, 132,272,000 was spent. As a result, the budget was over spent by R741, 996,000 or 10.04% of the allocation for the programme mainly as a result of the following:

- Over spending of R77, 461,000 in Community Health Clinics - mainly as a result of spending pressures in compensation of employees and in goods and services.
- Over spending of R8, 907,000 in Forensic Pathology Services mainly as a result of spending pressures in compensation of employees, goods and services and in machinery and equipment.
- Over spending of R656, 000,000 in District Hospitals mainly as a result of budget pressures in compensation of employees and in goods and services.

Programme 3: Emergency Medical Services

Spending in this Programme was according to budget. However, the programme continues to face service delivery challenges due to the shortage of resources. The Department is currently implementing various initiatives aimed at strengthening the services. The services are also in the process of being centralized to ensure the smooth and integrated operation thereof. Spending on emergency vehicles, staff and staff training has been intensified to ensure readiness for the 2010 Soccer World Cup.

Programme 4: Provincial Hospital Services

A total amount of R4, 085,278,000 was allocated to the programme. Actual spending for the year amounted to R4, 378,814,000, resulting in over expenditure of R293, 536,000. Over spending was recorded under the Regional Hospital Services Sub-Programme mainly due to the carry through effects of the implementation of OSD, the carry through effects of the implementation of the 2007/08 salary adjustments and general price increases.

Programme 5: Central Health Services

A total of R1, 538,406,000 was allocated to the Programme, R1,821,221,000 was spent resulting in over spending of R282,815,000. Over spending was recorded in Central Hospital Services and in Provincial Tertiary Hospital Services as a result of the carry through effects of the under funding of OSD and the 2007/08 salary adjustments.

Programme 6: Health Sciences and Training

A total of R502, 875,000 was allocated to this Programme. A total of R676, 601,000 was spent, resulting in over spending of R83,726,000 mainly as a result of the following:

- Over spending of R29, 020,000 in Nursing Training Colleges as a result of over spending on compensation of employees.
- Over spending of R11, 608,000 in Primary Health Care Training as a result of over spending on compensation of employees.
- Over spending of R40, 484,000 as a result of over spending on compensation of employees resulting from the effects of the increase in medical interns. The increase in the number of interns was on the basis of National Policy for the training of more health professionals, and was therefore inevitable.

Programme 7: Health Care Support Services

Spending on this Programme was according to the budget.

Programme 8: Health Facilities Management

The Programme was under spent by R76, 618,000. Under spending resulted from delays in the construction of facilities which impacted on the acquisition of equipment, as well as delays in the completion of Information Technology Projects funded from the Programme.

- Virements:

The Department applied to the Provincial Treasury for virements and the shifting of funds. These are reflected in detail under the Appropriation Statement.

2. Services rendered by the department

The organisational configuration of the Department forms an important basis for effective and efficient health service delivery in pursuance of the objectives set in the Strategic Plan, the Service Transformation Plan and the Annual Performance Plan of the Department. Restructuring is therefore inevitable, the aim being to provide a blue print for successful decentralisation of services to ensure effective service delivery and to strengthen the management of health services, especially at the primary healthy care level.

The role of Head Office is policy making, planning, systems development, procedural design, setting of norms and standards, and monitoring and evaluation. The District Offices are responsible for developing, coordinating and facilitating the implementation of an effective, efficient, sustainable and integrated health system. Part of the strategy is to ensure that there is sufficient capacity and readiness in Districts to assume responsibility and accountability for decentralised functions and delegations. Four main categories of services are provided by the Department, namely:

Primary Health Care Services

This category of services focuses on the prevention of illness and the provision of basic curative health services. These services include immunisation, health promotion, HIV and AIDS awareness, nutrition services, mother and child health services, communicable disease control, environmental health, oral and dental health, rehabilitation support, occupational health and chronic disease support.

Hospital Services

District Hospitals cater for those patients who require admission to hospital for treatment at general practitioner level, while Provincial Hospitals cater for patients requiring admission to hospital for treatment at specialist level. Tuberculosis Hospitals, Psychiatric Hospitals and Chronic Medical Hospitals (long-term) provide hospitalisation for patients suffering from tuberculosis, mental illnesses and those patients requiring long-term nursing care, respectively. Central and Tertiary Hospitals provide facilities and expertise needed for sophisticated medical procedures.

Forensic Pathology Services

These services are directed at ensuring integrity of forensic evidence and providing pathology services.

Emergency Medical Services

The aim of this category is to provide emergency care and transport for victims of trauma, road traffic accidents, and emergency medical and obstetric conditions. Planned patient transport is provided for inter-hospital transfer whilst indigent patients are transported between clinics and hospitals.

Tariff policy

The main source of revenue for the Department, over and above its voted amount, is patient fees which are based on the Uniform Patient Fees Schedule as prescribed by the National Department of Health. This fee structure was updated during the year to conform to adjustments at National level. Joint committees comprising the National and Provincial of Health effect these adjustments.

Free Services

Free services are provided in accordance with National policies to certain categories of patients, viz. pregnant women, children under six, certain communicable diseases, the aged, the poor and

persons with disabilities. There are no other free services rendered by the Department.

Had H0, which are the no fee paying patients, been charged an approximate amount of R40.27m would have been collected. This estimation is based on monthly statistics received from the health institutions.

Inventories

The total inventory on hand as at 31 March 2009 amounted R2.006 billion. This amount consists of consumables of R324 million, pharmaceuticals of R288 million and equipment of R1.394 billion. This amount excludes immovable properties, which are disclosed under the Department of Works.

3. Capacity constraints

The delivery of health services is dependent on the availability of all the necessary resources at the right quantity and the right mix to maximise the service delivery impact. The Department continues to strive to ensure that all the necessary resources are in place to enhance service delivery. However, the Department continues to face challenges due to shortage of skilled professional staff, inadequate health information systems, backlog in fixed infrastructure, inadequate machinery and equipment, increasing burden of disease and co-morbidities, as well as the gap in funding of healthcare needs in the province. As a response to these challenges, the Department has embarked on the following initiatives, as part of strengthening capacity for service delivery:

- Ongoing reprioritisation of activities in favour of priority areas of health services delivery, which guides the allocation of available resources;
- Maintaining in place service delivery agreements with the Department of Public Works, Ithala Bank and Independent Development Trust with a view to enhancing the capacity for infrastructure roll out;
- Expansion of Emergency Medical Services through increases in the vehicle fleet and personnel;
- Development of the Human Resource Plan that focuses effort on developing and recruiting staff to meet the service delivery needs of the Department;
- Offering bursaries for study in various healthcare disciplines;
- Integration of closely related programmes through capacity building programmes where staff is trained in the relevant areas and by creation of multi-purpose staff posts (e.g. HIV and AIDS, STI's, TB, PMTCT and Maternal, Child and Women's Health);
- Conclusion of contracts with Non-Governmental Organisations to supplement capacity for the delivery of healthcare services throughout the province;
- Strengthening of inter-sectoral collaboration to ensure that optimal service delivery is achieved through the pooling of resources; and
- Enhancement of Primary Health Care services, especially at Community Health Clinics and Community Health Centres to reduce overcrowding at Hospitals and improve access to services to a great extent.

4. Utilisation of donor funds

Donations received in Cash

During this financial year an amount of R111.928 million in respect of local and foreign donor funds was received by the Department. In addition an amount of R21.160 million was brought forward from the previous financial year, giving a total of R133.088 million for the year. Of this amount R104.364 million was spent, leaving a balance of R29.174 million has been carried into the 2009/10 financial year.

The amount of R111.928 million received includes:

- R84.120 million from the Geneva Global Fund to offset HIV, AIDS , and TB expenditure incurred by the Department on behalf of the Global Fund.
- R20.160 million from the European Union for the continuation of the projects for the Partnership for the Delivery of Primary Health Care.
- R6.000 million from Atlantic Philantrophies for strengthening capacity at rural nurse training institutions within the Province. Infrastructure planning is in progress. A further R6.000 million has been committed for disbursement to the Department in the new financial year.

REPORT OF THE ACCOUNTING OFFICER
For the year ended 31 March 2009

The balance of the donations was received for Health and Welfare Sector Education and Training Authority learnerships, HIV and AIDS Drug Trials and Registrar Training.

Donations in Kind

Italian funding to the value of R4.399 million was provided and spent on multi-sectoral management support for Primary Health Care. These funds are managed by the Italian Consulate and not by the Department.

The Geneva Global Fund received an additional amount of R64.194 million during this financial year for the enhancement of Care for HIV and AIDS patients. An amount of R121.943 million was spent in accordance with the objective of the fund. A further commitment of R44.613 million has been made by the Global Fund to offset the over-expenditure reflected on the report.
Agreements are concluded with the various donors and spending is managed accordingly.

5. Trading entities and public entities

The only trading activity for the Department of Health is the Provincial Pharmaceutical Supply Depot. This entity purchases pharmaceuticals from the suppliers and these are then distributed to the various institutions as requested. The pharmaceuticals are charged at actual cost plus a mark-up of 4% to 12% to cover the administrative costs.

An amount of R34, 130,000 was transferred to the entity during the year under review to supplement the value of the buffer stock. The substantial increase in the amount transferred was due to the need for an increase in the Anti-retroviral stock to ensure that the stock levels of other were not affected by the need for increase in ARV stock to cater for increases in the number of patients on the Anti-Retroviral Treatment Programme. The number of patients on treatment increased from 144,000 in 2007/08 to 205,000 in 2008/09.

The trading entity realised a surplus amounting to R39,967,000 during the year under review (2007/08: R438,000). The annual financial statements of the trading entity are reflected separately in this annual report.

6. Organisations to whom transfer payments have been made

Transfer payments are made to the following organisations in order to assist the Department in providing health care services to the population of KwaZulu-Natal:

- Local Municipalities, which provide primary health care services as well as environmental health services, and
- NGO's, which provide HIV and AIDS, Clinic, Mental Health and Hospital Services.

Transfer payments also include the payment of bursaries, claims against the State, leave gratuities, the skills levy, and a provision for the augmentation of the Medicine Trading Account.

The detail of the above transfer payments is reflected in Annexure 1 of this report.

7. Public private partnerships (PPP)

The Department has in place a public private partnership agreement with Cowslip Investments (Pty) Ltd and Impilo Consortium for the delivery of non-clinical services to the Inkosi Albert Luthuli Central Hospital. Details of the PPP and the transactions relating thereto are disclosed under note 35 of the financial statements.

8. Corporate governance arrangements

Situational analysis of Audit and Risk Management for the 2008-2009 financial year

The Audit and Risk Management component has performed a transversal function across the Department in that it dealt with audit matters affecting all health institutions and ensured that risks were identified and mitigated through the implementation of internal control measures. The component has worked closely with the Office of the Auditor-General of SA the Internal Audit Unit of the Provincial Treasury in the execution of its duties.

During the 2008-2009 reporting period, the Department was subjected to a multitude of audits by the Auditor General of SA as well as by the Internal Audit Unit. These audits include audits of the

financial statements of both the Department as well as that of the Provincial Pharmaceutical Supply Depot (PPSD), a trading entity in the Department as well as regularity audits at thirteen (13) institutions, Head Office and the various Conditional Grants. The Auditor-General also undertook a review audit of the general computer controls information system (SAP) at the Inkosi Albert Luthuli Central Hospital, commenced performance audits on the "Investment in Infrastructure" as well on the Public Private Partnership at the Inkosi Albert Luthuli Central Hospital.

In addressing the various audit queries, the Departments Audit and Risk Management Component had developed Risk Mitigation Plans and subsequently met with the senior management officials of the audited entities and discussed the identified risks, as well as the risk mitigation plans. In addition, Risk Owners and Action Owners were identified and timeframes were agreed upon to address the identified risks. Further, review audits were conducted to verify the responses that were supplied by the institutions and also to check on the status of the implementation of the action plans. In this regard, new Risk Response Plans were developed in relative to the findings of the review audit, which were communicated to the institutions.

The Department has as part of its risk management strategy conducted risk assessment exercises to determine the material risks to which the Department may be exposed to, and to evaluate the strategy for managing the identified risks. These exercises have involved the documenting of systems, procedures and processes with regards to risk areas at a functional/operational level and to prioritise them within each focus area that has the highest potential to impact (positively or negatively) on the achievement of the Department's/ Institutions objectives. The functional/operational focus areas of the risk assessments that have been developed involve financial management, supplies administration, procurement administration, human resource management, security administration as well as transport management.

The component had also embarked and finalised various risk management initiatives as part of its strategy to combat fraud and corruption. In this regard numerous workshops were conducted in 2008-2009 with the target audience being all officials falling within the management cadre/echelon. The campaign included inter alia workshops on the fundamentals of Risk Management, its effectiveness and analysis of the processes involved in mitigating potential risks; Fraud Prevention, which included the rollout of the Fraud Prevention Plan as part of the Departments Strategy in reducing the incidents of fraud and corruption as well as presentations on Corporate Governance, which incorporated a module on the relevant sections of the Public Finance Management Act.

The component has also been responsible for the management of the special project "Operation Cure" which is aimed at rooting out procurement related corruption in the Department. During the reporting period various suppliers and seven (7) officials of the Department were convicted on a total of 360 counts of corruption, 8 counts of fraud and 22 counts of money laundering. Further, the Department has been awarded compensation in the amount of approximately R 2.8 million emanating from these convictions.

9. Discontinued activities/activities to be discontinued

No activities were discontinued during the year under review.

10. New activities

The Department commenced with the operation of a number of new clinics and other facilities during the year under review, as part of its drive towards expanding access to services by the Communities of the Province.

11. Asset management

All assets have been captured in the asset register. All minimum requirements for asset management have been achieved. Furthermore, an asset register with new reporting requirements have been developed and will be rolled out to institutions in the 2009/10 financial year.

All milestones have been achieved business processes with new asset register requirements have been developed and will be rolled out to institutions in 2009/10 financial year.

The asset management function is decentralized due to the size and nature of the Department. Therefore capacity building and training of staff take long to complete because of the number of

REPORT OF THE ACCOUNTING OFFICER
For the year ended 31 March 2009

institutions that must be visited as part of on the job training. Assets Management is operated on a manual system, resulting to asset management information not being available on real time. The Department has approached the National Treasury for support with the implementation of an asset management system, in light of current budgetary constraints. Discussions with the National Treasury are in progress.

12. Events after the reporting date

There were no events after the reporting date that affected the financial statements as at 31 March 2009. However, there was strike in respect of the occupational specific dispensation. (See note 31).

The Department has undertaken a process to investigate irregular expenditure that have been identified and raised in the Auditor-General South Africa Report and will provide the outcomes to the Auditor-General on conclusion of the investigations.

13. Performance information

Information for health related indicators (clinical) is captured at source (i.e. Clinics) in registers, this information is collated on a weekly basis and is submitted to the relevant district hospital (referral pathway) for capturing into DHIS 1.4. Information from all hospitals – tertiary, regional and district is collated per District and forwarded to Head Office data management to enable the generation of Quarterly Reports for Treasury. Similarly, non clinical information is collated at District level and submitted to the Department's Monitoring and Evaluation component for analysis and reporting.

14. Standing Committee on Public Accounts resolutions

Reference to previous Audit Report and Scopa Resolutions	Subject	Findings on Progress
Resolution 63/2008	Report from the Task Team established to investigate the over-expenditure in the Department of Health in the 2007/2008 financial year **Resolution:** The Head of Provincial Treasury be requested to report by 15 January 2009	A three year turnaround plan was developed and tabled before the Legislature.
Resolution 64/2008	Lease of Trizon Towers **Resolution**	The matter is under review.
Resolution 65/2008	Investigation by the Office of the Premier relating to procurement irregularities **Resolution:** That the report on the investigation mentioned above be requested from the Office of the Premier for consideration by the Committee by 15 January 2009	The matter was referred to the Office of the Premier.

15. Prior modifications to audit reports

There were no prior modifications to audit reports.

16. Exemptions and deviations received from the National Treasury

No exemptions were requested from the National Treasury. The following exemptions have been obtained from the Provincial Treasury:

REPORT OF THE ACCOUNTING OFFICER
For the year ended 31 March 2009

- BAS/ Persal reconciliation

The Provincial Treasury had approved a practice note on the compilation of the reconciliation. Due to the size of the Department, the reconciliation according to the practice note proved impractical. The Department was thereafter given approval to deviate from the practice note and utilize the original approach, which had been accepted by the Auditor-General

- Disclosure of immovable assets

The disclosure of immovable assets is included under the annual financial statements of the Department of Works in accordance with a Provincial Treasury directive.

17. Approval

The annual financial statements set out on pages 346 to 428 are hereby approved by the Chief Financial Officer of the Department of Health: KwaZulu-Natal.

Mr. A.S.S Buthelezi
Chief Financial Officer
31 May 2009

The annual financial statements set out on pages 346 to 428 are hereby approved by the Acting Accounting Officer of the Department of Health: KwaZulu-Natal.

Dr. Y L Mbele
Acting Accounting Officer
31 May 2009.

Report of the Auditor-General
For the year ended 31 March 2009

REPORT OF THE AUDITOR-GENERAL TO THE KWAZULU-NATAL PROVINCIAL LEGISLATURE ON THE FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION OF VOTE NO 7: DEPARTMENT OF HEALTH FOR THE YEAR ENDED 31 MARCH 2009

REPORT ON THE FINANCIAL STATEMENTS

Introduction

1. I have audited the accompanying financial statements of the Department of Health (department) which comprise the appropriation statement, the statement of financial position as at 31 March 2009, and the statement of financial performance, the statement of changes in net assets and the cash flow statement for the year then ended, and a summary of significant accounting policies and other explanatory notes, as set out on pages 346 to 428.

The Accounting Officer's responsibility for the financial statements

2. The accounting officer is responsible for the preparation and fair presentation of these financial statements in accordance with the modified cash basis of accounting determined by the National Treasury, as set out in accounting policy note 1.1 and in the manner required by the Public Finance Management Act, 1999 (Act No. 1 of 1999) (PFMA) and the Division of Revenue Act, 2008 (Act No. 2 of 2008) (DoRA) and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The Auditor-General's responsibility

3. As required by section 188 of the Constitution of the Republic of South Africa, 1996 (Constitution) read with section 4 of the Public Audit Act, 2004 (Act No. 25 of 2004) (PAA) and section 40(2) of the PFMA, my responsibility is to express an opinion on these financial statements based on my audit.

4. I conducted my audit in accordance with the International Standards on Auditing read with *General Notice 616 of 2008*, issued in *Government Gazette No. 31057 of 15 May 2008*. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

5. An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

6. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Basis for qualified opinion

Property, plant and equipment

7. Disclosure notes 32 and 33 to the financial statements reflected closing balances of R2,208 billion and R45,517 million for major and minor property, plant and equipment, respectively. These closing balances did not include assets prior to 2004, which management estimated at R100 million. The department's records for these assets were incomplete in respect of locations, purchase dates, bar codes, and the number of items as well as values. Moreover, management's estimates were not supported by records, to permit the application of alternative

Report of the Auditor General
For the year ended 31 March 2009

procedures. Consequently, I was unable to obtain sufficient and appropriate audit evidence to satisfy myself as to the valuation, existence and completeness of property, plant and equipment as well as the effect of any disclosure adjustments to the amounts in note 32 and note 33 to the financial statements.

Qualified opinion

8. In my opinion, except for the possible effects of the matter described in the Basis for qualified opinion paragraph, the financial statements present fairly, in all material respects, the financial position of the Department of Health as at 31 March 2009 and its financial performance and cash flows for the year then ended, in accordance with the modified cash basis of accounting determined by the National Treasury, as set out in accounting policy note 1.1 and in the manner required by the PFMA and DoRA.

Emphasis of matters

I draw attention to the following matters on which I do not express a qualified opinion:

Basis of accounting

9. The department's policy is to prepare financial statements on the modified cash basis of accounting determined by the National Treasury, as set out in accounting policy note 1.1.

Irregular expenditure

10. As disclosed in note 26 to the financial statements, irregular expenditure to the amount of R1,182 billion was incurred. This amount comprises R968 million arising from overspending of the budget allocation on compensation of employees, R113 million in respect of expenditure incurred under the Health Professionals Training and Development grant in the absence of an approved amended business plan, as well as R101 million regarding deficiencies in tender processes.

Unauthorised expenditure

11. As disclosed in note 9 to the financial statements, the department exceeded the appropriated budget by R3,175 billion. This amount was made up of current and prior year balances of R1,402 billion and R1,773 billion, respectively.

Significant uncertainty

12. With reference to note 25 to the financial statements, a contingent asset to the value of R20 million was disclosed, reflecting overpayments made during the implementation of the occupation-specific dispensation for nurses.

Other matters

I draw attention to the following matters that relate to my responsibilities in the audit of the financial statements:

Un-audited supplementary schedule

13. The supplementary information set out on page 404 does not form part of the financial statements and is presented as additional information. I have not audited this schedule and accordingly I do not express an opinion thereon.

Non-compliance with applicable legislation

Public Finance Management Act and Treasury Regulations

14. Movable assets were not adequately safeguarded against misuse, theft, wastage and losses, as required by section 38(1)(d) of the PFMA and Treasury Regulation (TR) 10.1.

15. Legislative procedures embodied in TR 16A6 governing supply chain management procedures were not adhered to in respect of the awarding of tenders. Consequently, the department is likely to incur further irregular expenditure to the amount of R84 million, which was disclosed as commitments in note 20 to the financial statements.

Report of the Auditor-General
For the year ended 31 March 2009

16. Suppliers were not paid within 30 days of receipt of invoice, as required by section 38(1)(f) of the PFMA and TR 8.2.3.

Occupational Health and Safety Act

17. Section 4.7 of the Occupational Health and Safety Act, 1993 (Act No. 85 of 1993) (OHSA) was not adhered to, in that the department did not have a safety hazard policy.

18. Audits at certain hospitals revealed serious health risks regarding the handling, storage and disposal of medical waste. Access to medical waste was not always restricted and instances were noted where medical and municipal waste had been mixed. This is in contravention of section 24 of the Constitution and section 9 of the OHSA. In addition to the health hazard posed, the department could be held liable for claims against it.

Governance framework

19. The governance principles that impact the auditor's opinion on the financial statements relate to the responsibilities and practices exercised by the accounting officer and executive management and are reflected in the internal control deficiencies and key governance responsibilities addressed below:

Internal control deficiencies

20. Section 38(1)(a)(i) of the PFMA states that the accounting officer must ensure that the department has and maintains effective, efficient and transparent systems of financial and risk management and internal control. The table below depicts the root causes that gave rise to the deficiencies in the system of internal control, which led to the qualified opinion. The root causes are categorised according to the five components of an effective system of internal control. In some instances deficiencies exist in more than one internal control component.

Par. no.	Basis for qualified opinion	CE	RA	CA	IC	M
7.	Property, plant and equipment	2	3	6	1	1

21. Management did not ensure that internal controls for the management of property, plant and equipment were designed, implemented and operated in a manner that prevented and detected misstatements in the financial statements. Consequently, these deficiencies impacted on the valuation, existence and completeness of property, plant and equipment disclosed in the financial statements

Legend	
CE = Control environment	
The organisational structure does not address areas of responsibility and lines of reporting to support effective control over financial reporting.	1
Management and staff are not assigned appropriate levels of authority and responsibility to facilitate control over financial reporting.	2
Human resource policies do not facilitate effective recruitment and training, disciplining and supervision of personnel.	3
Integrity and ethical values have not been developed and are not understood to set the standard for financial reporting.	4
The accounting officer does not exercise oversight responsibility over financial reporting and internal control.	5
Management's philosophy and operating style do not promote effective control over financial reporting.	6
The department does not have individuals competent in financial reporting and related matters.	7
RA = Risk assessment	
Management has not specified financial reporting objectives to enable the identification of risks to reliable financial reporting.	1
The department does not identify risks to the achievement of financial reporting objectives.	2
The department does not analyse the likelihood and impact of the risks identified.	3
The department does not determine a risk strategy/action plan to manage identified risks.	4

Report of the Auditor General
For the year ended 31 March 2009

The potential for material misstatement due to fraud is not considered.	5
CA = Control activities	
There is inadequate segregation of duties to prevent fraudulent data and asset misappropriation.	1
General information technology controls have not been designed to maintain the integrity of the information system and the security of the data.	2
Manual or automated controls are not designed to ensure that the transactions have occurred, are authorised, and are completely and accurately processed.	3
Actions are not taken to address risks to the achievement of financial reporting objectives.	4
Control activities are not selected and developed to mitigate risks over financial reporting.	5
Policies and procedures related to financial reporting are not established and communicated.	6
Realistic targets are not set for financial performance measures, which are in turn not linked to an effective reward system.	7
IC = Information and communication	
Pertinent information is not identified and captured in a form and time frame to support financial reporting.	1
Information required to implement internal control is not available to personnel to enable internal control responsibilities.	2
Communications do not enable and support the understanding and execution of internal control processes and responsibilities by personnel.	3
M = Monitoring	
Ongoing monitoring and supervision are not undertaken to enable an assessment of the effectiveness of internal control over financial reporting.	1
Neither reviews by internal audit or the audit committee nor self-assessments are evident.	2
Internal control deficiencies are not identified and communicated in a timely manner to allow for corrective action to be taken.	3

Key governance responsibilities

22. The PFMA tasks the accounting officer with a number of responsibilities concerning financial and risk management and internal control. Fundamental to achieving this is the implementation of key governance responsibilities, which I have assessed as follows:

No.	Matter	Y	N
Clear trail of supporting documentation that is easily available and provided in a timely manner			
1.	No significant difficulties were experienced during the audit concerning delays or the availability of requested information.	✓	
Quality of financial statements and related management information			
2.	The financial statements were not subject to any material amendments resulting from the audit.		✓
3.	The annual report was submitted for consideration prior to the tabling of the auditor's report.	✓	
Timeliness of financial statements and management information			
4.	The annual financial statements were submitted for auditing as per the legislated deadlines as set out in section 40 of the PFMA.	✓	
Availability of key officials during audit			

Report of the Auditor-General
For the year ended 31 March 2009

No.	Matter	Y	N
5.	Key officials were available throughout the audit process.	✓	
Development and compliance with risk management, effective internal control and governance practices			
6.	Audit committee		
	• The department had an audit committee in operation throughout the financial year.	✓	
	• The audit committee operates in accordance with approved, written terms of reference.	✓	
	• The audit committee substantially fulfilled its responsibilities for the year, as set out in section 77 of the PFMA and Treasury Regulation 3.1.10.	✓	
7.	Internal audit		
	• The department had an internal audit function in operation throughout the financial year.	✓	
	• The internal audit function operates in terms of an approved internal audit plan.	✓	
	• The internal audit function substantially fulfilled its responsibilities for the year, as set out in Treasury Regulation 3.2.	✓	
8.	There are no significant deficiencies in the design and implementation of internal control in respect of financial and risk management.		✓
9.	There are no significant deficiencies in the design and implementation of internal control in respect of compliance with applicable laws and regulations.		✓
10.	The information systems were appropriate to facilitate the preparation of the financial statements.	✓	
11.	A risk assessment was conducted on a regular basis and a risk management strategy, which includes a fraud prevention plan, is documented and used as set out in Treasury Regulation 3.2.	✓	
12.	Powers and duties have been assigned, as set out in section 44 of the PFMA.	✓	
Follow-up of audit findings			
13.	The prior year audit findings have been substantially addressed.	✓	
14.	SCOPA resolutions have been substantially implemented.		✓
Issues relating to the reporting of performance information			
15.	The information systems were appropriate to facilitate the preparation of a performance report that is accurate and complete.	✓	
16.	Adequate control processes and procedures are designed and implemented to ensure the accuracy and completeness of reported performance information.	✓	
17.	A strategic plan was prepared and approved for the financial year under review for purposes of monitoring the performance in relation to the budget and delivery by the department against its mandate, predetermined objectives, outputs, indicators and targets (Treasury Regulations 5.1, 5.2 and 6.1).	✓	
18.	There is a functioning performance management system and performance bonuses are only paid after proper assessment and approval by those charged with governance.	✓	

23. The department has regressed in discharging its responsibilities relative to financial management and internal control, as evidenced by the many weaknesses, which were identified in procurement processes, asset and

Report of the Auditor General
For the year ended 31 March 2009

inventory management, compliance with applicable laws and regulations as well as the classification of transactions.

Investigations

24. The department had completed two investigations, while another five were ongoing at the reporting date. These investigations predominantly relate to irregularities in the procurement process.

REPORT ON OTHER LEGAL AND REGULATORY REQUIREMENTS

Report on performance information

25. I have reviewed the performance information as set out on pages 346 to 428.

The accounting officer's responsibility for the performance information

26. The accounting officer has additional responsibilities as required by section 40(3)(a) of the PFMA to ensure that the annual report and audited financial statements fairly present the performance against predetermined objectives of the department.

The Auditor-General's responsibility

27. I conducted my engagement in accordance with section 13 of the PAA read with *General Notice 616 of 2008*, issued in *Government Gazette No. 31057 of 15 May 2008*.

28. In terms of the foregoing my engagement included performing procedures of a review nature to obtain sufficient appropriate evidence about the performance information and related systems, processes and procedures. The procedures selected depend on the auditor's judgement.

29. I believe that the evidence I have obtained is sufficient and appropriate to report that no significant findings have been identified as a result of my review.

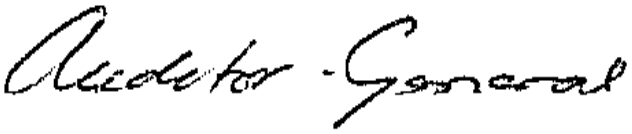
OTHER REPORT

Performance audit

30. A performance audit was conducted during the year under review concerning possible conflicts of interest within departments. At the date of this report, the audit was still in progress.

APPRECIATION

31. The assistance rendered by the staff of the Department of Health during the audit is sincerely appreciated.



Pietermaritzburg

31 July 2009

AUDITOR-GENERAL
SOUTH AFRICA

Auditing to build public confidence

Report of the Audit Committee
For the year ended 31 March 2009

REPORT OF THE AUDIT COMMITTEE ON VOTE 7 - HEALTH

The KwaZulu-Natal Provincial Audit Committee is pleased to present their report for the financial year ended 31 March 2009.

Audit Committee Members and Attendance:

The Audit Committee consists of the members listed hereunder. The committee is required to meet at least four times in a financial year as per its approved terms of reference. During the year under review a new chairperson was appointed in September 2008 due to the resignation of the previously appointed chairperson. During the financial year ending March 2009 a total of five (5) meetings were held.

Name of Member	No. of meetings attended
Ads B. S. Khuzwayo (newly appointed Chairperson)	5
Mr. V. Naicker	5
Ads W.S. Kuboni	3
Mrs. M.T. Sibanyoni	4

Audit Committee Responsibility

The Audit Committee reports that it has complied with its responsibilities arising from Section 38 (1)(a)(ii) of the Public Finance Management Act and Treasury Regulation 3.1.13. The Audit Committee also reports that it has adopted appropriate formal terms of reference as its Audit Committee Charter, has regulated its affairs in compliance with this charter and has discharged all its responsibilities as contained therein.

The Effectiveness of Internal Control

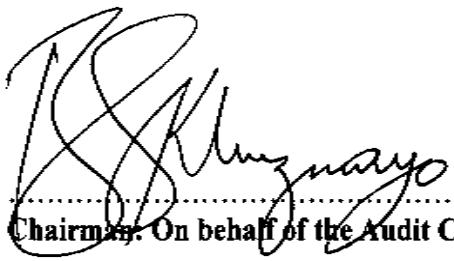
The system of controls is designed to provide cost effective assurance that assets are safeguarded and that liabilities and working capital are efficiently managed. In line with the requirements of the PFMA and the King II Report on Corporate Governance, Internal Audit provides the Audit Committee and management with assurance that the systems of internal controls are appropriate and effective. This is achieved by means of the risk management process, as well as the identification of corrective actions and suggested enhancements to the controls and processes. From the various reports of the Internal Auditors, the Report of the Auditor-General on the Annual Financial Statements including both any qualification and/or emphasis of matter, and the management report of the Auditor-General, it was noted that no significant or material non compliance with prescribed policies and procedures have been reported, except for Human Resource Management, Asset Management, Supply Chain Management, Financial Management and the Provincial Pharmaceutical Supply Depot.

The quality of in year management and monthly / quarterly reports submitted in terms of the Treasury Regulations and the Division of Revenue Act

The Audit Committee is satisfied with the content and quality of monthly and quarterly reports prepared and issued by the Accounting Officer and the Department during the year under review, except for the lack of adequate controls around the transfer of funds to benefiting institutions.

Evaluation of Financial Statements

The Audit Committee has reviewed the audited annual financial statements and the Auditor-General's management report and management's response thereto. The Audit Committee concurs and accepts the Auditor-General's conclusions on the annual financial statements, and is of the opinion that the audited annual financial statements be accepted and read together with the report of the Auditor-General.



Chairman: On behalf of the Audit Committee

Date: 07 August 2009

APPROPRIATION STATEMENT
For the year ended 31 March 2009

APPROPRIATION STATEMENT

Appropriation per Programme

	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
1. Administration									
Current payment	283,781	(1,518)	-	282,263	279,411	2,852	99.0%	276,213	274,953
Transfers and subsidies	649	1,518	-	2,167	2,165	2	99.9%	1,611	1,713
Payment for capital assets	5,054	-	-	5,054	2,490	2,564	49.3%	2,939	3,023
2. District Health Services									
Current payment	6,934,660	55,408	27,373	7,017,441	7,792,749	(775,308)	111.0%	6,002,747	6,856,897
Transfers and subsidies	338,355	(55,408)	-	282,947	282,953	(6)	100.0%	246,127	236,702
Payment for capital assets	89,888	-	-	89,888	56,570	33,318	62.9%	126,982	116,010
3. Emergency Medical Services									
Current payment	568,003	(845)	23,099	590,257	590,257	-	100.0%	481,093	522,638
Transfers and subsidies	8,326	845	-	9,171	9,171	-	100.0%	687	572
Payment for capital assets	64,906	-	8,026	72,932	72,932	-	100.0%	73,083	25,586
4. Provincial Hospital Services									
Current payment	4,013,806	(6,618)	-	4,007,188	4,299,744	(292,556)	107.3%	3,533,702	3,793,242
Transfers and subsidies	42,403	6,618	-	49,021	54,630	(5,609)	111.4%	53,509	51,115

APPROPRIATION STATEMENT
For the year ended 31 March 2009

	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
Payment for capital assets	29,069	-	-	29,069	24,440	4,629	84.1%	27,339	39,457
5. Central Hospital Services									
Current payment	1,269,990	-	-	1,269,990	1,547,758	(277,768)	121.9%	1,075,730	1,259,827
Transfers and subsidies	3,140	-	-	3,140	8,187	(5,047)	260.7%	3,062	627
Payment for capital assets	221,494	-	43,782	265,276	265,276	-	100.0%	206,925	147,249
6. Health Sciences and Training									
Current payment	533,113	-	-	533,113	618,938	(85,825)	116.1%	469,915	478,758
Transfers and subsidies	54,417	-	-	54,417	56,144	(1,727)	103.2%	43,991	42,600
Payment for capital assets	5,345	-	-	5,345	1,519	3,826	28.4%	8,728	2,975
7. Health Care Support Services									
Current payment					79	(79)			
Transfers and subsidies	34,130			34,130	34,130		100%	12,649	12,649
8. Health Facilities Management									
Current payment	399,981		(50,472)	349,509	338,010	11,499	96.7%	335,529	356,171
Transfers and subsidies					326	(326)			
Payment for capital assets	882,475		(51,808)	830,667	765,222	65,445	92.1%	942,867	736,636
9. Special Functions									
								-	41

APPROPRIATION STATEMENT
For the year ended 31 March 2009

	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
Current payment									
TOTAL	**15,782,985**	**-**	**-**	**15,782,985**	**17,103,101**	**(1,320,116)**	**108.4%**	**13,925,428**	**14,959,441**
Reconciliation with Statement of Financial Performance									
Add: Departmental receipt				168,049				148,544	
Direct Exchequer receipts				-				-	
Aid assistance				111,928				34,386	
Actual amounts per Statement of Financial Performance (Total Revenue)				16,062,962				14,108,358	
Add: Aid assistance					104,364				14,480
Direct Exchequer receipts									
Prior year unauthorised expenditure approved without funding									
Actual amounts per Statement of Financial Performance Expenditure (Total Expenditure)					17,207,465				14,973,921

APPROPRIATION STATEMENT
For the year ended 31 March 2009

Appropriation per economic classification

	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
Current payments									
Compensation of employees	9,118,823	(9,465)	-	9,109,358	10,077,044	(967,686)	110.6%	7,913,564	8,643,767
Goods and services	4,884,511	55,892	-	4,940,403	5,389,804	(449,401)	109.1%	4,261,365	4,898,719
Financial transactions in assets and liabilities	-	-	-	-	98	(98)		-	41
Transfers & subsidies									
Provinces & municipalities	85,177	(33,634)	-	51,543	51,538	5	100.0%	66,355	63,463
Departmental agencies & accounts	39,957	-	-	39,957	39,957	-	100.0%	17,119	17,119
Universities & technikons	-	40	-	40	40	-	100.0%	-	-
Non-profit institutions	267,007	(23,273)	-	243,734	243,734	-	100.0%	200,376	199,011
Households	89,279	10,440	-	99,719	112,437	(12,718)	112.8%	77,786	66,385
Payment for capital assets									
Buildings & other fixed structures	611,103	24,236	-	635,339	635,593	(254)	100.0%	841,123	623,762
Machinery & equipment	667,070	(24,236)	-	642,834	552,856	89,978	86.0%	547,624	429,978
Software & other intangible assets	20,058	-	-	20,058	-	20,058		116	17,196
Land & subsoil assets	-	-	-	-	-	-	-	-	-
Total	15,782,985	-	-	15,782,985	17,103,101	(1,320,116)	108.4%	13,925,428	14,959,441

APPROPRIATION STATEMENT
For the year ended 31 March 2009

DETAIL PER PROGRAMME 1 – ADMINISTRATION

Details per sub -programme	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
1.1 Office of the MEC									
Current payment	11,202	1,637		12,839	12,839	-	100.0%	9,442	11,140
Transfers and subsidies	15	(15)		-		-		14	2
Payment for capital assets	1,238			1,238	943	295	76.2%	360	756
1.2 Management									
Current payment	272,579	(3,155)		269,424	266,572	2,852	98.9%	266,771	263,813
Transfers and subsidies	634	1,533		2,167	2,165	2	99.9%	1,597	1,711
Payment for capital assets	3,816			3,816	1,547	2,269	40.5%	2,579	2,267
TOTAL	**289,484**	**-**	**-**	**289,484**	**284,066**	**5,418**	**98.1%**	**280,763**	**279,689**

APPROPRIATION STATEMENT
For the year ended 31 March 2009

DETAIL PER PROGRAMME 1 – ADMINISTRATION

Programme 1 Per Economic classification	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
Current payments									
Compensation of employees	171,211	(4,711)		166,500	163,648	2,852	98.3%	142,821	141,966
Goods and services	112,570	3,193		115,763	115,763	-	100.0%	133,392	132,987
Transfers & subsidies									
Provinces & municipalities	7	-1		6	4	2	66.7%	11	12
Households	642	1,519		2,161	2,161	-	100.0%	1,600	1,701
Payments for capital assets									
Machinery & equipment	4,996			4,996	2,490	2,506	49.8%	2,883	3,011
Software & other intangible assets	58			58		58		56	12
Total	**289,484**	**-**	**-**	**289,484**	**284,066**	**5,418**	**98.1%**	**280,763**	**279,689**

APPROPRIATION STATEMENT
For the year ended 31 March 2009

DETAIL PER PROGRAMME 2 - DISTRICT HEALTH SERVICES

Details per sub-programme	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
2.1 District Management									
Current payment	6,568	(2,746)		143,822	143,822	-	100.0%	126,060	133,942
Transfers and subsidies	1,119	(32)		1,087	1,087	-	100.0%	193	209
Payment for capital assets	3,958	1,665		5,623	5,623	-	100.0%	8,426	10,993
2.2 Community Health Clinics									
Current payment	1,361,394	32,167		1,393,561	1,494,357	(100,796)	107.2%	1,194,024	1,194,177
Transfers and subsidies	110,721	(32,167)		78,554	78,554	-	100.0%	92,489	88,288
Payment for capital assets	28,884			28,884	5,729	23,155	19.8%	20,304	12,516
2.3 Community Health Centres									
Current payment	482,719	17,328		500,047	500,050	(3)	100.0%	355,291	431,200
Transfers and subsidies	811	137		948	948	-	100.0%	1,186	583
Payment for capital assets	2,867			2,867	2,304	563	80.4%	3,711	4,114
2.4. Community Based Service									
Current payment	101,258	(8,497)		92,761	92,761	-	100.0%	98,668	103,108
Transfers and subsidies	8			8	8	-	100.0%	-	
Payment for capital assets	8	(8)		-	-	-		89	183
Other Community Services									

APPROPRIATION STATEMENT
For the year ended 31 March 2009

Details per sub-programme	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
2.5									
Current payment	430,097	(8,168)		421,929	421,929	-	100.0%	397,968	398,742
Transfers and subsidies	4,626	(2,489)		2,137	2,137	-	100.0%	2,824	664
Payment for capital assets	5,138	(72)		5,066	5,066	-	100.0%	8,849	12,146
2.6 HIV and AIDS									
Current payment	1,260,912	(82,548)		1,178,364	1,178,380	(16)	100.0%	965,174	1,016,807
Transfers and subsidies	75,067	(14,465)		60,602	60,602	-	100.0%	39,765	39,376
Payment for capital assets	1,717	(1,334)		383	383	-	100.0%	1,181	2,387
2.7 Nutrition									
Current payment	35,338	(13,703)		21,635	21,635	-	100.0%	33,113	84,616
Payment for capital assets				-		-		-	31
2.8 Forensic Pathology Services									
Current payment	82,862			82,862	89,717	(6,855)	108.3%	89,693	89,566
Transfers and subsidies	16			16	22	(6)	137.5%	-	13
Payment for capital assets	4,879			4,879	6,925	(2,046)	141.9%	29,323	17,597
2.9 District Hospitals									
Current payment	3,033,512	121,575	27,373	3,182,460	3,850,098	(667,638)	121.0%	2,742,756	3,404,739

APPROPRIATION STATEMENT
For the year ended 31 March 2009

Details per sub-programme	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
Transfers and subsidies	145,987	(6,392)		139,595	139,595	-	100.0%	109,670	107,569
Payment for capital assets	42,437	(251)		42,186	30,540	11,646	72.4%	55,099	56,043
TOTAL	**7,362,903**	**-**	**27,373**	**7,390,276**	**8,132,272**	**(741,996)**	**110.0%**	**6,375,856**	**7,209,609**

APPROPRIATION STATEMENT
For the year ended 31 March 2009

DETAIL PER PROGRAMME 2 - DISTRICT HEALTH SERVICES

Programme 2 Per Economic classification	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
Current									
Compensation of employees	4,532,812	40,508		4,573,320	5,264,489	(691,169)	115.1%	3,992,577	4,473,898
Goods and services	2,401,848	14,900	27,373	2,444,121	2,528,178	(84,057)	103.4%	2,010,170	2,382,999
Financial transactions in assets & liabilities				-	82	(82)		-	
Transfers & subsidies									
Provincial & Municipalities	84,648	-33,761		50,887	50,883	4	100.0%	66,036	63,184
University & Technikons		40		40	40	-	100.0%	-	
Non-profit institutions	233,937	-23,273		210,664	210,664	-	100.0%	161,871	160,499
Households	19,770	1,586		21,356	21,366	(10)	100.0%	18,220	13,019
Payment of Capital Assets									
Buildings & other fixed structures				-	138	(138)		-	1,124
Machinery & equipment	89,888			89,888	56432	33,456	62.8%	126,982	114,886
Total	**7,362,903**	**-**	**27,373**	**7,390,276**	**8,132,272**	**(741,996)**	**110.0%**	**6,375,856**	**7,209,609**

APPROPRIATION STATEMENT
For the year ended 31 March 2009

DETAIL PER PROGRAMME 3 - EMERGENCY MEDICAL SERVICES

Details per sub-programme	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
3.1 Emergency Transport									
Current payment	535,544	(3,227)	23,099	555,416	555,416	-	100.0%	460,931	502,184
Transfers and subsidies	8,248	846		9,094	9,094	-	100.0%	687	465
Payment for capital assets	59,073	4,487	8,026	71,586	71,586	-	100.0%	61,621	25,536
3.2 Planned Patient transport									
Current payment	32,459	2,382		34,841	34,841	-	100.0%	20,162	20,454
Transfers and subsidies	78	(1)		77	77	-	100.0%	-	107
Payment for capital assets	5,833	(4,487)		1,346	1,346	-	100.0%	11,462	50
TOTAL	641,235	-	31,125	672,360	672,360	-	**100.0%**	554,863	548,796

APPROPRIATION STATEMENT
For the year ended 31 March 2009

DETAIL PER PROGRAMME 3 - EMERGENCY MEDICAL SERVICES

Programme 3 Per Economic classification	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
Current									
Compensation of employees	389,625	-7,892		381,733	381,733	-	100.0%	341,360	341,040
Goods and services	178,378	7,047	23,099	208,524	208,524	-	100.0%	139,733	181,598
Transfers & subsidies									
Provinces & municipalities	5	506		511	511	-	100.0%	200	130
Households	8,321	339		8,660	8,660	-	100.0%	487	442
Payment of Capital assets									
Buildings & other fixed structures				-		-		-	576
Machinery & equipment	64,906		8,026	72,932	72,932	-	100.0%	73,083	24,998
Software & other intangible assets	-	-	-	-	-	-	-	-	12
Total	**641,235**	**-**	**31,125**	**672,360**	**672,360**	**-**	**100.0%**	**554,863**	**548,796**

APPROPRIATION STATEMENT
For the year ended 31 March 2009

DETAIL PER PROGRAMME 4 - PROVINCIAL HOSPITAL SERVICES

Details per sub-programme	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
4.1 General(Regional) Hospitals									
Current payment	2,811,840	16,044		2,827,884	3,120,440	(292,556)	110.3%	2,505,101	2,824,487
Transfers and subsidies	19,450	5,729		25,179	30,788	(5,609)	122.3%	29,520	31,319
Payment for capital assets	24,961	(1,632)		23,329	18,700	4,629	80.2%	20,459	34,558
4.2 Tuberculosis Hospitals									
Current payment	623,783	9,568		633,351	633,351	-	100.0%	526,439	464,998
Transfers and subsidies	16,555	89		16,644	16,644	-	100.0%	16,939	14,162
Payment for capital assets	2,412	1,218		3,630	3,630	-	100.0%	4,176	2,612
4.3 Psychiatric/Mental Hospitals									
Current payment	471,814	(25,008)		446,806	446,806	-	100.0%	406,008	406,084
Transfers and subsidies	2,044	701		2,745	2,745	-	100.0%	3,161	1,617
Payment for capital assets	1,185	693		1,878	1,878	-	100.0%	1,964	1,826
4.4 Sub-Acute, step down & Chronic Medical Hospital									
Current payment	95,042	(5,862)		89,180	89,180	-	100.0%	85,206	88,083
Transfers and subsidies	4,004	449		4,453	4,453	-	100.0%	3,847	3,820
Payment for capital assets	465	(233)		232	232	-	100.0%	694	461

APPROPRIATION STATEMENT
For the year ended 31 March 2009

Details per sub-programme	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
4.5 Dental Training hospitals									
Current payment	11,327	(1,360)		9,967	9,967	-	100.0%	10,948	9,590
Transfers and subsidies	350	(350)		-		-		42	197
Payment for capital assets	46	(46)		-		-		46	-
TOTAL	**4,085,278**	**-**	**-**	**4,085,278**	**4,378,814**	**(293,536)**	**107.2%**	**3,614,550**	**3,883,814**

DETAIL PER PROGRAMME 4 - PROVINCIAL HOSPITAL SERVICES

Programme 4 Per Economic classification	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
Current Payment									
Compensation of employees	2,959,699	-37,370		2,922,329	3,015,350	(93,021)	103.2%	2,540,592	2,703,673
Goods and services	1,054,107	30,752		1,084,859	1,284,394	(199,535)	118.4%	993,110	1,089,569
Transfers & subsidies									
Provinces & municipalities	509	-378		131	131	-	100.0%	106	129
Non-profit institutions	27,103			27,103	27,103	-	100.0%	33,084	33,703
Households	14,791	6,996		21,787	27,396	(5,609)	125.7%	20,319	17,283

APPROPRIATION STATEMENT
For the year ended 31 March 2009

Programme 4 Per Economic classification	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
Payment of Capital Assets									
Buildings & other fixed structures				-		-		-	337
Machinery & equipment	29,069			29,069	24,440	4,629	84.1%	27,339	39,120
Total	4,085,278	-	-	4,085,278	4,378,814	(293,536)	**107.2%**	3,614,550	3,883,814

DETAIL PER PROGRAMME 5 - CENTRAL HOSPITAL SERVICES

Details per sub -programme	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
5.1 Central Hospitals									
Current payment	313,645			313,645	316,194	(2,549)	100.8%	298,647	336,117
Transfers and subsidies	2,167			2,167	6,260	(4,093)	288.9%	27	18
Payment for capital assets	177,887		1,687	179,574	179,574	-	100.0%	115,604	91,373
5.2 Provincial Tertiary Hospitals Services									
Current payment	956,345			956,345	1,231,564	(275,219)	128.8%	777,083	923,710
Transfers and subsidies	973			973	1,927	(954)	198.0%	3,035	609
Payment for capital assets	43,607		42,095	85,702	85,702	-	100.0%	91,321	55,876
TOTAL	1,494,624	-	43,782	1,538,406	1,821,221	(282,815)	**118.4%**	1,285,717	1,407,703

APPROPRIATION STATEMENT
For the year ended 31 March 2009

DETAIL PER PROGRAMME 5 - CENTRAL HOSPITAL SERVICES

Programme 5 Per Economic classification	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
Current Payment									
Compensation of employees	601,791	-	-	601,791	717,374	(115,583)	119.2%	494,916	572,218
Goods and services	668,199	-	-	668,199	830,384	(162,185)	124.3%	580,814	687,609
Transfers & subsidies									
Provinces & municipalities	2			2	1	1	50.0%	-	3
Households	3138			3,138	8186	(5,048)	260.9%	3,062	624
Payment of Capital Assets									
Machinery & equipment	221,494		43,782	265,276	265,276	-	100.0%	206,925	147,249
Total	1,494,624	-	43,782	1,538,406	1,821,221	(282,815)	**118.4%**	1,285,717	1,407,703

APPROPRIATION STATEMENT
For the year ended 31 March 2009

DETAIL PER PROGRAMME 6 - HEALTH SCIENCES AND TRAINING

Details per sub- programme	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
6.1 Nursing Training Colleges									
Current payment	303,611			303,611	334,019	(30,408)	110.0%	265,512	275,516
Transfers and subsidies	1,832			1,832	1,754	78	95.7%	1,559	1,746
Payment for capital assets	2,349			2,349	1,039	1,310	44.2%	3,414	1,537
6.2 Ems Training Colleges									
Current payment	14,673			14,673	16,900	(2,227)	115.2%	18,350	12,394
Transfers and subsidies	-			-	5	(5)		62	-
Payment for capital assets	2,631			2,631	64	2,567	2.4%	4,215	1,058
6.3 Bursaries									
Current payment	-			-	791	(791)		-	638
Transfers and subsidies	41,945			41,945	44,103	(2,158)	105.1%	33,248	32,935
Payment for capital assets	-			-	-	-		-	-
6.4 Primary Health Care Training									
Current payment	53,483			53,483	65,284	(11,801)	122.1%	50,423	46,847
Transfers and subsidies	71			71	45	26	63.4%	782	5
Payment for capital assets	181			181	14	167	7.7%	595	40

APPROPRIATION STATEMENT
For the year ended 31 March 2009

Details per sub- programme	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
6.5 Training Other									
Current payment	161,346			161,346	201,944	(40,598)	125.2%	135,630	143,363
Transfers and subsidies	10,569			10,569	10,237	332	96.9%	8,340	7,914
Payment for capital assets	184			184	402	(218)	218.5%	504	340
TOTAL	592,875	-	-	592,875	676,601	(83,726)	**114.1%**	522,634	524,333

DETAIL PER PROGRAMME 6 - HEALTH SCIENCES AND TRAINING

Programme 6 Per Economic classification	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
Current Payments									
Compensation of employees	459,404	-	-	459,404	528,940	(69,536)	115.1%	398,491	409,832
Goods and services	73,709	-	-	73,709	89,982	(16,273)	122.1%	71,424	68,926
Financial transaction in assets & liabilities				-	16	(16)		-	-
Transfers & subsidies									
Provinces & municipalities	6	-	-	6	8	(2)	133.3%	2	5
Dept agencies & accounts	5,827	-	-	5,827	5,827	-	100.0%	4,470	4,470

APPROPRIATION STATEMENT
For the year ended 31 March 2009

Programme 6 Per Economic classification	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
Non-profit institutions	5,967	-	-	5,967	5,967	-	100.0%	5,421	4,809
Households	42,617	-	-	42,617	44,342	(1,725)	104.0%	34,098	33,316
Payment of Capital									
Buildings & other fixed structures	-	-	-	-	116	(116)	-	-	-
Machinery & equipment	5,345	-	-	5,345	1,403	3,942	26.2%	8,728	2,931
Software & other intangible assets	-	-	-	-	-	-	-	-	44
Total	592,875	-	-	592,875	676,601	(83,726)	**114.1%**	522,634	524,333

APPROPRIATION STATEMENT
For the year ended 31 March 2009

DETAIL PER PROGRAMME 7 - HEALTH CARE SUPPORT SERVICES

Details per sub-programme	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
7.1 Medicine Trading Account									
Current Payment	-	-	-	-	79	(79)	-	-	-
Transfers & Subsidies	34,130	-	-	34,130	34,130	-	100.0%	12,649	12,649
TOTAL	34,130	-	-	34,130	34,209	(79)	**100.2%**	12,649	12,649

Programme 7 Per Economic classification	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
Current payments									
Goods and services				-	79	(79)			
Transfers & subsidies									
Departmental agencies & accounts	34,130			34,130	34,130	-	100.0%	12,649	12,649
Total	34,130	-	-	34,130	34,209	(79)	**100.2%**	12,649	12,649

APPROPRIATION STATEMENT
For the year ended 31 March 2009

DETAIL PER PROGRAMME 8 - HEALTH FACILITIES MANAGEMENT

Details per sub- programme	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
8.1 Community Health Facilities									
Current payment	38,889	9,414		48,303	48,303	-	100.0%	46,304	32,113
Transfers & Subsidies	-			-	-	-		-	-
Payment for capital assets	194,881	37,441		232,322	232,322	-	100.0%	324,655	207,916
8.2 District Hospitals Services									
Current payment	111,956	40,526		152,482	152,482	-	100.0%	180,286	187,262
Payment for capital assets	393,669	69,795		463,464	463,464	-	100.0%	376,449	333,974
8.3 Emergency Medical Services									
Current payment	16,415		(14,299)	2,116	2,116	-	100.0%	3,761	1,198
Payment for capital assets	10,428	(7,810)		2,618	2,618	-	100.0%	15,101	7,619
8.4 Provincial Hospital Services									
Current payment	141,467	(40,526)	(36,173)	64,768	58,296	6,472	90.0%	51,372	59,980
Payment for capital assets	207,877	(60,000)	(42,217)	105,660	53,467	52,193	50.6%	172,328	98,475
8.5 Central Hospital Services									
Current payment	7,068			7,068	7,033	35	99.5%	3,842	5,551
Payment for capital assets	17,959		(9,591)	8,368	8,368	-	100.0%	15,738	6,450

APPROPRIATION STATEMENT
For the year ended 31 March 2009

Details per sub- programme	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
8.6 Other Facilities									
Current payment	84,186	(9,414)		74,772	69,780	4,992	93.3%	49,964	70,067
Transfers and subsidies	-			-	326	(326)		-	-
Payment for capital assets	57,661	(39,426)		18,235	4,983	13,252	27.3%	38,596	82,202
TOTAL	1,282,456	-	(102,280)	1,180,176	1,103,558	76,618	**93.5%**	1,278,396	1,092,807

APPROPRIATION STATEMENT
For the year ended 31 March 2009

DETAIL PER PROGRAMME 8 - HEALTH FACILITIES MANAGEMENT

Programme 8 per Economic classification	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
Current Payments									
Compensation of employees	4,281			4,281	5,510	(1,229)	128.7%	2,807	1,140
Goods and services	395,700		-50,472	345,228	332,500	12,728	96.3%	332,722	355,031
Transfers & Subsidies									
Households				-	326	(326)			
Payment of Capital Assets									
Buildings & other fixed structures	611,103	24,236		635,339	635,339	-	100.0%	841,123	621,725
Machinery & equipment	251,372	-24,236	-51,808	175,328	129,883	45,445	74.1%	101,684	97,783
Software & other intangible assets	20,000			20,000		20,000		60	17,128
Total	1,282,456	-	(102,280)	1,180,176	1,103,558	76,618	**93.5%**	1,278,396	1,092,807

APPROPRIATION STATEMENT
For the year ended 31 March 2009

DETAIL PER PROGRAMME 9 - SPECIAL FUNCTIONS

Details per sub programme	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
9.1 Special Functions									
Current payment								-	41
TOTAL								**-**	**41**

Economic classification	2008/09							2007/08	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
Current									
Compensation of employees								-	
Financial transactions in assets and liabilities								-	41
Total								**-**	**41**

NOTES TO THE APPROPRIATION STATEMENT
For the year ended 31 March 2009

Notes to the Appropriation Statement

1. Detail of transfers and subsidies as per Appropriation Act (after Virement):

Detail of these transactions can be viewed in note 10 Transfers and subsidies and Annexure 1 (A-L) to the annual financial statements.

2. Detail of specifically and exclusively appropriated amounts voted (after Virement):

Detail of these transactions can be viewed in note 1 (Annual Appropriation) to the annual financial statements.

3. Detail on financial transactions in assets and liabilities

Detail of these transactions per programme can be viewed in note 9 (Details of special functions (theft and losses)) to the Annual Financial Statements.

4. Explanations of material variances from Amounts Voted (after virement):

4.1 Per Programme:

	Final Appropriation	Actual Expenditure	Variance	Variance as a % of Final Appropriation
	R'000	R'000	R'000	
Administration	**289,484**	**284,066**	**5,418**	**2%**
The expenditure under this programme relates to the Head Office function. The under-expenditure relates mainly to force saving being implemented, mainly through the non-filling of posts in an effort to remain within budget.				
District Health Services	**7,390,276**	**8,132,272**	**-741,996**	**-10%**
The over-expenditure on this programme relates mainly to the higher than anticipated uptake of HIV and AIDS patients on ARV therapy, the increase in demand for health services, as well as inflationary pressures, including the cost of medicines, blood products, medical services, fuel and the cost of foodstuffs, especially at District Hospital level, In addition the occupational specific dispensation for nurses has exceeded the budget allocation for this purpose.				
Provincial Hospital Services	**4,085,278**	**4,378,814**	**-293,536**	**-7%**
The over-expenditure relates mainly to the increased demand for health services as well as general inflationary pressures, including the cost of medicines, blood products, medical services, fuel and cost of foodstuffs and cost of living. In addition the occupational specific dispensation for nurses has contributed significantly to this over-expenditure. A further contributing factor has been the decentralisation/transferring of services to Districts.				
Central Hospital Services	**1,538,406**	**1,821,221**	**-282,815**	**18%**
The over-expenditure on this programme was caused mainly by general inflationary pressures including the cost of medicines, blood products, medical services and cost of living expenses.				
Health Sciences and Training	**592,875**	**676,601**	**-83,726**	**14%**
The over expenditure is mainly due to the extension of the medical interns programme.				
Health Facilities Management	**1,180,176**	**1,103,558**	**76,618**	**-7%**
The variance is mainly due to the implementation of forced savings in an effort to remain within budget.				

(In the case of surpluses on programmes, a detailed explanation must be given as to whether it is as a result of a saving or under spending.)

NOTES TO THE APPROPRIATION STATEMENT
For the year ended 31 March 2009

		Final Appropriation	Actual Expenditure	Variance	Variance as a % of Final Apron.
4.2	**Per economic classification:**	**R'000**	**R'000**	**R'000**	**%**
	Current expenditure				
	Compensation of employees	9,109,358	10,077,044	-967,686	10.6
	Goods and services	4,940,403	5,389,804	-449,401	9.1
	Transfers and subsidies				
	Provinces and municipalities	51,543	51,538	5	0
	Departmental agencies and accounts	39,957	39,957	0	0
	Universities and technikons	40	40	0	0
	Non-profit institutions	243,734	243,734	0	0
	Households	99,719	112,437	-12,718	12.8
	Payments for capital assets				
	Buildings and other fixed structures	635,339	635,339	0	0
	Machinery and equipment	642,834	552,856	89,978	-14

STATEMENT OF FINANCIAL PERFORMANCE
for the year ended 31 March 2009

	Note	2008/09 R'000	2007/08 R'000
REVENUE			
Annual appropriation	*1*	15,782,985	13,925,428
Departmental revenue	*2*	168,049	148,544
Direct Exchequer Receipts		-	-
Aid Assistance	*3.1*	111,928	34,386
TOTAL REVENUE		**16,062,962**	**14,108,358**
EXPENDITURE			
Current expenditure			
Compensation of employees	*4.*	10,077,044	8,643,767
Goods and services	*5.*	5,389,804	4,898,719
Financial transactions in assets and liabilities	*6*	98	41
Aid Assistance	*3.1*	104,364	14,480
Total current expenditure		**15,571,310**	**13,557,007**
Transfers and subsidies		**447,706**	**345,978**
Transfers and Subsidies	*7*	447,706	345,978
Expenditure for capital assets			
Tangible capital assets	*8*	1,188,449	1,053,740
Software and other intangible assets	*8*	-	17,196
Total expenditure for capital assets		**1,188,449**	**1,070,936**
Direct Exchequer Payments		-	-
TOTAL EXPENDITURE		**17,207,465**	**14,973,.921**
SURPLUS/ (DEFICIT) FOR THE YEAR		**(1,144,503)**	**(865,563)**
Reconciliation of Net Surplus/ (Deficit) for the year			
Voted Funds		(1,320,116)	(1,034,013)
Department Revenue	*14*	168,049	148,544
Aid Assistance	*3*	7,564	19,906
SURPLUS / DEFICIT FOR THE YEAR		**(1,144,503)**	**(865,563)**

STATEMENT OF FINANCIAL POSITION
for the year ended 31 March 2009

	Note	2008/09 R'000	2007/08 R'000
ASSETS			
Current assets		**3,344,759**	**1,866,260**
Unauthorised expenditure	*9.1*	3,174,794	1,772,641
Cash and Cash Equivalent	*10.*	296	326
Prepayments and advances	*11*	390	395
Receivables	*12*	169,279	92,898
TOTAL ASSETS		**3,344,759**	**1,866,260**
LIABILITIES			
Current Liabilities		**3,332,083**	**1,859,292**
Voted funds to be surrendered to the Revenue Fund	*13*	75,019	149,335
Departmental revenue to be surrendered to the Revenue Fund	*14*	(12,979)	(15,860)
Bank overdraft	*15*	3,118,211	1,629,696
Payables	*16*	122,658	74,511
Local and foreign aid assistance unutilised	*3*	29,174	21,610
TOTAL LIABILITIES		**3,332,083**	**1,859,292**
NET ASSETS		**12,676**	**6,968**
Represented by:			
Recoverable revenue		12,676	6,968
TOTAL		**12,676**	**6,968**

Statement of Changes in Nett Assets

	2008/09 R'000	2007/08 R'000
Recoverable revenue		
Opening balance	6,968	5,345
Transfers	5,708	1,623
Debts raised	5,708	1,623
Closing balance	**12,676**	**6,968**

CASH FLOW STATEMENT
for the year ended 31 March 2009

Cash Flow Statement

	Note	2008/09 R'000	2007/08 R'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Receipts		**16,062,964**	**13,973,591**
Annual appropriated funds received	*1.1*	15,782,987	13,790,690
Departmental revenue received	*2*	168,049	148,515
Aid assistance received	*3*	111,928	34,386
Net (increase)/ decrease in working capital		(1,430,382)	(701,722)
Surrendered to Revenue Fund		(321,521)	(344,686)
Current payments		(14,169,157)	(12,330,264)
Transfers and subsidies paid		(447,706)	(345,978)
Net cash flow available from operating activities	*17*	**(305,802)**	**250,941**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for capital assets	*8*	(1,188,449)	(1,070,936)
Proceeds from sale of capital assets	*2.4*	-	29
(Increase)/ decrease in other financial assets		-	(600)
Net cash flows from investing activities		(1,188,449)	(1,071,507)
CASH FLOWS FROM FINANCING ACTIVITIES			
Increase/ (decrease) in net assets		5,708	1,623
Net cash flows from financing activities		5,708	1,623
Net increase/ (decrease) in cash and cash equivalents		(1,488,543)	(818,943)
Cash and cash equivalents at beginning of period		(1,629,370)	(810,427)
Cash and cash equivalents at end of period	*18*	(3,117,915)	(1,629,370)

ACCOUNTING POLICIES
For the year ended 31 March 2009

Accounting Policies

The Financial Statements have been prepared in accordance with the following policies, which have been applied consistently in all material aspects, unless otherwise indicated. However, where appropriate and meaningful, additional information has been disclosed to enhance the usefulness of the Financial Statements and to comply with the statutory requirements of the Public Finance Management Act, Act 1 of 1999 (as amended by Act 29 of 1999), and the Treasury Regulations issued in terms of the Act and the Division of Revenue Act, Act 1 of 2005.

1. Presentation of the Financial Statements

1.1 Basis of preparation

The Financial Statements have been prepared on a modified cash basis of accounting, except where stated otherwise. The modified cash basis constitutes the cash basis of accounting supplemented with additional disclosure items. Under the cash basis of accounting transactions and other events are recognised when cash is received or paid.

1.2 Presentation currency

All amounts have been presented in the currency of the South African Rand (R) which is also the functional currency of the department.

1.3 Rounding

Unless otherwise stated all financial figures have been rounded to the nearest one thousand Rand (R'000).

1.4 Comparative figures

Prior period comparative information has been presented in the current year's financial statements together with such other comparative information that the department may have for reporting. Where necessary figures included in the prior period financial statements have been reclassified to ensure that the format in which the information is presented is consistent with the format of the current year's financial statements.

A comparison between actual and budgeted amounts per major classification of expenditure is included in the appropriation statement.

1.5 Comparative figures - Appropriation Statement

A comparison between actual amounts and final appropriation per major classification of expenditure is included in the appropriation statement.

2. Revenue

2.1 Appropriated funds

Appropriated funds and adjusted appropriated funds are recognised in the financial records on the date the appropriation becomes effective. Adjustments to the appropriated funds made in terms of the adjustments budget process are recognised in the financial records on the date the adjustments become effective.

Total appropriated funds are presented in the statement of financial performance.

Unexpended appropriated funds are surrendered to the Provincial Revenue Fund, unless approval has been given by the Provincial Treasury to rollover the funds to the subsequent financial year. These rollover funds form part of retained funds in the annual financial statements. Amounts owing to the Provincial Revenue Fund at the end of the financial year are recognised in the statement of financial position.

2.2 Departmental revenue

All departmental revenue is paid into the Provincial Revenue Fund when received, unless otherwise stated. Amounts owing to the Provincial Revenue Fund at the end of the financial year are recognised in the statement of financial position. Amounts receivable at the reporting date are disclosed in the disclosure notes to the annual financial statements.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

2.2.1 Sales of goods and services other than capital assets

The proceeds received from the sale of goods and/or the provision of services is recognised in the statement of financial performance when the cash is received.

2.2.2 Fines, penalties & forfeits

Fines, penalties & forfeits are compulsory unrequited amounts which were imposed by a court or quasi-judicial body and collected by the department. Revenue arising from fines, penalties and forfeits is recognised in the statement of financial performance when the cash is received.

2.2.3 Interest, dividends and rent on land

Interest, dividends and rent on land is recognised in the statement of financial performance when the cash is received. No provision is made for interest or dividends receivable from the last day of receipt to the end of the reporting period.

2.2.4 Sale of capital assets

The proceeds received on sale of capital assets are recognised in the statement of financial performance when the cash is received.

2.2.5 Financial transactions in assets and liabilities

Repayments of loans and advances previously extended to employees and public corporations for policy purposes are recognised as revenue in the statement of financial performance on receipt of the funds. Amounts receivable at the reporting date are disclosed in the disclosure notes to the annual financial statements.

Cheques issued in previous accounting periods that expire before being banked are recognised as revenue in the statement of financial performance when the cheque becomes stale. When the cheque is reissued the payment is made from Revenue.

2.2.6 Gifts, donations and sponsorships (transfers received)

All cash gifts, donations and sponsorships are paid into the Provincial Revenue Fund and recorded as revenue in the statement of financial performance when received. Amounts receivable at the reporting date are disclosed in the disclosure notes to the financial statements.

All in-kind gifts, donations and sponsorships are disclosed at fair value in the annexure to the financial statements.

2.3 Aid assistance

Local and foreign aid assistance is recognised in the financial records when the department directly receives the cash from the donor(s). The total cash amounts received during the year is reflected in the statement of financial performance as revenue.

All in-kind local and foreign aid assistance are disclosed at fair value in the annexure to the annual financial statements.

The cash payments made during the year relating to local and foreign aid assistance projects are recognised as expenditure in the statement of financial performance. A receivable is recognised in the statement of financial position to the value of the amounts expensed prior to the receipt of the funds.

A payable is raised in the statement of financial position where amounts have been inappropriately expensed using local and foreign aid assistance, unutilised amounts are recognised in the statement of financial position.

3. Expenditure

3.1 Compensation of employees

Salaries and wages comprise payments to employees. Salaries and wages are recognised as an expense in the statement of financial performance when the final authorisation for payment is effected on the system (by no later than 31 March of each year).

ACCOUNTING POLICIES
For the year ended 31 March 2009

Capitalised compensation forms part of the expenditure for capital assets in the statement of financial performance.

All other payments are classified as current expense.

Social contributions include the department's contribution to social insurance schemes paid on behalf of the employee. Social contributions are recognised as an expense in the statement of financial performance when the final authorisation for payment is effected on the system.

3.1.1 Short term employee benefits

Short term employee benefits comprise of leave entitlements (capped leave), thirteenth cheques and performance bonuses. The cost of short-term employee benefits is expensed as salaries and wages in the statement of financial performance when the final authorisation for payment is effected on the system (by no later than 31 March of each year).

Short-term employee benefits that give rise to a present legal or constructive obligation are disclosed in the notes to the financial statements. These amounts are not recognised in the statement of financial performance.

3.1.2 Long-term employee benefits

3.1.2.1 Termination benefits

Termination benefits such as severance packages are recognised as an expense in the statement of financial performance as a transfer when the final authorisation for payment is effected on the system (by no later than 31 March of each year).

3.1.2.2 Medical Benefits

The department provides medical benefits for its employees through defined benefit plans. Employer contributions to the fund are incurred when the final authorization for payment is effected on the system. No provision is made for medical benefits in the Annual Financial Statements of the department.

3.1.2.3 Post employment retirement benefits

The department provides retirement benefits (pension benefits) for certain of its employees through a defined benefit plan for government employees. These benefits are funded by both employer and employee contributions. Employer contributions to the fund are expensed when the final authorisation for payment to the fund is effected on the system (by no later than 31 March of each year). No provision is made for retirement benefits in the financial statements of the department. Any potential liabilities are disclosed in the financial statements of the Provincial Revenue Fund and not in the financial statements of the employer department.

3.1.2.4 Other Employee Benefits

Obligations arising from leave entitlement, thirteenth cheque and performance bonus that are reflected in the disclosure notes have not been paid for at year-end.

3.2 Goods and services

Payments made for goods and/or services are recognised as an expense in the statement of financial performance when the final authorisation for payment is effected on the system (by no later than 31 March of each year). The expense is classified as capital if the goods and services were used on a capital project.

3.3 Interest and rent on land

Interest and rental payments are recognised as an expense in the statement of financial performance when the final authorisation for payment is effected on the system (by no later than 31 March of each year). This item excludes rental for the use of buildings or other fixed structures.

3.4 Financial transactions in assets and liabilities

Debts are written off when identified as irrecoverable. Debts written-off are limited to the amount of savings and/or under spending of appropriated funds. The write off occurs at year-end or when funds are available. No provision is made for irrecoverable amounts but amounts are disclosed as a disclosure note.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

All other losses are recognised when authorisation has been granted for the recognition thereof.

3.5 Unauthorised expenditure

Unauthorised expenditure is defined as:

- The overspending of a vote or the main division within a vote, or
- Expenditure that was not made in accordance with the purpose of a vote, or in the case of a main division, not in accordance with the purpose of the main division.

When discovered, unauthorised expenditure is recognised as an asset in the statement of financial position until such time as the expenditure is either approved by the relevant authority, recovered from the responsible person or written off as irrecoverable in the statement of financial performance.

Unauthorised expenditure approved with funding is recognised in the statement of financial performance when the unauthorised expenditure is approved and the related funds are received. Where the amount is approved without funding it is recognised as expenditure, subject to availability of savings, in the statement of financial performance on the date of approval.

3.6 Fruitless and wasteful expenditure

Fruitless and wasteful expenditure is defined as: expenditure that was made in vain and would have been avoided had reasonable care been exercised.

Fruitless and wasteful expenditure is recognised as an asset in the statement of financial position until such time as the expenditure is recovered from the responsible person or written off as irrecoverable in the statement of financial performance.

3.7 Irregular expenditure

Irregular expenditure is defined as:

Expenditure other that unauthorized expenditure, incurred in contravention or not in accordance with a requirement of ant applicable legislation, including:

- The Public Finance Management Act;
- The State Tender Board Act, or any regulations in terms of the Act; or
- Any provincial legislation providing for procurement procedures in the department.

Irregular expenditure is recognised as expenditure in the statement of financial performance. If the expenditure is not condoned by the relevant authority it is treated as an asset until it is recovered or written off as irrecoverable.

3.8 Transfers and subsidies

Transfers and subsidies are recognised as an expense when the final authorisation for payment is effected on the system (by no later than 31 March of each year).

3.9 Expenditure for capital assets

Capital Assets are assets that have a value of >R 5,000 per unit and that can be used repeatedly or continuously in production for than one year.

Payments made for capital assets are recognised as an expense in the statement of financial performance when the final authorisation for payment is effected on the system (by no later than 31 March of each year).

4. Assets

4.1 Cash and cash equivalents

Cash and cash equivalents are carried in the statement of financial position at cost.

ACCOUNTING POLICIES
For the year ended 31 March 2009

For the purposes of the cash flow statement, cash and cash equivalents comprise cash on hand, deposits held, other short-term highly liquid investments and bank overdrafts.

4.2 Prepayments and advances

Amounts prepaid or advanced are recognised in the statement of financial position when the payments are made.

4.3 Receivables

The accounting policy previously stated:
Receivables included in the Statement of Financial Position arise from cash payments made that are recoverable from another party.
Receivables outstanding at year-end are carried in the Statement of Financial Position at cost.
The last sentence of the accounting policy is subject to various interpretations. As a result, the accounting policy is revised to read as follows:
Receivables included in the Statement of Financial Position arise from cash payments made that are recoverable from another party.
Receivables outstanding at year-end are carried in the Statement of Financial Position at cost plus any accrued interest.

4.4 Inventory

Inventories purchased during the financial year are disclosed at cost in the notes.

4.5 Capital assets

A capital asset is recorded on receipt of the item at cost. Cost of an asset is defined as the total cost of acquisition.

5. Liabilities

5.1 Payables

Recognised payables mainly comprise of amounts owing to other governmental entities. These payables are recognised at historical cost in the statement of financial position.

5.2 Lease commitments

The accounting policy previously stated:
Lease commitments are not recognised in the Statement of Financial Position as a liability or as expenditure in the Statement of Financial Performance but are included in the disclosure notes.
Operating and finance lease commitments are expensed when the payments are made. Assets acquired in terms of finance lease agreements are disclosed in the Annexures and disclosure notes to the financial statements."
The accounting policy is subject to various interpretations. As a result, the accounting policy for lease commitments is revised to read as follows:

Lease commitments

Finance leases

Finance leases are not recognised as assets and liabilities in the statement of financial position. Finance lease payments are recognised as an expense in the statement of financial performance and are apportioned between the capital and the interest portions. The finance lease liability is disclosed in the disclosure notes to the financial statements.

Operating leases

Operating lease payments are recognised as an expense in the statement of financial performance. The operating lease commitments are disclosed in the disclosure notes to the financial statements."

5.3 Accruals

Accruals represent goods/services that have been received, but where no invoice has been received from the supplier at the reporting date, or where an invoice has been received but final authorisation for payment has not been effected on the system.

Accruals are not recognised in the statement of financial position as a liability or as expenditure in the statement of financial performance but are included in the disclosure notes.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

5.4 Contingent liabilities

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the department; or

A contingent liability is a present obligation that arises from past events but is not recognised because:

- It is not probable that an outflow of resources embodying economic benefits or service potential will be required to settle the obligation; or
- The amount of the obligation cannot be measured with sufficient reliability.

Contingent liabilities are included in the disclosure notes.

5.5 Commitments

Commitments represent goods/services that have been approved and/or contracted, but where no delivery has taken place at the reporting date.

Commitments are not recognised in the statement of financial position as a liability or as expenditure in the statement of financial performance but are included in the disclosure notes.

6. Net Assets

6.1 Capitalisation reserve

The capitalisation reserve comprises of financial assets and/or liabilities originating in a prior reporting period but which are recognised in the statement of financial position for the first time in the current reporting period. Amounts are transferred to the Provincial Revenue Fund on disposal, repayment or recovery of such amounts.

6.2 Recoverable revenue

Recoverable revenue represents payments made and recognised in the Statement of Financial Performance as an expense in previous years due to non-performance in accordance with an agreement, which have now become recoverable from a debtor.

Amounts are recognised as recoverable revenue when a payment made and recognised in a previous financial year becomes recoverable from a debtor in the current financial year.

7. Related party transactions

Related parties are departments that control or significantly influence the department in making financial and operating decisions. Specific information with regards to related party transactions is included in the disclosure notes.

8. Key management personnel

Key management personnel are those persons having the authority and responsibility for planning, directing and controlling the activities of the department.

Compensation paid to key management personnel including their family members where relevant, is included in the disclosure notes.

9. Public private partnerships

A public private partnership (PPP) is a commercial transaction between the department and a private party in terms of which the private party:

- Performs an institutional function on behalf of the institution; and/or
- Acquires the use of state property for its own commercial purposes; and

ACCOUNTING POLICIES
For the year ended 31 March 2009

- Assumes substantial financial, technical and operational risks in connection with the performance of the institutional function and/or use of state property; and
- Receives a benefit for performing the institutional function or from utilizing the state property, either by way of:
- Consideration to be paid by the department which derives from a Revenue Fund;
- Charges fees to be collected by the private party from users or customers of a service provided to them; or
- A combination of such consideration and such charges or fees.

A description of the PPP arrangement, the contract fees and current and capital expenditure relating to the PPP arrangement is included in the disclosure notes.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

Notes to the Annual Financial Statements

1. Annual Appropriation

1.1 Annual Appropriation

Included are funds appropriated in terms of the Appropriation Act for Provincial Departments (Equitable Share).

	Final Appropriation	Actual Funds received	Funds not requested/ not received	Appropriation received 2007/08
Programmes	**R'000**	**R'000**	**R'000**	**R'000**
Administration	289,484	289,484	-	280,763
District Health Services	7,390,276	7,390,276	-	6,375,856
Emergency Medical Services	672,360	672,360	-	554,863
Provincial Hospital Services	4,085,278	4,085,278	-	3,614,550
Central Hospital Services	1,538,406	1,538,406	-	1,285,717
Health Sciences and Training	592,875	592,875	-	522,634
Health Care Support Services	34,130	34,130	-	12,649
Health Facilities Management	1,180,176	1,180,178	-	1,143,658
Total	**15,782,985**	**15,782,987**	**-**	**13,790,690**

Provide an explanation for funds not requested/not received in the space provided below:

1.2 Conditional grants

	Note	2008/09 R'000	2007/08 R'000
Total grants received	*ANNEXURE 1A*	2,634,190	2,190,991
Provincial Grants included in Total grants received		294,832	259,758

(It should be noted that Conditional grants are included in the amounts per the Total Appropriation in Note 1.1)

2. Departmental revenue to be surrendered to Revenue Fund

		2008/09 R'000	2007/08 R'000
Sales of goods and services other than capital assets	*2.1*	158,432	142,248
Fines, penalties and forfeits	*2.3*	11	14
Interest, dividends and rent on land	*2.2*	3	13
Sales of capital assets	*2.4*	-	29
Financial transactions in assets and liabilities	*2.5*	9,603	6,240
Total Revenue		168,049	148,544
Less: Own revenue included in appropriation			
Departmental revenue collected		**168,049**	**148,544**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

Disclosure Notes to the Annual Financial Statements for the year ended 31 March 2008

			2008/09 R'000	2007/08 R'000
2.1	**Sales of goods and services other than capital assets**	2		
	Sales of goods and services produced by the department		157,526	142,248
	Sales by market establishment		9,917	-
	Administrative fees		5,865	5,090
	Other sales		141,744	137,158
	Sales of scrap, waste and other used current goods		906	-
	Total		**158,432**	**142,248**
2.2	**Interest, dividends and rent on land**	2		
	Interest		3	13
2.3	**Fines, penalties and forfeits**	2		
	Penalties		11	14
2.4	**Sales of capital assets**	2		
	Other capital assets		-	29
2.5	**Financial transactions in assets and liabilities**	2		
	Nature of loss recovered			
	Receivables		1,318	1,094
	Other receipts including recoverable revenue		8,285	5,146
	TOTAL		**9,603**	**6,240**

3.	**Aid assistance**		
3.1	**Assistance received in cash: Other**		
	Local		
	Opening balance	10,901	2,304
	Revenue	85,007	12,086
	Expenditure : Current	(87,037)	3,489
	Closing balance	8,871	10,901
	Foreign		
	Opening balance	10,709	(600)
	Revenue	26,921	22,300
	Expenditure : Current	(17,327)	10,991
	Closing balance	20,303	10,709
	Total		
	Opening Balance	21,610	1,704
	Revenue	111,928	34,386
	Expenditure : Current	(104,364)	14,480
	Closing balance	**29,174**	**21,610**
	Analysis of balance		
	Local and foreign aid receivable		
	Local and foreign aid un-utilised	29,174	21,610
		29,174	**21,610**
		2008/09	**2007/08**
		R'000	**R'000**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

4. Compensation of employees

4.1 Salaries and wages

Basic Salary	6,780,773	5,822,662
Performance award	1,202	96,109
Service Based	16,127	14,322
Compensative/circumstantial	815,412	737,201
Periodic payments	29,461	46,247
Other non-pensionable allowances	1,136,776	836,516
Total	**8,779,751**	**7,553,057**

4.2 Social contributions

4.2.1 Employer contributions

Pension	837,976	729,500
Medical	456,777	359,003
UIF	50	223
Bargaining council	2,235	1,945
Official unions and associates	223	24
Insurance	32	15
Total	**1,297,293**	**1,090,710**
Total compensation of employees	**10,077,044**	**8,643,767**
Average number of employees	**66,466**	**64,907**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

	Note	2008/09 R'000	2007/08 R'000
5. Goods and services			
Administrative fees		203	6,392
Advertising		27,948	69,731
Assets less then R5,000	5.1	41,450	63,669
Bursaries (employees)		306	134
Catering		17,236	30,593
Communication		103,323	107,655
Computer services	5.2	117,156	61,299
Consultants, contractors and special services	5.3	1,414,588	1,022,222
Entertainment		631	1,532
External audit fees	*5.4*	11,457	4,946
Inventory	*5.5*	2,770,743	2,491,732
Maintenance, repair and running costs			309,222
Operating leases		130,512	110,044
Owned and leasehold property expenditure	*5.6*	545,604	350,715
Transport provided as part of the departmental activities		21,261	23,976
Travel and subsistence	*5.7*	65,770	81,474
Venues and facilities		14,082	32,759
Training and staff development		36,349	49,849
Other operating expenditure	5.8	71,185	80,775
Total		**5,389,804**	**4,898,719**

		Note	2008/09 R'000	2007/08 R'000
5.1	**Assets less than R5,000**	*5*		
	Tangible assets		**41,450**	**63,669**
	Machinery and equipment		41,450	63,669
	Total		**41,450**	**63,669**

		Note	2008/09 R'000	2007/08 R'000
5.2	**Computer services**	*5*		
	SITA computer services		110,057	50,422
	External computer service providers		7,099	10,877
	Total		**117,156**	**61,299**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

		Note	2008/09 R'000	2007/08 R'000
5.3	**Consultants, contractors and agency/outsourced services**	5		
	Business and advisory services		5,806	429,510
	Infrastructure and planning		37,112	-
	Laboratory services		494,121	256,991
	Legal costs		6,579	5,187
	Contractors		205,536	-
	Agency and support/outsourced services		665,434	330,534
	Total		**1,414,588**	**1,022,222**

			2008/09 R'000	2007/08 R'000
5.4	**Audit cost – external**	5		
	Regulatory audits		7,217	4,873
	Performance audits		-	73
	Forensic Audits		4,240	-
	Total external audit fees		**11,457**	**4,946**

		Note	2008/09 R'000	2007/08 R'000
5.5	**Inventory**	*5*		
	Food and food supplies		184,996	206,014
	Fuel, oil and gas		230,414	69,782
	Other consumable materials		132,872	180,296
	Maintenance material		86,277	119,534
	Stationery and printing		53,097	58,658
	Medical supplies		2,083,087	1,857,448
	Military stores		-	-
	Total		**2,770,743**	**2,491,732**

The Total Inventory held on hand as at 31 March 2009 is R2,006billion, this amount consists of consumables R324million, pharmaceuticals of R288million and machinery and Equipment of R1,394billion

		2008/09 R'000	2007/08 R'000
5.6	**Travel and subsistence**		
	Local	64,602	80,968
	Foreign	1,168	506
	Total	**65,770**	**81,474**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

		Note	2008/09 R'000	2007/08 R'000
5.7	**Other operating expenditure**	5		
	Learner ships		393	-
	Professional bodies, membership and subscription fees		18,915	14,642
	Resettlement costs		8,518	13,645
	Other		43,359	52,488
	Total		**71,185**	**80,775**

		Note	2008/09 R'000	2007/08 R'000
6	**Financial Transactions in Assets and Liabilities**			
	Debts written off	6.1	98	41
	Total		**98**	**41**

		Note	2008/09 R'000	2007/08 R'000
6.1	**Debts written off**	6		
	Nature of debts written off			
	Staff debts written off		98	41
	Total		**98**	**41**

		Note		
7.	**Transfers and subsidies**			
	Provinces and municipalities	*ANNEXURE , 1B,1C*	51,538	63,463
	Departmental agencies and accounts	*ANNEXURE 1D*	39,957	17,119
	Universities and technikons	*ANNEXURE 1E*	40	-
	Non-profit institution	*ANNEXURE 1F*	243,734	199,011
	Households	*ANNEXURE 1G*	112,437	66,385
	Total		**447,706**	**345,978**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

	Note	2008/09 R'000	2007/08 R'000
8. Expenditure for capital assets			
Tangible assets		**1,188,449**	**1,053,740**
Buildings and other fixed structures	8.1	635,593	623,762
Machinery and equipment	8.1	552,856	429,978
Software and other intangible assets		**-**	**17,196**
Computer software	31	-	17,196
Other intangibles		-	-
Total		**1,188,449**	**1,070,936**

8.1 Analysis of funds utilised to acquire capital assets - 2008/09

	Voted Funds R'000	Aid assistance R'000	TOTAL R'000
Tangible assets	**1,188,449**	**-**	**1,188,449**
Buildings and other fixed structures	635,593		**635,593**
Machinery and equipment	552,856		**552,856**
Land and subsoil assets			**-**
Investment property			**-**
Biological assets			**-**
Software and other intangible assets	**-**	**-**	**-**
Capitalised development costs			**-**
Computer software			**-**
Mastheads and publishing titles			**-**
Patents, licences, copyright, brand names, trademarks			**-**
Recipes, formulae, prototypes, designs, models			**-**
Services and operating rights			**-**
Other intangibles			**-**
Total	**1,188,449**	**-**	**1,188,449**

8.2 Analysis of funds utilised to acquire capital assets - 2007/08

	Voted Funds R'000	Aid assistance R'000	TOTAL R'000
Total assets acquired	1,070,936		**1,070,936**

	2008/09 R'000	2007/08 R'000
9. Unauthorised expenditure		

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

9.1 Reconciliation of unauthorised expenditure

Opening balance		1,772,641	1,046,803
Unauthorised expenditure-current year	*9.2*	1,402,153	1,226,743
Amounts approved by Parliament/ Legislature (with Funding)		-	(500,905)
Unauthorised expenditure awaiting authorisation		**3,174,794**	**1,772,641**

Analysis of awaiting authorisation per economic classification

Current	3,174,794	1,772,641
Total	**3,174,794**	**1,772,641**

9.2 Details of unauthorised expenditure - current year

Incident	Disciplinary steps taken/criminal proceedings	2008/09 R'000
District Health Services	Net overspending on Programme	741,997
Provincial Hospital Services	Net overspending on Programme	293,536
Central Hospital Services	Net overspending on Programme	282,815
Health Science and Training	Net overspending on Programme	83,726
Health Care Support	Net overspending on Programme	79
	Total	**1,402,153**

		2008/09 R'000	2007/08 R'000
10.	**Cash and cash equivalents**		
	Cash on hand	296	326
	Total	**296**	**326**

		2008/2009 R'000	2007/2008 R'000
11.	**Prepayments and advances**		
	Travel and subsistence	**390**	**395**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

12 Receivable

	Note	2008/09 Less than one year R'000	One to three years R'000	Older than three years R'000	Total R'000	2007/08 R'000
Claims recoverable	12.1 Annex 3	52,340			52,340	31,700
Staff debt	12.2	9,609	13,449		23,058	13,938
Other debtors	12.3	93,881			93,881	47,260
		155,830	**13,449**	**-**	**169,279**	**92,898**

12.1 Claims recoverable

	Note	2008/09 R'000	2007/08 R'000
National departments			
Provincial departments		26,144	31,700
Public entities		198	
Private enterprises		25,451	
Universities and technikons		547	
Households and non-profit institutions			
Local governments			
Total		**52,340**	**31,700**

12.2 Staff debt

	2008/09 R'000	2007/08 R'000
Breach of Contract	2,770	13,938
Employee Debt	5,987	
Ex Employee Debt	13,760	
Government Accidents	(6)	
State Guarantee	79	
Supplier Debt	45	
Telephone Debt	3	
Other Staff Debt	420	
Total	**23,058**	**13,938**

12.3 Other debtors

	Note	2008/09 R'000	2007/08 R'000
Salary control accounts	12	17,558	11,053
Dishonoured Cheques		27	7
Inventory – CPS Interface		4,494	4,202
Inventory – CPS		71,802	31,998
Sundry debtors		-	-
Total		93,881	47,260

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

13. Voted funds to be surrendered to the Revenue Fund		2008/09 R'000	2007/08 R'000
Opening balance		149,335	279,580
Transfer from Statement of Financial Performance		(1,320,116)	(1,034,013)
Under-funding in 2004/05 received in 2006/07			
Add: Unauthorised expenditure for current year	*9.1*	1,402,153	1,226,743
Voted funds not requested/not received	*1.1*	-	(134,738)
Paid during the year	*20.1*	(156,353)	(188,237)
Closing balance		**75,019**	**149,335**

14. Departmental revenue to be surrendered to the Revenue Fund	2008/09 R'000	2007/08 R'000
Opening balance	(15,860)	(7,955)
Transfer from Statement of Financial Performance	168,049	148,544
Paid during the year	(165,168)	(156,449)
Closing balance	**(12,979)**	**(15,860)**

15. Bank overdraft	2008/09 R'000	2007/08 R'000
Consolidated Paymaster General Account	3,118,211	1,629,696
Total	**3,118,211**	**1,629,696**

16 Payables - current	Note	2008/09 R'000	2007/08 R'000
Clearing accounts	16.1	7,348	2,908
Other payables	16.2	115,310	71,603
Total		**122,658**	**74,511**

16.1 Clearing accounts	2008/09 R'000	2007/08 R'000
Salary control account	5,611	2,894
Debt Control Tax Debt	1,737	14
Total	**7,348**	**2,908**

16.2. Other payables	2008/09 R'000	2007/08 R'000
Pension recoverable account	9,119	6,170
Medsas Account	106,191	65,433
Total	**115,310**	**71,603**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

The Medsas Account relates to balances owing to the Provincial Pharmaceutical Supply Depot (PPSD). The corresponding debtor balance in the financial statements of the PPSD is R153, 212m. The difference is as a result of PPSD complying with the accrual basis of accounting as opposed to the cash basis and comprises adjustments for payables, receivables and depreciation at year-end, the Department being a related party to PMSC

		2008/09 R'000	2007/08 R'000
17.	**Net cash flow available from operating activities**		
	Net surplus as per Statement of Financial Performance	(1,144,503)	(865,563)
	Add back non-cash movements/ movements not deemed operating activities:	838,701	1,116,504
	(Increase/decrease in receivables – current	(76,381)	(33,129)
	Increase)/decrease in prepayments and advances	5	(67)
	(Increase) in other current assets		(725,238)
	(Decrease)/Increase in payables – current	48,147	56,712
	Proceeds from sale of capital assets		(29)
	Expenditure on capital assets	1,188,449	1,070,936
	Surrenders to revenue fund	(321,521)	(344,686)
	Other non-cash items	2	1,226,743
	Voted funds not requested/not received		(134,738)
	Net cash flow generated by operating activities	**(305,802)**	**250,941**

		2008/09 R'000	2007/08 R'000
18.	**Reconciliation of cash and cash equivalents for cash flow purposes**		
	Consolidated Paymaster General Account	(3,118, 211)	(1,629,696)
	Cash on hand	296	326
	Total	**(3,117,915)**	**(1,629,370)**

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

These amounts are not recognised in the financial statements and are disclosed to enhance the usefulness of the financial statements.

			Note	2008/09 R'000	2007/08 R'000
19.	**Contingent liabilities**				
	Liable to	**Nature**			
	Motor vehicle guarantees	Employees	*ANNEXURE 1G*	652	652
	Housing loan guarantees	Employees	*ANNEXURE1G*	36,512	41,544
	Claims against the department		*ANNEXURE 2B*	376,239	300,987
	Other departments (Interdepartmental Unconfirmed balances)		*ANNEXURE 4*	112,808	136,113
	Total			**526,211**	**479,296**

		2008/09 R'000	2007/08 R'000
20.	**Commitments**		
	Current expenditure		
	Approved and contracted	216,964	43,277
	Approved but not yet contracted	26,274	56,369
	Total	**243,238**	**99,646**
	Capital expenditure		
	Approved and contracted	1,541,199	621,108
	Approved but not yet contracted	2,571,223	1,571,676
		4,112,422	**2,192,784**
	Total Commitments	**4,271,470**	**2,292,430**

DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2009

		30 Days R'000	30+ Days R'000	2008/09 R'000	2007/08 R'000
21.	**Accruals**				
	Compensation of Employees	279	23	302	16,632
	Goods and services	147,949	85,049	232,998	195,147
	Building &other intangible Assets	4,020	177	4,197	-
	Transfers and subsidies	270	53	323	6,755
	Machinery and equipment	11,782	2,052	13,834	58,332
	Total	**164,300**	**87,354**	**251,654**	**276,866**

Listed by programme level

Administration		179	2,625
District Health Services		122,341	169,498
Emergency Medical Services		2,196	5,501
Provincial Hospital Services		88,524	71,673
Central Hospital Services		18,264	13,549
Health Sciences and Training		472	11,257
Health Facilities Management		19,678	2,763
Total		**251,654**	**276,866**
Confirmed balances with other departments	*ANNEXURE 4*	139,770	87,957
Confirmed balances with other government entities	*ANNEXURE 4*	86,053	-
Total		225,823	87,957

		2008/09 R'000	2007/08 R'000
22.	**Employee benefit provisions**		
	Leave entitlement	463,922	483,382
	Thirteenth cheque	285,341	259,005
	Capped leave commitments	723,703	699,033
	Total	**1,472,966**	**1,441,420**

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

23 Lease commitments

23.1 Operating leases expenditure

2008/09	Land	Buildings and other fixed structures	Machinery and equipment	Total
Not later than 1 year		43,856	204,001	247,857
Later than 1 year and not later than 5 years		65,134		65,134
Later than five years		48,617		48,617
Total lease commitments	**-**	**157,607**	**204,001**	**361,608**

2007/08	Land	Buildings and other fixed structures	Machinery and equipment	Total
Not later than 1 year		35,421	69,775	105,196
Later than 1 year and not later than 5 years		148,849		148,849
Later than five years		50,799		50,799
Total lease commitments	**-**	**235,069**	**69,775**	**304,844**

Cell phones Rental R1,733

		2008/09 R'000	2007/08 R'000
24.	**Receivables for departmental revenue**		
	Sales of goods and services other than capital assets	52,183	45,315
	Total	**52,183**	**45,315**

		2008/09 R'000	2007/08 R'000
25.	**Contingent Assets**		
	Occupation Specific Dispensation (OSD)	20,209	20,209
	Total	**20,209**	**20,209**

The outcome mainly indicates to a difference of interpretation and documentation that was not found on the personnel files during the AGSA review.

Based on the court case uncertainty still exists on whether the overpayments can actually be recovered and as a result no corresponding debtor could be raised in the financial statements.

Possible irregular expenditure could be incurred depending on the outcomes or resolutions reached on OSD payments.

DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2009

		2008/09 R'000	2007/08 R'000
26.	**Irregular Expenditure**		
	Irregular expenditure – relating to current year	1,181,960	
	Irregular expenditure awaiting con donation	**1,181,960**	**-**

			2008/09 R'000	2007/08 R'000
26.1	**Details of irregular Expenditure – Current year**			
	Incidents	**Disciplinary steps taken**		
	Techmed	Under investigation	99,646	
	Colosseum	Under investigations	1,169	
	Comp. of Employees	Budget exceeded	967,686	
	HPTD Grant	Not as per approved plans	113,459	
			1,181,960	**-**

The balance of R84, 190 million for Techmed has been disclosed as a commitment

		No. of Individuals	2008/09 R'000	2007/08 R'000
27.	**Key management personnel**			
	Political office bearers (provide detail below)			
	Officials:	1	1,328	774
	Level 15 to 16	3	3,328	2,800
	Level 14 (including CFO if at a lower level)	44	33,270	26,891
	Family members of key management personnel			
	Total		37,926	30,465

The MEC for Health Ms. P Nkonyeni

28 Public Private Partnership

Inkosi Albert Luthuli Central Hospital PPP

The Department has in place a public private partnership agreement with Cowslip Investments (Pty) Ltd and Impilo Consortium for the delivery of non-clinical services to the Inkosi Albert Luthuli Central Hospital. The Department is satisfied that the performance of the PPP partners was adequately monitored in terms of the provisions of the agreement.

The Department has the right to the full use of the assets and the consortium may not pledge the assets as security against any borrowings for the duration of the agreement.

The Impilo Consortium is responsible for the provision of the following goods and services:

- Supply of Equipment and IM&T Systems that are State of the Art and replace the Equipment and IM&T Systems so as to ensure that they remain State of the Art;
- Supply and replacement of Non-Medical Equipment;
- Provision of all Services necessary to manage the Project Assets in accordance with Best Industry Practice;
- Maintenance and replacement of the Departmental Assets in terms of the replacement schedules;

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

- Provision or procurement of Utilities and Consumables and Surgical Instruments; and
- Provision of Facilities Management Services.

The agreement was concluded with a view to provide the Department with the opportunity to concentrate on the delivery of clinical services at the highest standards in terms of quality, efficiency, effectiveness and patient focused care.

The Department is responsible for the employment of all healthcare staff and the administration staff, together with the provision of all consumables used in the provision of the healthcare services.

Impilo Consortium is required at its own cost and risk to provide, deliver, Commission, manage, maintain and repair (as the case may be) Project Assets and Department Assets (or part thereof), including the renewal or replacement of Project Assets and Department Assets at such times and in such manner as to enable it to meet the IM&T Output Specifications and the FM Output Specifications; as to ensure that the Department is, at all times, able to provide Clinical Services that fulfill Hospital's Output Specifications using State of the Art Equipment and IM&T Systems; as would be required having regard to Best Industry Practice; and as required by Law.

The replacement of assets over the period of the contract is based on the Replacement Programme which operates on a rolling basis. To that end, at least 1 (one) month prior to the start of each Contract Year thereafter, Impilo Consortium is required to furnish to the Asset Replacement Committee for approval a revised Replacement Programme.

The assets will only transfer to the Department at the end of the period of the agreement.

The Impilo Consortium has to ensure that, at the end of the Project Term the Project Assets and Department Assets comply with the requirements of the Agreement and are in a state of repair which is sound and operationally safe, fair wear and tear excepted and the items comprising each level of Project Assets specified in the agreement between them have an average remaining useful life not less than one third of the original useful life.

29 Public Private Partnership – (Continued)

Amendment 2 to the PPP agreement was concluded during December 2005. The main aim thereof was to consolidate various amendments agreed upon since the inception date of the contract and no additional financial implications were incurred as a result of the amendments.

The commencement date of the contract was 4 February 2002, with a final commissioning date for the hospital functions being 31 August 2003. The contract is for a period of 15 years from the commencement date. The Department has the option to renew the agreement only for a further year after 15 years.

The agreement requires the Department to pay a monthly service fee as stipulated in the schedule of payments to cover the monthly operational costs for facilities management, provision of information technology services, maintenance of equipment and the supply of equipment related consumables which the consortium is responsible for. The service fee is adjusted monthly for applicable performance penalties in accordance with the provisions of the penalty regime. The Department is also responsible for the payment of a quarterly fee towards the asset replacement reserve. The fees for the year under review were as follows:

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

	Actual Expenditure: 2008/09 R'000	Commitment for 2009/010 R'000	Payments from 01 April 2010 till the End of the contract R'000
Monthly Service Fee	331,567	338,064	2,730,514
Quarterly Fee	261,761	254,957	1,833,368
TOTAL	**593,328**	**383,114**	**4,563,882**

	Actual Expenditure: 2007/08 R'000	Commitment for 2007/08 R'000	Payments from 01 April 2009 till the end of the contract R'000
Monthly Service Fee	302,457	244,806	2,353,011
Quarterly Fee	141,216	196,452	1.072.196
TOTAL	**443,673**	**383,114**	**3.425.207**

Listed below were the expenditure incurred for the current and prior year:

	2008/09 R'000	2007/08 R'000
Contract fee paid		
Indexed component	593,328	443,673
Total	**593,328**	**443,673**

		Note	2008/2009 R'000	2007/2008 R'000
30	**Provisions**			
	Potential irrecoverable debts			
	Claims recoverable – Social Welfare porridge claims		16,306	
	Total		16,306	-
	Provisions			
	Other		7,908	7,908
	Total		7,908	7,908
	Total		24,214	7,908

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

		2008/2009 R'000
31	**Non- Adjusting Events After Reporting Date**	
	Non- Adjusting events or a statement that such an estimate Cannot be made	25,000
	TOTAL	25,000

32 Tangible Capital Assets

Movement in tangible capital assets per asset register for the year ended 31 March 2009

	Opening balance	Current Year Adjustments to prior year balances	Additions	Disposals/ Transfers	Closing balance
HERITAGE ASSETS	**Cost**	**Cost**	**Cost**	**Cost**	**Cost**
Heritage assets	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**
Machinery and Equipment	**1,697,542**	**-**	**557,298**	**42,496**	**2,212,344**
Transport Assets	405,663		101,087	42,496	464,254
Computer equipment	110,982		28,548	-	139,530
Furniture and Office equipment	66,080		3,618	-	69,698
Other machinery & Equipment	1,114,817		424,045	-	1,538,862
Total tangible assets	**1,697,542**	**-**	**557,298**	**42,496**	**2,212,344**

As discussed in the CFO Forum, National Treasury has confirmed with the Auditor General's technical unit that the opening balances of Minor Assets will not be audited but current movements.

The KwaZulu-Natal Provincial Treasury issued a guideline in respect of Asset Management Framework that assets purchased prior to 1st April 2004, where Department's did not keep accurate records of their acquisition, will be loaded onto the asset register with a value of R1.00 and purchase date of 31 March 2004.

DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2009

32.1 Additions to tangible capital asset per asset register for the year ended 31 March 2009

	Cash	Non-Cash	(Capital work in progress - current costs)	Received current year, not paid (Paid current year, received prior year)	Total
	Cost	Fair Value	Cost	Cost	Cost
	R'000	R'000	R'000	R'000	R'000
Machinery and equipment	**552,856**	**-**	**-**	**-**	**552,856**
Transport assets	101,087				101,087
Computer equipment	28,548				28,548
Furniture and Office equipment	3,618				3,618
Other machinery and equipment	419,603			4,442	424,045
Total capital assets	**552,856**	**-**	**-**	**4,442**	**557,298**

32.2 Disposals/ Transfers of tangible capital assets per asset register for the year ended 31 March 2009

	Sold (cash)	Non-cash	Total	Cash Received
	Cost	Fair Value	Cost	Actual
	R'000	R'000	R'000	R'000
Machinery and equipment		**42,496**	**42,496**	
Transport assets	**-**	**42,496**	**42,496**	
Total	**-**	**42,496**	**42,496**	

32.3 Movement in tangible capital assets per asset register for the year ended 31 March 2008

	Opening balance	Additions	Disposals	Closing Balance
HERITAGE ASSETS	**R'000**	**R'000**	**R'000**	**R'000**
Machinery and equipment	**1,267,564**	**429,978**	**-**	**1,697,542**

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

Transport assets	298,198	107,465		405,663
Computer equipment	64,302	46,680		110,982
Furniture and Office equipment	44,612	21,468		66,080
Other machinery and equipment	860,452	254,365		1,114,817
BIOLOGICAL ASSETS				
Total tangible assets	**1,267,564**	**429,978**	**-**	**1,697,542**

33 Minor assets

MINOR ASSETS OF THE DEPARTMENT FOR 31 MARCH 2009

	Intangible assets	Heritage assets	Machinery and equipment	Biological assets	Total
	R'000	R'000	R'000	R'000	R'000
Minor Assets			45,517		45,517
TOTAL	-	-	45,517	-	45,517

	Intangible assets	Heritage assets	Machinery and equipment	Biological assets	Total
Number of minor assets			10,705		10,705
TOTAL	-	-	10,705	-	10,705

34 Intangible Capital Assets

Movement in intangible capital assets per asset register for the year ended 31 March 2009

	Opening balance	Current Year Adjustments to prior year balances	Additions	Disposals	Closing balance
	Cost	Cost	Cost	Cost	Cost
	R'000	R'000	R'000	R'000	R'000
Computer software	17,196			-	17,196
Total intangible assets	**17,196**	**-**		**-**	**17,196**

DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2009

34.1 Movement in intangible capital assets per asset register for the year ended 31 March 2008

	Opening balance	Additions	Disposals	Closing balance
	Cost	Cost	Cost	Cost
	R'000	R'000	R'000	R'000
Computer software	-	17,196	-	17,196
Total intangible assets	-	17,196	-	17,196

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

ANNEXURE A

SCHEDULE – IMMOVABLE ASSETS, LAND AND SUB SOIL ASSETS

Opening Balances

In the 2006/2007 financial year the department had applied accounting circular 1 of 2007. The impact of this circular on the financial statements resulted in the cumulative balances on buildings, land and subsoil assets being transferred to the Provincial of Public Works. The balance that was transferred was R1, 192,520 which consisted of the following; dwelling (R167,750), non residential building (R1, 017, 779), other fixed structures (R6, 991).

Movements to immovable assets – 2007/2008

The department has applied the exemptions as granted by the National Treasury and thus immovable assets have not been disclosed on the face of the annual financial statements.

Additions

The additions for the current year on buildings, land and subsoil assets consisted of the following; dwelling (R 82, 200), non residential building (R 524,165), other fixed structures (R 17, 397).

Movements to immovable assets – 2008/2009

The addition for work in progress on buildings amounted to R791, 995 million.

The supplementary information presented does not form part of the annual financial statements and is un-audited.

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

ANNEXURE 1 A

STATEMENT OF CONDITIONAL GRANTS RECEIVED

NAME OF GRANT	GRANT ALLOCATION					SPENT			2007/08	
	Division of Revenue Act	Roll Over	DoRA Adjustments	Other Adjustments	Total Available	Amount received by department	Amount spent by department	% of Available funds spent	Division of Revenue Act	Amount spent by department
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
Division of Revenue Act										
National Tertiary Services	903,297			8,595	911,892	911,892	911,898	100%	789,578	789,578
HIV and AIDS Health	629,694			127,519	757,213	757,213	757,615	100%	466,922	466,922
Hospital Revitalisation	285,666	44,738			330,404	330,404	330,404	100%	315,456	333,523
Integrated Nutrition Programme	-				-	-	-			9
Health Professions Training & Development	212,092				212,092	212,092	212,092	100%	201,992	201,992
Provincial Infrastructure	294,832				294,832	294,832	294,832	100%	259,758	259,758
Forensic Pathology	127,757				127,757	127,757	149,093	117%	157,285	132,201
Total	2,453,338	44,738	-	136,114	2,634,190	2,634,190	2,655,934		2,190,991	2,183,983

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

ANNEXURE 1 B

STATEMENT OF UNCONDITIONAL TRANSFERS PAID TO PROVINCES

NAME OF DEPARTMENT	GRANT ALLOCATION				TRANSFER		SPENT			2007/08
	Amount	Roll Over	Other Adjustments	Total Available	Actual Transfer	% of Available Transferred	Amount received by department	Amount spent by department	% of Available funds spent by department	Total Available
	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000	%	R'000
Payments in respect of Motor Vehicle Licenses										
Claims against the State					1			1		
Department of Transport	1,335			1,335	1,043	78%		1,043		653
Armed Robbery & Short Prov										147
RSCLS										4
PMT Refund & Rem- Act of Grace					1			1		
	1.335	-	-	1,335	1,045		-	1,045		804

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

ANNEXURE 1 C

STATEMENT ON UNCONDITIONAL GRANTS AND TRANSFERS TO MUNICIPALITIES

NAME OF MUNICIPALITY		GRANT ALLOCATION			TRANSFER		SPENT			200708
	Division of Revenue Act	Roll Over	Adjustments	Total Available	Actual Transfer	% of Available Funds Transferred	Amount received by municipality	Amount spent by municipality	% of Available funds spent by municipality	Division of Revenue Act
	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000	%	R'000
Payments in respect of RSC levies										
Abaqulusi	541			541						468
Dannhauser	562			562						332
Edumbe	400			400						203
Emnambithi/Ladysmith	4,570			4,570						5,475
Endondasuka/ Mandeni	943			943	707	75%	707	707	100%	943
Endumeni	1,841			1,841	2,820	153%	2,820	2,820		1,669
eThekwini	40,041			40,041	36,406	91%	36,406	36,406	100%	36,483

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

ANNEXURE 1 C (continued)

STATEMENT ON UNCONDITIONAL GRANTS AND TRANSFERS TO MUNICIPALITIES

NAME OF MUNICIPALITY	GRANT ALLOCATION				TRANSFER		SPENT			200708
	Division of Revenue Act	Roll Over	Adjustments	Total Available	Actual Transfer	% of Available Funds Transferred	Amount received by municipality	Amount spent by municipality	% of Available funds spent by municipality	Division of Revenue Act
	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000	%	R'000
Hibiscus Coast	2,957			2,957	689	23%	689	689	100%	1,329
Kokstad										-
Kwa Dukuza	3,837			3,837	3,184	83%	3,184	3,184	100%	3,117
Matatiele										316
Mpofona	819			819						525
Msunduzi	8,085			8,085						3
Mthonjaneni	831			831	640	77%	640	640	100%	660
Newcastle	1,057			1,057						810
Okhahlamba	1,166			1,166						775
Richmond										-
Ubuhlebezwe										-
Ulundi										-
Umdoni	1,817			1,817	651	36%	651	651	100%	879
Umhlathuze	4,086			4,086	4,086	100%	4,086	4,086	100%	4,159
Umlalazi	2,029			2,029						1,496
Umngeni	1,126			1,126						652
Umshwathi										-
Umtshezi	1,891			1,891						1,239
Umuziwabantu	768			768	153	20%	153	153	100%	462

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

ANNEXURE 1 C (continued)

STATEMENT ON UNCONDITIONAL GRANTS AND TRANSFERS TO MUNICIPALITIES

NAME OF MUNICIPALITY		GRANT ALLOCATION			TRANSFER		SPENT			2007/08
	Amount	Roll Over	Adjustments	Total Available	Actual Transfer	% of Available Transferred	Amount received by municipality	Amount spent by municipality	% of Available funds spent by municipality	Division of Revenue Act
	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000	%	R'000
Umvoti	1,394			1,394	1,133					663
Uphongolo										-
Emadlangeni										-
Rounding										1
Umodoni Environment	71			71						
Umunziwabantu Env	31			31						
Umgeni Env	80			80						
Richmond Env	71			71						
Msunduzi Env	131			131						
Hibiscus Coast Env	142			142						
Umshwathi	33			393						
Umtshezi Env	54			54						
Enambithi Env	80			80						
Endumeni Env	80			80						
Umvoti Env	54			54						
Dannhauser Env	24			24						
Newcastle Env	90			90						
Utrecht Env	24			24						
Abaqulusi Env	47			47						
Uphongolo Env	32			32						
Ulundi Env	60			60						
Umlathuze Env	206			206						
Umlalazi Env	73			73						
Kwadukuza Env	104			104						
Mandeni Env	25			25						
Kokstad Env	66			66						

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

ANNEXURE 1 C (continued)

STATEMENT ON UNCONDITIONAL GRANTS AND TRANSFERS TO MUNICIPALITIES

NAME OF MUNICIPALITY		GRANT ALLOCATION			TRANSFER		SPENT			2007/08
	Amount	Roll Over	Adjustments	Total Available	Actual Transfer	% of Available Transferred	Amount received by municipality	Amount spent by municipality	% of Available funds spent by municipality	Division of Revenue Act
	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000	%	R'000
Ubhlebezwe Env	27			27						
Ethekwini Env	1,096			1,096						
Kwadebeka					16		16	16		
Hally Scott					6		6	6		
Molweni					2		2	2		
TOTAL	**83,822**	**-**	**-**	**83,822**	**50,493**		**50,493**	**50,493**		**62,659**

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

ANNEXURE 1 D

STATEMENT OF TRANSFERS TO DEPARTMENTAL AGENCIES AND ACCOUNTS

DEPARTMENTS/AGENCY/ACCOUNT	TRANSFER ALLOCATION				TRANSFER		200708
	Adjusted Appropriation Act	Roll Overs	Adjustments	Total Available	Actual Transfer	% of Available Transferred	Final Appropriation Act
	R'000	R'000	R'000	R'000	R'000	%	R'000
				-			
Cape Medical Depot Augmentation (PMSC)	34,130			34,130	34,130	100%	12,649
SDL	4,244			4,244	5,827	137%	4,470
State Vehicles and Rental Car Accident	4,244			4,244	-	-	-
	42,618	**-**	**-**	**42,618**	**39,957**		**17,119**

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

ANNEXURE 1 E

STATEMENT OF TRANSFERS TO UNIVERSITIES AND TECHNIKONS

	TRANSFER ALLOCATION						EXPENDITURE	200708
UNIVERSITY / TECHNIKON	Adjusted Appropriation Act	Roll Over	Adjustments	Total Available	Actual Transfer	Amount not Transferred	% of Available Transferred	Final Appropriation Act
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000
Donation and gifts U & T					40	(40)	-100%	
	-	-	-	-	**40**	**(40)**		-

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

ANNEXURE 1 F

STATEMENT OF TRANSFERS AND SUBSIDIES TO NON-PROFIT INSTITUTIONS

NON PROFIT INSTITUTIONS	TRANSFER ALLOCATION				EXPENDITURE		2007/08
	Adjusted Appropriation Act	Roll Over	Adjustments	Total Available	Actual Transfer	% of Available Transferred	Final Appropriation Act
	R'000	R'000	R'000	R'000	R'000	%	R'000
Transfers							
African Renaissance				-		0.0%	100
	-	-	-	-	-		100
Subsidies							
Austerville Halfway House	417			417	417	100%	333
Azalea House	384			384	384	100%	363
Bekimpelo/Bekulwandle Trust Clinic	5,586			5,586	5,586	100%	4,950
Benedictine Clinic	294			294	294	100%	275
Cheshire Day Car Centre (Educare)							92
Cleremont Day Care Centre	392			392	392		277
Day Care Club 91	46			46	46		54
Day Care Club 92							54
Doris Goodwin Special Hospital							
Dunstan Farrel Hospital (Santa)							
Durban School for The Deaf	156			156	156		146
Ekukhanyeni Clinic	148			148	49		138
Elandskop Oblate Hospital	354			354	354		331
Enkumane Clinic	212			212	212		198
Fosa Hospital (Santa)							
Happy Hour Amaoti	382			382	382		279
Happy Hour Durban North	196			196	196		139
Happy Hour Kwaximba	294			294	294		
Happy Hour Mariannhill	108			108	108		92

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

ANNEXURE 1 F (continued)

STATEMENT OF TRANSFERS AND SUBSIDIES TO NON-PROFIT INSTITUTIONS

NON PROFIT INSTITUTIONS	TRANSFER ALLOCATION				EXPENDITURE		200708
	Adjusted Appropriation Act	Roll Overs	Adjustments	Total Available	Actual Transfer	% of Available Transferred	Final Appropriation Act
	R'000	R'000	R'000	R'000	R'000	%	R'000
Happy Hour Mpumalanga	294			294	294		218
Happy Hour Ninikhona	157			157	157		78
Happy Hour Nyangwini	206			206	206		174
Happy Hour Overport	147			147	147		87
Happy Hour Phoenix	196			196	196		70
Hlanganani Ngothando DCC	353			353	353		92
Ikhwezi Cripple Care	1,179			1,179	1,179		1,006
Ikhwezi Dns	136			136	136		127
Jewel House	267			267	267		167
Joan Tennant House	289			289	289		152
John Peattie House	1,046			1,046	1,046		713
Jona Vaughn Centre	1,869			1,869	1,869		1,721
Lynn House	267			267	267		273
Madeline Manor	673			673	673		635
Masada Workshop	59			59	46		68
Masibambeni Day Care Centre	118			118	118		111
Matikwe Oblate Clinic	383			383	383		358
McCords Hospital	59,054			59,054	59,054		52,537
Mhlumayo Oblate Clinic							424
Montebello Chronic Sick Home	3,832			3,832	3,832		3,581
Mountain View Special Hospital	7,838			7,838	7,838		5,931
Noyi Bazi Oblate Clinic	386			386	386		361
Pongola Hospital	2,961			2,961	2,961		2,558

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

ANNEXURE 1 F (continued)

STATEMENT OF TRANSFERS AND SUBSIDIES TO NON-PROFIT INSTITUTIONS

NON PROFIT INSTITUTIONS	TRANSFER ALLOCATION				EXPENDITURE		200708
	Adjusted Appropriation Act	Roll Overs	Adjustments	Total Available	Actual Transfer	% of Available Transferred	Final Appropriation Act
	R'000	R'000	R'000	R'000	R'000	%	R'000
Scadifa Centre	801			801	801		693
Siloah Special Hospital	11,548			11,548	11,548		10,333
Sparks Estate	1,023			1,023	1,023		944
St. Lukes Home	423			423	423		399
St. Mary's Hospital Marianhill	76,911			76,911	76,911		68,381
Sunfield Home	111			111	111		105
Umlazi Halfway House	208			208	208		181
Phrenaid	80			80	80		75
Rainbow Haven	311			311	311		294
Sibusisiwe Home							212
Provincial Aids Action Unit I							-
District Service Delivery: Ugu (HIV&AIDS)	6,110			6,110	6,675		5,196
District Service Delivery: Umgungundlovu (HIV/AIDA)	6,419			6,419	3,874		1,742
District Service Delivery: Uthukela (HIV&AIDS)	2,690			2,690	2,702		694
District Service Delivery: Umzinyathi (HIV&AIDS)	4,277			4,277	2,499		1,880
District Service Delivery: Amajuba (HIV&AIDS)	2,794			2,794	1,576		509
District Service Delivery: Zululand (HIV&AIDS)	7,471			7,471	3,124		3,499
District Service Delivery: Umkhanyakude (HIV&AIDS)	6,860			6,860	4,089		2,115

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

ANNEXURE 1 F (continued)

STATEMENT OF TRANSFERS AND SUBSIDIES TO NON-PROFIT INSTITUTIONS

NON PROFIT INSTITUTIONS	TRANSFER ALLOCATION				EXPENDITURE		200708
	Adjusted Appropriation Act	Roll Overs	Adjustments	Total Available	Actual Transfer	% of Available Transferred	Final Appropriation Act
	R'000	R'000	R'000	R'000	R'000	%	R'000
District Service Delivery: Uthungulu (HIV&AIDS)	7,467			7,467	7,386		5,366
District Service Delivery: Ilembe (HIV&AIDS)	8,110			8,110	7,927		4,078
District Service Delivery: Sisonke (HIV&AIDS)	7,749			7,749	6,091		2,286
District Service Delivery: eThekwini (HIV&AIDS)	14,625			14,625	12,093		9,351
Head Office HAST							26
Philanjalo Hospice							1,337
Incorrect Expenditure 2007/2008							21
Budget Control Holding Fund	-		5,093	5,093			-
Genesis Care centre	750			750	197		-
Mhlummayo Clinic	454			454	454		-
Philanjolo Hospice	1,193			1,193	1,352		
Entabeni Step-Down Centre	450			450	600		
The Dream Centre	2,400			2,400	1,139		
TOTAL	**261,914**		**5,093**	**267,007**	**243,734**		**199,011**
	261,914		**5,093**	**267,007**	**243,734**		**199,011**

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

ANNEXURE 1 G

STATEMENT OF TRANSFERS AND SUBSIDES TO HOUSEHOLDS

HOUSEHOLDS	TRANSFER ALLOCATION				EXPENDITURE		200708
	Adjusted Appropriation Act	Roll Overs	Adjustments	Total Available	Actual Transfer	% of Available Transferred	Final Appropriation Act
	R'000	R'000	R'000	R'000	R'000	%	R'000
Employee Social Benefits – Leave Gratuity	32,136			32,136	38,870	121%	26,450
Bursaries Non Employees	41,945			41,945	44,110	105%	32,942
Claims against the state	14,170			14,170	27,134	191%	6,941
Donations and Gifts to households							
Employee Social Benefit - Local recreational Staff	220			-	128		-
PMT / Refunds and Remissions Act / Grace	-			-	-		52
Households							
Employee Social Benefit- Post Retirement	536				383		-
Employee Social Benefit Severance Pay	272			272	1,812	666%	
Total	**89,279**	**-**	**-**	**88,523**	**112,437**		**66,385**

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

ANNEXURE 1 H

STATEMENT OF GIFTS, DONATIONS AND SPONSORSHIPS RECEIVED FOR THE YEAR ENDED 31 MARCH 2009

NAME OF ORGANISATION	NATURE OF GIFT, DONATION OR SPONSORSHIP	200809	200708
		R'000	R'000
Received in Cash			
Mrs. Nhayla	Patient use at Inkosi Albert Luthuli Central Hospital	80	-
Impumelelo Innovations award trust	Training workshops and Info brochures - Vryheid community	40	
Capt Network	Greys hospital - set up research and employment of Coordinator	507	
Ben Booysen Air conditioning	Corporate governance component staff Christmas lunch	5	
Madlula protection Services	Corporate governance component staff Christmas lunch	2	
Orthalam and Medac	For use at staff year end function	2	
Bayer Health care	To use for Neurology workshops and congresses at Greys Hospital	10	
Subtotal		646	-

NAME OF ORGANISATION	NATURE OF GIFT, DONATION OR SPONSORSHIP	200809	200708
		R'000	R'000
Received in kind			
Prior year donation received			3,088
ABSA	3 Kiosk - Medical Chambers, Capital Towers, Natalia	201	
Buckle Family	Wheelchair - Addington Hospital	1	
Capitec	Entertainment - National Youth Indaba 26 June 2008	15	
Palm Stationers Manufacturers	250 Stationery Packs for Health Youth Indaba	5	
Ambu-care Industries	Entertainment - National Youth Indaba 23 June 2008	8	
Kelly Personnel	Computer training for 80 youth National Youth Indaba	14	
ABSA	Gift Hampers - National Youth Indaba	4	
Video Vision entertainment	150 DVD's for prizes at National Youth Indaba	10	

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

NAME OF ORGANISATION	NATURE OF GIFT, DONATION OR SPONSORSHIP	200809	200708
		R'000	R'000
ABI	10 Cases of Water and 5 Cases of Coke for Youth Indaba	1	
Umgeni Water	3000 Sachets of water - National Youth Indaba	1	
Damelin	Recording and Production of DVD's - National Youth Indaba	75	
Marvel Magic Meals	Nutritional food packs - National Youth Indaba	8	
MTN	Starter Packs MTN, Cell C and Vodacom - National Youth Indaba	35	
Department of Education	Kit Bags - National Youth Indaba	49	
Tau Tau	Gift hampers - fitness training - National Youth Indaba	3	
Ned Geref. Gemeente - Newcastle	20 Mattresses to Newcastle Hospital	1	
PPD South Africa	Clinical Trials at Greys Hospital	560	
Addington Hospital Board	Television set for ward 13 b at Addington Hospital	3	
Addington Hospital Board	For usage at Quality day and graduation at Addington	12	
Capitec	Sports kits to Inkosi Albert Luthuli Central Hospital	7	
Minolta	5 Digital cameras to EMRS Umgungundlovu	4	
Various Companies	Sports kits to Tongaat Community Health care centre	13	
Pietermaritzburg Andhra Sabha	10 blankets to Edendale Hospital	3	
St Andrews Hospital	Operating Microscope to St Andrews Hospital	297	
Zanini Bantwana	Play equipment to Edendale Hospital	14	
Tides Foundation of SA	Mazda double cab 4X4 to Catherine Booth Hospital	240	
Old Mutual	Television to Osindesweni Hospital	3	
Lions Club Estcourt	Fencing to play area at Emmaus Hospital	5	
Vodacom	Eye care consumables - Addington Hospital	160	
Chatsworth Charity Relay Association	5 wheel chairs to RK Khan Hospital	7	
Church of Jesus Christ of Latter - Day Saints	Television to Edendale Hospital	3	
Reproductive Health and HIV Research	13 air conditioners to RK Khan Hospital ARV clinic	64	
Fuchs Foundation - UKZN Paediatrics Dept	Breast Milk bank, office Equipment for King Edward VIII Hospital	540	
Nashua	3 gel printers to RK Khan Hospital	6	
Balakisten family	10 Wheel chairs RK Khan Hospital	3	
SAI Organisation	2 Wheel chairs RK Khan Hospital	15	
Crystal Macnicol	Jungle gym to Christ the King Hospital	1	
N3 Toll concession Duduza Initiative	Soft Toys to Greys, Edendale, Northdale, Estcourt and Ladysmith Hospitals	20	

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

NAME OF ORGANISATION	NATURE OF GIFT, DONATION OR SPONSORSHIP	200809	200708
		R'000	R'000
Broad Reach Health care	Wellness Clinic at St Andrews Hospital	13	
Impilo Consortium	Samsung Hi-fl and DVD player to Inkosi Albert Luthuli Central Hospital	4	
National Prosecuting Authority	Computer set to Prince Mshiyeni Hospital	7	
Dr. BT Oyeboza & Sr. EV Vilakazi	Television and DVD to Mahatma Gandhi Hospital	2	
UKZN School of Medicine	Computer set to Mahatma Gandhi Hospital	5	
Susan - Mary Foster	Various items to Paediatric ward at Christ the King Hospital	11	
Boxer Cash and Carry	Various items to Paediatric ward at Eshowe Hospital	29	
Bayer Health	Administration sets for setting up drips at Murchison Hospital	11	
PG Bison	Furniture items at Prince Mshiyeni Hospital	2	
Mzamo Child Guidance and Training	Disposable gowns to Prince Mshiyeni Hospital for Clinicians	8	
Main Theatre Staff at Prince Mshiyeni	1 Television and 4 Microwaves to Prince Mshiyeni Hospital	5	
Boxer Cash and carry	Various items to Paediatric ward at Ekhombe Hospital	26	
Broadreach Health Care	Structural changes to ARV clinic at GJ Crooks Hospital	205	
Mr. Anwar Dawood	Wheel chairs to Inkosi Albert Luthuli Central Hospital ward B1 west	25	
Victor Dlatz Foundation	Ultrasound machine to Addington Hospital	119	
Chemspec Paints	200 liters of Paint to RK Khan Hospital	8	
Game Store	Microwave to RK Khan Hospital - Therapy Unit	1	
Dundee Hospital Board	Microwave to Dundee Hospital	1	
Old Mutual Group Schemes	5 Floating Trophies to St Apollinaris Hospital	1	
Broad Reach Health care	Computers, Printers and network points to Ugu District Office	80	
Lions Club Scottburgh	Instruments for Cataract surgery to CJ Crooks Hospital	35	
Dr Al Bacus	LG Television set to Mahatma Gandhi Hospital	1	
Crossroads International	Various items to Paediatric ward at Richmond Hospital	16	
Mandeni Local municipality	Hlomendlini Clinic to serve as a Primary Health Care centre	1,500	
Reproductive and HIV Research Unit	Computer equipment to Cato Manor Clinic	30	
N. Mohamed - Motor City	Meals to Townhill Hospital	4	
Italian Co-operation	Vehicle to Umzinyathi Health District	51	
Broad Reach Health care	Upgrade of Remed Dispensing software to Ugu Health District	57	
Roche Pharmaceuticals	Cytmed Computer Programme for pilot project at Greys Hospital	36	

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

NAME OF ORGANISATION	NATURE OF GIFT, DONATION OR SPONSORSHIP	200809	200708
		R'000	R'000
Subtotal		4,704	3,438
TOTAL		5,350	3,438

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

ANNEXURE 1 I

STATEMENT OF AID ASSISTANCE RECEIVED

NAME OF DONOR	PURPOSE	OPENING BALANCE	REVENUE	EXPENDITURE	CLOSING BALANCE
		R'000	R'000	R'000	R'000
Received in cash					
Local					-
TB Global Fund	Strengthen Provincial Capacity for treatment and care of TB patients	4,338	-	-	4,338
Atlantic Philanthropies	Improvements to KZN College of Nursing	-	6,000	-	6,000
Canadian HIV trials Network Edendale	HIV / AIDS trials	523	71	242	352
Canadian trials Greys	HIV / AIDS trials	-	674	119	555
Bayer Health Care : Greys	Neurology	-	10	-	10
Dept of Water Affairs & Forestry	Cholera epidemic	361	-	237	124
Bristol Meyers	Management of HIV positive patients at Uthukela	43	-	43	-
Dept of Local Government & Traditional Affairs	Purchase of EMRS vehicles	2,935	-	-	2,935
HW Seta Learner ship Mseleni / Mosvold	Learnership to Mseleni & Mosveld Hosp	180	441	456	165
Astra Zeneca (Astra Zeneca Pharmacy)	Drug Trials	260	-	36	224
HW Seta Learnership St Aidens	Learnership to St Aidens Hosp	15	115	-	130
HW Seta Learnership Pharmacy	Learnership for the training of Pharmacy Assistants	91	-	85	6
HW Seta Learnership Head Office	Learnership	-	280	-	280
Zinc study (Nu-Health & Pfizer)	Drug Trials	51	-	7	44
Synthes (Pty) Ltd	Orthopaedic clinic trials	13	-	13	-
Rashid Suleiman & Associates	To be used at Institutions	5	-	-	5
Braun (Inkosi Albert Luthuli Central Hosp)	Staff awards programme	8	-	8	-
Braun (Inkosi Ngwelezana Hospital)	Training	1	-	-	1

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

NAME OF DONOR	PURPOSE	OPENING BALANCE	REVENUE	EXPENDITURE	CLOSING BALANCE
		R'000	R'000	R'000	R'000
Bhayla - Neurosurgery	Neurosurgery	20	-	20	-
Bhayla - Orthopaedic	Hip replacements	60			60
Impumumelelo Trust Innovation			40	16	24
HOCF Global Fund	HIV & AIDS	1,994	84,120	86,114	-
Agouron A (Pfizer)	Drug Trials	1	-	1	-
Zinc study (Nu-Health & Pfizer)					-
EU Funding(PHC)	Partnership for Delivery of PHC Programme	10,710	20,160	16,966	13,904
Psychiatric Observation	Claims to the Department of Justice		17		17
					-
					-
Subtotal		21,610	111,928	104,364	29,174
Received in kind					
Italian Funding			4,399	4,399	-
Global Fund for HIV&AIDS Patients	Enhancement of care for HIV&AIDS patients	32,373	64,194	121,943	(25,376)
					-
Subtotal		32,373	68,593	126,342	(25,376)
TOTAL		53,983	180,521	230,706	3,798

The 2007/2008 closing balance for donation in kind was R32,276 should be R32,373, therefore opening has been adjusted
It must be noted that R86,114m was transferred from Aid in kind to aid in cash received which forms part of the expenditure indicated in the Global Fund books.
A balance of R35, 825m has been transferred to Claim Recoverable. An amount of R17000. will be re-imbursed to Department of Justice for overpayment received
3rd quarter psychiatric observation claim. Donations on 2 accounts had to be rounded down in order to balance to the advance account.

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

ANNEXURE 2 A

STATEMENT OF FINANCIAL GUARANTEES ISSUED AS AT 31 MARCH 2009 - LOCAL

Guarantor Institution	Guarantee in respect of	Original Guaranteed capital amount	Opening Balance 1 April 2008	Guarantee drawdown during the year	Guarantee repayments/ cancelled/ reduced/ released during the year	Currency Revaluations	Closing balance 31 March 2009	Realised losses not recoverable i.e. claims paid out
		R'000	R'000	R'000	R'000	R'000	R'000	R'000
Motor vehicles								
Standard Bank	Motor Vehicles	969	652	-	-	-	652	-
Total Motor Vehicles Guarantee		**969**	**652**	**-**	**-**	**-**	**652**	**-**
Housing								
ABSA	Housing	12,692	10,050	156	757	(440)	9,009	-
BOE Bank Ltd	Housing	46	46	-	-	-	46	-
First Rand Bank Ltd	Housing	14,264	10,981	108	1,157	(177)	9,755	-
Green Start Home Loans	Housing	45	39	-	-	-	39	-
ITHALA Limited	Housing	1,973	1,818	80	79	(46)	1,773	-
Nedbank Ltd	Housing	3,269	2,509		256	(131)	2,122	-
Old Mutual Bank	Housing	12,898	10,169	9	1,602	(436)	8,140	-
Peoples Bank Ltd	Housing	446	314		46		268	-
SA Home Loans	Housing	51	49	211			260	-
Standard Bank	Housing	7,092	5,517	32	331	(162)	5,056	-
Company Unique Finance	Housing	102	52		7	(1)	44	-
Total Housing Guarantee		**52,878**	**41,544**	**596**	**4,235**	**(1,393)**	**36,512**	**-**
GRAND TOTAL		**53,847**	**42,196**	**596**	**4,235**	**(1,393)**	**37,164**	

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

ANNEXURE 2 B

STATEMENT OF CONTIGENT LIABILITIES AS AT 31 MARCH 2009

Nature of Liability	Opening Balance 01/04/2008	Liabilities incurred during the year	Liabilities Paid/cancelled/reduced during the year	Liabilities Recoverable (Provide details hereunder)	Closing Balance 31/03/2009
	R'000	R'000	R'000	R'000	R'000
Claims against the department					
Medico Legal	241,349	103,885	51,224		294,010
Claims against the State (Transport, Labour, Civil)	61,373	20,856			82,229
TOTAL	**302,722**	**124,741**	**51,224**	**-**	**376,239**

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

ANNEXURE 3 A

INTER-GOVERNMENTAL RECEIVABLES

Government Entity	Confirmed balance		Unconfirmed balance		Total	
	31/03/2009	31/03/2008	31/03/2009	31/03/2008	31/03/2009	31/03/2008
	R'000	R'000	R'000	R'000	R'000	R'000
Department						
Agriculture			38	15	38	15
Economic Development				13	-	13
Safety and Security			31	5	31	5
Social Welfare	130		625	802	755	802
Department of Labour			12		12	-
Education			1,000	263	1,000	263
KZN Legislature			5	4	5	4
KZNPA Library Services			85	58	85	58
Transport			4,861	2,460	4,861	2,460
Works	195		92	215	287	215
Office of the Premier			101	82	101	82
Royal Household				1	-	1
Social Welfare – nutritional packs				28,997	-	28,997
Independent Complaints Directorate			2	2	2	2
Housing		2		3	-	5

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

ANNEXURE 3

INTER-GOVERNMENTAL RECEIVABLES (continued)

Government Entity	Confirmed balance		Unconfirmed balance		Total	
	31/03/2009	31/03/2008	31/03/2009	31/03/2008	31/03/2009	31/03/2008
	R'000	R'000	R'000	R'000	R'000	R'000
Department						
Eastern Cape Department of Health	1,262	1,262		85	1,262	1,347
University of KwaZulu-Natal – joint medical				1,360	-	1,360
Department of Correctional Services			99		99	
Department of Local Government and Traditional Affairs	38		7		45	
KZN Treasury			226		226	
Department of Justice Psychiatric Observation			1,026		1,026	
Department of Social Development KZN			16,306		16,306	
Arts Culture and Tourism			3	3	3	3
	1,625	1,264	24,519	34,368	26,144	35,632
Other Government Entities						
Other debtors				737	-	737
Less (credit amount within claims recoverable account)			(10,765)	(4,668)	(10,765)	(4,668)
Rounding				(1)	-	(1)
South African Social Security Agency			198		198	-
Global Fund			35,826		35,826	-
Joint Medical Establishment			391		391	-
JEUDW			547		547	-
	-		**26,197**	**(3,932)**	**26,197**	**(3,932)**
TOTAL	**1,625**	**1,264**	**50,716**	**30,436**	**52,341**	**31,700**

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 March 2009

ANNEXURE 4 A

INTER – GOVERNMENTAL PAYABLES – CURRENT

GOVERNMENT ENTITY	Confirmed balance outstanding		Unconfirmed balance outstanding		TOTAL	
	31/03/2009	31/03/2008	31/03/2009	31/03/2008	31/03/2009	31/03/2008
	R'000	R'000	R'000	R'000	R'000	R'000
DEPARTMENTS						
Current						
Public Administrations Leadership and Management Academy	828				828	
Department of Transport	1,600			38,814	1,600	38,814
Department of Safety and Security					-	
Department of Justice and Constitutional Development	383	154			383	154
Department of Works	133,310	87,743	17,249	97,227	150,559	184,970
KZN – Office of the Premier	48				48	
KZN Department of Economic Development					-	
South African Police Services					-	
Department of Health: Pretoria					-	
Gauteng Department of Health	5	2			5	2
Northern Cape Department of Health	5	28			5	28
Limpopo Department of Health and Social Development		6			-	6
Western Cape Department of Health		24			-	24
KZN Department of Education	683					
Department of Water Affairs and Forestry	14					
Department of Health Eastern Cape	2,889					
National Prosecuting Authority	5					
TOTAL	**139,770**	**87,957**	**17,249**	**136,041**	**153,428**	**223,998**
OTHER GOVERNMENT ENTITY						
Current						
University of Kwa-Zulu Natal			28,795			
National Health Laboratory Services	86,053		66,764	72	152,817	72
TOTAL	**86,053**	**-**	**95,559**	**72**	**152,817**	**72**

ANNUAL FINANCIAL STATEMENTS

FOR

KWAZULU -NATAL PROVINCIAL PHARMACEUTICAL SUPPLY DEPOT

FOR THE YEAR ENDED 31 MARCH 2009

REPORT OF THE ACCOUNTING OFFICER
for the year ended 31 March 2009

TABLE OF CONTENTS

REPORT OF THE ACCOUNTING OFFICER
for the year ended 31 March 2009

REPORT OF THE ACCOUNTING OFFICER

1. GENERAL REVIEW OF THE STATE OF FINANCIAL AFFAIRS

The Provincial Pharmaceutical Supply Depot is a trading entity which is incorporated in South Africa.

The principal place of business is:

1 Higginson Highway

Mobeni

4060

The Pharmaceutical Supply Depot has shown a trading surplus of R 38,893 million for the period ended 31 March 2009. This has mainly been due to the effect of increased trading activities resulting in an annual turnover of R 1,264 billion, being an increase of 12.1% over the prior year. Operating costs also increased by 8.7% for the same period, due mainly to increased inventory purchases, however increase of 18.79% in administrative expenditure and other operating expenses contributed to increasing the overall operating costs. Inventory purchase prices did not increase significantly during the period under review.

The main factors contributing to the increase in trading activities were:

1.1 The continually increasing distribution of inventories due to the ongoing ARV Project, which are charged directly to the Institutions.

1.2 The number of patients serviced increased dramatically over the previous year, largely due to the increase in the number of clinics currently being serviced. These clinics were previously serviced by the various hospitals.

2. SERVICES RENDERED BY THE DEPARTMENT

2.1 The Provincial Pharmaceutical Supply Depot is the only trading entity operating within the administration of the KwaZulu-Natal Department of Health. This entity is responsible for the procurement and delivery of pharmaceuticals as listed by National Health Pharmaceutical Services and Provincial Health Pharmaceutical Services. The pharmaceuticals are procured from the suppliers and are then distributed to the various institutions as requested. Pharmaceuticals are charged at actual cost plus a mark-up of 4% to 12% to cover the administrative costs.

2.2 The tariff policy is structured as follows:

Surcharge of 5% - levied on all pharmaceutical items procured by and received at PPSD and thereafter delivered to the institutions.

Surcharge of 4% - levied on all pharmaceutical items procured by PPSD and delivered directly by the supplier to the said institutions.

Surcharge of 12% - levied on all pharmaceuticals that involve the use of PPSD human resources in terms of repacking, manufacturing, etc.

3. CAPACITY CONSTRAINTS

3.1 The increasingly limited availability of warehousing has continued to contribute to capacity constraints.

3.2 Although the Manufacturing Laboratories have ceased operating in accordance with pharmacy regulations, the Pre Packing of medicines and tablets continues to be a part of ongoing operations.

4. PERFORMANCE INFORMATION

Listed below is a table containing performance and outcome targets of PPSD, for the year under

REPORT OF THE ACCOUNTING OFFICER
for the year ended 31 March 2009

review:

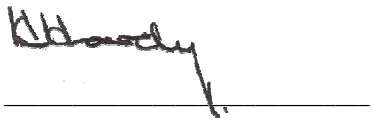
Objective	Indicator	2008/2009 (Target)	2008/2009 (Actual)
Increase in standard stock account	Stock level	R 134,939 million	R 134,939 million
Adequate working capital to support adequate stockholding	Stock Turnover	R 1349,390 million	R 1265,000 million
Sufficient stock available at end user	Service Level	95%	98%

Stock turnover target was not achieved due to cost containment adopted during the period under review (2008/2009).

APPROVAL

The annual financial statements set out on pages 440 to 449

have been approved by the Accounting Officer.



Mrs. H.G. Harding
Manager: Provincial Pharmaceutical Supply Depot
31 March 2009

REPORT OF THE AUDITOR-GENERAL
for the year ended 31 March 2009

REPORT OF THE AUDITOR-GENERAL TO THE KWAZULU-NATAL PROVINCIAL LEGISLATURE ON THE FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION OF PROVINCIAL PHARMACEUTICAL SUPPLY DEPOT TRADING ENTITY FOR THE YEAR ENDED 31 MARCH 2009

REPORT ON THE FINANCIAL STATEMENTS

Introduction

1. I have audited the accompanying financial statements of the Provincial Pharmaceutical Supply Depot which comprise the statement of financial position as at 31 March 2009, the statement of financial performance, the statement of changes in equity and the cash flow statement for the year then ended, and a summary of significant accounting policies and other explanatory notes, as set out on pages 440 to 449.

The accounting officer's responsibility for the financial statements

2. The accounting officer is responsible for the preparation and fair presentation of these financial statements in accordance with *South African Statements of Generally Accepted Accounting Practice* (*SA Statements of GAAP)* and in the manner required by the Public Finance Management Act, 1999 (Act No. 1 of 1999)(PFMA) and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The Auditor-General's responsibility

3. As required by section 188 of the Constitution of the Republic of South Africa, 1996 read with section 4 of the Public Audit Act, 2004 (Act No. 25 of 2004)(PAA) and section 40(2) of the PFMA, my responsibility is to express an opinion on these financial statements based on my audit.

4. I conducted my audit in accordance with the International Standards on Auditing read with *General Notice 616 of 2008*, issued in *Government Gazette No. 31057 of 15 May 2008*. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

5. An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

6. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

7. In my opinion the financial statements present fairly, in all material respects, the financial position of the Provincial Pharmaceutical Supply Depot as at 31 March 2009 and its financial performance and cash flows for the year then ended, in accordance with *SA Statements of GAAP* and in the manner required by the PFMA.

Other matters

8. Without qualifying my opinion, I draw attention to the following matters that relates to my responsibilities in the audit of the financial statements:

REPORT OF THE AUDITOR-GENERAL
for the year ended 31 March 2009

Governance framework

9. The governance principles that impact the auditor's opinion on the financial statements relate to the responsibilities and practices exercised by the accounting officer and executive management and are reflected in the key governance responsibilities addressed below:

Key governance responsibilities

10. The PFMA tasks the accounting officer with a number of responsibilities concerning financial and risk management and internal control. Fundamental to achieving this is the implementation of key governance responsibilities, which I have assessed as follows:

No.	Matter	Y	N
Clear trail of supporting documentation that is easily available and provided in a timely manner			
1.	No significant difficulties were experienced during the audit concerning delays or the availability of requested information.	✓	
Quality of financial statements and related management information			
2.	The financial statements were not subject to any material amendments resulting from the audit.	✓	
3.	The annual report was submitted for consideration prior to the tabling of the auditor's report.	✓	
Timeliness of financial statements and management information			
4.	The annual financial statements were submitted for auditing as per legislated deadlines, as set out in section 40 of the PFMA.	✓	
Availability of key officials during audit			
5.	Key officials were available throughout the audit process.	✓	
Development and compliance with risk management, effective internal control and governance practices			
6.	Audit committee		
	• The entity had an audit committee in operation throughout the financial year.	✓	
	• The audit committee operates in accordance with approved, written terms of reference.	✓	
	• The audit committee substantially fulfilled its responsibilities for the year, as set out in section 77 of the PFMA and Treasury Regulation 3.1.10.	✓	
7.	Internal audit		
	• The entity had an internal audit function in operation throughout the financial year.	✓	
	• The internal audit function operates in terms of an approved internal audit plan.	✓	
	• The internal audit function substantially fulfilled its responsibilities for the year, as set out in Treasury Regulation 3.2.	✓	

REPORT OF THE AUDITOR-GENERAL
for the year ended 31 March 2009

No.	Matter	Y	N
8.	There are no significant deficiencies in the design and implementation of internal control in respect of financial and risk management.	✓	
9.	There are no significant deficiencies in the design and implementation of internal control in respect of compliance with applicable laws and regulations.	✓	
10.	The information systems were appropriate to facilitate the preparation of the financial statements.	✓	
11.	A risk assessment was conducted on a regular basis and a risk management strategy, which includes a fraud prevention plan, is documented and used, as set out in Treasury Regulation 3.2.	✓	
12.	Powers and duties have been assigned, as set out in section 44 of the PFMA.	✓	
Follow-up of audit findings			
13.	The prior year audit findings have been substantially addressed.	✓	
14.	SCOPA/Oversight resolutions have been substantially implemented.	✓	
Issues relating to the reporting of performance information			
15.	The information systems were appropriate to facilitate the preparation of a performance report that is accurate and complete.	✓	
16.	Adequate control processes and procedures are designed and implemented to ensure the accuracy and completeness of reported performance information.	✓	
17.	A strategic plan was prepared and approved for the financial year under review for purposes of monitoring the performance in relation to the budget and delivery by the Provincial Pharmaceutical Supply Depot trading entity against its mandate, predetermined objectives, outputs, indicators and targets as set out in Treasury Regulations 5.1, 5.2 and 6.1.	✓	
18.	There is a functioning performance management system and performance bonuses are only paid after proper assessment and approval by those charged with governance.	✓	

11. The financial and risk management and internal controls adopted by the entity were sufficient and appropriate to enable fair financial reporting.

REPORT ON OTHER LEGAL AND REGULATORY REQUIREMENTS

Report on performance information

12. I have reviewed the performance information as set out on pages 440 to 449.

The accounting officer's responsibility for the performance information

13. The accounting officer has additional responsibilities as required by section 40(3)(a) of the PFMA to ensure that the annual report and audited financial statements fairly present the performance against predetermined objectives of the entity.

The Auditor-General's responsibility

14. I conducted my engagement in accordance with section 13 of the PAA read with *General Notice 616 of 2008*, issued in *Government Gazette No. 31057 of 15 May 2008*.

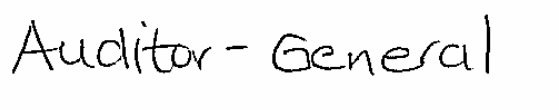
REPORT OF THE AUDITOR-GENERAL
for the year ended 31 March 2009

15. In terms of the foregoing my engagement included performing procedures of a review nature to obtain sufficient appropriate evidence about the performance information and related systems, processes and procedures. The procedures selected depend on the auditor's judgement.

16. I believe that the evidence I have obtained is sufficient and appropriate to report that no significant findings have been identified as a result of my review.

APPRECIATION

17. The assistance rendered by the staff of the Provincial Pharmaceutical Supply Depot entity during the audit is sincerely appreciated.



Pietermaritzburg

31 July 2009

ACCOUNTING POLICIES
for the year ended 31 March 2009

ACCOUNTING POLICY

1. CHANGES IN ACCOUNTING POLICIES AND DISCLOSURES

The accounting policies adopted are consistent with those of the previous year except as follows:

The PPSD has adopted the following new and amended IFRS and IFRIC interpretations during the year. The adoption of these revised standards and interpretations did not have any effect on the financial performance or position of the PPSD. They did however give rise to additional disclosures, including in some cases, revisions to accounting policies.

- IFRS 7 Financial Instruments: Disclosures

IFRS 7 requires disclosures that enable users of the financial statements to evaluate the significant of the PPSD's financial instruments and the nature and extent of risks arising from those financial instruments. The new disclosures are included throughout the financial statements. While there has been no effect on the financial position or results, comparative information has been revised where needed.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

2.1 Basis of preparation

The financial statements are prepared on the historical cost basis.

2.2 Presentation Currency

All amounts have been presented in the currency of the South African Rand (R).

2.3 Rounding

Unless otherwise stated all financial figures have been rounded to the nearest one thousand rand (R'000).

2.4 Going Concern

The financial statements are prepared on the assumption that the entity is a going concern and will continue in operation for the foreseeable future.

2.5 Revenue

Revenue is recognised to the extent that it is probable that the economic benefits will flow to the PPSD and the revenue can be reliably measured. Revenue is measured at a fair value of the consideration received, excluding discounts, rebates, and other sales taxes or duty. The following specific recognition criteria must also be met before revenue is recognised:

Revenue from the sale of goods is recognised when significant risks and rewards of ownership of the goods have been transferred at the point when the goods are handed over to the courier on site for delivery to respective health institutions.

2.6 Property, plant and equipment

Property, plant and equipment are stated at cost less accumulated depreciation and accumulated impairment losses. Such cost includes the cost of replacing part of the plant and equipment when that cost is incurred, if the recognition criteria are met. Likewise, when major inspection is performed, its cost is recognised in the carrying amount of the plant and equipment as a replacement if the recognition criteria are satisfied. All other repair and maintenance costs are recognised in profit or loss as incurred.

Depreciation is calculated on a straight line basis over the useful life of the asset as follows:

	%
Plant and equipment	10% - 16.67%
Vehicles	20% - 25.00%
Computer Equipment	25% - 33.33%
Furniture and Fittings	10% - 16.67%

An item of property, plant and equipment is derecognized upon disposal or when no future economic benefits are expected from its

ACCOUNTING POLICIES
for the year ended 31 March 2009

use or disposal. Any gain or loss arising on de-recognition of the asset (calculated as the difference between the net disposal proceeds and the carrying amount of the asset) is included in profit or loss in the year the asset is derecognized.

The asset's residual values, useful lives and method of depreciation are reviewed, and adjusted if appropriate, at each financial year end.

At each balance sheet date, the entity reviews the carrying amounts of its tangible to determine whether there is any indication that those assets may be impaired. If any such indication exists, the recoverable amount of the asset is estimated in order to determine the extent of the impairment loss (if any). Where it is not possible to estimate the recoverable amount for an individual asset, the recoverable amount is determined for the cash-generating unit to which the asset belongs.

If the recoverable amount of an asset (cash-generating unit) is estimated to be less than its carrying amount, the carrying amount of the asset (cash-generating unit) is reduced to its recoverable amount. Impairment losses are immediately recognised as an expense.

Where an impairment loss subsequently reverses, the carrying amount of the asset (cash-generating unit) is increased to the revised estimate of its recoverable amount, but so that the increased carrying amount does not exceed the carrying amount that would have been determined had no impairment loss been recognised for the asset (cash-generating unit) in prior years. A reversal of an impairment loss is recognised as income immediately.

2.7. Financial instruments – Financial assets

For the PPSD, there were no financial assets applicable.

2.8 Financial instruments – Financial liabilities

Financial liabilities comprise trade and other payables, which are recognised at cost. Trade and other payables are not restated to their fair value at year-end as they are settled within 30 days.

2.9. Inventory

Inventories are valued at the lower of cost and net realizable value. Costs incurred in bringing each product to its present location and condition are accounted for on weighted average cost basis.

Net realizable value is the estimated selling price in the ordinary course of business, less estimated costs of completion and the estimated costs necessary to make the sale.

2.10. Employee benefits

Post-employee benefits

Retirement

The entity provides a defined benefit fund for the benefit of its employees, which is the Government Employee's Pension Fund.

The entity is not liable for any deficits due to the difference between the present value of the benefit obligations and the fair value of the assets managed by the Government Employee's Pension Fund. Any potential liabilities are disclosed in the financial statements of the National Revenue Fund and not in the financial statements of PPSD.

Medical

No contributions are made by the entity to the medical aid of retired employees.

Short and long-term benefits

The cost of all short-term employee benefits, such as salaries, bonuses, housing allowances, medical and other contributions is recognised during the period in which the employee renders the related service.

The vesting portion of long-term benefits is recognised and provided for at balance sheet date, based on current salary rates.

ACCOUNTING POLICIES
for the year ended 31 March 2009

2.11. Irregular expenditure

Irregular expenditure

Irregular expenditure is defined as:
Expenditure, other than unauthorised expenditure, incurred in contravention or not in accordance with a requirement of any applicable legislation, including:

- the Public Finance Management Act
- the State Tender Board Act, or any regulations made in terms of this act, or
- any provincial legislation providing for procurement procedures in that provincial government.

It is treated as expenditure in the Statement of Financial Performance. If such expenditure is not condoned and it is possibly recoverable it is disclosed as receivable in the Statement of Financial Position at year-end.

Fruitless and wasteful expenditure

Fruitless and wasteful expenditure is defined as:
Expenditure that was made in vain and would have been avoided had reasonable care been exercised, therefore

- it must be recovered from a responsible official (a debtor account should be raised), or
- the vote. (If responsibility cannot be determined.)

Such expenditure is treated as a current asset in the Statement of Financial Position until such expenditure is recovered from the responsible official or written off as irrecoverable.

2.12. Capitalisation reserve

The capitalisation reserve represents an amount equal to the value held in a suspense account by Department of Health on behalf of the Provincial Medical Supply Centre for the procurement of pharmaceuticals.

2.13. Cash flow statement

The cash flow statement is prepared in terms of the direct method and discloses the effect that operating activities, investing activities and financing activities have on the movement of cash and cash equivalents during the year.

- **Operating Activities** are primarily derived from the revenue producing or primary operating activities of the entity.
- **Investing Activities** are the acquisition and disposal of long-term assets and other investments not included in cash equivalents.
- **Financing Activities** are activities that result in changes in the size and composition of the contributed capital and borrowings of the entity.

2.14. Related party and related party transactions

Related parties are departments that control or significantly influence entities in making financial and operating decisions. Specific information with regards to related parties is included in the notes.

ACCOUNTING POLICIES
for the year ended 31 March 2009

STATEMENT OF FINANCIAL POSITION

	Note	2008/09 R'000	2007/08 R'000
ASSETS			
Non-current assets			
Property, plant and equipment	6	**3,172**	**3,025**
Current assets		**237,034**	**164,803**
Inventory	7	83,820	71,256
Interface account	8	153,214	93,548
		240,206	**167,828**
EQUITY			
Capital and Reserves	9	210,386	137,799
Total Equity		**210,386**	**137,799**
LIABILITIES			
Current Liabilities			
Trade and other payments	10	**29,820**	**30,029**
Total equity and liabilities		**240,206**	**167,828**

STATEMENT OF FINANCIAL PERFORMANCE
For the year ended 31 March 2009

STATEMENT OF FINANCIAL PERFORMANCE

	Note	2008/09 R'000	2007/08 R'000
REVENUE			
Sale of goods	1	1,263,662	1,127,273
TOTAL REVENUE		**1,263,662**	**1,127,273**
EXPENDITURE			
Cost of Sales	2	(1,191,581)	(1,098,851)
Other expenditure		(33,188)	(27,985)
Administrative Expenses	3	(11,269)	(7,871)
Staff Costs	4	(19,779)	(18,044)
Other operating expenses	5	(2,140)	(2,070)
TOTAL EXPENDITURE		**(1,224,769)**	**(1,126,836)**
NET SURPLUS FOR THE YEAR		**38,893**	**438**

STATEMENT OF FINANCIAL PERFORMANCE
as at 31 March 2009

CHANGES IN EQUITY

	Accumulated Surplus/ (Deficit)	Capitalisation Reserves	Total Equity
	R'000	R'000	R'000
Balance as at 1 April 2006	41,353	88,160	129,513
Surplus for the year	438	-	438
Transfers to/ (from) reserves	(4,800)	12,649	7,849
Balance as at 31 March 2007	**36,991**	**100,809**	**137,800**
Surplus for the year	38,893	-	38,893
Transfers to/ (from) reserves	(437)	34,130	33,693
Balance as at 31 March 2008	**75,447**	**134,939**	**210,386**

CASH FLOW STATEMENT
for the year ended 31 March 2009

CASH FLOW STATEMENT

	Note	2008/09 R'000	2007/08 R'000
Cash flows from operating activities			
Cash received from Provincial Departments		1,203,996	1,102,961
Cash paid to suppliers and employees		(1,236,882)	(1,110,158)
Net cash outflows from operating activities	11	**(32,886)**	**(7,197)**
Cash flows from investing activities			
Acquisition of Property, Plant and Equipment	12	(807)	(651)
Net cash outflows from investing activities		**(807)**	**(651)**
Cash flows from financing activities			
Net Increase in Reserves		33,693	7,848
Net cash flows from financing activities	13	**33,693**	**7,848**
Net increase in cash and cash equivalents		**-**	**-**
Cash and bank balances at the beginning of the year		-	-
Cash and bank balances at the end of the year		**-**	**-**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2009

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

		2008/09 R'000	2007/08 R'000
1.	**SALES OF GOODS**		
	Provincial Departments	1,263,649	1,127,270
	Other	13	3
		1,263,662	**1,127,273**
2.	**Cost of Sales**		
	Opening inventory	71,256	78,508
	Purchases	1,204,039	1,091,599
	Depreciation	53	-
		1,275,348	**1,170,107**
	Less Closing Inventory	(83,820)	(71,256)
		1,191,528	**1,098,851**
3.	**Administration Expenses**		
	General administrative expenses	10,452	6,534
	Stationery and printing	646	964
	Bank charges	3	5
	Training and staff development	168	368
		11,269	**7,870**
4.	**Staff Costs**		
	Wages and Salaries		
	- Performance awards	-	240
	- Basic salaries	11,259	10,532
	- Periodic payments	1,901	1,338
	- Overtime pay	1,772	1,296
		14,932	**13,406**
	Social contributions (Employer's contributions)		
	- Medical	1,017	841
	- UIF	-	4
	- Official unions and associations	4	5
		1,021	**850**
	Defined Pension contribution plan expense		
	- Current service cost	**1,473**	**1,370**
	Other long-term employee benefits including long-service leave, profit sharing, deferred compensation	**2,353**	**2,419**
		19,779	**18,045**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2009

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

		2008/09 R'000	2007/08 R'000
4.	**Staff Costs (continued)**		

The Accounting Officer of the Department of Health has appointed the Manager of the Provincial Pharmaceutical Supply Depot.

During the 2008/2009 financial year, the Manager received a basic salary package of R429 149 per annum.

5. Other operating expenses

Maintenance, repairs and running costs	1,365	1,338
- Property and buildings	-	483
- Machinery and Equipment	-	-
- Other maintenance, repairs and running costs	1,365	855
Depreciation	607	476
- Assets carried at cost	607	476
- Assets carried at re-valued amounts	-	-
Consumables	64	146
Municipal Services	0	0
Travel and Subsistence	104	108
	2,140	**2,068**

6. Property, plant and equipment

VEHICLES		
Opening net carrying amount	**210**	**220**
- Gross carrying amount	478	478
- Accumulated depreciation	(268)	(258)
Depreciation charge	(53)	(10)
Closing net carrying amount - 31 March	**157**	**210**
- Gross carrying amount	478	478
- Accumulated depreciation	(321)	(268)
COMPUTER EQUIPMENT		
Opening net carrying amount	**493**	**695**
- Gross carrying amount	1323	1,315
- Accumulated depreciation	(830)	(619)
Additions	29	8
Depreciation charge	(170)	(211)
Closing net carrying amount - 31 March	**352**	**493**
- Gross carrying amount	1352	1,323
- Accumulated depreciation	(1,000)	(830)

6. Property, plant and equipment (continued)

OFFICE FURNITURE AND FITTINGS		
Opening net carrying amount	**822**	**336**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2009

	2008/09 R'000	2007/08 R'000
- Gross carrying amount	1,374	731
- Accumulated depreciation	(552)	(395)
Additions	622	643
Depreciation charge	(182)	(157)
Closing net carrying amount - 31 March	**1,262**	**822**
- Gross carrying amount	1,996	1,374
- Accumulated depreciation	(734)	(552)
Other machinery and equipment		
Opening net carrying amount	**1,501**	**1,599**
- Gross carrying amount	1,941	1,941
- Accumulated depreciation	(440)	(342)
Additions	156	-
Depreciation charge	(255)	(98)
Closing net carrying amount - 31 March	**1,402**	**1,501**
- Gross carrying amount	2,097	1,941
- Accumulated depreciation	(695)	(440)
TOTAL PROPERTY, PLANT AND EQUIPMENT		
Opening net carrying amount	**3,025**	**2,850**
- Gross carrying amount	5,115	4,464
- Accumulated depreciation	(2,090)	(1,614)
Additions	807	651
Depreciation charge	(660)	(476)
Closing net carrying amount - 31 March	**3,172**	**3,025**
- Gross carrying amount	5,922	5,115
- Accumulated depreciation	(2,750)	(2,090)

7. Inventory

Raw Materials	53	450
Finished goods	83,767	70,806
	83,820	**71,256**

8. Interface account

Medsas Account - Department of Health		
Medsas: Capital	134,939	100,809
Medsas: Pre-Pak	(53)	(487)
Medsas: Cut, Make and Trim	-	(995)
Medsas: Stock	(83,767)	(70,806)
Medsas: Stock Surplus	2,787	6,448
Revenue Accrual - BAS surplus	30,473	14,377

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2009

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

	2008/09 R'000	2007/08 R'000
Revenue Accrual - Prior year duplicate depreciation	-	3,889
Medsas: Stock Loss	(4,062)	(11,027)
Claims Recoverable KZN	-	(1,944)
Medsas: Claims Payable	85,283	25,170
Accrual Adjustments		
Closing Property, Plant and Equipment	(5,922)	(5,115)
Movement in Property, Plant and Equipment (additions)	807	650
Closing Accumulated Depreciation	2,750	2,090
Movement in Accumulated Depreciation	(660)	(476)
Closing Capped Leave Provision	2,203	2,060
Movement in Capped Leave Provision	(143)	(483)
Closing Uncapped Leave Provision	101	91
Movement in Uncapped Leave Provision	(10)	(8)
Accumulated Surplus – Prior year COS error adjustment	34,428	34,428
Accumulated Surplus – 2005/06 year IAS 8 adjustment	2,125	2,125
Medsas: Claims Payable – adjustment error	(59,412)	-
Current year net inventory - cost of sales	12,564	(7,250)
Revenue Accrual – BAS sales excess	(1,074)	-
Revenue for DOH error in Adjustment	(145)	-
	153,214	**93,548**

9. CAPITAL AND RESERVES

ACCUMULATED SURPLUS		
Balance at the beginning of the year	**36,990**	**41,353**
Surplus for the year	38,893	438
Correction of prior year error	-	-
Transfers	(436)	(4,800)
Balance at 31 March	**75,447**	**36,991**
RESERVES		
Balance at the beginning of the year	**100,809**	**88,160**
Transfers	34,130	12,649
Balance at 31 March	**134,939**	**100,809**

Capital and reserves (continued)

TOTAL EQUITY		
Balance at the beginning of the year	**137,799**	**129,513**
Surplus for the year	38,893	437
Correction of prior year error		-
Transfers	33,694	7,849

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2009

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

		2008/09 R'000	2007/08 R'000
	Balance at 31 March	**210,386**	**137,799**
10.	**Trade and other payables**		
	Trade creditors	25,872	25,172
	Accruals	1,644	762
	Other payables	-	-
	Revenue accrual account		1,944
	Leave pay commitments	2,304	2,151
		29,820	**30,029**
11.	**Reconciliation of profit before taxation to cash generated from/(utilised in) operations**		
	Surplus/(deficit) before taxation	**38,893**	**438**
	Adjusted for non-cash movements/ working capital changes:	**(71,779)**	**(7,635)**
	- Depreciation on property, plant and equipment	660	476
	- (Increase)/ decrease in inventories	(12,564)	7,252
	- (Increase) in receivables	(59,666)	(24,309)
	- Increase/ (Decrease) in payables	(209)	8,946
	- Correction of prior period errors	-	-
	Cash generated from operations	**(32,886)**	**(7,197)**
12.	**Cash flows from investing activities**		
	Purchase of Property, Plant and Equipment	**(807)**	**(651)**
13.	**Cash flows from financing activities**		
	Increase in capital reserves	34,130	12,649
	Prior year surplus paid	(437)	(4,800)
		33,693	**7,849**
14.	**Operating Leasing**		
	Commitment Under Operating Lease		
	Minimum Lease Payments for Period Less Than 1 Year	87	191
	Minimum Lease Payments for Period Greater than 1 Year But Less Than 5 Years	-	87
	Minimum Lease Payments for Period Less Greater 5 Years	-	-
	Totals	**87**	**278**

Operating leases are in respect of office equipment, i.e. photocopier machines, and those whose long-term leases have expired are now rented on a month-to-month basis. Operating leases are assets leased by the PPSD under which the lessor effectively retains all the risks and benefits of ownership. Operating lease payments or contingent rentals are recognised as an expense and charged to the

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2009

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

		2008/09 R'000	2007/08 R'000
	statement of financial performance on a straight-line basis over the period of the lease.		

15. Contingent Liabilities

Housing Guarantees	17	36

16. Impairment of Assets

The entity did not have any impairment of assets during the 2008/2009 financial year. As a result no impairment losses were recognised in the income statement.

17. Taxation

The entity is not liable for any income tax in terms of Section 10(1)(a) of the Income Tax Act, as amended. The entity is not registered for Value Added Tax in terms of the Tax Authorities media statement dated 27 September 1991, which was subsequently confirmed by value-added tax directive dated 21 January 2003.

18. Related Party and Related Party Transactions

The Provincial Pharmaceutical Supply Depot is the only trading entity operating within the administration of the KwaZulu-Natal Department of Health. This entity is responsible for the procurement and delivery of pharmaceuticals as listed by National Health Pharmaceutical Services and Provincial Health Pharmaceutical Services. The pharmaceuticals are procured from the suppliers and are then distributed to the various institutions as requested. Pharmaceuticals are charged at actual cost plus a mark-up of 4% to 12% to cover the administrative costs. Further details in this regard are provided in the Accounting Officer's report. The movement in balances and funds between the Provincial Pharmaceutical Supply Depot and the Department is included in the above notes to the annual financial statements.

19. Financial risk management objectives

PPSD's principal financial instruments consist of trade receivables and trade payables, which arise directly from its operations. The potential risks arising from PPSD's financial instruments are cash flow risk, liquidity risk and credit risk. However, as PPSD is funded by the Department of Health and its only supplier is the Department of Health, these potential risks are not applicable.

NOTES

ABBREVIATIONS AND ACRONYMS

ABBREVIATIONS & ACRONYMS

ABBREVIATIONS / ACRONYMS	
ABET	Adult Basic Education and Training.
ACADEMIK	Research Project, Antiretroviral Cohort Adverse Event Monitoring in KwaZulu-Natal.
ADD	Acknowledgement of Debt
AEFI	Adverse Events Following Immunisation.
AFP	Acute Flaccid Paralysis.
AIDS	Acquired Immune Deficiency Syndrome.
ALOS	Average Length of Stay.
ALS	Advanced Life Support.
ANC	Ante Natal Care.
APP	Annual Performance Plan.
ART	Anti Retroviral Therapy.
ARV	Anti Retroviral.
ASGI-SA	Accelerated and Shared Growth Initiative of South Africa.
BANC	Basic Ante Natal Care.
BAS	Basic Accounting System
BEE	Black Economic Empowerment.
BLS	Basic Life Support.
BOD	Burden of Disease.
BOR	Bed Occupancy Rate.
CBC	Community Based Carers.
CBO	Community Based Organisation
CCA	Critical Care Assistance.
CCG's	Community Care Givers.
CCMDU	Central Chronic Medication Dispensing Unit.
CCMT	Comprehensive Care Management & Treatment.
CDC	Communicable Disease Control.
CEO	Chief Executive Officer.
CHC	Community Health Centre.
ChildPIP	Child Problem Identification Programme.
ChIP	Child Health Problem Identification Programme.
CHW	Community Health Worker.
CIO	Chief Information Officer.
COE	Compensation of Employees.
COEC	College of Emergency Care.
COHSASA	Council for Health Service Accreditation of Southern Africa.
COSH	Church of Scotland Hospital.
CPD	Continuous Professional Development.
CPS	Central Provincial Stores.
CPSS	Central Pharmaceutical Supply Store.
CSIR	Council for Scientific and Industrial Research.
CSO's	Community Service Officers.
CRH	Centre for Rural Health.
CTOP	Choice on Termination of Pregnancy.

DHER	District Health Expenditure Review.
DHIS	District Health Information System.
DHP's	District Health Plans.
DHS	District Health System.
DIO's	District Information Officers.
DOE	Department of Education.
DOH	Department of Health.
DORA	Divisions of Revenue Act.
DOTS	Directly Observed Treatment Short Course.
DPS	Dry Blood Spot.
DPSA	Department of Public Service Administration.
DQS	Data Quality Self-Assessment Tool.
DTP	Diphtheria, Tetanus and Pertussis.
DUT	Durban University of Technology.
EAP	Employee Assistance Programme.
ECP	Emergency Care Practitioner.
EDL	Essential Drug List.
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EH	Environmental Health.
EHP	Environmental Health Practitioner.
eHR.za	Electronic Health Record.
EMP	Environmental Management Plan.
EMRS	Emergency Medical Rescue Services.
EMS	Emergency Medical Services.
EN to RN	Enrolled Nurse to Registered Nurse.
ENA to EN	Enrolled Nurse Assistant to Enrolled Nurse.
EPI	Expanded Programme on Immunisation.
EPT	Emergency Patient Transport.
EPWP	Expanded Public Works Programme.
ESV	Emergency Services Vehicle.
ETBR	Electronic Tuberculosis Register.
ETR.net	Electronic Register for TB.
FBO	Faith Based Organisations.
FET	Further Education and Training.
FIO	Facility Information Officer.
GIS	Geographic Information System.
GITO	Government Information Technology Officer.
GP's	General Practitioners.
HAART	Highly Active Ante-Retroviral Therapy.
HAST	HIV, AIDS, STI and TB.
HBC	Home Based Carer.
HCBC	Home & Community Based Carers.
HIS	Hospital Information System.
HIV	Human Immuno Virus.

ABBREVIATIONS & ACRONYMS

HOD	Head of Department.
HP	Health Promotion.
HPS	Health Promoting Schools.
HPSP	Health Promoting Schools Programme.
HPC	Health Promoting Clinic.
HPCSA	Health Professions Council of South Africa.
HPH's	Health Promoting Hospitals.
HPT&D	Health Professional Training and Development.
HPV	Human Pappiloma Virus.
HR	Human Resources.
HRD	Human Resource Development.
HRKM	Health Research & Knowledge Management.
HRP	Human Resource Plan.
HRSC	Human Sciences Research Council of South Africa.
HST	Health Systems Trust.
HTA's	High Transmission Areas.
HWSETA	Health and Welfare Sectoral Educational Training Authority.
IALCH	Inkosi Albert Luthuli Central Hospital.
ICAT	Infection Control Assessment Tool.
ICD 10	International Classification of Disease (Version 10).
ICEE	International Centre for Eye Care Education.
ICPD	International Conference on Population Development.
ICT	Information, Communication Technology.
IDP	Integrated Development Plan.
IDT	Independent Development Trust.
IEC	Information, Education and Communication.
IGR	Inter-Governmental Relations.
ILS	Intermediate Life Support.
IMAI	Integrated Management of Adulthood Illnesses.
IMCI	Integrated Management of Childhood Illnesses.
IMS	Incident Management Systems.
INDS	Integrated National Disability Strategy.
IPC	Infection Prevention & Control.
ISC	Inter-Sectoral Collaboration.
IT	Information Technology.
KMC	Kangaroo Mother Care.
KZN	KwaZulu-Natal.
KZNPPHC	KwaZulu-Natal Progressive Primary Health Care.
KZNPTC	KwaZulu-Natal Pharmacy and Therapeutics Committee.
LC	Lay Counsellor.
lePRS	Integrated Electronic Patient Record System.
LSF	Light Steel Framework.
M&E	Monitoring and Evaluation.
M2M2B	Mothers-to-Mothers-to-Be.
MCC	Medicines Control Council.

MC&WH	Maternal Child & Women's Health.
MDG	Millennium Development Goals.
MDR	Multi Drug Resistant.
MDR TB	Multi Drug Resistant Tuberculosis.
MEC	Member of the Executive Council.
MEDSAS	Medical Stores Administrative System.
MHCA	Mental Health Care Act.
MICU	Medical Intensive Care Unit.
MIDP	Mortuary Infrastructure Development Plan.
MIOS	Minimum Inter-Operability Standards
MIPAA	Men in Partnership against AIDS.
MIS	Management Information System.
MLW	Mid Level Worker.
MO	Medical Officer.
MOU	Memorandum of Understanding
MRC	Medical Research Council.
MSA	Medical Scheme Act.
MSP	Master Systems Plan.
MSS	Master Systems Specifications.
MTEF	Medium Term Expenditure Framework.
MTS	Modernisation of Tertiary Services.
MTSF	Medium Term Strategic Framework.
NDQS	National Data Quality Assessment System.
NEPAD	New Economic Partnership for African Development.
NGO's	Non Governmental Organisations.
NHC	National Health Council.
NHI	National Health Insurance.
NHIS	National Health Information System.
NHLS	National Health Laboratory Services.
NHS	National Health System.
NICD	National Institute for Communicable Diseases.
NICU	Neo-Natal Intensive Care Unit.
NIP	National Integrated Nutrition Programme.
NMIR	National Minimum Information Requirements.
NMIS	National Management Information System.
NOPEP	Non Occupational Post Exposure Prophylaxis.
NPO's	Non-Profit Organisations.
NQF	National Qualification Framework.
NSP	National Strategic Plan.
NTCP	National Tuberculosis Control Programme.
NVP	Nevirapine.
OIS	Organisational Improvement Services.
OPD	Out-Patient Department.
OSD	Occupation Specific Dispensation.

ABBREVIATIONS & ACRONYMS

PBECP	Professional Board for Emergency Care Personnel.
PC's	Personal Computers.
PCP	Pneumocystis Carinii/ Pneumocystis Jirovesii Pneumonia
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis.
Persal	Personnel and Salaries System.
PEPFAR	United States President's Emergency Plan for Aids Relief.
PFMA	Public Finance Management Act.
PHAST	Participatory Health and Sanitation Transformation.
PHC	Primary Health Care.
PITC	Patient Initiated Testing & Counselling.
PMDS	Performance Management and Development System.
PMO's	Principal Medical Officers.
PMR	Peri-natal Mortality Rate.
PMSC	Provincial Medical Supply Centre.
PMTCT	Prevention of Mother to Child Transmission.
PN	Professional Nurse.
PNC	Post Natal Care.
POPD	Paediatric Out-Patient Department.
PPIP	Peri-Natal Problem Identification Programme.
PPSD	Provincial Pharmaceutical Supply Depot.
PPT	Planned Patient Transport.
PTB	Pulmonary Tuberculosis
PTSS	Patient Through Service System.
QA	Quality Assurance.
RED	Reach Every District.
RUDASA	Rural Doctor's Association of South Africa.
SADC	Southern African Development Cooperation.
SADHS	South African Demographic & Health Survey.
SAPS	South African Police Service.
SAQA	South African Qualifications Authority.
SASSA	South African Social Services Agency.
SCM	Supply Chain Management.
SDA's	Service Delivery Agreements.
SETA	Sector Education Training Authority.
SHS	School Health Services.
SITA	State Information Technology Agent.
SLA	Service Level Agreement.
SMME's	Small Medium and Micro Enterprises.
SMS	Senior Management Service.
SOP	Standard Operating Procedures.
SPSS	Statistical Package for Social Science
SSA	Sub-Saharan Africa
Stats SA	Statistics South Africa.
STI's	Sexually Transmitted Infections.

STP	Service Transformation Plan.
TAT	Turn Around Time.
TB	Tuberculosis.
TED	Targeted Enterprise Development.
THP's	Traditional Health Practitioners.
TM	Traditional Medicine
TOP	Termination of Pregnancy.
UKZN	University of KwaZulu-Natal.
UNICEF	United Nations Children's Fund
UNISA	University of South Africa.
VCT	Voluntary Counseling and Testing.
WHO	World Health Organisation.
WOE	Women Owned Enterprises.
XDR	Extreme Drug Resistant.
XDR TB	Extreme Drug Resistant Tuberculosis.

HEALTH
KwaZulu-Natal

PR: 99/2009
ISBN: 978-0-621-38569-4

Design and Layout by the Strategic Planning Unit