ANNUAL PERFORMANCE PLAN

NORTHERN CAPE HEALTH DEPARTMENT

2007/08 TO 2009/10

Updated February 2007

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ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
AFP	Acute Fluid Paralysis
ART	Anti-Retroviral treatment
ARV	Anti-Retro Virals
BAS	Basic Accounting System
BOR	Bed Occupancy Rate
CBO	Community-based Organisation
CDL	Chronic Disease of Lifestyle
CEO	Chief Executive Officer
CHBC	Community Home Based Care
CPD	Continuous Professional Development
COHSASA	Council for Health Service Accreditation of Southern Africa
CTOP	Choice on Termination of Pregnancy
DHIS	District Health Information System
DOT	Direct Observed Treatment
ECP	Emergency Care Practitioners
EHWP	Employee Health Wellness Programme
EPI	Extended Programme on Immunisation
EPR	Electronic Patient Record
FTE	Full-Time Employment
GETC	General Education and Training Certificate
HBC	Home Based Care
HIV	Human Immuno Virus
HRD	Human Resource Development
HRM	Human Reosurce Management
ICT	Information Communication Technology
IHPF	Integrated Health Planning Framework
IMCI	Integrated Management of Childhood Illnesses
MCWH	Mother Child and Womens Health
MDP	Management Development programme
MDR	Multi-Drug Resistant
MISS	Minimum Information Security Systems
MVA	Motor Vehicle Accidents
NDOH	National Department of Health
NGO	Non-Governmental Organisations
NQF	National Qualification Framework
OSW	Office on the Status of Women
PERSAL	Personal Salary
PHC	Primary Health Care
PHO	Port Health Organisation
PMDS	Performance Management and Development System
PMTCT	Prevention of Mother to Child Transmission
PPIP	Peri-natal Problem Identification Programme
PTB	Pulmonary Tuberculosis
QA	Quality Assurance
RTC	Regional Training Centre
SAMDI	South African Management and Development Institute
SLA	Service Level Agreements
STI	Sexually Transmitted Diseases
TAT	Turn Around Time
TB	Tuberculosis
TQM	Total Quality Management

VCT	Voluntary Counselling and Testing
XDR	Extreme Drug Resistant

INTRODUCTION AND SIGN OFF BY MEC

The challenges we have faced in the past years have made us to continuously re-evaluate our strategic plans in order to reflect our new approach to these challenges. Our Annual Performance Plan therefore is based on our ever-evolving strategies within which we are re-positioning our Human Resources, skills and capital to positively respond in an efficient manner to the health needs of our people, and improve our health services.

We are expanding our infrastructure to maximize access to health facilities as part of our broader 2014 Health Plan. In these Infrastructural Projects, ARV Sites also form an integral part of our planning in dealing with the scourge of HIV and AIDS in all spheres of our society. It is our commitment to the Northern Cape people that we comprehensively and collectively deal with all the diseases that are threatening the well-being of our people. We will however also pay attention to TB, XDR TB and MDR TB.

We continue to provide training and enhance skills of our staff to equip them for better service provision. The Annual Performance Plan then becomes our yearly guide for improving customer care services in our facilities. We will, as part of our performance plans this year, continue with the recruitment drive to attract skilled and experienced Health Professionals into our province as part of our Recruitment and Retention Strategy.

As part our continuous campaigns we run Schools Health Promotion programme and Health Promotion in general to inculcate Healthy Lifestyle into the minds of young people and the broader society of our province.

We will further monitor and evaluate our performance as a Department through our own internal processes, and by receiving feedback and suggestions from the communities we serve. The Annual Performance Plan therefore becomes our yardstick for assessing and bench-marking our Performance in order to improve our services

.....
MS ES SELAO
MEC FOR HEALTH
NORTHERN CAPE
DATE: 23.03.07

INTRODUCTION AND SIGN OFF BY THE ACTING HEAD OF DEPARTMENT

We have made a commitment to achieve definite targets, as spelt out in our vision 2014, the Health Plan of our Provincial Government. This therefore binds us to a set of deliverables which can measure the quality of life that we seek to contribute as a department. We are certainly better poised to meet the challenges of creating sustainable livelihoods.

This conviction emanates from continued emphasis of strengthening our Primary Health Care and Preventative measures that amongst others translate into healthy lifestyles. The revitalization of our primary health care facilities and strengthening the referral pathways will make the system function effectively and efficiently. All of these and other actions that are spelt out in this document are the foundations of our performance plan as a department.

Notwithstanding the constraints of limited resources and the impediments of scarce skills the Annual Performance Plan of the department reflects a strategic definition of our challenges and how we have approached them. The ongoing policy review processes that we are undertaking will comprehensively respond to the need to create efficiency gains. As a learning organization the department sees this Annual Performance Plan as part of an overall plan of reinventing itself into an organization that is truly of the 21st Century.

I am certain that we have built a team that understands and lives the vision of SERVICE EXCELLENCE FOR ALL.

……..
MS M. THUNTSI
ACTING HEAD OF DEPARTMENT
DATE: 22.03.07

VISION

Health Service Excellence for all.

MISSION

Empowered by the Peoples' Contract, our caring and multi- skilled staff is committed to provide comprehensive quality services using evidence-based care strategies to promote a healthy society in which we care for one another.

VALUES

- Respect (towards colleagues and clients, rule of law and cultural diversity)
- Honesty (Discipline, Integrity and Ethics)
- Excellence through effectiveness, efficiency and quality health care.
- Humanity (Caring, Institution, Facility and Community)

PART A: GENERAL INFORMATION

1. STRATEGIC OVERVIEW

INTRODUCTION

The Northern Cape Department of Health is driven by vision 2014 which outlines the departments' strategic objectives, indicators and milestone that ensure that services strategies are integrated and delivered with excellence to the community. Vision 2014 is guided by the national health systems plan. The Department has achieved great results in most of the areas that it has set goals for itself. Plans are still in place to improve the quality of care and service delivery and to implement our 2014 vision namely "Health Service Excellence for All."

2. SITUATION ANALYSIS

2.1 Geography

The Northern Cape is one of the nine provinces of the Republic of South Africa. It has by far the biggest land mass of all the provinces, it covers 29.7% of South Africa's land surface at 361,830 square km (Gauteng 1.4% or 17,010 square km) (*Stats SA-2000*). The Northern Cape is bounded by the Atlantic Ocean on the west, Namibia and Botswana to its North.

Map 1: Regions of the Northern Cape

The Northern Cape has five administrative districts comprising **Pixley Ka Seme,** with its district capital in De Aar; **Frances Baard** with its capital in Kimberley; **Siyanda**, which includes large sections of the Kalahari desert, has its capital in Upington; the **Namaqua** region, known for its minerals and seasonal flowers, has Springbok as its capital; and **Kgalagadi**, has Kuruman as its capital.

- **Pixley Ka Seme:** The semi-arid Pixley Ka Seme region comes alive with abundant flowers at the first sign of the summer rains. Colesberg is an important stopover for travelers to and from the hinterland to the coast.
- **Frances Baard:** This area, formerly known as the Diamond Fields, hosts the famous city of Kimberley and its diamonds. Kimberley was the site of a prolonged siege during the South African War (Anglo-Boer War). Places of interest include The Oppenheimer Memorial Gardens, the Pioneers of Aviation Memorial, Cecil John Rhodes' statue, the Nooitgedacht Glacial Pavements near the Barkley West.
- **Namaqua:** Is known more for its spring flower display between August and October of each year. It currently is one of only six world plant sites namely the Cape Floral Kingdom.

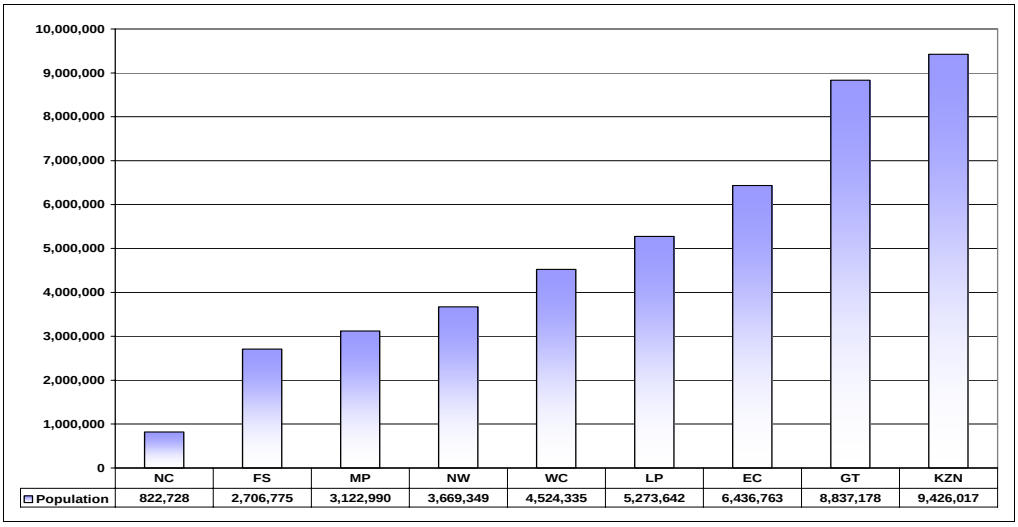
- **Siyanda:** Formerly known as The Lower Orange, this region is a rich farming area. It is traversed by the Orange River from the east. The capital Upington serves as an administrative and commercial centre.
- **Kgalagadi:** It is a region of dramatic contrasts, a land where stretched-out semi-desert dunes meet up with vineyards and farmlands.

2.2 Population

The Northern Cape is sparsely populated and houses some 1, 094, 500 people including the new provincial boundaries (*Mid-Year Estimates, 200*6). Afrikaans is widely spoken by almost all racial groups, followed by Setswana speakers at 20% isiXhosa 6.3%. English follows a distant fourth at 2.4% then to lesser proportions isiZulu. About 70% of the population is urbanised while the rest is rural. Females outnumber males by four per cent, being 51% and 47% respectively (*Stats SA-2000*).

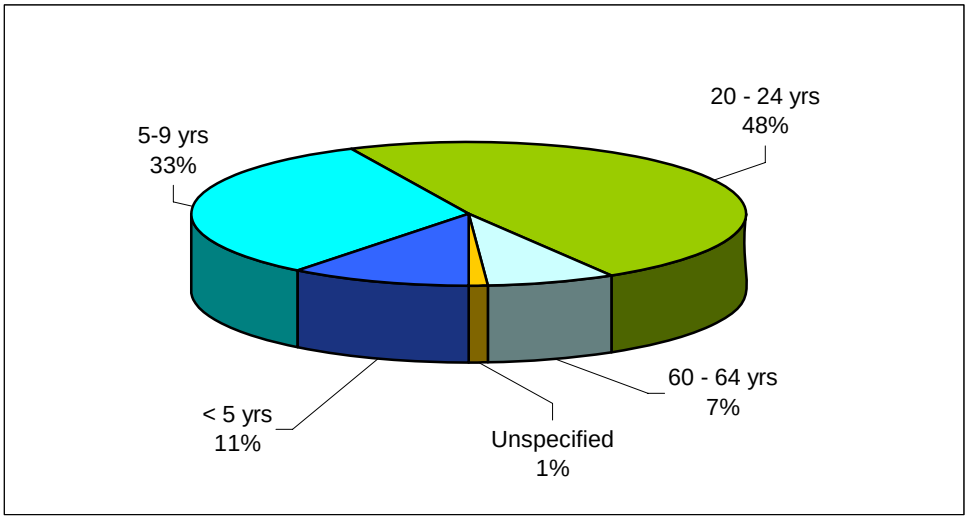
The last remaining true San (Bushman) people live in the Kalahari area of the Northern Cape. The area, especially along the Orange and Vaal rivers, is rich in San rock engravings. A good collection can be seen at the McGregor Museum in Kimberley. The province is also rich in fossils.

GRAPH 1: POPULATION OF SOUTH AFRICA

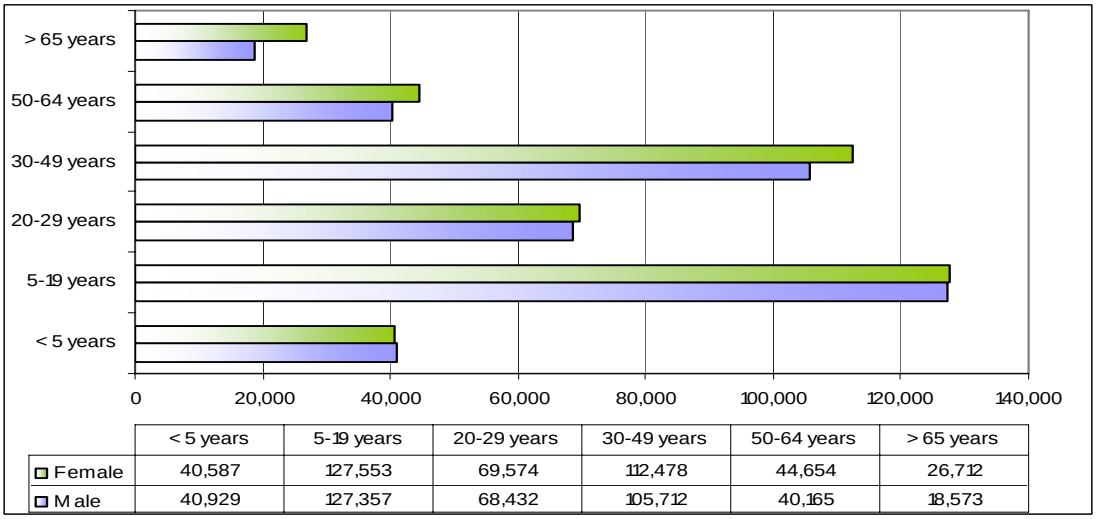


The official unemployment rate of the Northern Cape is 23, 5% (*Labour Force Survey, March 2006*).

GRAPH 2: POPULATION AGE DISTRIBUTION

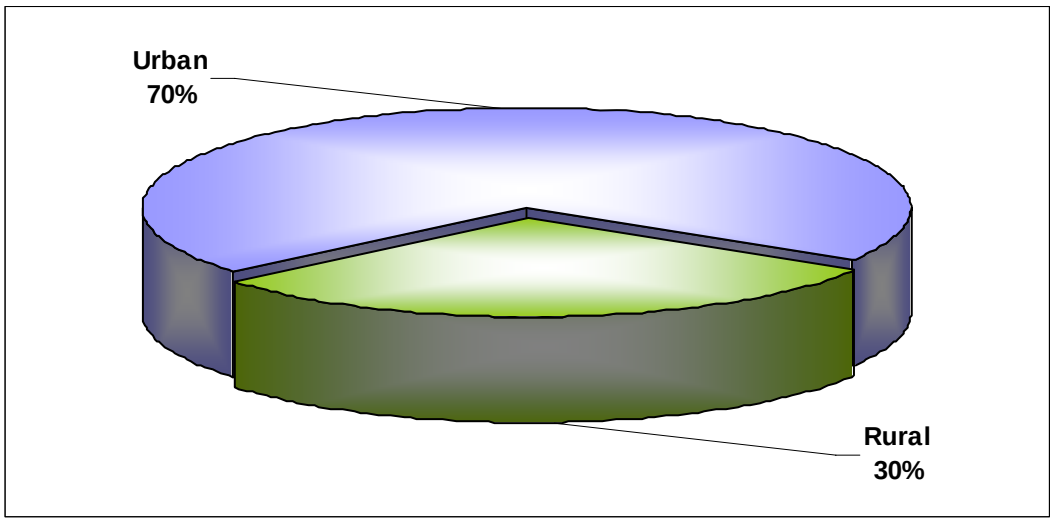


GRAPH 3: POPULATION AGE DISTRIBUTION BY GENDER



	< 5 years	5-19 years	20-29 years	30-49 years	50-64 years	> 65 years
Female	40,587	127,553	69,574	112,478	44,654	26,712
Male	40,929	127,357	68,432	105,712	40,165	18,573

GRAPH 4: URBAN VERSUS RURAL POPULATION



2.3 Agriculture and industry

The Northern Cape is displaying a tremendous growth in value-added activities, including game-farming. Food production and processing for the local and export market is growing significantly. Underpinning the growth and development plan of the province are the investment projects that link up with the existing plans of the Namaqua Development Corridor. The focus is on the beneficiation and export of sea products.

The economy of a large part of the Northern Cape, depends on sheep-farming, while the karakul-pelt industry is one of the most important in Gordonia. The province has fertile agricultural land. In the Orange River Valley, especially in Upington, Kakamas and Keimoes, grapes and fruit are intensively cultivated.

Wheat, fruit, peanuts, maize and cotton are produced at the Vaalharts Irrigation Scheme near Warrenton.

2.4 Mining

The Northern Cape is rich in minerals. The country's chief diamond pipes are found in Kimberley. In 1888, the diamond industry was formally established with the creation of De Beers Consolidated Mines. Alluvial diamonds are also extracted from the beaches and the sea between Alexander Bay and Port Nolloth.

The Sishen Mine near Kathu is the biggest source of iron ore in South Africa, while the copper mine at Okiep is one of the oldest mines in the country. Copper is also mined at Springbok and Aggenys. The province is also rich in asbestos, manganese, fluorspar, semi-precious stones and marble.

GRAPH 5: MAIN WATER SOURCE TO HOUSEHOLDS

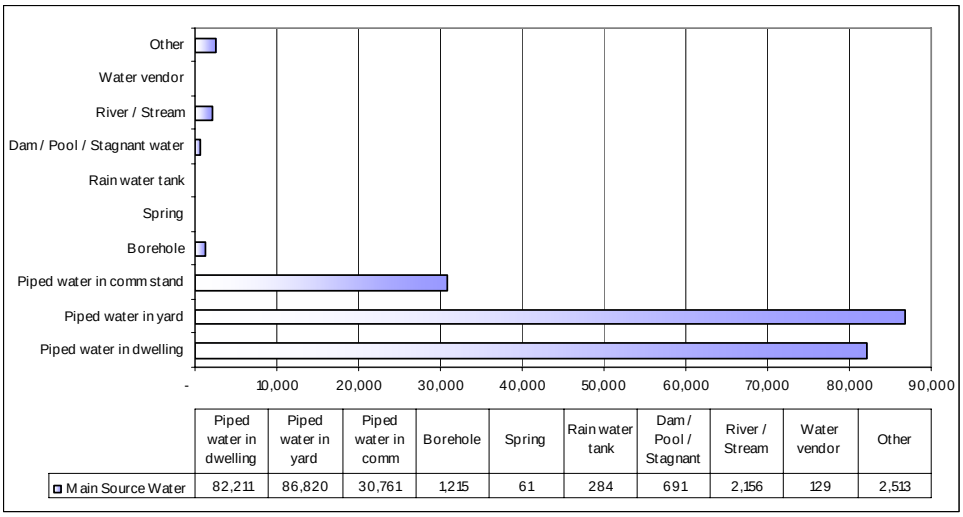
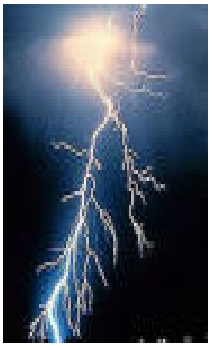


TABLE 1: SOCIO-ECONOMIC INDICATORS FOR NORTHERN CAPE AND SOUTH AFRICA

Indicators		Northern Cape	South Africa
Area as a % of total SA		29.7	100
Population density (2001) people per km		2.3	36.8
Literacy rate (20+ years)	1996	78.3	80.7
	2001	81.8	82.1
Unemployment rate (strict definition)	2001	33.4	41.6
% Households with piped water inside	2001	96.6	84.5
% Households with no toilet	2001	11.2	13.6
% Households using electricity for cooking	2001	59.0	51.4
% Households with telephone	2001	41.8	42.4

2.5 Climate



The Northern Cape is a dry region with fluctuating temperatures and differing topographies. The weather is typically that of a desert and semi-desert areas. In January temperatures in the Northern Cape usually reach between 33ºc and 36ºc, and can exceed 40 ºc. During winter, day temperatures are mild (22 ºc), but at night it can be extremely cold (often below 0 ºc). In winter, snow can often be seen in the mountains surrounding Sutherland, one of the coldest towns in Southern Africa.

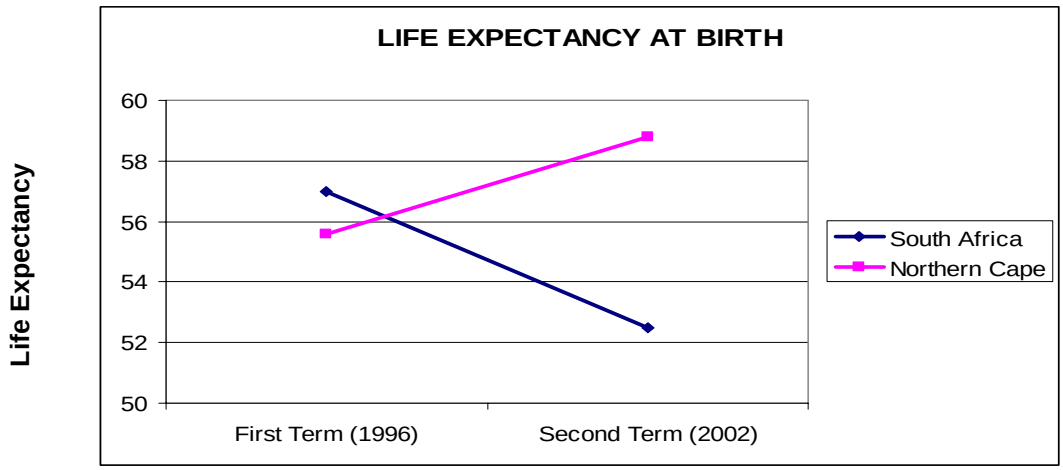
The annual rainfall is never high (50 mm to 400 mm) and is always lower than the rate of evaporation. The western areas of the province, which include the Namakwa region and small sections of the Kalahari, receive rainfall during the winter months.

3. EPIDEMIOLOGICAL PROFILE

3.1 AVERAGE LIFE EXPECTANCY

The average life expectancy at birth has increased in the Northern Cape. This is regarded as particularly significant, since the life expectancy at birth for the country as a whole has decreased.

GRAPH 6: LIFE EXPECTANCY AT BIRTH



The decrease nationally is largely due to the impact of HIV & AIDS. The Northern Cape experiences an increase in life expectancy, from 55.6 to 58.8 years.

3.2 BURDEN OF DISEASE

3.2.1 HIV AND AIDS

According to the National HIV & Syphilis Antenatal Sero-Prevalence Survey 2005, the Northern Cape showed a slight increase in the prevalence of HIV and AIDS from 17.6% in 2004 to 18.5% in 2005. This results in the province maintaining its position of second lowest prevalence rate, after the Western Cape Province.

The prevalence of Syphilis however, remains of great concern in the Province. Statistics show a significant increase from 7.0% in 2004 to 8.5% in 2005, this being the highest rate in South Africa. Although all districts are affected, Kgalagadi district shows the highest incidence in 2005. As this is based on the results of the Antenatal Survey 2005, the Department is considering a more general survey in order to establish any other contributing factors to this problem. A High Transmission Area service point is being planned for this district in order to also anticipate the increase in population following the recent de-establishment of existing municipal boundaries.

GRAPH 7: HIV PREVALENCE TREND

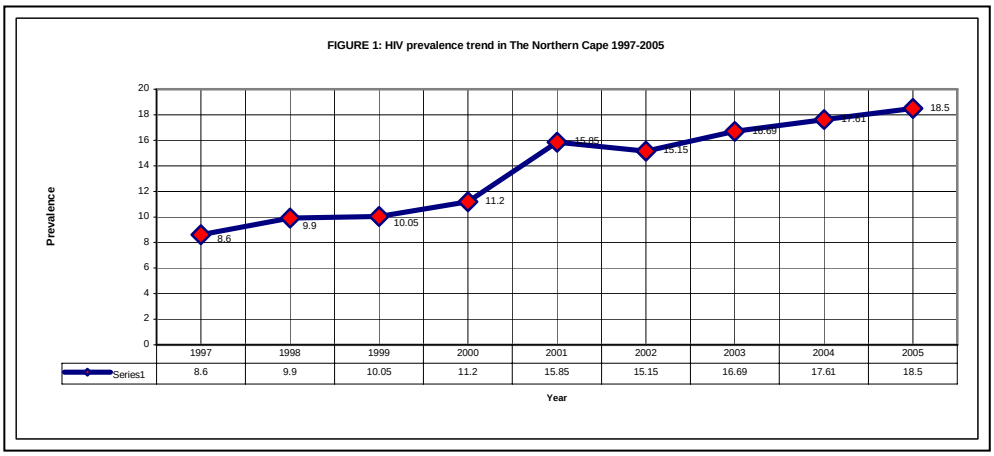


TABLE 2: SYPHILLIS TREND

Province	RPR Prev 2003	RPR Prev 2004	RPR 2005 prev
Northern Cape	8.6	7.0	8.5
Gauteng	2.1	0.9	4.3
Western Cape	5.5	1.6	4.0
Free State	3.8	3.8	3.0
Mpumalanga	1.8	1.3	2.9
Eastern Cape	3.8	2.4	2.5
North West	2.0	2.1	1.9
KwaZulu Natal	1.4	0.8	1.2
Limpopo	1.7	0.9	1.1
South Africa	**2.7**	**1.6**	**2.7**

Awareness and Prevention

Voluntary counselling and testing (VCT) has become a widely used intervention aimed at improving behaviour change of those who have been tested (UNAIDS, 1999). Research findings have illustrated that people who are properly pre and post-counselled during VCT, take greater precautions toward reducing their risk of transmission (UNAIDS, 1999). Availability of VCT is considered a factor in reducing stigma surrounding HIV based upon increased awareness, fostered dialogue, problem solving and behaviour change.

VCT is currently (2007) offered at all fixed PHC facilities. This offering is expected to expand to non-fixed facilities during 2007/08. In order to prevent new infections, the Province will be embarking on a strategy to increase the number of people testing for HIV through rigorous marketing. This includes the ACCESS VCT program introduced by a partner, Right to Care in 2007 as well as increasing the number of counsellors trained in HIV and AIDS counselling. The management of Sexually Transmitted Infections (STI`s) will be improved by

- Training more Health Care Professionals in the Syndromic Management of STI's
- Distribution of at least 80 000 female condoms and 6 500 000 male condoms by the end of 2007/8.

Care and Support
Support groups are designed to build self-confidence, help people cope with their diagnosis, overcome depression and create social networks to prevent feelings of isolation. In the spirit of improving public/private partnerships, this programme also promotes a joint approach to dealing with the management of HIV and AIDS in the community. There are currently 48 active and registered NGOs in the province.

The Community Home Based Care Programme is implemented through an estimated 600 HBC givers in the province. More Home based caregivers are likely to be appointed in the next financial year through the Expanded Public Works Programme (EPWP).

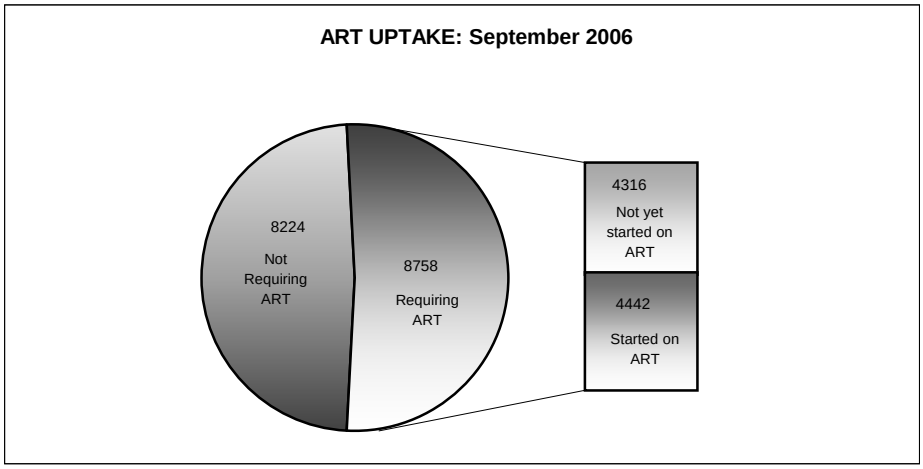
In addition, a comprehensive Palliative Care Model is being piloted in the Frances Baard and Pixley ka-Seme districts in partnership with Family Health International (FHI).

Treatment

Anti Retroviral Therapy (ART) Programme

Launched on 26 July 2004, the Comprehensive Care, Management and Treatment (CCMT) Plan has made great strides in the province since. There are now 10 accredited ARV Treatment Service Points and as at the end of September, the Anti Retroviral Therapy (ART) Programme uptake is illustrated in the following graph:

GRAPH 8: ART UPTAKE



The challenge currently faced by the Province is to scale-up services to ensure that all patients who qualify for ART are able to commence treatment as soon as possible. It is envisaged that a total of 15 000 patients will have been enrolled for ART by the end of 2007/08.

Nutrition

A team of dieticians, peer educators, counsellors and master trainers provides nutritional support. This entails the provision of vitamins and other nutritional supplements and promotion of healthy practices including education on malnutrition, pregnancy and lactation, avoidance of alcohol, breastfeeding, good hygiene practices, infant feeding and care for pregnant women.

TB Control

Tuberculosis, a socio- economic disease, still poses as a major public health challenge in the Northern Cape Province today more than ever in its long-drawn-out history. Important factors aggravating TB and hampering its control include increased migration especially seasonal work, increase in the HIV prevalence, high poverty levels, poor nutrition, inadequate housing, high defaulter rates and inadequate case finding.

The province is to embark on an aggressive strategy to effectively tackle this problem in line with set targets of the 2014 Strategic Health Plan of the Department.

The Provincial TB Control Programme plays a role of planning, budgeting, co- ordination, facilitation and evaluation of TB services in the province. The districts have a responsibility of implementation of TB services at Primary Health Care level including district hospitals.

MDR TB

Often referred to as a man- made disease, MDR is posing a challenge to the control of TB in the province. The province has 185 reported MDR TB cases.

XDR TB

To date (March 2007) a total of 9 XDR cases have been confirmed. A provincial communication strategy for X-DR TB is in the process of being finalized, as are Infection Control measures being strengthened at all health facilities.

Emerging and Re-Emerging Infectious Disease

Successful Control of Communicable Disease needs good surveillance. The main causes of morbidity and mortality are diarrhoeal diseases, acute respiratory infections, Varicella, other communicable diseases such as Meningococcal meningitis and haemorrhagic fevers.

The recent outbreaks in the province have created opportunities to network with other departments. Linkages have been formed with Department of Agriculture and Department of Local Government. To create the surveillance system, timeliness is made a priority. Case definitions and the reporting systems have been re – designed to be simple and fast.

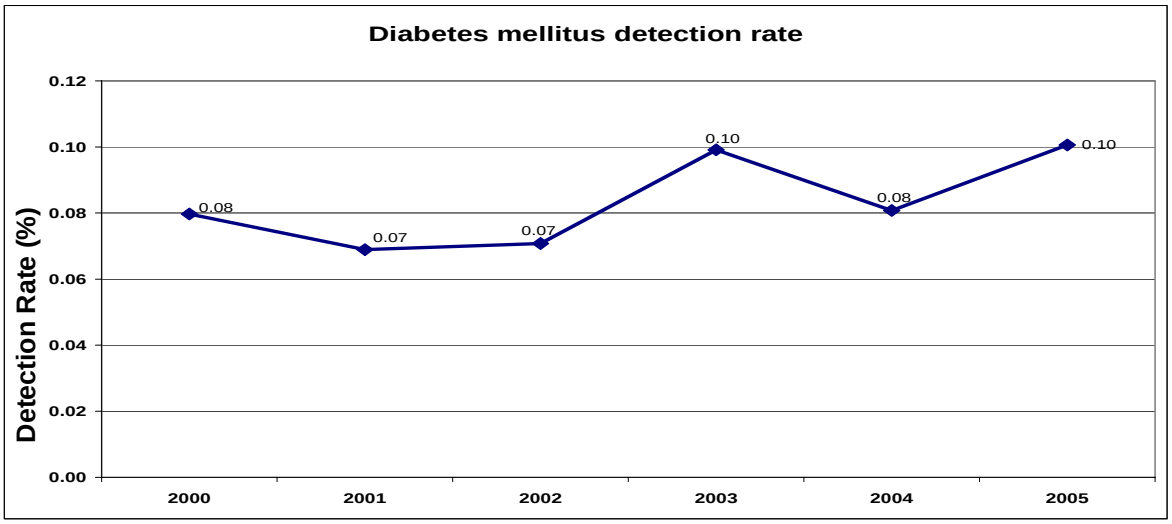
3.3 EMERGING CHRONIC CONDITIONS ASSOCIATED WITH A WESTERN LIFESTYLE

3.3.1 CHRONIC CONDITIONS

Based on self-reported chronic conditions, major conditions in the Northern Cape are blood pressure, ischemic heart disease, diabetes and tuberculosis. Asthma and chronic bronchitis also appear to be particular problems for men whereas in women blood pressure, emphysema and tuberculosis are predominant. Men receiving treatment for hypertension in the Northern Cape are double that of the national average (21,5% compared to 10,7%), whilst the figure for women taking medication is 35% compared to 27,7% nationally.

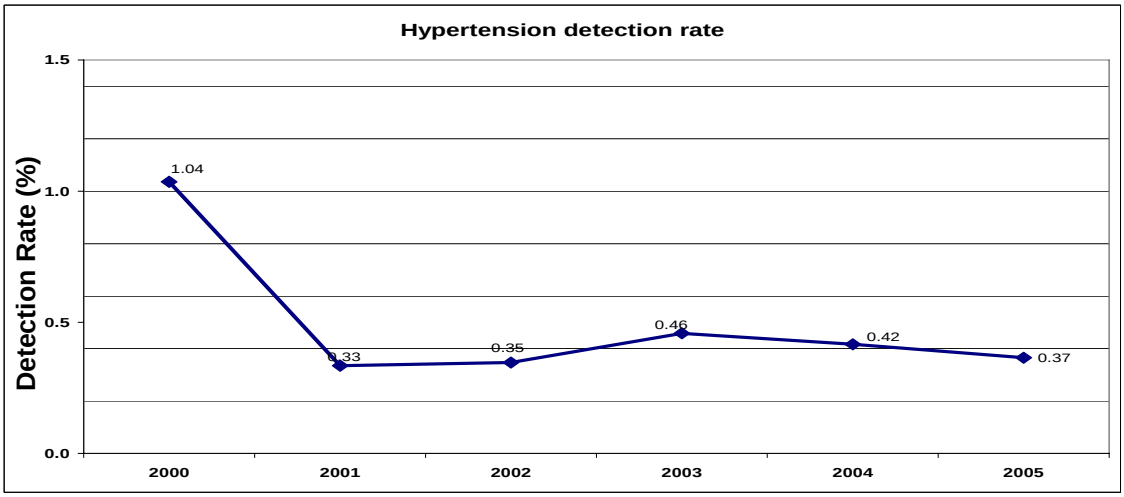
The most prevalent chronic conditions in the Northern Cape are hypertension and diabetes

GRAPH 9: DIABETES MELLITUS DETECTION



Note: Age group is 45 years and older

GRAPH 10: HYPERTENSION DETECTION RATE



Note:* Age group is 45 years and older

The incidence rate of chronic obstructive airways disease is at 2.7 per 1000 of the population and epilepsy at 1.5 per 1000 of the population.

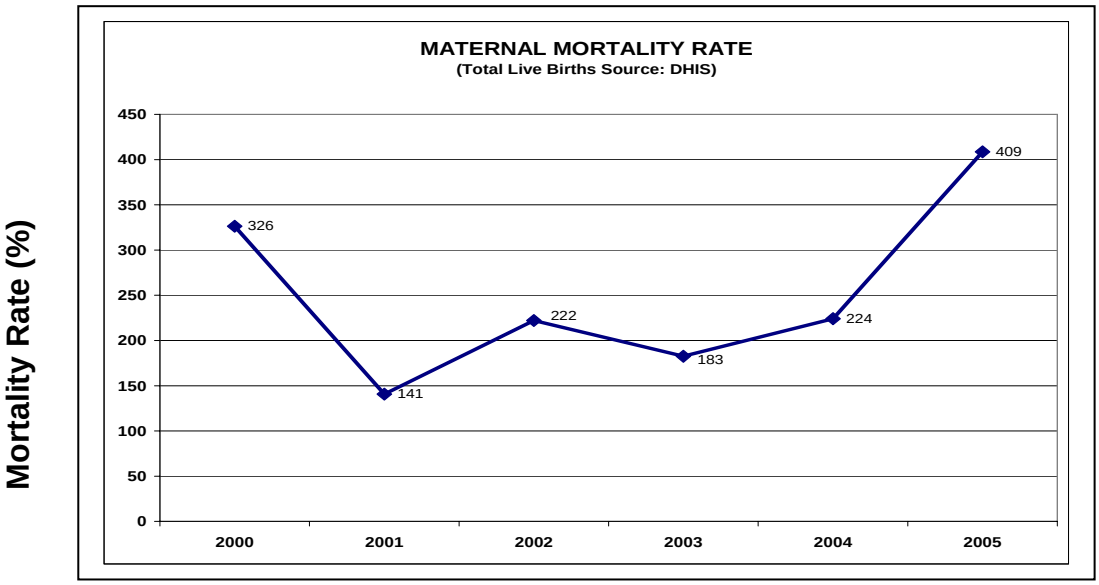
3.3.2 WOMEN'S HEALTH

Maternal Health

The maternal mortality ratio for 2006 is 308/100 000 per annum. The increase in maternal mortality figures over the last few years is of grave concern to the Department of Health. The increase in maternal mortality is being felt throughout the country and is likely to be due to the increased risk of complications in pregnant women with AIDS related disease.

Nevertheless, the Department committed itself to making labour as safe as possible. In this regard, a "Saving Mothers Programme" was initiated. A new specialist was recruited in 2002. Staff receives ongoing support and evaluation and facilities are being upgraded to ensure that full theatre facilities are available in areas of need. The remarkable success of this programme is evident in the decreased maternal mortality rate in the 2003 estimates.

GRAPH 11: MATERNAL MORTALITY RATE



One way of ensuring that labour is as safe as possible is to prepare adequately during the pregnancy. This requires the pregnant woman to attend antenatal clinics. The figures for antenatal clinic attendances as well as improved tetanus vaccination rates (a vaccination useful in pregnancy) suggest that antenatal visits are increasing.

Choice on Termination of Pregnancy

Data for this section reflects positive investments in the facilities for Choice on Termination of Pregnancy (CTOP), with resultant increases in access to the CTOP service. There have also been improvements in the extent of condom distribution.

GRAPH 12: TERMINATION OF PREGNANCY

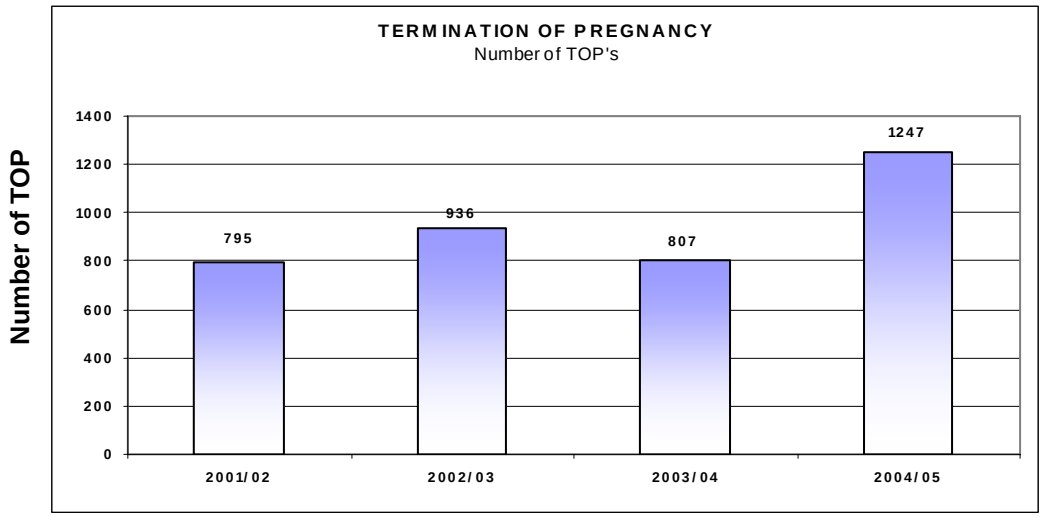


TABLE 3: TRENDS IN KEY PROVINCIAL MORTALITY INDICATORS

Indicator	SADHS 1998	SADHS 2003	Target
Infant mortality (under 1)	41.8	46	45 per 1,000 live births by 2005
Child mortality (under 5)	14.3	14.3	59 per 1,000 live births by 2005
Maternal mortality	192.7 (2002)	167.2 (2003)	100 per 100,000 live births by 2005

4. ACCESS TO HEALTH CARE SERVICES

Persons living in towns of the Northern Cape are all within 5km of a health facility. It is in the rural areas where this is not the case and mobiles service these areas. The Province is the largest with regard to land mass and has 47 mobile units. Access to health services has an important role to play in supporting health promotion activities, taking a lead in caring and support to people living with HIV, and in supporting appropriate home-based care.

Access to health facilities by the youth in the Province (based on time taken to reach a medical facility) does not appear to be poor. 35% of the youth have access to a facility closer than 15 minutes away and 36% have access between 15 – 30 minutes. Youth, especially those living in rural settlements tend to use clinics more than private general practitioners

5. QUALITY OF CARE IMPROVEMENTS

The department launched the Batho pele principles and provided subsequent training of health care workers. Patients Rights Charter was also launched and various community or mass mobilization strategies to create public awareness of these rights were undertaken.

One survey on Batho pele was conducted and inputs are still being analysed. A complaints procedure has been implemented at all facilities. The month of November marked the annual celebration of quality assurance month, and great strides have been made by all facilities throughout the province to implement quality assurance activities in line with the quality assurance theme, “putting our patients first”. A provincial

Quality Assurance workshop was held to develop and adopt a common QA strategy with uniform indicators for implementation by all the facilities.

Subsequently, district support visits were conducted. The purpose of the visits was to conduct a situational analysis on quality assurance activities and experiences at these facilities, and to develop service delivery improvement plans.

5.1 EMERGENCY MEDICAL SERVICES

Pre Hospital care has rapidly evolved to be an integral and exciting component of the health care system. Advances in medicine and technology allow us to bring highly specialised emergency care to patients in their homes and on our roads. Service delivery has been enhanced with the purchasing of fully equipped vehicles as well as the employment of contract emergency care practitioners and Planned Patient Transport Drivers to pursue the ideal of excellence in service

The number of staff from 2001/2 to date currently has changed drastically which has allowed us to alleviate the 1 person crew to a certain extent. This has also helped to improve response times of 15 minutes in urban areas and 40 minutes in rural areas.

The department has also embarked on Refresher courses as well as Intermediate courses for the full time staff. Radios have been fitted in new vehicles that were purchased and a new Repeater was installed at Kimberley Hospital to improve communications. An Electronic Patient Record System (EPR) was also installed in 16 Ambulances.

TABLE 4: EMERGENCY MEDICAL SERVICES PERSONNEL & VEHICLES

District	Permanent ECP	Contract ECP	Total ECP	AEA	BAC	PTV Drivers	Admin staff	General Assistant
Frances Baard	152	57	209	32	120	5	2	1
Namaqua	42	49	91	6	36	2	0	0
Siyanda	148	0	148	9	139	2	1	2
Pixley ka Seme	57	69	126	5	52	10	0	0
Kgalagadi	23	0	23	2	21	0	0	0
Total	**422**	**175**	**597**	**54**	**368**	**19**	**3**	**3**

District	Ambulance	Rescue/Response	PTV	Trailer	Utility Vehicle
Frances Baard	31	4	6	2	1
Namaqua	32	3	7	2	0
Siyanda	25	3	6	0	0
Pixley Ka Seme	47	3	13	3	0
Kgalagadi	17	1	4	2	0
TOTAL	**152**	**14**	**36**	**8**	**1**

6. PRIORITIES AND STRATEGIC GOALS

Strategic goals for the Northern Cape Province

- Promoting the growth diversification and transformation of the provincial economy
- Poverty reduction through social development
- Developing request levels of human and social capital
- Improving the efficiency and effectiveness of governance and other development institutions
- Enhancing infrastructure for economic growth and social development

Priorities of the National Department of Health 2006/07-2008/09

- Development of service transformation plans
- Strengthening of human resources
- Strengthening physical infrastructure
- Improving quality of care
- Strategic health programmes

Priorities of the Northern Cape Department of Health

- Governance and management of District Health Services
- Health lifestyles
- Maternal and neonatal mortality and morbidity
- Financial management systems
- Revitalization and modernization of health facilities
- Emergency medical services
- Comprehensive care, management and treatment of HIV and AIDS, STIs and TB
- Comprehensive forensic medical services
- Human resources planning, development and management
- Research and information management
- Communication technology
- Quality of care
- Non- communicable diseases

Challenges

- The stigma, poverty and the distances in the Northern cape posses serious challenges for providing a comprehensive management and treatment of HIV and AIDS
- TB still poses a challenge in the province despite the highly effective free treatment

Achievements 2006/07

- Service Transformation Plan (STP) developed and submitted to National Department of Health (NDOH)
- Operationalise Garies hospital in January 2007.
- Taking over of Alexander Bay hospital
- Incorporation of Kgalagadi into the Northern Cape Province
- Establishment of sub-directorate Policy and Planning
- Establishment of fully fledged Human Resource Management unit
- The trucks have full consultation rooms on board and facilities for minor procedures to be conducted on board. The trucks have been deployed to Kgalagadi district.
- Relieved pressure on Intensive Care Unit (ICU) by establishing High Care Beds (Neurosurgery, Obstetrics and Gynecology).

- Following the approval by Budget Council on the transfer of mortuaries from South African Police Service (SAPS) to Department of Health (DOH), the transfer has been effected and the take over was on 1st April 2006.
- Vehicles to the value of R5.5 million procured for the mortuary service
- New ambulances have been dispatched to areas that never had a locally stationed ambulance before e.g. van Zylsrus, Kuboes etc.
- Electronic patient records system has been launched and is being implemented
- Installation of thumb print laptops into ambulances with a computerised patient information linked to the electronic patient record at Kimberly hospital

Commitments 2007/08

- Increase access to ART treatment to 15 000 eligible patients
- Accreditation of health-care facilities for the comprehensive treatment, care and support of HIV/AIDS patients
- Strengthen the roll-out of the TB Crises Management Plan
- Intense surveillance measures to investigate the extent of XDR TB in the Province and develop a strategy to manage and control MDR and XDR TB.
- Upgrade 22 holding facilities (mortuaries on hospital grounds)
- The Dept is also committed to give wheelchairs and other assistive devices to deserving patient in spite of limited resources. An amount of R1 million is earmarked for this programme.
- Seven additional clinics will be built in the New Year. These are Laxey Clinic, Heuningsvlei Clinic, Tsineng Clinic, Bendel Clinic, Hartswater, Hondeklipbaai, Pampierstad and Oliphantshoek are the additional clinics that will be built for the communities in the respective towns at an estimated cost of R20.5 million
- Train 30 forensic nurses
- Improve the rumeneration of health professionals over the next three years
- The oncology department is currently being re-vamped in partnership with Elle Lilly
- Burns unit is going to be modernized to increase the capacity to meet the needs
- The child health clinic is also going to be upgraded and its capacity increased at a cost of R 350,000
- A 24 hrs casualty service will be opened at Galeshewe Day Hospital (GDH)
- Internet kiosk at the specialized clinics will also be opened for the clients as mechanism of community empowerment
- Satellite Radiology services will also be opened at the out patient clinics thus providing a one stop service to our clients
- A head and neck center and a dental laboratory will opened as apart of service expansion program
- New patient and hospital linen will be procured to restore the dignity of the clients
- Provide all the ECP's with new uniforms

	2003-04 Actual	2004-05 Actual	2005-06 Actual	2006-07 Estimate	2007-08 Projection	2008-09 Projection	2009-10 Projection
Total uninsured population	658,182	658,182	658,182	658,182	787,106	787,106	787,106
CPIX multiplier	1.084	1.041	1.000	0.953	0.909	0.868	0.831
	4,153,394,000	4,696,576,000	5,047,696,000	4,395,336,000	4,855,468,000	5,152,583,000	5,435,975,000

TABLE 5: Trends in provincial public health expenditure

	2003-04 Actual	2004-05 Actual	2005-06 Actual	2006-07 Estimate	2007-08 Projection	2008-09 Projection	2009-10 Projection
Current Prices							
Total	832,624,373	836,021,923	1,096,575,000	1,374,228,000	-	-	-
Total per person	1,012	1,016	1,333	1,670	-	-	-
Total per uninsured person	1,265	1,270	1,666	2,088	-	-	-
Total capital	42,387,168	83,729,000	152,500,000	294,568,000	-	-	-
Constant (2005/06) prices							
Total	902,564,821	870,298,822	1,096,575,000	1,309,639,284	1,327,086,369	1,424,743,024	1,538,361,848
Total per person	1,097	1,058	1,333	1,592	1,349	1,448	1,564
Total per uninsured person	1,371	1,322	1,666	1,990	1,686	1,810	1,954
% of total spent on:							
District health services	39.3%	40.7%	38.4%	36.3%	48%	47%	46%
Provincial hospital services	31.4%	29.3%	26.9%	23.4%	24.3%	23.6%	23.3%
All personnel	51.1%	56.4%	47.7%	44.3%	53.1%	50.7%	50.0%
Capital	5.1%	10.0%	13.9%	21.4%	15.0%	15.9%	16.8%
Health as % of total public expenditure	20.0%	17.8%	21.7%	31.3%	30.1%	31.9%	34.1%

PART B: PERFORMANCE PLANS

7. PROGRAMME 1 – ADMINISTRATION

7.1 HUMAN RESOURCES

Situation analysis

Human Resources Management (HRM) has been developed to a Directorate level. Human Resource Development (HRD) and administration component have been placed on a trajectory from being generalist to becoming specialist as a result of a changing environment dictated by legislation. HR managed to develop delegations for Hospitals, Districts, and different management levels. Procedures on HR were developed.

Challenges and concerns

- Financial resources for the scarce skills programme
- The direct absorption of learners/interns into formal employment.
- Functional Employee Health Wellness Programme (EHWP) Unit and policy implementation
- Scarcity of Pharmacists.

Proposed corrective action

- Encourage learners/interns to apply for vacant posts in the Department.
- EHWP Policy approval and establishment of Unit
- Offer bursaries to prospective Pharmacy students – Grade 12
- Job offers to Community Services Pharmacists.

Table HR 6: Situational analysis and projected performance for human resources (excluding health sciences and training)

Indicator	Type	2005/06	2006/07	2007/08	2008/09	2009/10	National target 2007/08
Input							
Medical officers per 100,000 people	No	3.4	4.0	5.5	7.0	9.5	18.7
Medical officers per 100,000 people in rural districts	No	8.0	9.0	10.0	11.0	11.5	12.2
Professional nurses per 100,000 people	No	1.0	1.5	3.0	5.0	9.5	105
Professional nurses per 100,000 people in rural districts	No	1.3	1.3	1.5	3.2	5.0	92.5
Pharmacists per 100,000 people	No	16.3	16.6	17.5	19.5	22.5	34
Pharmacists per 100,000 people in rural districts	No	23.5	25.0	27.5	29.5	31.5	24
Process							
Vacancy rate for professional nurses	%	34	34	30	27	24	15
Attrition rate for doctors	%	35	35	34	33	32	25
Attrition rate for professional nurses	%	31	31	29	28	27	25
Absenteeism for professional nurses	%	8	8	8	8	7	5
Output							
Doctors recruited against target	%	25	25	27	29	33	80
Pharmacists recruited against target	%	15	15	17	19	21	60
Professional nurses recruited against target	%	10	10	12	14	16	90
Community service doctors retained in the	%	15	15	18	21	24	40

Indicator	Type	2005/06	2006/07	2007/08	2008/09	2009/10	National target 2007/08
province							
Quality							
Hospitals with employee satisfaction survey	%	0	50	50	50	50	50
Efficiency							
Nurse clinical workload (PHC)	No	2871	2871	2871	2871	2871	2871
Doctor clinical workload (PHC)	No	30333	30333	30333	30333	30333	30333
Outcome							
Supernumerary staff as a percentage of establishment	%	-36.6	-33.0	- 30.0	-27.0	-23.0	21.5

Table HR 7: Provincial objectives and performance indicators for human resources

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09
Create a caring and conducive environment for a vibrant workforce	Departmental Policy in place	Policy in a Draft format	Complete policy	Implementation	Monitoring and evaluation of policy effect
	Fully functional Employee Health Wellness (EHW) centre	1 Kimberly Hospital Complex	All districts to have at least 1 functional unit: 1) Gordonia 2) De Aar 3) Kuruman 4) Springbok 5) Calvinia 6) Henrietta Stockdale Nursing College	All Level 1 facilities to have a functional EHW unit	Monitoring and Evaluation of EHW Programme
Develop a skilled and competent workforce through human resource planning, development and management	Established Regional Training Centres (RTC) Improved coordination of Education, Training and Skilling in the province	0	Kimberley Hospital RTC operational	Upington RTC operational De Aar RTC operational	Monitoring and Evaluation of RTC Programme
	Number of Professionals enrolled for CPD	350	120	240	300
	Service Level Agreements (SLA) completed	0	Completion of SLA		Review of all SLAs

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09
	Develop Skills improvement programme for IT Staff for the maintenance and development of IT Infrastructure completed	0	30	60	120
	Number of staff trained on Management Development Programme (MDP)	2	Presidential Strategic Leadership Development Programme (SAMDI Level 13-16) = 10	10	10
		12	Advanced Management Development Programme (SAMDI Level 9-12) = 20	40	60
		0	Emerging Management Development Programme (SAMDI Level 6-8) = 40	80	120
	Total number of various categories on Community Service	60	Doctors 30 Nurse 20 Clinical Associates 80	30 20 80	30 30 80
	Number of support personnel who receive transversal training	30	60	200	400
	Number of staff beneficiaries of bursary scheme (Intake)	63	Doctors =100 Nurses =100 Clinical Associates =100 Management = 40 Admin = 60	100 100 100 40 60	100 100 100 40 60

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09
	Number of Learnership enrolments	660	Nursing = 300 Primary Healthcare = 30 Advanced Midwifery Master Trainers training = 6 Psychiatry Master Trainers training = 6	300 30 6 6	500 90 6 6
	Number of Internship enrolments	20	30	50	80
	Number of Mid level worker enrolments	0	0	30	50
	Fully functional ICT Labs as per proposal to improve Technological capabilities of our facilities and staff	0	KHC and College	All Level 1 facilities to have a functional ICT Computer Lab 100% achievement	Evaluate effect of ICT Lab
	Number of staff trained through ICT Lab	0	120	360	600
	Competency profile framework completed and implemented	SMS and MMS members	Levels 1- 10		Review all Competency profiles
Improve employee performance through people management	Competency profiles for all occupations Completed job profiles for all occupations PMDS fully implemented	Incorrect competency profiles and job profiles	Develop generic competency profiles for all occupations by end October 2006 Complete generic job profiles for all occupations by end October 2006. Develop generic work plans for all occupational categories by end January 2007	Roll out job profiles and competency profiles for all occupations	Monitoring and Evaluation of Job profiles and Competency profiles for all employee categories

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09
Develop timeous accurate and reliable HR information for managers and staff	% Personnel reached with information sessions	Ad-hoc and not measured	33	50	100
	% Reduction in audit queries	The number of Audit queries for this period by far exceed acceptable standards of good governance	50	75	90
Promote measures in handling discipline and grievance	% Reduction in turn around	Currently ranging between 3 – 6 months	50	75	

Table HR 8: Public health personnel in 2005/06

Categories	Number employed	% of total employed	Number per 1000 people	Number per 1000 uninsured people	Number per 100 000 people	Vacancy rate
Medical officers[3]	265	46.24	3434	2747	2.75	53.76
Medical specialists	16	43.24	56875	45500	45.5	56.76
Dentists[3]	25	59.52	36400	29120	29.12	40.48
Dental specialists	0					0
Professional nurses	972	67.08	936	749	0.92	32.9
Staff nurses	272	68.86	3345	2676	2.67	31.14
Nursing assistants	670	67.88	1358	1086	1.08	2.12
Student nurses	878	100	1036	829	0.82	0
Pharmacists[3]	55	62.79	16851	13481	13.48	37.21
Number of physiotherapists	42	64.28	21666	17333	17.33	35.72
Number of occupational therapists	17	56.66	53529	42823	42.823	43.34
Number of psychologists	6	50	151666	121333	121.33	50
Number of radiographers	52	63.41	17500	14000	14.0	36.59
Number of Basic Ambulance Assistants	439	100	2072	1658	1.65	0
Number of Ambulance Emergency assistants	52	100	17500	14000	14.0	0
Number of Paramedics	1	2	910000	728000	728	98
Number of nutritionists	9	90	101111	80888	80.88	10
Number of dieticians	18	72	50555	40444	40.44	18

Categories	Number employed	% of total employed	Number per 1000 people	Number per 1000 uninsured people	Number per 100 000 people	Vacancy rate[5]	% of total personnel budget	Annual cost per staff member
Number of Community Care-Givers (even though not part of the PDoH staff establishment)	1200	100	0.015	0.016	0.133	0		12000
Doctor clinical workload (PHC clinics)	93	33	9677	77	7828			194272

7.2 COMMUNICATION

Situation analysis

The Communication unit plays a supporting role to all directorates in the department to ensure that all their communication needs are addressed and fulfilled on time. The unit provides advice on what best communication methods should be implemented to effect the necessary impact.

The Communication Policy guidelines have been finalized and are awaiting the Health Management Committee's approval. This will enable the unit to implement the 'Branding the department'. The proposed communication structure has been submitted for approval as well and will hopefully be filled soon. The human resource limitation is a challenge especially when units have activities at the same time. The creation of a structure is crucial in order to function effectively and efficiently in providing support for other units. The unit is currently developing and distributing the internal monthly newsletter.

Priorities

- To promote effective internal communication
- To communicate effectively with external stakeholders of the department
- To establish and maintain corporate image of the department
- To provide communication support to all units of the directorate

Strategic goals

- To operate in a fully functional unit with both human resources and equipment available in order to achieve the objectives outlined for the unit.
- To concentrate more on proactive activities other than reactionary after events have overtaken. The Comtask recommendations highlight the structure for a communication unit that will yield the desired results.

Analysis of constraints

- Limited human resources pose a challenge to fully implement the objectives.
- Unavailability of equipment is also contributing to the challenges.
- Challenges faced with regards to publishing the newsletter on time because of delay with articles as well as sourcing of photographs.

Measures planned to overcome them

- Recruitment of personnel
- Acquire relevant equipment
- Embark on in-service training to ensure that all members are up to date with the developments in the communication industry.

Table Com 9: Provincial objectives and performance indicators for Communications

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
Develop and implement a Communication Policy	Communication Policy developed	Communication Policy submitted for approval	Communication Policy approved.	Policy implemented	Policy implemented	Policy implemented
Coordinate the implementation of an effective internal communication strategy	Number of Quarterly updates	0	2	4	4	4
	Number of Departmental directories produced	0	1	2	2	2
	Number of newsletter editions produced	1	4	12	12	12
	Quarterly signed minutes of review	0	2	4	4	4
Coordinate the implementation of an effective external communication strategy	Number of media briefing sessions held	Ad hoc	2	4	4	4
	Number of stakeholder meetings held	1	1	4	4	4
	Articles published on webpage and media	4	6	12	12	12
	Number of radio talk shows	6	6	12	12	12
	Number of Annual Plan sessions held	2	2	4	4	4
Portray a positive image of the department	Number of facilities correctly branded	20	40	60	60	80

7.3 POLICY AND PLANNING

Situation analysis

The Policy and Planning Directorates' responsibility is to develop, monitor and implement the departments Strategic Framework and Provincial priorities. It also ensures that the provincial priorities are aligned to the National priorities. This is achieved through a continuous process of assessment and evaluation including the directing with the budgetary process in terms of the identified priorities.

Planning still poses a big challenge in the department and has a negative impact on service delivery. The unit has undertaken a resolution to hold regular strategic planning sessions to market the Government Planning Cycle to ensure that proper planning is done and in accordance with Treasury Regulations.

Adherence to the planning cycle plays a major role in strengthening the budget bid for the department. Also critical is the quality of the reports produced for monitoring purposes and improving the quality of all our planning and reporting documents in general. The directorate has pledged itself to positioning itself in such a way that its processes are strengthened to ensure efficiency in the department.

Legal and Policy Framework

- National Health Act, 61 of 2003
- Public Finance Management Act, 1 of 1999
- Treasury Regulations, March 2005

Priorities

- Support development and analysis of policies
- Monitor and evaluate the implementation of Annual Performance Plan (APP) and 2014 health plan
- Compile and produce reports
- Align the budget to health plan

Strategic Goal

To plan, budget, monitor and evaluate departmental projects

Analysis of constraints

- Lack of understanding of the budget cycle
- Inadequate compliance with reporting timelines by programmes

Measures planned to overcome them

- Conduct workshops on the budget cycle processes
- Implement budgetary measures that will encourage compliance by programmes

Table P&P 10: Provincial objectives and performance indicators for Policy and Planning

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
Monitor the implementation of Annual Performance Plan (APP) and vision 2014	Number of quarterly performance reports	4 quarterly reports produced	4 quarterly reports produced	4 quarterly reports produced	4 quarterly reports produced	4 quarterly reports produced
	Annual review and Report	Annual report produced	Annual report produced	Annual report produced	Annual report produced	Annual report produced
	Annual Performance Plan	Annual Performance Plan produced	Annual Performance Plan produced	Annual Performance Plan produced	Annual Performance Plan produced	Annual Performance Plan produced
Strengthen and support health policy development and approval	Number of proposed health policies approved	-	Policies approved	Policies approved	Policies approved	Policies approved
Monitoring the implementation of policies	Annual policy report	Annual policy report produced	Annual policy report produced	Annual policy report produced	Annual policy report produced	Annual policy report produced
Review all newly developed policies and programmes	Number of policies and programmes reviewed	-	Review report compiled	Review report compiled	Review report compiled	Review report compiled

7.4 Legal Services and Labour Relations

Situational Analysis

The period that employees are on suspension without finalization of investigations and hearings is drastically reduced. A Legal Advisor has been included as part of the Supply Chain Management (SCM) processes to ensure all legal requirements are compiled with. The department is in the process to scrutinize current contracts and Service Level Agreements (SLA's) applicable to the Department to determine the level of compliance with the said terms and conditions. This process is hampered due to the lack of a database of all contracts and SLA's in the Department. There is no designated security manager or employees appointed in the Security Management Unit to ensure compliance with Minimum Information Security Systems (MISS) document. Security Management Committee has been established.

Legal and Policy Framework

The unit is responsible for legal advice to the department and therefore works with all legislation, policies and legal principals in the country.

Priorities

- Monitor compliance with legislation
- Training of managers and front line staff on legislation relevant in their units.
- Finalise outstanding provincial legislation for submission to the Provincial Legislature.
- Compliance with Minimum Information Security Systems (MISS) Document.
- Contract Management.
- Reduce cases of professional negligence.
- Reduce Motor Vehicle Accidents (MVA's).
- Recovery of damages suffered by the department from employees and third parties, due to professional negligence.
- Monitor compliance with Collective Agreements.
- Train managers and frontline staff on the interpretations and application of collective agreements.
- Prompt finalization of grievances.

Strategic Goal

Legislative compliance and reform

Analysis of constraints

- Lack of human resources, including no designated security manager.
- Law Library to be improved and sustained.
- Lack of capacity building in the Legal Services Directorate.
- Lack of retention strategy to retain legal officers.
- No database of all contracts and SLA's in the Department

Measures planned to overcome them

- Appointment of additional legal administration officers.
- Implement retention strategy to retain senior experienced legal officers in the Directorate.
- Purchase additional research material and the allocation of an additional budget for that purpose.
- Training of legal officers in legislative drafting and accident reconstruction.
- Prepare database of contracts and Service Level Agreements applicable in the Department.

Challenges

Legal Services and Labour Relations
Legislative Compliance

The directorate did not finalise the audits on departmental compliance with legislation applicable to the department. Managers not yet trained on legislation relevant to their departments. The above failures, was due to the fact that it was a challenge to compile a list of all legislation relevant to the Department, because there is no law library. In addition we also requested line managers to assist us with the said information on legislation in their departments / units but the process is very slow.

Legislative Drafting

The unit did not train any member in the Directorate on legislative drafting due to financial constraints. We did not prepare the completed list of all outstanding provincial legislation, as it was dependant on the list of applicable national legislation, which was a challenge to compile, as indicated above. We also did not finalise the program on the finalisation of outstanding provincial legislation, as it was dependant on the list of outstanding provincial legislation.

Contract Management

The unit does not have a full complete data base of contracts and service level agreements in the department yet. It is a challenge to get same from line managers. Various attempts has been made to obtain same but to no avail. We did not scrutinise all SLA's and contracts before signature, as some have not been submitted to the legal unit.

Medico Legal Services

Medico-Legal investigations could not be finalized within one month after receipt of the said complaint. This is due to *inter alia* a huge backlog of outstanding cases and/or complaints. The fact that patient records are also not readily available and sometimes are missing, contributes to the delay.

Motor Vehicle Accident

The unit still did not clear the whole backlog of MVA's under investigation. Not all backlogs of MVA under investigation could be cleared due to the challenges faced in reporting MVA's.

Labour Relations
Individual Labour Relations

Grievances are not finalised within the prescribed timeframes. There is no concerted effort on the part of Managers to resolve grievances at the local level. This is exacerbated by the attitude that grievances are the terrain of the Labour Relation Unit. This happens despite training having been given to a number of managers.

Collective Bargaining

The compliance with collective agreements in the department is a challenge. Managers do not have a common understanding of the interpretation and application of collective agreements. This also contributes heavily to the total number of grievances in the department.

Table LS & LR 11: Provincial objectives and performance indicators for Legal Services and Labour Relations

Objective	Indicator	Actual 2005/06	Estimate 2006/ 7	Target 2007/8	Target 2008/9	Target 2009/10
Training of managers and frontline staff on Legislation, relevant to their work.	Number of pieces of legislation managers being trained on Number of managers trained on the said legislation.	Information available only indicates legislation relevant to 10 units in the Department. 216 managers trained on 5 pieces of legislation which amounts to 9% of legislation applicable to the Department of Health.	All Managers being trained in 10% of legislation.	All Managers to be trained on 28 pieces of legislation which amounts to 50% of all applicable legislation.	Managers to be trained in all 56 pieces of legislation which amounts to 100% of all applicable legislation.	-
Monitoring of compliance with legislation.	Number of checklist developed to determine level of compliance with all legislation applicable to the department.	0% - no checklist developed yet.	Checklist for 28 pieces of legislation prepared.	Checklist for 56 pieces of legislation prepared.	-	-
	Number of checklists completed, and provincial audits done, and submitted to the Accounting Officer.	0% - no checklist has been completed or provincial audits done on compliance with legislation.	50% - checklists and provincial audits for 28 of 56 acts to be finalized.	100% - checklists and provincial audits for all 56 of acts to be finalized.	-	-
	Monitoring tool to determine level of compliance with legislation in the Department.	0%	100% in place.	-	-	-
Finalise provincial legislation for	Number of provincial bills	2 draft provincial bills have been prepared namely:	2 Bills submitted to provincial legislature, and 2	2 Bills approved by Provincial Legislatures and 2	2 Bills approved by Provincial	-

Objective	Indicator	Actual 2005/06	Estimate 2006/ 7	Target 2007/8	Target 2008/9	Target 2009/10
submission to Provincial Legislature.	submitted to Legislature	Northern Cape Health Bill and Northern Cape initiation Schools Bill, for presentation to Executive Management Council.	other bills presented to Departmental Executive Management Council for submission to provincial legislature.	more submitted to the Provincial Legislature for discussion.	Legislature and 2 more submitted for discussion.	
Compliance with minimum information security systems (MISS) document.	Security management Unit in place.	0% - no unit has been established.	No unit formally established.	Establish Unit	-	-
	Staff appointed in the Security Management unit.	No staff appointed.	No staff appointed.	Staff appointed in the security management unit.	-	-
Develop and implement coordinated security plan for the Department.	Coordinated Security plan / policy in place in line with MISS.	0% - no consolidated report exist on the status quo on current security measures and breaches. 10% - fragmented security measures exist in terms of I.T. Security document security and physical security. 10% - fragmented security measures exists.	Status quo report on current available security measures and security breaches in the department, including level of compliance with the MISS document.	100% - coordinated security plan and policy to be finalized that will include financial implications and implementation strategy and security vetting program for all employees and service providers.	30% - compliance with MISS document.	60% - compliance with MISS document.
Ensure compliance with contracts and service level agreements.	Reports on level of compliance with contracts and SLA's, by service providers and legal advice provided in terms of remedies available to the department.	0% - no report is available as legal unit is not in possession of copies of contracts and SLA's.	20% - of all existing contracts and SLA's perused, to determine level of compliance, advice given and action taken to ensure compliance with terms and conditions by service provider.	100% - all current contracts and SLA's perused and legal advice given and actions taken to ensure compliance with terms and conditions.	-	-
	Quarterly	0% - no reports	Quarterly reports	Quarterly report on	-	-

Objective	Indicator	Actual 2005/06	Estimate 2006/ 7	Target 2007/8	Target 2008/9	Target 2009/10
	reports on compliance with terms and conditions of contracts and service level agreements by service providers received, and legal advice provided to Accounting Officer, Chief Financial Officer and line managers.	are readily available on compliance with terms and conditions by service providers.	on level of compliance with 10% of all current SLA's and contracts in the department.	level of compliance with 100% of all current SLA's and contracts in the department.		
Information sessions with managers including their responsibility in terms of ensuring compliance with terms and conditions by service providers.	Number of managers who attended information sessions managers on contracts and service level agreements relevant to their units.	0% - no information sessions held with managers to make them fully aware of terms and conditions of contracts and SLA's relevant in their units, and their responsibility to ensure compliance by service providers.	Information sessions held with managers on 10% of all contracts applicable in their respective units, level of compliance by service providers and their roles to ensure compliance.	Information sessions held with managers on 100% of all current SLA's and contracts relevant to their units.	-	-
Implement a clear and effective complaints procedure for all health facilities.	Number of Merit investigations into complaints of professional negligence finalized, within one month.	0% merit investigations takes longer than 30 days due to backlog of complaints under investigation which are currently 58.	30%	80%	100%	-
	Number of managers and front line staff attending information sessions on Medico Legal matters and hazards in the work	72 managers trained on medico legal matters and medico legal hazards in the work place.	10% of all EMS and Casualty personnel trained on medico legal matters.	60% of EMS and Casualty Personnel trained.	100% of EMS and Casualty Personnel trained.	-

Objective	Indicator	Actual 2005/06	Estimate 2006/ 7	Target 2007/8	Target 2008/9	Target 2009/10
	place.					
Clear backlog of complaints.	Number of investigations finalized to clear backlog and reports submitted to Accounting officer.	25% - total complaints under investigation are 77 and 19 finalised with 58 medico legal complaints currently under investigation.	45 of the pending investigations to be finalized.	All 58 complaints that are part of the backlog of complaints finalized.	-	-
Finalise the investigations of all motor vehicle accidents (MVA's) within one month.	Number of investigations finalized within one month.	0% - no investigation are finalized within one month, due to backlog of MVA's under investigation.	0% - no investigation are finalized within one month, due to backlog of MVA's under investigation.	60% of investigations finalized within one month.	100% of investigations finalized within one month.	Substantive reduction in Motor Vehicle Accidents (MVA's) due to negligence of employees.
Capacity building of legal admin officers.	Number of legal admin officers trained in investigating MVA's, including accident reconstruction.	0% - no formal training provided to legal admin officers on investigating MVA's.	0% - no formal training provided to legal unit on accident reconstruction.	5 legal admin officers to be trained in accident reconstruction.	-	-
Civil action against third parties to recover damages suffered by the department.	Money recovered from third parties for damages that arise as a result of their negligence.	0% - nothing was recovered from employees. 100% - 9 cases are pending against third parties, with the total amount involved R517 324.00.	100% - all damages suffered by the Department due to negligence of third parties, to be recovered.	-	-	-
Implementation of Grievance Procedures at operational level.	Numbers of managers trained on labour relations and handling of grievances at operational level.	216 managers trained. Informal information sessions held with frontline staff.	Ongoing training to be provided.	-	-	-
	Level of compliance	0% - no grievances	30% - of all grievances	70% - of grievances to be	100% - of grievances to	-

Objective	Indicator	Actual 2005/06	Estimate 2006/ 7	Target 2007/8	Target 2008/9	Target 2009/10
	with grievance procedures, grievances finalized within specified time frames, and the number of grievances resolved at operational level.	resolved within specified time frames.	received to be finalized within specified time frames.	finalized within specified time frames.	be finalized within specified time frames.	
Prompt finalization of disciplinary hearings.	Number of misconduct cases of employees on precautionary suspension within 30 days..	0% - investigations not finalized within 30 days.	80% - of investigations into misconduct by employees on precautionary suspension to be finalized within 30 days.	100% - of investigations into misconduct by employees on precautionary suspension to be finalized within 30 days.	-	-
Training of managers on interpretation and application of collective agreements.	Programme finalized for training of managers on interpretation and application of collective agreements.	0% - no program in place.	0% - no program in place.	100% - program in place.	-	-
	Percentage of collective agreements managers trained on.	0% - no training for managers on interpretation and application of collective agreements.	0% - no training for managers on interpretation and application of collective agreements.	Managers to be trained on 40% of all collective agreements.	Managers to be trained on 100% of all collective agreements.	-
Compliance with collective agreements.	Status quo report on level of compliance with collective agreements.	0% - no report.	0% - no report.	100% - report finalized.	-	-

Objective	Indicator	Actual 2005/06	Estimate 2006/ 7	Target 2007/8	Target 2008/9	Target 2009/10
	Number of checklists prepared for managers to determine compliance with all individual collective agreements as they are applicable to their units.	0% - no checklist prepared yet.	0% - no checklist prepared yet.	40% - checklist prepared for 40% of collective agreements.	100% - checklist for all collective agreements finalized.	-
Appeals to be finalized within 30 days.	Appoint an additional appeal authority to finalise appeals within 30 days.	50% - backlog of appeals were reduced but not finalized within 30 days.	50% - backlog of appeals were reduced but not finalized within 30 days.	100% - backlog cleared, and appeals finalized within 30 days.	-	-
Sound working relations with organized labour.	Number of formal meetings held with organized labour.	75% - regular meetings with 3 of the 4 recognized unions.	75% - regular meetings with 3 of the 4 recognized unions.	100% - regular meetings with all recognized unions.	-	-
Report financial misconduct to SAPS for criminal prosecution.	Number of cases reported to SAPS.	6 cases are currently with SAPS.	6 cases are currently with SAPS.	100% - all cases of financial misconduct to be reported to SAPS.	-	-

7.5. GENDER

Situation analysis

The unit is guided by two broad goals as indicated below and six areas of involvement which are policy, gender mainstreaming, coordination and planning, advocacy, liaison and networking and capacity building. The misconception of gender as dealing with women's issues and advocacy programmes, only adds to the burden of the programme. An engendered, sensitive budget is vital for the operations of this unit.

The National Gender Policy Framework compels each department to develop institutional mechanisms that will implement gender mainstreaming. In order for this unit to execute gender mainstreaming regarding the external and internal transformation of the health sector, sufficient capacity is needed. A proposed gender unit is envisaged for the provincial department of health in order to sustain gender mainstreaming at various service points. For the unit to be effective, it needs to be well resourced. The department renders services to:

Community Health Centres: 17
Clinics: 100
District Hospitals: 20
These figures exclude mobile points.

The proposed organogram is as follows: Deputy Director, Assistant Director, Senior Admin-Officer (**5**)Admin-Officer and Admin Clerk (**6**)

There is a need for all staff members to be sensitized around the Gender Policy. It will amplify the unit's focus regarding gender mainstreaming amongst senior managers. Sensitization of all staff in gender policy guidelines is imperative to gain buy-in and support from all staff to implement gender mainstreaming.

The unit has successfully managed to coordinate and facilitate a variety of advocacy programmes and campaigns with the limited human resources under very stressful circumstances.

Legal and policy framework

- Gender Policy Guidelines for the Department of Health
- Constitutional commitment to gender equality
- Sexual Harassment Policy
- HIV and AIDS Workplace Policy
- White Paper for the Transformation of the Health System in South Africa
- Employment Equity Act
- Sexual Offences Bill
- Convention on the Elimination of All Forms of Discrimination Against Women
- Convention on the Rights of the Child
- Gender Policy for the World Health Organisation
- Policy and Institutional Framework for Gender Mainstreaming in SADC
- Health Sector Framework Policy Document for SADC
- Constitutional commitments to gender equality
- National Policy Framework for Women's Empowerment and Gender Equality
- Promotion of Equality and Prevention of unfair Discrimination Act of 2000

Priorities

- Strengthen the gender unit
- Capacitate managers on the Gender Policy Guidelines
- Build gender equality within the Health Delivery System itself
- Gender-sensitize health policies and legislation
- Eliminate gender based discrimination in Human Resources
- Advocate for the creation of an equal balance between sexes in decision making positions
- Improve responsiveness to client needs

Strategic Goals

- Incorporate gender into all departmental policies and programmes
- Promoting gender equality and equity in organizational development

Table Gen 12: Objectives and Indicators for Gender

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Targets 2007/08	Targets 2008/09	Targets 2009/10
Train all staff in Gender Policy Guidelines	Number of staff trained in Gender Policy Guidelines		-	All senior managers	50 middle managers	60 middle managers
Coordinate and facilitate advocacy campaigns on gender issues	Two Advocacy campaigns coordinated and facilitated		2	2	2	2
Strengthen and coordinate strategic partnership	Number of National Health Gender Forum quarterly Meetings attended		3	4	4	4
	Number of Joint Monitoring and Evaluation Meetings attended		10	10	10	10
	Number of Provincial Health Gender Forum Meetings conducted		3	4	4	4

TABLE 13: Trends in provincial public health expenditure for Programme 1: Administration

	2003-04 Actual	2004-05 Actual	2005-06 Actual	2006-07 Estimate	2007-08 Projection	2008-09 Projection	2009-10 Projection
Current Prices							
Total	57,676,221	50,638,541	56,491,000	69,847,000	-	-	-
Total per person	70	62	69	85	-	-	-
Total per uninsured person	88	77	86	106	-	-	-
Total capital	661,168	468,000	4,194,000	836,000	-	-	-
Constant (2005/06) prices							
Total	62,521,024	52,714,748	56,491,000	66,564,191	58,963,194	62,093,705	65,286,195
Total per person	76	64	69	81	60	63	66
Total per uninsured person	95	80	86	101	75	79	83
Total capital	716,706	487,188	4,194,000	796,708	1,531,665	737,800	706,350

8. PROGRAMME 2: DISTRICT HEALTH SERVICES

8.1 DISTRICT HEALTH

Situational analysis

The provision of District Health Services focuses on a decentralized management system and an integrated provision of health care services. Structuring services in order to ensure equitable access to health care services remains a priority to the province.

The Northern Cape Province is divided into five districts namely:

- Frances Baard
- Pixley Ka Seme
- Kgalagadi
- Namakwa
- Siyanda

Frances Baard District has the largest population followed by Siyanda. The Namakwa District is characterized by large distances and sparse population.

The main health problems in the Pixley Ka Seme district are tuberculosis and HIV & AIDS. Due to the fact that several roads go through the area; the incidence seems to be especially high on those routes. A well established TB/HIV programme is in place which includes VCT/CHBC and PMTCT services. Since August 2004 an Anti Retroviral treatment site has been established.

Cross boundaries issues

Referrals to the Northern Cape including self-referrals from the Western Cape (Rietpoort Clinic and Molsvlei Clinic) are received at Garies Hospital in the Namakwa district. Kgalagadi District services patients across the boundary from North West province and at Hartswater from Taung, also in the North West province.

District hospitals

There are 14 Level I hospitals and 1 Level II hospital which is Gordonia Hospital. This hospital serves as a referral hospital for Siyanda and Namakwa.

Hospital Boards

Three out of the 14 level I district hospitals still have the old hospital boards in operation. New hospital boards are to be appointed in the near future for all district hospitals.

Gordonia hospital

Overcrowding of hospital with average bed occupancy of 120 – 140% at any one time.

De Aar hospital

Plans are underway to build a new hospital

Kuruman hospital

A new hospital for the Kgalagadi health district is critical. This will be influenced by the business plan drawn for tshwaragano and Kuruman

Table DHS14: District health service facilities by health district

Health district[1]	Facility type	No.	Population[2,5]	Population per PHC facility[5] or per hospital bed	Per capita utilisation[6]
Siyanda District	Non fixed clinics[3]	38	167 911	PHC-10 494	PHC – utilisation – 2.7
	Fixed Clinics[4]	10			
	CHCs	6			
	Sub-total clinics + CHCs	58			
	District hospitals	4			
Frances Baard District	**Non fixed clinics3**	5	259 490	PHC- 11 282	PHC – utilisation – 2.8
	Fixed Clinics	22			
	CHCs	1			
	Sub-total clinics + CHCs	28			
	District hospitals	4			
Pixley Ka Seme District	Non fixed clinics[3]	38	131686	PHC- 4 540	PHC – utilisation – 3.1
	Fixed Clinics[4]	27			
	CHCs	2			
	Sub-total clinics + CHCs	198			
	District hospitals	9			
Kgalagadi District	**Non fixed clinics**	1	36 881	PHC-6 147	PHC – utilisation – 3.9
	Fixed Clinics	6			
	CHCs	0			
	Sub-total clinics + CHCs	7			
	District hospitals	1			
Namakwa District	**Non fixed clinics**		86 489	PHC-2514	PHC – utilisation –3.4
	Fixed Clinics	22			
	CHCs	8			
	Sub-total clinics + CHCs	73			
	District hospitals	2			
Province	**Non fixed clinics3**		682 457	PHC- 6562	PHC – utilisation – 3.18
	Fixed Clinics4				
	CHCs				
	Sub-total clinics + CHCs				
	District hospitals				

Table DHS15: Personnel in district health services by health district

Health district	Personnel category[1]	Posts filled	Posts approved	Vacancy rate (%)	Number in post per 1000 uninsured people
Siyanda	**PHC facilities**				
	Medical officers	1.8(sessional Dr)	3	30	0.01
	Professional nurses	70	119	41.1	0.41
	Pharmacists	1	1	0	0.005
	Community health workers	225	285	21.05	1.3
	District hospitals				
	Medical officers	13 perm.12 Comm Serv.	46	45.6	0.15
	Professional nurses	115	151	23.8	0.68
	Pharmacists	3	6	50	0.01
Frances Baard	**PHC facilities**				
	Medical officers	0	2	100	0
	Professional nurses	110	115	5.5	0.7
	Pharmacists	0	2	100	0
	Community health workers	452	600	25	1.74
	District hospitals				
	Medical officers	5	6	16.7	.07
	Professional nurses	49	52	5.77	0.5
	Pharmacists	2	7	80	0.3
	PHC facilities				
Pixley K a Seme	Medical officers	10	12	17	0.08
	Professional nurses	80	103	22.3	0.61
	Pharmacists	4	4	0	0.03
	Community health workers	247	280	11.80	1.88
	District hospitals				
	Medical officers	14	16	12.5	0.11
	Professional nurses	80	104	23	0.61
	Pharmacists	5	5	0	0.04
	PHC facilities				
Kgalagadi	Medical officers	2	2	100	0.05
	Professional nurses	25	27	7.50	0.68
	Pharmacists	0	2	100	0
	Community health workers	90	90	0	2.44
	District hospitals				
	Medical officers	5	8	37.5	0.14
	Professional nurses	26	30	13.33	0.7
	Pharmacists	0	2	100	0
	PHC facilities				
Namakwa	Medical officers	6	8	25	0.07
	Professional nurses	62	94	34.04	0.71
	Pharmacists	3	4	25	0.03
	Community health workers	79	134	41.03	0.91
	District hospitals				
	Medical officers	9	10	10	0.02
	Professional nurses	44	47	6.4	0.51
	Pharmacists	2	2	0	0.02

Table DHS16: Situation analysis indicators for district health services

Indicator	Type	District 2005/06 Frances Baard	District 2005/06 Pixley Ka Seme	District 2005/06 Siyanda	District 2005/06 Namakwa	District 2005/06 Kgalagadi	National target 2003/4
Input							
Provincial PHC expenditure per uninsured person	R	156.33	224	152.40	112.5	-	0
Local government PHC expenditure per uninsured person	R	0	0	0	0	0	0
PHC expenditure (provincial plus local government) per uninsured person	R	0	0	0	0	0	227
Professional nurses in fixed PHC facilities per 100,000 uninsured person	No		60.75	41.69	71.69		107
Sub-districts offering full package of PHC services	%	50	60	50	75	50	60
EHS expenditure (provincial plus local govt) per uninsured person	R	0	0	0	0	0	9
Process							
Health districts with appointed manager	%	100	100	100	100	100	92
Health districts with plan as per DHP guidelines	%	100	100	100	100	100	48
Fixed PHC facilities with functioning community participation structure	%	0	25	12.3	0	70	69
Facility data timeliness rate for all PHC facilities	%	80	80	80	80	80	80
Output							
PHC total headcount	No	841 685	546 791	556 399	391664	144 782	0
Utilisation rate – PHC	No	2.8	3.1	2.7	3.4	3.9	2.3
Utilisation rate - PHC under 5 years	No	4.9	4.8	4.0	4.8	5.9	3.8
Quality							
Supervision rate	%	25	50	25	25	50	78
Fixed PHC facilities supported by a doctor at least once a week	%	100	100	100	85	100	31
Efficiency							
Provincial PHC expenditure per headcount at provincial PHC facilities	R	183	57	85.46	-	53.63	99
Expenditure (provincial plus LG) per headcount at public PHC facilities	R	0	0	0	0	0	99
Outcome							
Health districts with a single provider of PHC services	%	0	90	66	100	100	50

Table DHS17: Situation analysis indicators for district hospitals sub-programme

Indicator	Type	Province wide value 2001/02	District Frances Baard 2005/06	District Pixley Ka Seme 2005/06	District Siyanda 2005/06	District Namakwa 2005/06	District Kgalagadi 2005/06	National target 2003/4
Input								
Expenditure on hospital staff as % of district hospital expenditure	%	0	71	60	67.8	72	74	
Expenditure on drugs for hospital use as % of district hospital expend	%	0	20	24	-	-	6	11
Expenditure by district hospitals per uninsured person	R	0	207	470	360.61	-	380	
Process								
District hospitals with operational hospital board	%	0	16.6	33	0	0	0	76
District hospitals with appointed (not acting) CEO in post	%	0	17	15.3	0	100	0	69
Facility data timeliness rate for district hospitals	%	0	75	75	75	75	70	34
Output								
Caesarean section rate for district hospitals	%	0	21	6.9	10.22	15	13	12.5
Quality								
District hospitals with patient satisfaction survey using DoH template	%	0	70	11.11	0	O	85	10
District hospitals with clinical audit (M and M) meetings every month	%	0	8.3	10	100	O	80	36
Efficiency								
Average length of stay in district hospitals	Days	3.3	3.3	1.9	3.79	2.6	1.8	4.2
Bed utilisation rate (based on usable beds) in district hospitals	%	78.5	60.2	51	81.70	43	86	68
Expenditure per patient day equivalent in district hospitals	R	0	-	958	617.97	-	449.3	814 in 2003/04 prices
Outcome								
Case fatality rate in district hospitals for surgery separations	%	1.2	0	0.6	1.44	-	-	3.9

Policies

All policies applicable to District Health Systems and programmes to be implemented in the District

Priorities

- Ensure accessibility of services. Operating hours at clinics to be extended. All clinics with no hospital within a radius of 50 km or more to operate 24hours and in the event there is no adequate staff, a standby system to be implemented. All other clinics that have a hospital in the vicinity will extend service hours until 20:00
- Expand provision of Primary Health Care targeting full implementation of the PHC core package.
- Implement Batho Pele Principles at all health facilities.
- In an effort to generate revenue, the private preference beds principle will be rolled out to 10 additional District Hospitals providing level 1 health care services.
- A new approach to management (Supervisory posts at clinics and Management at Health Facilities) to be implemented
- Modernization and Maintenance of facilities
- Several new clinics and hospitals to be build in the Province during 2007/08
- New secondary hospitals to be build in De Aar and Upington
- ARV treatment sites to be expanded

Analysis of constraints and measures planned to overcome them

Constraints

- Shortage of staff especially in the Professional nurse category where there are often no applications for a post
- Lack of critical equipment at facility level
- Difficulty to cover all areas with limited staff and vehicles
- The status of Namaqua has to be corrected – the HR shortage is hampering delivery.
- Recruitment and retention of professional nurses, with resultant high mobility of staff.
- Lack of accommodation and other incentive (except for rural allowance) eg transport.
- Train nurses in PHC, Dispensing course, the use of computers and fax machine.
- Management and supervisory posts at all health facilities to be implemented
- The appointment of supervisors and clinic managers is not concluded
- Many PHC clinics are in need of major maintenance intervention e.g. painting, re-roofing and fencing.
- Budget to districts is not sufficient to cover all the needs
- No dedicated financial manager in the districts. A person to be appointed per district to solely deal with finances. This will help to see that all internal financial control measures are in place.
- Insufficient Human Resources in place especially the Professional Nurse. The shortage contributes to long waiting time at health facilities. Measures like fast queue system etc. to address this are not effective. Intake numbers for student nurse training has to be drastically increased to try and alleviate the shortage in future.

Measures planned to overcome them

- Budgeting process for districts or PHC to consider the DHER and DHP for the current year.
- The need for a different approach to recruitment of nurses (foreign, exchange programme, etc) we are recycling nurses.
- Training is critical to motivate and skill staff.

- The appointment of supervisors and clinic managers is critical to ensure quality of care.
- Appointment of all critical staff including clerks, nurses, ECP…
- PHC facilities to be prioritized for revitalization. Revitalization to include accommodation for staff.
- Improved allocation of appropriate transport vehicles for the districts
- Appropriate vehicles to be used for mobile service for the rural communities.
- Equitable share for all districts to access critical clinical equipment at all health facilities.
- Maintenance plan critical
- With the community service in place services like Physiotherapy, Speech and Occupational therapy, Radiography and pharmacy services have improved on coverage of all communities.
- District health information officers have been appointed during 2005/06.
- District Health Plan in place
- Functional integration of all services at facilities
- Some hospital boards and clinic committees do exist. This need to be strengthened
- National health programmes are implemented
- Primary Health Care Package is delivered at all facilities

Table DHS 18: Provincial objectives and performance indicators for district health services

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
To measure the workload per facility/nurse	PHC Headcount	2315164	2500 000	2500 500	2500 600	2500700
To facilitate appropriate funding/budget allocation for PHC	Provincial expenditure per uninsured persons at provincial PHC facilities	161	161	182	190	200
	Utilisation rate - PHC	3.0	3.5	3.5	3.5	3.5
To bring the utilization rate in line with the national norm.	Utilisation rate - PHC under 5 years	3.0	4	5	5	5
Improve quality of health care delivery	PHC Supervision rate	40	50	70	80	100

Table DHS 19: Provincial objectives and performance indicators for district hospitals

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
Measure number of surgical interventions	Number of separations	108 269	110 000	115 000	120 000	125 000
	Patient Day Equivalents	375 442	400 000	405 000	410 000	415 000
Estimate the utilization of OPD	OPD headcounts	111 544	120 000	130 000	140 000	
Measure the bed occupancy rate	Bed Utilisation Rate	65	68	70	72	75
Measure the number of caesarean section performed.	Caesarean Section Rate	14.8	14	12	11	11
	Average length of stay	3.0	3.1	3.2	3.5	4
	Expenditure per patient day equivalent	650	675	700	750	800

Table DHS20: Performance indicators for district health services

Indicator	Type	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10	National target 2007/08
Input							
Uninsured population served per fixed public PHC facility	No	6562	6500	6000	5500	5000	<10,000
Provincial PHC expenditure per uninsured person	R	161	165	165	165	165	0
Local government PHC expenditure per uninsured person	R	0	0	0	0	0	0
PHC expenditure (provincial plus local government) per uninsured person	R	0	0	0	0	0	274
Professional nurses in fixed PHC facilities per 100,000 uninsured person	No	68.28	70	80	90	100`	130
Sub-districts offering full package of PHC services	%	60	70	80	90	100	100
EHS expenditure (provincial plus local govt) per uninsured person	R	0	0	0	0	0	13

Indicator	Type	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10	National target 2007/08
Process							
Health districts with appointed manager	%	100	100	100	100	100	100
Health districts with plan as per DHP guidelines	%	100	100	100	100	100	100
Fixed PHC facilities with functioning community participation structure	%	22	50	100	100	100	100
Facility data timeliness rate for all PHC facilities	%	60	70	100	100	100	100
Output							
PHC total headcount	No	2315164	2500 000	2500500	2500 600	2500700	0
Utilisation rate - PHC	No	3.0	3.5	3.5	3.5	3.5	3.5
Utilisation rate - PHC under 5 years	No	3.0	4	4.5	5	5	5.0
Quality							
Supervision rate	%	40	50	70	80	100	100
Fixed PHC facilities supported by a doctor at least once a week	%	97	100	100	100	100	100
Efficiency							
Provincial PHC expenditure per headcount at provincial PHC facilities	R	58	60.00	70.00	78.00	78.00	78
Expenditure (provincial plus LG) per headcount at public PHC facilities	R	0	0	0	0	0	78
Outcome							
Health districts with a single provider of PHC services	%	66	100	100	100	100	100

Table DHS 21: Performance indicators for district hospitals sub-programme

Indicator	Type	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10	National target 2007/08
Input							
Expenditure on hospital staff as % of district hospital expenditure	%	68	68	65	62	62	62
Expenditure on drugs for hospital use as % of district hospital expend	%	0	0	0	0	0	11
Expenditure by district hospitals per uninsured person	R	675	700	800	850	900	900
Process							
District hospitals with operational hospital board	%	0	100	100	100	100	100
District hospitals with appointed (not acting) CEO in post	%	25	50	100	100	100	100
Facility data timeliness rate for district hospitals	%	75	80	85	90	95	100
Output							
Caesarean section rate for district hospitals	%	14.8	14	12	11	11	11
Quality							
District hospitals with patient satisfaction survey using DoH template	%	33	50	75	100	100	100
District hospitals with clinical audit (M and M) meetings every month	%	40	50	75	100	100	100
Efficiency							
Average length of stay in district hospitals	Days	14.8	14	12	11	11	11
Bed utilisation rate (based on usable beds) in district hospitals	%	65	68	70	72	75	
Expenditure per patient day equivalent in district hospitals	R	675	700	800	850	900	900
Outcome							
Case fatality rate in district hospitals for surgery separations	%	1.7	1.2	1	0.8	0.6	3.5

Table DHS22: Transfers[1] to municipalities and non-government organisations

Municipalities	**Purpose of transfer**	**Year 1 2005/06 MTEF projection)**	**Year 2 2006/07 (MTEF projection)**	**Year 3 2007/08 (MTEF projection)**
	Environmental & PHC services	6 861 074	7 419 720	7 000 000
Total municipalities	N/A	**6 861 074**	**7 419 720**	**7 000 000**
Non-government organisations				
Noord Kaap Vigs Forum	VCT & CHBC Programmes	1 250 000	2 000 000	2 500 000
Chis†ana	CHBC	1 046 800	1 500 000	2 000 000
Aids Council	0	300 000		
Nightingale Hospice	0	900 000	1 020 000	1 100 000
Mother Theresa	0	500 000	500 000	600 000
NGO Kgalagadi	0	120 000	120 000	120 000
Total NGOs	0	4 116 800	5 140 000	6 320 000

8.2 PRIORITY PROGRAMMES

8.2.1 QUALITY ASSURANCE

Situation analysis

Improving the quality of health care in districts and hospitals is something everyone, in management is, or should be, striving for. Quality of care is a priority in health service delivery, and is listed as a pillar in the development of a sound district health system. “A key lesson is that in many cases quality can be improved by making changes to health care systems without necessarily increasing resources.”

It is essential that there is an understanding of this within districts and hospitals so that management teams and units within these structures can be fully involved with any quality improvement process, and, more importantly, initiate their own quality improvement activities.

Many programmes have been introduced in an effort to improve the quality of health care at all levels. This included the launch of a patient’s rights charter nationally in 1999, followed by the provincial launch in 2003. In addition a national QA policy was developed in 2001, and the provincial QA policy is currently in draft form.

A provincial quality assurance unit is in place and it is tasked with the responsibility of instituting quality of care programmes across the health department (i.e. in hospitals, clinics, and programmes)

Policies

- The QA interventions are informed by the overarching
- Ten Point Plan of the *Health Sector Strategic Framework 1999 – 2004*,
- *Strategic Priorities for the National Health System 2004 - 2009*
- *National Policy on Quality in Health Care*, *Health Act 60 0f 2003,*
- *Chapter 10 of Constitution 1996, of the Republic of South Africa*

Strategic Goals

- Creating an environment in which health care quality can flourish
- Building the capacity to improve quality.

Priorities

- To establishment of Hospital boards for central hospitals, and to establish clinic committees were a need exists, in order to strengthen community participation
- To develop regulations or terms of reference to inform these structures.
- To continue district support visits at the remaining level one hospitals, including Kimberley hospital
- To develop quality assurance service delivery plans of all outstanding hospitals
- To develop a provincial infection control policy, and to strengthen the infection control programme across all public health institutions
- To pilot the infection control quality assessment tools at Kimberley and Kuruman hospital, and to document all findings accordingly.
- To reposition the clinic supervision, and to roll it out in all five districts
- To functionalise our quality and infection control structures at provincial and district level
- To forge partnerships with Council for health service accreditation of South Africa (COHSASA) in the development and monitoring of health care standards

Analysis of constraints and measures planned to overcome them

Constraints

- Shortage of staff within the provincial quality assurance sub- directorate in order to deliver interventions in response to the goals and objectives of the unit.
- The establishment of a standard compliance unit or inspectorate within the department, in support of conducting clinical audit programmes and the development of a clinical risk policy
- The lack of dedicated quality assurance coordinators or link persons within the district
- Delays in the overall roll out of the clinic supervision programme, and poor coordination and feedback
- Poor coordination, in particular routing of complaints from the facilities (attributed to staff shortage and facility and district level)

Measures to overcome constraints

- Renew the organogram for the quality assurance directorate, and appoint additional staff according to strategic need (e.g. infection control manager (AD), quality assurance manager (AD), Clinic audit manager, preferably a medical doctor, two senior administration officers
- Reconstitute Provincial Quality Assurance Committee that will be responsible for setting performance standards, and monitoring compliance
- Strengthen intradepartmental relationships, e.g. joint planning between outbreak response, environmental health, mental health, health promotion, pharmaceutical services, hospital revitalization programme, emergency services, district health services and other related programmes
- Embark support visits or benchmarking exercises in other provinces with best practice programmes

Table QA 23: Provincial objectives and performance indicators for Quality Assurance

Objective	Indicator	2005/06 (Actual)	2006/07 (Estimate)	2007/08 (Target)	2008/09 (Target)	2009/10 (Target)
Provision of programme management capacity	Number of staff employed	-	3	6	8	8
Conduct clinical audits at public sector hospitals	Percentage of public sector hospitals performing clinical audits	10%	50%	70%	100%	100%
Resolve complaints within 25 days	Percentage of complaints resolved within 25 days	95%	100%	100%	100%	100%
Conduct client satisfaction surveys at facilities	Percentage of facilities that have conducted an external client satisfaction survey and published results within the last 12 months	0	0	75%	100%	100%
Monitor the implementation complaints	Percentage of facilities implementing the	65%	70%	75%	100%	100%

Objective	Indicator	2005/06 (Actual)	2006/07 (Estimate)	2007/08 (Target)	2008/09 (Target)	2009/10 (Target)
procedure in the five districts	complaints procedures in the districts.					
Integrate the total quality management approach at 80 % of facilities and programmes	% Of facilities implementing Total Quality management (TQM)	20%	30%	80%	100%	100%
Strengthen public awareness on QA activities	Number of awareness sessions held (radio talk slots)	2	20	20	20	20
	Number of QA conference or workshops/seminar held	-	2	2	2	2
	Number of hosp. Boars established	0	0	3	5	5
	Number of QA committees established	0	4	10	20	20
	Number of clinic committees established	0	3	10	20	20
Audit compliance of districts with the implementation of the PHC package.	% Of Districts implementing the complete PHC package.	70%	75%	80%	85%	90%
Audit the implementation of supervision programme in all Districts	% Of Districts implementing a strategic supervision system	20%	65%	70%	100%	100%
Accredit public health hospitals	% Of hospitals supported through COHSASA accreditation process	-	-	50%	80%	100%
Develop an effective marketing and communications strategy	%Promotional material/articles procured (toll free line, news paper articles)	-	40%	60%	80%	100%

8.2.2 MATERNAL, CHILD AND WOMEN'S HEALTH (MCWH)

Situation analysis

Maternal Health

The maternal mortality ratio for 2006 is 308 per 100 000 per annum. There is a substaintial increase in the ratio, which could be attributed to the scourge of HIV/AIDS, which undermines efforts to reduce maternal mortality due to indirect causes. On the other hand the data from DHIS is not totally reliable as data is still outstanding from some facilities in the province, which definitely have an impact on the maternal mortality ratio.

The maternal death notification process is in place since 1998, to notify all maternal deaths to the National Committee for Confidential Enquiries into Maternal Deaths (NCCEMD). All women that die anytime from conception up to 42 days after delivery are classified as maternal deaths. This also includes deaths that occur after a termination of pregnancy (TOP) was performed as well as co-incidental deaths, like motor vehicle accidents, suicide etc.

Presently there are 134 fixed primary health care facilities of which 109 are providing antenatal services, these are complemented by satellite and / or mobile clinics.

Peri-natal mortality rate has increased from 51/1 000 to 60.0/1 000 during the previous financial year. The neonatal mortality rate is at 12,7/1 000. Still born: Neonatal death ration: 4.0:1. Focus should be on our antenatal care and Intrapartum care because it is quite evident that our babies die before they are born. More training on the peri-natal education programme (PEP) is needed. This is distance training. Seven PPIP sites are presently operational with plans to increase the sites from seven to nine (Prieska and Douglas Hospitals). Foetal alcohol syndrome is a challenge in our province and two workshops has been conducted.

Due to the high prematurity rate in the province Kangaroo Mother Care is encouraged. All level one hospitals are providing Kangaroo Mother Care. This is a challenge because of the infrastructure as it cannot be provided continuously at some of the hospitals. Kimberley Hospital Complex is the only hospital that has a full Kangaroo Mother Care unit and the breast feeding lodge.

Contraceptive services integrated into PMTCT and HIV/AIDS were financed and conducted by Family Health International in all five districts for professional nurses and counsellors. Ten professional nurses were trained in pap smear taking. They will now train other nurses in pap smear taking. The Department is planning to extend the termination of pregnancy (TOP) services to De Aar, Postmasburg, Colesburg, Warrenton and Douglas. The CTOP amended act was challenged by the non governmental organizations. In response to this a range of provincial consultative meetings were scheduled, which commenced in February 2007 and to be continued in March and April 2007.

Child Health

The number of trained IMCI practitioners has increased from 265 to 282. The number could have been less but for pre-service training where 17 final year pre-service nurses exited the college with IMCI case management skills.

The total numbers of health facilities that are implementing IMCI are 130. There are 100 health facilities implementing IMCI at 60% saturation. The IMCI strategy is still being offered as a short course at the nursing college pending inclusion into the 4 years basic curriculum. No doctors were trained in IMCI because from 33 doctors trained only 7 are remaining. Only 4 are actively involved in active IMCI activities. Anti retroviral therapy in paediatrics algorithm has been included in IMCI.

The incidence of diarrhoea <5 years increased from 11% to 27.1% with the mortality of 3, 9. The incidence of pneumonia <5 years is currently at 26.1 from the previous 11.52%. Community IMCI sites are still 8.

School health services are implemented in all 5 districts. A clinic adopts a cluster of schools in its catchment area to render health services. Frances Baard has appointed two Professional Nurses to do the follow-up in schools and at the homes of affected children.

The immunization status of children fully immunized <1 year remains above the 90% range from 103% to 96.7% provincially. Hundred percent of acute flaccid paralysis (AFP) was detected with 100% stool adequacy. Measles 1st dose coverage in children <1 year remained constant at 100%.

Polio campaign conducted in Siyanda and Namaqualand district 10 – 21 July 2006. The coverage obtained in these districts were Siyanda = 94% and Namaqualand = 90%. This campaign was done because of the outbreak of polio in Namibia and these districts are bordering Namibia.

A similar polio campaign was conducted throughout the province in October 2006 with 90% coverage. Pre-campaign evaluations were done during both rounds. The (RED) Reach Every District Strategy workshop was held in Bloemfontein in November 2006. All districts were presented. This strategy is to be implemented throughout the province.

Health facility visits regarding Extended Programme on Immunization (EPI) done in the Kgalagadi, Namakwa, Frances Baard, Siyanda and Pixley ka Seme districts. Training on EPI Disease Surveillance was done in November 2005 in the Frances Baard district.

Youth and Adolescent Health

The current rate of teenage delivery in the province is at 8.9%. There is a decrease on the teenage deliveries under 18 years of age, however, there is a high rate of termination of pregnancies amongst teenagers, especially above 12 weeks.

Health Care Workers Training on Youth Friendly Services

The Health Care Workers training on Youth Friendly Services (YFS) started in 2001 and the total number of trained health care workers to date is at 230. The following activities took place during the 2006/07 financial year**:**

- Six Life Skills Workshops were held in the Frances Baard, Siyanda and Pixley Ka Seme districts
- Two HIV and AIDS awareness campaign in the Frances Baard and Siyanda districts targeting young people, and
- The first Youth Indaba was held in Nelspruit, Mpumalanga. The second national youth indaba will be hosted by the Northern Cape Province in June 2007.

Prevention of Mother to Child Transmission – HIV/AIDS

The prevention of mother to child transmission of HIV programme was implemented in the province as from 2001. The programme has expanded from the 7 pilot sites to 122 sites out of 134 in the province. To date – 151 health professionals had been trained in the programme. The HIV testing uptake varies from 90 – 80% with the coverage of 80%. Polymerase Chain Reaction (PCR) testing is being done in all primary health care facilities and hospitals.

Table MCWH 24: Situation analysis indicators for MCWH

Indicator	Type	Province wide value 2004/05	Province wide value 2005/06	Province wide value 2006/07	FB 2006/07	Siyanda 2006/07	Pixley 2006/07	Kgalagadi 2006/07	Namaqua 2006/07	National Target 2007/08
Incidence										
First trimester functional TOP services	%	40%	40%	40%	20%	20%	0%	0%	0%	100%
Second trimester functional TOP services	%	35%	35%	35%	35%	0%	0%	0%	0%	70%
Fixed PHC's offering PMTCT	%		64%	81,3	92%	44,4	96,4	86%	94,2	100%
Process										
AFP detection rate	%	100%	100%	100%	100 %	200%	100 %	0%	100 %	100%
AFP stool adequacy rate	%	100%	100%	100%	100 %	100%	100 %	0%	100 %	100%
Output										
Schools at which phase 1 health services are being rendered	%	100%	100%	87%	50%	20%	10%	1%	5%	100%
(Full) Immunisation coverage under 1 year	%	96.2%	103%	96,7%	100.2 %	7680.1 %	121.6 %	153.2 %	62.8 %	90%
Antenatal coverage	%	113,5	110,1	105,8	116,8	93,1	115,4	225,8	73,4	80%
Measles coverage under 1 year	%	96.2%	107.6%	97.8%	99.8 %	83.1%	122.7 %	168.3 %	60.4 %	90%
Antenatal visits per antenatal client		4,3	4.5	4,9	4,8	4,5	5,1	4,2	6,1	5
Tetanus Toxoid protection for pregnant women rate	%	57,7	60,8	74,2	72,7	46,5	72,8	137,5	41,8	80%
First Antenatal visit before 20 weeks rate	%	47,5	46,4	48,6	34,4	51,3	56,5	29,9	62,2	50%
Fixed PHC facilities implementing IMCI	%	70%	75%	65%	70%	68%	67%	50%	66%	80%
Target population screened for cervical cancer	%	2%	2%	3%	4%	3%	3%	5%	2%	7%
Quality										
Facilities certified as baby friendly	%	13	17	30				20		
Fixed PHC facilities certified as youth friendly	%	80	80	127	31	21	33	35		
Fixed PHC facilities implementing IMCI	%	70%	75%	65%	70%	68%	67%	66%	50%	80%
Outcome										
Institutional delivery rate for women under 18 years	%	11.3%	88%	8.7%	8.3%	8.7%	8.4%	9.3%		
Not gaining weight under 5 years	%	39.7%	40.3%	44.9%	43.2	56.06	41.04	51.3		

Indicator	Type	Province wide value 2007/08	Province wide value 2008/09	Province wide value 2009/10	District A 2003/04	District B 2003/04	District C 2003/04	National target 2003/4
Incidence								
Hospitals offering TOP services	%	100%	100%	100%	100%	100%	0%	0%
CHCs offering TOP services	%	100%	100%	100%	100%	0%	0%	0%
Process								
Fixed PHC facilities with DTP-Hib vaccine stock out	%	-	-	-	-	-	-	
AFP detection rate	%	100%	50.9%	100%	100%	100%	0%	0%
AFP stool adequacy rate	%	100%	100%	50%	50%	50%	0%	0%
Output								
Schools at which phase 1 health services are being rendered	%	100%	100%	50%	50%	50%	0%	0%
(Full) Immunisation coverage under 1 year	%	91.3%	96.2%	97%	94	76	82	116
Antenatal coverage	%	97,35%	108,5%	106,2%	91,3	83,8	103,9	130,1
Vitamin A coverage under 1 year	%							
Measles coverage under 1 year	%	93,1%	99,3%	101%	97%	83%	90%	118%
(Full) Immunisation coverage under 1 year	%	-	1.9%	2.6%	3.41%	4.4%	6%	2.7%
Antenatal coverage	%							
Vitamin A coverage under 1 year	%	0	0	25%	5%	5%	5%	5%
Measles coverage under 1 year	%							90
Cervical cancer screening coverage	%							15
Quality								
Facilities certified as baby friendly	%	13	17	30				20
Fixed PHC facilities certified	%	80	80	127	31	21	33	35

Indicator	Type	Province wide value 2007/08	Province wide value 2008/09	Province wide value 2009/10	District A 2003/04	District B 2003/04	District C 2003/04	National target 2003/4
as youth friendly								
Fixed PHC facilities implementing IMCI	%	-	-	-	-	-	-	
Outcome								
Institutional delivery rate for women under 18 years	%	11.3%	88%	8.7%	8.3%	8.7%	8.4%	9.3%
Not gaining weight under 5 years	%	39.7%	40.3%	44.9%	43.2	56.06	41.04	51.3

Policies

- The ten point plan of the Sector Strategic Framework
- Millennium Development goals
- School Health Policy
- National Youth and Adolescent Policy Guidelines
- Health Act 61of 2003
- Child Care amendment Act 96 of 1996
- Policy and management guidelines for common causes of maternal deaths
- Maternity care guidelines
- Maternal death act of 1997(Act 63 of 1977)
- Integrated management of childhood illnesses guidelines
- EPI Disease Surveillance policy guidelines
- Choice of Termination of Pregnancy act (Act 92 of 1996)
- National Contraceptive framework and policy guidelines
- National Youth Commission amendment act 19 of 2001
- Public Finance Management Act.
- Genetic policy guidelines
- Saving babies 2003
- CCMT Policy guidelines

Priorities

- Reduction in the maternal and childhood morbidity and mortality rate
- Ensure that all PHC facilities have at least four health workers trained in IMCI case management in all districts
- Implement the Household and Community component of IMCI in at least two sites per district
- Intensify cervical cancer screening in rural areas. Provision of a comprehensive reproductive health service for men and women
- Improve access to HIV testing and counselling at ANC clinics
- Extend choice on termination of pregnancy services to all districts
- Decrease the infant and child mortality rate.
- Maintain immunization coverage in all districts
- Reduce the Perinatal morbidity and mortality.
- Reduce the incidence of birth defects.
- Conduct a successful health facility survey as a monitoring and evaluation

Strategic goal

To improve the health of mothers, babies, women and youth by reducing morbidity and mortality and promoting the quality of life.

Analysis of constraints and Measures to overcome constraints

Constraints

- No MCWH coordinators in the districts.
- Problems with high staff-turn over in the districts
- Choice of Termination of Pregnancy (CTOP) is not accepted in the primary health care service.
- Inadequate budget
- Vastness of the province which impacts on the monitoring and evaluation
- Unavailability of doctors

Measures to overcome constraints

- Recommend appointment of MCWH coordinators at district level.
- Recognize and acknowledge scarce skills.
- Choice of Termination of Pregnancy (CTOP) to be addressed by senior management
- Senior management to address inadequate budget.

Table MCWH 25: Provincial objectives and performance indicators for MCWH

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
To monitor that all deliveries occur in health care facilities	Total Deliveries at all facilities	15 618	17 000	18 000	19 000	20 000
Reduce the proportion of births among girls < 18 years	Teenage delivery rate	9	8	7	6	5
Improve immunization coverage	Full Immunisation coverage	96.7%	90%	95%	95%	95%
Achieve Polio immunization coverage	Declared Polio free	100%	2 cases per 100 000 children under 15 years of age	2 cases per 100 000 children under 15 years of age	Declared Polio Free by December 2008	Polio free
Achieve measles elimination	% Reduction of measles cases	3	Reduce by 80% from the total cases reported in 2006	Elimination status reached	Maintain elimination status	Maintain elimination status

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
To improve access to ARV for pregnant women	% of health facilities with providers trained in PMTCT and ARV programme	91,2%	95%	96%	100%	100%
Improved interventions to deal with HIV and AIDS	Number of facilities that offer PMTCT	122	125	128	130	135
	% pf pregnant women testing for HIV	70%	85%	90%	100%	100%
To saturate PHC facilities with skilled IMCI practitioners	Total of PHC facilities with 80% saturation of IMCI practitioners	67%	70%	80%	90%	95%
Improve the first antenatal visits before 20 weeks	First antenatal visits before 20 weeks rate	46,4%	50%	52%	55%	60%
Improve the tetanus Toxoid protection rate for pregnant women	Tetanus Toxoid protection for pregnant women rate	60,8%	65%	70%	75%	80%
To reduce the number of mortalities from unsafe abortion	Percentage of first trimester functional TOP services	40%	40%	60%	100%	100%
	Percentage of second trimester functional TOP services	35%	35%	70%	70%	75%
To screen women aged 30 years and above for cervical cancer	Percentage of target population screened for cervical cancer	2%	3%	7%	70% (over ten years from the date of initiation)	70% (over ten years from the date of initiation)
To promote contraceptive use through education and service delivery	Percentage of tubal ligations in women over 35 years of age and parity 5 or more	2%	8%	60%	60%	70%
	Percentage of women using contraceptives	29.5%	31.4%	60%	60%	70%

Table MCWH 26: Performance indicators for MCWH

Indicator	Type	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	National target 2007/08
Incidence								
Incidence of severe malnutrition under 5 years	%							
Incidence of pneumonia under 5 years	%	8,68	11,52	26,1	23,1	20,1	17,1	3%
Incidence of diarrhea with dehydration under 5 years	%	No data	11%	27.1%	24.1%	21.1%	17,1	5%
Input								
IMCI Case management courses conducted	%	70%	75%	33%	70%	80%	95%	100%
First trimester functional TOP services	%	40%	40%	40%	100%	100%	100%	100%
Second trimester functional TOP services	%	35%	35%	35%	70%	70%	70%	70%
Advertising strategies for TOP services	%	0%	0%	0%	100%	100%	100%	100%
Target population screened for cervical cancer	%	2%	3%	3%	7%	7%	7%	70%
Women using contraceptives	%	29.5%	29.2%	31.4%	60%	60%	60%	60%
Tubal ligations done in women over 35 years of age and parity 5 or more	%	2%	2%	8%	60%	60%	60%	60%
Process								
AFP detection rate	%	100%	100%	100%	100%	100%	100%	100%
AFP stool adequacy rate	%	100%	100%	100%	100%	100%	100%	100%
Output								
Antenatal coverage	%	113,5	110,1	105,8	90%	80%	80%	80%
First antenatal visits before 20 weeks rate	%	47,5	46,4	50	52	55	60	50%
Antenatal visits per antenatal clients		4,3	4,5	4,2	4,8	4,9	5	5
Tetanus Toxoid protection for pregnant women rate	%	57,7	60,8	74,2	76	78	80	80%
Monitoring and evaluation of trained IMCI practitioners	%	40%	60%	80%	90%	100%	100%	
Schools at which phase 1 health services are being rendered	%	0	13%	20%	40%	60%		
(Full) Immunisation coverage under 1 year	%	103%	96.7%	90%	95%	95%	95%	95%
Antenatal coverage	%	113.1	109.6	100%	100%	100%	80%	
Vitamin A coverage under 1 year	%						80%	

Indicator	Type	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	National target 2007/08
Measles coverage under 1 year	%	109.1%	97.8%	90%	95%	95%	90%	90%
Cervical cancer screening coverage	%	2.6%	3.5%	10%	15%	20%	15	
Quality								
Health Facility	%	0%	0%	100%	0%	0%	100%	100%
Facilities certified as baby friendly	%	35	37	37	40	42	30	
Fixed PHC facilities certified as youth friendly	%	20%	20%	30%	30%	30%	30	
Fixed PHC facilities implementing IMCI	%	67%	70%	75%	70%	80%	90%	100%
Outcome								
Trained IMCI practitioners implementing IMCI	%	60%	70%	80%	67%	70%	90%	100%
Not gaining weight under 5 years	%	4,5	4	3,5	3	2,5		
Incidence								
The % of ANC clients testing HIV	%	40%	57%	85%	90%	95%	100 %	
Input								
Fixed facilities offering PMTCT services	No	7	84	122	128	130		

8.2.3 HEALTH PROMOTION

Situation analysis

The core business of the unit is to create and develop comprehensive community based programmes. These are; enhance community participation in the health education activities, promote healthy lifestyles among communities, create a health conscious community, implement the health promoting schools initiative and create awareness on epidemic preparedness and outbreak response.

In the previous financial year, the unit paid more attention on strengthening different Health Promotion activities in the districts. Primary focus was paid on the establishment of community health promotion forums, the identification and confirmation by the Department of Education of 32 new Health Promoting schools, training of both provincial and district health promotion personnel on organic method of growing food gardens for both schools and health facilities, creating health consciousness through radio talks, participate in outbreak awareness campaigns on polio alert, cremian congo fever in the Siyanda district, e.t.c. and jointly hosted and participated in health calendar activities with other units within the department and other government events.

Policies

- Draft National Health Promotion Policy
- Tobacco Control Amendment Act , (Act 12 of 1999)
- Convention of the Rights of the Child, 1997 – Chapters 5 and 7;
- South African Schools Act, 1996 and
- Child Care Act, 1983.

Strategic Goals

- Develop integrated and comprehensive community awareness, empowerment programmes.
- Design and implement awareness and advocacy strategies for health calendar and other departmental programmes.
- Facilitate community liaison linkages to ensure full community participation
- Develop awareness and advocacy programmes for emerging and re – emerging diseases
- Implement the Health Promoting Schools initiative

Analysis of constraints

- Lack of health consciousness among communities
- Lack of strategic partnerships with other organizations and departments
- Lack of use of electronic media in most health facilities and in the community

Measures planned to overcome them

- Regular surveillance of emerging and re-emerging diseases and strengthen health awareness campaigns in the community
- Strengthen all health education initiatives
- Strengthen relations with existing health organizations and other government Departments

- Establish community liaison linkages and hosting of regular community information sessions

Table HP 27: Provincial objectives and performance indicators for HP

Measurable Objective	Indicator	Actual 2005/06	2006/07 Estimate	2007/08 Target	2008/09 Target	2009/10 Target
Establishment of functional community health promotion forums	Number of functional health promotion forums	0	12	20	30	60
Development of comprehensive community development programmes	Number of people participating in physical activity programmes	0	450	900	1350	1800
Implement worksite physical activity programmes e.g. soccer, netball, fun walk, ball room dance	Number of personnel participating in sporting codes	200	300	500	650	800
Monitor the implementation of Tobacco Control Amendment Act	Number of public places visited to enforce compliance	0	20	40	60	80
Coordinate debates, poster design, essay writing at schools and communities on drug, and alcohol abuse	Number of activities aimed at reduction of drug and alcohol abuse	0	5	15	20	30
Implement 200 community based food garden projects	Number of food garden projects	3	15	20	30	50
Design and implement health awareness and advocacy campaigns in line with the health calendar	Number of towns receiving multi-media awareness campaigns per municipal area	0	125	150	200	250
	Number of health calendar activities hosted	18	18	20	22	25
Ensure and maintain a healthy and safe schooling environment	Number of schools implementing the HPS initiative	13	25	50	75	105
Implement health promotion plan based on alert and endemic threshold of priority diseases	Number of community information sessions held in line with threshold of priority diseases	8	12	16	20	20

8.2.4 ENVIRONMENTAL HEALTH

Situation Analysis

The sector in health that directly deals with the correlation between the environment and health is the environmental health sector. The National Health Act, 2003 (Act 61 of 2003) effectively divided environmental health into municipal health services, to be rendered by district and metropolitan municipalities, and environmental health services to be rendered by the various Departments of Health (national and provincial).

The Constitution of the Republic of South Africa (Act 108 of 1996) in Chapter 2 states it clearly that everyone has the right to an environment that is not harmful to his/her health or well-being. Environmental health is a preventative service and focuses on the correlation between the environment and human health. Primarily this service is being guided by legislation (international, national, provincial and local government municipal by-laws). At provincial level the core function of the Environmental Health unit is the rendering of port health services, malaria control and the control over hazardous substances. The provincial department of health also has the responsibility of planning, coordinating, monitoring and evaluating health services, including municipal health services, as well as controlling the quality of these health services.

Environmental health is a comprehensive service that cuts across a wide operational spectrum. The environmental health unit therefore operates at all government levels and in collaboration with various government departments.

Daily interaction with local and district municipalities are necessary to ensure that environmental health matters, in the areas of jurisdiction of these municipalities, are dealt with effectively. This can vary from dealing with complaints to strategizing and planning for the rendering of services as well as information sharing. Frequent interaction with the National Department of Health is also necessary as information needs to flow between the National Government and Provincial Government.

Collaboration with other provincial and national departments, such as the Department of Water Affairs and Forestry, the Department of Labour, the Department of Tourism, Environment and Conservation, etc. is an integral part of the operational environment of this unit. There is frequent, essential contact with other provincial Environmental Health units, especially in provinces bordering on the Northern Cape.

Currently international contact is very limited, but when this service is fully operational more contact with neighboring countries, and in particular Namibia and Botswana, can be expected. Internally this unit frequently collaborates with units such as Communicable Disease Control, HIV and Aids, Health Promotion, etc. This unit also collaborates with the five district offices regarding issues such as information sharing, port health services, chemical safety, hazardous substances, campaigns, outbreaks and community services.

In order for the unit to function effectively and achieve its objectives it is crucial that a second Assistant Director be appointed as a matter of urgency. The current vacancy rate makes it difficult for the unit to interact with all stakeholders mentioned as frequently as is required. This will relieve a great deal of pressure on the Manager enabling him to focus on strategic leadership in the programme.

Legal and Policy Framework

- The Constitution of South Africa (Act 108 of 1996)
- The National Health Act (Act 61 of 2003)
- The International Health Regulations Act (Act 28 of 1974)
- The Foodstuffs, Cosmetics and Disinfectants Act (Act 54 of 1972)
- The Hazardous Substances Control Act (Act 15 of 1973)
- The Tobacco Products Control Amendment Act (Act 12 of 1999)
- The Environment Conservation Act (Act 73 of 1989)
- National Environmental Management Act (Act 107 of 1998)

- Provincial ordinances (mostly of the then Province of the Cape of Good Hope)
- Municipal by-laws
- Amendments to and regulations under mentioned legislation

Priorities

- Appointment, authorization and induction training of adequate number of Port Health Officers at designated land ports of entry as per the International Health Regulations Act (Act 28 of 1974)
- More effective rendering of port health services at Upington International Airport by stationing the Siyanda environmental health personnel at the airport.
- Implementing the National Health and Hygiene Strategy for Water Supply and Sanitation Services after finalizing the provincial implementation plan.
- Finalize and implement the provincial malaria surveillance and prevention plan, specifically in the Siyanda and Kgalagadi districts.
- Reduce the turn around time for the issuing of licenses and evaluation of hazardous substances premises in accordance with the Hazardous Substances Act (Act 15 of 1973)
- Develop and update the data base of all dealers in hazardous substances, licensed or not.
- Review the data base of all health care risk waste generators in the province.
- Develop a data management system for environmental health indicators in line with the national health indicators.
- Continuous staff development in the unit.
- Develop an Environmental Health plan for the Northern Cape for the FIFA World Cup 2010.
- Appointment of adequate management personnel at the provincial office.

Strategic Goal

Creating an environment that is not harmful to the health and well being of everyone in the Northern Cape Province. This will include people living in the province and also people visiting or traveling through the province.

Analysis of Constraints and Measures to Overcome Them
Constraints

- Providing offices and accommodation for port health officers at Nakop and Vioolsdrift border control posts before appointment, authorization and induction training of adequate number of Port Health Officers can take place.
- Rendering environmental health services (including municipal health services) in a legal, effective and coordinated manner throughout the province in order to achieve the objectives of the programme and focus on the environmental health indicators.
- Management of health care risk waste throughout the province.
- Lack of Environmental Health personnel at Provincial, district and municipal level. Inadequate number of management personnel at the provincial office adds a lot of extra pressure on existing personnel.

Measures to Overcome Constraints

- The HOD of Health should initiate high level political intervention through the MEC for Health and the MEC for Housing and Local Government as district municipalities' effectiveness and service delivery is also a Local Government matter.

- Funding to be availed, by the Northern Cape Department of Health and the Development Committee of the National Border Control Operational Coordinating Committee (BCOCC), to provide the necessary accommodation and infrastructure/equipment at Nakop and Vioolsdrift.
- The unit will become actively involved in surveillance of health care risk waste generators and involve itself whenever service contracts need to be finalized.
- Appointment of a second Assistant Director at the provincial office and staffing of district offices. Devolution of municipal health services should address staff shortages at municipal level.

Table EH 28: Objectives and Indicators For Environmental Health

Objective	Indicators	Actual 2005/6	Estimate 2006/7	Target 2007/08	Target 2008/9	Target 2009/10
Coordinate malaria Control	A surveillance programme in place.	0	1	1	1	1
	Number of actions of Surveillance /education.	0	5	20	20	20
	% of cases investigated.	0	No cases.	100%	100%	100%
	% of locations /areas sprayed following cases reported.	0	Spraying to follow cases.	100%	100%	100%
Render effective port health services	% of aircraft cleared at Upington airport.	0	90%	100%	100%	100%
	% of consignments cleared at Nakop & Vioolsdrift border posts.	0	0%	50%	100%	100%
Coordinate control of hazardous substances and premises	Number of premises complying with legislation and licensed.	0	56	60	60	65
	Number of education sessions conducted to hazardous substances retailers.	0	56	60	60	65
Coordinate a chemical safety programme	% of organophosphate poisoning investigated after being reported.	0	80%	100%	100%	100%
	Number of education sessions held.	0		20	20	30
Surveillance of health care risk waste management	Number of health care risk waste generators complying with guidelines & legislation.	0	27	80	132	132
Surveillance of Department of Health premises	Number of hospitals surveyed.	0	0	6	22	22
	Number of Community Health Centres (CHC) surveyed.	0	0	4	16	16
	Number of clinics surveyed.	0	0	21	85	85

Objective	Indicators	Actual 2005/6	Estimate 2006/7	Target 2007/08	Target 2008/9	Target 2009/10
	Number of government mortuaries surveyed.	0	0	7	7	7
Revival of district environmental health forums	Number of district environmental health forums functional.	0	5	5	5	5
Facilitating the functioning of the provincial environmental health forum	Number of provincial environmental health meetings held.	0	1	4	4	4
Implementing the National Health & Hygiene Strategy relating to Water supply & Sanitation services	Implementation of the National Health & Hygiene Strategy in all 5 districts.	0	0	1 per district	1 per district	1 per district
Develop and implement a data base for environmental health.	An environmental health data base developed and implemented in line with the national environmental health indicators	0	1	1	1	1
Managing environmental protection	% of environmental development applications received and commented on.	0	100%	100%	100%	100%
Managing exhumations & reburials	% of applications for exhumations & reburials received and attended to.	0	100%	100%	100%	100%
	A provincial act on exhumations & related issues finalized and enacted by the provincial legislature.	0	0	1	0	0
Develop a provincial plan for Environmental Health for the 2010 FIFA World Cup	A provincial environmental health plan, for the FIFA World Cup, developed.	0	0	1	0	0
	5 District implementation plans for 2010 developed.	0	0	5	0	0
Developing the staff of the environmental health unit	Number of training sessions / workshops attended.	0	10	20	20	20

8.2.5 ORAL HEALTH

Situation analysis

Oral Health Services are provided at a primary and secondary level in the province. The services are provided from all major centers including Springbok, Calvinia, Upington, De Aar, Kuruman and Kimberley. Many clinics and rural areas are served by our outreach programme by road and by Red Cross flights. Schools oral health services are also rendered from some major centres especially from Kimberley. One community service dentist (CSD) is based at each of these centres whilst five are based in Kimberley and one in Kimberley Hospital Complex, who assist the principal dentist there. All the districts have 1 permanent Dentist who mentor and support the CSD.

Policies

National Oral Health Strategy Document

Priorities

- Preventive, promotive, curative and rehabilitative oral health services should be provided in the Province.
- Planning of services should be geared towards ensuring that Oral Health Services are accessible to everybody in the Northern Cape.
- Increase PHC-facilities, through the province, delivering oral health care services by ensuring that these services are being made available in all districts hospitals, CHC and Mobile units.
- Emphasis should be on the preventative approach with health education being a priority. School oral health services should be incorporated within the primary health care approach.
- Promotive services should focus on the determinants of health and disease. Oral health services should be coordinated with other health programmes within the Department viz. Health Promotion and Mother, Child and Woman Health and with programs offered by other departments such as Education.
- On the building of clinics and upgrading programme, oral health programme managers must be consulted at the planning stage. All accommodation plans and needs for public oral health services will be dealt with in accordance with the health facilities planning directives.
- The regular maintenance of oral health equipment is an essential part of our efficient oral health service. Special measures will have to be instituted to ensure the cost effective, speedily available and effective maintenance of equipment. In order to achieve this, contracts will be drawn up with locally recommended service and maintenance companies.

Strategic Goal

- Compliance with the oral health policy
- Provision of a full package in oral health
- Increase human resource
- Provision of specialized services
- Reduce referrals
- Increase awareness programmes
- Sustainability in services
- Increase capacity training and development

Analysis of constraints and Measures to overcome them
Constraints

- Unable to acquire dental mobile units and employ more oral health personnel due to budgetary constraints.
- Lack of proper equipment in most clinics
- Also when some services were decentralized like oral health the budget stayed behind thus putting a lot of pressure in the already limited budget for the districts.
- No survey has been done to determine exactly where we are, due to the difficulty in acquiring a specialist in community dentistry.
- Most clinics are dilapidated, still waiting for the approval of their upgrading
- Most workshops and funding for studies are not yet, policy still to be approved

Measures to overcome constraints

- To acquire 5 in built mobile dental units from donors.
- To employ more dental assistants and oral hygienists to promote oral health education
- To audit all equipment, instruments and dental materials at dental clinics and prepare a report on the needs of the clinics.
- To screen, educate and treat the dental anomalies in school children by on-going school oral health services.
- To ensure oral health's participation in health promoting schools
- To liaise with other units and departments to educate the community about oral hygiene.
- To have patient friendly clinics which are properly located
- To purchase new dental equipment for clinics
- To service all Dental equipment
- Staff to attend different workshops, conferences and lectures to stay abreast with the latest developments in dentistry.

Table OH 29: Provincial objectives and performance indicators for Oral Health

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
Implement a provincial Oral Health policy	% of Oral health facilities complying with oral health policy	0%	Policy developed	100%	100%	100%
All 8 major dental clinics to provide a full package of primary oral health services to rural and remote areas	No. of dental clinics audited for equipment and instrument needs	8	8	8	8	8
	No. of fully equipped dental clinics which were audited	0	2	4	6	8
Provide district hospitals with oral health facility	% of district hospitals providing a full package of oral health	0%	20%	60%	100%	100%

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
	% of district hospital with dentist providing a full package of oral health	0%	20%	60%	100%	100%
Increase the Dentist: Population ratio must be 1:100 000	% increase in dentist	40%	50%	60%	70%	100%
Provide ortho and prostho (dentures) in 60% of district hospitals	% of Prosthodontic and Orthodontic equipment purchased in 60% of district hospitals	0%	20%	30%	40%	50%
	A dedicated budget for prostho an ortho patients	0	1mil	1mil	1mil	1mil
	Number of appointed prosthodontics and orthodontists	0	1	2	2	2
Each district to have 1 mobile unit	Number of mobile units in each district	0	2	4	5	
	Number of nodal clinics and remote clinics visited by the mobile units in each districts	0	20%	30%	50%	70%
Expose number of schools to organized school preventative program.	Number of schools exposed to school preventative program (oral health)	30%	40%	60%	100%	100%
Provide continuous oral health services in all 5 districts	Sustainable service delivery in all 5 districts	5	5	5	5	5
Train number of health workers in oral health	The number of health workers trained per annum	2	2	2	2	2

8.2.6 REHABILITATION, CHRONICS AND GERIATRICS

Situation analysis

Rehabilitation, chronics and Geriatrics focuses on the care for the elderly and people with disabilities. The care primarily deals with non-communicable disease such as hypertension, diabetes, cardiacs and also eye care services like cataract surgeries, spectacles, Low -Vision care. Access to free health care services, access to buildings and assistive devices like hearing aids, orthopedic devices and wheelchairs becomes critical.

In 2006 an ophthalmic outreach service was started in the districts. The aim of the service was to treat special cases at district level, and then no referral to KHC would be necessary but due to lack of personnel in the eye clinic, the service has been discontinued. Rehabilitation service is a fairly new service that was established with the introduction of community services

There are no step-down facilities in the districts for patients discharged from acute care. Patients are discharged from hospital and sent directly home without the necessary aftercare. Complications e.g. bedsores, contractures and other complications can develop resulting in a costly readmission to the hospital.

A dedicated budget for assistive devices, wheelchair and hearing aids is critical. Currently the backlog is at 564 wheelchairs with an estimated cost of R1, 5 million and 360 hearing aids estimated at R1, 008.000.00

Support groups have to be established for chronic patients, people with disabilities and the elderly. The purpose is to assist clients, provide information, reduce relapses as well as to share ideas and feelings on certain topics.

Legal and policy framework

- Cervical Cancer / Screening Programme
- Testing for cancer at primary and hospital level
- Palliative care for adults
- Primary Prevention of Chronic Diseases of Lifestyle (CDL)
- Primary Prevention and Prophylaxis of Rheumatic Fever and Rheumatic
- Heart diseases for health professionals at Primary level
- Management and Control of Asthma in children at primary level
- Management of Asthma in Adults at primary level
- Early detection and management of Arthritis
- Management of menopause
- Prevention and management of overweight and obesity
- Cataract Surgery in South Africa
- Management and Control of Eye Conditions at primary level
- Prevention of Blindness in South Africa
- National programme for Control and management of Diabetes type 2 at primary level
- National programme for Control and management of Hypertension at Primary Level
- Guideline for the Prevention of Hearing Impairment due to Otitis Media at primary level
- National Rehabilitation Policy
- Standardization of Provision of Assistive Devices in South Africa
- Free health care for disabled people at hospital level
- White Paper on an Integrated National Disability Strategy
- Promotion of Active Ageing in older adults at Primary Level
- Prevention of Falls of Older Persons
- Prevention, Early Detection / Identification and Intervention of Physical
- Abuse of Older Persons at primary level
- Clinical management of psycho-geriatrics

- Home-Based Care / Community- Based Care
- Long Term Domiciliary Oxygen Therapy
- Management of Osteoporosis at hospital level / Preventative measures at
- Primary level
- Foot health at primary level
- Stroke and Transient Ischaemic attack management
- A District Hospital Service Package for South Africa
- The Primary Health Care Package for South Africa - A set of Norms and Standards

Priorities

- Improve, promote and maintain accessibility to quality care, through interventions to reduce morbidity and mortality related to chronic conditions, injuries and disabilities
- Establish a comprehensive framework for inter-sectoral collaboration to expedite service delivery to persons with disabilities, older persons and persons with chronic diseases
- Improve and promote knowledge and skills of all service providers and the public
- Monitor and evaluate the implementation of chronic disease, rehabilitation and geriatric guidelines and policies
- Improve, promote and maintain accessibility to drugs, medical supplies, assistive devices and health facilities

Strategic Goals

- Provide a comprehensive, accessible and affordable chronic disease-, rehabilitation- and geriatric service to all individuals to enable them to live as normal as possible
- To protect and promote the rights of persons with non-communicable diseases, disabilities as well as older persons.

Analysis of constraints and measures planned to overcome them
Constraints

- There is only One Orthopaedic workshop in the Province – this is a challenge for wheelchair repairs.
- Limited Sub-Acute (step down) facilities that can render rehabilitation and palliative care services
- Limited equipment/facilities and permanent employed rehabilitation therapists in districts for rehabilitation.
- Lack of trained ophthalmic nurses in the districts
- Lack of dedicated clinics for chronic diseases, older and disabled persons.
- Lack / no rehabilitation /after care / palliative services after discharge from acute care resulting in a break of continuum of care
- Limited dedicated services for chronic diseases at PHC facilities
- Limited / no support groups for chronic conditions
- Early intervention to prevent chronic onset / disability
- Poor knowledge and availability of assistive devices / rehabilitation services

Measures

- Establish fully operational orthopaedic workshop in each of the five districts
- Establish wheelchair repair centres in each of the five Districts, including a mobile
- Establish Sub-Acute (step-down) services in all five the districts
- Ensure that all district hospitals /CHC's have the basic equipment/facilities for rehabilitation services
- Ensure the employment of permanent employed physio, speech and occupational therapists in each of the five districts
- Establish public / private partnership where services are not available

- Trained ophthalmic nurses in each of the five districts
- Dedicated clinics at all the PHC facilities for chronic diseases, disabled and the elderly
- Establish support groups
- Multi-skilled Community Home Based Care – Volunteers and other categories of personnel.
- Comprehensive health promotion program
- Establish Rehabilitation, geriatric and chronic disease coordinating committees per district

Table RCG 30: Provincial objectives and performance indicators for Rehabilitation, Chronics and Geriatrics

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
Reduce waiting time at PHC facilities for chronic disease, disabled and geriatric clients	%of PHC / CHC facilities with dedicated clinics / fast lanes per districts	2%	20%	50%	80%	100%
	% of geriatric service centers with PHC services per districts	0	5%	15%	30%	50%
	% of examination rooms with all the necessary equipment	0	50%	75%	100%	100%
Strengthen support to chronic disease, disabled and geriatric clients	% of PHC facilities with a support groups per district	0	5%	15%	30%	50%
	% of confirmed diabetic clients issued with glucometers	0	0	15%	30%	60%
	% of persons with Category 3 or 4 asthma issued with a personal peal flow meter	0	0	15%	30%	60%
Reduce incidence of chronic disease and disability	% of target population screened for diabetes per district	0	10%	20%	30%	50%
	% of confirmed diabetic clients screened for diabetic retinopathy	0	2%	5%	10%	20%
	% of target population screened for hypertension per district	0	10%	20%	30%	50%
	% of children screened for visual impairment per district	0	10%	20%	30%	40%
	% of adults screened for hearing impairment per district	0	5%	10%	15%	20%
	% of children screened for hearing impairment per district	0	10%	20%	30%	40%
	% of adults screened for disabilities per district	0	10%	15%	20%	25%
	% of children screened for disabilities per district	0	10%	20%	30%	40%

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
Strengthen geriatric services at PHC level	% of PHC facilities per district with a program to lower the burden of disease associated with lack of physical activity in older persons	0	10%	25%	50%	75%
	% of residential care facilities per district with a program to lower the burden of disease associated with lack of physical activity in older persons	1%	10%	25%	50%	75%
	% of PHC facilities per district with a program to increase awareness and understanding of the risk of depression and suicide among older persons	0	0	10%	20%	30%
	% of Residential care facilities per district with a program to increase awareness and understanding of the risk of depression and suicide among older persons	0	0	10%	20%	30%
	% of PHC facilities per district with a program for prevention and early detection / identification and intervention of abuse in older persons	0	0	10%%	20%	30%
	% of Residential care facilities per district with a program for prevention and early detection / identification and intervention of abuse in older persons	0	0	10%%	20%	30%
	% of PHC facilities per district with a program to improve the quality of live of older persons struggling with substance abuse and / or misuse through effective interventions	0	0	10%%	20%	30%

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
	% of Residential care facilities per district with a program to improve the quality of live of older persons struggling with substance abuse and / or misuse through effective interventions	0	0	10%%	20%	30%
	% of Residential care facilities with sound medication management practices per district	0	5%	15%	30%	50%
Raise awareness on men's health	% of PHC facilities with dedicated men's health clinic per district	0	5%	20%	40%	60%
Provide assistive devices within a short waiting period in all districts.	% of District hospitals with essential assistive devices per district	0	5%	15%	50%	75%
	% of clients discharged with necessary assistive devices	0	2%	25%	50%	75%
	% of hospitals with a lending depot per district	0	0	10%	20%	50%
	Number of wheelchair repair centres per district	1	1	1	2	2
Increase access to specialized care	Number of spinal cord units	0	0	0	1	1
	Number of renal units per districts	1	1	2	2	4
	Number of operational orthopaedic centres	1	1	1	2	2
	% of district hospitals with functional physiotherapy unit per district	2	2%	5%	10%	15%
	% of district hospitals with functional occupational therapy unit per district	2	2%	5%	10%	15%
	Number of speech and Audiology unites	1	1	1	2	2
	% of district hospitals with stroke /rehabilitation units per district	0	2%	8%	15%	25%
	Number of low vision centres	0	0	1	1	2
	Number of eye care centres	1	1	2	3	4
Provide specialized professional service providers	Number of ophthalmic nurses employed	1	1	6	6	10
	Number of refraction practitioners employed	1	1	1	6	6
	Number of optometrists employed	1	1	2	2	3
	Recruitment at rural schools for candidates to be trained as Orthotic &	0	1	1	1	1

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
	prosthetic practitioners					
	Number of O & P practitioners employed / trained	4	4	4	8	8
	Recruitment at rural schools for candidates to be trained as podiatrists	0	1	1	1	1
	Number of podiatrists employed	0	0	1	2	3
	Number of wheelchair repair practitioners employed	0	10	10	20	20
	Number of stoma therapists trained	0	0	2	4	6
	Number of care givers trained per district to assist chronic diseases, geriatric and disabled clients	0	0	15%	30%	50%
	Number of cataract case finders trained	0	0	10	20	30
	% of PHC facilities with one professional trained in Primary Eye Care per District	0	5%	20%	40%	60%
	Number of mobility and orientation instructors employed	0	0	2	4	5
Provide specialized rehabilitation services	% of visual impaired and blind persons trained in mobility and orientation	0	0	10%	20%	60%
	Number of parents trained per district	30	30	60	80	100
Increase research and development capacity	Dataset on disability	0	1	1	1	1
	Dataset on rehabilitation services	0	1	1	1	1
	Dataset on eye care services	0	1	1	1	1
	Dataset on cancer	0	1	1	1	1
	Dataset on geriatric services	0	1	1	1	1
	Dataset on chronic diseases	0	1	1	1	1

8.2.7 MENTAL HEALTH

Situation analysis

Mental Health deals with four areas, Mental retardation/Intellectual Disability, Substance Abuse, Child Psychiatry and Community Psychiatry governed by the new Mental Health Act 17 of 2002 which replaces the old Mental Health Act 18 of 1973. According to the Mental Health Care Act, No. 17 of 2002, the Department of Health is responsible to provide care, treatment and rehabilitation for the severe and profound intellectually disabled persons. Presently there is no database on the total and whereabouts of these categories. Nursing care services for these persons are very limited and mainly available for children. Transformation of Mental Health services is slow but progressing.

Currently, services for substance abuse are provided at hospitals only. These services should be integrated and be provided at each level of care.
Provincial Substance Abuse Forum has been established with all relevant role players hosted by Social Services.
National Health Substance Abuse and Detoxification Policy Guidelines document is in the final process of adoption.

Accessibility of psychological services has increased with the appointment of the community psychologists. The increase in psychological problems such as Para suicides, abuses, violence, traumatic stressors etc places more demands for psychological services especially psychologists and counsellors.

Policies

- National Health Policy Guidelines for improved Mental Health in South Africa
- 1997 White Paper on Transformation of Health Services. Ch. 12 Mental Health and Substance Abuse.
- The Mental Health Care, Act 17 0f 2002
- National Health Act, 16 of 2003
- National Drug Master Plan 1999 – 2004 [currently being revised]
- National Child and Adolescent Mental Health policy guidelines

Priorities

- The establishment of the Mental health Review Board established in 2005
- Designation of West End Hospital as a Psychiatric Hospital
- Readiness of a facility in a General hospital for 72-hour observation.
- Training of all mental health care providers.
- Designation of a psychiatric hospital for our State patients ad mentally ill prisoners
- Sufficient and competent human resources

Analysis of constraints and measures planned to overcome them

Constraints

- Implement the Mental Health Care Act with limited and scarce recourses
- Increase accessibility and availability of Psychological services
- Integrate Substance Abuse services at the different levels of Health Care
- Human resources
- Support systems

Table MH 31: Provincial objectives and performance indicators for Mental Health

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
Formulate and implement provincial mental health policy guidelines	Number of policies developed and implemented, at least one for two of the four sub-programmes of mental health	0	2	2	2	2
Implement the Mental Health Care Act.	% of districts with at least four mental health care nurse practitioners	0	40%	20%	20%	20%
	% of districts with at least one person trained in child psychiatry	20%	20%	20%	20%	20%
	% of districts with at least one 72 hour psychiatric observation facility and providing services in a general hospital	20%	20%	20%	20%	20%
	% of Districts with at least one community –based service for mentally ill patients	20%	20%	20%	20%	20%
	% of districts with at least one care, treatment & rehabilitation centre for severe and profound intellectual disabled persons	20%	20%	20%	20%	20%
	% of health facilities providing post trauma counselling	20%	20%	20%	30%	30%

8.2.8 INTEGRATED NUTRITION PROGRAMME

Situation analysis

The nutrition intervention programme targeting clients who attend health facilities and are found to be malnourished or at risk of becoming malnourished, is operational at all the Primary Health Care facilities in the province. A protocol for the assessment and treatment of HIV, AIDS and TB patients is followed.

Health workers are trained every year to improve the reliability of growth monitoring information. Electronic scales and studio metres were procured for PHC facilities to improve the accuracy of the data.

Nutrition counselling is given according to the National Food Based Dietary Guidelines at PHC facilities where nutrition advisors or nutritionists are situated. Healthy lifestyles are promoted to all clients. Posters and pamphlets were printed on several nutrition related topics.

High dose Vitamin A supplementation forms part of the Nutrition Intervention Policy guidelines that is revised annually.
Training of Food Service workers is ongoing to ensure the implementation of the Food Service Management Policy. New equipment for kitchens was procured.

Nine hospitals in the province have already received Baby Friendly Status and our target for this year is 13 maternity facilities. The Integrated Nutrition Programme forms part of the task team for the Integrated Food Security and Nutrition Programme of the province. Other role players include Departments of Agriculture, Education and Social Services.

Policies

- National INP Strategic Framework
- Provincial Policy Guidelines for Nutrition interventions at Health Facilities
- Provincial Food Service Policy

Priorities

- Nutrition Interventions at Health Facilities
- Baby Friendly Hospital Initiative
- Food Service Management
- Provincial policy guidelines for Nutrition Interventions at Health Facilities (Reviewed yearly) Guidelines cover Nutrition Education, Vitamin A supplementation, Food Supplementation, Growth Monitoring and promotion and monitoring and evaluation
- Growth monitoring and promotion
- Training is given to Health workers on Growth monitoring and promotion every year in all districts
- Reliable equipment was procured for PHC facilities
- Strategies to decrease maternal morbidity and mortality
- Food supplementation for all pregnant mothers
- Nutrition Education for women of child bearing age
- Strategies to improve access to reproductive health services.
- Strategies to reduce under 5 morbidity and mortality

Strategic Goals

- To prevent and reduce the incidence of severely malnourished children under five years
- To prevent and reduce growth faltering among children 0-60 months of age
- To have maternity facilities declared Baby Friendly
- To ensure that Food Service Units comply with the Provincial Food Service Management Policy

Analysis of constraints and measures planned to overcome them

- The Integrated Nutrition Programme does not receive a conditional grant any more therefore we rely on allocations made to districts.
- Supplements are partly procured from the HIV/AIDS conditional grant
- Community Service Dietitians assist in rural areas.
- Nutrition Advisors play a crucial role in nutrition education and monitoring of patients on supplementation. Some PHC facilities do not have nutrition advisors.

Table INP 32: Provincial objectives and performance indicators for Integrated Nutrition Programme

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
Contribute to the reduction of malnutrition in children under 5 years of age	Incidence of severe malnutrition under 5 years	0,8	0,5	0,4	0,3	0,2
Prevent and reduce growth faltering among children	Number of children not gaining weight reduced	4	3,5	3	2,5	2
Monitor if facilities provide baby friendly services.	% of facilities that are baby friendly	37	37	40	42	45
Contribute to the institutional care of clients through food service systems for the provision of balanced nutrition	% of Food Service units complying with Provincial food service Management policy	50	60	80	85	90

8.2.9 HEALTH INFORMATION

Situational Analysis

Health Information is a support programme in the department, responsible to manage all the data coming through from the five health districts, validate, analyse and disseminate information. The unit uses health indicator reviews as output for end users. The unit serves as a centre of Monitoring and Evaluation of programme performance indicators. The unit is also responsible for the provincial surveillance system on notifiable medical conditions, provide support during outbreaks and during surveys, provide training and technical support to districts and other health programmes.

The unit currently has a small team of five staff members making it difficult to do comprehensive data analysis, data validations and verifications and compile strategic monitoring tools. This affects data quality. The capacity at the district level needs strengthening.

The unit is currently busy working on a draft Health Indicator Review for the year 2006/07, policy on information management and also strengthening the feedback mechanisms. The unit is striving to position itself as a strategic decision support component of the department.

Policies:

- The National Health Act, 61 of 2003
- E-government
- South African Health Sector Strategic Framework, 2004 – 2009
- Northern Cape Department of Health Vision 2014
- National Health Information System for South Africa, Data Flow Policy

Priorities

Based on the need for access to accurate information for decision making within the department, the following priority areas were identified:

- Produce credible information to support optimal decision making in the department
- Establish a centre for monitoring and evaluation within the department
- Use of health information for action, and create information sources for that purpose.
- Inter-departmental relationships for information sharing
- Fully functional District Health Information System
- Support Vital Registration System
- Provision of burden of diseases reports
- Design the Decision support system
- Monitoring and Evaluation of priority programmes

Strategic Objectives

The strategic objective of the unit is to ensure best practices in information management and evidence decision making.

Analysis of constraints and measures to overcome them

Constraints

- Lack of data validation and analysis time for both provincial and district Information Officers.
- Lack of technical expertise in the districts.
- Parallel data collection systems in the districts.
- Access to managerial information.

Measures

- Install the computer program for District Health Information System
- Further training for District Health Information Officers
- Integrate data collection systems for different programmes in the districts
- Create a data warehouse to serve the information needs of the management
- Establishment of provincial Health Information System Committee that will facilitate the development of inter-departmental information systems.
- Fill the vacant posts in the unit.

Table HI 33: Provincial objectives and performance indicators for Health Information

Measurable Objective	Performance Measure Indicator	Actual 2005/06	Estimate 2006/07	2007/08 Target	2008/09 Target	2009/10 Target
Provide Disease trends reports in the districts	No of districts producing Annual reports of Disease Health trends	0	1	5	5	5
Increase the number of facilities achieving data quality index threshold score	Number of districts achieving data quality index threshold score	0	3	5	5	5
Improve facility data timeliness rate in all the PHC facilities	Number of districts receiving 95% of expected reports from facilities in time	0	3	5	5	5
Instil a culture of Information Management	Facilities trained on using information for action	0	Half	ALL	ALL	ALL
	Number of health district adhering to data flow policy	0	3	5	5	5
	No of facilities monitored on data management per year	0	20	40	40	40
	Percentage of facilities achieving data quality index score	0	50% hospitals, 25% clinics	75% hospitals, 50% of clinics	100% hospitals, 75% clinics	100% hospitals, 100% clinics
	Implementation of Information management policy	No policy	Policy approved	Policy Implemented	Policy approved and Implemented	Policy implemented

Measurable Objective	Performance Measure Indicator	Actual 2005/06	Estimate 2006/07	2007/08 Target	2008/09 Target	2009/10 Target
Integrate private health facilities into the District Health Information System	Number of private facilities reporting	0	1	2	3	4
Strengthen the Provincial information Committee.	Number of meetings per year	0	1	2	2	2
Implement electronic health information databases in all facilities	Percentage of facilities running a computerized DHIS	0	50%	100%	100%	100%
E-health projects	Number of research projects conducted per year	1	1	2	2	2
Improve data accessibility	Programme Data and Information coverage	0	New Provincial Minimum dataset	New Provincial Minimum, EMS, Environmental Health, Forensics	All datasets	All datasets
	Number of programme managers trained on DHIS Pivot tables	0	5	9	-	-
Active disease surveillance system	Percentage of facilities reporting weekly	50%	75%	100%	100%	100%
Create information management expertise in the department.	Number of information officers attended health information or Monitoring and Evaluation training	2	2	5	-	-
Strengthen Monitoring and Evaluating process in the department	Number of programmes with Monitoring and Evaluation plans in place.	0	9	-	-	-
	Number of quarterly indicator review per programme	0	1 per year	2 per year	4 per year	4 per year
	Annual Health indicator Review	0	1	1	1	1

8.3 COMMUNICABLE DISEASE

8.3.1 HIV & AIDS, STI & TB CONTROL

Situation Analysis

The Communicable Disease Directorate operates as an integrated Unit for the management and control of a specific group of related infectious diseases namely; HIV and AIDS, Sexually Transmitted Diseases (STI`s), Tuberculosis and Emerging & Re-emerging Infectious Diseases (also colloquially known as Communicable Disease Control). The interrelatedness of these three sections is seen specifically with current HIV/TB co-infection rates, and to a lesser extent HIV with Hepatitis. In this regard a dedicated Project Manager has been appointed in order to facilitate the collaboration between HIV and Tuberculosis in the province.

The recent release of the National HIV and Syphilis Prevalence Survey, 2005 – South Africa, has revealed some very key findings regarding the HIV and AIDS situation in the country. According to this survey, the following findings are of note:

HIV prevalence in South Africa

Year	South Africa	Northern Cape
2004	29.5 %	17.61
2005	30.2 **%**	18.5

- Seven Provinces in the country show a notable increase between 2004 and 2005, except for Gauteng Province (2004 - 33.1% and 2005 – 32.4%) and KwaZulu-Natal Province (2004 – 40,7% and 2005 39.1%)

In view of HIV prevalence trend in South Africa, statistics show that there has been a steady increase of new HIV infections over the past five years:

- 2001- 24.8%
- 2002- 26.5%
- 2003- 27.9%
- 2004– 29.5%
- 2005- 30.2%

This vital observation could mean that, HIV and AIDS epidemic is stabilizing in South Africa and possibly over a period of time it will start to decrease gradually.
A significant increase in HIV prevalence in South Africa is noted in all age groups except for the age group 20- 24 years, which has shown a slight decrease from 30.8 % in 2004 to 30,6 % in 2005. This observation could mean that the continued HIV prevention messages targeting the youth are starting to have a positive effect in terms of preventing new HIV infections.
Northern Cape HIV Prevalence rate of 18.5% in 2005 is the second lowest prevalence rate in the country, after Western Cape with 15.7 % in 2005.

Syphilis Prevalence

Year	South Africa	Northern Cape Province
2004	1.6 %	2.7 **%**
2005	7.0 %	8.5 **%**

Syphilis prevalence remains a great concern in Northern Cape Province. The statistics shows a significant increase of 1.5 % from 7.0% in 2004 and 2005 prevalence rate of 8.5% is the highest in South Africa.

This vital observation poses serious challenges for the province and could mean that an independent survey or research that will focus on the entire population in the province, not only Ante natal clinic attendees, as it is the case with the Ante-natal HIV and Syphilis survey, is required

Table HIV 34: Situation analysis indicators for HIV & AIDS, STI`s and TB control

Indicator	Type	Prov wide value 2004/05	Prov wide value 2005/06	District Frances Baard 2005/06	District Pixley ka-Seme 2005/06	District Siyanda 2005/06	District Namakwa 2005/06	District Kgalagadi 2005/06	National target 2005/6
Input									
ARV treatment service points compared to plan	%	5	8	1	3	2	1	1	13
Percentage Fixed PHC facilities offering VCT	%	71	91						100
Hospitals offering PEP for occupational HIV exposure	%	50	70						100
HTA Intervention sites compared to plan	%	0	1	0	1	0	0	0	2
Process									
TB cases with a DOT supporter	%		79.9%	77.2%	84.9%	92.7%	79.4%	82.7%	
Fixed facilities with any ARV drug stock out	%	0	Yes						0
Fixed PHC facilities drawing blood for CD4 testing	%	51	67						80
Output									
STI partner treatment rate	%		21.46	16.5	34.46	26.72	16.87	23.75	
Nevirapine dose to baby coverage rate	%	60							100
Patients registered for ART compared to target	%	2031	6353	0	0	0	0	0	5000
TB treatment interruption rate	%		18.7%	12.8%	16.9%	14.4%	7.3%	8.8%	
Quality									
CD4 test at ARV treatment service points with turnaround time >6 days	%	0	0	0	0	0	0	0	0
TB sputa specimens with turnaround time > 48 hours	%		60.8%	96.8%	40%	40.9%	78.6%	9.42	
Outcome									

Indicator	Type	Prov wide value 2004/05	Prov wide value 2005/06	District Frances Baard 2005/06	District Pixley ka-Seme 2005/06	District Siyanda 2005/06	District Namakwa 2005/06	District Kgalagadi 2005/06	National target 2005/6
New smear positive PTB cases cured at first attempt	%		48.4%	39.6%	42.1%	52.3%	64.5%	68.4%	
STI treated new episode among ART patients - annual % change	%	Not collected yet	534						134

Policies

HIV/AIDS & STI strategic plan for South Africa-2005
The Comprehensive Care, Management and Treatment (CCMT) Plan for HIV and AIDS
The medium term development plan of the national tuberculosis control programme for 2002-2005
The TB Crisis Plan 2005

Priorities

- Prevent infection of people who are not infected through an integrated awareness and promotion strategy.
- Promote responsible, healthy sexuality through interactive campaigns.
- Promote the health of people living with the virus.
- Implement effective community and home based care as part of the Comprehensive Plan to ensure a minimum of 1 caregiver per 15 clients from 2005.
- Provide dignified palliative care with facilities in every district by 2008.
- Support compliance for life for those on treatment.
- Provide appropriate evidence based Anti Retroviral Treatment
- Provide appropriate evidence based treatment of opportunistic infections.
- Manage implementation of care packages (e.g. Nutrition and Social support) in a responsible accountable transparent manner
- Support the rights of our clients to non-discrimination through external and internal campaigns.
- Expand community participation in caring for communities living with HIV&AIDS. (Expanding involvement of community structures in the Community Home Based Care programme to meet targets.)
- Support participation of people living with HIV & AIDS in advancing the Comprehensive Plan through coordinated partnerships around specific activities

Strategic Goals

- To provide comprehensive care and treatment for people living with HIV and AIDS;
- To facilitate the strengthening of the national health system in South Africa.

TableHIV 35: Provincial objectives and performance indicators for HIV & AIDS, STI

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
To reduce the incidence of HIV and AIDS	Number of VCT sites operational	122	125	220	236	250
	Number of operational non-medical sites.	14	20	30	40	50
	Number of Health Care Professionals (HCP's) trained	100	200	300	400	500
	Number of counsellors trained	379	500	550	600	650
	Number of Health Care facilities with Syndromic Management protocols in place	100%	100%	100%	100%	100%
	Number of Professional Nurses and doctors trained in the Syndromic Management Protocol	199	350	500	650	800
	Number of female condom outlets	14	40	65	90	115
	The number of male condoms distributed	4 000 000	4 500 000	6 500 000	7 000 000	7 500 000
	Number of female condoms distributed	39 000	60 000	80 000	100 000	120 000
	The number of HTA sites functional	1	2	4	5	6
To increase awareness on HIV and AID	Number of IEC material printed.	0	30 000	40 000	50 000	60 000
	Number of billboards erected	0	30	35	40	45
	Number of Messages printed on communal transport	60	30	20	10	5
	Number of awareness messages printed on grocery bags	0	0	1000	1000	1000
Implement effective community and home based care as part of the comprehensive plan	Number of HBC givers recruited	440	600	600	600	600
	Number of HBC givers trained -new	75	525	175	100	100
	Number of HBC structures linked to PHC Clinics	38	38	0	0	0
	Database of all HBC service providers established	None	Database established	Database established	Database established	Database established
	Number of Monthly, quarterly	12 reports produced	12 reports produced	12 reports produced	12 reports produced	12 reports produced
	and annual progress and financial reports	4 reports produced	4 reports produced	4 reports produced	4 reports produced	4 reports produced

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
	produced	1 report produced	1 report produced	1 report produced	1 report produced	1 report produced
	Number of quarterly M&E site visits and or meetings conducted	4 site visits and or meetings conducted	4 site visits and or meetings conducted	4 site visits and or meetings conducted	4 site visits and or meetings conducted	4 site visits and or meetings conducted
	Number of HBC kits supplied to HBC's	440	600	600	600	600
	Number of new HBC givers trained	525	175			
To provide Care and Support for people living with HIV and AIDS	The number of People Living With AIDS Support Groups supported	10	20	20	30	30
Providing dignified palliative care	Palliative Care Program in place	50%	50%	100%	100%	100%
To improve the health status of people living with HIV and AIDS	Percentage of accredited ART service points with nutritional services.	100%	100%	100%	100%	100%
To improve the health status of people living with HIV and AIDS	Proportion of eligible new HIV positive patients receiving nutritional supplements (macro)	45%	50%	55%	60%	65%
	Number of joint collaboration meetings with other departments to improve food security issues. (IFSNP)	4	7	8	8	8
	Number of M&E support visits conducted in facilities.	24	24	24	24	24
	Number of health care workers trained in the context of TB, HIV and AIDS.	202	200	100	100	100
	Number of monthly and quarterly reports written.	12 4	12 4	12 4	12 4	12 4
	Percentage of accredited ART service points with nutritional services.	100%	100%	100%	100%	100%

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
To increase access to comprehensive HIV and AIDS care and treatment	Number of Hospitals Accredited as ART Service points	3	10	15	20	25
	Number of fixed PHC facilities Accredited as ART Service points	5	16	18	20	25
	Number of fixed PHC facilities drawing blood for CD4 testing	55	83	160	220	280
	Number of registered ART patients – ART start	2000	2500	6000	8000	10000
	Number of ART assessment first visits	10 000	12 000	25 000	40 000	50 000
	Number of HIV patients medically eligible for ART on waiting list	5 000	4 000	3 500	2 500	1 000

8.3.2 TUBERCULOSIS (TB, including TB/HIV coordination)

Situational Analysis

A steady rise has been marked over the past three years in the prevalence and incidence rate of Tuberculosis in the country. Although the Northern Cape Province has not been listed as one of the priority provinces, the prevalence and incidence rate of Tuberculosis is on the increase. The Northern Cape has the 2nd highest TB incidence rate in the country.

There has been a steady increase in the incidence rate since 2001 with a slight dip in 2004

GRAPH 13: TB Incidence Rate

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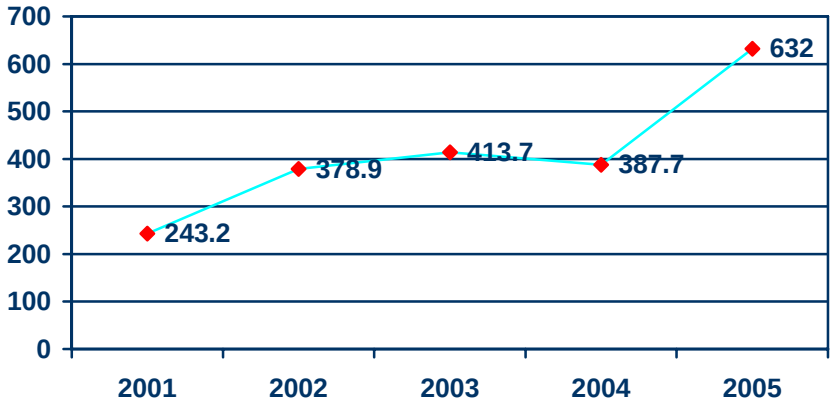
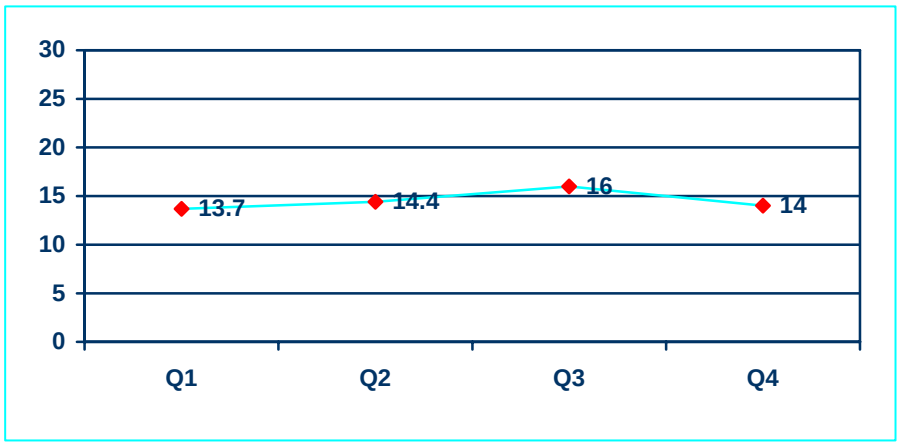


The high TB defaulter rate and not evaluated cases is a cause of concern despite the increased awareness

campaigns.

GRAPH 14: TB defaulter rate, Q1-Q4 2005/06



- Defaulter rates still remains more than 10%
- Problems are still experienced with case holding especially in the Siyanda and Frances Bard districts
- Seasonal and migrant working contributes to increase in defaulter rate

The cure rate has improved from 42.7% in quarter 4, 2004 to 48.4% in quarter 4, 2005. The low cure rate can be attributed to high defaulter rate and high numbers of not evaluated cases. The province has 153 MDR TB patients (excluding Francis Baard) to date and 64% (98) of them are from the Siyanda District.

There are 9 XDR TB cases in the province and 4 borderline cases. The prevention of the escalation of XDR TB cases is of priority. Tuberculosis is one of the opportunistic infections found in people living with HIV and AIDS. During quarter 3, 2006, 57.7% of TB cases tested positive to HIV. Similar results have been reported over the past three quarters.

The strengthening of the TB interventions and full implementation of the DOT Strategy needs to be intensified in order to achieve targets as set. In the Northern Cape Siyanda and Frances Baard have been identified as priority districts, however the focus areas for implementation of crisis plan will be the all high caseload facilities and in-patient care facilities.

Priorities

- Cure all new smear positive patients at first attempt
- Ensure compliance to TB treatment and minimize interruption rate
- Improve tracing of contacts
- Strengthen laboratory service and district health system to improve sputum turn – around times.
- Review and strengthen DOT support model and increase DOT coverage to 90% of patients.
- Strengthen TB services in farming community and correctional services.
- Assist districts to develop supervision and monitoring systems for community DOTS.

Objectives

- To achieve 85% Tuberculosis cure rate
- Reduce morbidity and mortality attributable to Tuberculosis
- Decrease the interruption rate to < 10 %
- Reduce the sputum turn-around time to < 48 hrs.
- To improve data management at district level

Strategies Goals

- Improve the quality of TB management through monitoring and evaluation
- Prevent the development of drug resistance TB
- To strengthen TB in- patient care
- To strengthen referral of TB patients

Analysis of constraints and measures planned to overcome them

- The HIV and AIDS programme is currently funded through the Conditional Grant, this funding is said to be coming to an end in the next 2 or 3 years. In that regard the province has to be prepared to absorb the cost for running an effective HIV and AIDS Programme in the next few years.
- Funding from the equitable share is very limited, posing serious challenges for other programme e.g TB Control and Emerging/re-emerging Infectious Diseases. These programmes are currently under-funded.
- Implementation of the CCMT and TB Crisis Plan requires dedicated positions on the staff establishment. Most of these are scarce skills that are very difficult to recruit in the province e.g Doctors, Pharmacists and Dieticians.
- No easily accessible tertiary partner for the Regional Training Centre
- Accredited service providers are difficult to find in the Northern Cape
- Sometimes low national stock levels present stock-outs at provincial and district level.
- Suppliers also tend to leverage against outstanding invoices
- The availability and accessibility of the female condoms is still a challenge

Table HIV 36: Provincial objectives and performance indicators for TB control

Objective	Indicator	Actual 2005/05	Estimate 2007/08	Target 2008/09	Target 2009/10	Target 2010/11
Achieve 85% TB cure rate by 2014	New smear positive PTB cases cured at first attempt	42.7%	45%	50%	55%	60%
	TB interruption rate	12.5%	11%	10%	9%	8%
	Successful treatment completion rate new cases	24%	40%	50%	60%	65%
	New smear conversion ate	42.4%	50%	60%	65%	70%
Ensure good quality of TB laboratory services	Percentage of sputum with a Turn Around Time < 48 hours	60.8%	70%	80%	90%	90%
Ensure adherence to TB treatment	Percentage of TB patients on DOT	79.9%	85%	90%	90%	90%
	Percentage of Community Health Care Workers trained in DOT	100%	100%	100%	100%	100%
	Percentage of MDR TB amongst new TB cases	3.5	3.2	3	2.8	2.6
Reduce the incidence rate of TB to 200/ 100 000 population by 2014	TB incidence rate per 100 000 population	500/100 000	450/100 000	400/100 000	350/100 00	340/100 000

8.3.3 COMMUNICABLE DISEASE CONTROL

Situational Analysis

Successful Control of Communicable Diseases needs good surveillance. Health workers would not be able to detect outbreaks and alert people early or identify groups at increased risk of death from communicable diseases. The Communicable Disease Control unit investigates suspected outbreaks for a variety of reasons. The primary public health reason is to control and prevent further disease and mortality. Even for diseases that are well characterised, an outbreak provides opportunities to gain additional knowledge by assessing the impact of control measures and the usefulness of epidemiology and laboratory techniques. In responding to the various issues the Communicable Disease Control unit has developed and started a network with the five districts in the Northern Cape.

The main objective is to integrate the 2010 soccer world games plan into the provincial strategic plan to ensure preparedness for the prevention, management and control of communicable diseases. The world cup provides a global stage on which nations of the world come together to reaffirm common humanity. This country has hosted several world games but the magnitude of this event is enormous. Influx of people of the world over a period of approximately 6 –8 weeks in several provinces within the country is anticipated. The challenge facing the country is the importation or transfer of communicable diseases; those that are epidemic prone and those that are of public health importance. The spectrum of threatening diseases includes:

- Waterborne and water related diseases
- Food borne diseases
- Meningococcal diseases
- Respiratory diseases e.g. influenza, Severe Acute Respiratory Syndrome (SARS)
- Vector borne diseases e.g. malaria
- Animal bites
- Zoonoses e.g. rabies, viral hemorrhagic fevers
- Sexually transmitted infections
- Nosocomial infections

The anticipated output is the incorporation of objectives into operational plans of financial years 07/08; 08/09

Policies

National Health Act, 61 of 2003
International Health Regulations Act, 78 of 1973
National Guidelines on Epidemic Preparedness and Responses

Strategic Goal

Scale up epidemic preparedness and responses to reduce morbidity and mortality of infectious diseases

Priorities

- Strengthen Epidemic Preparedness and Response (EPR) prevention, management and control of communicable diseases and outbreaks.
- Improving epidemic preparedness and rapid response strategies to reduce morbidity, mortality and disability due to infectious diseases.
- Improve / promote and maintain accessibility of relevant health information regarding communicable diseases to the public.
- Improve quality of health care though monitoring and evaluation of processes of communicable diseases policy and guidelines.
- Improve the Private and Public Health Sector's awareness and understanding of Emerging and Re – Emerging Infectious Diseases.

- Reporting on IDSR (Integrated Disease Surveillance and Response) South Africa is a signatory of the 1999 Technical Framework on Epidemic Preparedness and Responses in SADC. IDSR is important and compulsory for the following reasons:
    - For Epidemiology and Priority Disease Surveillance
    - Early Warning System and detection of epidemic – prone diseases
    - For Epidemic Preparedness and decision making
    - For Rapid Systematic Epidemic Response
    - Create opportunities for training and capacity building
    - Monitoring and Evaluation

Analysis of constraints and Measures planned to overcome them
Constraints

- Communicable Disease Control is unfortunately not adequately funded in the province, while expenditure for the unit has grown, given the number and nature of outbreaks that have occurred in the province.
- The provincial Communicable Disease Control unit has developed and circulated a large number of guidelines related to the control and prevention of infectious diseases. All the activities directed towards reducing morbidity and mortality are costly.
- The development and design of new organogram is critical for epidemic preparedness and response capacity, as Communicable Disease Control does not appear in the district health organizational structure.
- Training programs are not well attended because of shortage of health professionals at clinics and hospitals.
- There are more risk factors that may predispose most people to infections, for example, increased travel, displacements, poverty, overcrowding and high HIV/AIDS prevalence rate.
- The Northern Cape, being the largest province borders four provinces and two SADC countries place the population at risk as shown in the recent polio outbreak in Namibia and Botswana.

Measures planned to overcome constraints

- The funding of Communicable Disease Control is critical for program management in order to respond to the needs of populations and to ensure effective Epidemic Preparedness and Response.

Table PREV 37: Situation analysis indicators for disease prevention and control Communicable Disease Control

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
Coordinate and support the implementation of clinical guidelines and protocols	Implementable document available on guidelines and protocols on Infectious and Communicable diseases.	N/A	80%	100%	100%	100%
	Implementable Pandemic Influenza plan.	N/A	20%	80%	100%	100%
	Costed 2010 World Soccer Games on communicable diseases.	N/A	50%	80%	100%	100%
Heighten response time to disease epidemics to < 24 hours in the province.	% of districts that have log registers for epidemics	N/A	10%	50%	80%	100%

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
	Functional surveillance centre.	0	0	1	1	1
	Number of districts reporting.	2	3	4	5	5
	% Districts reporting in < 12 hours.	> 72 hrs	> 48hrs	< 24 hrs	< 12 hrs	< 12 hrs.
	Implementable rumour surveillance document.	0	0	1	1	1
Strengthen capacity of health care providers to scale up epidemic preparedness and response	Number of health care providers trained in EPR	200	300	400	1000	1000
Provide effective information, education and communication in collaboration with Health Promotion and partners	Number of alerts sent based on seasonality of diseases	1	6	8	10	10
	Number of districts reached.	0	3	4	5	5
	Number of campaigns held.	1	2	3	4	5
Establish quality control measures to monitor the implementation of communicable diseases control strategies	Number of EPR assessments held.	2	4	5	5	5
	Number of functional ORT meetings per district.	6	12	24	36	36
	% Of contacts treated and managed.	50%	60%	80%	100%	100%
	Number of diarrhoeal sentinel sites established.	0	0	1	3	5
	Outbreak evaluation report.	2	3	4	5	5
Coordinate and support the implementation of clinical guidelines and protocols	Implementable document available on guidelines and protocols on Infectious and Communicable diseases.	0	80%	100%	100%	100%
	Implementable	0	20%	80%	100%	100%

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
	Pandemic Influenza plan.					
	Costed 2010 World Soccer Games on communicable diseases.	0	50%	80%	100%	100%
Heighten response time to disease epidemics to < 24 hours in the province.	% of districts that have log registers for epidemics	0	10%	50%	80%	100%
	Functional surveillance centre.	0	0	1	1	1
	Number of districts reporting.	2	3	4	5	5
	% Districts reporting in < 12 hours.	> 72 hrs	> 48hrs	< 24 hrs	< 12 hrs	< 12 hrs.
	Implementable rumour surveillance document.	0	0	1	1	1
Strengthen capacity of health care providers to scale up epidemic preparedness and response	Number of health care providers trained in EPR	200	300	400	1000	1000
Provide effective information, education and communication in collaboration with Health Promotion and partners	Number of alerts sent based on seasonality of diseases	1	6	8	10	10
	Number of districts reached.	0	3	4	5	5
	Number of campaigns held.	1	2	3	4	5
Establish quality control measures to monitor the implementation of communicable diseases control strategies	Number of EPR assessments held.	2	4	5	5	5
	Number of functional ORT meetings per district.	6	12	24	36	36
	% Of contacts treated and managed.	50%	60%	80%	100%	100%
	Number of diarrhoeal sentinel sites established.	0	0	1	3	5

Table PREV 38: Provincial objectives and performance indicators for Communicable Disease Control

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
Coordinate and support the implementation of clinical guidelines and protocols	% of facilities where guidelines are kept and maintained	0	80%	100%	100%	100%
Provide rapid response to districts in suspected or/and outbreaks/epidemics.	% of districts that have monitoring charts for epidemics	10%	50%	80%	100%	100%
Strengthen capacity of health care providers to scale up epidemic preparedness and response	Number of health care providers trained in EPR	200	300	400	1000	1000
Provide effective information, education and communication in collaboration with Health Promotion and partners	Number of alerts sent based on seasonality of diseases	1	6	8	10	10
Establish quality control measures to monitor the implementation of communicable diseases control strategies	% of endemic conditions cases reported	60%	80%	100%	100%	100%

Table PREV 39: Performance indicators for Communicable Disease Control

Indicator	Type	2004/05	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10	National target 2007/08
Input								
Trauma centres for victims of violence	No	0	0	0	0	0	0	1 per district
Process								
CHCs with fast queues for elder persons	%	0	0	0	0	0	0	20
Output								
Health districts with health care waste management plan implemented	No	0	0	0	0	0	0	All districts
Hospitals providing occupational health programmes	%	0	0	0	0	0	0	100
Schools implementing Health Promoting Schools Programme	%	13	13	15	15	18	18	26

Indicator	Type	2004/05	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10	National target 2007/08
(HPSP)								
Integrated epidemic preparedness and response plans implemented	Y/N	N	Y	Y	Y	Y	Y	Yes
Integrated communicable disease control plans implemented	Y/N	N	Y	Y	Y	Y	Y	Yes
Quality								
Schools complying with quality index requirements for HPSP	%	0	0	0	0	0	0	
Outbreak response time	Days	5	3	2	2	2	2	2
Outcome								
Dental extraction to restoration rate	No	0	0	0	0	0	0	0.4
Malaria fatality rate	No	0	0	0	0.25 %	0.25 %	0.25 %	0.25%
Cholera fatality rate	No	0	0	0	0	0	0	0.5
Cataract surgery rate	No	0	0	0	0	0	0	1,000
Trauma centres for victims of violence	No	0	0	0	0	0	0	1 per district

TABLE 40: Trends in provincial public health expenditure for Programme 2: District health services

	2003-04 Actual	2004-05 Actual	2005-06 Actual	2006-07 Estimate	2007-08 Projection	2008-09 Projection	2009-10 Projection
Current Prices							
Total	327,841,544	340,864,669	421,305,000	499,516,000	-	-	-
Total per person	398	414	512	607	-	-	-
Total per uninsured person	498	518	640	759	-	-	-
Total capital	643,000	2,034,000	8,734,000	27,658,000	-	-	-
Constant (2005/06) prices							
Total	355,380,234	354,840,120	421,305,000	476,038,748	636,030,027	669,890,189	708,531,306
Total per person	432	431	512	579	646	681	720
Total per uninsured person	540	539	640	723	808	851	900
Total capital	697,012	2,117,394	8,734,000	26,358,074	18,146,367	11,347,364	8,185,350

9. PROGRAMME 3 – EMERGENCY MEDICAL & PATIENT TRANSPORT SERVICES

Situation analysis

Recruitment and training to improve staffing performance levels

- Province has recruited contract workers whilst working in conjunction with HR in creating full time posts & revising the Organogram.
- Province has also embarked on refresher course as well as intermediate courses for the full time staff.
- The department needs employ more ECP's as well as the Administration Component for EMS
- Number of staff from 2001/2 to date currently has changed drastically which has allowed us to alleviate the 1 person crew to a certain extent.

Capital purchase programme

- Fully equipped Ambulances have been purchased and distributed and we are still waiting for those Ambulances which are been converted
- Electronic Patient Record system has been installed in 16 Ambulances.

Radio communication model

- Radio's have been fitted in new vehicles that were purchased and a new repeater was installed at Kimberley Hospital
- Submission has been made for other repeaters to be installed for us to have optimal communication
- A submission has also been made for the control centre for Frances Baard immediately whilst others will follow

Policies

- Standards Operating Procedure
- Job Description
- EMS Bill (Act)
- Road Traffic
- Criminal Procedure Act

Priorities

- Finalising of the Organogram
- Training
- Uniform
- Infrastructure
- Communication

Strategic goals

- Recruitment
- Skills building
- Alleviate one person crew
- Replacement and Additional vehicle policy
- Take salary level to be in line with the rest of the country
- Employment of ALS Personnel

Analysis of constraints

- Budget not within Provincial office
- Shortage of staff at all levels, from Administration to operations

- There is a Health Information System in place but for us to achieve optimal results to the collation of raw data into outputs it would be necessary for EMS to employ & train information Officers in the Districts as well as at the Provincial office

Measures planned to overcome the constraints

- Consideration of a Decentralized model as opposed a Provincial model to be considered.
- Replacement of all old repeaters, as well as to build the control centres.
- Purpose built basis to be constructed
- A conditional Grant for EMS to take the above processes forward, a Financial Manager to be employed.
- Support Systems like Admin, training, etc would assist to overcome our challenges & constraints

Table EMS 41: Provincial objectives and performance indicators for EMS and patient transport

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
	Number of ambulances operational	152	180	200	220	260
	Total number of kilometres travelled	116438	200000	200000	200000	200000
	Number of patients transferred	83618	80000	80000	80000	80000
	Call outs serviced by a single person crew	30508	20000	20000	20000	10000
	Percentage of P1 (priority 1/ red codes) calls with a response of <15 minutes in urban areas	-	70%	70%	75%	80%
	Percentage of P1 (priority 1/ red codes) calls with a response of <40 minutes in rural areas	-	50%	60%	70%	80%
	Percentage of calls (P1/P2/P3) not responded to within 1hour of receiving a call		60%	40%	30%	20%
	Percentage of operational ambulances rostered with single person crews	-	50%	40%	30%	0%
Implement Two crew system	100% two crew system	56.6%	86%	100%	100%	100%
Response times within norms and standards	Total number of vehicles	152	180	220	260	300
	Vehicles less than 300 000km	85	184	0%	0%	0%

Table EMS 42: Performance indicators for the EMS and patient transport

Indicator	Type	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10	National target 2007/08
Input							
Rostered Ambulances per 1000 people	No	-	0.3	0.3	0.3	0.3	0.3
Process							
Kilometres travelled per ambulance (per annum)	Kms	116438	200000	200000	200000	200000	
Locally based staff with training in BLS BAA	%	86.1	54.4	45	30	25	100
Locally based staff with training in ILS AEA	%	13.7	45.5	53	65	70	
Locally based staff with training in ALS Paramedics	%	0.2	0.9	2	5	5	
Quality							
Response times within national urban target (15 mins) calls with a response of <15 minutes in an urban area	%	43.2	75	80	90	95	100
Response times within national rural target (40 mins) calls with a response of <40 minutes in a rural areas	%	36.4	75	80	90	95	100
Call outs serviced by a single person crew (Percentage of operational rostered ambulances with single person crews)	%	43.4	0	0	0	0	0
Efficiency							
Green code patients transported by ambulance	%	64.5	10	0	0	0	
Ambulances with less than 500,000 kms (200 000 kms)on the clock	%	80.6	100	100	100	100	100

TABLE 43: Trends in provincial public health expenditure for Programme 3: Emergency medical services

	2003-04 Actual	2004-05 Actual	2005-06 Actual	2006-07 Estimate	2007-08 Projection	2008-09 Projection	2009-10 Projection
Current Prices							
Total	39,187,279	53,386,218	72,688,000	99,351,000	-	-	-
Total per person	48	65	88	121	-	-	-
Total per uninsured person	60	81	110	151	-	-	-
Total capital	250,000	10,876,000	16,240,000	24,272,000	-	-	-
Constant (2005/06) prices							
Total	42,479,011	55,575,053	72,688,000	94,681,503	90,653,661	96,208,916	101,780,728
Total per person	52	68	88	115	92	98	103
Total per uninsured person	65	84	110	144	115	122	129
Total capital	271	11,322	16,240	23,131	4,545	4,557	4,571

10. PROGRAMME 4 – PROVINCIAL HOSPITALS SERVICES

10.1 Provincial Hospitals

Situation analysis

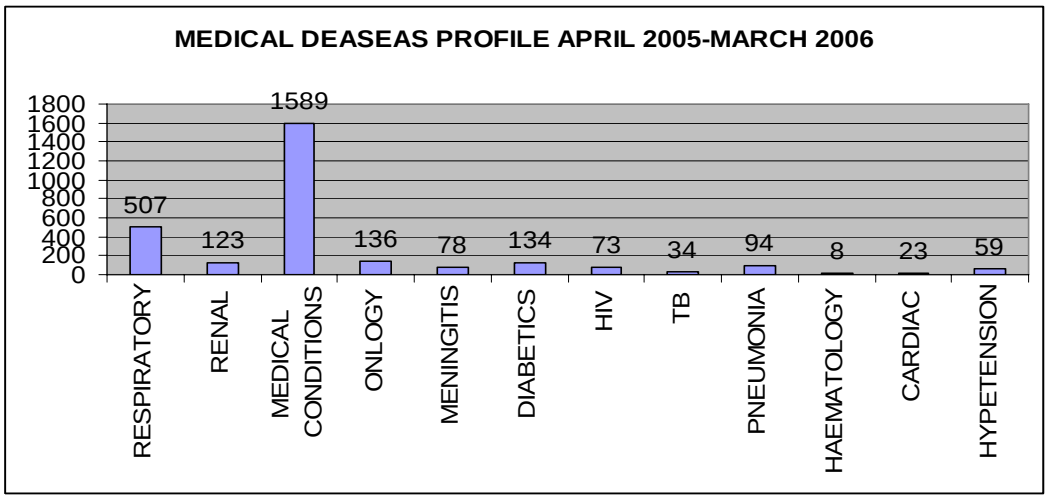
Part of the Kimberley focus is on epidemiological information which includes key hospital indicators, medical and paediatric disease profiles and patients flow. The hospital key indicators include inpatients days, bed occupancy and Average Length of Stay (**ALOS**).

From April 2005 – March 2006 Kimberley Hospital Complex experienced 171 364 inpatient days whilst bed occupancy was at 85% (An inpatient day is a unit of measure utilised to indicate the services rendered to admitted patients). This indicates an overall measurement of the workload for the hospital. According to District Health Information Systems (DHIS) guidelines, bed occupancy for regional hospital like KHC should maximise at 75%. Kimberley hospital is 10% above the DHIS guidelines. One of the reasons is an increase of demand for health services at Kimberley hospital. On average for the period 2005-2006 one patient spent 7.1 days i.e. the Average Length of Stay (ALOS) at Kimberley hospital. ALOS ranges between 4-8 days (DHIS, 2006), this implies that KHC ALOS is within the range as indicated by DHIS.

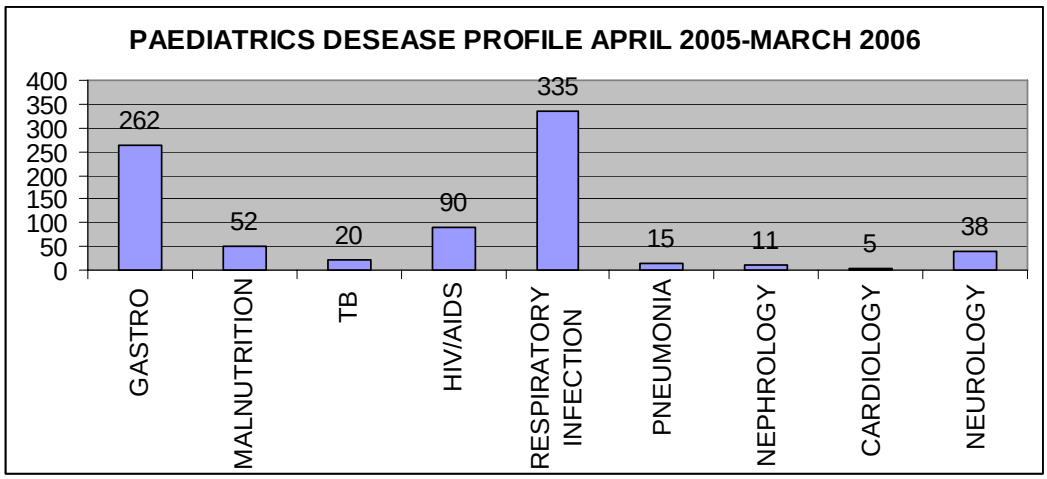
There were 34 542 admissions and 31 902 separations during the same period. On the other hand there were 2 525 patients from other provinces and 2 203 of those were from neighbouring provinces.

Figures below indicate both medical and paediatric disease profiles at KHC for the period 2005-2006. Medical disease profile covers a range of disease from respiratory infections to chronic diseases such as hypertension, whilst paediatric disease profile includes diarrhoeal infections and malnutrition. The graphs further show the number of new patients by disease for the period indicated

Graph 15: Medical Diseases Profile April 2005 – March 2006



Graph 16: Paediatrics Diseases Profile April 2005-March 2006



Priorities

- To improve the health status of the people of the Northern Cape, by providing high quality clinical services, and that these services would continue to develop and improve over the coming years.
- The oncology department is currently being re-vamped in partnership with Elle Lilly
- Burns unit is going to be modernized to increase the capacity to meet the needs
- The child health clinic is also going to be upgraded and its capacity increased at a cost of R 350,000
- A 24 hrs casualty service will be opened at GDH
- Internet kiosk at the specialized clinics will also be opened for the clients as mechanism of community empowerment
- Satellite Radiology services will also be opened at the out patient clinics thus providing a one stop service to our clients
- A head and neck center and a dental laboratory will opened as apart of service expansion program\
- New patient and hospital linen will be procured to restore the dignity of the clients
- All the ECP's will be provide new uniforms

Analysis of constrains and measures planned to overcome them
Constraints

- Limited financial resources for attracting certain scarce skills for the provision of all tertiary hospital services
- National problem of brain drain particularly nurses.
- The old and deteriorating hospital building make it very expensive to maintain.
- Maintenance costs of most hospital equipments are high due to wear and tear and need replacement rather than repairs.

Measures to overcome constrains

- The hospital senior management has planned a holistic approach to face the above mentioned challenges.
- Lobby for a higher budget allocation from the department of health.
- Increase intake of students for auxiliary nursing training.
- Improve working and leaving conditions of workers and also help to attract and retain certain scares skills to the hospital complex.

Table PHS44: Public hospitals by hospital type

Hospital type	Number of hospitals	Number of beds	Beds per 1000 uninsured people[1]		
			Provincial average	Highest district (include name)	Lowest district (include name)
Regional	1	583			
Central					
Specialist hospitals	**1.** West End Psychiatric hosp.	96			
	2. W/End TB (MDR)	30			
	3. Upington TB	36			
Total public	**15**	**745**	**15.13**		

Table PHS45: Public hospitals by level of care

Hospital type	Number of hospitals providing level of care	Number of beds	Beds per 1000 uninsured people[1]		
			Provincial average	Highest district (include name)	Lowest district (include name)
Level 1	13	496	75.71		
Level 2	2	151	20.77		
Level 3	1	583	15.13		
All acute levels					

Table PHS46: Situation analysis indicators for regional hospitals

Indicator	Type	Province wide value 2005/06	National target 2003/4
Input			
Expenditure on hospital staff as % of regional hospital expenditure	%	68.9	
Expenditure on drugs for hospital use as % of regional hospital expend	%	0.91	12
Expenditure by regional hospitals per uninsured person	R	546	
Process			
Regional hospitals with operational hospital board	%	100	80
Regional hospitals with appointed (not acting) CEO in post	%	100	75
Facility data timeliness rate for regional hospitals	%	90	43
Output			

Indicator	Type	Province wide value 2005/06	National target 2003/4
Caesarean section rate for regional hospitals	%	47	22
Quality			
Regional hospitals with patient satisfaction survey using DoH template	%	20	20
Regional hospitals with clinical audit (M&M) meetings every month	%	90	90
Efficiency			
Average length of stay in regional hospitals	Days	7.1	4-8
Bed utilisation rate (based on usable beds) in regional hospitals	%	87	72
Expenditure per patient day equivalent in regional hospitals	R	546	1,128
Outcome			
Case fatality rate in regional hospitals for surgery separations	%	6.1	2.5

Strategic goals

- Provide additional support for family health services
- Reduce inappropriate referrals
- Develop an integrated maternity service
- Relieve pressure on ICU by establishing High Care beds (Neurosurgery & obstetrics and gynaecology)
- Increase inpatient capacity through effective bed management
- Establish an integrated mental health service
- Improve the patient food service

Improving Emergency Medical Services

Table47: Kimberley Hospital Complex Tertiary Service Package

1	Accident & Emergency	**17**	Lipidiology
2	Angiography	**18**	Maxillo-facial Surgery
3	Burn Unit	**19**	Medical Oncology
4	Clinical Haematology	**20**	MRI
5	Clinical Immunology	**21**	Neonatal ICU
6	Colorectal Surgery	**22**	Nephrology (Renal Dialysis)
7	CT Scan	**23**	Neurosurgery
8	Dermatology	**24**	Ophthalmology
9	Ear/Nose/Throat	**25**	Orthopaedic
10	Endoscopy Unit	**26**	Paediatric ICU
11	General Cardiology	**27**	Plastic Surgery
12	General Surgery	**28**	Sonar
13	Genetics	**29**	Spinal Injury Management
14	Hepatobiliary Surgery	**30**	Tertiary Obstetrics & Gynaecology
15	Intensive Care	**31**	Urology
16	Internal Medicine	**32**	Vascular Surgery

Table PHS 48: Provincial objectives and performance indicators for regional hospitals

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
Provide additional support for family health services	Designated facility for clinical, academic and administrative purposes in place	90%	100%	100%	100%	100%
	Referral pathways established	70%	80%	90%	100%	100%
Reduce inappropriate surgical referrals	Protocols developed and disseminated for elective referral	60%	80%	100%	100%	100%
Increase surgical capacity with more day case operating	Dedicated day theatre capacity (incl. staff) and recovery beds identified	80%	85%	90%	95%	95%
	Procedures to be undertaken as day theatre case identified	65%	70%	75%	80%	85%
	Additional theatre capacity opened	60%	65%	70%	75%	85%
Improve women and family centred health promotion	Percentage of women receiving breast-feeding advice within 8 hours of delivery	60%	70%	80%	90%	95%

Table PHS 49: Performance indicators for general (regional) hospitals

Indicator	Type	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10	National target 2007/08
Input							
Expenditure on hospital staff as % of regional hospital expenditure	%	68.9	67.5	66.2	66	66	66
Expenditure on drugs for hospital use as % of regional hospital expend	%	4.83	5.31	6.4	8.32	11.65	12
Expenditure by regional hospitals per uninsured person	R	546	579	614	657	703	
Process							
Regional hospital with operational hospital board	%	100%	100%	100%	100%	100%	100
Regional hospitals with appointed (not acting) CEO in post	%	100%	100%	100%	100%	100%	100
Facility data timeliness rate for regional hospitals	%	90%	95%	100%	100%	100%	100
Output							
Caesarean section rate for regional hospitals	%	47	50	45	40	35	18
Quality							
Regional hospital with patient satisfaction survey	%	100%	100%	100%	100%	100%	100

Indicator	Type	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10	National target 2007/08
using DoH template							
Regional hospital with clinical audit (M&M) meetings every month	%	100%	100%	100%	100%	100%	100
Efficiency							
Average length of stay in regional hospital	Days	7.1	7.5	7.5	7.0	6.5	4-8
Bed utilisation rate (based on usable beds) in regional hospital	%	87	85	80	75	75	75
Expenditure per patient day equivalent in regional hospital	R	579	614	657	703	752	1,128
Outcome							
Case fatality rate in regional hospitals for surgery separations	%	6.1	4.4	3.52	2.86	2.3	2.0
Number of separations		30673	32207	33818	35509	37285	
Patient Day Equivalents		579	614	657	703	752	
OPD headcounts		140319	147335	154702	15796	16585	
Bed Utilisation Rate		87	85	80	75	75	
Caesarean Section Rate		47	45	40	35	30	
Case fatality rate for surgery separations		6.1	4.4	3.52	2.86	2.3	
Average length of stay		7.1	7.5	7.5	7.0	6.5	4 - 8
Expenditure per patient day equivalent		579	614	657	703	752	

10.2 PHARMACEUTICAL FACILITIES

Situational Analysis

Pharmaceutical Services in the Northern Cape is a sub-directorate, which falls under the Chief Directorate: Hospital Services within the Department of Health. The core business is to provide an excellent pharmaceutical service.

The target service level set for pharmaceutical services was number out of stock items, i.e a service level of 100% for 2006/07.

A comparative analysis between 2005 and 2006 demonstrates a steady incline in service level in October and November of this year in comparison with the same period last year.
This has made a large impact in the districts with patients amazed that they do not need to return to fetch items which were out of stock on their prescriptions and with pharmacists rejoicing that they are able to offer an efficient service to their clients.

Service levels in both years show a pattern of decline from February through to May due to the depletion of funds for pharmaceuticals just prior to the new financial year. During this period many accounts are placed on hold by suppliers. After the onset of the new financial year payments are once again resumed. Most suppliers have a lead time of six to eight weeks and subsequent improvement of service levels from June. Of note is a 100% service level which is maintained for antiretrovirals (ARVs) due to the conditional grant paying for these items. The average service level achieved between April and December 2006 for pharmaceuticals was 63%.

Priorities

- Ensuring that all essential pharmaceuticals are accessible and available at our facilities
- Ensuring the procurement, distribution and supply of safe, efficacious and quality products to clients and facilities.
- Ensuring compliance to Good Pharmacy Practice and Current Pharmacy Legislation
- Promoting the rational drug use of pharmaceuticals by prescribers, dispensers and patients

Legal & Policy Framework

The National Drug Policy (NDP)
Pharmacy Act 53 of 1974
Medicines and Related Substances Control Act 101 of 1965
"*Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa*"
Health Act no 63 of 2003.
Quality standards, ethics and professional standards.

Analysis of Constraints and Measures to Overcome Them

- Only 47% of hospitals, 38% of community health centres and 18% of primary health care clinics have the temperature of the area where medicine is stored controlled by the use of air conditioners.
- The majority of facilities have functional refrigerators, although back-up generators are not available in many facilities.
- Adequate and suitable areas for the storage of medicine in primary health care clinics are lacking.

Infrastructure and equipment

- Renovate/build new pharmacies at Springbok and Kuruman;
- Improve security of medicines at all facilities in the province;
- Ensure that PHC clinics have dedicated medicine rooms of sufficient size, patient counselling and waiting areas;
- Increase access to Internet/Intranet in all facilities;
- Roll-out computerisation including computerised inventory systems;
- Procure reference materials needed; and Install emergency generators and/or refrigerators where needed.
- Renovation of depot and new furniture
- Maintain high standards of cold management in facilities

Selection and procurement

- An active role be played by the provincial PTC and that the committee be driven by Pharmaceutical Services;
- PTCs be established at hospital/district level;
- Training be provided as needed.

Distribution and storage

- Develop provincial procedure manual for the province which is supported by customised SOPs per institution;
- Dedicated vehicles be provided for the scheduled delivery of medicine directly to facilities;
- Operation plan be put in place to prioritise infrastructural improvements needed e.g. installation of air conditioners where medicine is stored, security measures and safety equipment

Systems and processes

- Rationalise manufacturing and pre-packing as far as possible;
- Centralise manufacturing and pre-packing at the Depot;
- Strengthen the down referral system including patient education;
- Centralise dispensing of referral prescriptions;
- Promote rational drug use including the supply of medicine information at all levels; and
- Improve financial management of the medicine budget.

Table PHS54: Provincial objectives and performance indicators for Pharmaceuticals

Objectives	Indicators	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
To implement a fully operational EPR system at selected hospitals, community health centres and accredited ARV sites	No. of Facilities with optimally functioning electronic ordering systems	0	13	26	30	30
To optimise provincial pharmaceutical stock management	Percentage of total orders which are emergency orders	0	15%	5%	5%	5%
	Percentage of medication ordered out of stock	0	37%	25%	20%	15%
To ensure all requested	Percentage of deliveries	0	40%	80%	100%	100%

Objectives	Indicators	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
pharmaceuticals are delivered to the facilities on time	according to depot schedule					
To develop and implement an HR plan for recruitment, retention and skills development in pharmaceutical services	Percentage of hospitals and Community Health Centres with responsible pharmacists	0	42,5%	59,5%	70%	80%
	No. of new ARV pharmacist assitants posts created and filled at ARV sites	0	2	26	25	25
	No. of pharmacist assistants learnership	0	0	25	25	25
	No. of pharmacist assistants scholarships	0	0	50	25	25
	No. of pharmaceutical services training courses presented	0	11	30	24	24
Establish Provincial Prepack Unit	Prepack unit established in province	0	0	1	0	0

TABLE 51: Trends in provincial public health expenditure for Programme 4: Provincial hospital services

	2003-04 Actual	2004-05 Actual	2005-06 Actual	2006-07 Estimate	2007-08 Projection	2008-09 Projection	2009-10 Projection
Current Prices							
Total	261,626,000	244,905,000	295,230,000	322,256,000	-	-	-
Total per person	318	298	359	392	-	-	-
Total per uninsured person	397	372	449	490	-	-	-
Total capital	8,194,000	1,097,000	6,958,000	6,337,000	-	-	-
Constant (2005/06) prices							
Total	283,602,584	254,946,105	295,230,000	307,109,968	321,834,177	335,764,100	358,185,930
Total per person	345	310	359	373	327	341	364
Total per uninsured person	431	387	449	467	409	427	455
Total capital	8,882,296	1,141,977	6,958,000	6,039,161	7,272,000	6,076,000	5,817,000

11. PROGRAMME 5: HEALTH SCIENCES AND TRAINING

Situational Analysis

As part of the college's strategic planning review process, we have made some findings, which we strongly believe if addressed the college will move to higher levels. The department's inputs to the Provincial Growth and Development Strategy (PGDS) are silent about the role the college should play, as the only nursing training institution in the province, in growing the economy of the province. The college is faced with a challenge of repositioning itself to play a meaningful role in not only providing a service, but to also become a real engine for growth and development. However, the question is whether the college, not only in its current form but in its real orientation and focus, is able to do this.

The core business of the college is carried out by the following units/disciplines:

- Administration
- Community Health Nursing Science
- General Nursing Science
- Midwifery
- Psychiatric Nursing Science
- Student Affairs

The College is currently having the Auxiliary Nurses Programme (R 2176), Four Year Comprehensive Course (R425) and Bridging Course programmes running.
Five hundred and fourty Learnership are awaiting the Auxiliary examination results; the first years (271), third years (3), and fourth years (76) student nurses are still on training. The first year students are still awaiting registration from the South African Nursing Council whilst the College and the Department is addressing the requirements raised by the South African Nursing Council.

The moratorium on student intake is not yet lifted. Application for additional clinical facilities for student placement has been sent to the South African Nursing Council (SANC) for accreditation, i.e. Gordonia, De Aar, Springbok, Kuruman and Medi – Clinic Hospitals. National Institute for Higher Education (NIHE) situational analysis as a training facility has also been sent to SANC for accreditation.

As part of our planning, we have also discussed in detail the development of action plans and individual work plans that will ensure that our daily activities are responding to this strategic plan. We seek to transform this institution from an ordinary training institution to a result –driven organization that delivers on the government's contract with the people.

Policies

- Constitution of RSA of 1996
- Nursing Act 50 of 1978 and its related regulations
- National Health Act 61 of 2003 and related legislation
- Mental Health Care Act no 17 of 2002
- Medicine and Related Substance Control Act of 1995
- SAQA Act 58 of 1995
- Higher Education Act 101 of 1997
- Employment Equity Act 55 of 1998
- ETQA Regulations

Priorities

- A Nursing Education specialist to assist in putting Quality Management system in place.
- Filling of vacant posts to achieve the teacher – learner ratio of 1:25.
- Capacity building for staff
- Development and implementation of policies , procedures and guidelines
- Establishment of the governance and management structures and systems within the Nursing Education Institution.
- Curriculation in all programmes with approved unit standards taking into consideration the Community Based Education and problem – based learning approaches.
- Accreditation of additional clinical facilities for student placement.
- Twinning program/s nationally and internationally.
- A balance between service demands and supply.

Strategic Goal

To produce a competent Health Care Practitioners

Analysis of constraints and measures planned to overcome them

Constraints

- Three hundred (300) Student Nurses not yet registered by the South African Nursing Council due to inadequate resources
- Librarian, Secretary, HOD – for Community, Administrative Clerks, Vice Principal and Tutor posts not yet filled.
- Budget for the Library not yet available as well as budget in general.
- Shortage of accredited clinical facilities, the limited number of tutors and learning environment which is not conducive to teaching and learning hampers the delivery of quality education.
- Awaiting approved unit standards from the SANC in order to recurriculate
- Inadequate accredited facilities
- The existing Workplace Skills Plan does not embrace College specific needs
- Limited human and material resources compromise the quality of training and teaching.

Measures planned to overcome

- Comply to the South African Nursing Council requirements
- Recurriculate whilst waiting for unit standards from SANC
- Conduct situational analysis of non- accredited facilities and submit to South African Nursing Council for accreditation
- Design a college specific Workplace Skills Plan and submit to Provincial HRD
- Appointment of staff, budgeting and purchasing of equipment and improve on infrastructure
- Autonomy of the College
- Nursing Education Specialist to put in place Quality Management System
- Appoint Governing Structures

Table HS&T 52: Objectives and Indicators for Health Sciences and Training

Measurable Objective	Indicator	Main Category	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
Implement Curriculum R425,R683,R2176	Curriculum implemented	All students 4 Year Programme (Bridging) 1st & 2nd year Nurse auxiliary	Curriculum Implemented	Curriculum Implemented	Curriculum Implemented	Recurriculate and submit to SANC for approval	Implement the new curriculum
Implement the midwifery curriculum	Number of students in Midwifery training.	Third year students	70	3	134	24	100
		fourth year students	19	40	0	0	134
		one year diploma students	30	17	17 until June 2007	0	0
Improve quality of training	Number of students for accompaniment	Third year students	70	3	134	24	100
		Fourth year students	19	40	0	0	134
	Number of students Evaluated	Third year students	70	3	134	24	100
		fourth year students	19	40	3	137	134
Adhere to R2488 and R254	Number of students placed in accredited clinical facilities	Third year students	70	3	134	24 first semester 134 second semester	100
		Fourth year students	19	40	0	134	24
	Number of students evaluated	Third year students	70	3	134	24	100

Measurable Objective	Indicator	Main Category	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
		fourth year students	19	40	0	0	134
Implement the approved curriculum of R425	Curriculum implemented	2nd, 3rd and 4th year Students	Implemented	Implemented	Recurriculate and submit to SANC for approval	Implementation of new curriculum	implementation
Elect SRC	SRC Elected	Students	-	-	Elect SRC	Elect SRC	Elect SRC
Decentralize training facilities within the province to enhance more recruitment and training of nursing staff	Established additional Colleges for nurse training				Build or establish nursing college in two districts	2 nursing colleges established Staff and students established	Operational
Implement Quality Management System	Policies, structures and processes in place.	Policies Structures Processes	50%	100%	100%	100%	100%

TABLE 53: Trends in provincial public health expenditure for Programme 5: Health sciences

	2003-04 Actual	2004-05 Actual	2005-06 Actual	2006-07 Estimate	2007-08 Projection	2008-09 Projection	2009-10 Projection
Current Prices							
Total	11,108,895	17,079,226	26,749,000	24,200,000	-	-	-
Total per person	14	21	33	29	-	-	-
Total per uninsured person	17	26	41	37	-	-	-
Total capital	-	-	247,000	200,000	-	-	-
Constant (2005/06) prices							
Total	12,042,042	17,779,474	26,749,000	23,062,600	21,785,094	22,116,494	22,382,553
Total per person	15	22	33	28	22	22	23
Total per uninsured person	18	27	41	35	28	28	28
Total capital	-	-	247,000	190,600	90,900	86,800	83,100

12. PROGRAMME 6: HEALTH CARE SUPPORT SERVICES

Situation analysis

Forensic Pathology Services

The transfer of the medico-legal mortuaries from South African Police Services (SAPS) to Health has been completed and is effective as of 1st April 2006, the Implementation will be gradual over the next MTEF period. R24 631million was received as a Conditional Grant in 2006/07 for the financial year. There was a rollover R4087 000 from the previous financial year.

With regard to staff for the new Forensic Pathology Service, positions were advertised and interviews were held in November/December 2006 for second batch of mortuary staff. Application for this2nd batch has been effective as of 1st March 2006.

Information Technology equipment, Autopsy equipment and furniture has been delivered. The unit has received 15 additional vans for the year 2006/07 financial year. All mortuary vans and Sedans have been branded with Departmental colours. One of the old vehicles was involved in an accident in Kgalagadi district.

Permission to upgrade Kimberley, Upington and De Aar mortuaries was granted by the Department of Public works in January 2007. An implementation agent will be appointed to oversee the process of upgrading mortuaries. A sexual assault seminar and launching of vehicles were held in December 2006.

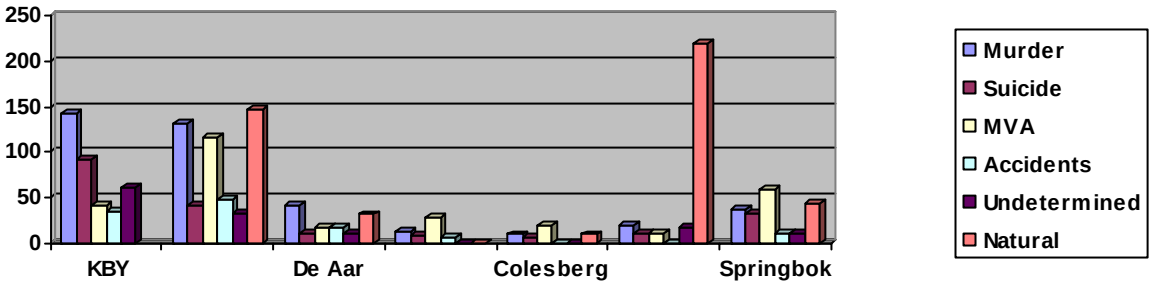
Table 54: Summary of Caseload Statistics

OUTPUT	PERFORMANCE MEASURE	2006/07
Autopsies performed	Autopsies per month	1147
Clinical cases seen	See table below	
Increasing the pool of trained forensic nurse	Number of trained forensic nurse and examining victims of sexual assault	6363

Table 55: Post-mortems in the Northern Cape 2006/7

Place	Murder	Suicides	Accidents	Natural	MVA	Undetermined	TOTAL No
Kimberley	218	101	103	100	187	57	766
Upington	131	40	48	147	116	32	514
De Aar	41	11	16	31	33	10	125
Calvinia	18	10	0	221	11	17	72
Springbok	36	32	11	44	59	11	188
Kuruman	13	7	5	0	27	0	52
Colesberg	9	5	0	9	18	0	41
	466	**206**	**183**	**552**	**451**	**127**	**1758**

GRAPH 17: Post mortems in the Northern Cape



Clinical Forensic Services

Training of Forensic Nurses was conducted in 2002/03. This training was dependant on the availability of nurses.

Clinical Forensic Services are rendered at the following: Thuthuzela Care Centre where examination of victims of sexual assault and domestic violence are done and Kimberley Hospital Complex doing the same range of services including drunken driving. In De Aar we have Ethembeni Care Centre, Bopanang Care Centre in Upington, Kuruman and Norvalspont.

The nurse at Thuthuzela Care Centre has been appointed as the new PEP co-ordinator. Two nurses for Kimberley Hospital Complex were then transferred to Thuthuzela as Forensic Nurses.

Table 56 Clinical Cases in the Northern Cape Province 2004/05 – 2006/07

	2004	**2005**	**2006**	**2007**
Common assault	97	97	0	0
Sexual Assault	605	1058	427	534
Sexual Assault minor	13	279	149	31
DNA testing	115	172	139	113
HIV counseling and testing	242	398	361	95
HIV negative	56	97	322	49
HIV positive	9	15	39	6
Clients on ARV	107	2650	320	48
Domestic Violence	1269	295	2578	322
Drunken Driving	295	138	131	7
Referrals	57	245	115	27
PEP	81	398	320	48
Child abuse	2	0	0	0
J88	1	0	0	0
Indecent assault	1	0	158	26
TOTAL	**2950**	**5754**	**5059**	**1306**

Priorities

- Launching of vehicles
- Community seminars
- Establish 24 hour service at Thuthuzela Care Centre

- Performance of good quality autopsies
- Examinations of survivors of sexual offences and domestic violence
- Upgrade mortuaries
- Appoint second batch of staff
- Appointment / head hunting new doctors

Constraints

- Shortage of trained forensic nurses
- Integration forensic curriculum into four year nursing course
- Slow phase of upgrading mortuaries

Table HCS 57: Provincial objectives and performance indicators for support services

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
Implement the transfer of medico-legal mortuaries from SAPS to Health	Effectiveness of mortuaries transfer	Business Plan submitted to National offices	Kuruman /Springbok to be upgraded	Commencement of Kimberley , Upington, De Aar, and 26 mortuaries facilities	Replace 5 worn-out mortuary vehicles	7 mortuaries
Increasing the pool of trained forensic nurses	Number of trained forensic nurses and medical practitioners examining victims of sexual assault	9 Trained forensic nurses.	15 Nurses	30 nurses	45 nurses	60 nurses
	Data of trained forensic nurses compiled	1x training session	1x training session	1x training session	1x training session	
Participating in the integrated approach to combating violence against women and children	1 seminar held 3x cluster meeting attended	Organize 3 Community forum meetings	Conduct seminars in Kuruman and Siyanda	Evaluation of previously seminars	Produce new programmes of action based on the evaluation in 08/09	1 seminar held 3x cluster meeting attended

Table 58: Trends in provincial public health expenditure for Programme 6: Health care support services

	2003-04 Actual	2004-05 Actual	2005-06 Actual	2006-07 Estimate	2007-08 Projection	2008-09 Projection	2009-10 Projection
Current Prices							
Total	101,811,803	59,219,311	87,809,000	65,018,000	-	-	-
Total per person	124	72	107	79	-	-	-
Total per uninsured person	155	90	133	99	-	-	-
Total capital	-	-	41	-	-	-	-
Constant (2005/06) prices							
Total	110,363,994	61,647,302	87,809,000	61,962,154	7,235,640	7,614,964	7,759,047
Total per person	134	75	107	75	7	8	8
Total per uninsured person	168	94	133	94	9	10	10
Total capital	-	-	41,000	-	-	-	-

13. PROGRAM 7: HEALTH FACILITIES MANAGEMENT

Situation analysis

There are six projects, four of these projects are on site and two are in planning. The four projects that are on site are:

- Psychiatric
- Gordonia
- Barkley West
- De Aar.

The total projected cost for the medium term is R461 000 000, R309 684 000, R234 000 000. This is for the 2007/08, 2008/09, 2009/10 medium term year.

The two projects that are in planning are:

- Kimberley
- Postmasburg

The total projected cost for the medium term is R 262 500 000, R 297 500 000, R 378 000 000. This is for the 2007/08, 2008/09, 2009/10 medium term year.

Hospital projects

Colesberg

- Due to expanded service package, the design of additional accommodation to house rehabilitative services is receiving attention and NDOH requires a special motivation.
- Documentation has been prepared to procure a contractor to complete the outstanding amounts of work, which includes the landscaping and final portion of road works. A tender advertised for this work and an inspection will be held in early December.
- Furniture for the staff accommodation will now be procured
- The project implementation plan for additional work that is required has been prepared and will be submitted for approval by National Dept of Health to access finance although budget constraints could be a problem.

Calvinia

- Landscape/ Gardening to be documented for new quotations.
- Due to expanded service package, the design of additional accommodation to house rehabilitative services is receiving attention and NDOH requires a special motivation.
- The project implementation plan for additional work that is required has been prepared and will be submitted for approval by National Dept of Health to access finance although budget constraints could be a problem.

New Mental Health Facility

- The contractor doing the sewer has still not completed the work.
- The main contractor is making slow progress and is significantly behind programme.
- The contractor for the construction of the bulk water supply and reservoir is substantially behind programme and did not meet his original completion date of 21 July 2006, the process to terminate the contact is underway, awaiting outcome and there is still no progress from Dept Roads, Transport and Public Works.
- A number of engineering design issues continue to receive special attention.
- Concerns regarding the generally poor progress on have been articulated to dept of works.
- The spend rate on this project is well below the projected cash flow.
- New project managers have been appointed and are preparing a recovery methodology

Garies

- The completion dates have been determined
- Final inspections to produce the snag lists are underway and the commissioning of equipment is well advanced.
- The external works and the gardens are complete
- Urgent attention is required for the recruitment of staff.
- A mobilisation plan to prepare for occupation during late January 2007 is being prepared.
- All equipment is being procured and will be funded by the donor – Reckitt Benkiser (Dettol)
- The name of the hospital is still to be determined – this is now urgent.

Upington

- Good progress is being made with the detail planning.
- The earthworks are progressing well and the concrete retaining wall is nominally behind programme, the work will be substantially completed by December 2006.
- A serious problem with the lower end of the site has been arrested by the involvement of a specialist structural/ geotechnical engineer. Special foundation requirements have been identified and quotations have been received – work commenced in early September and to be completed by early December.
- The awarding of the building tender is on hold pending a solution to the budget availability, this affects the projected cash flow.

De Aar

- Good progress is being made with the detail planning.
- The earthworks are progressing well although some rain delays have been experienced, completion is set for November 2006.
- Contact has been made with national roads regarding the intersection with N10 and the possible use of road service and the document is to be drafted and submitted.
- The building tender closed on the 27th October 2006 and has been adjudicated with the intention to award – delayed now due to budget constraints.

Barkley West

- The building contractor is progressing well with wetworks component of the project.
- The roof is currently being erected
- The civil engineering contractor eventually achieved first handover.
- The performance of the Architect remains a challenge.
- The accommodation for support services has been finalised and construction has commenced.

Postmasburg Hospital

- The tender for civil engineering services and earthworks closed on 29th September and has been adjudication with the intention to award – delayed due to budget constraints.
- The award f the civil engineering tender is on hold a solution to the budget availability, this affects the projected cash flow.

New Kimberley Hospital

- Technical Consultants have been appointed.
- Awaiting formal approval of Business Case by NDOH.
- Budget constraints could be a problem.

New Revitalization

- A Business Case is being prepared for the new Kuruman Hospital and must be revised to accommodate a Regional Hospital Facility.
- Urgent attention is required for the Port Nolloth and Hartswater Business Cases for urgent submission.
- Budget constraints could be a problem

Clinics

The following clinics are at the following status:

- Galeshewe Phutanang – service commenced on 31 July 2006
- Petrusville –service commenced on 04 August 2006.
- Noupoort – Eurekaville – a contractor has been appointed and is making satisfactory progress on site
- Noupoort – Kwazamuxolo - a contractor has been appointed and is making satisfactory progress on site

Construction on the following new clinics is due to commence during this financial year. Tenders were advertised early September 2006 not withstanding the slow progress made by the civil engineering consultants. The tenders closed on 13 October 2006 and have been technically evaluated before submission to SCM, however budget constraints are impacting on the awarding of these tenders.
An extension to the validity of tenders has been requested to allow expenditure to be incurred in the new financial year.

- Douglas – The site has been finalised.
- Platfontein – The site has been finalised.
- Nonzwakazi – De Aar, the site has been finalised.
- Phillipstown – The site has been finalised.
- Diben – The site has been finalised
- Upgrading of Groblershoop CHC maternity section – drawings are to be prepared and tenders are to be prepared in the New Year.

ARV Clinics

The following clinics are receiving attention:

- Springbok – items outstanding
- GDH – additional work required, to be determined
- De Aar – work required to be determined
- Kuruman – design to be finalised during site visit to be arranged.
- Jan Kempdorp – planning to be finalised
- KH peads clinic – planning finalised, implementation to proceed immediately, work to be put in hand shortly as soon as stores and lodge are moved.

Table HFM 59: Historic and planned major project completions by type

Objective	Indicator	Actual 2005/06	Estimate 2006/07	Target 2007/08	Target 2008/09	Target 2009/10
Construction of New Hospitals	Implement ation	-	Barkly West, Mental Health Facility De Aar, Upington Postmasbur g	Barkly West, Mental Health Facility, De Aar, Upington Postmasburg New KH Kuruman Port Nolloth Hartswater	Mental Health Facility, De Aar Upington Postmasburg New KH Kuruman Port Nolloth Hartswater Prieska	Kakamas Warrenton Hopetown New KH Kuruman Prieska
Construction of New Clinics	Implement ation	-	Platfontein Nonzwakazi Douglas Phillipstown Deben Groblershoo p Maternity	Morrisdraai Kuruman Clinic Lepelfontein Schmidtsdrift Upington Mental Health Clinic	Morrisdraai Kuruman Clinic Lepelfontein Schmidtsdrift Upington Mental Health Clinic	Majeng Bankhara Bergsig Niekerkshoop
Upgrading of CHC's	Implement ation	-	Garies	Welkom Jan Kempdorp	Welkom Jan Kempdorp Tshwaragano	Nababiep Groblershoop Tshwaragano

Table 60: Trends in provincial public health expenditure for Programme 7: Health facilities management

	2003-04 Actual	2004-05 Actual	2005-06 Actual	2006-07 Estimate	2007-08 Projection	2008-09 Projection	2009-10 Projection
Current Prices							
Total	33,372,000	69,929,000	136,303,000	294,040,000	-	-	-
Total per person	41	85	166	357	-	-	-
Total per uninsured person	51	106	207	447	-	-	-
Total capital	32,639,000	69,254,000	116,086,000	235,265,000	-	-	-
Constant (2005/06) prices							
Total	36,175,248	72,796,089	136,303,000	280,220,120	190,584,576	231,054,656	274,436,088
Total per person	44	88	166	341	194	235	279
Total per uninsured person	55	111	207	426	242	294	349
Total capital	35,380,676	72,093,414	116,086,000	224,207,545	168,041,376	203,278,656	239,534,088