STRATEGIC PLAN FOR

MPUMALANGA PROVINCIAL HEALTH DEPARTMENT

FOR 2003/04 - 2005/06

March 2003

Contact

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ENDORSEMENT BY MEMBER OF THE EXECUTIVE COUNCIL

In our quest to meet the constitutional imperatives, we have set ourselves the task of ensuring a health system capable of delivering quality health care to all our citizens efficiently and in caring environment. The vehicle of ensuring that is the implementation of the Strategic Plan for the 2003/2004 to 2005/2006 MTEF period.

The Strategic Plan is an attempt to achieve what is mostly enshrined in the Constitution of the country, 1996, Act 108 of 1996.

In the development of this Strategic Plan, much emphasis was given to the National Legislation and policies, more especially the National Health Sector Strategic Framework 1999-2004. The district health expenditure reviews and audits played a central role in the finalization of this Strategic Plan.

I would like to acknowledge and thank all those who have participated during the process of developing this Strategic Plan, for dedicating their time and energy to this all-important task.

It is my hope that we will unite in implementing this document, inspired by the will to improve the health of our people and ensure a brighter future for the aged, youth and our children. Let us unite in pushing back the frontiers of poverty.

I, as the Executive Authority of the Mpumalanga Health Department endorse this strategic plan and will put all my energies in ensuring the implementation of the document

MS M.N.S. MANANA
MEC: DEPARTMENT OF HEALTH

INTRODUCTION AND SIGN-OFF BY THE HEAD OF DEPARTMENT

This document represents a strategic plan for Mpumalanga Department of Health over the medium term period from 2003 to 2006. The document emerges from concerted efforts of the departmental planning committee, together with the three district-management and district health expenditure review teams. Invaluable experience was indeed gained with appreciated technical support from the Equity Project.

The process of developing this strategic plan document started in May 2002, as required in the prescribed format from the National Department of Health and National Treasury. The department held numerous workshops to ensure consistency of common understanding of our strategic direction among all departmental personnel and other stakeholders.

A total of six workshops were held between May 2002 and April 2003, with senior management, programme managers, local municipality partners, district teams and other support personnel.

The document depicts a number of health care delivery problems and challenges facing our province in general, and our department in particular. Many of these are mainly related to problems of access and utilisation of health services, and the mal-distribution of financial and other resources. This process has proven very invaluable because it has for the first time provided a picture of what we are currently faced with, together with challenges present and opportunities to look ahead and plan for the improvement of service delivery over the coming three-year period in Mpumamalanga.

Advocate R Charles
Head of Department
Mpumalanga Department of Health

Acknowledgement

Co-ordinating the Strategic Planning Process within our department, in the new prescribed format hasn't been only daunting at times, but it has been the greatest learning process that will be looked back at the greatest feelings of appreciation in doing things just a little bit differently. The process was daunting because it demanded commitment from individuals who were not exposed to this type of work and therefore demanded a different approach to co-ordination and interpretation of the prescripts the National Departments of Health and Treasury. Nonetheless, the efforts put forward by all who were involved cannot be applauded enough, especially considering the difficulties encountered in interpreting and eventually coming up with a document which is meant to provide the strategic direction of this the department of Health, in Mpumalanga.

We would like to particularly single out Mr David H. Collins and Mr Bupendra Makan from the Equity Project's Management Sciences for Health for their continued and relentless technical support throughout the development process of this document. Our appreciation goes out to our Departmental Senior Management for their support and guidance as well as the departmental staff members, from different levels who heeded the call to attend and participate and provided meaningful inputs at the numerous provincial workshops held during the process of developing the document.

Last but by no means least we would like to thank the Honourable Ms Sibongile Manana, our MEC for Health and Head of Department, Ms Rina Charles, for their relentless support and guidance in ensuring the completeness and finalisation of this important, most key document which directs our performance as a provincial department of health.

Provincial Strategic Planning Co-ordinating Team

Mr RM Mnisi
Ms PE Gwala

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-natal Care
BAS	Basic Accounting System
CBDC	Cross Boundary District Council
CHC	Community Health Centre
DC	District Council
DHER	District Health Expenditure Review
DHIS	District Health Information System
DHS	District Health System
DIO	District Information Officer
DOH	Department of Health
DO	District Office
Dr.	Doctor
DOTS	Directly Observed Treatment Short-course
EDL	Essential Drug List
EDM	Ehlanzeni District Municipality
EHO	Environmental Health Officer
EMS	Emergency Medical Services
GIS	Geographical Information System
HIV	Human Immunodeficiency Virus
HST	Health systems Trust
IP	Inpatient
LDOH	Limpopo Department of Health
LP	Limpopo Province
MDOH	Mpumalanga Department of Health
MLL	Minimum Living Level
MP	Mpumalanga Province
NGO	Non-Governmental Organisation
OP	Outpatients
PAS	Personnel Administration Standard
PC	Per Capita
PHC	Primary Health Care
PHO	Port Health Officer
PMTCT	Prevention of Mother To Child Transmission
PN	Professional Nurse
RDP	Rural Development Plan
SDIO	Local Municipality Information Officer
SPS	Strategic Position Statement
STI	Sexual Transmitted Infections
TB	Tuberculosis
TLC	Transitional Local Council
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

EXECUTIVE SUMMARY

The Mpumalanga Strategic Planning Document purports to outline and present the provincial strategic direction for the forthcoming medium term period for 2003 to 2006. In preparing this document, the new format, which was developed and later prescribed by the National Departments of Treasury and Health, was followed. Part A of the document presents the overall provincial picture of the health services provision. Part B presents Programme 2, 3, 4. 6 and 8 as well as sub-programmes HIV/AIDS, STI, and TB and Nutrition as prescribed.

A situation analysis is presented for each programme and sub-programme, followed by policies and priorities, key constraints and objectives and performance indicators for these programmes. Due to some difficulties in trying to compile an overall district health services profile, we made use of the limited information available and provided from the three districts. The information used in this document although used for the purpose of developing a strategic plan, will need to be re-looked at and reviewed for the next strategic period. It will also be used as the baseline to particularly help district management teams in reorganising services. The situation analyses depicts the current picture of where the provinces is in terms of the health service provision, distribution of health resource between health districts and challenges from the various health needs and organizational constraints that prevalent in the provinces

Wherever possible, the Provincial Strategic Position Statement, as produced by the consultants, Turner and Townsend, in 2001, was consulted to develop the medium strategic plans for the department. For instance, in as far as the reallocation of hospital beds and levels of care reallocation are concerned, the SPS document was used to assess where the province stands and how the reallocations should be planned for.

The document goes on to present trends in expenditure as well as planned budgets over the medium term as a total for Mpumalanga Department of Health as well as by each programme and sub-programme.

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Broad policies, priorities and strategic goals

Mpumalanga Department of Health has adopted the following Vision and mission to provide a strategic direction for its employees as well as all stakeholders in the provision of health care services in the provinces.

Vision

Is a caring and humane society in which all the inhabitants of Mpumalanga have access to affordable, good quality health service.

Mission

To provide and improve access to health care for all, and reduce inequity and to focus on working in partnership with other stakeholders to improve the quality of care on all levels of the health system especially preventive and promotive health and to improve the overall efficiency of the health care delivery system.

Departmental Core Values

Mpumalanga Department of Health has adopted the following as its core values which are at the heart of our commitment to the community we serve:

Commitment to service delivery
Professional competency
Integrity
Discipline
Ubuntu
Empathy
Loyalty
Care

1. LEGISLATIVE AND OTHER MANDATES

The Department derives its mandate from the following: -

The Constitution of the Republic of South Africa (Act 108 of 1996)
MEDICAL SCHEMES AMENDMENT BILL, 2002
MENTAL HEALTH CARE BILL, 2002
CHOICE ON TERMINATION OF PREGNANCY ACT, 1996 (ACT NO. 92 OF 1996)
HEALTH ACT, 1977 (ACT NO. 63 OF 1977)
HEALTH PROFESSIONS ACT, 1974 (ACT NO. 56 OF 1974)
MEDICINES AND RELATED SUBSTANCES CONTROL ACT, 1965 (ACT NO. 101 OF 1965
MENTAL HEALTH ACT, 1973 (ACT NO. 18 OF 1973)
NURSING ACT, 1978 (ACT NO. 50 OF 1978)
PHARMACY ACT, 1974 (ACT NO. 53 OF 1974)
STERILIZATION ACT, 1998 (ACT NO. 44 OF 1998)
PUBLIC SERVICE ACT 38 OF 1999
PROMOTION OF ADMINISTRATIVE JUSTICE ACT 3 OF 2000 (JUDICIAL MATTERS AMENDMENT ACT 42 OF 2001).
WHITE PAPER ON TRANSFORMATION, 1997
PUBLIC FINANCE MANAGEMENT ACT (PFMA) (AS AMENDED BY ACT 29 OF 1999).

Other Legislative Mandates are, inter alia:
South African Medical Research Council Act, 1991 (Act No. 58 of 1991)
Tobacco Products Control Act, 1993 (Act No. 83 of 1993)
South African Medicines and Medical Devices Regulatory Authority Act, 1998 (Act No. 132 of 1998)
Academic Health Centres Act, 1993 (Act No. 86 of 1993)
Allied Health Professions Act, 1982 (Act No. 92 of 1982)
Dental Technicians Act, 1979 (Act No. 19 of 1979)
Foodstuffs, Cosmetics and Disinfectants Act, 1972 (Act No. 54 of 1972)
Hazardous Substances Act, 1973 (Act No. 15 of 1973)
Occupational Diseases in Mines and Works Act, 1973 (Act No. 78 of 1973)
National Health Laboratory Service Act, 2000 (Act No.37 of 2000)
National Policy for Health Act, 1990 (Act No.116 of 1990)
Human Tissue Act, 1983 (Act No. 65 of 1983)
International Health Regulations Act, 1974 (Act No. 28 of 1974)
Medical Schemes Act, 1998 (Act No. 131 of 1998)
Health Donations Act, 1978 (Act No. 11 of 1978)

2. SECTORAL SITUATIONAL ANALYSIS

BACKGROUND

Mpumalanga Province is situated on the eastern-most part of South Africa with a terrain which renders it one of the most difficult areas in South Africa to access and thus to deliver essential health services. The province is bordered by 4 of the 9 provinces, namely Gauteng, Free State, KwaZulu-Natal and Limpopo Province, as well as Mozambique and Swaziland.

Due to its location, the province faces an influx of patients from both the neighbouring provinces as well as the two neighbour countries, Mozambique and Swaziland. Mpumalanga province consists of 3 Health Districts, called: Ehlanzeni, Nkangala and Gert Nsibande (formerly known as Eastvaal).

Mpumalanga Provincial Map

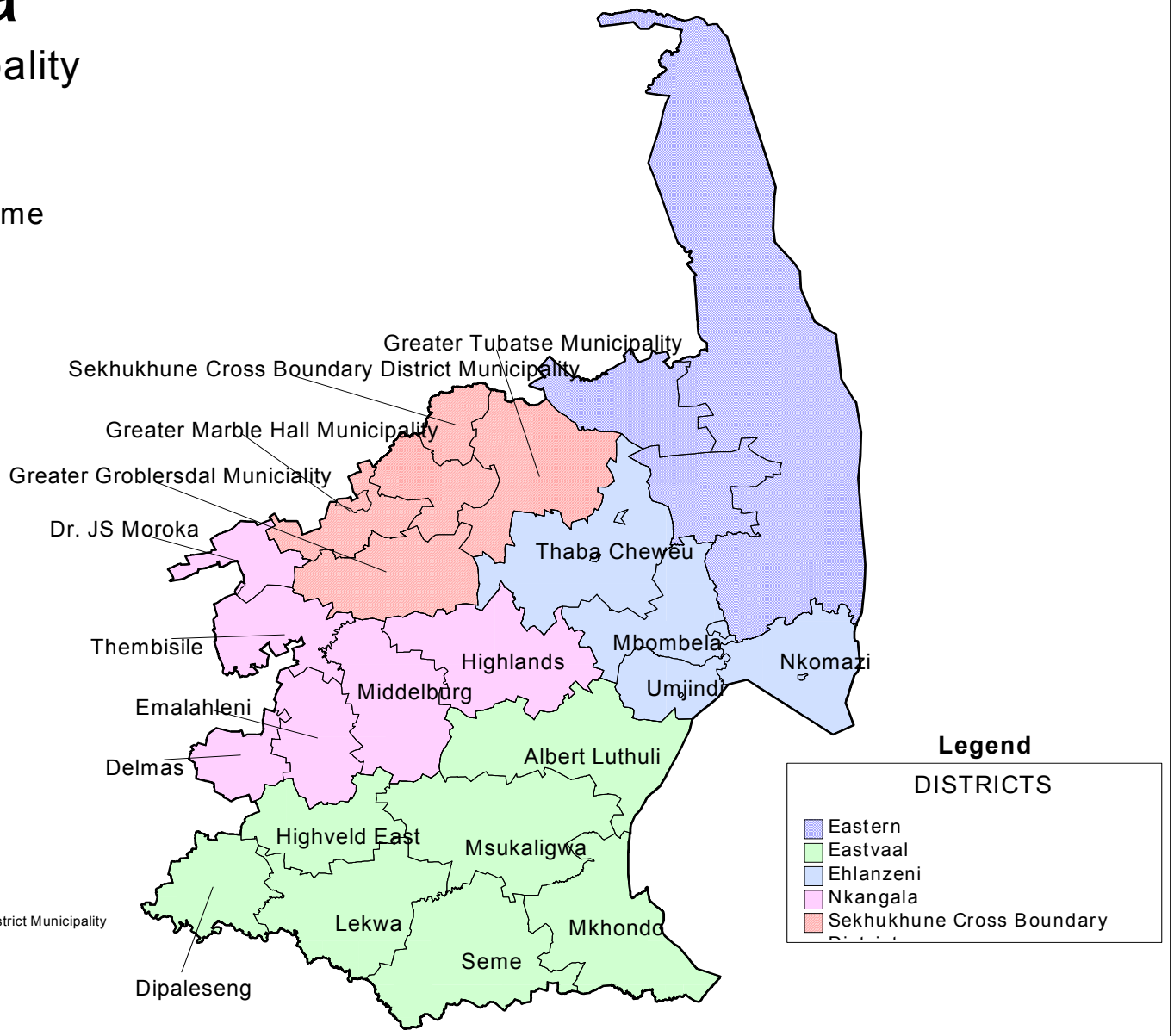
The province measures 79 490 km^2. This is about 6.5% of the land area of South Africa. Geographically the province is 2^{nd} smallest in the country after its neighbor, Gauteng. Land Area distribution in South Africa by province is shown in Table 2 below:

[2]

Mpumalanga

Section 12 Local Municipality

Common Name	Section 12 Name
Marble Hall	Greater Marble Hall Municipality
Groblersdal	Greater Groblersdal Municipality
Burgersfort/Ohrigstad/Eastern Tubatse	Greater Tubatse Municipality
Elukwatini/Carolina	Albert Luthuli
Ermelo	Msukaligwa
Piet Retief	Mkhondo
Volksrust	Seme
Standerton	Lekwa
Balfour	Dipaleseng
Highveld Ridge	Highveld East
Delmas	Delmas
Witbank	Emalahleni
Middelburg	Middelburg
Belfast	Highlands
KwaMhlanga	Thembisile
Mdutjana	Dr JS Moroka
Lydenburg\Sabie	Thaba Chweu
Nelspruit	Mbombela
Barberton	Umjindi
Nkomazi	Nkomazi
Southern	Sekhukhune Cross Boundary District Municipality



The provincial map depicts the demarcations by district and local municipality boundaries. It also includes the Sekhukhune cross boundary region, which have major implications with regard financing and delivery of health services in the province. For instance, patients flow from Limpopo Province (Thubatsi), Greater Sekhukhuni, Swaziland Kwa-Zulu Natal and Mozambique to access Health Facilities into Ehlanzeni District, Nkangala and Eastvaal Health facilities.

Demographic Profile

By comparison, Mpumalanga Province is ranked the 3rd most rural province in the country of the total population, 60.9% live in rural areas, whereas the balance of 39.1% live in the urban areas. For South Africa, the ratio is 53.9% urban and 46.1% non urban. As at mid 2000, an estimated 3 million people were living in the province, the estimated racial make-up is shown in table 2.

Table 1: % Urban/Non-urban population distribution by province (1996 census)

Province	EC	FS	GP	KZN	MP	NC	LP	NW	WC	SA
Urban	36.6	68.8	97	43.1	39.1	70.1	11	34.9	88.9	53.7
Non-urban	63.4	31.4	3	56.9	60.9	29.9	89	65.1	11.1	46.3

Source: Pop census 1996

Table 1 shows urban/non-urban population distribution between provinces. The comparisons clearly depicts differences which show Mpumalanga provinces as one of the most rural provinces, led by the Eastern Cape, following closely after North West.

Like most provinces in South Africa, the majority of the people living in Mpumalanga are of the African decent (89% Africans living in Mpumalanga Provinces compared to the South African average of 77%). The remaining 11% is made up of Whites at 9%, Coloureds at 0.7% and Indians who only make up 0.5% of the total population in this province.

Table .2 Racial Composition

	Mpumalanga	South Africa	Total South Africa
Africans	89%	77%	33 879 852
Coloured	0.7%	8.7%	3 796 858
Indian/Asian	0.5%	2.5%	1 092 522
White	9%	10.3%	4 521 664
Other/unspecified	0.6%	0.9%	394 803

According to the Population Census of 19996, there are more females than males in Mpumalanga province. The proportions are reported as follows: 51.4% (1 792066) and 486% males (1 693 800). The majority of the population is aged between 10 and 14 years of age at an estimated 340 000.
The population groups under the age of 15 and over the age of 60 years are not considered economically active and such they are dependent on the balance that are economically active to support them. Therefore looking at the table above, the percentage population that is dependent equals 39.*% and the balance of only 60.2% are potentially economically active. Considering the high rate of unemployment (estimated at about 37%) a dependency ratio of 68.25% has been calculated.

In Mpumalanga, the fertility rate recorded in 1998 was an average of 3.1 children per woman. The average fertility rate for South Africa was recorded at 2.9 children per woman in 1998. This was further calculated as 4.0 children per African Women in rural areas and 2.4 children for African Women in urban areas.

Household Data

Information received from the Electricity Regulator, estimates that there are 641, 565 households in the province of Mpumalanga. That figure was further disaggregated to 272,330 for urban and 369 253 for rural households. See further break down of household data in the Annexure for district plans.

Employment

As at 1999, the unemployment figure for Mpumalanga was: out of a population of about 1.8 million the number of people employed was estimated to be 692,00. Using the strict definition, the number of unemployment was estimated to be 224,000 (24%). Using the expanded definition of unemployment, the number increased to 407,000 (37%).

This compares favorably with that of other provinces as depicted in the table below. However, unemployment constitutes a real and growing problem for Mpumalanga and is a significant contributor to the level of poverty in the province. Notably, it is the rural African women and children who are mostly affected by this state of affairs.

Although the provincial unemployment rate is an average 37%, there are a number of local municipal areas within some districts that have unemployment rates over 43%. Of the total unemployment figure for Mpumalanga, the Male : Female unemployment ratio of 39.6%:60.4% is estimated, whereas the urban : rural split is estimated at 76.9%:23.1%.

Income

The index of disposable income for Mpumalanga is 9% lower than the national average and the 5th poorest in the country. The National Bureau for Market Research defined the disposable annual income per capita as at 2000 to be as follows:

Province	**Disposable Income**
Gauteng	R25 988
Western Cape	R20 777
Northern Cape	R12 482
Free State	R12 334
Mpumalanga	R 11 088
Kwa-Zulu Natal	R 10 592
North Wes	R 9 638
Eastern Cape	R7 792
Limpopo	R 6 021
South Africa	**R13 502**

Given the defining line of poverty (as defined in the Poverty and Inequality in South Africa Summary Report 1988) at earning less than R431 per month per person household, or up to R1 840 per 8 person household, the 1996 census indicated the poverty profile, per race group in the province to be as follows:

Poverty Profile per Race Group

African	Colored	Indian	White	Total
1 753 000	7 000	2 000	28 00	1 790 000
69.8%	35.5%	11.9%	11.1%	63.9%

Infra-structural Development

Water and Sanitation

According to the Mpumalanga Department of Health the following statistics have been given to the province:
Of the total population in Mpumalanga, 51% have a tap inside their house (the average for South Africa is 39%), 20% have a tap on site, 28% use a public or community tap and 2% have none at all. 43% of population have their refuse collected by the local authority, 3% use a community dumping site, 34% use pits within their site and 20 have no access to refuse collection at all. 32% of the population have flushing toilets inside their houses (compared to 35% for South Africa, 10% have flushing toilet outside their house (compared to 19% for South Africa), 44% still use pit latrines, 4% use bucket latrines and 9% have nothing at all. The obvious conclusion from these statistics is that this creates potential health problems for the province.

Electricity Supply

By 1999 of the estimated 11 households in South Africa, only 53% used electricity to cook with. In Mpumalanga, the number of households using electricity to cook was estimated at 72%.

Human Development Index

The HDI for South Africa is 0.677, which falls within the medium level of human development. For Mpumalanga, the HDI is reported at 0.694. Although higher than the national average, wealth and resources are not equally distributed by race or geographic location, given the substantially higher rural population within the province, and so there are huge differences between racial groups and the HDI indicator is not a good indicator to use in Mpumalanga.

Collaboration with other Health Services Providers

There is a working relationship between the clinics, hospitals and the private sector. One such example is the use of the scanner at Nelspruit Private Hospital that prevents head injuries and spinal patients from being transported for more than 200km to obtain a scan at the provincial regional hospital in Witbank. However, there is potential and a need for this relationship to be further developed.

The moratorium imposed on the issuing of new licences for private hospitals has limited the development of further private facilities in the province. There is however even more potential to develop stronger public-private partnership initiatives for the delivery of health care in the province.

Population Health Needs

HIV/ AIDS

Mpumalanga is reported to be the third highest HIV positive incidence in the country after Free State and KwaZulu-Natal. It is also reported that in this province, the highest incidence is found in the 15-19 year age group. By mid 2000 there were an estimated 320 000 people infected with HIV/Aids in Mpumalanga, which represents over 10% of the total population of the province. According to the Provincial Healthcare Position Statement, the surveillance data from the TB hospitals portrayed the rapid evolution of the dual HIV/TB epidemic in rural South Africa. The profound impact on the epidemiological profile and outcomes of admitted TB patients are realities requiring the urgent attention of health planners and policy makers in South Africa. The rate of infection is particularly alarming in districts that are situated on the migrant and trucking routes throughout the province.

Tuberculosis

In Mpumalanga TB is diagnosed and treated according to the directly observed treatment, instituted at primary health care clinics. Patients who cannot be treated on an ambulatory basis are admitted to one of three non-governmental (South African National Tuberculosis Association – Santa) hospitals or municipal TB hospitals in the province. The TB register in 1999 demonstrated a 36% increase in admission between 1998 and 1999 despite no change in admission policy. The slight decrease in admission during 2000 may have resulted from an active attempt to refer appropriate patients to local active home-based care project.

Malaria

Mpumalanga province is one of the provinces in South Africa that was hardest hit by malaria and cholera in recent years. In 1999 most malaria cases were reported in KZN (53%) followed by Mpumalanga at 23% and Limpopo at 18%. Nationally 32 015 cases of malaria were reported with 230 deaths in 1999. These figures have increased to 36717 cases and 280 deaths in 2000. These increases were associated with floods that hit Mozambique at the beginning of 2000. Mpumalanga response to the outbreak has

been commended as being one of the finest in the country and it was reported that the province was able to contain the outbreak effectively.

Population Morbidity and Mortality Rates.

Mpumalanga province, which has a predominantly rural and African population at approximately 89%, is particularly susceptible to having a high incidence of infant mortality. Compared to other provinces, the Infant Mortality Rate for Mpumalanga is 37.2%, which rates as the 6th highest in South Africa.

Infant mortality rate by province 1998	
Province	Rate
Eastern Cape	61.2
Free State	50.5
Gauteng	36.3
Kwa-Zulu Natal	36.8
Mpumalanga	37.2
North West	43.1
Northern Cape	52.1
Limpopo	47.3
Western Cape	30.2
South Africa	45.4

Source: National Department of Health

Top Ten Causes of Hospital Admission

The top ten causes of hospital admission in the province have be reported as the following (not listed in order of priority):

Pneumonia
Immuno Suppression
TB
Gastro Enteritis
Diabetes Mellitus
Cardio Vascular Accidents
Motor Vehicle Accidents
Cancer
Hypertension
Cardiac Conditions

The causes of death are directly related with the service input in terms of services rendered and level of accessibility to those services. Due to the prevailing laws it is however difficult to access the exact causes of death, therefore the list above is only a reflection of what is available from the hospital records. The Immuno-suppression and other HIV/Aids related diseases form the bulk of these causes.

Mpumalanga Provincial Health Resource Distribution.

Table2: Public hospitals

Hospital type	**Number**	**Number of beds [1]**	**Beds per 1000 people [2,3]**	**Beds per 1000 uninsured people[2]**
District[3]	22	3393	0.959	0.007beds
General (regional)	2	650	0.184	0.209beds
Central	0	0	0	0
Tuberculosis[5]	1	5656	1.598	1.817
Psychiatric[5]			---	---
Total	**25**	**9699**	---	---

Table 2 shows the number of hospitals by type in the province, number of beds as well as number of beds per 1000 population. It shows that there are mostly district level hospitals that any other types. This shows and over-supply of district level hospital beds compared to the regional and central level hospital. The Provincial SPS process also depicted the need to increase the supply of the level 2 and 3 beds and a minimal reduction of level 1 beds.

Human Resources

Table3: Public health personnel[1]

Categories	Number Employed	% Of total Number Employed	Number per 1000 people[2]	Number per 1000 uninsured people[2]	Vacancy rate	% Of total Personnel budget	Average annual Cost per staff Member
Medical officers[3]	306	59	0.086	0.098	213	8.43	251990
Medical specialists	8	28	0.0023	0.003	21	0.17	19531
Dentists	45	67	0.13	0.014	22	1.00	202820
Dental specialists	0	0	0	0	0	0.00	83798
Professional nurses	2220	82	0.628	0.713	489	20.33	0
Staff nurses	967	94	0.273	0.311	160	7.49	70900
Nursing assistants	1723	74	0.487	0.554	608	9.75	51782
Student nurses	447	52	0.126	0.144	407	1.90	38936
Pharmacists[3]	78	57	0.022	0.025	60	1.00	117294
Allied health professionals and technical staff[4]	1387	75	39.2	43.6	464	15.32	81683
Managers, administrators and logistical support staff	4027	75	---	---	1370	36.36	---
Total	**11 208**	**74**			**3814**	**100**	

The SPS document reported that in June 2001 the department was 22.6% understaffed. It however, stated further that this number did not correspond with feedback received from staff at all facilities as well as written feedback contained in numerous management reports. It went on to state that vacant posts were "lost" when posts were vacant at the time that the budget was done.

Table4: Evolution of expenditure by budget programme in (R million)[1]

Programme	**2000/01 (actual)**	**2001/02 (actual)**	**2002/03 (estimate)**	**2003/04 (budget)**	**2004/05 (MTEF projection)**	**2005/06 (MTEF projection)**
1. Administration	97,152	111,016	131,982	191,701	173,191	202,119
2. DHS	886,368	1,076,260	1,241,230	1,379,352	1,494,262	1,608,080
3. EMS	-	-	-	70,031	82,933	87,909
4. Provincial Health Services	91,339	160,221	187,004	290,730	319,081	338,226
6. Health Sciences & Training	25,816	32,638	38,461	48,225	55,601	58,937
7. Health Care Support services	9,847	12,664	33,467	26,793	32,669	34,629
8. Health Facilities Management	13,752	63,763	69,598	113,496	138,928	173,391
Total programme	**1,117,368**	**1,456,562**	**1,701,742**	**2,101,818**	**2,315,056**	**2,503,291**

Table 4 shows some interesting trends regarding provincial health expenditure especially as it pertains to district health services (DHS) and administration in proportion to the total expenditure over the MTEF period. In the 2000/01 DHS expenditure amounted to 78.2% of the total compared to the projected 70.3% in 2005/06. On the other hand Administration expenditure in 2000/01 amounted to 8.6% whereas in 2005/06 it is projected to be 9.9% of total expenditure. This clearly shows a nominal increase over the years on administration costs vs. a nominal decrease in service delivery expenditure for an example DHS.

Table5: Trends in provincial public health expenditure in (R million)

Expenditure	**2000/01 (actual)**	**2001/02 (actual)**	**2002/03 (estimate)**	**2003/04 (budget)**	**2004/05 (MTEF projection)**	**2005/06 (MTEF projection)**
Total	**1,117,368**	**1,456,562**	**1,656,566**	**1,887,969**	**2,001,244**	**2,121,318**
% Of total spent on:	874,083	1,040,493	1,189,192	1,329,962	1,435,631	1,492,705
- DHS[3]		256,408	285,449	252,207	288,001	293,133
- PHS[4]						
- CHS[5]	770,531	808,174	922,857	987,610	1,046,866	1,109,678
- All personnel						
Total capital[2]	26,096	93,391	135,002	146,248	155,022	164,323
Health as % of total public expenditure	16.27%	17.23%	16.99%	16.62%	15.98%	15.51%

Table 5 shows the declining trends health expenditure as a percentage of total public expenditure. The demand for the provision of health care in Mpumalanga far outweighs the resources available to fund it. In addition, medical inflation as well as the impact of wage drifts up even greater demands on the available resources. The HIV/epidemic, Tuberculosis, Mental Health, cross boundary flows, restructuring of the DHS and upgrading of tertiary services demands also impact negatively on the provincial health budget.

Table 6: Trends in provincial public health expenditure in constant 2002/03 prices

Expenditure	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	Average annual change (%)	2003/04 (budget estimate) [2]
Total[3] **(R million)**	1029073	1162360	1230353	9.3	1269265
Total per person[4]	R343	R381	R396	7.4	R401
Total per uninsured person[4]	R381	R423	R440	7.4	R446

In calculating the uninsured population for Mpumalanga it was estimated that only 12% of the total population is covered by some form of private medical insurance. It is therefore evident that total expenditure per person does not differ greatly to that of the uninsured resulting to an estimated 90% being dependent on the public sector.

PART B. BUDGET PROGRAMME AND SUB-PROGRAMME PLANS

PROGRAMME: DISTRICT HEALTH SERVICES (DHS).

Situation Analysis

Introduction

Mpumalanga has been demarcated into three health districts – Nkangala, Ehlanzeni and Gert Sibande, with a few cross boundary municipalities. There are a total of 17 local municipalities within these health districts. The department has adopted the district health system as a vehicle for the delivery of Primary Health Care. In addition, the department is moving toward a comprehensive health service delivery system is at the district level. A recent audit on the PHC core package has shown that most facilities in the province are already providing the core package.

Fixed public primary health care facilities

The following tables show the distribution of Health Care facilities in the provinces.

T**able1: Fixed public primary health care facilities (clinics plus community health centers)**

PHC facilities[1]	Number	Average population per facility
Province wide	248	11824
Least served health district[3]	Gert Sibande	14148
Best served health district[3]	Ehlanzeni	12058

Basic Infrustructure Service in district Facility network by health district

Health District	Facility Type	No.	No. (%) with electricity supply from grid	No. (%) with piped water supply
Gert Sibande	Clinics	61	100	98
	CHCs	6	100	100
	District Hospitals	9	100	100
Nkangala	Clinics	81	100	100
	CHCs	14	100	100
	District Hospitals	7	100	97
Ehlanzeni	Clinics	77	99	100
	CHCs	9	100	100
	District Hospitals	7	100	100

Ehlanzeni health district has all its facilities supplied with electricity and piped water systems, although the electricity supply is not completely reliable because some facilities still depend on stand-by generators in cases of interruptions in the supply of electricity.

Personnel in district Health service by Health District

Health District	Personnel Category	Number Employed	Number per 1000 people
Nkangala District	Medical Officers	58	0.016
	Professional Nurses	750	0.212
	Pharmacists	10	0.0028
	Allied Professionals	449	0.127
Ehlanzeni	Medical Officers	91	0.026
	Professional Nurses	850	0.240
	Pharmacists	18	0.005
	Allied Professionals	39	0.011
Gert Sibande	Medical Officers	81	0.023
	Professional Nurses	645	0.182
	Pharmacists	20	0.006

Sub-Programme Area: District Management

The district offices are functioning on skeleton staff. Most of the personnel in the Districts were absorbed from previous health districts. The District Management teams are expected to support all local Municipalities and the cross-boundary municipalities in the districts. Lack of transport, and insufficient Humana Resources hampers efficient support needed at the local municipality level.

The key to an optimum service level in the districts is the following:

- Health services are organized and managed efficiently and effectively
- Equity is improved through the process of devolution by ensuring that health local municipalities share resources fairly
- Planning is based on an informed assessment of the local situation
- Planning is jointly made in an integrated platform

Key Challenges

The districts have generally reported the following as key challenges in delivering an optimum health service at the district level:

- Buildings, especially of health facilities are generally in need of upgrading
- Outreach services are not evenly distributed but mostly unavailable due to shortage of transport
- The turn around time for repairs and maintenance is estimated at between 1 and 6 months on vehicles
- Mobile services have been suspended in some areas due to vehicle hijackings and non-replacement
- Facilities are not functioning as designed due to staff shortage or structural problems
- Dire shortage of staff especially the medical and paramedical staff
- New clinics are opened without proper staff establishment
- Lack of allied health professionals for outreach services
- General shortage of medical equipment and instruments
- Poor communication and support from the Provincial Provisioning Tender section (lease agreement on equipment, etc. is wearisome.
- Incorrect placement of personnel on the PERSAL system is affecting budget expenditures and need an extensive review.

Description Of Planned Quality Improvement Measures

The key improvement measures as identified by the district management teams include the following:

1. Revive the Batho-Pele Programme that has already been launched.
2. Facilitate the continuous implementation of the Patients Rights Charter and obligations of the patients
3. Implement and sustain the complaint mechanisms in all health facilities.

4. Review and revise all protocols.
5. Re-establish a peer review at all health facilities.
6. Revive clinic committees and hospital boards to enhance community participation in health facilities.
7. Identify training needs and offer appropriate skills development activities.

Performance Indicators for the district management sub-programme

Objective	Indicator	2001/02 (Actual)	2002/03 (Estimated)	2003/04 (Target)	2004/05 (Target)	2005/06 (Target)
Increase PHC mobile service points by 10% annually	Number of new mobile points established	2468	2614	2875	3162	3478
Maintain percentage of fixed public PHC facilities offering the full package of PHC services	Proportion of fixed public PHC facilities offering the full PHC package	95%	100%	100%	100%	100%
Training of at least one PHC Nurse in Family Planning per facility by March 2004	% Of PHC nurses trained in Family Planning		100%	100%	100%	100%
Increase percentage of public PHC facilities visited at least once per month by a supervisor	% Of public PHC facilities visited at least once per month by a supervisor	80%	90%	100%	100%	100%

Performance Indicators for the district hospital sub-programme

Objectives	2001/02 Actual	2002/03 Estimate	2003/04 Target	2004/05 Target	2005/06 Target
Expenditure on hospital staff as percentage of total hospital expenditure	68%	66%	64.8%	62.1%	62.1%
Expenditure on drug of hospital use as percentage of total hospital expenditure	16.1%	8.6%	10.3%	10. %	10%
Expenditure on hospital maintenance as percentage of total hospital expenditure	1.2%	3.4%	2.4%	2.4%	2.4%
Hospital expenditure per person	R148	R185	R237	R206	R222
Percentage hospitals with appointed CEO in place	0	80%	100%	100%	100%
Percentage of hospitals with operational hospital boards	0	0	100%	100%	100%

District Health Services Financials

	Summary of expenditure and estimates: Programme 2: District Health Services					
R'000	2000/01 Actual Expenditure	2001/02 Actual Expenditure	2002/03 Est. Actual	2003/04 Voted	2004/05 MTEF Budget	2005/06 MTEF Budget
District Management	1,295	6,501	1,984	49,644	52,623	55,517
Community Health Clinics	11,690	12,143	20,864	211,823	228,532	251,102
Community Health Centres			115,996	127,824	139,643	159,671
Community Based Services	114,424	32,362	9,407			
Other Community Services	-	-	6,817	-	-	-
HIV/ Aids			8,439	26,287	27,864	29,397
Nutrition			6,572	62,789	66,556	70,217
Hospital Mgt. & Quality Impr. Grant			83	13,337	14,137	14,915
Coroner Services						
District Hospitals	758,959	1,025,254	1,060,274	871,915	948,230	1,009,667
Malaria Control			10,794	15,733	16,677	17,594
Total	**886,368**	**1,076,260**	**1,241,230**	**1,379,352**	**1,494,262**	**1,608,080**

SUB-PROGRAMME: HIV/AIDS, TB AND STI'S

EXECUTIVE SUMMARY

HIV/AIDS/TB/STI is now under programme 2, meaning it is a programme under District Health System (DHS), which is a vehicle through which the delivery of Primary Health Care (PHC) is taking place.

The objective of this restructuring is to facilitate and integrate the delivery of HIV/AIDS/TB/STI services at the lowest possible level of government. It is highly applauded by all levels of government as a long awaited process.

Resource allocation

The province has 300 clinics or Primary Health Care centres and twenty-seven hospitals. Over 95% of our services are provided by these facilities, the remainder goes to private sector and NGO/CBOs. The Directorate spends R6,60 per capita for its services, while the districts spend an average R40 per capita on holistic care, which HIV/AIDS/TB/STI related are major component. The Directorate has a total staff of eight (8) people to successfully implement the provincial HIV/AIDS/TB/STI programme. Surely, this impedes or makes it virtually impossible to effectively tackle the epidemic in our province.

Sustainability

HIV/AIDS/TB/STI services are vertical and parallel to their sister services in the facilities. This alarms for a disaster since the provincial personnel is insufficient, and there not enough funds to sustain an isolated programme. The situation intensifies stigma in our service beneficiaries.

Surely the programme urgently needs personnel and full integration to be sustainable.

INTRODUCTION

Being informed of the FIVE-YEAR STRATEGIC PLAN, and the provincial mission and vision, the HIV/AIDS/TB/STI Directorate has adopted the following mission and vision to guide it in reviewing the past and planning for the future.

VISION: **A caring and humane health service environment in which all the inhabitants of the Mpumalanga province have access to affordable, comprehensive, integrated quality HIV/AIDS/TB/STI services.**

MISSION: **We provide the following priority HIV/AIDS/TB/STI services, namely;**

Treatment, care and support
Prevention
Programme management and administration
Partnership with stakeholders
Research, monitoring and evaluation

MPUMALANGA PROVINCE AND HIV/AIDS

Demographic projections indicate that our provincial population has increased to approximately 3,2 million, of which 10% is infected. Our antenatal HIV survey 1999-2001 present the following:

DISTRICT	**1999**	**2000**	**2001**
Eastvaal	29,4	36,0	31,9
Nkangala	20,1	20,5	22,2
Ehlanzeni	32,5	34,5	37,1
TOTAL	27,3	29,6	29,2

Estimated number of pregnant women HIV positive per 100 000

REGION	1999	2000	2001
Eastvaal	294	360	319
Enkangala	201	205	222
Ehlanzeni	325	345	371
Total	820	910	912

The above figures can be extrapolated to represent sexually active population (15 = 49 years)

CORE VALUES

To our infected and affected community we pledge:
Holism
Integrity
Respect for dignity
Sensitivity
Care and support

ADMINISTRATIVE CHALLENGES

Finance and Financial management:

Activities of the programme are funded mainly by conditional grant.
Limits of these grants cut out programmes like
Condom Logistics
Partnership
STI/STD
Awareness Activities

TRANSPORT/INFRASTRUCTURE

Most of the work is done in the districts by provincial staff
There is a need for dedicated transport for staff as well as staff, both at district and provincial.
Condoms, VCT kits and awareness material require storage places in every district. This is a deficit.

HUMAN RESOURCE

Critical under this is community-based personnel
Provincially, the directorate needs more staff to run efficiently and effectively.

PROGRAMME CHALLENGES

PMTCT
Integration with other health services on site
Shortage of staff, lack of continuity of care and family counselling services (couple counselling)
Building debriefing services for staff
Lack of advocacy and information, education and communication in local languages

VCT
Integration with other services on site
Promoting advocacy, accessibility and use of the service.
Equiping our facilities for the provision of the service**.**

BROADER HIV/AIDS/TB
Lack of joint planning, collaboration and integration strategy
Development of a roll-out strategy for the programme.

STEP-DOWN SERVICES
Financial management accounting for the conditional grant at facility level.
Linking step down facilities with home based care services.
Measuring the impact of a step down facility within the hospital.

HCBC
Developing an appraisal system for NGOs rendering home based care services.
Planning the sustainability of home based care services.
Integrating home-based care within primary health care.

4. BUDGET PROGRAMME AND SUB-PROGRAMME PLANS

Programme: HIV/AIDS/TB/STI Services

For proper management of HIV/AIDST/TB/STI services, District plans should be inclusive of local municipality plans, namely jointly produced. Overlapping of services should be minimised, especially where identified. The objectives and budget for the year 2003/4 is hereby presented per sub-programme.

The Provincial Office is functioning on a skeleton staff due to unavailability of approved staff establishment. Most of the personnel in the Province are National staff and/or absorbed from the National Department of Health. This Provincial Management Team is expected to plan, support and implement provincial the plan. Lack of transport, and insufficient Human Resource hampers efficient implementation of this programme, which has an ever-increasing conditional grant budget.

Condition	**2001**	
	No.	**No. Per 100 000 people**
HIV antenatal seroprevalence	29,207	
VCT uptake	400	
PMCT – HIV positive – HIV negative – counselled / tested – on nevirapine	200 100 87 200 47	--- --- --- --- ---
STIs (total cases)	137000	
Syphilis cases	2740	
New smear positive TB cases		
All TB cases reported		
PTB cases reported		

The TB programme is currently run separate from the HIV/AIDS/STI programme and it has not been easy getting TB data.
PMTCT Information for1999-2000 is not available because the programme was not yet established.

Performance indicators for the HIV/AIDS/STI/TB programme

Objective	Indicator[1]	2002/03 (Estimate) [2]	2003/04 (Target)	2004/05 (Target)	2005/06 (Target)
Strengthen 60 NGO/CBOs providing HCBC services.	60Organisations funded	20 NGO/CBOs	13 NGO/CBOs	17 NGO/CBOs	10
Establish six (6) Step Down facilities	Facilities existing AND operational	----------	3 facilities	3 facilities	Sustain and Evaluate efficiency
Establishment of 145 PMTCT sites	145 Facilities providing PMTCT services	10 hospitals	17 hospitals	28 CHCs	90 clinics and mobiles
Establish at least 300 new medical VCT sites	300 new sites existing.	74 sites	87 sites	80 sites	59 sites
Ensure effective application of the Syndromic Management of Sexually Transmitted Infections in 90% of public health facilities	300 Health Care Facilities	90 PHCs	90 PHCs	60 PHCs	60 PHCs
Establish 110 community based condom distribution points.	110 sites established	40 sites	35 sites	20 sites	15 sites
Organise 80 awareness events	80 events organised	20 events	20 events	20 events	20 events
Establish 34 peer education Programmes	34 Peer Education projects existing	8 projects	12 projects	8 projects	6 projects
Human Resource Development AND Staffing	Vacancy rate reduced to 0	10%	70%	90%	100%
Broaden stakeholder involvement by Establishing 20 functional and Programme based HIV/AIDS structures in the province by 2005	20 functional HIV/AIDS structures.	3 District AIDS Councils	17 local AIDS Councils	3 District AIDS Councils	17 local AIDS Councils
Conduct regular surveillance and evaluate impact of all interventions in the province.	Quarterly and annual reports on all intervention programmes.	Reports	Reports	Reports	Reports
Build capacity to sectors and stakeholders on HIV/AIDS	Training reports	Reports	Reports	Reports	Reports

Table: Evolution of expenditure by budget programme and sub-programme in current prices (R million)[1]

Sub-programme	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)
Home/Community Based Care	---------	R 786	R 9 000	R 10 160	R 11 176
Step Down Facility	---------	…….	R 3 000	R 8 013	R 8 814
Prevention of Mother-to-Child Transmission	---------	R 294	R 9 000	R 11 555	R 12 710
Voluntary Counselling and Testing	---------	R 752	R 3 600	R 4 192	R 4 611
Condom Logistics	---------	--------	R 1 000	R 1 100	R 1 200
Sexually transmitted Infections	---------	--------	R 1 000	R 1 100	R 1 210
Awareness, Education and Information	--------	--------	R 2 290	R 2 519	R 2 770
Capacity Building (ATICC)	---------	---------	R 2 000	R 2 200	R 2 500
Social mobilisation	---------	---------	R 1 360	R 1 500	R 1 750
Administration and Management (Staffing)	---------	---------	R 2 540	R 5 000	R 5 373
TB/HIV/AIDS Integration	---------	--------	R 400	R 440	R 500
Total programme	**R 1 326**	**R 1 833**	**R 35 190**	**R 47 779**	**R 52 615**

The expenditure information available for 2001/2 is not per sub-programme. There were no specific allocations for those sub-programmes where no estimates are available for 2002/3. No expenditure was incurred on the step-down programme for 2002/3. The PMTCT programme is no longer piloted but is rolled out, hence a huge budget for 2003/4.

A.4. HIV/AIDS, STI, TB control programme

Table: Performance indicators for the HIV/AIDS/STI/TB control programme*

This plan is province based, and not district, hence the district column has been removed.
The TB programme is currently run separate from the HIV/AIDS/STI programme and it has not been easy getting TB data.

Indicator	**Province wide value**	**National target by 2005**
Input		
Total dedicated expenditure on HIV/AIDS activities	R20 000 000	
Percentage of public PHC facilities** where condoms are freely available	98%	100%
Percentage of provincial hospitals and fixed PHC facilities** offering VCT	20%	
Percentage of facilities of all types offering syndromic management of STIs	97%	
Number of health districts using DOTS (with names)	1	All districts
Number of TB/HIV health districts (with names)	1	
Percentage of TB cases with a DOT supporter	--	
Process		
HIV/AIDS plan formulated with stakeholders	0	
Percentage of TB cases reported on	---	100%
Output		
Number of people trained in syndromic management of STI	96	
Smear positive PTB cases as percentage of all PTB cases	---	50-70%
New smear positive PTB cases as percentage of expected number of cases	50%	70%
Quality		
Average TB specimen turn around time	----	< 48 hours

Percentage of TB cases who are being re-treated		6-8%
Percentage of new smear positive PTB cases who interrupt treatment	----	<10%
Efficiency		
Percentage of dedicated HIV/AIDS budget spent	30%	100%
Outcome		
Antenatal HIV seroprevalence rate	29,2%	
Syphilis prevalence rate at sentinel sites	2,0%	
PTB smear conversion rate at 2 months for new cases	50%	> 85%
PTB smear conversion rate at 3 months for re-treated cases	40%	> 80%
Percentage of new smear positive PTB cases cured at first attempt	30%	> 85%
Percentage of TB cases that are MDR	7%	< 1%

Table: Evolution of expenditure by budget programme and sub-programme in (R million)

Sub-programme	**2001/02 (actual)**	**2002/03 (estimate)**	**2003/04 (budget)**	**2004/05 (MTEF projection)**	**2005/06 (MTEF projection)**
Home/Community Based Care	---------	**R 786**	**R9 443**	**R10 160**	**R10 160**
Step Down Facility	---------	**R0000**	**R5 407**	**R 8 013**	**R 8 814**
Prevention of Mother-to-Child Transmission	---------	**R 294**	**R5 763**	**R11 555**	**R12 710**
Voluntary Counselling and Testing	---------	**R752**	**R 3 948**	**R 4 192**	**R 4 611**
Administration and Management (Equitable share)	**R 1 326**	**R 1 083**	**R 14 913**	**R 16 182**	**R 17 889**
Total programme	**R 1 326**	**R 2 917**	**R 39 474**	**R 50 102**	**R 54 185**

SUB-PROGRAMME: PRIMAY SCHOOL NUTRITION PROGRAMME

SUB-PROGRAMME: INTEGRATED NUTRITION PROGRAMME

VISION

The vision of the Integrated Nutrition Programme (INP) is optimum nutrition for all South Africans.

MISSION

The Integrated Nutrition Programme's mission is to improve the nutritional status of people in Mpumalanga through implementing integrated nutrition activities.

1. INTRODUCTION

The Integrated Nutrition Programme (INP) in Mpumalanga is transformed into an integrated, multidisciplinary, multi-phased initiative and provides a framework for sustainable, people-driven nutrition interventions, which forms an integrated part of the Primary and Secondary Health Care Packages delivered in the Province.
The implementation of the programme is subjected to the policies of the National INP of which a strategic plan and grant allocation is done till 2007.

Context for planning:

Planning for the Integrated Nutrition Programme (INP) takes place within the context of the Health Sector Strategic Framework (HSSF).

The INP is discussed under the strategic objective to decrease morbidity and mortality rates through strategic interventions where the objective for nutrition is to strengthen nutrition interventions to prevent and manage malnutrition. The relevant key implementation strategies for the INP in the province are indicated as follows:
Intensify efforts to implement the INP.
Strengthen nutrition interventions at both health facility and community levels to rehabilitate malnourished children.
Work with other sectors to tackle the root causes of poor nutrition and poverty.
Promote, educate and advocate good nutrition.

The implementation of the INP in Mpumalanga:
The INP in Mpumalanga operates without any fragmentation by means of:
Community-Based components, which focus on nutrition interventions in primary schools as well as communities, within the Primary Health Care framework in the District Health System structure.
Structures at community level, especially community development projects and local health facilities will be built upon to strengthen household food security, nutrition education and advocacy.

Health Facility Based components, which focus on interventions in health facilities and access to nutrition through health services.

Target groups:
The Integrated Nutrition Programme will mainly focus on the most poverty -stricken communities at large where the following groups will be the project beneficiaries:
malnourished children under the age of 5 years,
unemployed women and youths,
primary school children,
persons with diseases of lifestyle and chronic diseases such as AIDS and Tuberculosis
people with disabilities
nutritionally at risk people

RESOURCE ALLOCATION:
2.1 Provincial intervention:
The INP is mainly provincially co-ordinated by a very limited staff component.
District intervention:
An inadequate skeleton staff of Nutrition professionals facilitates the implementation of the INP. The implementation takes place in all health facilities, 1334 schools and communities through out the province, where it is driven by an integrated team of health professionals.

SUSTAINABILITY:
The Strategic Plan needs to be read in conjunction with the following:
The Health Sector Strategic Framework for 1999 to 2004. (HSSF)
Strategic and Operational Plans of the National Department of Health.
Strategic and Operational Plans of Provincial Departments of Health.
National and Provincial Medium Term Expenditure Framework Plans.
The Year 2001 to 2005: Health Goals, Objectives and Indicators.

The provincial Integrated Nutrition Programme is based on current constraints and challenges facing the nutritional status and social development of the population in Mpumalanga and in South Africa.

Sustainable development of community members (unemployed women) in the areas of combating poverty, by involving them in food security projects.

4. SITUATION ANALYSIS

Epidemiological information:

Table: Baseline nutrition indicators*

Indicator	Provincial status	Data source
Child stunting (u.5y)	26,8	National Food Consumption Survey 1999
Child wasting	2.5	National Food Consumption Survey 1999
Child underweight	5.3	National Food Consumption Survey 1999
Child severe underweight	2.7	National Food Consumption Survey 1999
Child vitamin A deficiency	33%	South African Vitamin A Consultative Group Survey 1995
Child iron deficiency	7%	South African Vitamin A Consultative Group Survey 1995
Iodine deficiency disorders	41.7%	National Iodine Deficiency Disorder Survey 1998
Exclusive breast feeding	7% (RSA)	South African Demographic and Health Survey 1998
RtHC coverage	79.5%	South African Demographic and Health Survey 1998
People living in poverty	63.9%	Poverty 1996
Household food insecurity	57-75%	National Food Consumption Survey 1999

Socio economic and social development situation:

The community is rural, and very poor. A large proportion of the adult population is unemployed, and the few that are employed usually work in urban areas.

Needs of the beneficiaries

Poverty Alleviation
Improvement in Household Food Security
Community development and empowerment
Food security in poverty stricken targeted primary schools

KEY CHALLENGES:

Implement human resource plan
Intra-and inter-sectoral integration
Collaborated planning and prioritisation
Effective financial and administrative support system to streamline the expenditure process of the INP funds between provincial and district level
Effective implementation at district level according to approved business plan
Branching of training
Flow of material and information
Transfer of Primary School Nutrition Programme to Department of Education

4.1 Programme constraints and measures to overcome them

Human resources:
Incomplete structures and vacant posts: Lack of human resources at provincial, community and institutional level, which is seriously straining the implementation of the programme.
Measures planned: Budget request submitted. Rely on approved organogram as motivation of approval of posts.

Finance:
The ineffective application of funds in projects and initiatives at district level:
Lack of knowledge and trained personnel to implement and do financial management at level of implementation.
Measures planned: Training Ito PFMA and motivation for appointment of staff.

Information:
Ineffective reporting, monitoring and surveillance: Lack of performance at operational level
Measures planned: Re-Training of staff and implementation of control systems.

Operational time budget vs. implementation time e.g. p/a
Lack of human resources at operational level strains implementation time and equal expenditure.
Measures planned: Capacity building of resources

Logistics:
-Transport: Extreme shortage on vehicles to perform duties in communities and outreach to health facilities
Measures planned: Pressure in terms of vehicle allocation. Motivate more intense integration with other outreach activities.

Technical areas:
-IT equipment: Inadequate provision to operational staff
Measures planned: Pressure in terms of procurement at district level. Motivation for short term integrated use.

4**. Scope Of The INP: Policies, Priorities And Broad Strategic Objectives**

FOCUS AREA	**STRATEGIC OBJECTIVE**	**POLICIES**	**PRIORITIES**
4.1 disease specific nutrition support, treatment and counselling.	To improve and maintain the nutritional status of all patients in need.	National guidelines, national and provincial policies and provincial protocols.	-Standardise therapeutic service provided by dieticians -Encourage the formation of support groups -Supplement the diet of high risk malnourished children, pregnant women and lactating mothers -Support the establishment of Nutrition Rehabilitation Centres
4.2 growth monitoring and promotion	To contribute to the optimal growth of infants and young children through activities at facilities in the province	National guidelines, national and provincial policies and provincial protocols	-Reach 30% of children under the age of 60 months attending clinics with G.M -Improve community awareness on growth monitoring through awareness and education campaigns
4.3 nutrition, promotion, education and advocacy	To improve awareness of the inp amongst policy- and decision makers as well as other relevant stakeholders on nutrition	National guidelines, national and provincial policies and provincial protocols	-Implementation of policies and protocols to support and contribute to achieving the goals and objectives of the INP in terms of: micro nutrient control malnutrition control growth monitoring HIV and other debilitating diseases Breast feeding Advocacy plans for

			professionals
4.4 micro nutrient malnutrition control.	To ensure control through direct supplementation for vulnerable groups, diet diversification and fortification of commonly consumed foods.	National guidelines, national and provincial policies and provincial protocols	-Supply of vitamin A supplementation to pregnant and lactating women and children under 5 years -Promote the production of micro-nutrient rich food -Implement provincial fortification awareness plan
4.5 food service administration	To improve and maintain the food service administration service in the province	National guidelines, national and provincial policies and provincial protocols	-Address the need for optimal Food Service Management structure -Standardise and upgrade Food Service Management service
4.6 promotion, protection and support of breast feeding	To ensure the implementation of the breast feeding intervention and the upgrading of health facilities in the province to become baby friendly	National guidelines, national and provincial policies and provincial protocols	-18 hour course -Form breast feeding support groups -Support health facilities to become Baby Friendly - Community awareness and participation through educational campaign during breast feeding week in August 2002
4.7 contribution to household food security.	To alleviate temporary hunger	National guidelines, national and provincial policies and provincial protocols	-Approximately 450100 needy primary school learners are provided with a daily nutritious

			meal -Incorporate mothers / caregivers of malnourished children in development initiatives -Create income generating opportunities -Implementation of community & school poverty alleviation projects, -prepare for transfer of PSNI from Department of Health to Department of Education
Nutrition information support system	To implement an effective and efficient nutrition information system for planning, policy formulation and management.	National guidelines, national and provincial policies and provincial protocols	-Establish a data base at district and provincial level -Reliable statistics from all facilities as prescribed. -Data processed periodically as decided
Support system- human resource plan	To ensure the implementation of a human resource plan	National guidelines, national and provincial policies and provincial protocols	-Establishment of a provincial human resource structure -Establishment of a sub-district human resource structure -Establish specialised nutrition service -Establish specialised food service administration service -Ensure continued professional development

Financial and administration support system	To implement interventions in the most cost effective and efficient way	National guidelines, national and provincial policies and provincial protocols	-Proper financial control measures -Maintain and improve the present financial and administrative system

6.PLANNED QUALITY IMPROVEMENT MEASURES

6.1 TABLE: OBJECTIVES AND EVOLUTION OF PERFORMANCE INDICATORS FOR THE INP

OBJECTIVE	INDICATOR	National target by 2005	2001/02 actual	2002/03 est.	2003/04 target	2004/05 target	2005/06 target
	Input						
To ensure the implementation of a human resource plan	Percentage of nutrition posts filled at all levels against nutrition staff establishments	100%	65%	69%	75%	80%	85%
	Process						
To implement all the inp interventions in the most cost effective and efficient way	Provincial business plan submitted and approved by national department by 15 March each year	Each province		30 March	15 March	15 March	15 March
Ditto	Provincial quarterly progress reports submitted to national department by 10th working day of following quarter	Each province		50%	100%	100%	100%
To ensure that proper financial control measures are in place	Provincial monthly financial reports in terms of Division of Revenue Act submitted to national department by 10th working day of following month	Each province		100%	100%	100%	100%
	Output						
To contribute to the optimal growth and health of infants since birth at facilities in the province	Percentage of new-born babies given road to health chart**	85%	79.5%	80%	85%	85%	85%

To ensure that needy primary school learners from an estimated 1 334 targeted primary schools in poverty stricken areas; including farming, rural, deep rural and informal settlements are included in the feeding programme;	Percentage of targeted primary schools with feeding programmes against total targeted primary schools	96%	100%	96%	100%	100%	100%
To ensure that the implementation of the provincial primary school feeding programme comply according to national policy for number of feeding days	Number of actual school feeding days as percentage of target number of school feeding days	156 days	76.9% (120days)	100%	100%	National MTEF unknown	National MTEF unknown
	Quality						
To ensure the upgrading of health facilities in the province to become baby friendly	Percentage of facilities with maternity beds certified as baby friendly against total facilities with maternity beds	15%	11%	22%	37%	45%	50%
To ensure that the implementation of the provincial primary school feeding programme comply to the national policy for menu specifications	Percentage of targeted schools where actual servings for school feeding comply with requirements and specifications of the standardised menu options	100%	100%	100%	100%	100%	100%
	Efficiency						
To implement the INP in the most cost effective and efficient way	Percentage of INP conditional grant spent	100%			100%	100%	100%

To implement the poverty relief projects to implement all the INP interventions in the most cost effective and efficient way in the most cost effective and efficient way	Percentage of special allocation for poverty relief spent	80%	90% paid out. 26% accounted for.	Nil received	60%	70%	80%
	Outcome						
To contribute to the optimal growth of infants and young children at facilities in the province	Average percentage of children under five years of age monitored for nutrition status in district health facilities showing faltering or failure of weight gain (DHIS monthly data aggregated over the year)	-	-	baseline			
To address the reduction of the prevalence of severe malnutrition among children under the age of 60 months	Average percentage of children under five years of age monitored for nutrition status in district health facilities diagnosed as suffering from severe malnutrition (DHIS monthly data aggregated over year)	-	-	baseline			
Ditto	Percentage of stunted children under five years***	< 20%	26.8%			25%	
Ditto	Percentage of underweight children under five years***	< 10%	5.3%			5%	
Ditto	Percentage of wasted children under five years***	< 2%	2.5%			2%	
Ditto	Percentage of severely underweight children under	< 1%	2.7%			2%	

	five years***						
To reduce sub-clinical vitamin a deficiency in children under 5 years and pregnant and lactating women	Percentage of vitamin A deficient children under five years***	0%	33%			10%	
To reduce iron deficiency to 3% by 2006	Percentage of iron deficient children under five years***	0%	7%			5%	3%
To eliminate iodine deficiency disease by 2004	Percentage of iodine deficient children under five years***	0%	41.7%			30%	
To ensure the implementation of the breast feeding intervention	Percentage of infants exclusively breast fed at six months**	10%	un-known	not in DHIS	baseline	10%	

PROGRAMME: REGIONAL HOSPITALS

(A) Situation analysis

1. Epidemiology
The major level 2 and 3 health needs in the province relate to a disease profile typical of developing countries and in particular to rural populations. This is compounded by a high incidence of trauma related to motor vehicle accidents and person to person trauma. The N4 highway runs through the centre of the province and links the country to the tourist areas in the east and to Mozambique further east.

The level 2 and 3 health needs are poorly matched with resources due to a significant deficit of South African registered specialists and allied health practitioners. This is partially compensated for by sessional specialists who work in state facilities and by Cuban doctors who operate in dedicated disciplines as full time employees of the state.

2. Hospitals
Of the 27 provincial hospitals, two have been currently earmarked as regional facilities viz. Witbank and Rob Ferreira. Selected level 2 services are however also provided at other hospitals such as Philadelphia, Themba and Ermelo. It is envisaged that these hospitals will be further developed to provide a comprehensive package of regional referral services in the future. Each of the districts should in future have a regional referral hospital with Rob Ferreira and Witbank providing selected provincial tertiary services in addition to the level-2 package of services. There are currently no step-down facilities in the province although this is seen as a priority to ensure cost effective utilisation of acute beds.

PPP projects have also not been piloted as yet. Whereas there are inactive beds available in the province, the main constraint is human resources. The potential for a PPP would currently thus only be implementable through a leasing arrangement of physical facilities.

Presently district hospitals refer patients to the nearest larger hospital, which may be able to treat a specific condition. These hospitals refer to the above-mentioned hospitals, which in turn refer to Witbank. Witbank refers to Pretoria Academic and Kalafong hospitals in Gauteng or any other Gauteng hospital willing to assist. The hospitals in the North Western area of the province refer primarily (via Philadelphia) to Garankuwa hospital in Gauteng.

The referral route is however subject to being by-passed if the patient is in need of sub-specialist management for example neurosurgery and cardio thoracic surgery etc. The following table represents the level 2/3 services currently available at Witbank and Rob Ferreira hospitals with a rough allocation indicating levels of beds within the hospitals. There are 5 hospitals in the province, which treat TB patients exclusively. Three of these are SANTA facilities, one is a Local Government facility (Sesifuba) and the other is a Provincial Hospital (Bongani). The SANTA hospitals and Sesifuba are fully subsidised by the province and provide a total of 632 beds whilst Bongani provides an additional 56 beds. Most of the patients in these hospitals have dual infection with HIV. There is 36 bed Multi Drug Resistant (MDR) Unit attached to the Witbank SANTA facility. This unit is overcrowded and has to discharge patients prematurely to provide beds for newly diagnosed MDR patients.

Table: Number of beds in central hospitals

Central Hospital	No. of levels 3 / 4 beds	No. of levels 1 & 2 beds	Total no. of usable beds
Rob Ferreira	4	277	281
Witbank	22	325	347
Total	26	602	628

Table: Level 2/3 Services of Mpumalanga Provincial Hospitals

Level 2	Medicine		Paediatrics		Surgery		O&G		Anaesthesia		Psychiatry		Orthopaedics Surgery		Family Medicine		Ophthalmology		ENT	
	Full Time	*Sessional*	*Full Time*	*Sessional*	*Full Time*	*Sessional*	*Full Time*	*Sessional*	*Full Time*	*Sessional*	*Full Time*	*Sessional*	*Full Time*	*Sessional*	*Full Time*	*Sessional*	*Full Time*	*Sessional*	*Full Time*	*Sessional*
Witbank	*		*		*		*		*			*	*		*					*
Rob Ferreira		*				*						*			*			*		*
Total																				

Table :

Level 3	Renal Dialysis	ICU	Neonatal ICU	CT Scan	Complex orthopaedics	Complex Ophthalmology
Witbank	Out sourced	*	*	*	*	
Rob Ferreira	Out sourced	*		Out sourced	*	*

* Indicates Availability

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B) Policies, Priorities Strategic objectives and challenges

1. Upgrade package of level 2 /3 services at Witbank and Rob Ferreira

National Department of Healthy Policy states that province should develop their own level 2 and 3 services. Level 2 services should be funded essentially from the provincial equitable share, whilst for level 3 service, the National Tertiary Services (conditional) grant is available. The Health Professions Training and Development Grant (HPTDG) is available to refund provinces for providing a decentralised training platform for health profession undergraduates and develop capacity to sustain basic specialist services.

Currently the only established level 2 services are available at Witbank Hospital and the departments at this hospital are not fully staffed. One level 2 Hospital is totally insufficient for the province resulting in a significant number of level 2 patients still being referred to Gauteng. The priority is to strengthen services at Witbank and develop resident (24hour) level 2 services at Rob Ferreira Hospital.

The following plan provides details of this priority:

Both hospitals to have full package of level 2 services i.e. At least 2 full time specialists and 4 medical officers in each of the following departments.
Internal Medicine
Paediatrics
General Surgery
O& G
Anaesthesia
Orthopaedics
Psychiatry
Family Medicine

The following departments should have one specialist and 1or 2 medical officers.

Ophthalmology
ENT
Radiology
These departments would provide in-house training as well as outreach services to surrounding hospitals. They would also provide referral services to these hospitals for level 2 referrals.

The following tertiary services should also be established or expanded at Witbank and Rob Ferreira.

Renal Dialysis Unit - Permanent units one for each hospital (currently out-sourced)
Dermatology - sessions
Neurology - sessions
Burns Unit - 1 at each hospital
Cardio thoracic surgery - Sessions
Neurosurgery - 1 full time specialist each hospital.
Neonatal ICU - 1 additional for Rob Ferreira
CT Scan - 1 Additional scanner for Rob Ferreira
Spinal Unit - One unit for the province (Site to be determined by situational analysis)
Haemophilia Services - 1 at each hospital
Maxillo Facial Surgery - Sessions
Orthodontics - Sessions
Urology - Session

Note: i) The above level 2 and 3 services should be supported by appropriate health technology and allied health services. Levels of nursing personnel would also need to be increased to support this services.
ii) Services packages to comply with national guidelines documents (for regional hospitals)

2. Develop the basic package (8 disciplines) of level 2 services as well as trauma units at other earmarked hospitals.

The basic level 2 package to be developed at Themba, Philadelphia and Ermelo Hospitals. Trauma unit to be established at Rob Ferreira, Ermelo and Philadelphia

3. Step down beds /facilities (SPS objective)

Above mentioned hospitals to allocate or establish step down beds to approximately 10% of current usable beds. This would be to ensure adherence to budget and compliance with national average length of stay (ALOS) norms.

4. Patients Transport

A plan to be developed in line with the provincial referral patterns to cater for intra- and inter-provincial referrals.

5. Revitalisation, organisational development and Quality Improvement

Physical Infrastructure – At Witbank, 2 additional theatres are currently under construction as well as OPD, casualty and admission upgrade.

At Rob Ferreira planning is being finalised for conversion of 2 wards into psychiatric wards. The following facilities are also planned, OPD, Casualty, Dental unit and laundry.

OD - Support personnel to be established for complex CEO's i.e. Finance, HR, PR and LR units.
CEO post at Witbank to be filled.
Delegations to CEO's as per national proposal linked to performance agreements.
Cost Centre pilot at Witbank to be evaluated, enhanced and rolled out to Rob Ferreira.
Hospital boards to be established at both hospitals as per National Health Bill guidelines
Appropriate hospital information system or upgrade of DHIS for both hospitals

Quality Assurance
The following projects are being implemented.

Witbank – Patient satisfaction survey
Suggestion boxes
Help desk
Morbidity and Mortality meetings
Clinical Audit in selected department

Rob Ferreira – Maternal and neonatal mortality reduction
Tuberculosis case management
Nosocomial infection reduction improvement
Batho Pele for admissions clerks
Environment cleaning campaigns.

Conditional Grants

NTSG – To fund existing tertiary services and for development of additional services after 1 year moratorium.

HPTDG – To fund proposed additional specialist posts in 1 above together with registrar posts in selected departments.
NOTE: 2 of the 4 medical officer posts in each department could be registrar posts.

Additional MDR beds

The overcrowding at Witbank MDR Unit poses a serious infection risk to staff as well as the community due to premature discharges. The priority is thus for the building and staffing of phase 2 of the unit which will provide an additional 36 beds. Funds are available for this development.

(C) Constraints
1. Recruitment of specialists, Medical officers and allied health professionals

Posts need to be created and advertised with appropriated incentives such as improved starting notches, links with academic institutions and car/travel packages. These incentives should be jointly developed with our academic partners, UP and Medunsa. Residential accommodation should also form part of these packages. (part of revitalisation projects)

2. Retention of existing staff
Incentives in 1 above to be made available to existing staff.

3. Decentralisation /delegation of powers
NDOH to be invited to present decentralisation proposal to the department. All stake holders to be represented. i.e. Politicians, Local Government Office Bearers, other departments (esp. Treasury, Finance) and labour organisations.

Meeting to consider implementation of this proposal in the province.

PROGRAMME 4: (PROVINCIAL HOSPITALS) STRATEGIC PLAN

Objectives	Indicators	2001/2002	2002/2003	2003/2004	2004/2005	2005/2006
1. Develop the basic package of level 2/3 services at Rob Ferreira and Witbank as well as trauma units at other earmarked hospitals.	**Availability of a functional unit.** No. of trained/appointed personnel. Availability of equipment. mplemented package.	**Partial package at Witbank.**	**Advertise complete package for Rob Ferreira and Witbank hospitals**	**Complete basic package at Witbank and Rob Ferreira.** Partial package (level 2) at Philadelphia, Themba and Ermelo. Planning for Trauma Units.	**Complete package Philadelphia, Themba and Ermelo (level 2).** Trauma unit established at all level 2 hospitals.	**Ongoing**
2. Develop renal unit.	**Availability of a functional renal unit.**	**Outsourced at Witbank and Rob Ferreira.**	**Same**	**In house unit at Rob Ferreira and Witbank. (Acute only).**	**Same with chronic patient capability.**	**Same**
3. Further develop and improve radiological and CT scan services.	**No. of trained/appointed personnel.** Availability of equipment at Rob Ferreira.	**CT scanner at Witbank.**	**Recruit additional staff for Rob Ferreira.**	**CT scanner at Rob Ferreira with trained staff.**	**Ongoing**	**Ongoing**

4. Establish and improve neonatal and adult ICU facilities.	**No. of trained/appointed personnel.** Availability of equipment at Rob Ferreira.	**4 adult ICU beds at Rob Ferreira and Witbank.** 2 bed neonatal unit at Witbank	**Same**	**Open 2 additional beds Rob Ferreira and Witbank.** Open neonatal ICU at Rob Ferreira.	**Open 2 additional beds (adult and neonatal)**	**Open 2 additional beds. (adult and neonatal)**
5. Establish provincial spinal unit.	**No. of trained/appointed personnel.** Availability of equipment.	**No unit**	**No unit**	**10 bed acute unit.**	**10 beds additional for rehab. (medium term)**	**Ongoing**
6. Establish burns unit at each hospital	**No. of trained/appointed personnel.** Availability of equipment.	**No unit**	**No unit**	**5 bed unit Rob Ferreira and Witbank.**	**10 bed unit Rob Ferreira and Witbank.**	**Ongoing**
7. Establish and improve tele-medicine services.	**No. of trained/appointed personnel.** Availability of equipment.	**4 sending and 1 receiving unit.**	**Same**	**2 additional sending units Rob Ferreira receiving unit.**	**2 additional sending units.**	**2 additional sending units.**
8. Establish step down facilities.	**Availability of step down facilities.**	**No step down facilities**	**Same**	**20 beds at Rob Ferreira and Witbank.**	**30 beds at Rob Ferreira and Witbank.**	**± 10% step down beds at each**

					20 step down beds establish at Philadelphia, Themba and Ermelo.	**hospital.**
9. Develop efficient patient transport.	**Improved referral system.**	**Hospital based transport system**	**Same**	**Inter district bus system.**	**Inter provincial system**	**Ongoing**
10.Build and Staff phase II of MDR Unit at Witbank SANTA.	**Additional 36 functional beds.**	**1st phase functional.**	**Obtain political approval .**	**Construct and equip facility.**	**Commission and operate facility.**	**Ongoing**

Witbank and Rob Ferreira

Indicator	Province wide value	Hospital range	Witbank	Rob Ferreira
Input				
1. Expenditure on hospital staff as percentage of total hospital expenditure	55.9	54.57 – 57.2	54.57	57.2%
2. Expenditure on drugs for hospital use as percentage of total hospital expenditure	14.3	10.7 – 17.9	17.9%	10.7%
3. Expenditure on hospital maintenance as percentage of total hospital expenditure	1.55	1.0 – 2.1	2.1	1.0%
4. Useable beds per 1000 people*	0,05	0.09 - 01	0.1	0.09
5. Useable beds per 1000 uninsured people*	✓		✓	✓
6. Hospital expenditure per person*				
7. Hospital expenditure per uninsured person*	✓		✓	✓
Process				
8. Percentage of hospitals with operational hospital board	0	0	0	0
9. Percentage of hospitals with appointed (not acting) CEO in place	50%	0-100%	0	100%
10. Percentage of hospitals with business plan agreed with provincial health department	0	0	0	0
11. Percentage of hospitals with up to date asset register	100%	100%	100%	100%
12. Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level	No delegations	0	No delegations	No delegations
Output				
13. Separations per 1000 people*	940	920-960	920	960
14. Separations per 1000 uninsured people*	✓		✓	✓
15. Patient day equivalents per 1000 people*	83.66	835 - 880	880	835
16. Patient day equivalents per 1000 uninsured people*	✓		✓	✓
17. Patient fee income per separation	R 11.09	9.9 – 12.3	R 9.9	R 12.3
Quality				
18. Percentage of hospitals in facility audit condition 4 or 5	100%	100%	100%	100%
19. Percentage of hospitals that have conducted and published a patient satisfaction survey in last 12 months	100%	0 - 100%	100	100%
20. Percentage of hospitals with designated official responsible for coordinating quality management	100%	0 - 100%	100%	100%
21. Percentage of hospitals with clinical audit (Morbidity&Mortality) meetings at least once a month	100%	0 - 100%	100%	100%
Efficiency				
22. Average length of stay	4.6	4.5 – 4.7	4.5	4.7

23. Bed utilisation rate (based on useable beds)	81.5%	80 – 83.5	80%	83.5%
24. Expenditure per patient day equivalent	R 8.55	R 7.4 – 9.6	R 7.4	R 9.6
Outcome				
25. Case fatality rate for surgery separations	4.9%	3.9 – 5.8	5.8%	3.9%

Witbank Hospital

Indicator	Province wide value	2001/02 Actual	2002/03 estimate	2003/04 target	2004/05 target	2005/06 target
Input						
26. Expenditure on hospital staff as percentage of total hospital expenditure	✓	54.57%	59.4%	62.7%	66.5%	70%
27. Expenditure on drugs for hospital use as percentage of total hospital expenditure	✓	17.9%	19%	20%	25%	30%
28. Expenditure on hospital maintenance as percentage of total hospital expenditure	✓	2.1%	2.3%	2.9%	3.7%	4.4%
29. Useable beds per 1000 people*		0.1	0.12	0.14	0.16	0.18
30. Useable beds per 1000 uninsured people*	✓	✓	✓	✓	✓	✓
31. Hospital expenditure per person*						
32. Hospital expenditure per uninsured person*	✓	✓	✓	✓	✓	✓
Process						
33. Percentage of hospitals with operational hospital board	0	0	?	?	?	?
34. Percentage of hospitals with appointed (not acting) CEO in place	0	0	?	?	?	?
35. Percentage of hospitals with business plan agreed with provincial health department	0	0	50%	100%	100%	100%
36. Percentage of hospitals with up to date asset register	100%	100%	100%	100%	100%	100%
37. Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level	No delegations	No delegations	?	?	?	?
Output						
38. Separations per 1000 people*	94.0	92%	92%	93%	95%	95%
39. Separations per 1000 uninsured people*	✓	✓	✓	✓	✓	✓
40. Patient day equivalents per 1000 people*	83.66%	880	900	920	940	960
41. Patient day equivalents per 1000 uninsured people*	✓	✓	✓	✓	✓	✓
42. Patient fee income per separation	R 11.09	R 9.9	R 11.3	R 12.6	R 14.40	R 18.35
Quality						
43. Percentage of hospitals in facility audit condition 4	100%	100%	100%	100%	100%	100%

or 5						
44. Percentage of hospitals that have conducted and published a patient satisfaction survey in last 12 months	50%	0	50%	75%	100%	100%
45. Percentage of hospitals with designated official responsible for coordinating quality management	100%	100%	100%	100%	100%	100%
46. Percentage of hospitals with clinical audit (Morbidity&Mortality) meetings at least once a month	100%	100%	100%	100%	100%	100%
Efficiency						
47. Average length of stay	4.5	4.5	4.4	4.3	4	3.7
48. Bed utilisation rate (based on useable beds)	83.5%	80%	83%	85%	88%	90%
49. Expenditure per patient day equivalent	R 8.55	R 7.45	R 7.55	R 7.74	R 7.98	R 8.13
Outcome						
50. Case fatality rate for surgery separations		5.8	5.6	5.4	5	4.7

Rob Ferreira Hospital:

Indicator	Province wide value	2001/02 Actual	2002/03 Estimate	2003/04 Target	2004/05 Target	2005/06 Target
Input						
51. Expenditure on hospital staff as percentage of total hospital expenditure	√	57,2%	60%	59%	58%	57%
52. Expenditure on drugs of hospital use as percentage of total hospital expenditure	√	10,7%	17%	16%	15%	14%
53. Expenditure on hospital maintenance as percentage of total hospital expenditure	√	1%	5%	4%	3%	2%
54. Useable beds per 1 000 people*		0,1	0,16	0,18	0.20	0,22
55. Useable beds per 1 000 uninsured people*	√	√	√	√	√	√
56. Hospital expenditure per person*						
57. Hospital expenditure per uninsured person*	√	√	√	√	√	√
Process:						
33.Percentage of hospitals with operational hospital board	0	0	0	50%	100%	100%
34.Percentage of hospitals with appointed (not acting) CEO in place	0	0	100%	100%	100%	100%

35. Percentage of hospitals with business plan agreed with provincial health department	0	0	0	100%	100%	100%
36. Percentage of hospitals with up to date asset register.	100%	100%	100%	100%	100%	100%
37. Maximum permitted value of procerement at discetion of hospital CEO without reference to provincial level.	No delegations	No delegations	No delegations	Delegated	Delegated	Delegated
Output:						
38. Separations per 1 000 people*	940	940	960	960	940	970
39.Separations per 1 000 uninsured people*	√	√	√	√	√	√
40. Patient day equivalents per 1 000 people*	83.66%	835	840	860	880	900
41. Patient day equivalents per 1 000 uninsured people*	√	√	√	√	√	√
42. Patient fee income per separation	R11.90	R12.30	R15.00	R20.00	R30.00	R40.00
Quality:						
43. Percentage of hospitals in facility audit condition 4 or 5	100%	100%	100%	100%	100%	100%
44. Percentage of hospitals that have conducted and published a patient satisfaction survey in last 12 months	50%	100%	100%	100%	100%	100%

Indicator	Province wide value	2001/02 Actual	2002/03 Estimate	2003/04 Target	2004/05 Target	2005/06 Target
45. Percentage of hospitals with designated official responsible for coordinating quality management	100%	100%	100%	100%	100%	100%
46. Percentage of hospitals with clinical audit (Morbidity & Mortality) meetings at least once a month.	100%	100%	100%	100%	100%	100%
Efficiency:						
47. Average length of stay	4.5	4.7	4.5	4.3	4.1	3.9
48. Bed utilisation rate (based on useable beds)	83.5%	83.5%	84%	86%	88%	90%
49. Expenditure per patient day equivalent	R8.55	R9.60	R9.00	R8.50	R8.00	R7.50
Outcome:						
50. Case fatality rate for surgery separations	4,9%	3,9%	4.0%	3.8%	3.4%	3.0%

Table: Evolution of expenditure by budget programme and sub-programme in current prices (R million)[1]

Sub-programme	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)
Witbank	R 63 151 605	R 83 227 000	R 84 227 000	R 92 690 000	R 101 966 000
Robs	R 74 977 677	R 76 912 920	R 70 526 535	R 75 110 759	R 79 992 959
NTSG	R 37 588 000	R 38 413 000	R 39 237 000	R 41 400 000	R 42 200 000
HPTD Grant	R 23 455 514	R 30 347 000	R 34 456 000	R 36 900 000	R 62 500 000
Total	**R 199 172 796**	**R 228 899 920**	**R 228 446 535**	**R 246 100 759**	**R 286 658 959**
2. Bongani & Santa	R 18 725 489	R 18 338 303	R 29 400 000	R 31 311 000	R 33 346 215
3.Life Care	R 9 892 318	R 9 936 000	R 9 000 000	R 9 585 000	R 10 208 025
Total programme	**R 227 790 603**	**R 257 174 223**	**R 266 846 535**	**R 286 996 759**	**R 330 213 199**

Table: Evolution of expenditure of budget programme in (R million)

	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)*	2004/05 (MTEF projection)*	2005/06 (MTEF projection)*
Total	R 256 408	R 285 448	R 178 513	R 190 116	R 202 474
Total per person	R 72.59	R 80.70	R50.47	R53.75	R57.24

* 2003/04, 2004/05 and 2005/06 cannot not be reported as complete, because the National grant figures are not available for these outer years.

PROGRAMME: EMERGENCY MEDICAL SERVICES

1. Situation analysis

EMS is experience a lack of qualified staff. Most of the staff has the basic training. Limited intermediate trained staff. No advanced life support in the province.
Lack of staff
Limited training ability as there is a lack of training staff.
Vehicles that are utilised are not conducive to the rural conditions.
Lack of management structure.
Inadequate control measures for equipment and vehicles.
Excessive amounts of overtime used.
No adequate uniform for the staff.
Drop in staff morale and thus productivity, due to an increased P.P.T.S. load and no management structure.
Excessive amount of transfers due to lack of P.P.T.S.
Lack of adequate control room staff.
No appropriate bases
A total lack of equipment
Non compliance of staff to professional board rules and ethics.

Policies, priorities and broad strategic objectives

A standard operational procedure should be adopted.
Fully operational training structures with clear guidelines. An intensive training program.
Appointment of a training staff structure.
A P.P.T.S. structure and management to be proposed and approved.
Appointment of a management structure.
A standardised shift roster.
A standard approved provincial uniform.

Analysis of constraints and measures planned to overcome them

Lack of funds for training. Thus there is a need to identify the most important courses and fast track that program.
Lack of funds
Lack of appropriate vehicles. Thus a tender needs to be written with the right vehicle specification that are in line with the provinces needs by the E.M.S specialists as vehicle are equipment.
Lack of funds to employ management structure. Thus key post should be filled. Acting managers at this point have no commitment.
Lack of staff participation, due to no structure. Education of staff to understand the direction that EMS is taking.

4. Description of planned quality improvement measures

An adequate CPD program needs to be implemented to improve the quality of the patient's care.
An intensive driving program needs to be implemented.
An education program needs to be implemented to inform staff of all rules and regulations, norms and standards.

Situation analysis
No established bases
No separation from EMS
Insufficient adequate vehicle to perform function.
Vehicles are not designed to too accommodate the patients they transport.
Lack of qualified staff. Most of the staff has no medical training.
Inadequate control measures for equipment and vehicles.
No control of P.P.T.S.
There is insufficient staff to perform the function

Policies, priorities and broad strategic objectives
A standard operational procedure should be adopted.
Fully operational training structures with clear guidelines. An intensive training program.
A separate leg needs to be set up within the EMS management structure, with independent P.P.T.S. staff
A standardised provincial shift roster.
A standard approved provincial uniform.
Proper control of P.P.T.S.

Analysis of constraints and measures planned to overcome them
Lack of funds for training. Thus there is a need to identify the most important courses (driving) and fast track that program.
Lack of appropriate vehicles. Thus a tender needs to be written with the right vehicle specification that are in line with the provinces needs, by the appropriate specialists as these are deemed as equipment and not vehicles.
.
Description of planned quality improvement measures

An adequate program needs to be implemented to improve the quality of the patient's care.
An intensive driving program needs to be implemented.
An education program needs to be implemented to inform staff of all rules and regulations, norms and standards.
Proper control with routes and schedules set up.

The following three tables show the allocation of vehicles by EMS station for each of the three health districts.

EASTVAAL

Station	Location	No. of vehicles
Bethal	Bethal hospital	2
Carolina	Carolina hospital	1
Delmas	Bernice Samuels hospital	2
Elukwatini	Embuleni hospital	2
Ermelo	Ermelo Hospital	2
Control eastvaal	CTMC	0
Daggakraal	Amesfoort hospital	1
Volksrust	Amajuba hospital	2
Piet retief	Piet Retief Hospital	2
Driefontien	Driefontien clinic	1
Leandra	Leandra municipality	1
Evander	CTMC	3
Balfour	Siyathemba Clinic	1
Standerton	Standerton hospital	2
Total		22

EHLANZENI

Station	Location	No. of vehicles
Tonga	Tonga Hospital	2
Bongani	Pholla Nsikazi Clinic	1
Themba	Themba hospital	1
Nelspruit	Rob Ferreria hospital	2
Shongwe	Shongwe hospital	2
Barberton	Barbeton Hospital	1

Control ehlanzeni	Anderson st	0
Sabie	Sabie hospital	1
Lydenburg	Lydenburg hospital	2
TOTAL		12

EKANGALA

Station	Location	No. of vehicles
Control ekangala	Middelburg fire station	0
Zaaiplaas	Zaaiplaas clinic	2
Witbank	Witbank hospital	5
Middelburg	Middelburg hospital	3
Groblersdal	Groblersdal hospital	2
Belfast	HA Grove CHC	2
Mmamathlake	Mmamathlake hospital	2
Philadelphia	Philadelphia hospital	3
Kwamahlanga	Kwamahlanga hospital	3
TOTAL		22

SUMMARY

Station	Location	No. of vehicles
Bethal	Bethal hospital	2
Carolina	Carolina hospital	1
Delmas	Bernice samuels hospital	2
Elukwatini	Embuleni hospital	2
Ermelo	Ermelo Hospital	2
Control eastvaal	CTMC	0
Daggakraal	Amesfoort hospital	1
Volksrust	Amajuba hospital	2

Piet retief	Piet Retief Hospital	2
Driefontien	Driefontien clinic	1
Leandra	Leandra municipality	1
Evander	CTMC	3
Balfour	Siyathemba Clinic	1
Standerton	Standerton hospital	2
Tonga	Tonga Hospital	2
Bongani	Pholla Nsikazi Clinic	1
Themba	Themba hospital	1
Nelspruit	Rob Ferreria hospital	2
Shongwe	Shongwe hospital	2
Barberton	Barbeton Hospital	1
Control ehlanzeni	Anderson st	0
Sabie	Sabie hospital	1
Lydenburg	Lydenburg hospital	2
Control ekangala	Middelburg fire station	0
Zaaiplaas	Zaaiplaas clinic	2
Witbank	Witbank hospital	5
Middelburg	Middelburg hospital	3

(Groblersdal	Groblersdal hospital	2
Belfast	HA Grove CHC	2
Mmamathlake	Mmamathlake hospital	2
Philadelphia	Philadelphia hospital	3
Kwamahlanga	Kwamahlanga hospital	3
Total		**56**

Table: Public health personnel[1]

Categories	**Number employed**	**% of total number employed**	**Number per 1000 people[2]**	**Vacancy rate**	**% of total personnel budget**	**Average annual cost per staff member**
National Diplomats (advanced)	0	0	0	15	2.06	120 990
Critical care assistants (advanced)	0	0	0	15	2.06	106 275
Ambulance emergency care assistants (intermediate)	54	12.34	0.000018	201	34.98	65 901
Basic ambulance assistants (basic)	381	86.98	0.000127	0	52.26	53 398
Students	0	0	0	0	0	0
Allied health professionals and technical staff[4]	0	0	0	0	0	0
Managers, administrators and logistical support staff	3	0.68	---	60	8.64	---
Total	**438**	**100**		**291**	**100**	

Table: Public health personnel[1]

Categories	Number employed	% of total number employed	Number per 1000 people[2]	Vacancy rate	% of total personnel budget	Average annual cost per staff member
National Diplomats (advanced)	1	25	0.0000003	1	12.5	120- 990
Critical care assistants (advanced)	1	25	0.0000003	3	25	106 275
Ambulance emergency care assistants (intermediate)	0	0	0	5	31.25	65 901
Basic ambulance assistants (basic)	0	0	0	0	0	53 398
Students	0	0	0	0	0	0
Allied health professionals and technical staff[4]	0	0	0	0	0	0
Managers, administrators and logistical support staff	2	50	---	3	31.25	---
Total	**4**	**100**		**12**	**100**	

Table: Performance Indicators For Emergency Medical Services*

Indicator	National Target	2002/2003 estimated	2003/04 target	2004/05 target	2005/06 target
Input					
Number of vehicles per 1000 people		0.017	0.025	0.032	0.035
Process					
Number of vehicles replaced per year**			10	10	10
Output					
Total kilometres travelled per year*		1017000	Not available	Not available	Not available
Number of patients transported per 1000 people per year*		0.04	Not available	Not available	Not available
Quality					
Proportion of locally based staff with training in life support at basic level***		87.2%	73%	60%	45%
Proportion of locally based staff with training in life support at intermediate level		12.4%	25%	35%	45%
Proportion of locally based staff with training in life support at advanced level		0.4%	2%	5%	10%
Efficiency					
Cost per patient transported		700	770	847	931
Outcome					
Proportion of response times within current national targets	Urban area < 15 mins. Rural area < 40 mins.	10%	25%	35%	50%

Performance indicators for emergency medical services.

Indicator	National target	2002/2003 estimate	2003/04 target	2004/05 target	2005/06 target
Input					
Number of vehicles per 1000 people		0.017	0.025	0.032	0.035
Process					
Number of vehicles replaced per year**			10	10	10
Output					
Total kilometres travelled per year*		1017000	Not available	Not available	Not available
Number of patients transported per 1000 people per year*		0.04	Not available	Not available	Not available
Quality					
Proportion of call outs answered by single person crew		0	0	0	0
Proportion of locally based staff with training in life support at basic level***		87.2%	73%	60%	45%
Proportion of locally based staff with training in life support at intermediate level		12.4%	25%	35%	45%
Proportion of locally based staff with training in life support at advanced level		0.4%	2%	5%	10%
Efficiency					
Cost per patient transported		700	770	847	931
Outcome					
Proportion of response times within current national targets	Urban area < 15 mins. Rural area < 40 mins.	10%	25%	35%	50%

*It is impossible to estimate the number of kilometres that will be travelled as well as the patients that will be transported.

** Additional vehicles will be purchased per year as per the policies on replacement and additional vehicles.

*** It should be note that the decrease in basic qualified staff is due to an intensive training program

Table: Performance Indicators For EMS Training

Indicator	Province	Evander	Barberton
Output			
Numbers of basic graduates by main category per year	2	0	2
Numbers of intermediate graduates by main category per year	20	20	0
Quality			
Attrition rates per year of formal training courses by main category of course	0	0	0
Percentage of entrants who graduate from formal training courses by main category of course	39.5	63	16
Efficiency			
Average training cost per graduate by main category	7390	11360	3420
Outcome			
Percentage of graduating basic ambulance assistance in a public service post within three months of graduation	100		100
Percentage of graduating ambulance emergency assistances in a public service post within three months of graduation	100	100	

PROGRAMME: HEALTH SICENCES AND TRAINING

SITUATIONAL ANALYSIS

In order for the Department of Health to be able to deliver effectively on its mandate of providing and improving access to quality health care for all, it needs to have an adequate skills supply. This can be achieved through skills programmes targeted to the key occupational classes.

Although our Department is in a somewhat fortunate position in that most of the health workers enter already with some kind of professional qualification, trends in the field of health have demanded that training and continual development becomes a vital element in order to sustain the delivery of health care services.

Mpumalanga being a rural province places heavy demands on human resources. We need to staff our hospitals, clinics, and other healthcare facilities with optimum personnel that is skilled to render the services expected.

The nursing college with its satellite nursing schools in some hospitals provides training for nurses. We unfortunately have to rely on institutions of higher learning from other provinces in order to have a supply of the other health professionals. In this regard the introduction of community service for these professions is going a long way in providing a steady supply of scarce skills to the department.

The construction of new healthcare facilities in various areas in the province implies that the department must ensure that it keeps these adequately staffed. This against the backdrop of health professionals being lured into areas that offer them better remuneration packages and incentives. There prevails also, by virtue of the rural nature of the province, the tendency for qualified professionals to avoid placement in remote workstations.

It therefore weighs heavily on the department to raise staff morale and keep these officials interested whilst operating within resources that will always be unlimited.

ABET programmes and generic management training are beginning to receive the necessary attention. The establishment of the Skills Development Committee is ensuring that training is made accessible to members of staff at all levels.

1 POLICIES AND STRATEGIES

- The White Paper on Public Service Training and Education, 1998,
- Public Service Regulations, 2001
- Employment Equity Act, 1998,
- Skills Development Act, 1998.
- Skills Development Levies Act, 1998
- S.A. Nursing Council rules and regulations
- Higher Education Act
- Health Bill
- Health Sector strategic Framework, 1999 to 2004
- Whit Paper on Transforming Service Delivery in S.A.

2 TRAINING NEEDS ASSESSMENT AND GAP ANALYSIS

An effort has been made by the Human Resource section to try and obtain an assessment of training needs in the various sections. This has proved to be an enormous yet worthwhile exercise in that it offers the opportunity to consult the employees on the training needed in order to perform their jobs.

It should be mentioned that there is extensive training and development taking place in the department, with particular focus on health care providers. This is complemented by an aggressive ABET programme initiated after realising that there exists a need to address literacy and numeracy among the lower categories of staff. We are able to register about 500 adult learners a year, taking a sizeable R2, 1m from our training budget.

The nursing college has an intake of about 100 students each year for the comprehensive course only. With 15 tutors in the main campus supported by 8 hospitals presenting the clinical practice for the students and pupil nurses, it is a humble attempt to try and maintain a steady supply of nursing personnel to our facilities. However in order for us to be able to address the health care holistically it has emerged that we need to put particular focus on Primary health care at clinic level. We have thus registered some of our nurses in institutions such as SAMHS, University of Pretoria, Garankuwa Hospital, etc.

We have also detected the need to make available adequate personnel in the lower categories of the nursing personnel i.e. the enrolled nurses and auxiliary nurses. At a later stage we introduce bridging programmes so as upgrade these categories in their career paths.

The health programmes allow for us to focus on specific human resource development strategies that give impetus to the realisation of the goals of these programmes. Training in the area of Maternal, child and women health is being spearheaded by programmes like the Integrated Management of Childhood Illnesses, sexuality education, etc.

Some of the training programmes are:

- Financial Management (PFMA)
- Post basic formal clinical courses e.g. trauma, ICU, theatre, orthopeadics, PHC, etc.
- Short Courses e.g. palliative care, eye care wound management, counselling, quality assurance, PEP.
- NQF Assessor, OBE.
- IMCI, STI, Vitamin A protocol , TB Management.
- VCT, PMTCT.
- Infection Control
- First Aid
- Batho-Pele, Patient's Right Charter, Customer care.
- Computer skills.
- LOGIS, PERSAL,
- Health Information.
- Performance Management Development System
- ABET
- Management skills
- Labour relations
- Rational drug use and effective prescribing
- Strategic planning and budgeting

TRAINING PROGRAMME	NUMBER OF STAFF IN SECTION:				
	ALREADY TRAINED	STILL TO BE TRAINED			Available In/Out Dept
		2003/04	2004/05	2005/06	
IMCI	3 250	4 900	5 650	6 570	7 yes
PMTCT	8 300	9 2000	10 1950	11 2400	12 yes
PFMA	13 150	14 600	15 260	16 200	17 yes
Batho Pele	18 2500	19 650	20 710	21 650	22 yes
Abet	23 1026	24 600	25 500	26 400	27
Computer Skills	28 130	29 1000	30 790	31 700	32 yes
Logis	33 40	34 90	35 60	36 65	37 yes
Performance Mgt Dev Sys	38 900	39 5000	40 1250	41 1100	42 yes
Labour Relations	43 2500	44 300	45 500	46 400	47 yes
Rational Drug Use	48 800	49 150	50 210	51 180	52 yes
Quality Assurance	53 600	54 500	55 400	56 600	57 yes
Primary Health Care	58 110	59 300	60 230	61 340	62
Bridging	63 250	64 200	65 300	66 250	67 yes
Midwifery	68 60	69 90	70 120	71 130	72 yes

Strategic Planning & Budgetiing	73 90	74 200	75 320	76 370	77
Management Skills	78 80	79 80	80 65	81 45	82
College	83 448	84 450	85 400	86 400	87
Bursaries	88 259	89 300	90 300	91 280	92
Training Other	93 1300	94 1500	95 1600	96 1550	97

KEY CHALLENGES

- We have to complete the process of developing an HR plan that will detail the profile of the personnel, the skills matrix and other pointers that will make HR a strategic function, and the DPSA has offered to assist in this regard.
- As mentioned earlier, the department is competing with other organizations that promise better remuneration packages to our members of staff, prompting these to resign, thus resulting in continued staff shortages.
- The workplace is in itself relatively unstable due to people looking for better opportunities elsewhere.
- We have to constantly contend with members of staff, particularly the interns and community service personnel that are de-motivated by working in rural conditions.

- Some of our bursary students need to be followed up in order to ensure that they honour their obligation to serve in the province.

- The department does not always have adequate financial resources to address this backlog

98 OBJECTIVES AND PERFORMANCE INDICATORS

- Training programmes for primary health care nurses; reorientation programmes for primary health care

- Training programmes for mid-level workers (e.g. radiography, physiotherapy, occupational therapy).

- Skills development and other training programmes (e.g. in management, integrated management of childhood illnesses, counselling, home based care, ABET, leadership, computer skills, and on the job training)

98.1 Table:

98.1.1 Objectives	**Indicator**
1. To develop and improve the skills of health professionals in the Mpumalanga Province –	Continuous in-service education programmes in place in the institutions
2. To support health professionals with continuing professional development programmes	All health professionals receiving the expected quota of CPD points
3. To develop General Assistants on basic education in numeracy and literacy through the ABET programmes until they attain NQF level 4	Annual registration of ABET learners taking place and exams written.
4. To conduct induction programmes for all newly employed members of staff.	All newly appointed employees to be subjected to intensive induction programmes shortly after being appointed
5. To conduct generic training for employees	An approved training programme to be implemented throughout the year.

Table : Summary of expenditure and estimates: Program 6: Health Sciences and Training

R'000						
	2000/01 Actual	**2001/02 Actual**	**2002/04 Actual**	**2003/04 Voted**	**2004/05 MTEF**	**2005/06 MTEF**
Nursing Training college	19,940	23,868	26,958	28,001	31,961	33,879
EMS Training College	66	280	514	1,413	1,512	1,603
Bursaries	5,810	8,490	10,989	12,375	15,241	16,156
Primary Health Care Training				3,000	3,210	3,403
Training Other				1,236	1,323	1,402
ABET				2,200	2,354	2,494
Total	**25,816**	**32,638**	**38,461**	**48,225**	**55,601**	**58,937**

Program 8: Health Facilities and Capital Stock

Objective

To provide selected new facilities in previously under-serviced areas of high level demand, and to Rehabilitate, refurbish and upgrade health facilities.

Situation Analysis

The following health care facilities at Kwa-Mhlanga, Rob Ferreira, Piet Retief, Emerlo Hospitals and Doctors residences have been successfully refurbished under the Reconstruction and Rehabilitation project. New Health Centres and Clinics have been almost completed at Moloto, Nokaneng, Seabe and Perdekop.

Table: Facility construction, upgrades and rehabilitation (R '000)*

New construction	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)	Total project estimate
New Clinics & CHC					28 572	40 266	
- Mmamethlake CHC	1300	2800					4 100
- Perdekop Clinic		426	1873				2 299
- Moloto CHC		1190	1159				2 349
- Nokaneng Clinic		868	1331				2 199
- Seabe Clinic		1182	1117				2 299
- Amsterdam CHC							
- Moutse CHC			1800	500	2 400		4 700
- Bhuga Clinic			422	600	3 028		4 050
- Silindile Clinic			421	500	1 499		2 420
- Iswepe Clinic				5 000			5 000
- Kangema Clinic				5 000			5 000
- Buffelspruit				5 000			5 000
- Escalation & Slipp				5 021			5 021
Programme 3							
Total new construct.	1 300	6 466	8 123	21 621	35 499	40 266	----
Upgrade Clinics				12 090			
Hospitals							
- Piet Retief Hosp.	2 965	11 601	17 500	52 666	25 000	15 500	125 232
- Themba Hospital	1 638	4 202	1 500	6 000	12 000	15 000	40 340
- Rob Ferreira Hosp.		825	3 500	7 000	18 200	23 700	53 225
- KwaMhlanga Hosp.			5 450	6 199	4 500	0	16 149
- Mmamethlake			2 500	3 410	3 150		9 060
- Embhuleni Hosp.			2 500	3 510	2 000	0	8 010
- Ermelo Hosp.					13 092	16 825	29 917
- Witbank Hosp.					5 603	10 219	15 822
- Groblersdal Hosp.			600	0	9 424		10 024
- Evander Hospital			300	0	0	12 219	12 519
- Delmas Hospital			300	0	6 460		6 760
- Sabie Hospital			1 500	0	0	10 662	12 162

Programme 3							
Total upgrading and rehabilitation	4 603	16 628	32 950	78 765	99 429	104 125	----

Table: Physical condition of district facility network

Facility type	**No.**	**Average 1996 NHFA condition grading[1]**	**Average 2000 NHFA condition grading**	**Outline of major rehabilitation projects since last audit**
Visiting points[2]		---		
Clinics[3]		---		
CHCs		---		
Barberton	---	3	3	
Bongani	---	3	3	
Sabie	---	4	4	
Shongwe	---	3	4	New Maternity, Theatre, Paediatrics, Female and Male surgical wards. New Kitchen.
Themba	---	3	3	Upgrade of Walkways/Ablution Blocks, Lifts, New Palisade Fence and New Boiler Construction of a new Administration block commenced in March 2003 and will be completed in March 2004

Matibidi	---	4	4	
Tonga	---	---	4	
Amajuba	---	4	4	
Bernice Samuel Delmas	---	---	3	
Bethal	---	4	3	
Carolina	---	4	3	
Elsie Ballot	---	4	4	
Embhuleni	---	4	4	Construction of new wards commenced in January 2003 and will be completed in March 2004
Ermelo	---	4	4	New Doctor's Flats, Upgrade of Fence and Parking Area
Evander	---	4	4	
Piet Retief	---	4	3	Construction of a new 140 bed hospital commenced in July 2002 and will be completed in July 2004
Standerton	---	4	4	
Groblersdal	---	4	4	
H A Grove Belfast	---	4	4	
KwaMhlanga	---	4	4	Construction of 2 new wards commenced in August 2002 and will be completed in December 2003
Lydenburg	---	4	4	
Middelburg	---	4	3	

Mmamethlake	---	4	4	Construction of a new Administration block commenced in August 2002 and will be completed in October 2003

Table: Physical condition of hospital network

Hospitals by type	**Average 1996 NHFA condition grading[1]**	**Average 2000 NHFA Condition grading**	**Outline of major rehabilitation projects since last audit**
General			
Rob Ferreira	4	4	Upgrade of Wards 9, 10 & 11 / Upgrade Lifts
Witbank	4	4	Upgrade of Obstetrics / X-Ray, Casualty / OPD / Paediatrics

Programme 8:

Table 6.1	Summary of expenditure and estimates: Programme 8: Health Facilities Management					
R'000	**2000/01 Actual Expenditure**	**2001/02 Actual Expenditure**	**2002/03 Est. Actual**	**2003/04 Voted**	**2004/05 MTEF Budget**	**2005/06 MTEF Budget**
	R,000	R,000	R,000	R,000	R,000	R,000
Community health facilities (Clinics and CHS's)						
New Facilities and replacement						
Upgrading						
Rehabilitation						
Maintanance						
Emergency medical rescue services						
New Facilities and replacement						
Upgrading						
Rehabilitation						
Maintanance						
New Facilities and Replacement	6,876	-	14,423	22,621	39,499	69,266
New Facilities and replacement			4,500			
Amsterdam CHC			1,800			
Moutse CHC			1,800			
Perdekop Clinic			1,873			
Moloto CHC			1,159			
Nokaneng Clinic			1,331			
Seabe Clinic			1,117			
Moutse East Clinic				5,000		
Moutse West Clinic				500		
Silindile Clinic			421	500		

Iswepe Clinic				5,000		
Bhuga Clinic			422	600		
Buffelspruit Clinic				5,000		
Escalation & Slippage				6,021		
Rehabilitation/ Renovation	3,387					
Conditional Grants	3,489					
Provincial Hospital Service		8,573	13,175	25,209	31,137	33,100
Upgrading& Mainta. Of Hosp. & Clinics			13,175			
KwaMhlanga Hospital		8,573		6,199		
Mmamethlake Hospital				3,410		
Embhuleni Hospital				3,510		
Upgrading of Clinics				12,090		
Hospital Rehabilitation / Renovation		54,190	42,000	65,666	68,292	71,025
Piet Retief Hospital		54,190	11,500	52,666		
Themba Hospital			170	6,000		
Rob Ferreira Hospital			3,200	7,000		
Witbank Hospital			1,700			
Philadelphia Hospital			2,900			
Ermelo Hospital			1,200			
KwaMhlanga Hospital			5,450			
Mmamethlake Hospital			1,730			
Embhuleni Hospital			1,500			
Groblersdal Hospital			600			
Evander Hospital			450			
Delmas Hospital			450			
Sabie Hospital			450			
Barberton Hospital			250			
Repairs- Various Hospital			935			
Mechanical equipment			2,510			
Middleburg Pham. Depot			2,300			

Medical Equipment			1,705		
Escalation & Slippage			3,000		