DEPARTMENT OF HEALTH
INTRODUCTION

This document represents the strategic plan for the North West Provincial Department of Health (NWDoH) for the Medium Term Expenditure Framework (MTEF) period 2003 to 2005 (financial year 2003/2004). It begins with part A, consisting of a statement of policy and commitment by the MEC, an overview by the accounting officer and the background against which health service provision in the North West Province is set. The document continues to part B that consists of budget programme and sub-programme plans as prioritized by the national Department of health for this financial year.

PART A: STRATEGIC OVERVIEW

1. STATEMENT OF POLICY AND COMMITMENT BY THE MEC

The Departmental strategic planning process is a result of careful review and planning based amongst others on the provincial priorities and a number of guiding policies within the health sector. Through this process we have committed ourselves to continue to implement a wide range of policies that are meant to fundamentally transform our health care delivery system. Significant steps have already been taken in this direction but a lot still needs to be done.

Provision of efficient health care services at a local level remains the outcome of a process of careful integrated development planning and implementation. The importance of the involvement of municipalities in this process cannot be overemphasized. Programmes aimed at delivering health care services especially to rural and farm communities will be intensified. All principles of the primary health care approach become most evident in the need to provide adequate and equitable services in rural areas.

We will continue to strengthen programmes that will achieve maximum utilization of existing human resources through amongst others, ensuring proper placement of skills, retraining and multi-skilling. New structures will be staffed by skilled people in order to ensure efficiency and effectiveness in management and administration. We will continue to put where there is none or strengthen internal control systems that would assist us to better manage various programmes in the Department especially finances. Development and maintenance of these systems will assist in the control costs associated with health care interventions and to ensure regular supply and distribution of goods and services. Systems will also guarantee the collection and utilization of relevant information needed for decision-making on health care financing and re-distribution.

There will be an effective coordination of resources and programmes directed at infrastructure upgrading and development. Communicable diseases impact negatively on the economy, skills base and on the already burdened health services financial resources. It remains the aim of the Department to intensify the implementation of programmes that are aimed at prevention, immunization and treatment of curable and opportunistic infections amongst the communities of the province. Recognising the importance that poverty plays in the well being of all South Africans especially vulnerable groups like children, we will continue to intensify nutrition interventions which will promote and support the dignity and self respect of recipients.

Although the burden on health care coupled with the stretched resources remains a primary concern, we are confident that through the implementation of this plan, we will be able to make a significant positive impact in the lives of many people in the North West Province.

2. OVERVIEW BY THE ACCOUNTING OFFICER

The Department of Health has a tradition of holding annual planning workshops called Lekgotla. The Lekgotla is held twice a year, one February /March for purposes of operational plans review and the other in October/ November for strategic planning reviews. The November 2001, Lekgotla looked at the existing strategic plan document, in the context of new challenges posed by the restructured local government arena.

The senior management of the Department had to hold an initial review workshop facilitated by Sediba Consulting . The managers looked at various policy documents and previous planning documents i.e. Strategic Planning Framework (Ten Point Plan) of National Health Department, Report of Provincial Executive Planning Lekgotla, Departmental Scenario Planning Document, DHS Policy Decisions and Departmental Strategic Plan. The managers also considered the new legislative framework that covers local and district municipalities' environment especially the following, Municipality Structures Act, Municipality Systems Act and the recommendations of Municipality Demarcation Board in regard to new district and local municipality boundaries.

In the light of local government legislative changes, and the consideration of the New Public Service Regulations and Public Finance Management Act, the Strategic Plan for North West Health Department was adopted for refinement by the November 2001 LEKGOTLA. The Strategic Plan Document encapsulates the following strategic goals:

(i) Providing Quality Health Services;
(ii) Providing accessible, equitable and affordable comprehensive PHC services;
(iii) Well functioning and competitive hospital services;
(iv) Implementation of integrated health programs;
(v) Well managed and effective District Health System;
(vi) Competent, empowered and performance focused employees;
(vii) Appropriate and effective organizational systems; and
(viii) Effective management of the Department's finances and assets.

With this strategic plan, and the allocated funds for the next three-year cycle, the Department believes that it has the necessary courage, zeal and commitment to meet the target set. With support of treasury, the political head of DOH, and the able and competent staff, I believe that the North West communities stand to benefit greatly.

3. VISION, MISSION, VALUES AND STRATEGIC GOALS

The vision, mission, values and strategic goals of the Department are as follows:

3.1 VISION

Optimum health for all individuals and communities in the North West Province.

3.2 MISSION

To ensure access to affordable, equitable, quality, caring health services for all in the North West Province through:

- ✓ Community involvement and partnerships;
- ✓ Batho Pele Principles and the Patients' Rights Charter;
- ✓ Innovation driven performance; and
- ✓ By valuing our people and their diversity.

3.3 VALUES

- ✓ The Department is customer driven (Batho Pele Standards). We work towards understanding our customer's needs, to continuously deliver beyond their expectations, and provide comprehensive quality health care services.
- ✓ We are performance driven. The Department strives to improve and excel. We have set aggressive service delivery targets through our Integrated Implementation Programme.
- ✓ We value people and their diversity. The Department values fairness in all its dealings with people.

3.4 STRAGEGIC GOALS

(i) Providing quality health care;
(ii) Providing accessible, equitable and affordable comprehensive PHC services;
(iii) Well-functioning and competitive hospital services;
(iv) Implementation of integrated Health Programs;
(v) Well managed and effective District Health System;
(vi) Competent, empowered and performance focused employees;
(vii) Appropriate and effective organisational systems; and
(viii) Effective management of the Department's finance and assets

4. LEGISLATIVE FRAMEWORK

The core purpose of the Department is to provide health services to all people of the North West Province. This is done within the framework of the following legislation that has given rise to and governs the existence of the Department:

- ✓ State of the Nation Address;
- ✓ State of the Province Address;
- ✓ National Minister of Finance Budget Speech;
- ✓ Health Act of 1977;
- ✓ National Health Bill;
- ✓ Provincial Health Bill; and
- ✓ The Governance Act (1997).

Recently with developments in the country, this framework and the scope of the Department's activities has come to be influenced by the following additional measures:

- ✓ The New Public Service Regulations;
- ✓ The Public Finance Management Act;
- ✓ Recommendations of the Municipality Demarcation Board;
- ✓ The Municipal Structures Act; and
- ✓ The Municipal Systems Act;
- ✓ WHO guidelines
- ✓ Health Sector Strategic Framework (Ten Point Plan) of National Health Department
- ✓

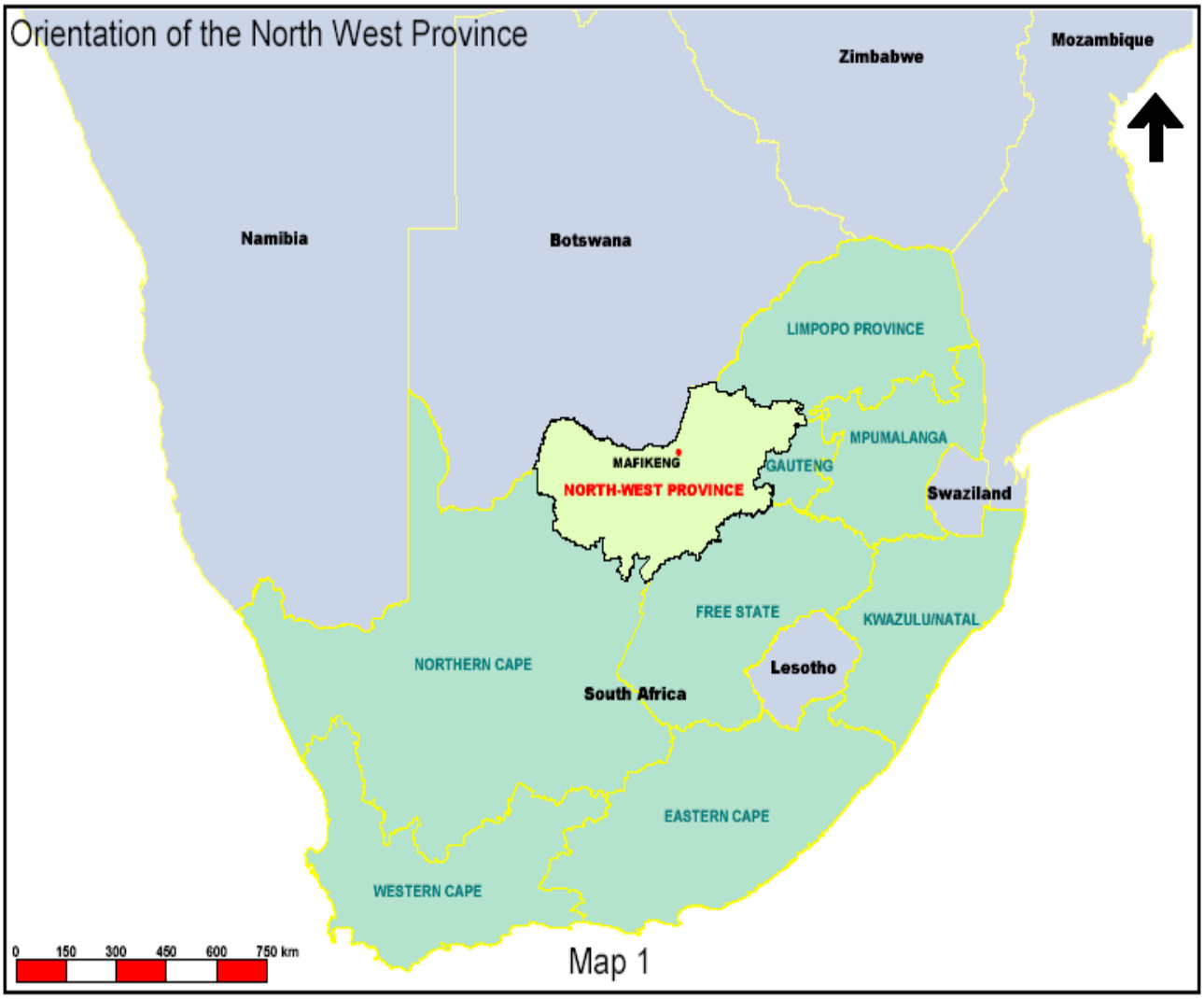
The implication of some of these policies is that they have compelled the Department of Health to carry out its activities differently. For instance, the effect of the enactment of the Municipal Structures Act and the Municipal Systems Act has been to force governance of health institutions to be in line with current realigned municipality boundaries. Further, both the MSA and MSSA have changed the composition of health districts from 18 to 22 according to the new local municipality boundaries. Thus, the Department of Health is now required to carry out its mandate according to realigned boundaries of District and local municipalities.

5. SITUATION ANALYSIS

The North West Department of Health is situated in the North West Province, which is centrally located in the sub-continent. This province has direct road and rail links to all of the Southern African countries. Geographically, this Province is situated towards the western side of South Africa. It borders the Northern Province to the north, Gauteng to the east, the Free State to the south- east, the Northern Cape to the south-west and Botswana to the west and north. Altitude ranges from one to two thousand meters above sea level.

Figure 1 : *Map Depicting Location of North West Province*

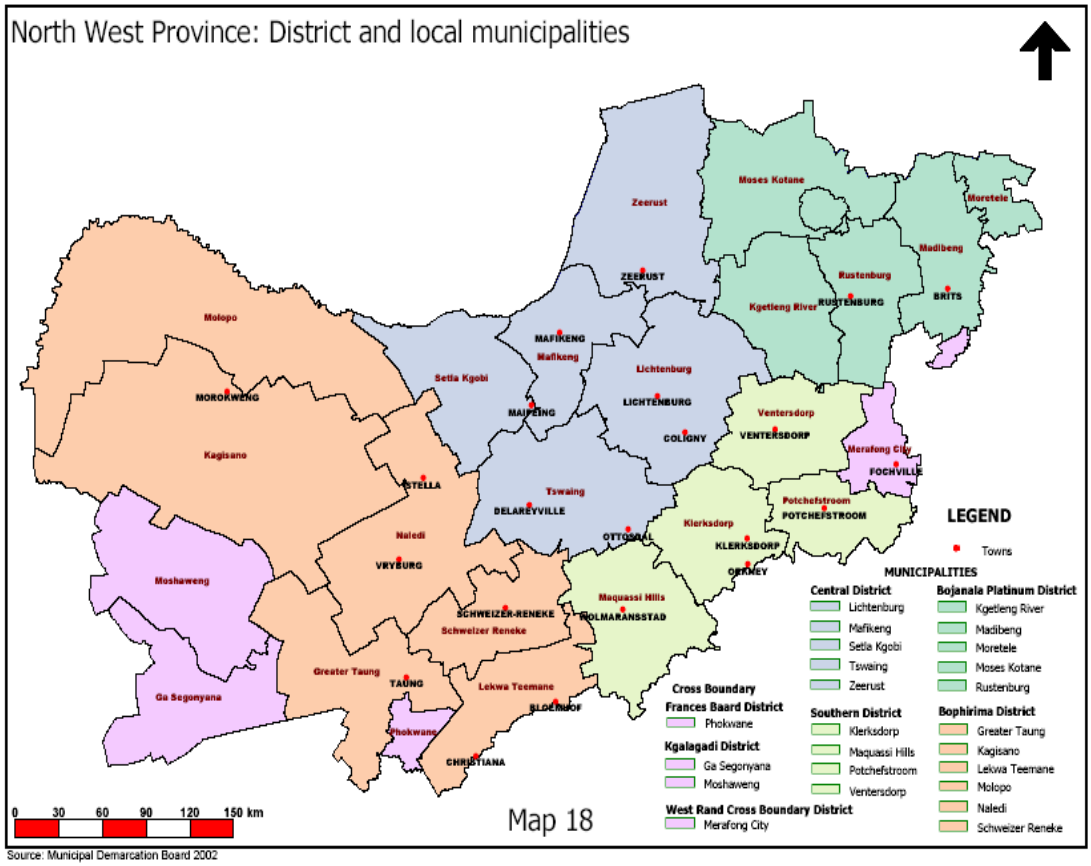
North West is spatially a medium-sized province, covering 116 320 km2, or 9,7 per cent of the total surface area of South Africa. Before the demarcation process the Province consisted of 5 regions and 27 magisterial districts. The Eastern and Far East Regions were merged to become Bojanala District. The Vryburg region is now known as Bophirima District



In terms of recent demarcations, the North West Province was demarcated as follows:

a) District Councils;
b) Cross Border District Councils;
c) Local Municipalities; and
d) Cross border Local Municipalities.

Figure 2: *Map Depicting District and Local Municipalities of the North West Province*



Source: Municipal Demarcation Board 2002

In the Central District, Mafikeng dominates the district and is also the capital of the province. Its administrative infrastructure is well developed and includes facilities such as convention centre, state of the art recording studio, university and airport. In the west of the province (Bophirima District) there is Vryburg the beef producing capital of the province. In the northern part (Bojanala District), the city of Rustenburg represents the major industrial and residential centre, boasting well-developed industrial and mining infrastructures as well as excellent tourism facilities and sites. In the densely populated far-eastern area of the province, Mabopane, Brits, Ga-Rankuwa and Temba are residential, agricultural and industrial centres, and the economy of this area is linked to that of neighboring Gauteng Province. In the Southern District Potchefstroom and Klerksdorp are the two important economic centres.

5.1 MAJOR FLOW OF PATIENTS ACROSS PROVINCAL BOUNDARIES

Unofficial cross border flow:

From North West to Gauteng:

- Southern District (Wedela and Fochville) to Vereeniging
- Bojanala district (Britz and Odi) to Ga-Rankuwa
- Bojanala district (Jubilee) to Kalafong and Pretoria academic

From North West to Northern Cape:

- Kudumane (within Kgalagadi cross boundary district) to Kudumane

From Free State to North West:

- Parys to Southern District (Viljoenskroon and Vredefort)

Official referral pattern for tertiary/quaternary services (Klerksdorp hospital is the first referral point, but if Klerksdorp cannot manage cases then the following apply)

North West to Gauteng

- Southern and Bophirima districts to Chris Hannie Baragwanath
- Central District to Ga-Rankuwa

5.2 CLIMATE

The climate and rainfall patterns in the North West influence living conditions and farming practices. The Province, a semi arid region is primarily a summer rainfall area with many sunshine days and warm temperatures in summer and mild winters. Its average rainfall is above the average for South Africa indicating some advantage for agriculture and food production.

5.3 POPULATION CHARACTERISTICS AND SOCIAL CONDITIONS

The North West province has 3 354 825 people according to the 1996 population census projected to 2001. Roughly 65% of people in the province live in non-urban areas. The population density is 31 people per square kilometre, which is slightly less than the national average of 36 people per square kilometre and considerably less than Gauteng's ±468 people per square kilometre. The province's low population density has several implications with regard to the rendering of health services, particularly to small communities in rural areas. The Department has to operate a number of mobile clinics to render health services to communities that live far from fixed health facilities.

Table 1: *Demographic Indicators*

Demographic Indicators	North West	South Africa
Annual population growth rate(1993 figure DBSA 1994)	3.1%	2.4%
Average household size (Census 1996)	4.6	4.4
Crude death rate (for 2001 from SAHR 2001)	12.5/1000	11.7/1000
Population projection (StatsSA Mid-Year Estimates for 1996)	3,354,825	40,583,573
Population projection (StatsSA Mid-Year Estimates for 1998)	3,481,200	42,130,500
Population projection (StatsSA Mid-Year Estimates for 1999)	3,562,280	43,054,306
2000 With AIDS	3,532,824	43,291,441
2000 Without AIDS	3,566,777	43,685,699
2001 With AIDS	3,604,472	44,328,322
2001 Without AIDS	3,625,924	44,560,644
2002 With AIDS	3,085,164	45,167,445
Public sector dependent population: 2001 With AIDS (from Fiscal Review 2001	3,135,891 (86% of above "2001 with AIDS" figure)	37,058,477

The Province's population is growing at a higher rate than the average for South Africa. Average household size is at the same level than the average for the country. Crude death rate is slightly higher than the average.

Table 2: *Socio-economic Indicators*

Socio-Economic Indicators	North West	South Africa
GDP per capita (from StatsSA HDI 2001 for 1996)	3,509 PPP USD	5,916 PPP USD
Adult literacy rate (1996)	73.2	85.9
Education level – no schooling (1996)	22.7	19.3
Age dependency ratio (From StatsSA Mid-Year Estimate 2002)	63.5	64.4
Unemployment rate for 1999 (From StatsSA October Household Survey - expanded definition)	42.1	36.2
Unemployment rate for 1999 (From StatsSA October Household Survey - official definition)	23.5	23.3

Gross domestic product per capita is two-thirds of the average of the country, while the expanded unemployment rate is 42.1%, indicating the high prevalence of poverty in the province. The adult literacy rate is also lower than the average for the country.

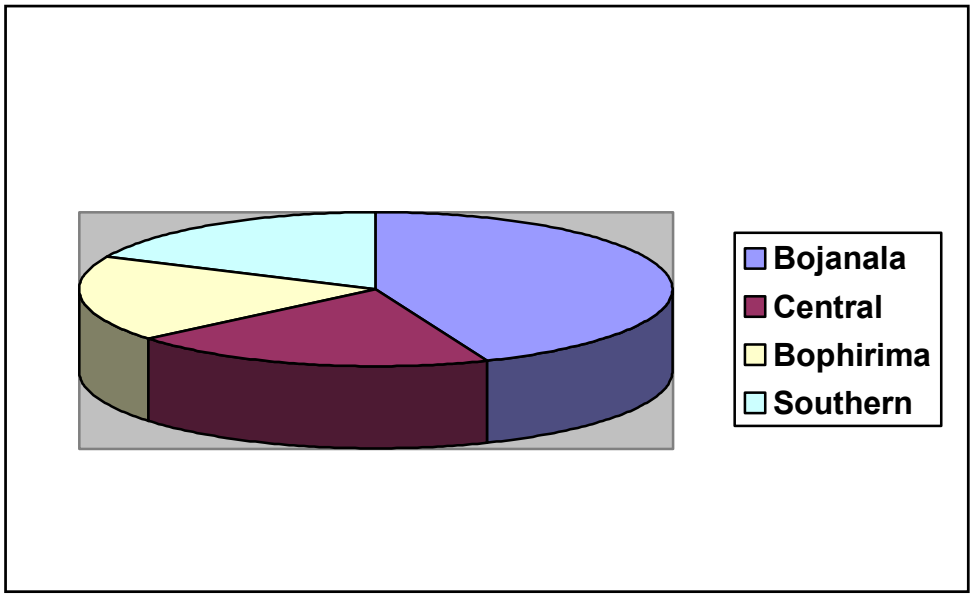
Table 3: *Disability:*

Disability Indicators	North West	South Africa
Prevalence of disability (1996 Census)	8.3%	6.5%
Prevalence of disability (1998 CASE Survey)	3.1%	5.9%
Prevalence of hearing disability (1996)	1.6	1.0
Prevalence of mental illness (1996)	0.7	0.5
Prevalence of physical disability (1996)	1.8	1.4
Prevalence of sight disability (1996)	3.4	2.7

Available figures for disability prevalence vary widely reflecting the lack of clarity regarding the actual situation in the province.

The distribution of the population by health district is as follows: Bojanala (44%), Central (20%), Bophirima (18%) and Southern (18%).

Figure 3: *Population Distribution by Health District*



The distribution of the population by age group is as follows: under 15 years (34%), 15-44 (49%), 45-64 (12%), and 65+ (5%). The distribution shows that the province has a young population, which is typical of most developing countries.

Figure 4: *Population Distribution by Age Group*

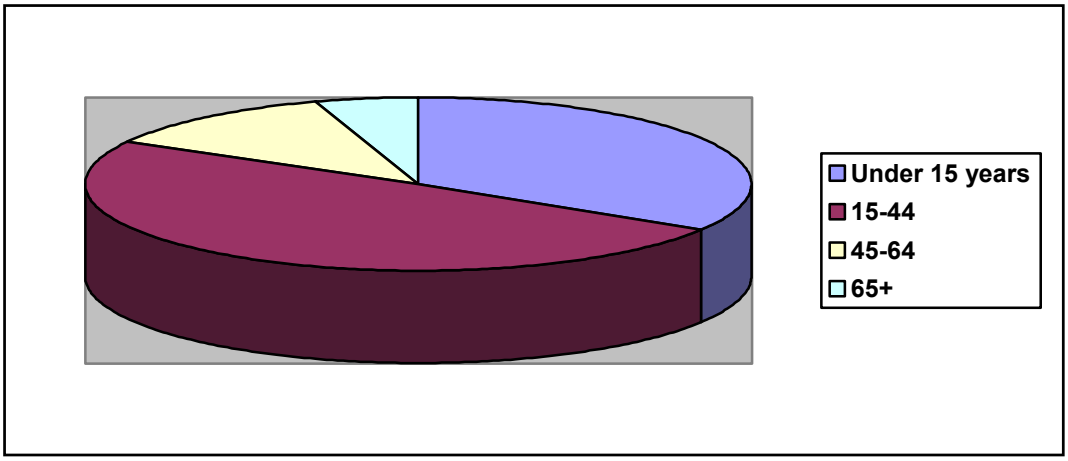


Table 4 below, shows the profile of the population of the province by health district based on the 1996 census figures. The extent of poverty is high, with over half of the households with an annual income of less than R12, 001. Only 30% of households had in-house piped water and 32% had flush toilets. These environmental factors have an impact on the occurrence of water-related diseases.

Table 4: *Population of the North West Province by Health Districts and Sub-district, including some Household Characteristics According to the 1996 Census Data*

Districts and Sub-District	Total population	% of households with in-house piped water	% of households with flush toilets	% of households with electricity	% of households with telephones	% of households with income less than R12,000 per annum
Bophirima						
Ganyesa	100,030	11	9	18	6	77
Kudumane	143,867	5	4	22	2	72
Vryburg	60,520	46	63	56	24	60
Taung	201,276	14	12	14	6	75
Schweizer-Reneke	81,851	27	23	64	19	63
Lekwe-Teemane						
Molopo-Bophirima						
Central						
Mafikeng	255,658	31	24	39	18	54
Zeerust	132,893	15	17	32	12	69
Lichtenburg	129,978	40	35	55	22	57
Tswaiing/Delareyville	151,444	13	10	16	6	70
Setlagobi						
Southern						
Wolmaransstad	79,913	25	22	60	17	70
Klerksdorp	334,497	54	62	68	31	44
Ventersdorp	31,726	27	21	30	20	65
Potchefstroom	166,772	56	73	56	38	39
Bojanala						
Mogwase	203,218	13	10	26	6	53
Rustenburg	370,910	35	43	51	21	37
Brits	165,417	34	44	46	22	45
Odi	423,311	32	34	34	14	44
Moretele	322,014	13	11	65	4	50
Kgetleng Rivier						
Province	**3,355,295**	**30**	**32**	**44**	**17**	**52**

Figure 5: *Percentage of Households per Health District with basic infrastructure*

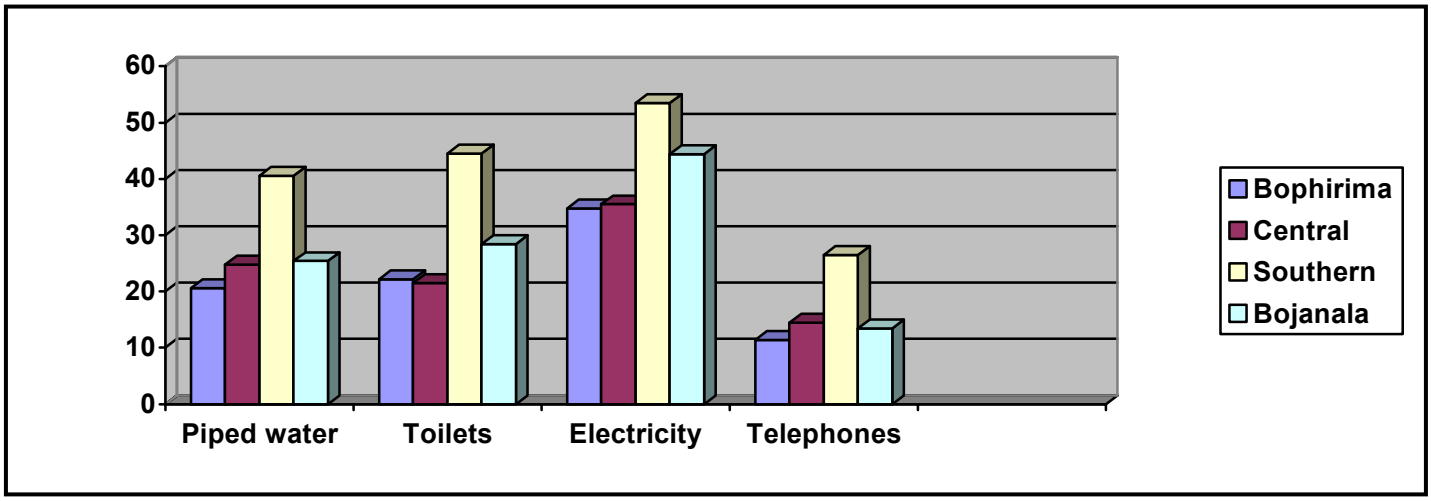
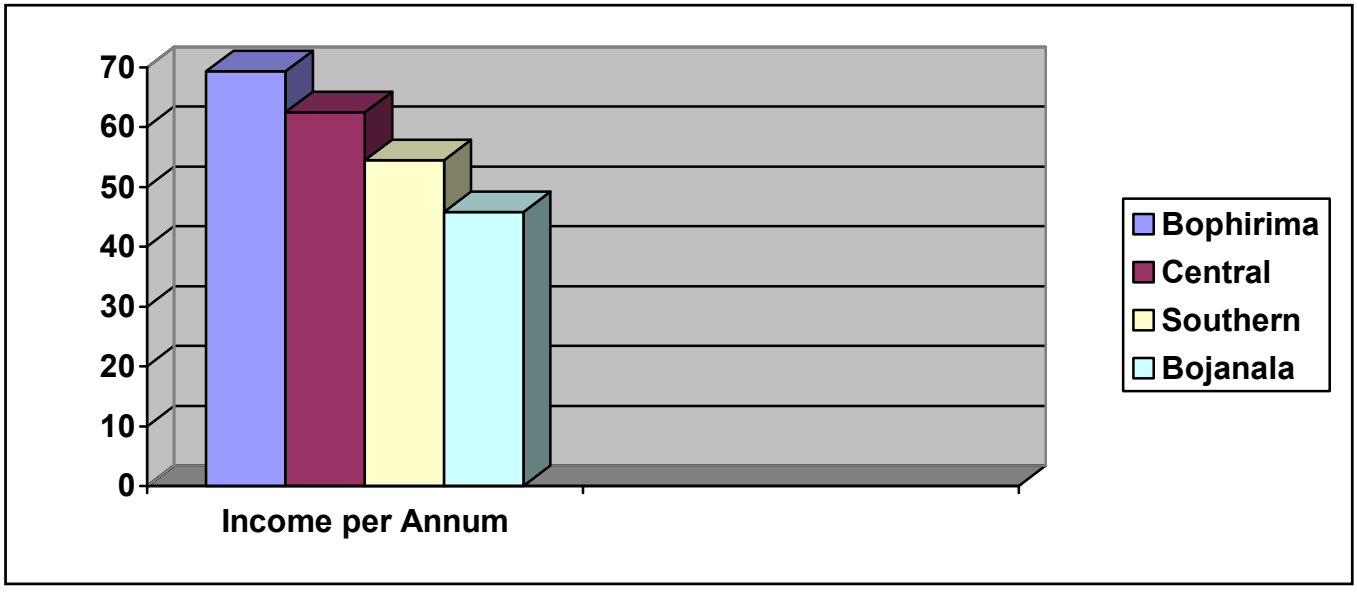


Figure 6: *Percentage of Households per Health District with an Income less than R12,000*



5.4 MAIN PUBLIC HEALTH CONCERNS

The infant mortality rate (SADHS 1998) for the North West Province was 42.0 and in South Africa, 45.0. The Life expectancy at Birth according to Statistics South Africa HDI of 1996 was 53.3 for the North West Province and 57.0 for South Africa. Finally the under 5-mortality rate (SADHS of 1998) for the North West 56.0 and South Africa 61.0. These rates reflect the relatively poor socio economic conditions prevalent in the province.

Table 5: *Most Reported Communicable Diseases*

Infectious Disease Indicators (2001)	North West
Reported cases of cholera (per 100,000)	0.03
Reported cases of malaria (per 100,000)	9.4
Reported cases of measles (per 100,000)	2.5 (after investigation found to not be measles)
Reported cases of TB (per 100,000)	306.5
New smear positive cases cured (%)	52.4 (2000)
Reported cases of typhoid (per 100,000)	0.09
Reported cases of viral hepatitis (total per 100,000)	0.4
Syphilis prevalence rate (% antenatal)	4.0 % (77% reduction since 1998)
HIV/AIDS prevalence rate (% antenatal):	25.2 %

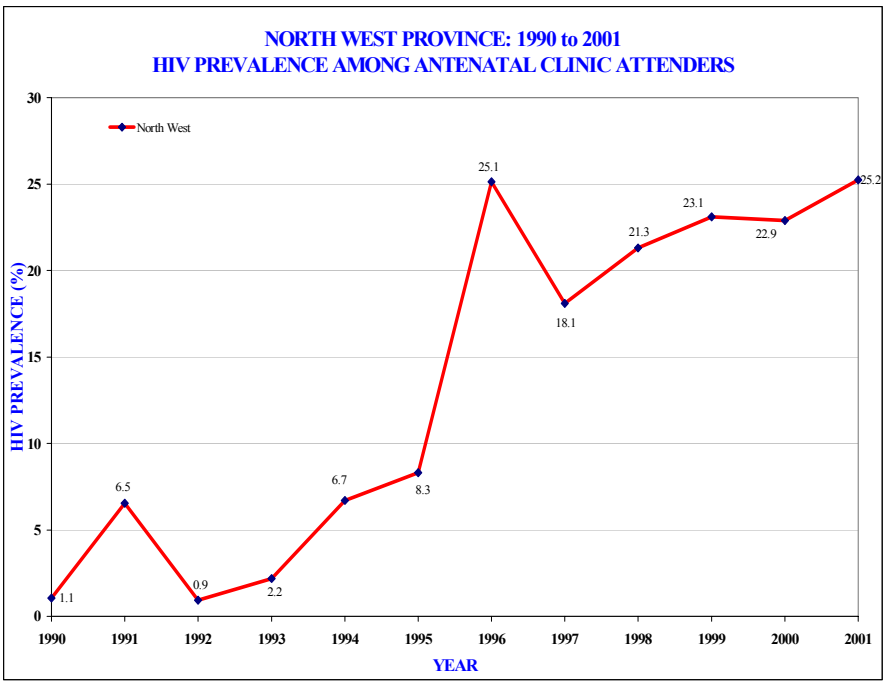
During 2000 61% of all TB patients completed treatment and of those who were bacteriologically proven to have TB, 52.4% were proven cured (the target is 85%). Unfortunately 26.4% of smear positive patients did not complete treatment because they either died, were transferred or defaulted. This makes it impossible to reach the target of 85% cured.

For the year 2000 only 48% of all smear positive cases converted to smear negative within 3 months (target 85%). The two main reasons given for this poor performance were that smears were not collected at all by staff in some facilities, or collected outside the times set by the National policy (this added up to 32% of cases). Only 14% of smear positive patients discontinued treatment before the end of 3 months due to death, transfer or treatment interruption.

Sputum turn-around time improved during 2001 as an average of 71% of sputum results were available in less than 48 hours after the specimen was collected. Fifty-eight new MDR TB patients were admitted during 2001, making up 0.41% of all TB cases diagnosed during 2001. This is less than the estimated 1% of all new patients and 4% of all re-treatment patients set as the average incidence for the country.

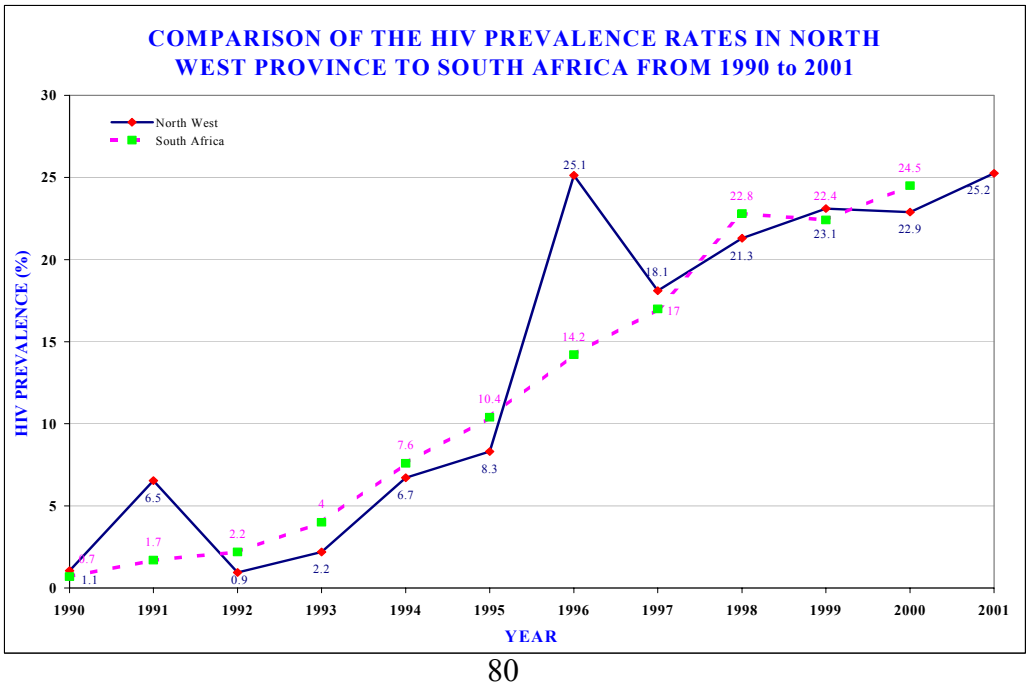
All cases of cholera were imported and the necessary precautionary measures were taken to ensure prevention of their spread in the province.

Figure 7: *HIV Prevalence Among Antenatal Clinic Attenders*



The prevalence of HIV infection among antenatal clinic attenders in the North West province for 2001 is estimated at 25.2% (95% confidence interval (CI) 21.888-28.597). HIV prevalence has increased from 1.1% in 1990 to 25.2% in 2001 (see Figure 1). The prevalence has increased by 10.3% in 2001 as compared to year 2000. It should be noted that the sample sizes between 1990 and 1996 were small and excluded the former Bophuthatswana. The prevalence of 25.1% in 1996 was probably a result of biased sampling in certain districts.

Figure 8: *Comparison of HIV Prevalence Rates in the NW to South Africa*



Above figure shows a comparison between North West province and South Africa. It can be seen that there is a concurrent increase in the prevalence between 1990 and 2001, except for the peak in 1996 in North West which was probably due to sampling bias.

Figure 9: *Comparison between HIV Positives and Syphilis Positives Per Region*

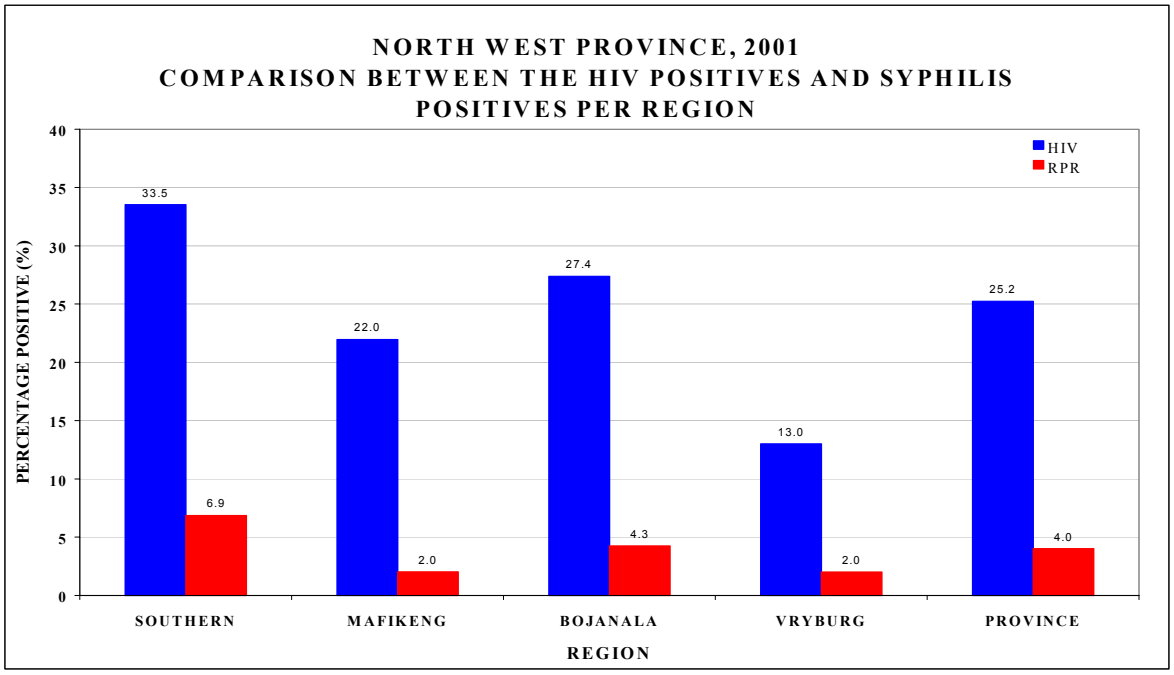


Table 6: *Maternal Care Indicators*

Maternal Care Indicators	2001	2002
Antenatal visits per client	4.1	4.1
Caesarean Section rate	13.9%	14.3%
Teenage Pregnancy rate	11%	9%
Male urethral discharge incidence		2.23/1000
Terminations of Pregnancy (TOPs)	2050	3363
Maternal mortality ratio (DHIS 1998)	135/100 000	150/100 000

The number of antenatal care visits per client has remained stable at 4.1 over the last two years. This is more than the required national norm of 3 visits per pregnancy.

Caesarean section rate is slightly up from 13.9% in 2001 to 14.3% in 2002.

Teenage pregnancy rate has slightly decreased from 11% in 2001 to 9% in 2002.

Terminations of Pregnancy has increased by 64% from 2001 to 2002.

Table 7: *CTOP Status in the Province*

Functional Sites	Number of TOPs Done	Year
9 out of 17	2050	2001
14 out of 17	3363	2002

There has been a steady improvement in the accessibility of CTOP services in the Province. Major problem were experienced at facility level with personnel regarding personal values related to the CTOP service. Management issues were more related to personal issues, which impacted on the overall implementation of the programme. These constraints were addressed through Values-Clarification workshops, which had a positive impact at most health facilities.

Table 8: *Nutrition Indicators*

Nutrition Indicators	North West	South Africa
Iodine Deficiency:		
1998 children <100mcg/l rural	13.1%	
1998 children <100mcg/l urban	30.2%	
Obesity (%):		
1998 Men	5.4	9.1
1998 Women	18.8	29.4
Stunting (%):		
1994 Age 6-71 months	11.6	22.9
1999 Age 1-9 years	24.9	21.6
Wasting (%):		
1994 Age 6-71 months	4.5	2.6
1999 Age 1-9 years	5.7	3.7

Table 9: *Child Health Indicators*

Child Health Indicators	North West
Diarrhoea incidence < 5 per 1000 (2002)	14/1000
Immunisation coverage of children < 1 year (2002)	72%

Diarrhoea incidence has decreased from 20.8 per 1000 in 2001 for under 5 years to 14 per 1000.

Immunisation coverage has decreased from 82% in 2001 to 72% in 2002, implying that increased emphasis needs to be given to the Expanded Programme for Immunisation.

(i) TB and AIDS related conditions
(ii) Pneumonia
(iii) Diabètes
(iv) Trauma
(v) Hypertension
(vi) Cardiac failure
(vii) Pre-eclamptic Toxaemia
(viii) Gastro-enteritis
(ix) Burns
(x) Abortions and Ectopic pregnancy

5.5 BROAD STRUCTURE OF PUBLIC HEALTH SERVICE

The Department has the following health facilities:

- 2 provincial (level 2) hospital complexes (2 provide specialist psychiatric services as well) and 1 provincial hospital;
- 20 district hospitals
- 7 community hospitals
- 327 fixed clinics and health centres including local government clinics
- 77 mobile clinics.

Table 10: *Fixed Public Primary Health Care Facilities (clinics plus community health centres)*

PHC facilities1	Number	Average population per facility
Province wide	327	11 009
Bophirima (least served health district in terms of access)	81	8 000
Bojanala (best served health district in terms of access)	134	12 375
Southern	34	19 058
Central (best served in terms of both access and average population per facility)	78	9 231

The North West Department of health does not view the measure of service to communities only in terms of number of fixed facilities in a health district, but also in terms of the population's access to facilities (km distance from nearest service). In a rural province such as the North West Province, accessibility is influenced by population distribution. Thus, although in terms of average population per facility Bophirima health district seems to the best off, it is the district where mostly one would find small groups of the population located in rural outskirts, making it the district where some communities have poor access because of long distances to the nearest clinic. These communities are periodically served by mobile clinics. Bojanala and Southern consist mainly of urban centres where access in terms of distance is good.

Table 11: *Public Hospitals*

Hospital type	Number	Number of beds (Autho-rised)	Beds per 1000 people	Beds per 1000 uninsured people (80% of population)
District and community[1]	27	3 613	1.1	1.4
General (regional)	4	2 244	0.7	0.9
Central	0	0	0	0
Sub-total acute hospitals	31	5 857	1.75	2.2
Tuberculoses	0	0	0	0
Psychiatric [2]	2	1 520	0.5	0.6
Chronic medical and other specialised			0	0
Total	**31**	**7 377**	**2.19**	**2.8**

Note stats are for authorised beds. Open beds will result in an average of 14 % less regarding total figures

5.6 PUBLIC HEALTH PERSONNEL

By March 2002, the Department had 15,255 employees, of which 75% were female and 0.4% disabled. This figure includes those employees additional to the approved funded staff establishment. The staff composition by population group was as follows: African (90%), Coloured (1.9%), Indian (0.3%) and White (7.8%). The bulk of the Department's employees (43%) were nurses. There were 53 foreign health professionals, excluding Cuban and Belgian health professionals who were employed on a government-to-government agreement. The total personnel expenditure during 2001/2 was 68% of the total budget. In this period, the Department had a total staff establishment of 22,351 consisting of both funded and unfunded posts. The number of persons employed additional to the approved staff establishment was 540, distributed throughout our clinics, hospitals, districts and the provincial office.

[1] District Hospitals are 19 and Community Hospitals are 8

[2] These are psychiatric units that form part of two of the hospital complexes namely Klerksdorp/Tshepong/Witrand/Potchefstroom Complex and Mafikeng/Bophelong Complex.

Table 12: *Population/post Level Breakdown*

POST LEVELS															
POPULATION GROUP	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**TOTAL**
Black Male	42	1,306	516	352	215	412	200	221	118	10	77	15	13			3,498
Black Female	60	2,685	762	1,040	1,551	1,841	475	1,650	105	23	22	7	2	1		10,224
Indian Male	0	0	0	0	0	0	0	0	8	0	11	4	1			29
Indian Female	0	0	2	0	0	1	2	3	7	0	4	0	0			19
Coloured Male	1	22	4	11	3	5	3	1	2	1	0	0	0			53
Coloured Female	1	69	32	33	38	33	12	25	2	0	0	1	0			246
White Male	1	26	18	32	26	14	17	10	51	1	97	12	2		1	308
White Female	1	12	115	113	515	134	74	183	49	10	31	5	0			878
TOTAL	**106**	**4,120**	**1,449**	**1,581**	**1,984**	**2,440**	**788**	**2,093**	**342**	**45**	**242**	**44**	**18**	**1**	**1**	**15,255**

Table 13: *Approved Posts/Additional Posts: Filled/Vacant/Frozen*

	FILLED	**VACANT**	**FROZEN**	**NUMBER OF POSTS**
APPROVED POSTS				
NORMAL	14,705	7,591	0	544
SESSION	10	45	0	55
CASUAL	0	0	0	0
TOTAL	14,715	7,636	0	22,351
ADDITIONAL POSTS				
NORMAL	540	4	0	544
SESSION	0	0	0	0
CASUAL	0	0	0	0
TOTAL	540	4	0	544
GRAND TOTAL	**15,255**	**7,640**	**0**	**22,895**

The overall picture of health personnel is as shown in the table below:

Table 14 : *Public Health Personnel*

Categories	Number employed	%of total number employed	Number per 1000 people National Averages	Number per 1000 uninsured people	Vacancy rate	% of total personnel budget	Average annual cost per staff member
Medical Officer	337	2%	0.1	0.2	0.1	5.48%	183962
Medical Specialist	60	0,3%	0 .02	0 .1	0.02	1.26%	419773
Dentists	46	0,2%	0 .01	0 .01	0.01	0.67%	376711
Dental Specialist							
Professional Nurses	3001	19%	0.9	1	1	29.39%	110849
Staff Nurses	1211	8%	0.4	0.5	0.4	7.93%	74097
Nursing Assistants	2518	16%	0.7	0.7	0.9	13.22%	59414
Student Nurse	409	3%	0.1		0.1	1.71%	47326
Pharmacists	75	0,5%	0.02	0.03	0.02	0.78%	118336
Allied Health Professional and Technical Staff	169	1%	0.05		0.06	1.64%	109504
Managers, Administrators and Support Staff	7852	50%	2.3		3	37.93%	54672
TOTAL	**15678**	**100%**				**6662**	**100%**	**1554649**

The percentage of NW population that have health insurance is estimated at 13% (figure for 1999 from the 2001 Intergovernmental Fiscal review). This places the number of uninsured people in the province at 2918 698. The NW is slightly below the national averages for all categories of health workers (for those where national averages are available) except for nursing assistants and dentists where the province is on par with the national average. National averages are however not a good indicator of how well or how poorly staffing needs are being addressed. Our performance in terms of this would be better measured if there were national targets to gauge this against.

5.7 TRENDS IN PROVINCIAL PUBLIC HEALTH EXPENDITURE

From 1998 trends in provincial public health expenditure, are as shown in the table below. Unfortunately, no data is available for 1995 to 1997.

Table 15: *Trends in Provincial Public Health Expenditure in Current Prices (R million)1*

Programme	1998/99 (actual)	1999/00 (actual)	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget[2)]	2004/05 (MTEF projection)	2005/06 (MTEF projection)
Administration	37132.0	38330.0	70129.0	69152.0	83233.0	103714.0	116202.0	129238.0
District Health Services	854747.0	943848.0	898853.0	945184.0	1195529.0	1264461.0	1330327.0	1542879.0
Emergency Medical Services	0.0	0.0	52886.0	53240.0	57040.0	96609.0	92191.0	112055.0
Provincial Hospital Services	396113.0	328591.0	445767.0	480585.0	537071.0	639823.0	744216.0	841326.0
Central Hospital Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Health Sciences and Training	29692.0	26912.0	33010.0	35619.0	46069.0	63891.0	75683.0	81317.0
Health Care Support Services	24201.0	42566.0	34590.0	49831.0	55017.0	70290.0	86954.0	89309.0
Health Facilities Management	107.0	3595.0	26250.0	65381.0	0.0	118566.0	158203.0	166585.0
Municipal own expenditure	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Department of Public Works	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Table 16 : *Trends in provincial public health expenditure by economic classification in current prices (R million)*

Programme	1998/99 (actual)	1999/00 (actual)	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget[2)]	2004/05 (MTEF projection)	2005/06 (MTEF projection)
Personnel	971530.0	984094.0	1081520.0	1158856.0	1254756.0	1479116.0	1571736.0	1684927.0
Transfer payments	54455.0	55157.0	65418.0	40378.0	47968.0	53809.0	59113.0	70863.0
Administrative expenditure	40716.0	36778.0	48682.0	52592.0	58601.0	64709.0	68676.0	82337.0
Stores	204045.0	210161.0	226835.0	230848.0	268039.0	315186.0	338065.0	390114.0
Professional and special services	43769.0	75607.0	63205.0	96676.0	234517.0	157895.0	219202.0	292104.0
Other current expenditure	2476.0	1113.0	0.0	7537.0	74888.0	99328.0	136572.0	177702.0
Equipment	24894.0	17309.0	49575.0	46724.0	34300.0	68745.0	52209.0	98077.0
Infrastructure	107.0	3595.0	26250.0	65381.0	890.0	118566.0	158203.0	166585.0

Table 17 : *Trends in Provincial Public Health Expenditure in current prices (R million)*

Programme	1995/96 (actual)	1996/97 (actual)	1997/98 (actual)	1998/99 (actual)	1999/00 (actual)	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget[2)]	2004/05 (MTEF projection)	2005/06 (MTEF projection)
Total	293.0	307.7	323.0	339.2	356.1	374.0	392.6	412.3	432.9	454.5	477.3
% of total spent on:											
District Health Services	35.2%	0.4	0.4	0.4	0.4	0.4	0.5	0.5	0.5	0.5	0.6
Provincial Hospital Services	27.3%	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.4
Central Hospital Services	0.0%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Personnel	58.5%	0.6	0.6	0.7	0.7	0.7	0.8	0.8	0.9	0.9	1.0
Total Capital	35.0	36.8	38.6	25001.0	20904.0	75825.0	112105.0	35190.0	187311.0	210412.0	264662.0
Health as a % of total public expenditure	17.2%	17.0%	16.9%	16.8%	17.2%	17.3%	16.9%	17.2%	17.2%	17.3%	17.4%

Municipal own expenditure is included with DHS expenditure
It would be better to compare the figures without including DPW expenditure unless that figure is broken down ober programmes.
Personnel is calculated as a % of Total DOH Recurrent Expenditure, unless there is a breakdown of municipal own expenditure by economic classification.
Define total public expenditure?

Table 18 : *Trends in provincial public health expenditure in constant 2002/03 prices (R million)*

Programme	1998/99 (actual)	1999/00 (actual)	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	Average annual change %	2003/04 (budget)
Total	1793015.3	1724854.8	1812666.5	1835040.9	1973959.0	227.7%	2215912.8
Total per person	1,699,576	1,606,059	1,657,979	1,648,766	1,742,223	221.9%	1,921,190.52
Total per uninsured person	1,888,418	1,784,510	1,842,199	1,831,962	1,935,803	221.9%	2,134,656.13
Average change							
Total	389370.9%	-3.8%	5.1%	1.2%	7.6%		12.3%
Total per person	382484.4%	-5.5%	3.2%	-0.6%	5.7%		10.3%
Total per uninsured person	382484.4%	-5.5%	3.2%	-0.6%	5.7%		10.3%

The Treasury formula for calculating the annual average change is ((outer yr/base year) to the power of (^on excel) times (1/number of years from base to outer))

In the above table that is 7 years from the base year of 1995/96 to the last year of 2002/03

Table 19 : *Inflation Rates and Population Figures*

	1995/96 (actual)	1996/97 (actual)	1997/98 (actual)	1998/99 (actual)	1999/00 (actual)	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget[2)]
Population growth rate		1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%
Population	1,000,000								
Medical aid membership %	10%	10%	10%	10%	10%	10%	10%	10%	10%

Table 20 : *Evolution of Expenditure by budget programme and sub-programme in current prices (R million)*

Sub-programme	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget[2)]	2004/05 (MTEF projection)	2005/06 (MTEF projection)
District Management	25509.0	34760.0	39916.0	35951.0	28844.0	33072.0
Coomunity Health Clinics	170063.0	181693.0	199862.0	210848.0	236832.0	302693.0
Community Health Centres	138674.0	151846.0	161880.0	292227.0	311195.0	375673.0
Community Based Services	0.0	0.0	7800.0	4000.0	4008.0	3572.0
Other Community Services	9145.0	11050.0	5000.0	5044.0	5246.0	5350.0
HIV/AIDS	0.0	0.0	30419.0	42891.0	40479.0	56024.0
Nutrition	39391.0	38941.0	47795.0	71967.0	84583.0	61790.0
Coroner Services	0.0	0.0	0.0	0.0	0.0	0.0
District Hospitals	516071.0	526894.0	568098.0	601533.0	619140.0	704705.0

Table 21 : *Evolution of Expenditure of Budget Programme in Constant 2002/03 prices*

Expenditure	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	Average annual change %	2003/04 (budget)
Rands					
Total (R million)	1,043,443.1	1,020,870.8	1,060,770.0	0.8%	1,188,593.3
Total per person (Rand)	954,399	917,242	936,239	-1.0%	1,030,507
Total per uninsured person[5]	1,060,443	1,019,158	1,040,266	-1.0%	1,145,008
Average change					
Total		-2.2%	3.9%		12.1%
Total per person		-3.9%	2.1%		10.1%
Total per uninsured person		-3.9%	2.1%		10.1%

Table 22 : *Inflation rates per Stats SA*

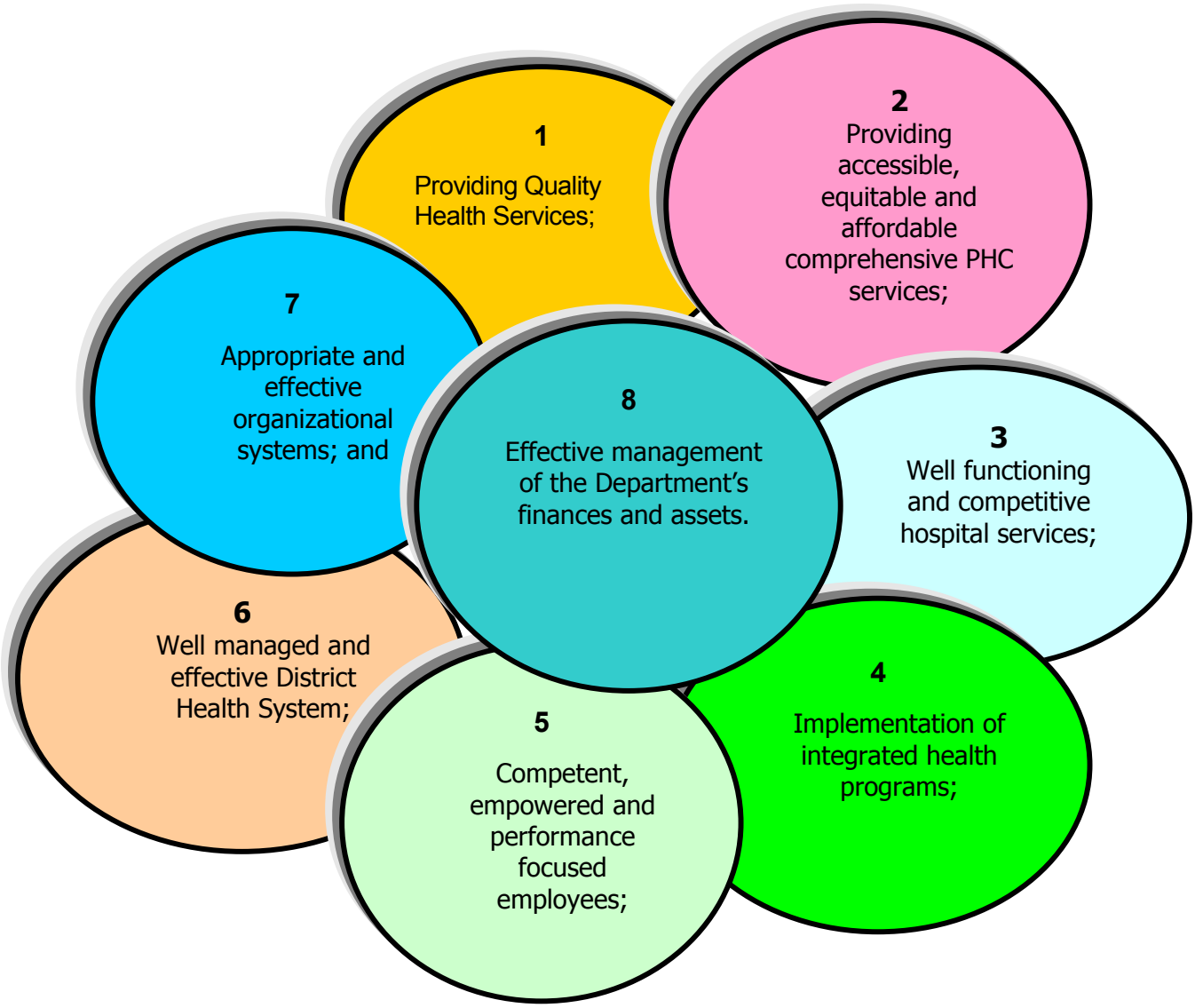
Change by financial year								
	March 1995	**March 1996**	**March 1997**	**March 1998**	**March 1999**	**March 2000**	**March 2001**	**March 2002**
CPIX Index			79.5	84.8	90.9	97.6	104.9	113.3
CPI Index	71.3	75.7	83.0					

5.8 MAJOR HEALTH SERVICE CHALLENGES

The key challenges identified over the MTEF period are as follows:-

- ✓ Exodus of skilled personnel to other provinces/high staff turnover rate. Inability to attract or keep rare clinical professionals within the Province;
- ✓ To strengthen the Provincial Council on AIDS;
- ✓ To finalize the restructuring of EMS Services such that access to all communities, but especially to rural communities is improved;
- ✓ Huge backlog in the maintenance of health facilities;
- ✓ To decentralise district health services to the appropriate level;
- ✓ To improve tuberculosis control, especially with regard to cure rate, smear conversion rate and interruption rate;
- ✓ To expand voluntary counselling and testing sites, as well as prevention of mother to child transmission of HIV sites;
- ✓ To increase the number of clinics having four or more doctor visits per month, so that primary health care nurses can be appropriately supported;
- ✓ To improve quality of services by implementing clinical guidelines and improving peer review and clinical audit mechanisms at all facilities;
- ✓ To improve the implementation of the Uniform Patient Fees billing systems at all hospitals so as to ensure greater revenue generation;
- ✓ To expand the cervical cancer surveillance service;
- ✓ To integrate the various departmental and transversal information systems into one management information system to assist in better decision-making and planning;
- ✓ To develop a comprehensive medico-legal service while integrating police mortuaries into the Department;
- ✓ To identify the targeted number of cases with acute flaccid paralysis, so that the eventual aim of being certified polio-free can be achieved;
- ✓ To develop EAP and OHS structures at Head Office, Regional Offices and Provincial hospitals;
- ✓ Review and realignment of the organizational structure to ensure good management of the department; and
- ✓ Scarcity of skilled management within the head office and regions.

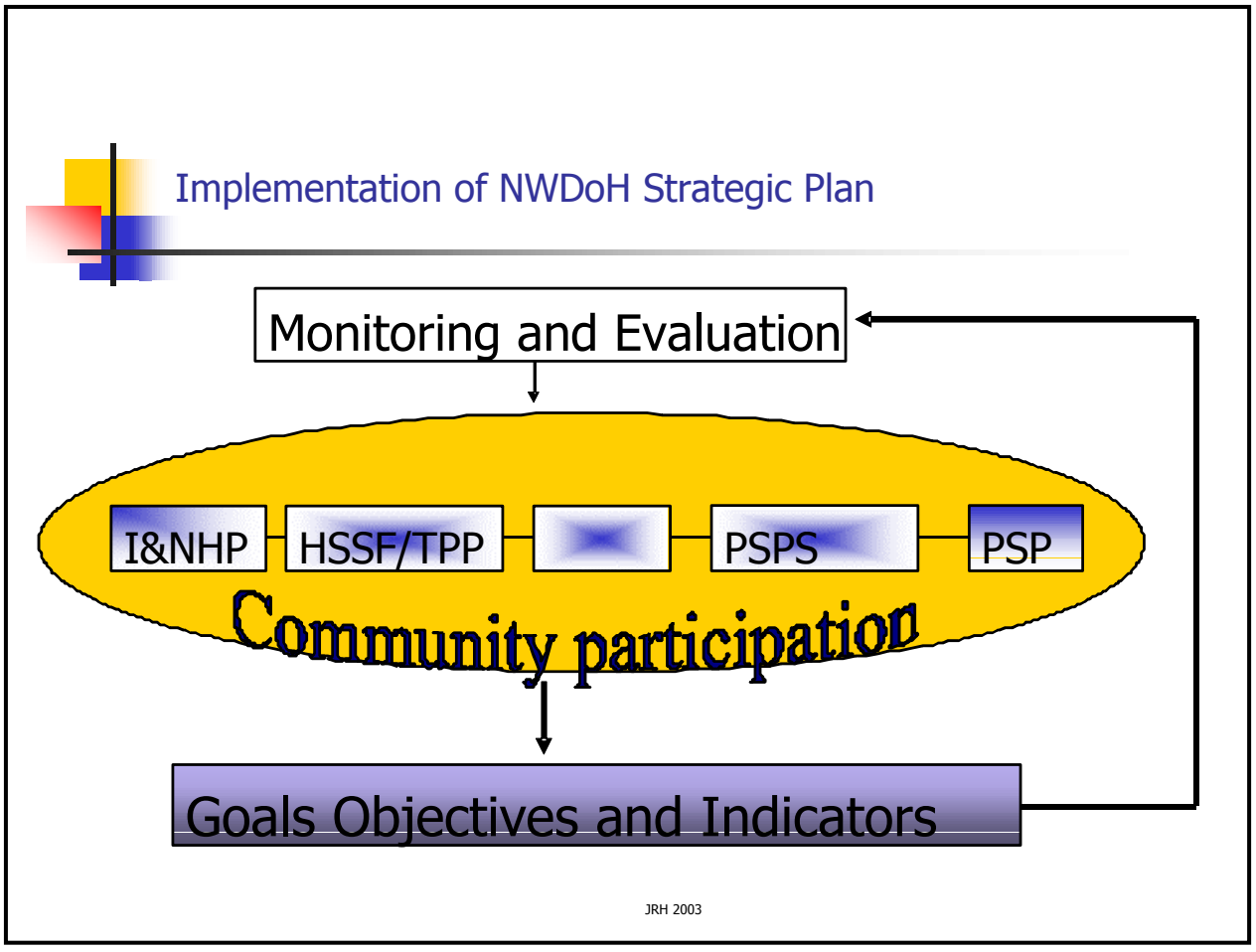
6. STRATEGIC GOALS



PART B: BUDGET PROGRAMME AND SUB PROGRAMME PLANS

7. LINKAGE TO STRATEGIC POSITION STATEMENT AND TEN POINT PLAN

This Strategic Plan is guided by International and National Health Policy (I&NHP) and has thus been developed within the broad framework of the NWDoH's draft Strategic Positioning Statement (PSPS), while keeping it aligned to the National 10 Point Plan (HSSF/TPP). The services of NWDoH are based on real community needs obtained through community representation in service planning and delivery structures. The Strategic Plan has to operationalised into a business plan with **"SMART"** objectives and indicators. Achievement has to be continuously monitored and periodically evaluated to facilitate the re-planning that is a requirement of continuous quality improvement (CQI).



8. ANALYSIS OF CONSTRAINTS AND PLANS TO OVERCOME THEM

Table 23 : *Strategic areas, constraints and measures to overcome them*

STRATEGIC AREA	CHALLENGES/CONSTRAINTS	MEASURES TO OVERCOME
Finance	Appropriate implementation and use of UPFS and the reduction of outstanding fees. Lack of computer hardware. Unmotivated and untrained staff	Motivate and train staff. Provide required IT infrastructure
Health Service Provision	To develop protocols and SOPs for all major conditions. To keep alos, BOR and PDE within acceptable norms. To develop level two services further. To further develop step-down facilities and home-based care. To increase the number of cataract operations. Prevention of maternal and neonatal deaths. Implementation of new mental health Act. Adequate operationalization of agreements with academic institutions. Disease profile (HIV, MDR and TB) The activity load has increased, with more lab tests being done than before and more medication being prescribed. To finalize the restructuring of EMS Services such that access to all communities, but especially to rural communities is improved;	Regular and adhoc reviews of protocols and their application. Employ cost containment measures. Improve working conditions and remuneration packages to attract and keep qualified specialists and senior medical officers. Obtain funding for step down facilities and home-based care. Ensure that nursing staff is adequately trained. Obtain necessary equipment and additional sessional ophthalmologists for more cataract operations Increase in the department's budget to absorb the increased activity load.
CQI	Decrease the incidence of cases to be reported to CIC. Well organized patient record system	Obtain adequately trained staff and reliable equipment.

STRATEGIC AREA	CHALLENGES/CONSTRAINTS	MEASURES TO OVERCOME
Human Resource Management and Development	Attraction of scarce skills. Unskilled staff with lack of interest. High staff turnover.	Incentives for attracting and maintaining staff. Incentives for training.
Capital Works and maintenance programme	Development of a facility Master Plan and ensure adequate maintenance of hospital buildings. There is a limitation of Hospital Reconstruction and Rehabilitation (HR&R)Grant not covering the needs of level 2 hospitals Currently this program is focused on level one hospitals.	To secure the funding and suitable contractors for required maintenance
Decentralized Management of hospitals and districts	Appointment of competent managers in relevant positions. Ensuring continued capacity building amongst existing managers.	Constant training and retention of skilled staff with differentiated delegations according to capacity

9. DESCRIPTION OF PLANNED QUALITY IMPROVEMENT MEASURES

- Increase the number of departments (management, administration and service provision) that have their Batho Pele Agreements monitored quarterly.
- Setting of service standards and monitoring service delivery against these standards.
- The establishment of a complaints mechanism for all customers of the department.
- Further role out of the COHSASA programme
- The department has increased the personnel budget for service provision areas in a concerted effort to attract and appoint the required specialists as well as to improve staffing levels in these areas.
- Ensure the appropriate and most beneficial use of the National Tertiary Services grant so that patients in need of tertiary care will receive this at the least possible inconvenience.
- Appropriate and efficient use of other Conditional Grants to:
    - Effect annual improvements and procure required medicines
    - Training and development of hospital staff
    - Implementation and increase of new hospital services
    - Develop a program for planned patient transport.

10. DISTRICT HEALTH SERVICES

10.1 SITUATION ANALYSIS

The Province is divided in four Districts; Bophirima in the South West with Vryburg as the main town, Bojanala in the East with Rustenburg as its main town, Central in Central with Mafikeng as the main town and Southern in the South with Klerksdorp as the main town. The districts is divided up into sub-districts as follows:

- **Bophirima:** Vryburg, Ganeysa, Kudumane, Taung, Schweizer Reneke, Lekwa Teemane and Bophirima
- **Bojanala:** Rustenburg, Moses Koatane, Moretele and Odi, Madibeng and Kgtleng Rivier
- **Central:** Mafikeng, Lichtenburg, Zeerust, Tswaiing and Setla-Kgobi
- **Southern:** Klerskdorp, Potchefstroom, Ventersdorp, Wolmeranstad,

Table 24: *District health services facility by health district*

Health Districts	Facility Type	No	Average population per facility	No of district Hospitals beds (Authorised)	District hospital beds per 1000 people	District hospital beds per 1000 uninsured people
Bojonala District	Visiting Points	881	-	-	-	-
	Clinics	124	-	-	-	-
	CHCs	5	-	-	-	-
	Sub-total clinics+CHCs	129	12,189	-	-	-
	District and community Hospitals	7	200,7	1,405	0.95	1.2
Central District	Visiting Points	1396	-	-	-	-
	Clinics	66	-	-	-	-
	CHCs	8	-	-	-	-
	Sub-total clinics+CHCs	74	15058	-	-	-
	District and community Hospitals	8	83,746	943	1.4	1,8

Health Districts	Facility Type	No	Average population per facility	No of district Hospitals beds (Authorised)	District hospital beds per 1000 people	District hospital beds per 1000 uninsured people
Bophirima District	Visiting Points	205	642843	-	-	-
	Clinics	70	147901	-	0.47	-
	CHCs	13	69151	-	0.06	-
	Sub-total clinics+CHCs	82	217052	-	-	-
	District and community Hospitals	11	53,413	1 068	1.8	2,3
Southern District	Visiting Points	1666	413	-	-	-
	Clinics	32	22451	-	-	-
	CHCs	7	102636	-	-	-
	Sub-total clinics+CHCs	39	18421	-	-	-
	District and community Hospitals	2	306,386	179	0.3	0.4
Rural Development Node (Kgalagadi)	Visiting Points	-	-	-	-	-
	Clinics	-	-	-	-	-
	CHCs	-	-	-	-	-
	Sub-total clinics+CHCs	-	-	-	-	-
	District Hospitals	-	-	-	-	-

Note that in Southern two regional hospitals also supply District beds
Note stats are for authorized beds. Open beds will result in an average of 14 % less regarding total figures

Table 25: *Utility Status Within Facilities*

Health Districts	Facility Type	No	Number (%) with electricity supply from grid	Number (%) with piped water	Number (%) with fixed line telephone
Bojonala District	Clinics	124	95	98	68
	CHCs	5	100	100	75
	District Hospitals	6	100	100	100
Central District	Clinics	77	79	89	61
	CHCs	11	100	100	88
	District Hospitals	4	100	100	100
Bophirima district	Clinics	70		100	61
	CHCs	13	100	100	100
	District Hospitals	5	100	100	100
Southern District	Clinics	26	100	100	
	CHCs	7	100	100	100
	District Hospitals	2	100	100	100
Rural Development Node (Kgalagadi)	Clinics				
	CHCs				
	District Hospitals				

Table 26: *Facility Grading*

Health Districts	Facility Type	No	Average 1996 NHFA condition grading					Any later provincial audit grading (with date					Outline of major rehabilitation projects since last audit
			1	2	3	4	5	1	2	3	4	5	
Bojanala District	Visiting Points	881											
	Clinics	124	X	X									
	CHCs	5	X	X									
	District Hospitals	5	X	X									
Central District	Visiting Points	1396											
	Clinics	66	X	X									
	CHCs	8	X	X									
	Sub-total clinics+CHCs	74											
	District Hospitals	4	X	X									
Bophirima District	Visiting Points												
	Clinics		X	X									
	CHCs		X	X									
	Sub-total clinics+CHCs												
	District Hospitals		X	X									
Southern District	Visiting Points	1666											
	Clinics	32	X	X									
	CHCs	7	X	X									
	Sub-total clinics+CHCs	39											
	District Hospitals	2	X	X									
Rural Development Node (Kgalagadi)	Visiting Points												
	Clinics		X	X									
	CHCs		X	X									
	Sub-total clinics+CHCs												
	District Hospitals		X	X									

Table 27: *National Grading definitions*

Category	Description
A	As new, appropriate (purpose designed) for proposed use; requires almost no attention; annual maintenance allowance should be 1% of budget; zero backlog maintenance.
B	Good condition; generally suitable for use; needs normal maintenance, or minor repairs or alterations to remain in use, annual maintenance allowance should be 3% of budget; zero backlog maintenance.
C	Poor condition; requires major repairs and/or is suitable for its proposed use; but rehabilitation or alterations will not exceed 65% of replacement cost; annual maintenance allowance should be 8% of budget; average cost of refurbishment 50% of replacement cost.
D	Replace; requires major repairs or is suitable for its current function, such that renovation costs would exceed 70% of replacement cost; annual maintenance allowance should be at least 8% of budget, but may not be worthwhile unless no replacement will be available.
E	Condemn; should be demolished and replaced; effectively no useful value.

Table 28: *Personnel within Districts*

Districts	Categories	Number employed	Number employed per 1000 people
Bojanala District	Medical Officer	44	0.3
	Medical Specialist		
	Dentists	17	0.01
	Dental Specialist		
	Professional Nurses	829	1
	Staff Nurses	249	0.2
	Nursing Assistants	453	0.3
	Student Nurse		
	Pharmacists	13	0.01
	Allied Health Professional and Technical staff	997	0.66
	Managers, Administrators and Logistical Support Staff	300	0.2
	TOTAL	**2290**	**1.92**

Districts	Categories	Number employed	Number employed per 1000 people
Central District	Medical Officer	39	0.156
	Medical Specialist	1	0
	Dentists	9	0.05
	Dental Specialist	4	0.018
	Professional Nurses	626	3.138
	Staff Nurses	210	1.104
	Nursing Assistants	458	2.458
	Student Nurse		
	Pharmacists	9	0.05
	Alied Health Professional and Technical Staff	50	0.32
	Managers, Administrators and Logistical Support Staff	1153	4.497
	TOTAL	**2558**	**12.524**
Bophirima District	Medical Officer	30	19.56
	Medical Specialist		
	Dentists		
	Dental Specialist		
	Professional Nurses	454	1.29
	Staff Nurses		
	Nursing Assistants		
	Student Nurse		
	Pharmacists	6	97.8
	Alied Health Professional and		
	Technical Staff		
	Managers, Administrators and Logistical Support Staff		
	TOTAL		
Southern District	Medical Officer	13	0.018
	Medical Specialist	4	0.005
	Dentists	11	0.015
	Dental Specialist	1	0.001
	Professional Nurses	131	0.18
	Staff Nurses	6	0.008
	Nursing Assistants	63	0.087

Districts	Categories	Number employed	Number employed per 1000 people
	Student Nurse		
	Pharmacists	3	0.004
	Alied Health Professional and	13	0.018
	Technical Staff		
	Managers, Administrators and	180	0.25
	Logical Support Staff		
	TOTAL	**425**	**0.586**

10.2 POLICIES, PRIORITIES, BROAD STRATEGIC GOALS

(i) Ensure effective management of the district' finances and assets;
(ii) Ensure the provision of quality health care services in districts;
(iii) Facilitate the process of continuous quality improvement (CQI);
(iv) Facilitate the appropriate appointment and development of human resources to ensure competent and performance focused employees;
(v) Ensure effective and appropriate organizational systems within districts;
(vi) Ensure the availability of suitable in all districts;
(vii) Develop and maintain an appropriate referral system;
(viii) Establish and maintain appropriate governance structures all health facilities; and
(ix) Facilitate decentralized management of districts.

10.3 KEY CHALLENGES/CONSTRAINTS PER DISTRICT OVER STRATEGIC PLAN PERIOD AND MEASURES TO OVERCOME THEM

Table 29: *Challenges/needs per Strategic Area*

STRATEGIC AREA	CHALLENGES/NEEDS
1. Finance and asset management	The lack of effective and efficient financial systems and policies Under utilization of vehicles and other assets of the department
2. Decentralization of management	The involvement of the Department in the process of development IDP's The lack of coordination of health services The lack of transparency by municipalities
3. Health Service provision	The development and implementation of policies, protocols and workplans – referral systems, clinical protocols Extend hours in all clinics and 24 hr in CHC's DHIS
4. Continuous Quality Improvement	The establishment of clinical audit committees in every sub-districts
5. Human resource management and development	The high levels of vacancy rate in all health facilities
6. Organizational development	
7. Capital works, maintenance programme and logistical priorities	The lack of maintenance agreements with local authorities to maintain the health facilities
8. Support services	The lack of SLA with companies providing outsource support services (laundry, claim, catering and security)
9. Governance	The lack of health advisory committees at district and sub-district

10.4 APPRAISAL OF EXISTING SERVICES AND PERFORMANCE DURING THE PAST YEAR

a) Finance and Asset Management

- An computerized asset management system has been implemented at 35% of all sub-districts;
- 94% Of districts submitted monthly expenditure reports

b) Decentralisation of Management

- Delegations to District and sub-district level with regard to Finance, Human Resources and Procurement;
- Draft service level agreements with municipalities

c) Health Services Provision

- 75% of full immunized at 1 year old
- 77% of sub districts with IMCI
- Two district established centers for survivors of violence
- 151 VCT sites established
- 52 % of cure rate for TB
- 2 208 cataracts removed

d) Continuous Quality Improvement

- 98% of facilities monitored on a quarterly bases concerning Batho Pele
- 98% of facilities display patient rights charter
- 5 Clinical guidelines developed
- 80% of Governance structures functioning

e) Human Resource Management

- Tender specifications approved for outsourcing of HR Plan
- Community services implemented for dentists, pharmacists and doctors
- All directors and above signed PMA's

f) Capital Works maintenance programme and logistical priorities

- 12% Of hospitals with Hospitals Master Plan

g) Support Services

- 6 Hospitals use Teleraidiology
- 26 Hospitals use Pharmacy MIS
- Parastatal establish for Integrated laboratory services

h) Governance

- Provincial Health Act passed
- PCA Bill passed
- UPFS revised

10.5 DESCRIPTION OF PLANNED QUALITY IMPROVEMENT MEASURES

1. Strengthening the Batho-pele programme that has already been initiated;
2. The establishment of a complaints mechanism in all health facilities.
3. The introduction of peer review and clinical audits at all health facilities.
4. The strengthening of governance structures and committees in all health facilities through which communities and users can change the way in which health services are provided in the public sector.
5. Benchmarking "the Patient Centered Care" for patient satisfaction
6. Functional Research Projects in clients' satisfaction and efficiency gains
7. Establishment of help desk concepts in institutions
8. Dissemination of research information through Regional mini-conferences. (Second conference 08 August 2002).
9. Project on decreasing outpatients waiting time
10. Improving patient care through implementation of hotel service package in all five-district hospitals.
11. Strengthen Work Improvement Team Strategy.
12. Improve staffing levels at District hospitals and Primary Health Care clinics and Community Health Centres.
13. Implement and strengthen PMDS.

10.6 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 30: *Objective and Indicators per Financial Year*

OBJECTIVE	INDICATOR	2001/ 2002 actual	2002/ 2003 estimate	2003/ 2004 target	2004/ 2005 target	2005/ 2006 target
Develop a budget allocation strategy that will ensure equitable distribution of sources	% of districts receiving the allocation based on allocation as per capita expenditure	0	0	0	75	100
Improve the financial management capacity of managers for all institutional managers	% of districts that spend over or under with in 2% of their allocation	0	0	25	75	100
Redevelop cost centre management at sub district level	% Of sub district with established cost centres			33	66	100
Improve system for asset man. Revenue collection, procurement and internal control	% Of institutions (sub districts, clinics hospitals districts offices) with complete asset registry	0	0	25	75	100
	% Of institutions meetings their set targets	0	0	50	75	100
	% Of purchases complying withps1 0f 2002	0	25	50	75	100
	The % of sub district and hospitals that comply with PFMA	60	75	80	90	100

OBJECTIVE	INDICATOR	2001/ 2002 actual	2002/ 2003 estimate	2003/ 2004 target	2004/ 2005 target	2005/ 2006 target
Increase number of CHC that render 24 hr services	% of CHC rendering 24 hr service		30	40	50	60
Increase the frequency of current visit to at least once a month to health services in rural and farming communities	% of mobile points receiving 1 or more visits per month	20%	20%	40%	50%	55%
Increase TB cure rate by 5% per year	% of increase in cure rate	Once a month	30%	60%	90%	100%
Increase the percentage of HIV positive antenatal clients enrolling in the PMCT programme	% of HIV positive antenatal clients enrolling in the PMCT programme					
Increase number of VCT sites for services to be render at every health facility	% of fixed health facilities rendering VCT services at every health facility	50%	60%	70%	80%	90%
Reduce nutrition deficiency disorders in children under 5 years	% of malnutrition kids reported at clinics	50%	60%	70%	80%	90%
To build capacity in terms of information management to improve the culture of using information for management	% of sub-district and hospital report with evidence of correct information used	40%	50%	60%	80%	90%
Establish clinical audit committees in every sub-district	% of sub-district with fictional clinical audit committees	-	50%	70%	90%	100%
Ensure at least one Cohassa hospital per district	% of district with one or more	-	-	70%	80%	100%
Decrease vacancy rate in all health facilities by 10% per year through rural incentives for health professionals	% decrease in vacancy rate	50%	40%	30%	20%	10%

OBJECTIVE	INDICATOR	2001/ 2002 actual	2002/ 2003 estimate	2003/ 2004 target	2004/ 2005 target	2005/ 2006 target
Increase the number of personnel evaluated according to work plans	% of personnel	10%	10%	30%	50%	70%
Increase the percentage of faculties that are adequately maintained by means maintenance agreements by local authorities	% of facilities with approved maintenance agreements	0	0	30%	60%	90%
Increase the completion of approved health facilities	% of completed facilities	0	0	30%	60%	90%
Increase the completion of approved Health facilities	% of completed facilities	0	0	30%	60%	90%
Maintain and improve drug management and compliance with EDL at all health facilities	% of compliant health facilities with three of less per script	80	80	90	100	100
Develop and review clear guidelines and operational procedures for the management of EMS	% of districts with developed guidelines	20%	30%	50%	70%	90%
Increase the number of available EMS vehicles to appropriated levels	% of sub-districts that have EMS vehicles	3/50 000	3	6	6	6
Improve the existing telemedicine sites in Central and Bophirima and Bojanala by establishing operational links with relevant treasury institutions and establish a site in southern region	% of diagnoses through telemedicine	0	10%	20%	20%	30%
Develop and ensure SLA with companies providing outsource support services (laundry, claim, catering and security)	% of contracts with SLA	0	0	50%	70%	100%
Re-aligning the local management areas with the new local government ward boundary	% of realigned areas	50%	50%	100%		

OBJECTIVE	INDICATOR	2001/ 2002 actual	2002/ 2003 estimate	2003/ 2004 target	2004/ 2005 target	2005/ 2006 target
Reorganise present governance structure to be in line and part of local government structures	% of reorganised governance structures	0	0	50%	75%	100%
Establish the provincial health advisory committee district and sub-district	% of governance structures trained	0	0	75%	100%	
Develop uniform referral system for the North West Province	% of uniform referral plans	0	0	75%	100%	

10.7 SPECIFIC AND MEASURABLE OBJECTIVES FOR DISTRICT HOSPITALS

Table 31: *Objective and Indicators per Financial Year*

OBJECTIVE	INDICATOR	2001/ 2002 actual	2002/ 2003 estimate	2003/ 2004 target	2004/ 2005 target	2005/ 2006 target
Improve the financial management capacity of managers for all institutional managers	% of districts that spend over or under with in 2% of their allocation	0	0	25	75	100
Improve system for asset man. Revenue collection, procurement and internal control	% of institutions (sub districts, clinics hospitals districts offices) with complete asset registry	0	0	25	75	100
To build capacity in terms of information management to improve the culture of using information for management	% of sub-district and hospital report with evidence of correct information used	50	50	60	70	80
Ensure at least one Cohassa hospital per district	% of district with one or more	-	-	25	50	75
Decrease vacancy rate in all health facilities by 10% per year through rural incentives for health professionals	% decrease in vacancy rate	50%	50%	40%	30%	20%
Increase the number of personnel evaluated according to work plans	% of personnel evaluated according to work plans	10%	10%	30%	505	70%
Increase the percentage of faculties that are adequately maintained by means maintenance agreements by local authorities	% of facilities with approved maintenance agreements	-	-	50%	75%	100%

OBJECTIVE	INDICATOR	2001/ 2002 actual	2002/ 2003 estimate	2003/ 2004 target	2004/ 2005 target	2005/ 2006 target
Increase the completion of approved health facilities	% of completed facilities	0	0	30%	60%	100%
Increase the completion of approved health facilities	% of completed facilities	0	0	30%	60%	90%
Improve the exiting telemedicine sites in Central and Bophirima and Bojanala by establishing operational links with relevant treasury institutions and establish a site in Southern Region	% of diagnoses through telemedicine	0	0	10%	20%	30%
Develop and ensure SLA with companies providing outsource support services (laundry, claim, catering and security)	% of facilities with SLA	0	0	50%	70%	100%

10.7.1 PROGRAMME 2 : DISTRICT HEALTH SERVICES

Table 32: *Programme Summary of Expenditure According to Programme*

Sub-programme (R'000)	Programme Summary of Expenditure and Estimates					
	2000/ 2001 Actual	2001/ 2002 Actual	2002/ 2003 Est. Actual	2003/ 2004 MTEF	2004/ 2005 MTEF	2005/ 2006 MTEF
1 District Management	25,509	34,760	39,916	**35,951**	28,844	33,072
2. Community Health Clinics	170,063	181,693	199,862	**210,848**	236,832	302,693
3. Community Health Centres	138,674	151,846	161,880	**292,227**	311,195	375,673
4. Community-based Services	-	-	7,800	**4,000**	4,008	3,572
5. Other Community Services	9,145	11,050	5,000	**5,044**	5,246	5,350
6. HIV/ AIDS	-	-	30,419	**42,891**	40,479	56,024
7. Nutrition	39,391	38,941	47,795	**71,967**	84,583	61,790
8. Coroner Services	-	-	-	**-**	-	-
9 District Hospitals	516,071	526,894	568,098	**601,533**	619,140	704,704
Total programmes	898,853	945,184	1,060,770	**1,264,461**	1,330,327	1,542,878

- Provision for youth Centres program has been made within the community based services
- Provision for recruitment of community services specialists have been provided under other community services
- Provision for HIV/AIDS sub-program is only for conditional grants. Other provisions for HIV/AIDS and related illness is spread in the entire departmental allocation
- Coroner services have not yet been transferred to the department.

It appears as if the budget for programme 2 has increased by only 1 percent. This is due to the fact that in prior years Emergency Medical Services (EMS) was budgeted for in programme 2 while for the next financial year, this has been catered for in a separate programme, EMS. The new structure came as a result of national budget structure for consistencies and easier comparisons with other provinces. An amount of R57 million was included in the 2002/3 financial year.

The budget structure has been changed to take into account the following sub-programmes:

⇒ Community Health Clinics
⇒ Community Health Centres
⇒ Community Based Services
⇒ Other Community Services

The modification of the budget structure was to have a uniform structure for the country as whole for comparison purposes.

In the current financial year. capital projects relating to district hospitals were included in programme 2. For the coming financial year, capital projects have been accounted for in a separate programme, namely Health Facilities Management. The exclusion of capital projects in programme 2 has distorted the actual increase in programme 2.

The actual increase in programme 2 is therefore 20% over the 2002/3 financial year.

The conditional grant for HIV/Aids has increased by 60% to R32 million. The HIV/Aids sub-programme includes an amount of R10 million which has been allocated to the Provincial Aids Council.

The conditional grant for Nutrition has increased by 65% to R71 million. The increase will be utilized to increase the number of pupils to be fed and to cater for the increase in costs per pupil.

An amount of R4 million has been set aside for the expansion of the Youth Centres.

R6,5 million has been provided for the acquisition of mobile clinics with the view of having at lease 1 mobile clinic per district.

Transfer payments have remained the same at R45 million. This is due to the fact that the PCA has been established as a public entity resulting in its allocation of R10 million being allocated as a transfer payment. In the previous and current financial year, PCA's budget was included in the department's budget and only R180 000 was allocated for transfer payment.

10.7.2 PROGRAMME 7 : HEALTH CARE SUPPORT SERVICES

Table 33: *Programme Summary of Expenditure According to Programme*

Sub-programme (R'000)	Programme Summary of Expenditure and Estimates					
	2000/ 2001 Actual	2001/ 2002 Actual	2002/ 2003 Est. Actual	2003/ 2004 MTEF	2004/ 2005 MTEF	2005/ 2006 MTEF
1. Laundries	6,164	8,991	9,532	**13,201**	18,103	18,377
2. Engineering	11,678	17,156	12,644	12,977	16,234	15,869
3. Forensic Service	-	-	-	**-**	-	-
4. Orthotic and Prothetic Services	1,864	2,345	2,542	**3,801**	4,303	4,275
5. Medicine Trading Account	14,884	21,339	30,299	**40,311**	48,314	50,788
Total programmes	34,590	49,831	55,017	**70,290**	86,954	89,309

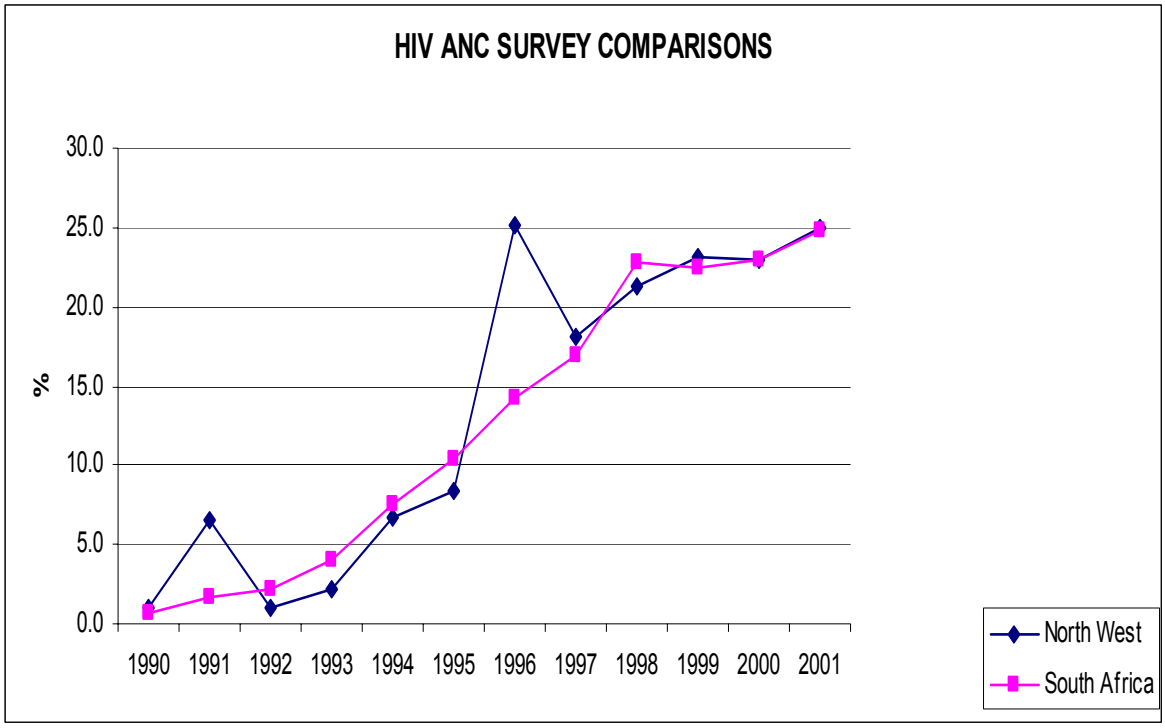
The Department does not manage a trading account for acquisition and distribution of medicines. The program is run internally through the assistance of a consultant agency/company

11. HIV/AIDS/STI

11.1 SITUATIONAL ANALYSIS

HIV/AIDS is currently one of the most devastating health conditions affecting the health of millions throughout the world including the Northwest Province. It is estimated that 60 million people have been infected since the beginning of the epidemic and in 2001 alone an estimated 5 million would have acquired HIV infection. The UNAIDS estimated 3.5 million new infection occurred in 2001 bringing to 28.5 million the total number of people living with HIV/AIDS in Sub-Saharan Africa. In the Northwest Province we see an upsurge of the HIV infection from 22.9% in 2000 to 25.2 in 2001 in total with the highest still the Southern Region. The province in its endeavor to deal with HIV/AIDS implements the SA HIV/AIDS strategic document after customizing to the Province. Sexually transmitted infections (STIs) are as endemic in the eighteen districts of the four regions in the North West province as is in the rest of South Africa. The provincial population consists of 3 354 825 inhabitants of which 60,000 (30% of general population) are miners working in the large platinum and gold mines. It is estimated that of women attending public antenatal clinics 25.2% are HIV infected while 4% have syphilis with women in their late 20's continuing to have the highest HIV prevalence rates. Healthcare provision is mostly by the public service. Case management is by means of the Syndromic approach, which is a national policy.

11.1.1 Epidemiological Information



11.2. POLICIES, PRIORITIES AND BROAD STRATEGIC GOALS

11.2.1. Policies and Priorities

The Provincial HIV/AIDS/STI adopted the National HIV/AIDS strategies and policies in its implementation. In the Province the National strategy was adapted to the Province in the IDC where each department was given certain sections to deal with, with the Department of Health becoming the lead department to drive the implementation of the policy. These programs use the National strategy but implementation becomes Programme specific. In programmes like Home Based Care (HBC), Prevention of Mother To Child Transmission (PMTCT) and Voluntary Counselling and Testing (VCT) adaptations have to be made to fit with the demographic situation in the Province.

11.2.2. Broad Strategic Goals

- To improve the management and control of STI's
- To provide preventative services
- To provide treatment care and support
- To offer human and legal rights
- To commission research and do proper surveillances
- To target special groups in communities
- To render services for youth and provide life skills
- To implement and evaluate a comprehensive prevention, care and support package for HIV/AIDS/STI/TB.

11.3 KEY CHALLENGES AND CONSTRAINTS OVER STRATEGIC PLAN PERIOD AND MEASURES TO OVERCOME THEM

Table 34: *Key Challenges and Constraints over the Strategic Plan Period*

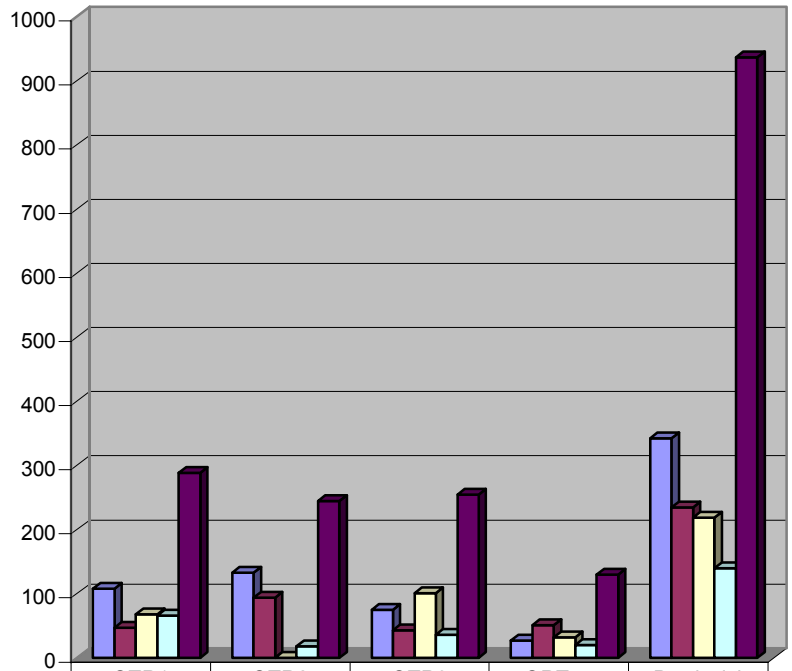
CHALLENGES AND CONSTRAINTS	MEASURES TO OVERCOME
Objective : To Promote Safe and healthy Sexual Behaviour	
Health promoters are not been used relevantly (often used as drivers or clerks). No policy guidelines or job description, are in temporary posts, are distributed inequitably in the regions, current promoters lack the required skills and their activities are not monitored. There are no offices for the health promoters and their services are not community focused.	Establishment of Health Promotion as a Sub-Directorate. Appointment of Health promoters as investment to the province to complement nurses' activities. Promoters to be provided with. Their programme should be structured such that they serve as the link between the clinics and the community.
Objective : To Improve the Management and Control of STI	
Shortage of nurse's. Nurses who are in place have insufficient skills in STI management. Not sufficient consultation space in facilities. Poor turn around time of syphilis specimen. Examination equipment not adequate (speculums, examination lights, etc.) Lack of commitment from Private Doctors regarding application of the Syndromic management of STI.	Appointment of nurses. Extension of the scope of practice of enrolled nurses. Training of nurses on Syndromic management of STIs. Procurement of RPR machines for on-site testing and treatment. Repair and purchasing of examination equipment. Piloting Syndromic management with private doctors

CHALLENGES AND CONSTRAINTS	MEASURES TO OVERCOME
Objective : To Improve Access to VCT	
Shortage of trained Counsellors. Not enough nurses to provide services. Difficulty training personnel in posts. Difficulty using existing personnel as trainers. No coordination in training. Related training manuals are diverse and not uniform. No counsellors' accreditation guidelines. Staff rotation threatens service continuation. VCT is not yet part of PHC package thus still seen as a vertical service. Delay in awarding of tender to a NGO Facilities' lay out not conducive to counselling. Sites not properly equipped. Lack of follow up after testing. Services are more referrals that voluntary. Service accessibility hampered by other competing priorities in facilities. No clear protocols from the department Lack of NGO and private sector involvement. Tertiary institutions are not fully utilized in training.	Outsourcing of counselling to NGO. Consider conscious client flow planning. Provision of bare equipment essentials. Bring together all relevant manuals for uniform training. Coordination of training must be a directive. Rotation across clinics to consider the implications to service. To consciously work on integrating VCT into PHC HIV/AIDS projects. Mobilise Health Promoters to market the service in the community. Information to districts to be coordinated and consistent. Trained providers to be effectively utilized. National to finalize Rapid Testing quality protocols. Vigorous stakeholder lobbying to be undertaken.
Objective : To Reduce Mother to Child Transmission	
Shortage of nurses trained in PMTCT. Shortage of counsellors. Insufficient counselling space at facilities. Lack of coordination of complimentary activities from other Directorates. Lack of district pro-activeness in implementing the services. Insufficient monitoring and evaluation of service.	Integration of PMTCT into PHC services. Outsource training and placement of counsellors Establishment of forum that will ensure that each directorate plays part in attaining the departmental objectives. District and sub-districts management should actively participate. Involve a suitable NGO in monitoring and evaluation of service.

CHALLENGES AND CONSTRAINTS	MEASURES TO OVERCOME
Objective : To Provide Treatment Care and Support in the Health Facilities and the Communities	
Shortage of nurses, Nurses employed lack HBC skills. Over loading of hospital beds. No policy guidelines. No consistent procedures to follow Services are not fully implemented. Lack of skilled volunteers in the communities. High turn over of volunteers who provide the services. Inconsistency in the approaches. Poor quality service. Referral processes are not clear. Services are not coordinated.	Train nurses on HBC skills. Fund NGO's to provide the services. Establishment of step down care facilities. Collaboration with policy planning unit for policy formulation. Train community members on HBC. Establishment of Deputy Directors forum to look at common and complimentary operational issues and to synergise all activities towards continuous quality improvement.
Objective : Conduct Regular Surveillance	
Shortage of support staff. Lack of information from epidemiology unit. No working relationship between directorates (no sense of customer care. E.g. STI/HIV/AIDS is a customer to Knowledge Management, Logistics, HR, Finance, etc). Continuous poor services due to lack of information for planning. Lack of involvement of Private agencies.	Appointment of unit staff. Reprioritization of DD forum for operational issues discussions. Required information from epidemiology unit. Initiate collaboration with private agencies in this sector.

11.4 APPRAISAL OF EXISTING SERVICES AND PERFORMANCE DURING THE PAST YEAR

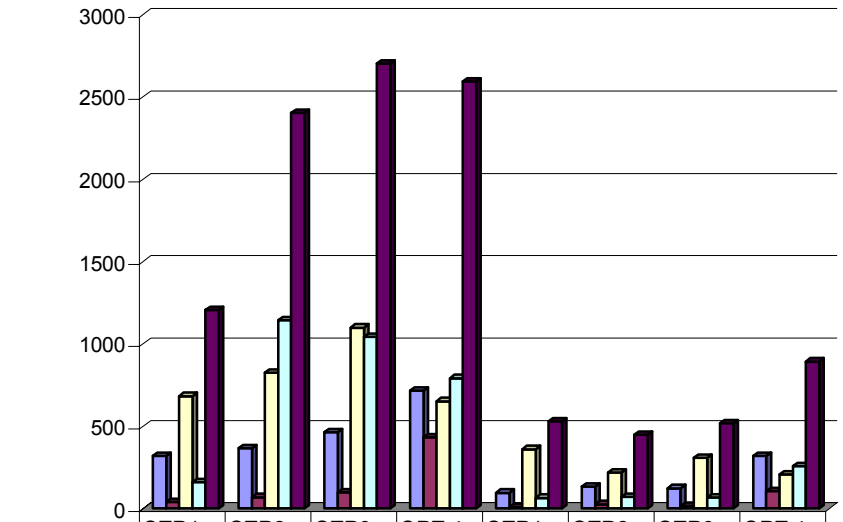
Figure 10 : *Number of Nurse counsellors Trained 2001/2*



	QTR1	QTR2	QTR3	QRT 4.	Provincial
BOJANALA	108	133	75	27	343
KLERKSDORP	47	94	43	51	235
MAFIKENG	68	0	101	32	219
VRYBURG	66	18	36	20	140
TOTALS	289	245	255	130	937

The graph above shows the department has trained a sizeable number of nurses for this intervention. The obstacle is that staff rotation inhibits proper implementation of the service because people who are trained are placed to other areas. This delays the uptake of the programme. There needs to be serious talks around this issue with the District Managers in view of remedying the situation.

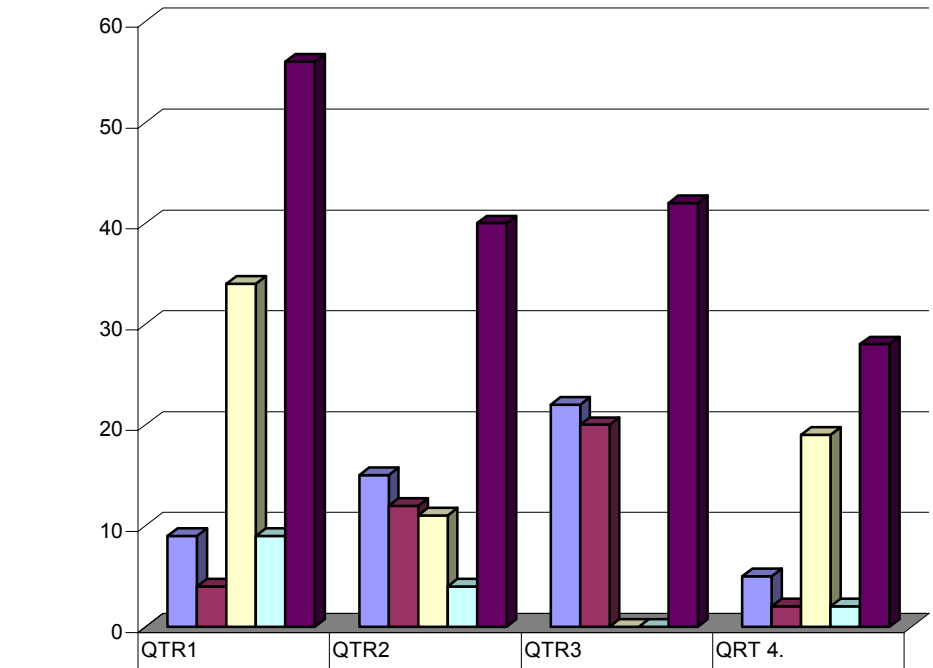
Figure 11 : *Test Performance for 2001/2*



	NO OF TESTS				NO.OF POSITIVES			
	QTR1	QTR2	QTR3	QRT 4.	QTR1	QTR2	QTR3	QRT 4.
Bojanala	321	366	464	717	96	134	124	321
Klerksdorp	41	69	98	434	8	26	18	107
Mafikeng	683	826	1099	652	361	219	309	208
vryburg	162	1143	1042	792	66	70	68	257
Totals	1207	2404	2703	2595	531	449	519	893

It is encouraging to see people coming for testing. What is worrying is that HST survey results have shown more referral cases as compared to voluntary cases presenting for testing. This calls for vigorous marketing of this intervention, exploring ways in which the community will gain confidence to nurses in issues relating to confidentiality. However, the sero-positivity remains low even with increased testing

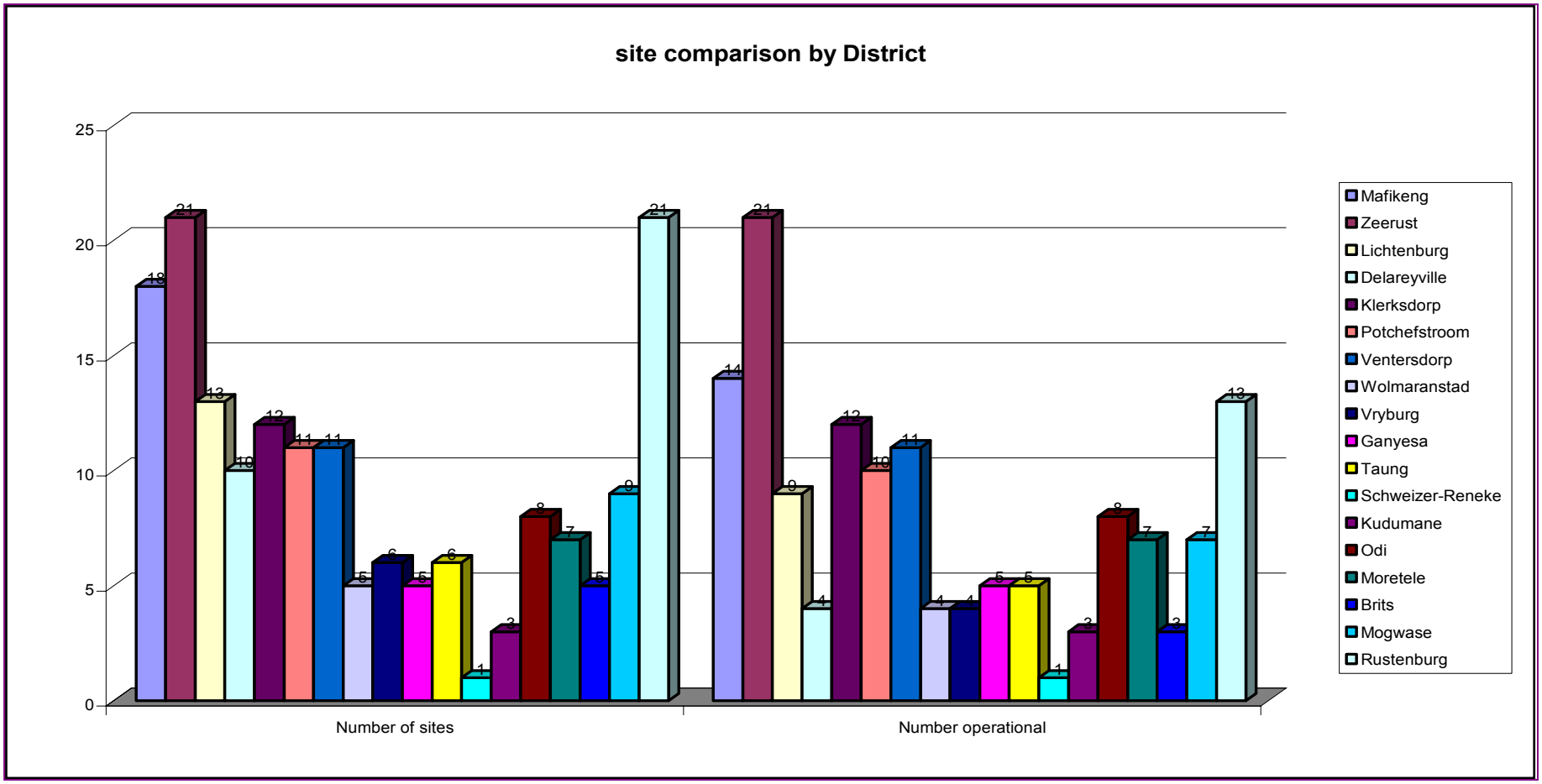
Figure 12 : *Site Increase per Region*



	QTR1	QTR2	QTR3	QRT 4.
Bojanala	9	15	22	5
Klerksdorp	4	12	20	2
Mafikeng	34	11	0	19
Vryburg	9	4	0	2
Total	56	40	42	28

Sites continue to increase. The objective of this current financial year was to increase sites. The problem the department is facing is that some sites that were established were later closed due to shortage of staff to manage them. Careful planning is required by the District managers in identifying sites. It is important to establish sites that will sustain the programme.

Figure 13 : *Site Comparison by District*



The graph shows sites that were established and those that are functional. This tells us that sustainability is important. The latter can be achieved if there is close working relationship between the Regional, District and the Provincial Office in identifying genuine sites. There are Districts which have sustained their sites.

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Figure 14 : *Districts Individual Education on HIV/AIDS September 2001- March 2002*

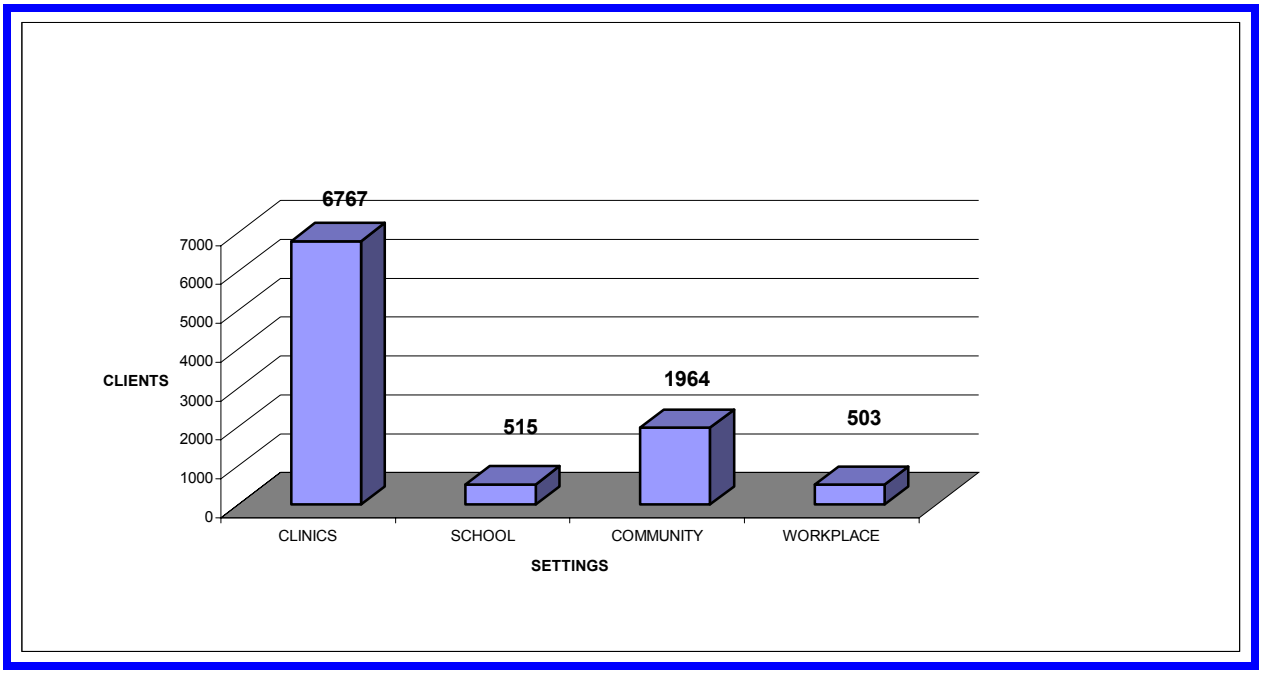
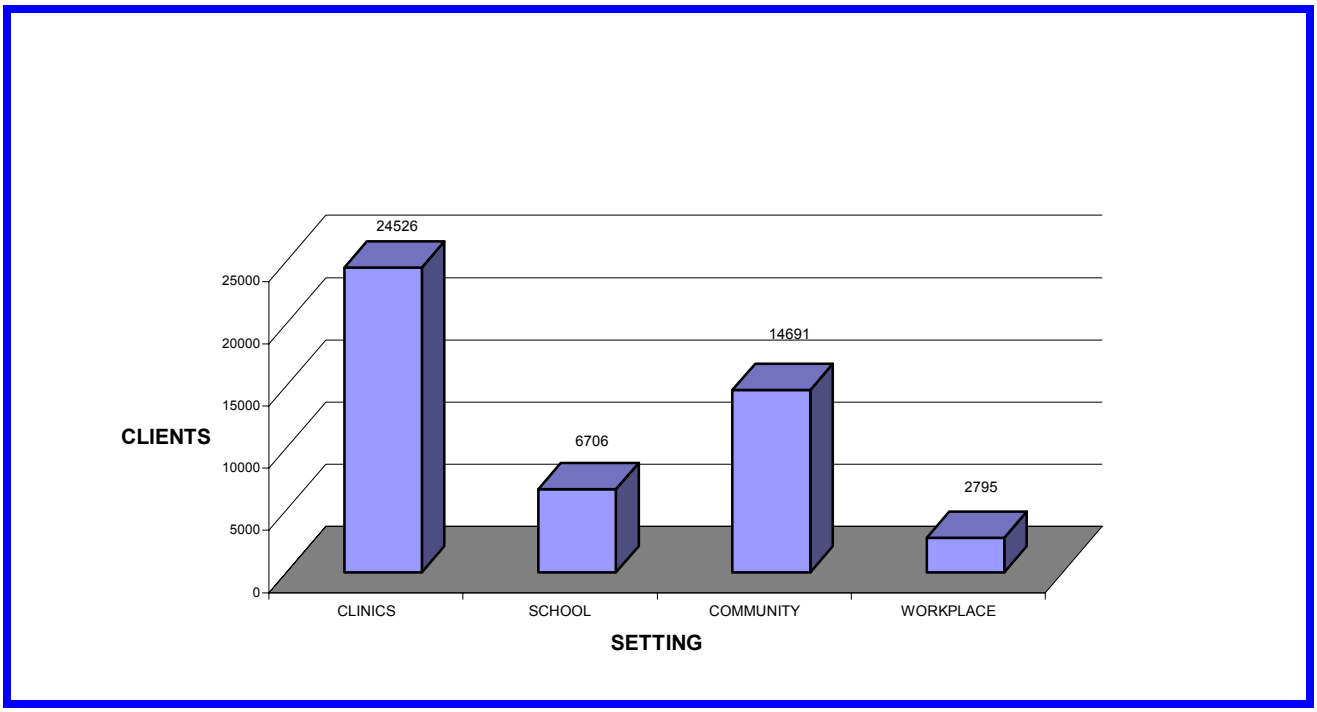


Figure 15 : *Group Education on HIV/AIDS September 2001-March 2002 QTR 2 &3*



This programme came late in the year. Clinics still form the primary catchment area for education. This shows that the PCA needs to mobilise the community for education. This means that the department needs to devise strategies that will establish confidence in community education. Some illnesses that present to the clinics do not warrant clinic presentation, rather the problems can be dealt with in the communities.

11.6 DESCRIPTION OF PLANNED QUALITY IMPROVEMENT MEASURES

Table 35 : *Quality Improvement Measures*

OBJECTIVES	PLANNED QUALITY IMPROVEMENT MEASURES
PROVIDE THE MANAGEMENT AND CONTROL OF STI's	Train nurses on Syndromic management of STI's Purchase on-site RPR machines for onsite treatment Implement the Disca tool Improve the contact/partner tracing and treatment Asymptomatic tracing of STI's through Antenatal clinics and Family planning sites On site clinic visits
TO PROVIDE TREATMENT, CARE AND SUPPORT TO THE COMMUNITIES AND THE FACILITIES	Train nurses on management of opportunistic infections, Palliative care and HBC Recruitment of retired nurses for mentorship Capacitate the community on HIV/aids drug literacy Provide home based care kits to NGO's Support NGO's for HBC activities Development of monitoring tool Implement NGO's mentoring programme Involve PWA support structures in the planning phase To develop a database for all HBC beneficiaries and monitor the intervention
TO REDUCE MOTHER TO CHILD TRANSMISSION	Training of nurses, lay counsellors and other professionals Intensified health education programme for pregnant mothers On-site visits Monitoring tools
TO INCREASE ACCESS TO VCT	Train nurses on VCT Capacitate the community on the importance of VCT Regular on-site visits
TO PROVIDE ACCESS TO FEMALE AND MALE CONDOMS	Funding of NGO to do condom demonstration to the consumers Condom branding (National) Social marketing
TO MONITOR RESEARCH AND SURVEILLANCE	Conceptual understanding between the Provincial Epidemiology unit, STI/HIV unit and Regional managers on information needed To collaborate with universities on research topics

11.7 MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS FOR HIV/AIDS STI & TB

Table 36 : *Measurable Objectives and PAs for HIV/AIDS, STI and TB*

OBJECTIVES	INDICATORS	2001 / 2002 Actual	2002 / 2003 Estimated	2003 / 2004 Target	2004 / 2005 Target	2005 / 2006 Target
Broad Goal: To Provide Preventative Service for HIV/AIDS/ STI						
To increase access to male and female condoms	No. of male condoms per male adult population 15-49 yrs distributed per week	3	5	7	7	7
	No. of condoms per female adult population 15-49 years distributed per week	100	250	600	800	1000
To increase PMTCT access	No. of PMTCT sites operational	2	29	82	105	125
To improve PMTCT uptake	No. of women enrolled to the programme	279	1000	2000	3000	4000
Broad Goal : To Provide Appropriate Treatment, Care and Support						
To provide treatment for opportunistic infection	Availability of Opportunistic infections drugs No. of health facilities providing services	4	20	30	50	120
To provide effective Home Based care programmes in the Province	No. of Home Based Care beneficiaries.	1999	3127	4000	5000	6000
	No. of NGO's supported	32	181	199	219	241

OBJECTIVES	INDICATORS	2001 / 2002 Actual	2002 / 2003 Estimated	2003 / 2004 Target	2004 / 2005 Target	2005 / 2006 Target
Broad Goal: To Improve the Management and Control of STI						
To reduce the incidence of Urethral Discharge	% of male population 15-49 years presenting at the health facilities with urethral discharge	6.6	6	5.5	5	4.5
To reduce the incidences of syphilis	% of adult population 15-49 years with syphilis infection	4%	3.5%	3%	2.5%	2%
To reduce Genital ulcer Diseases	% of adult population presenting at the health facilities with genital ulcer diseases.	-	-	5%	4.5%	4%
To improve STI contact treatment	No. of STI contacts treated	7.3%	60%	70%	80%	90%
Broad Goal: Improve Access to VCT						
To expand VCT sites	No. of operational sites established	141	220	335	450	550
To improve VCT uptake	No. of clients tested	7899	1,108 080	1,231 200	1,368 000	
	No. of Health care Workers trained.	1950	2300	2600	2900	3200
	No. of functioning Counsellors	400	400	400	400	400

12. TUBERCULOSIS

12.1 SITUATION ANALYSIS

The TB incidence rate in the province was 376/100 000 population in 2000/01 as compared to 410/100 000 in 2001/02. These incidence rates are well above the international norm (200/100 000). 57% (8203) reported cases in 2001 never had TB before (new cases). This number excludes TB cases diagnosed by X-ray. 58% (83331) of all cases were males while 42% (6033) were females. The majority of females are in the 15-24 age group.

12.2 POLICIES, PRIORITIES, BROAD STRATEGIC OBJECTIVES

This programme's management within the NWDoH is guided by the National TB Control Programme Policy Guideline and the National TB Treatment Protocols. The broad goals of the programme are:

- To improve case detection;
- To achieve cure rate of at least 85%
- To reduce overall mortality rate due to TB.
- To reduce multi-drug resistance (MDR) TB
- To implement and evaluate a comprehensive prevention, care and support package for HIV/AIDS/STI/TB.

Appraisal of existing services and performance during the past year according to the incidence of PTB in the Northwest province unfortunately increased to 410/100 000 in 2002/2003 as compared to 376/100 000 in 2001/2002.

A similar trend is observed with the cure rate that regressed from 52% in 2000 to 47% in 2001. The reason for this however is not purely that patients are not cured. There is a tendency among facility staff to not test patients' sputa at the end of the treatment period, but to simply sign them off as cured. As a result there is no bacteriological proof of cure rates, thus the low result. The much better smear conversion rate is also a testimony of this. The smear conversion rate improved from 61% in 2001/2001 to 72% in 2002/2003.

12.3 CHALLENGES, CONSTRAINTS AND MEASURES TO OVERCOME THEM

Inadequate resource allocation in TB (personnel and funding). The NWDoH is planning to address this in 2003/2004 financial year through better utilization of conditional grants and increased budget for operational staff.

Competing priorities (HIV/AIDS & TB). This will also be addressed through better utilization of available resources.
Impact of HIV/AIDS on TB morbidity and mortality. To overcome this better collaboration is required between the two programmes to enhance prevention strategies for both conditions, to effect early detection and to ensure completion of TB treatment since TB can be cured even is someone is HIV positive.

Impact of poverty on TB morbidity and treatment compliance. This problem needs to be effectively and sustainably addressed at a macro policy level. At programme level food parcel and soup kitchen programmes are applied. The department also liaises with NGOs to assist TB patients to access sustainable development projects such vegetable gardens.

12.4 QUALITY IMPROVEMENT MEASURES

- Public awareness and health promotion;
- Community involvement for active participation. eg DOT supporters;
- Forging partnerships: eg. Mines;
- Capacity building of personnel at all levels;
- Working towards collaborative approach with HIV/AIDS; and
- Planning more NGO involvement

Table 37 : *Measurable objectives and performance indicators.*

Objective	Indicator	Actual 2001/02	Estimate 2002/03	Target 2003/04	Target 2004/05	Target 2005/06
To improve the PTB cure rate to systematically reach the national target of 85%	PTB Cure rate	47	Not available	>60	>70	85
To improve smear conversion rate for the intensive period.	Sputum conversion rate	61	72	>80	>80	85
To increase the number of patients on DOT	% patients on DOT	93	96	>90	>90	100
To reduce treatment interruption rate	% treatment interruption	12	-	<5	<5	<5
To reduce the incidence of multi-drug resistant TB	% multi-drug resistance	0.46	0.5	<1	<1	<1

13. INTEGRATED NUTRITION PROGRAMME

13.1 SITUATION ANALYSIS

Nutrition Epidemiological Situation

Table 38 : *Indicating the Provincial and National Status on the Nutrition Epidemiological Situation*

INDICATOR	PROVINCIAL STATUS	NATIONAL STATUS
Child Stunting	24.9%	21.6%
Child Wasting	5.7%	3.7%
Child (1-9 yrs) Underweight Moderate	15.3%	10.3%
Child (1-9 yrs) Underweight Severe	1.3%	1.4%
Vitamin A deficiency	32.0%	33.3%
Child iron deficiency: Anaemic	24.5%	21.4%
Iodine deficiency	0%	
BMR>30 Females >15 yrs	18.8%	29.4%
BMR>30 Males >15 yrs	5.4%	9.1%

Malnutrition is the manifestation of interrelated causes. The above nutrition situation is typical of a poverty stricken province that is mostly rural. Child stunting is indicative of chronic malnutrition associated with poverty where communities are unable to meet their nutrient requirements due inadequate intake resulting from household food insecurity.

Wasting and underweight are indicative of current dietary inadequate indicate which may relate to disease and household food insecurity. With most citizens of the province dependent on agriculture for income or survival, seasonal malnutrition as shown by rates of wasting is common. Underweight is also indicative of chronic inadequate dietary intake.

The cut-off points according to WHO for vitamin A to be classified as a public health problem is 20%. Therefore, the vitamin A deficiency in the province is a public health problem. Iron deficiency has implications on cognitive development of children and results from poor intake.

BMR refers to body mass index. A body mass index of between 25 and 30 is indicative of overweight. A BMR of above 30 is classified as obesity. Overweight and obesity are serious risk- factors for hypertension and heart failure, diabetes and other disease relating to life style. These types of diseases are fast becoming a public health problem.

Although stats are not available for breastfeeding rates, indications are that, breastfeeding, particularly exclusive breastfeeding for the first six months of life is low. The transmission of the HIV virus through breast milk does not help the situation either.

13.2 POLICIES, PRIORITIES, BROAD STRATEGIC GOALS

The Integrated Nutrition Programme (INP) in the Province will be based on the National INP Framework and implemented within the Strategic Framework of the Provincial Department of Health to contribute towards the strategic goal of improving the health status of communities through implementation of integrated health programmes.

Table 39 : *The core strategies for the INP in the Province*

FOCUS AREA	STRATEGIC OBJECTIVES
Promotion, protection and support of breastfeeding.	Reduction & Prevention of infant and child malnutrition particularly underweight, stunting & wasting
Micronutrient malnutrition control	Prevention of micronutrient deficiencies particularly of vitamin A deficiency in children & breastfeeding women.
Disease-specific nutrition support, treatment, and counselling.	Nutritional support & treatment of diseases & trauma, particularly severe malnutrition; diseases of lifestyle, *HIV/AIDS- contribution to the quality of life as part of the treatment plan* & support
Growth monitoring and promotion	Promotion of optimum nutrition and prevention of growth faltering in children five years of age and below.
Contribution to household food security.	Augmentation of household food security through targeted feeding & promotion of community-based actions around household food security issues & nutrition.
Nutrition promotion, education and advocacy	Improved nutrition knowledge, & behaviour & conceptual understanding of INP & nutrition in general
Food service management	A functional food service management system to ensure client satisfaction, food safety & prevent institutional malnutrition
SUPPORT SYSTEMS	
Human resource plan	Developed provincial human resource plan for the INP.
Administrative & financial management system	Strengthened administrative and financial management practice for the INP
Nutrition information system	Improved nutrition information gathering, reporting & analysis.

13.3 KEY CHALLENGES AND CONSTRAINTS OVER STRATEGIC PLAN PERIOD AND MEASURES TO OVERCOME THEM

Table 40 : *Key Challenges and Constraints over the strategic plan period and measures to overcome them*

AREA	CHALLENGE	SOLUTION
Human Resources	• Absence of an HR plan for the programme • High % of vacant post against the approved staff establishment • Limited number of nutrition personnel with the required technical nutrition skills	• Develop an HR plan for the INP (draft INP HR policy already developed). The plan to include recruitment placement, retention of skilled personnel & database. • Develop an in-service training programme to enhance technical nutrition knowledge of personnel with no nutrition background but whose core function is nutrition services • Identify & collaborate with academic institution for assistance in nutrition training of such personnel (entry modules on nutrition to enhance technical knowledge)
Technical Areas	• Inadequate nutrition technical skills and knowledge	• In-service training to upgrade knowledge of nutrition personnel particularly those without nutrition background but whose core function is nutrition • Filling of vacant Dieticians and nutritionist posts
Finance	Underdeveloped financial management skills as one moves to the lower levels of the management structure i.e. officers who are the first line of contact have under developed financial management skills.	• Appropriate in-service training for nutrition personnel on financial management and terminology within the Public service.
Information	• Nutrition information collected not aligned to the strategic objectives • Underdeveloped documentation of processes and successful undertakings.	• Nutrition indicators to be included in the provincial information and reporting system. • In-service training on report writing skills and basic research will improve the documentation/recording of undertakings.

AREA	CHALLENGE	SOLUTION
Conceptualisation	• Under developed common conceptualisation of integrated nutrition programming at various level of the management structures. Nutrition is perceived to be only concerned with primary school feeding • Though nutrition is part of the Essential Primary Health Care Package its implementation seems divorced from other district planning activities accept for school feeding.	• Develop a nutrition advocacy strategy • The provincial nutrition policies and guidelines should be adopted as official documents that will guide implementation of nutrition services. • In-service training on basic nutrition concepts for officials whose core business is nutrition but do not have a background on nutrition. • Facilitate the inclusion of nutrition in the district planning processes.
Management	• Underdeveloped link between departmental strategic direction and programme requirements often resulting in reactive decision-making	• Align managerial vision with programmatic realities & requirements – link strategic planning with operational plans and budgets. • Enhance decisiveness in making critical decisions on issues that have great & immediate impact on strategic thrust & implementation of the programme.

13.4 APPRAISAL OF EXISTING SERVICES AND PERFORMANCE DURING THE PAST YEAR

a) Primary School Nutrition Programme

In 2001, the Department undertook an ambitious yet noble process to decentralize the School Feeding Scheme with the main of enhancing community participation and development whilst feeding our children a nutritious meal.

In the past two years that this novel approach has been implemented, major strides have been made. In 2001 58 % of children were fed. In 2002 97% of the targeted children have been fed. The expenditure is at 92% (this figure will be updated) for 2002/03 compared to 72% in 2002/01.

In 2003/04 financial the Department intends to increase the cost factor from R1.10 to R1.50 per child inclusive of administration cost due the exorbitant hike in food prices over the last eight months. The 60% target of learners to be fed will be increased to 80% practically it means about three quarters of our primary school children have a chance of getting a meal through school feeding. All children from grade 0-7 in the school system will be fed. R94 million (R71m from National and R22 from the province) will be spent to feed our children through community involvement and empowerment. The number of women contracted as PSNP service providers has increased from to 5000 in 2002/03. With this envisaged increased coverage, the number of service providers is also expected to increase.

The new scheme is characterized by fewer disruptions in service delivery. Community involvement and say in the programme is prominent. The service providers have reported improvements in their lives due the opportunity made available even for the " ordinary" community members regardless of their educational levels and status in the community.

This majestic rise to a programme that we can all be proud still has challenges and areas that need improvement. As with lessons learned in 2001, the experience gained in 2002 will be employed to further develop the programme.

Sustained training and skills transfer is fundamental to ensure that the PSNP SMME's grow beyond school feeding for long-term benefits. Forging linkages and collaborations with other service and development agencies to build the capacity of PSNP Service Providers will fast track the growth beyond PSNP. Communities are not passive recipients of services but are masters of their own actions and development Enhancing administrative systems in the districts that are lagging behind to the expected standards and norms. All these are issues that have been isolated for improvement.

b) Micronutrient Deficiencies

Micronutrient deficiency is often called silent malnutrition because by the time the deficiency becomes visible, damage has already been done. Vitamin A deficiency is one of the public health nutrition problems faced by the province. Besides causing blindness, vitamin A deficiency contributes poor child development and exaggerates the effects of an infection that otherwise in a normal child is not fatal.

It is against this background that the Department initiated the Vitamin A supplementation programme for children 0-60 months and post-partum women to combat the deficiency simultaneously contributing to the reduction of infant mortality. The thrust in the past year has been getting the programme off ground to ensure that every child who attends any of our health facilities has a 100% chance of being supplemented with vitamin A.

The output of this process is that 95% of our facilities have started with the programme. Presently, 4 963 women who gave birth in our facilities have been given a dose of vitamin A. About 20 851 children have received their dose of supplementation. These figures might seem small but one death is a death too many.

In the ensuing year the focus will be on marketing the service to increase awareness and knowledge about micronutrient deficiencies. In line with the National Food Fortification Programme, the Department will be engaged in activities to educate the communities about the benefits of fortifying wheat flour for brown and white bread and maize meal with vitamin A.

c) Management of Severe Malnutrition (PEM Scheme)

In 2002 the Department embark on a project to revitalize the Management of Severe Malnutrition (PEM Scheme) in hospitals, clinics and in the home front. The Department has been able to admit 6 816 new cases into the scheme, 6 319 have been diagnosed with severe malnutrition and 9 270 have not shown weight gain. This only applies to children who were captured by the health system. The ideal is to have no children suffering form malnutrition and those solemnly admitted into the scheme should be rehabilitated never to relapse. This illustrates the need to simultaneously improve other social, economic and developmental concerns in addition to health services.

In the new financial, the Department will strive to strengthen the project and extend it beyond health facilities into communities. The availability of technical knowledge and skills in the form of Community Service Dieticians will greatly enhance the project so that it realizes its maximum potential. In addition this the growth monitoring and promotion aspects will be revived to ensure that every child has a road to health chart and growth faltering is detected early before it becomes severe.

d) Dietetic Services

In the past few years, particularly in the era of the HIV/AIDS scourge, nutrition management of disease as part of treatment, care and support has become increasingly important. The Department will therefore, be engaged in activities to improve dietetic services to ensure that patients admitted in our health institutions receive a comprehensive care that money can buy.

e) Promotion, Support and Protection of Breastfeeding

Breastfeeding has always been regarded as the best and first choice for infant feeding. However, the transmission of the HIV virus through breast milk has cast doubt to an extent that breastfeeding as the first and safest infant feeding option is eroding. Therefore, the Department will vigorously tackle the issue of breastfeeding and correct infant feeding in general to ensure that mothers, caregivers and communities have access and are given correct information, advice and support whether they chose to breastfeed or use alternative feeding methods regardless of their status.

13.5 DESCRIPTION OF PLANNED QUALITY IMPROVEMENT MEASURES

- Develop nutrition guidelines and protocols to improve nutrition services to those of COHSASA standards in health institutions;
- Develop in-service programme for nutrition personnel who do not have a qualification or background to improve their knowledge and skills on basic nutrition concepts and terminology;
- Developed INP management framework to assist with planning, monitoring and management of nutrition activities particularly at district level;
- Identify essential nutrition indicators that will be included in the provincial information management system for the assessment of progress towards achieving objectives of the programme.

13.6 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Some of the nutrition indicators or impact can only be measured after a given period, normally three-five years after the introduction of an intervention. The reduction of stunting, which cannot be cured but prevented through proper infant feeding practices, improvements in maternal nutrition and simultaneous actions aimed at improving economic, developmental and other social disparities.

Therefore, the indicators below will be for the period 2002-2007. Where possible performance indicator will be included. Otherwise the indicators that can be used are process indicators to measure progress towards achieving intended impact.

Table 41: *Measurable objectives and performance indicators*

Objective	Indicator		2001/02 (actual)	2002/03 (estimate)	2003/4 (target)	2004/05 (target)	2005/06 (target)
	Output	Outcome					
To reduce &/or prevent infant & child malnutrition	Guidelines for management of malnutrition in place and implemented. BFHI at public health hospitals		-	Management of severe malnutrition guidelines developed & implementation resumed during this financial year Implement the BFHI Strategy	All Public health institutions implementing the management of severe malnutrition guidelines X3 health facilities assessed for baby friendliness	X3 hospital achieving BFHI Status	Continue
To reduce and prevent the prevalence of micronutrient deficiencies particularly of vitamin A deficiency in children & breastfeeding women.	Vitamin A Supplementation Programme	Reduction from 32% to 20%	Nil	All public health institutions providing vitamin A supplementation prophylactics and curative purposes	Continue with vitamin A supplementation Food fortification project	Continue	Continue

Objective	Indicator		2001/02 (actual)	2002/03 (estimate)	2003/4 (target)	2004/05 (target)	2005/06 (target)
	Output	Outcome					
To nutritionally treat, & manage diseases & trauma, particularly severe malnutrition; diseases of lifestyle, *HIV/AIDS- contribution to the quality of life as part of the treatment plan* & support	Guidelines & protocols Performance against COHSASA standards for dietetic services in health institutions	Reduction of deaths due to hospital malnutrition	-	Guidelines developed: Management of Severe Malnutrition PEM Scheme			

Objective	Indicator		2001/02 (actual)	2002/03 (estimate)	2003/4 (target)	2004/05 (target)	2005/06 (target)
	Output	Outcome					
To promote optimum nutrition & prevent growth faltering in children five years of age.	# of children with RtHC # of clients counselled on proper infant feeding practices	Reduction in the number of children being admitted in the "PEM Scheme" (suffering from severe malnutrition Application of knowledge gained by clients – can be done through research and home visits of those in the programme. Same as for objective 1.					

Objective	Indicator		2001/02 (actual)	2002/03 (estimate)	2003/4 (target)	2004/05 (target)	2005/06 (target)
	Output	Outcome					
To contribute to household food security through targeted feeding & promotion of community-based actions around household food security issues & nutrition.	# of learners fed #of schools fed # of districts managing the PSNP Budget versus expenditure # of PSNP Service Providers contracted	? Impact of the PSNP can be measured through research					

Objective	Indicator		2001/02 (actual)	2002/03 (estimate)	2003/4 (target)	2004/05 (target)	2005/06 (target)
	Output	Outcome					
To improve nutrition knowledge, & behaviour & conceptual understanding of INP & nutrition in general	#of IEC Material developed # Awareness & Promotion Campaigns		Develop Nutrition IEC Material: Poster promoting breastfeeding Vitamin A	Material on infant feeding & HIV AIDS Information material on the PSNP, BFHI	Develop Nutrition IEC Material	Continue	Continue

Objective	Indicator		2001/02 (actual)	2002/03 (estimate)	2003/4 (target)	2004/05 (target)	2005/06 (target)
	Output	Outcome					
To provide functional food service management system to ensure client satisfaction, food safety & prevent institutional malnutrition	Service level agreements (contracts) Deviation from service level agreements Adherence or deviation from COHSASA standards	Nutritionally adequate meals served according to clients requirements Improved client satisfaction Decreased plate wastage (obtained through plate wastage study)					

14. EMERGENCY MEDICAL SERVICES

14.1 SITUATION ANALYSIS

Emergency Medical Services is one of the major services provided by the health sector. It consumes about R 63 million per annum in the North West Province, about 3.6 % of our annual health budget.

The Provincial Health Department experienced frustration as a result of our inability to ensure effective management of the Emergency Medical Services. The service was given on an agency basis to the Regional Services Councils to manage by the previous Transvaal Provincial Administration. The Regional Services Councils in turn subcontracted the services to the local municipalities. Although the services were funded 100% by the Provincial Health Department, the Department felt unable to get the local municipalities to respond to its requests. The province did not have any effective management systems to objectively hold the Regional Service Councils accountable.

The Department received numerous complaints from the community about poor responsiveness to requests for assistance. Although the MEC had delegated the service provision to local municipalities he remained responsible for ensuring effective service provision. Provincial health facilities including clinics and hospitals also complained about a lack of adequate service provision, with regards transfer of patients.

In many cases the EMS services continued to confine their operations to the municipal boundaries. It meant that many rural communities were denied access to services. The service remains one dominated by white males, and this was particularly true of the management structures. The local municipalities in the Southern Region consumed over 40% of the resources, despite serving less than 25% of the population.

As a result of poor availability of services several of our managers had resorted to the use of private ambulance services. This was at a significant cost and was not budgeted since the entire allocation was given to the municipalities. The drivers were not adequately trained, and appropriate equipment was not installed in the vehicles.

As a result of the situation described above, the North West Department of Health decided to terminate the agency agreements and provincialize the service.

14.2 STRATEGIC PRIORITIES, OBJECTIVES AND POLICIES.

- Improve provincial response times to get closer to 15 minutes in urban areas and 40 minutes in rural areas.
- Fill 85% of the vacant posts
- Develop a replacement policy for vehicles
- Improve the communication systems within the province
- Develop a emergency service policy
- Establish a Health Professional Council accredited training institution within the province

14.3 KEY CHALLENGES OVER THE STRATEGIC PLAN PERIOD

- To produce the greatest improvement in the Emergency Medical Services in the North West Province, given the nature of our current situation and reduce the likelihood of failure of the service
- To determine the most critical areas to focus on over the next seven months and to develop a plan of what needs to be done in the 2003/2004 financial year and in the two subsequent financial years to improve the viability and effectiveness of the service
- To build a common understanding of what the major problems of the service are, a common vision of what we want the service to become, and an agreement on what we need to do to bridge the gap and move towards our vision.

14.4 APPRAISAL OF SERVICES AND PERFORMANCE DURING THE PAST YEAR AS DESCRIBED IN THE PROVINCIAL STRATEGIC ANALYSIS

The Emergency Medical Service in the North West province has been run by the District Directors. As yet there is no norms or standards within the province. The lack of vehicles, staff and adequate buildings is the greatest concern.

14.5 DESCRIPTION OF PLANNED QUALITY IMPROVEMENT MEASURES

- An adequate continuous professional development (CPD) program needs to be implemented to improve the quality of the patient 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.

14.6 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

***Table 42**: Format for presentation of objectives and evolution of performance indicators*

Objective	Indicator	2001/02 (actual)	2002/03 (estimate)	2003/4 (target)	2004/05 (target)	2005/06 (target)
Establishment of Communication and Control Centres	a working two-way radio system in ambulances and base stations	0%	0%	50%	75%	!00%
	Working District Control Centres	0%	0%	50%	75%	100%
	a single emergency number management system in place of existing fragmented one	0%	0%	50%	75%	100%
Ensure EMS training	Staff qualified with Basic Ambulance Certificate and Drivers License	80%	95%	100%	100%	100%
	Working Provincial EMS College	0%	0%	100%	100%	100%
	EMS College to provide training for BAC, BAC refresher courses and Advanced/defensive driver training courses r.	0%	0%	75%	100%	100%
	EMS college to develop capacity and registration to provide AEA courses	0%	0%	10%	75%	100%

Objective	Indicator	2001/02 (actual)	2002/03 (estimate)	2003/4 (target)	2004/05 (target)	2005/06 (target)
Improved Management of Vehicles	Audit number and state of repair of all vehicles in each station.	0%	50%	100%	Update database	Update data base
	A vehicle replacement plan	0%	50%	100%	100%	100%
	Station manager authority to manage maintenance.	0%	0%	50%	100%	100%
Develop Standard Operating Procedures and Policies	EMS policy	0%	0%	75%	100%	100%
	Training policy	0%	50%	100%	100%	100%
	Standard operational procedures	0%	50%	100%	100%	100%

1. An objective may have one indicator or more than one indicator of the same or different types.
2. Where data are available.

Table 43: *Performance indicators for emergency medical services**

Region:

Indicator	Bojanala Region	Southern Region	Central Region	Bophirima Region	Province	National target
Input						
1. Number of vehicles per 1000 people	0.2	0.04	0.01	0.16	0.41	-
Process						
2. Number of vehicles replaced per year	0	6	0	0	6	-
Output						
3. Total kilometres travelled per year	2 241 780	1 378 959	346 000	234 434	4 201 173	-
4. Number of patients transported per 1000 people per year	24	71,62	70	50.84	54,115	-
Quality						
5. Percentage of call outs answered by single person crew	0%	0%	0%	10%	2.5	-
6. Percentage of locally based staff with training in life support at basic level	97%	95%	100%	12%	76%	-
7. Percentage of locally based staff with training in life support at intermediate level	3%	3%	15%	5%	6.5%	-
8. Percentage of locally based staff with training in life support at advanced level	0%	0%	0%	0%	0%	-
Efficiency						
9. Cost per patient transported	R13.00		17.00		R15	-
Outcome						
10. Percentage of response times within current national targets	72%	68.75%	100%	100%	85.18%	Urban area < 15 mins. Rural area < 40 mins.

* Populations should be those of resident people. Any major cross boundary flow of patients should be explained in the text.
The symbol ✓ means that the indicator value should be reported.

14.7 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

EMS has been classified as a programme as opposed to a sub-programme. In the current financial year, R57 million was allocated to EMS, and this has been increased to R96 million for the 2003/4 financial year. The increase will be utilized to purchase additional ambulances and patient transport. There is a tremendous increase in the personnel budget to cater for the fully fledged provincialised emergency medical services.

NB. Provision for vehicles/transport, is for Ambulances and Patient Transport. Patient transport has in previous years not been provided for based on the expectation that the Department of Transport would provide for such, based on the then provincial policy.

14.7.1 PROGRAMME 3: EMERGENCY MEDICAL SERVICES

Table 44: *Programme Summary of Expenditure According to Programme*

	Programme Summary of Expenditure and Estimates					
Sub-programme (R'000)	**2000/ 2001 Actual**	**2001/ 2002 Actual**	**2002/ 2003 Est. Actual**	**2003/ 2004 MTEF**	**2004/ 2005 MTEF**	**2005/ 2006 MTEF**
1. Emergency Transport	52,886	53,240	57,040	**92,627**	87,413	106,321
2. Planned Patient Transport	-	-		**3,982**	4,778	5,734
Total programmes	52,886	53,240	57,040	**96,609**	92,191	112,055

15. PROVINCIAL HOSPITAL SERVICES

15.1 SITUATION ANALYSIS

The province has one provincial (level two) hospital namely Rustenburg Provincial Hospital and two provincial (level two) hospital complexes consisting of five hospitals of which two are specialized mental health hospitals. Theses complexes are:

a) Klerksdorp/Tshepong - Potchefstroom - Witrand (KTPW) hospital complex
b) Mafikeng-Bophelong hospital complex

These hospitals strive to deliver their services within a framework of appropriate financial management and quality service delivery. The following is a brief situation analysis for these facilities.

The North West Province has 3.5 million people[3]. Southern District consists of KTPW hospital complex delivers level one hospital services to Potchefstroom and Klerksdorp districts (combined population of 501 269), level two services to the entire Southern District (18% of the population/630 000) and level three services to the entire province.

Mafikeng/Bopelong Hospital complex serves a population of 690 976 in the Mafikeng district.

The catchment area for Rustenburg hospital is Mogwase, Rustenburg and Britz sub-districts with a total population of 739 545

[3] 1996 population census projected to 2000

Table 45 : *Number of open beds in provincial hospitals by level of care*

Provincial hospital (or complex)	Bed category	No. of level 3 / 4 beds	No. of levels 1 and 2 beds	Total no. of beds
Klerksdorp/Tshepong Hospital Complex	***Open Beds***	100	773	873
Klerksdorp/Tshepong Hospital Complex–	***Approved Beds***	140	875	1015
Potch Hospital	***Open beds***	L 1 = 201 / L 2 & 3 = 134		310
	Approved beds			335
Witrand Hospital :	***Open beds***		1062	1062
	Approved beds		1152	1152
Mafikeng	**Open beds**	10	380	390
	Approved beds			544
Bopelong	**Open beds**			312
	approved		368	368
Rustenburg	**Open beds**	0	295	295
	Approved beds			350

Tertiary services rendered by the KTPW hospital complex are ICU, surgical, Orthopaedics, Ophthalmology, Neonatology, Burns Unit, Renal Unit, Oncology, Urology, Maxillo – facial surgery, Internal medicine, General surgery, ENT, Obstetrics and Gynecology, Specialized Mental Health Services i.e. care for the Mentally Retarded and Psychiatric Illnesses. Klerksdorp/Tshepong has a step down facility.

Mafikeng-Bopelong provides level one and two services and these are OPD, casualty, ICU, theatre, maternity, gynae, surgical, orthopaedic, paediatric, medical, renal, occupational health, infection control.

Level two services rendered by Rustenburg Hospital are general ICU, orthopaedic, neonatal, internal medicine, general surgical, obstetrics, gynae, kangaroo baby care.

15.1.1 Major flow of patients across provincial boundaries

Unofficial cross border flow:

From North West to Gauteng:

- Southern District (Wedela and Fochville) to Vereeniging
- Bojanala district (Britz and Odi) to Garankua
- Bojanala district (Jubilee) to Kalafong and Pretoria academic

From North West to Northern Cape:

- Kudumane (within Kgalagadi cross boundary district) to Kuruman

From Free State to North West:

- Parys to Southern District (Viljoenskroon and Vredefort)

Official referral pattern for tertiary/quaternary services (Klerksdorp hospital is the first referral point, but if Klerksdorp cannot manage cases then the following apply)

North West to Gauteng

- Southern and Bophirima districts to Chris Hannie Baragwanath
- Central District to Garankua

15.1.2 Conditional Grants

Table 46: *KTPW Conditional grants 01 04/2001 to 31/03/2002*

RENAL UNIT	
No of patients – Acute	36
No of patients – Chronic	353
No of Dialysis – Acute	170
No of Dialysis – Chronic	4218
No of Perineal dialysis – Acute	0
No of Perineal dialysis – Chronic	52
Outpatients –Chronic	652
Outpatients –Transplants	171
Outpatients –Follow – up	408
ONCOLOGY UNIT	
Total no of outpatients	1927
Total no new patients	319
Total no of chemotherapy treatments	847
C T SCAN	
Total scans	2861
M D R TB UNIT	
No of outpatients	639
No of inpatients	258
No of conversions	559
E M S ICU	
Total ICU patients transfer	151
Total ordinary patients transfer	94
OPHTHALMOLOGY UNIT	*Started functioning from June 2001*
Total patients	644
BURNS UNIT	*Started functioning from June 2001*
Total inpatients	117
JOINT SURGERY	*Started functioning from June 2001*
Total hip replacements	30
Total knee replacements	26
IN PATIENT ONCOLOGY	
Total inpatients	692

Table 47 : *Conditional Grants Witrand Hospital*

PSYCHIATRIC UNIT	
Total in-patients (PDE)	5673

Table 48 : *Conditional grants Rustenburg Hospital – 01/04/01 till 31/03/02*

E M S ICU	
Total ICU patients transfer	Figures unavailable
Total ordinary patients transfer	Figures unavailable

15.1.3 Public Private Partnerships (PPP)

Table 49 : *Public Private Partnerships*

Hospital	Initiative
Klerksdorp / Tshepong Hospital	Anglo Gold Adoption of wards
Potchefstroom Hospital	Friends of the Hospital
Witrand Hospital	Parents Association SJGD Students
Rustenburg Provincial Hospital	CT Scans at private radiologists' rooms Medunsa / outreach Private caterers Pitseng Kgalagadi Madia private security Bongani funeral Undertakers An agreement with Netcare is being planned
Mafikeng/Bopelong	Working on an arrangement with private Orthotist. PPP arrangements being negotiated with two medical officers for our step-down facility in ward 9.

15.1.4 Physical Condition of Hospital Network

Table 50: *Facility construction, upgrades and rehabilitation (R'000)*

New construction	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)	Total project estimate
Programme 1 total						----
Programme 2 total - Project 1 - Project 2						----
Programme 3 total - Project 1 - Project 2 etc						----
Total new construct.						----
Upgrading/rehab.						
Programme 1 total						
Programme 2 total - Project 1 - Project 2						
Programme 3 total - Project 1 (Witrand Hospital – Rehabilitation Unit (R&R Grants)		R1,200 000	R600 000			**R1,800 000**
- Project 2 (Witrand Hospital – Upgrading of wards 2E, 3, 4, 8, 11, 12, PU)		R 300 000	R800 000	R800 000	R800 000	**R2,700 000**
- Upgrading of Kitchen Etc		R 300 000	R400 000			**R700 000**
Total upgrading and rehabilitation		**R1,8 000 000**	**R1,800 000**	**R800 000**	**R800 000**	**R5,200 000**

Hospitals by type	Average 1996 NHFA condition grading[4]	Any later provincial audit grading (with date)	Outline of major rehabilitation projects since last audit
General			
Potchefstroom	4	none	
Klerksdorp/Tshepong			**Tshepong Hospital West Wing:** • Total renovation/decoration of Admissions, First Visits & Out Patients Departments • Total renovation/decoration of Burn's Unit • Upgrading of Toilets, two wards, • Upgrading Main Entrance, Nurses Quarters • Total renovations/decoration of VIP Flat • Smoking Area **Klerksdorp Hospital East Wing:** • Renovation/ Decoration of Oncology Ward for In-Patients • Upgrading of Pharmacy Bulk-Stores • Upgrading of Dietician Department • Total painting and decoration of Paediatrics Ward (Ward 10) Total painting, tiling and decoration
Mafikeng	3		
Rustenburg Hospital	4	None	None
Central			
None in NW			
Tuberculosis			
None in NW			
Psychiatric			
Witrand			
Bopelong	3		
Chronic medical and other specialised			
None in NW			

See Table 27 page 39 for grading definitions

[4] See Annexure A for NHFA condition grading

15.1.5 Ten most common conditions treated across all provincial hospitals

(xi) TB and AIDS related conditions
(xii) Pneumonia
(xiii) Diabètes
(xiv) Trauma
(xv) Hypertension
(xvi) Cardiac failure
(xvii) Pre-eclamptic Toxaemia
(xviii) Gastro-enteritis
(xix) Burns
(xx) Abortions and Ectopic pregnancy

15.2 APPRAISAL OF EXISTING SERVICES AND PERFORMANCE DURING THE PAST YEAR

(i) Finance and Asset Management

Revenue generation (especially with regard to debt collection) at the provincial hospitals has been reported to have improved, but KTPW and Rustenburg report that current record keeping is poor and a hospital such as Potcefstroom lacks the structural capacity. These issues will be addressed over the coming MTEF period. Mafikeng Bopelong Hospital Complex (MafBop) reports revenue generation of 31 % above target for this period. The UPFS has been implemented at Rustenberg hospital. OPD however is not functioning and generally the admissions captured are incorrect. At MafBop the cost unit system have been implemented even though is not yet functioning well. All created cost unit were allocated with their budget to control. 40% of the system is effective but this is due to the fact that the system is still new.
At K/T/P/W manual cost centers have been created and the conditional grants have been applied effectively. See table 50 above. At Rustenburg Hospital the ICU conditional Grant funds were exhausted in November 2002 and no carry through funding was received for orthopaedics, EMS and Urology.

At MafBop there is an institutional tender committee that sits for assistance with specs and ensures that there is fairness on the recommendations to the departmental tender committee. Rustenburg hospital is awaiting provincial instructions to get started with it tender committee.

(ii) Health Service Provision

A number of general protocols (internal prescripts) have been developed, updated and circulated (67 in Rustenburg hospital alone) Rustenburg hospital also revised and published 66 clinical protocols. Standard operating procedures for management of priority health programmes within hospital context have been developed and distributed for implementation. These have been integrated into the quality improvement programmes. T MafBop an independent monitoring team has been formed to monitor quality improvement issues including implementation of the standard, policies and procedures.

At KTPW, the average length of stay (alos) have increased while at Rustenburg hospital it has been 4.8 days (within the norm). At Rustenburg hospital the bed utilization rate is 93% and the PDE is R669. At MafBop the alos is 4.2 while the bed occupancy rate is 61%, with a PDE of R731.50.

Regarding the New Mental health Act, staff of Bopelong and Witrand hospitals have attended orientation and preparatory workshops. Currently inputs are being solicited broadly on implementation strategies. The Mental Health review Board has unfortunately not been established yet. Such structures need to be in place before it can be advanced on implementation.

Basic research was done at Rustenburg hospital for example on patient waiting times, use of partograms, etc. At MafBop a Research committee was formed and terms of reference was established. Agreement forms and questionnaires developed. Committee sits weekly. Two research applications was approved this year.

KTPW has a partnership with WITS university (to recruit more specialists), Rustenburg has an agreement with Medunsa.

(iii) Continuous Quality Improvement

MafBop

Ethics committee for clinical governance has been revived. Terms of reference and questionnaires developed. Committee sits weekly. Two cases dealt with this year. Patient satisfaction is assessed on patient discharge through patient questionnaires. The complaint procedure is established for external customers, not fully established for internal customers (staff), but are measured on monthly basis. 2002/03 had a high mortality rate in ICU and High Care. Changes have been made for 2003/04 and effectiveness will be monitored.

Since May 2002 there were no cases referred from our institution to Clinical Investigation Committee (CIC) because the chairperson of Ethics Committee, left the institution and this caused a decline in the functioning of the Committee , as a result only ten (10) cases were referred and others are still outstanding .

The Patient Right Charter is displayed in Tswana and English in all the wards. Education of patients and staff education are on going.

Progress in terms of the Employee Assistance programme (EAP) is good because employees are aware of the service and we get both the self and supervisory referrals. EAP have been taken over by Provincial health department and sessions are conducted in the hospital and employees are happy about the service.

An organisation wide Risk Management programme was rolled out in February '03 after proper coaching was done. Prior to this roll out, this programme was one of the health and safety programmes. With the few weeks that this programme has been put in place, there has been a major shift in the way risks are handled, that is not only are the risks identified but action is taken and outcome reported.

Rustenburg

A Complaints mechanism is in place for patients. Infant mortality decreased, but Maternal Mortality increased. 100% of cases are reported to the CIC. Work still needs to be done regarding the patients rights charter since it is not displayed at all required sites. The employee assistance programme is in place, the COHSASSA programme is in progress and hospital activities is communicated to the community through the hospitals board. A supervisor is on duty 24 hrs per day. A problem is being experienced with patient records since misfiling occurs in about 90% of cases. A monitoring mechanism is in place for risk management purposes.

KTPW

A risk management control programme has been established in each department.

(iv) Human Resource Management and Development

Rustenburg

The hospital experienced a high staff turnover. Three medical officers' posts were filled, but could not attract any full time specialists. No employment equity plan in place yet. No management training was done but clinical staff received training. Occupational Health and Safety Unit is not yet operational. Health and Safety Committee is not yet operational due to lack of capacity. The union forum is active and meets with management once a month.

MafBop

This hospital is experiencing a lack of key posts as well as a shortage of professional nurses due to Krause Model, only 45 posts for professional nurses were created and are all filled. Motivations for creation of additional professional nurse posts were submitted and up to now the Establishment is not yet revised. Employment equity plan in process of being developed. 20% of management and clinical staff had skills development training. The hospital managed to attract and appoint specialists, radiographers, pharmacists, occupational therapists and a principal medical officer through external advertisements and head hunting. The occupational health unit is serviced by a sessional doctor. Union forums are operational in the hospital.

(v) Organizational Development

Rustenburg

The organogram does match the areas of responsibility within the hospital and due to freezing of posts, responsibilities have to be realigned. Posts have been assigned clear functions but some problems are experienced due to non-filling of posts. There is an extended Top Management in place.

MafBop

The complex organogram indicating areas of responsibilities has been forwarded to the Department for approval and it will be finalized by the 31/03/2003 and will be implemented on 01.04.2003. Clear areas of responsibility has been assigned through signed PMA's and Job descriptions. Several structures are in place that ensure joint decision making and shared leadership.

(vi) Capital Works Maintenance Programme

MafBop

In terms of hotel services the core package of amenities has been developed. Plate system has been implemented. Proper signage has been provided in and outside of the Complex. Gardening has been completed. Repainted hospital complex. TV's, VCR, and TV stands were installed in all targeted areas. Procurement of cutlery and crockery in targeted wards. Vending machine for cell phone card vouchers installed. Procurement of Hexagon tables and chairs for gardens. Provision for appropriate seating for patients. Dietician has been appointed. Still planned is installation of vending machines for cool drinks, furnishing of all waiting areas, provision of colour coded linen and curtains.

(vii) Support Services

Rustenburg

Pharmaceutical services

In place 97% availability of EDL drugs

Laboratory

Service delivered by National Health Laboratory. Functioning well.

Telemedicine

Equipment in place, Not functioning due to problems at Klerksdorp Hospital.

Catering

Private catering by Pitseng Kgalagadi in place. Certain shortcomings w.r.t. quantity, etc.

Laundry

We use the Gauteng service at Roslynn – Masekane Laundry. Experiencing many problems.

Transport

Hospital experiences a shortage of drivers and decent vehicles

Security Services

Supplied privately by Madia Services. Needs to be improved.

MafBop

Pharmaceuticals

Complex struggled for many years to recruit a Chief Pharmacist and ultimately became successful with its recruitment strategy in 1999 with the appointment of Ms. Lebeko-Ratlhagane. The programme o f community Pharmacist was rolled out in 2000 and Ms. Lebeko-Ratlhagane managed to actively support and coach one community Pharmacist before being moved to provincial office. Proper systems are in place but currently there is a problem with the management of Pharmacy as there is no Senior Pharmacist.

Laboratory

Services rendered are up to standard – The Laboratory falls under the NHLS.

Telemedicine

The province is a pilot site for teleradiology. An arrangement was made with Kerksdorp/Tshepong Hospital Complex to be the receiving site and that district hospitals such as Zeerust/Lehurutshe, Thusong/Gelukspan would send their films for reporting through MafBop. In 2001/02 the system was used to contact Canada with Ultrasound remote lectures for the benefit of North West Student Ultrasonographers. Seminars have also been held with District Nurses on communicable diseases as well as pandemic outbreaks like the Ebola virus. The National Ministry was involved which says they are positive with the system. During the first phase of inception of the pilot project, there were delays of reports coming from Klerksdorp as Dr. Swanepoel was overwhelmed by sheer numbers of requests from the 5 centres across the North West Province. Due to these delays there was subsequently a loss of interest among the referring Doctors, this leading to the system laying idle for the better half of year 2002. Cases that were sent included Ba Swallows, TB cases and Abdominal examinations which were a resounding success in terms of positive diagnosis.

Catering

Service rendered by Royal Food Services was up to standard. 10 Pots, 3 gas stoves, 2 electrical pots, 5 steam pots were purchased. Dietician and two community service dieticians employed. Plate system was introduced.

Laundry Services

The laundry was renovated and new washing drying machines were installed that improved on the service rendered by the laundry. Production level is high – Complex is rendering laundry services to District clinics & Mmacon.

(viii) Decentralization of management

The tender process for COHSASA was concluded and an Executive training program is part of the program. The first module scheduled for 25 – 27 March 2003. All Hospitals have General Manager posts for District Hospitals and CEO posts for Regional Hospitals

The Department experienced a high turnover regarding hospital managers due to different Provinces not appointing managers on the same levels for same size hospitals nationally. All General Managers and CEO's have signed PPMA's and the CDHSD and Regional Directors did perform a first 6 monthly evaluation. Training on the new format distributed by the DPSA was however not done. Delegations as distributed regarding HR, Finance and procurement was re-delegated.

15.3 CHALLENGES, CONSTRAINTS AND MEASURES TO OVERCOME THEM

Table 51: *Challenges, constraints and measures to overcome them*

Strategic Area	Challenge/constraint	Measure to Overcome
Finance	Appropriate implementation and use of UPFS and the reduction of outstanding fees. Lack of computer hardware. Unmotivated and untrained staff	Motivate and train staff. Provide required IT infrastructure
Health service Provision	To develop protocols and SOPs for all major conditions. To keep alos, BOR and PDE within acceptable norms. To develop level two services further. To further develop step-down facilities and home-based care. To increase the number of cataract operations. Prevention of maternal and neonatal deaths. Implementation of new mental health Act. Adequate operationalization of agreements with academic institutions. Disease profile (HIV, MDR and TB) The activity load has increased, with more lab tests being done than before and more medication being prescribed.	Regular and adhoc reviews of protocols and their application. Employ cost containment measures. Improve working conditions and remuneration packages to attract and keep qualified specialists and senior medical officers. Obtain funding for step down facilities and home based care. Ensure that nursing staff are adequately trained. Obtain necessary equipment and additional sessional ophthalmologists for more cataract operations Increase in the department's budget to absorb the increased activity load.

Strategic Area	Challenge/constraint	Measure to Overcome
CQI	Decrease the incidence of cases to be reported to CIC. Well organized patient record system	Obtain adequately trained staff and reliable equipment.
Human Resource Management and Development	Attraction of scarce skills. Unskilled staff with lack of interest. high staff turnover.	Incentives for attracting and maintaining staff. Incentives for training.
Capital Works and maintenance programme	Development of a facility master plan and ensure adequate maintenance of hospital buildings. There is a limitation of Hospital Reconstruction and Rehabilitation (HR&R)Grant not covering the needs of level 2 hospitals Currently this program is focused on level one hospitals.	To secure the funding and suitable contractors for required maintenance
Decentralized Management	Fully implement all the modules for the COHSASA executive training program. Implementation of the PMDS ensuring performance, productivity with increase in input, throughput, output and outcomes regarding service delivery. Delegations still not enabling enough to create decentralized hospital management environment.	All managers to consult the K/T/P/W Complex on the roll out of the COHSASA project. Work programs to include KPA'I's Constant training and retention of skilled staff with differentiated delegations according to capacity

15.4 POLICIES, PRIORITIES, BROAD STRATEGIC GOALS

The provincial hospitals function within the scope of national and provincial policies of which the two important guiding frameworks are the National Ten Point Plan and the eight strategic goals of the NWDoH cited on page 30 of this document. The following are the hospital specific strategic goals:

(i) Ensure effective management of the hospitals' finances and assets
(ii) Ensure the provision of quality health care services in hospitals
(iii) Facilitate the process of continuous quality improvement (CQI)
(iv) Facilitate the appropriate appointment and development of human resources to ensure competent and performance focused employees
(v) Ensure effective and appropriate organizational systems within hospitals
(vi) Ensure the availability of suitable hospital infrastructure
(vii) Develop and maintain an appropriate referral system
(viii) Establish and maintain appropriate governance structures for hospitals
(ix) Facilitate decentralized management of hospitals

15.5 PLANNED QUALITY IMPROVEMENT MEASURES

- Increase the number of departments within hospitals that have their Batho Pele Agreements monitored quarterly.
- Setting of service standards and monitoring service delivery against these standards.
- Further role out of the COHSASA programme
    - The department has increased the personnel budget for hospitals in a concerted effort to attract and appoint the required specialists.
- There was a drastic reduction in movable capital during 2002/3 due to a departmental decision to shift to district health services specifically for mobile services to improve services for the farming communities. From 2003 to 2004 onwards mobile funding will have been addressed adequately. Therefore provision for provincial hospitals was increased again according to their needs.
- Utilities (electricity and water) - both these items were previously the competency of public works. Since 2002/3 they have been shifted to the Health department, (services and payment rendered within the department) thus increasing the budget. The department will endeavour to administer this function such that facilities are ensured of these utilities.
- Ensure the appropriate and most beneficial use of the National Tertiary Services grant so that patients in need of tertiary care will receive this at the least possible inconvenience.
- Appropriate and efficient use of other Conditional Grants to:
    - Annual improvements plus new medicines
    - Training and development of hospital staff
    - Implementation and increase of new hospital services
    - Develop a program for planned patient transport.

15.6 SPECIFICATION OF MEASURABLE OBJECTIVES

Table 52: *Hospital Specific Measurable Objectives*

Objective	Indicator	2001/2002 actual	2002/2003 estimate	2003/2004 target	2004/2005 target	2005/2006 target
Financial Management						
Implement cost centre management at ward level in all hospitals	The presence of functional cost centres at ward level in all hospitals	0	0	33%	66%	100%
Health Service Provision						
Improve hospital efficiency	Average length of stay	Regional 4.8	7.1 days	6.5 days		
Reduce non-HIV related Peri-natal mortality rate by 20%	Peri-natal mortality rate (per 1000 live births)	45%	50%	35%		
Reduce non-HIV related maternal mortality rate by 20%	% Reduction of non-HIV related maternal mortality rate (per 100,000 live births)	N/A	5% 150/100 000	20% 120/100 000		
Departmental Systems						
Integrate Management Information from all current stand alone data bases into a Common Departmental Management Information System (CDMIS)	Percentage of Databases integrated into CDMIS	0	0	30%	70%	100%

Objective	Indicator	2001/2002 actual	2002/2003 estimate	2003/2004 target	2004/2005 target	2005/2006 target
Continuous Quality Improvement						
Strengthen Batho Pele	% of facilities Batho Pele agreement monitored quarterly	98%	30%	80%		
Ensure investigation of CIC	% of CIC cases investigated completely out of total No CIC cases reported	88%	70%	65%		
Develop provincial Quality Framework	Quality framework available	Not available	Framework available	Framework Available	Framework available	Framework available
Implement patients rights charter	% of facilities displaying Patients' Rights Charter	98%	30%	100%		
Establish complaints mechanism in all fixed facilities	% of facilities implementing complaints mechanism	98%	50%	100%		
Develop and implement clinical guidelines	Number of clinical guidelines implemented	5	4	10		
Introduce peer review and clinical audit	% of hospitals conducting maternal and Peri-natal meetings every month	70%	60%	100%		
Establish Governance structures	% of Governance structures functioning (meeting 6 times per year)	80%	50%	90%		
Develop mechanisms to ascertain views and expectations of users	% of facilities (hospitals) with patient satisfaction surveys conducted this year	98%	40%	80%		
Implement work improvement team strategy (WITS)	% of districts with WITS teams	65%	50%	80%		

Objective	Indicator	2001/2002 actual	2002/2003 estimate	2003/2004 target	2004/2005 target	2005/2006 target
Provide employees undergoing stress with counseling and assistance	Number of employees counselled	401	75	600		
Human Resource Management and Development						
Strengthen hospital management	% of hospitals with general managers appointed	88%	90%	95%		
Train hospital management teams	% of hospitals implementing training for management teams	N/A	20%	95%		
Increase the number of CEOs evaluated according to signed PMAs	Increase the number of CEOs evaluated according to signed PMAs	2/3 (67%) of provincial hospitals	20% (All provincial hospitals)	100% of provincial and district hospitals with PMAs		
Organizational Development /Capital Works Maintenance Programme						
Develop and implement a hospital master plan facility	% hospitals implementing hospital master plan	12% of hospitals	30% hospitals implement master plan	90%		
Decentralised Management						
All hospital management teams in the Province to attend all the modules for the COHSASA Executive training program as were identified in the business plan.	Number of management teams Number of modules for the COHSASA Executive training program	N/A	21 Hospital teams 1 Module	21 Hospital teams 5 Modules	N/A	N/A.

Objective	Indicator	2001/2002 actual	2002/2003 estimate	2003/2004 target	2004/2005 target	2005/2006 target
All Hospital General Manager posts for District Hospitals and CEO posts for Regional Hospitals to be evaluated and graded according to National criteria and parity.	Number of posts Evaluated Number of posts Upgraded National parity achieved / not achieved	N/A	N/A	12 evaluated 12 graded and approved according to evaluation 70 % National parity achieved /not achieved	21 evaluated 21 graded and approved according to evaluation 90 % National parity achieved /not achieved	31 evaluated 31 graded and approved according to evaluation 95 % National parity achieved /not achieved
All Directors (CEO's) and Managers (A/D upwards) to have signed PPMA's by 15 April 2003	Number of Directors (CEO's) and Managers (A/D upwards) to have signed	N/A	100 % signed	100 % signed	100 % signed	100 % signed
All GM's / CEO's / Directors KPA's to be linked to work programs and Departmental philosophy / value system	Available and submitted weekly workplans linked to KPA's / Departmental philosophy / value system	N/A	N/A	75 % of all GM's / CEO's / Directors	85 % of all GM's / CEO's / Directors	95 % of all GM's / CEO's / Directors

Objective	Indicator	2001/2002 actual	2002/2003 estimate	2003/2004 target	2004/2005 target	2005/2006 target
Quarterly evaluations to be done	Percentage quarterly evaluations done	N/A	70 % evaluated 6 monthly	100 % evaluated 6 monthly 70 % evaluated 3 monthly	80 % evaluated 3 monthly	100 % evaluated 6 monthly
Training on the new format distributed by the DPSA was however never received	% of Managers trained	N/A	N/A	70 %	85 %	100 %
Delegations to be annually reviewed to ensure the achievement of the goal of fully decentralized hospital management.	Delegations annually reviewed	HR, Procurement and financial delegations annually reviewed	HR, Procurement and financial delegations annually reviewed	HR, Procurement and financial delegations annually reviewed	HR, Procurement and financial delegations annually reviewed	HR, Procurement and financial delegations annually reviewed
	Compatibility to NDOH/DPSA norms/standards to achieve decentralized management.	N/A	60 % Compatibility to NDOH / DPSA norms / standards to achieve decentralized management.	70 % Compatibility to NDOH / DPSA norms / standards to achieve decentralized management.	80 % Compatibility to NDOH / DPSA norms / standards to achieve decentralized management.	95 % Compatibility to NDOH / DPSA norms / standards to achieve decentralized management.

15.6.1 PROGRAMME 4 : PROVINCIAL HOSPITAL SERVICES

Table 53: *Programme Summary of Expenditure According to Programme*

Sub-programme (R'000)	Programme Summary of Expenditure and Estimates					
	2000/ 2001 Actual	2001/ 2002 Actual	2002/ 2003 Est. Actual	2003/ 2004 MTEF	2004/ 2005 MTEF	2005/ 2006 MTEF
1. General (Regional) hospitals	363,005	394,375	449,358	**535,227**	611,914	694,275
2. Tuberculosis Hospitals	-					
3. Psychiatric/Mental hospitals	82,762	86,210	87,713	**104,596**	132,302	147,051
4. Sub-acute, Stepdown and Chronic Medical Hospitals	-	-	-	**-**	-	-
5. Dental Training Hospitals	-	-	-	**-**	-	-
6. Other Specialised Hospitals	-	-	-	**-**	-	-
Total programmes	445,767	480,585	537,071	**639,823**	744,216	841,326

The budget has been increased by 19% over the current year. Main increases are on personnel budget at 20%, Stores at 19%, equipment at 100% and increase for maintenance and utilities 21%.

The increase in the budget for provincial hospital services will be applied as follows:

- Maintenance , repairs and Utilities (electricity and water)
  Both these items were previously the competency of public works. Since 2002/3 they have been shifted to the Health department, (services and payment rendered within the department) thus increasing the budget.

- Disease profile (HIV, MDR and TB)
  The activity load has increased, with more lab tests being done than before and more medication being prescribed. This has also caused an increase in the budget.

- Personnel
  The increase here would be applied to the effort of attracting and appointing the required clinical staff and specialists.

- Equipment
  There was a drastic reduction in movable capital during 2002/3 due to a departmental decision to shift to district health services specifically for mobile services to improve services for the farming communities.
  From 2003 to 2004 onwards mobile funding will have been addressed adequately. Therefore provision for provincial hospitals was increased again according to their needs.

- Conditional Grants (National Tertiary Services)
  Since 2000/1 this funding was constant, with no increase increases.

- Other Conditional Grants
  Increases in new hospital services:
    - Annual improvements plus new medicines
    - Training and development of hospital staff
    - Implementation of new services

  This program will also benefit from the development program for planned patient transport.

- Limitation of Hospitals Reconstruction and Rehabilitation (HR&R)Grant to cover the needs of level 2 hospitals
  Currently this program is focused on level one hospitals.

15.6.2 PROGRAMME 8 : HEALTH FACILITIES MANAGEMENT

Table 54: *Programme Summary of Expenditure According to Programme*

Sub-programme (R'000)	Programme Summary of Expenditure and Estimates					
	2000/ 2001 Actual	2001/ 2002 Actual	2002/ 2003 Est. Actual	2003/ 2004 MTEF	2004/ 2005 MTEF	2005/ 2006 MTEF
1. Community Health Facilities	10,500	26,152	53,903	**58,627**	65,358	67,587
2. Emergency Medical Rescue Services	-	-	-	**-**	-	-
3. District Hospital Services	7,875	19,615	77,224	**41,957**	**64,992**	69,299
4. Provincial Hospital Services	7,875	19,614	3,632	**17,982**	**27,853**	29,699
5. Central Hospital Services	-	-	-	**-**	-	-
6. Other Facilities	-	-	-	**-**	-	-
Total programmes	26,250	65,381	134,759	**118,566**	158,203	166,585

Provision of funds for facilities management includes conditional grants for hospital revitalization and the infrastructure grant, as well as the provincial allocation from the equitable share.

16. CENTRAL HOSPITAL SERVICES

There are no central hospital services in this province.

17. HEALTH SCIENCES AND TRAINING

17.1 SITUATION ANALYSIS

17.1.1 Policies and strategies informing Human Resource Development

i) Skills Development Act and Skills development Levies Act
   - Encourages employees to use workplace as an active learning environment

ii) Departmental Policy on Human Resources Development
   - Coordination of training, bursaries and grants

iii) Departmental Workplace Skills Plan
   - Links the training plans with strategic plan

iv) Employment equity Act and Employment Equity Plan
   - Promotes equality in the workplace
   - Audits inform appointment plans

v) Nursing Act and related regulations
   - Promotion and maintenance of professionalism and effective standards for education and practice

vi) Higher Education Act
   - Guides the placement and governance of institutions of higher learning

vii) SAQA Act
   - Facilitates the implementation of the NQF and establishment of SAQA

17.1.2 Training needs assessment and gap analysis

- ✓ Previous student intake was high (100 students) and presently has been reduced to a number of 50 per annum
- ✓ Tutor to student ratio is still high, which makes it difficult to reach all students for both theory and practical
- ✓ Infra-structural problems, e.g. lack of transport for accompaniment, lack of classrooms for large intake of learners, curtail the number of learners to be trained. Due to the current tutor learner ratio (one tutor to fifty learners instead of one tutor to twenty learners), availability is limited to structured accompaniment programmes and block periods
- ✓ Introducing training of professional nurses in speciality programmes / post basic programmes, e.g. Advanced Midwifery, Paediatric nursing Theatre technique would strengthen clinical knowledge for basic learners who will be have human resource with advanced skills at hand
- ✓ The challenge of HIV/AIDS infections which will have an impact on the training needs in the long term. An attempt has been made to link needs analysis to the Departmental strategic planning. Consultation was initiated with institutional training committees
- ✓ Generally, training is not linked to organisational needs but to individual needs with the exception of the Cuban programme (doctors and electro medical engineering). This programme was derived from the challenges facing the Department
- ✓ The challenge to link training to Departmental HR requirements thus remain

17.1.3 Numbers and types of institutions for health professions education in the province

The North West Province has two universities and two nursing colleges. NWDoH provides posts to the two universities for the basic nursing degree.

Table 55 : *Courses offered per Institution*

INSTITUTION	COURSES OFFERED	MAIN CATEGORIES OF PERSONNEL TRAINED	QUALIFICATIONS OF FACULTY STAFF
University of the North West (UNW)	Degree in Nursing Science –	Professional nurses	100% post graduate degrees
Potchefstroom University (PUCHE)	Degree in Nursing Science	Professional nurses	100% post graduate degrees
Excelsius Nursing College	Diploma in Nursing and Midwifery (basic nurse programme)	Full time training for school leavers, enrolled nurses and enrolled nursing auxiliaries – outcome: Professional nurses	22 Nurse educators, the college principal and vice principal – 90% basic degree with additional qualification in nursing education
	Diploma in Midwifery – Full time training for professional nurses with registration as general nurse	outcome: Professional nurse with registration in midwifery	
	Diploma in Theatre nursing Science (post basic programme) – Full time training for professional nurses with basic nursing registration	outcome: Professional nurses with an additional qualification in theatre nursing	
	Diploma in Nursing (Bridging programme) – Full time training for enrolled nurses	outcome: Professional nurses with basic registration in general nursing	
	Diploma in Community Nursing (post basic programme)	Full time training for professional nurses with basic nursing qualifications	

INSTITUTION	COURSES OFFERED	MAIN CATEGORIES OF PERSONNEL TRAINED	QUALIFICATIONS OF FACULTY STAFF
Mmabatho College of Nursing (MMACON)	Diploma in Nursing and Midwifery (basic nursing programme)	– Full time training for school leavers, enrolled nurses and enrolled nursing auxiliaries – outcome: professional nurses	22 Nurse educators- 100% basic degree with an additional qualification in nursing education, and 40% post graduate degrees
	Diploma in Midwifery – Full time studies for professional nurses with registration as a general nurse	outcome: professional nurses with registration as a midwife	
	Diploma in psychiatric nursing – Full time studies for professional nurses with registration in general nursing and midwifery	outcome: professional nurses with an additional qualification in psychiatric nursing	

Table 56 : *Appraisal of training programmes during the past year : Mmacon Nursing College*

Programme	Total number on training	Number Qualified	Attrition
Diploma in Nursing & Midwifery (R425)	187	34	2
Diploma in Midwifery	55	27	29
Diploma in Psychiatric nursing	9	4 -	5

Table 57 : *Appraisal of training programmes during the past year : Excelsius Nursing College*

Programme	Total number on training	Number Qualified	Attrition
Diploma in Nursing Science (General, Psychiatric, Community) and Midwifery	242	17	11
Diploma in General Nursing Science (Bridging Programme)	99	55	2
Diploma in Midwifery	56	43	1
Diploma in Clinical Nursing Science, health Assessment, Treatment and Care	56	72	0
Diploma in Operating Theatre Nursing Science	7	0	0

17.1.4 Main areas of Health research

Research over this MTEF period will focus on:-

- HIV/AIDS/STIs ;
- TB;
- Nutrition;
- Traditional Medicine;
- Human Resources;
- Health Promotion;
- Pharmaceuticals;
- Evaluation Research;
- Health Information;
- Trauma; and
- EMS

17.1.5 Key Challenges Over Strategic Period

- Linking all training to the Departmental strategic plan and needs of institutions (vs funds to fund posts for placement of qualifying nurses) Linking output of nurse training to departmental HR needs, particularly in the face of the impact of HIV/AIDS infections.

- Achieving access for learners from disadvantaged communities at PU for CHE. Discussions held with the University and Provincial Youth commission on ways of addressing equity issues.

- Upgrading the skills of enrolled nurses to be become professional nurses: gaps created in our services
  - Presently Nursing Education Institutions need extra tutors to be able to do effective facilitation and meet the ratio of 1:10(nurse educator to learner ratio)
  - Colleges need extra drivers for effective implementation of CBL
  - Within the area of material resources there is shortage of bigger classrooms to accommodate 100 learners and transport to ferry learners to and from various practical areas.
  - Shortage of subsidized cars seriously affect accompaniment of learners in various clinical facilities
  - Implementation of community based education within the limited human and material resources.

17.2 PRIORITIES AND BROAD STRATEGIC OBJECTIVES

17.2.1 Training Programmes for Primary Health Care Nurse Training

- **Approach :** To train in the province for the province
- **Strategic Priority:** To ensure that all professional nurses working in PHC settings are trained in PHC skills.
- **Target :** To train 20 professional nurses /school/an so that all clinics will be staffed with PHC trained nurses by 2005
- **Duration of Re-orientation Programmes:** six months

17.2.2 Training Programmes for Mid-level workers

- Dentistry
- Pharmacy (To accelerate the training of pharmacy assistants)
- Radiography
- Physiotherapy
- Will be implemented in association with Academic institutions that have tertiary links with the Department
- Nursing
  - Training for enrolled nurses was discontinued in 1996
  - Training for enrolled nursing auxiliary is implemented in various hospitals throughout the province

17.2.3 Structured in-service Education/continuing professional Development Programmes

- There is no policy or structured Departmental programme
- Each institution arranges its own in-service programme which is not differentiated from skills development and other training
- Thus to be linked to the MTEF this needs to be addressed

17.2.4 Curriculum Innovation and Development

- Community Based Education incorporating the Problem Based Learning approach has been implemented in the basic 4 yr. diploma in nursing
- All post basic programmes need to be reviewed to be in line with CBE, PBL & outcomes based approach
- National priority programmes are to be incorporated into basic & post basic nursing programmes

17.2.5 Uses of Conditional Grant for Health Professional and Development

- R30 890 000 for the financial year 2002/03 is utilized for day to day management of colleges which includes costs incurred for basic programmes & diploma in midwifery

- R2 800 000 has been targeted for the planning & development of post basic programmes that would support provincial hospitals (Operating Theatre Technique, Critical Care Nursing, Paediatric Nursing & Advance Midwifery)

- R4 200 000 has been targeted for the appointment of registrars & specialists at provincial hospitals

17.2.6 Health Research Policy

- The policy is based on the flow chart which incorporates the flow chart for research projects requesting permission only and those requesting permission and funding, i. e.:
  (i) he researcher submits research proposal to NW Department of Health for permission only, then 3 people review the proposal and submit comments to DRC chairperson within 3 weeks
  (ii) DRC chairperson writes researcher within 1 week indicating whether or not permission is granted
  (iii) If funding below R7 500 is requested then same process as when requesting permission is followed, if funding is approved then chairperson writes motivation to Finance to release funds which must be paid within 3 weeks
  (iv) If funding is rejected a letter is written to the researcher within 1 week by chairperson
  (v) If funding is approved then researcher should submit a quarterly report regarding research progress and expenditure (including receipts where possible, otherwise statement on use of money for particular activities, e.g consumables, own time spent, etc., and should be in line with his/her work plan / budget.
  (vi) Department may withdraw funding to a researcher if expenditure and progress reports are not submitted on a quarterly basis and there is no clear indication that money was utilised for research purposes only.

17.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Table 58 : *Analysis of Constraints*

AREA	CONSTRAINTS
To train 20 professional nurses per nursing school per annum (100 /yr.) in PHC	
Finance	No constrains
Personnel	Mentors not appropriately placed i.e. in accredited facilities
Organization & Management	- PHC is a post basic diploma. Therefore it is at level 6 on the NQF but is placed regionally. - Quality control in terms of academic standards is thus questionable. - Staff shortage compromises the targets set for training i.e. Professional nurses are not released for training
Physical Infrastructure	Limited infrastructure for training Services: there is no programme in place for retention of trained staff
PLANS TO OVERCOME THESE	
➢ Regional management structures to ensure that all accredited facilities are staffed with mentors ➢ Nursing schools should be assessed for infrastructural upgrading ➢ Placement of PHC training should be objectively reviewed i.e as a higher programme it should be placed at institutions of higher education.	
AREA	**CONSTRAINTS**
Training Programmes for mid-level workers **To accelerate training of employees in targeted learnerships and to upgrade auxiliary workers**	
Finance	Institutions are expected to carry all costs related to training & often have not planned for such training
PLANS TO OVERCOME THESE	
Contribution toward the skills levy needs to be reviewed to serve as a source of funding for skills development	

AREA	CONSTRAINTS
To provide targeted Training (Skills Development and In-service Education)	
Finance	Contribution towards skills levy needs to be reviewed to serve as source of funding for skills development
Personnel	One skills development facilitator for the Department not realistic especially with a staff complement of 17,000 Absence of posts for training officers at all institutions compromises training programmes
Organisation and Management	There is no uniformity in terms of posts for training coordinators
Physical Infrastructure	
PLANS TO OVERCOME THESE	
➢ Review staff structure at regional & institutional level with the view to appointing skills development facilitators & training coordinators at district /institutional level. ➢ HRD sub directorate should be capacitated to plan and implement in house training programmes (curriculum development etc.) ➢ Needs analysis to be aligned toward improving organizational efficiency i.e. linkage with WSP & strategic objectives ➢ Needs analyses collated at institutional & regional level should be endorsed by organized labour	
AREA	**CONSTRAINTS**
To ensure that Curricula innovation is dynamic and that all Curricula incooperate National priority programmes	
Finance	- Budget of colleges compromises effective functioning; - Current financial year reflects an over expenditure on almost all standard items
Personnel	- Inadequate teaching staff - Ratio of nurse educator/learner 1:50, instead of 1:10 - No student counselors - Inadequate number of drivers
Organisation and Management	- Education & training vs. Service delivery (core function of the Department overshadows education & training) - Annual authorization for appointment of students is a drawback to efficient planning

Physical Structures	- Insufficient office space - Inadequate library facilities& equipment - Small classrooms - Other facilities for student training, e.g. research facilities are lacking
PLANS TO OVERCOME THESE	
- The budget of colleges should be reviewed in line with outputs & specifically the expenditure incurred for support & administrative activities] - Review of college's post structure is essential to maintain quality in education & training - The process for annual authorization of posts should be replaced with an HR plan that outlines targets for training for the next five years - Colleges should be assessed & included in capital projects for the Department - Current affiliation agreements with Universities need to be evaluated	
AREA	**CONSTRAINTS**
Health Research	
Finance	- Researchers have not been funded for two years in succession. - This is due to the fact that researchers have not complied with the requirement of the Department - The above requirements were sent to researchers after research proposals were are approved
Personnel	- Only one staff member is appointed in an official research related post. - Members of the Departmental research committee are not fully capacitated to review research proposal for post graduate degrees
Organisation and Management	Researchers do not submit reports on completion of research

17.4 DESCRIPTION OF PLANNED QUALITY IMPROVEMENT MEASURES

a) Improve the capacity of the Provincial Curriculum committee of the province
b) Institution based quality and peer review committees to be established.
c) Accelerate the training of moderators, assessors and verifiers
d) Put in place academic support programmes for candidates who access training through RPL process.
e) Promote effective use of the workplace skills plan
f) Set guidelines for structured in-service programmes
g) Capacitate health care workers in research methodologies

17.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 59 : *Specification of measurable objectives*

Objective	Indicator	2002/3 (actual)	2003/4 (target)	2004/5 (target)	2005/6 (target)
Train nurses in basic programmes which incorporates CBE, PBL, & RPL approaches	Number of nurses in training	421	468	552	628
Provide relevant and targeted training programmes to enhance performance	Number of nurses in post basic programmes	317	386	345	345
Improve the learners' pass rate at the colleges at all levels	% pass rate at each level	77%	80%	83%	88%
Ensure that all training programmes are accredited	Percentage of training programmes accredited	100% of nursing programmes accredited	50% of new nursing programmes accredited 50% of skills programmes accredited	100% of new nursing programmes accredited 50% of skills programmes accredited	100% skills programmes accredited
Provide the necessary support for personnel development to improve their abilities	Percentage of bursaries and study leaves awarded annually	75%	80%	85%	90%
	Percentage of employees identified for appropriate learnerships	0	25%	45%	60%
	Number of learners recruited to participate in the Cuban scholarship	20	20	20	20
Develop research capacity in the Province	Number of functioning regional committees. Number of research projects funded by the Department. Number of regional research conferences conducted annually.	2 2 2	4 4 3	4 6 4	4 6 4

17.6 PERFORMANCE INDICATORS FOR INSTITUTIONS OF HEALTH SCIENCES AND TRAINING

Table 60 : *Performance Indications and Targets per year*

Please tick institution type: ☒ university □ technikon ☒ college/school of nursing

Indicator	Province Wide value	By Institution							
		Actual 2002/3		Target 2003/4		Target 2004/5		Target 2005/6	
		Nursing college x 2	University x 2	Nursing college x 2	University x 2	Nursing college x 2	University x 2	Nursing college x 2	University x 2
Input									
1. Number (and percent change) in intake of students by main category (at least for medical courses, basic & post basic nursing courses and mid-level worker training									
1.1. Diploma in Nursing & Midwifery	421	248	173	281	187	370	186	442	186
1.2. Diploma in general nursing	94	94	0		0	0	0	0	0

Indicator	Province Wide value	By Institution							
		Actual 2002/3		Target 2003/4		Target 2004/5		Target 2005/6	
		Nursing college x 2	University x 2	Nursing college x 2	University x 2	Nursing college x 2	University x 2	Nursing college x 2	University x 2
(Bridging programme)									
1.3. Diploma in Midwifery	86	86	0	151	0	90	0	90	0
1.4. Diploma in Psychiatric nursing	9	8	0	15	0	15	0	15	0
1.5 Diploma in Operating Nursing Science	7	7	0	15	0	15	0	15	0
1.6 Diploma in Clinical Nursing Science Health Assessment Treatment and care	122	140	0	100	0	120	0	120	0
1.7 Diploma in Advance Midwifery	0	0	0	30	0	30	0	30	0
1.8 Diploma in Critical care	0	0	0	10	0	15	0	15	0
1.9. Diploma in Paediatric nursing	0	0	0	10	0	15	0	15	0
1.10 B Cur – full time	74	0	74	0	0	0	0	0	0
1.11 B Cur (Ed et Adm)		0	574	0	0	0	0	0	0

Indicator	Province Wide value	By Institution							
		Actual 2002/3		Target 2003/4		Target 2004/5		Target 2005/6	
		Nursing college x 2	University x 2	Nursing college x 2	University x 2	Nursing college x 2	University x 2	Nursing college x 2	University x 2
Process									
2. Improved representation of disadvantaged demographic groups and students of rural origin in Nursing college intake									
2.1 Number of males	57	57	0	30	10	30	10	30	10
2.2. Number of females	267	177	90	40	15	40	15	40	15
2.3. Number of Africans	433	369	94	46	16	50	16	50	16
2.4. Number of Asians	2	2	0	6	12	30	12	30	12
2.5. Number of Coloureds	15	13	2	8	12	30	12	30	12
2.6. Number of Whites	108	18	90	20	10	30	10	0	0
3. Proportion of mid-level training programmes	65	65	0	49	0				0
4. Number (percent change) of basic graduates by category									

Indicator	Province Wide value	By Institution							
		Actual 2002/3		Target 2003/4		Target 2004/5		Target 2005/6	
		Nursing college x 2	University x 2	Nursing college x 2	University x 2	Nursing college x 2	University x 2	Nursing college x 2	University x 2
4.1 Basic programmes	88	Excelsius – 54 (71%) Mmacon: 34 (80.5%)		80	0	82	85	0	0
5. Numbers(percent change) of post basic graduates by main category									
5.1 PHC	93	Excelsius: 61 (100%) Mmacon: 32 (100%)		90	0	90	0	90	0
5.2 Midwifery	114	Excelsius: 72 (82%) Mmacon: 42 (76%)		0	0	0	0	0	0
5.3 Community Nursing	22	Excelsius: 22 (81%)		0	0	0	0	0	0
Psychiatric nursing		Mmacon 4		12		15		15	
Quality									
6. Attrition rates per entrants who graduate from				0	0	0	0	0	0

Indicator	Province Wide value	By Institution							
		Actual 2002/3		Target 2003/4		Target 2004/5		Target 2005/6	
		Nursing college x 2	University x 2	Nursing college x 2	University x 2	Nursing college x 2	University x 2	Nursing college x 2	University x 2
formal training courses by main category of course									
6.1 Diploma in Nursing & Midwifery	4	Excelsius (3) Mmacon (1)	0	3	0	3	0	4	0
6.2 Diploma in Midwifery	26	26	0	5	0	5	0	5	0
6.3 Diploma in general nursing	0	0	0	0	0	0	0	0	0
6.4 Diploma in Psychiatric nursing	5	Mmacon 5	0	3	0	2	0	0	0
6.5 Diploma in Community Nursing	0	0	0	0	0	0	0	0	0
6.6 Diploma in Clinical Nursing Science Health Assessment Treatment and care	0	0	0	0	0	0	0	0	0
7. Percentage of first year entrants who graduate formal training	0	0	0	0	0	0	0	0	0

Indicator	Province Wide value	By Institution							
		Actual 2002/3		Target 2003/4		Target 2004/5		Target 2005/6	
		Nursing college x 2	University x 2	Nursing college x 2	University x 2	Nursing college x 2	University x 2	Nursing college x 2	University x 2
by main category of course									
Efficiency									
8. Average training cost per graduate by main category									
8.1 Basic programme (D4)	51000-0	51 000-00	same	55590-00	same	60593-00	same	66046-00	Same
Outcome									
9. Percentage of graduating doctors in a public service post within three months after completion of community service	0	0	0	0	0	0	0	0	0
10. Percentage of graduating professional nurses in a public service post within three months after completion									
10.1 Post basic	100%	100%	0	100%	0	100%	0	100%	0

Indicator	Province Wide value	By Institution							
		Actual 2002/3		Target 2003/4		Target 2004/5		Target 2005/6	
		Nursing college x 2	University x 2	Nursing college x 2	University x 2	Nursing college x 2	University x 2	Nursing college x 2	University x 2
students									

NB:
Information under INPUT –
1.1 – Numbers are inclusive of Enrolled nurses & Enrolled nursing assistants following the programme
1.2 – No targets set for subsequent years because Bridging programme is phased out
1.3 - The increase during 2003/2004 is due to nurses following a three year study- moving from bridging programme to midwifery
1.10 – Universities unable to provide information for subsequent projections
1.11 – 2002/2003 actuals include students in other provinces on distant learning with the universities

17.6.1 PROGRAMME 6 : HEALTH SCIENCE AND TRAINING

Table 61: *Programme Summary of Expenditure According to Programme*

Sub-programme (R'000)	Programme Summary of Expenditure and Estimates					
	2000/ 2001 Actual	2001/ 2002 Actual	2002/ 2003 Est. Actual	2003/ 2004 MTEF	2004/ 2005 MTEF	2005/ 2006 MTEF
1 Nurse Training Colleges	27,287	26,922	37,447	**47,228**	56,387	61,589

2. EMS training colleges	354	1,353	1,213	**2,500**	1,900	1,950
3. Bursaries	450	1,132	-	**-**	-	-
4. Primary health care training	1,969	3,066	4,770	**6,166**	12,349	11,764
5.Training Other	2,950	3,146	2,639	**7,997**	5,047	6,014
Total programmes	33,010	35,619	46,069	**63,891**	75,683	81,317

The programme's budget has increased by 39% over the current financial year. The main increases are in nurses training colleges at 27%. Personnel costs have increased by 27% over the current financial year. The programme has been previously under funded due to the programme being funded solely on the conditional grant.

Transfer payments have been increased by R4.6 million to cater for arrear transfer incurred for Cuban students in the previous financial year.

Training for EMS has also been budgeted for in this programme