DEPARTMENT OF HEALTH

STRATEGIC PLAN 2005 - 2008

HEALTH FOR BETTER LIFE!

Department of Health

Strategic Plan 2005-2008

04 April 2005

TABLE OF CONTENTS

PART A. STRATEGIC OVERVIEW

1 Foreword by the Executive Authority

It gives me pleasure to put forward the Departmental three year strategic plan for the Medium Term Expenditure 2005/2008 cycle. The plan is based on the format for strategic plans of Provincial Health Departments and guided by National Health and Gauteng Provincial Government priorities. In addition the plan takes account of the inter-sectoral priority programmes, ensuring that services are optimally integrated and co-ordinated for easy access by communities and delivered in a manner that represents value for money from the public resources invested.

The endorsement of this plan represents the priorities for this term of government. Considerable progress has been made in improving the health of our communities and improving access to health services, promoting gender equity and quality of our health services.

We remain committed to the vision of ***'Health for a Better Life' as*** health is both a pre-condition as well as an outcome of development.

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

A number of strategic goals that will lead to improved health status of the people in Gauteng in the next five years have been identified.

- Promote health, prevent and manage illnesses or conditions with emphasis on poverty, lifestyle, trauma and violence and psychosocial factors
- Effective implementation of the comprehensive HIV and AIDS strategy
- Strengthen the district health system and provide caring, responsive and quality health services at all levels
- Implement the people's contract through effective leadership and governance
- Become a leader in human resource development and management for health
- Operate smarter and invest in health technology, communication and management information systems

Great challenges lie ahead to further extend access to our services and to improve the quality of the care we provide. However, in all humility, I feel that I can claim, on behalf of the Department and all those who have worked tirelessly that we have delivered in this first Decade of Democracy and have laid a firm foundation for an excellent health service in our Province. We will continue to deliver in this next term of government, at an accelerated rate, the kind of health care to all our citizens that is worthy of the noble principles enshrined in our national Constitution, and of the sacrifices made by so many of our forebears to give us back our freedom and our dignity.

2 Foreword by the Head of the Department

The third term of government provides an excellent opportunity to deliver on the new mandate of government. Our primary constituency is vulnerable and poor communities, whose lives are most adversely affected by poor living and working conditions and preventable diseases, including HIV and AIDS. Our services aim to reach the broad Gauteng population with a range of interventions that include health promotion and public health programmes to influence lifestyle and behavioural change, primary health care, hospital and emergency medical services and a vast range of clinical and non-clinical support services.

This strategic plan which covers the 2005/2008 Medium Term Expenditure Framework period gives us the opportunity to re-commit ourselves to the vision of ***Health for a Better Life***. This vision has also been adopted as our vision 2014 that will guide our efforts over the next 10 years. In the accompanying strategic plan, we commit ourselves to 6 strategic goals that have been enumerated by the MEC for Health.

Our environmental analysis and 10 year review shows that we have made important strides in turning around the inherited apartheid era health system and have laid the legislative, policy and structural foundation on which to realise our vision. A number of our health status indicators show the considerable progress made since 1994. In going forward we need to consolidate on the gains made and address the challenges outlined in the main body of the document.

Our strategic direction supports the strategic position statement driven by the national Department of Health. During this MTEF, we will continue the implementation of an ambitious Services Improvement Plan (SIP), to re-organise our service for improved health status and affordability, and the implementation of a more affordable and equitable staff establishments. The latter will be supported through the implementation of our human resource development strategy, which (among other things) is aimed at positioning us as an employer of choice. We are committed to the successful implementation of this strategy which will be rolled out over the short to medium term. A phased approach with effective communication is important for effective organizational change.

Our values, key priorities, strategies and resource requirements are outlined in this strategic plan. Intensive and on-going support for the HIV and AIDS expanded programme in partnership with other government departments and all relevant stakeholders will remain a key focus for the period of the MTEF. We will continue to focus our attention on health programmes that have the greatest impact on health outcomes.

The priorities outlined in the strategic plan require the strengthening of all management systems in the Gauteng Department of Health, service delivery and our ability to monitor and evaluate health outcomes vis-à-vis investments made. Key prerequisites for our ability to

mitigate the effects of AIDS are management commitment, community / stakeholder involvement, effective service delivery models and adequate dedicated resources.

The provision of quality health care is an ethos to which we commit ourselves to and this will remain a strategic priority for the MTEF period. An additional area of focus is that of ensuring that attitudes from frontline staff to central office top management are consistent with delivering on the Patient's Rights Charter and Service Pledge.

We will also aim to maximise revenue from patient fees, and our Folateng wards will be expanded to increase the number of private patients at our facilities and to position ourselves for national health care financing restructuring initiatives.

Special efforts will be made to reduce the backlog of infrastructure and equipment, but this requires significant funding. In this regard we will investigate the viability and cost effectiveness of utilising Public Private Partnerships as a vehicle for innovative financing mechanisms to be able to realize the desired outcomes of our CAPEX programme.

The success of all the programmes of the Gauteng Department of Health is largely dependent on access to comprehensive, accurate health information. Our information management and information technology strategy is being finalised.

We have made progress in developing strategic plans that are linked to budgets. All our senior managers have been involved in the process of revising this MTEF strategic plan, and this process was cascaded to middle managers, and number of stakeholders through strategic planning workshops and consultative forum.

We have no doubt that we have the will, skills and expertise to tackle the challenges and deliver on our mandate.

3. Sectoral Situation Analysis

3.1 Demographic Profile

Gauteng constitutes 19.7% of the South African total population, making the province the second largest after Kwazulu Natal. The 2001 census revealed a total population of about 8.8 million people with 5.4% of the population being foreign born. The high population growth of 20.3% between 1996 and 2001 is both through in-migration of young adults in search of employment and natural increase.

Gauteng's population is predominately made up of Black Africans (73.8% of the total) followed by whites (19.9%), Coloureds (3.8%), and Asians (2.5%). There is a slight predominance of men (50.3%) to women (49.7%) as compared to the rest of South Africa where women are in the majority. Gauteng has relatively more people (72%) in the economically active age groups (15-64 yrs), compared to the national average (63%). Only 23.6% of the population were under 15 years of age and 6.2% over 60 years of age.

Gauteng is the most densely populated Province in South Africa. The distribution of the total population of 8.8 million is highly urbanised. Urbanisation in the province has diverse characteristics demonstrated by densely populated informal settlements on the periphery of the formal areas as well as peri-urban communities that are normally sparsely populated and situated far from economic development

According to the 1995 and 1999 Household Survey's the medically uninsured population of Gauteng increased from approximately 59.7% in 1995 to 73.1% in 1999. This means that there are additional pressures on the public health care system in the province as traditionally paying users resort to the public health sector. The escalating costs of medical aid will continue to force additional users to turn to the public sector for their health needs. According to Census 2001, 23.9% of households in Gauteng live in informal housing as compared to 16.4% for South Africa as a whole.

There are a very low percentage of households without toilets (3.6%) as compared to 13.6% for South Africa as a whole. Our improved access to running water, sanitation and health services have led to the decline of infectious diseases of childhood as the major cause of death. Gauteng has a relatively small area with poor sanitation and access to piped water in the (mainly rural) Metsweding District Municipality. This could pose as a threat for outbreaks of water-borne diseases and other health crises.

A review of health of the population of Gauteng shows a complex and wide burden of conditions or illnesses related to poverty, malnutrition, emerging and re-emerging communicable diseases such as HIV/AIDS, tuberculosis, trauma and violence; chronic diseases of lifestyle such as hypertension, diabetes and mental illness.

3.2 Abridged epidemiological profile

Table 1 below shows available information on mortality. The key 2003 SADHS results will only be available at the end of 2005

Table 1. Trends in key provincial mortality indicators

Indicator	SADHS 1998
Infant mortality (under 1)	36.3 per 1 000 live births
Child mortality (under 5)	45.3 per 1 000 live births
Maternal mortality Ratio	112 per 100 000 live births

1. Data should be taken from the SADHS in 1998 and 2003. Where reliable estimates for the intervening years are available these can be added to the table
2. Health goals, objectives and indicators 2001 to 2005, 3. Source: SADHS

Child Health

Good progress has been made on child health services in the province. The Expanded Programme on Immunisation (EPI) has markedly reduced the risk of children dying from vaccine preventable conditions. The immunisation coverage for children less than 1 year of age has increased from 72.4% in 1998 to almost 80% in 2003.The Mass immunization campaign conducted in 2004 achieved 90% and 91% coverage for polio and measles respectively with 1.4 million children immunized and has positively positioned the province to contribute to the goal of declaring South Africa 'polio-free' by 2005.

The HIV and AIDS epidemic is posing a challenge in that there has been an increasing trend in child (CMR) and infant (IMR) mortality rates in Gauteng. We await the latest South African Demographic and health survey. The implementation of the comprehensive HIV and AIDS strategy will have a positive impact in addressing these challenges overtime.

- In 1994/95 South African Vitamin A Consultative Group (SAVACG) study showed that about 23.5% of children aged 6-7 months have been found to be having vitamin A deficiency in Gauteng. Vitamin A supplementation has been prioritised as studies have shown that correcting vitamin A deficiency improves childhood morbidity and mortality. Stunting was the most common form of under-nutrition occurring in 20.4% of children between the ages 1 to 9 years. GDH continued to implement feeding scheme in 1718 crèches reaching 58219 children.

Women's health

The Saving Mothers Report, released by the Minister of Health on 8th March 2003, estimated a maternal mortality ratio of 112 per 100 000 live births for Gauteng. The major direct causes of deaths have been identified as hypertension in pregnancy, obstetric haemorrhage, early pregnancy related deaths (abortion and ectopic pregnancy), and pregnancy related sepsis, embolism and acute collapse.

Indirect causes of death include non-pregnancy related infection (mostly due to HIV and AIDS) and pre-existing medical conditions. A significant finding is that there has been a decrease in the proportion of early pregnancy related deaths due to ectopic pregnancies and septic abortions from 11.6% in 1998 to 7.7% for the period 1999 to 2001. It was also shown that the proportion of all nationally reported deaths occurring in Gauteng has been decreasing.

The Department has increased the access to contraceptive services including emergency contraception to improve the health status of women by reducing unwanted pregnancies and the risks associated with childbirth. The 2003 teenage delivery rate was approximately 6%, showing the impact of our various interventions such as the youth friendly health services, joint life skills programme, health promotion campaigns and partnerships.

Communicable Diseases

Notifiable Medical Diseases

There has been a fluctuating trend in 5 notifiable communicable diseases such as viral Hepatitis, Meningococcal infection, Cholera, Malaria and suspected measles. There were 4 cholera case reported in 2003 and no cholera case was reported in 2004.

Tuberculosis

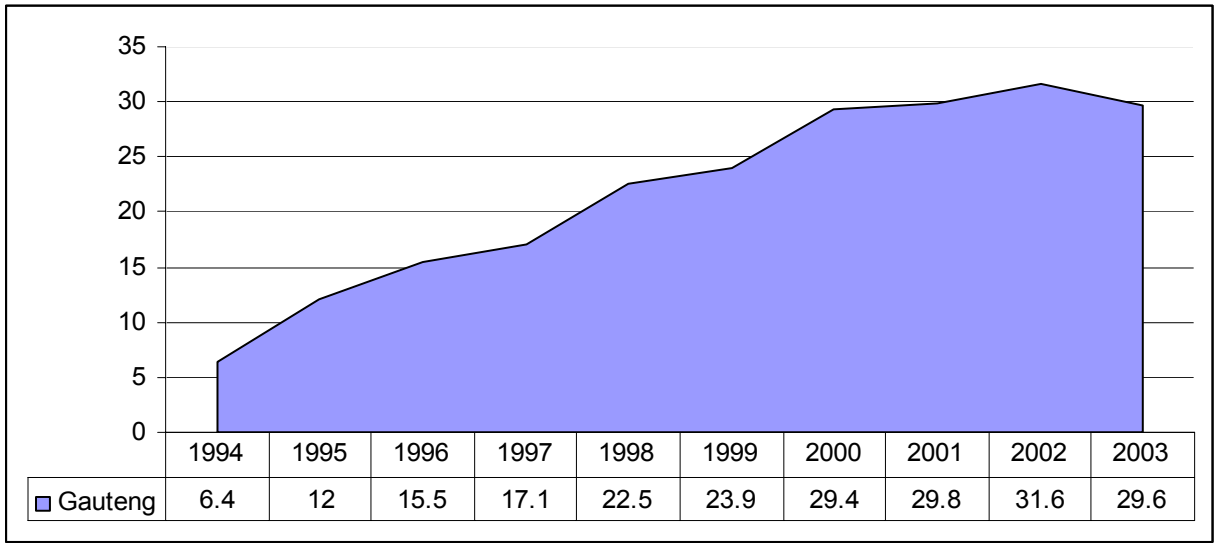
Gauteng has managed to implement the national TB control programme with a good level of co-ordination between the HIV and AIDS and TB programmes. Some district TB programmes have achieved cure rates of over 80%. Improved collaboration with the National Health Laboratory Services (NHLS) has led to improved turnaround for sputum results with 96% being available within a week and 60% within 2 days.

TB however, remains a major public health problem. In Gauteng, the number of new cases of TB (the incidence rate) has increased from 123 per 100 000 in 1998 to 373 per 100 000 in 2001.

HIV / AIDS and STI

The 2003 HIV sero-prevalence rate amongst pregnant women in Gauteng is approximately 29.6%. We are encouraged by the recent trends in sero-prevalence rates that suggest that rates of infection may be levelling off. As can be seen in figure 1, there appears to be levelling off of the epidemic over the last two years and this is a reason for cautious optimism.

Figure 1. Antenatal HIV sero-prevalence for Gauteng (1994-2003)



Source: GDH Annual Report 2001/02 and National HIV and Syphilis Antenatal Sero-Prevalence Survey in South Africa 2003

Results of the National HIV and Sexual Behaviour Survey of 15-24 year olds, conducted in 2003 shows the prevalence of HIV for youth living in Gauteng province at 9.2% as compared to Kwazulu Natal with 14.1%. Gauteng has the highest levels of awareness (91%) of the LoveLife programme designed to raise HIV awareness and promote prevention.

Chronic non-communicable diseases of lifestyle

Non-communicable diseases present a major health burden to the country. The epidemiological and health transition South Africa is undergoing has resulted in the country experiencing both poverty related diseases, trauma and an increasing number of people developing chronic diseases that are related to increased urbanisation and poor lifestyles.

The South African Demographic and Health Survey (SADHS) of 1998 included some of the lifestyle risk factors and commonly occurring chronic conditions in people above 15 years (which were self-reported). It was found that 42% of men and 12% of women in Gauteng smoked regularly (SA: Men-42%; Women-11%). There were higher smoking rates in urban areas than non-urban areas, particularly for women and the more educated smoke less than the less educated. The rates of smoking were highest among Coloured men and women. Ten percent of teenagers were found to be regular smokers

Violence and Trauma

High murder, assault and rape statistics constitute a public health problem. A 1998 study in our hospitals revealed over 1 million cases of trauma were treated during the year, at a cost to the health system of nearly R 0.5 billion, as well as untold misery and suffering to the injured and their families. We continue to implement awareness programmes and are beginning to see results of our inter-sectoral endeavours. An analysis of deaths at our medico-legal mortuaries shows that Gauteng has experienced a decrease of 21.8% in non-natural deaths between 1996 to 2003.

Mental Health

Mental health problems constitute 8.1% of the global burden of disease. The prevalence of disabling mental health conditions are about 15% to 20% in SA and 1% to 3% suffer from severe mental disorders. This would translate into about 100 000 to 250 000 people in Gauteng who have severe mental illness, while approximately 1.5 million would be less severely affected.

Oral Health

Oral health problems and specifically tooth decay (60% in children) is one of the most common diseases in South Africa. The burden of tooth decay however falls disproportionately on those who belong to the lower socio-economic groups. Oral manifestations of HIV infections are also increasing the burden of oral health problems. Seventy percent of patients with HIV infections present with oral lesions.

People with disabilities

According to Census 2001, the population for people with disabilities makes up 4% of the total population of Gauteng. In terms of disability breakdown, Sedibeng has (albeit marginally) the highest proportion of disabled people (5%) among its population, followed closely by Metsweding district (4.9%). Tshwane Metropolitan has the lowest proportion of disabled people (3.3%).

3.3. Intra and inter provincial equity in provision of services

The Department has started to move to an equitable allocation of the budget across the various regions since 2002-03. The publication of the 2001 census figures enabled the Department to do more accurate allocations. Equity should be achieved in the 2005-06 budget. One of the principles of the process was not to disadvantage any region regarding budget allocations but rather allocate above inflationary related resources to the previously disadvantaged regions. However due to resource restrictions, a challenge remain to allocate funds to Primary Health care to the level proposed in the Integrated Health Planning Framework.

3.4 Resource rends

Table 2: Trends in key provincial service volumes

Indicator	1999/00 (actual)	2000/01 (actual)	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)
PHC headcount in PHC facilities	8 635 785	9 640 812	10 088 379	10.4 million	12.5 million	11 million
PHC headcount in hospitals	Not separated from hospital headcount					
Hospital separations	708005	704009	719381*	758353	604704	763728

* Admissions

3.5 Our key achievements from 1994 to 2004.

Our achievements for past ten years as indicated below have taken into account achievements for the period 2001 to 2003.

We have improved the health of our communities

- Almost 80% of our children in the Province are vaccinated against infections of childhood.
- The 2004 Mass Immunisation programmes for Polio have contributed to the goal of declaring South Africa 'Polio-free' by the year 2005.
- The Integrated Management of Childhood Illness (IMCI) programme has helped to reduce childhood illnesses and prevent deaths. For example, diarrhoea among children less than 5 years decreased from 204 per 1000 (1998) to 59.4 per 1000 children in 2002.
- There has been improvement in many indicators of health with an overall decrease in the incidence of diseases such as measles, malaria and viral hepatitis.
- The Perinatal Problem Identification Programme (PPIP) and Kangaroo Mother Care have been implemented in hospitals in order to reduce the preventable causes of perinatal morbidity and mortality.
- Implementation of the *Termination of Pregnancy Act* has lead to a 33% decrease in deaths due to ectopic pregnancies and septic abortions.
- Programmes such as the cervical cancer-screening programme, campaigns on the prevention of violence against women, breast cancer awareness and the pregnancy termination services have contributed to an improvement of the health of women.
- The expansion of Sexually Transmitted Infection (STI) services in Gauteng has resulted in a decrease in the syphilis prevalence rate from a high of 16.2% in 1998 to 2.7% in 2003.
- In 2004 the Department's prevention of blindness campaign benefited 4 200 people through providing cataract surgery and corneal transplants.

We have established an equitable, non-racial and quality health system for the entire population

- The department has implemented free health care for children under the age of six and pregnant mothers.
- Our free primary health care services have improved access to care for Gauteng residents, from just over 1 million visits in 1994 to over 12 million in 2003.
- Every year, more than 100 000 women have supervised deliveries in our health facilities.

- We have implemented a large scale intersectoral HIV and AIDS programme, with a focus on social mobilization and communication, prevention, treatment, care and support and organisation.

- Every woman in the province has access to the Prevention of Mother to Child Transmission Programme for HIV/ AIDS, in all hospitals and community health centres with maternity services and 60% of clinics with antenatal services.

- The number of voluntary counselling and testing (VCT) sites has been tripled from 41 to 295 in 2004.

- Home-based care services are provided in all our municipalities.

- All our medico-legal centres and 29 other facilities provide post-exposure prophylaxis for HIV for survivors of sexual assault. 50.9% of facilities provide 24 hour service.

- Gauteng now provides more than 8 million condoms per month (up from 1 million in 1996) and high condom usage has been confirmed by surveys with sex workers and youth. Surveys have shown that the easy accessibility of condoms has led to 70% percentage of Gauteng's youth using condoms consistently.

- Services for people with disabilities have improved with over 90% of facilities being accessible to the disabled people. The wheelchair backlog has been cleared. Since 1994, we have provided more than 12 300 wheelchairs, buggies, hearing aids and walking aids to people with disabilities.

- We have established partnerships with mental health NGOs and provide subsidies for 4 777 clients with severe or profound intellectual disability or severe psychiatric disorders.

- During 2003, an independent survey found that 82% of people who used health care services in the past year were satisfied with our services. About three quarters of respondents indicated that they would recommend the use of government health services.

- We have implemented a comprehensive quality assurance programme, which includes the Patient Rights Charter and the Service pledge, Khanyisa Awards for Service Excellence, formal accreditation, training and other support systems to improve hospitality services.

- The Khanyisa Awards for Service Excellence encourage continuous quality improvement in health care and customer-oriented service, in line with the Batho-Pele principles.

- We introduced Folateng wards at four hospitals to cater for the needs of privately insured and medical aid patients.

We provide value for taxpayers' money

- We boast some of the finest health care professionals and Centres of Excellence at our

hospitals. Some of these Centres of Excellence include the: Spinal, Kangaroo and Paediatric Oncology units at Kalafong Hospital; wound, neurosurgery and eye units in the Dr George Mukhari Hospital; neurophysiology unit and medical oncology units in the Pretoria Academic Hospital, trauma and oncology units in Johannesburg Hospital; renal and hand units in Chris Hani Baragwanath Hospital; spinal unit in Natalspruit Hospital and the colorectal surgical unit at Helen Joseph hospital.

- We have successfully transformed the Gauteng health department into an organisation that is representative of the population it serves and has the capacity to deliver quality services. We have exceeded our employment equity targets, with 81% black staff, 77% female staff and 40% of women in senior and middle management positions. We employ 110 people with disabilities.

- We have increased the management and clinical skills of our staff in order to provide comprehensive services to address community needs. Since 1994, we have provided continuing education and training to more than 10 000 staff members per annum.

- We have strengthened our partnerships with our three medical schools and have entered into formal agreements with them to ensure a quality service platform for medical education.

- We have transformed nursing colleges in Gauteng, from institutions reflecting the previous apartheid planning to modern teaching institutions, which are responsive to the needs of the country**.**

- Great strides have been made in implementing information systems to improve efficiency. We have established modern, computerised health information systems, with successful implementation in 9 hospitals and 5 clinics.

- The implementation of the Public Finance Management Act (PFMA) has improved financial management, efficiency and accountability. For the financial year 2003/2004, the GDH received the unqualified audit for the Auckland Park Medical Supplies Depot from the Auditor -General. This is proof that the Department has made significant strides in providing better value for money and is becoming more effective as an organisation.

- Between 1997/98 and 2003/04, revenue collected has increased by 52% from R131 million to over R190 million.

- We have included community voices in governance, through the establishment of hospital boards, community health committees and other structures for participation.

4. Broad Policies, Strategic Objectives and Goals

The Province of Gauteng is the economic heartland of the country, contributing approximately 33% to the gross domestic product of South Africa in 2002. Within this context, the Gauteng Department of Health (hereafter referred to as GDH) subscribes to the vision of *"Health for a Better Life"*. As a public sector department, the GDH strives to achieve the goals of a good health care system. The goals reflect good health as the main

return on investment (ROI), a quality health care response to the communities' expectations and needs, financial viability, financial fairness (the poor are not left worse off) and a reduction of inequalities in service delivery.

During 2004 the Department of Health reviewed its priorities for the next MTEF period in consideration of the following

- The people's contract enumerated in the speeches of the President, Premier and related ministries.
- The priorities of the National Department of Health
- Provincial government's five year programme of action 2004-09
- Departmental five year programme of action
- Environmental factors, key health problems and challenges in the health sector
- Existing and proposed legislation

4.1 Alignment of Departmental goals with proposed National Health Priorities

Departmental Goals	National Health Priorities
1. Promote health, prevent and manage illnesses or conditions with emphasis on poverty, lifestyle, trauma and violence and psychosocial factors	• Promote healthy lifestyles • Improve management of communicable diseases and non-communicable illnesses
2. Effective implementation of the comprehensive HIV and AIDS strategy	• Form part of the communicable diseases priority indicated above
3. Strengthen the district health system and provide caring, responsive and quality health services at all levels	• Strengthen primary health care, EMS and hospital service delivery systems • Contribute towards human dignity by improving quality of care • Strengthen support services
4. Implement the people's contract through effective leadership and governance	• Improve governance and management of the NHS • Prepare & implement legislation • Strengthen international relations
5. Become a leader in human resource development and management for health	• Human resource planning, development and management
6. Operate smarter and invest in health technology, communication and management information systems	• Planning, budgeting and monitoring and evaluation

4.2 Alignment of Health strategic goals with GPG strategic priorities

Health goals	GPG priorities				
	Enable faster economic growth and job creation	**Fighting poverty and building safe, secure and sustainable communities**	**Fostering healthy, skilled and productive people**	**Deepening democracy and nation building and realizing the constitutional rights of our people**	**Building an effective and caring environment**
Promote health, prevent and manage illnesses or conditions with emphasis on poverty, lifestyle, trauma and violence and psychosocial factors	**X**	**X**	**X**		**X**
Effective implementation of the comprehensive HIV and AIDS strategy	**X**	**X**	**X**		**X**
Strengthen the district health system and provide caring, responsive and quality health services at all levels		**X**	**X**	**X**	**X**
Implement the people's contract through effective leadership and governance	**X**		**X**	**X**	**X**
Become a leader in human resource development and management for health	**X**		**X**	**X**	**X**
Operate smarter and Invest in health technology, communication and management information systems	**X**		**X**	**X**	**X**

4.3 Provincial Health Strategic Direction

Our Vision

The vision of the department is "***Health for a better life"***

Our Mission

The Gauteng Health Department aims to promote and protect the health of our people, especially those most vulnerable to illness and injury.

Through innovative leadership and management we provide quality health services and strive to:

- Ensure a caring climate for service users

- Implement best practice health care strategies
- Create a positive work environment
- Provide excellent and appropriate training for health workers
- Listen to, and communicate with, our communities and staff
- Establish management systems for effective decision making
- Forge partnerships with others
- Obtain the greatest benefit from public monies

Our work is reflected in the enhanced well being of our clients and staff, the social and economic development of our province and a more just society

4.4 Guiding values and principles

Underpinning our vision, mission and strategic priorities are a set of guiding values and principles:

- Listening to, communicating and working with the people
- Putting the poor and vulnerable groups at the centre of our initiatives
- A strong commitment to Batho Pele, service excellence and quality of care
- Entrenching the Patients' Rights Charter and our own Service Pledge
- Efficient and effective use of public resources
- Implementing the people's contract, share experiences and building partnerships with the private sector, universities, trade unions, other spheres of government and community based organisations to make our Province, our continent and the world a better place
- Equity in resource allocation and service provision
- Ensuring access to services, with an emphasis on the following key determinants:
  - Distance
  - Personnel attitudes and skills
  - Condition of facilities and equipment
  - Availability of medicines and supplies

- Ensuring sustainability and affordability of all initiatives
- Creating a conducive work environment and caring for our staff to enable the delivery of our mandate

4.5 Strategic Goals and Objectives

Each of the six strategic goals of the Department has a number of strategic objectives formulated through a consultative process. The goals and objectives serve as the platform from which the individual budget programmes strategic plans of the department is being developed for the MTEF cycle. Collectively the programme plans form the blueprint on which implementation towards the achievement of the goals can take place. Table 1 below shows the alignment of Departmental strategic goals with strategic objectives and the challenges faced in achieving the five year priorities.

Table 3. Departmental strategic priorities and corresponding strategic objectives

Overall Strategic Goals	Strategic Objectives
1. Promote health, prevent and manage illnesses or conditions with emphasis on poverty, lifestyle, trauma and violence and psychological factors **Key challenges** • Understanding and responding to the needs of the poor and vulnerable groups • Providing information, education, communication (health literacy) to the community at large, emphasizing key risk factors that contribute to disease and deaths • Health outcomes are not commensurate with health care spending • Complex and wide burden of conditions or illnesses related to poverty, malnutrition, emerging and re-emerging communicable diseases such as HIV/AIDS, tuberculosis, severe acute respiratory syndrome; trauma and violence; chronic diseases of lifestyle such as hypertension, diabetes etc. • Addressing the problem of violence, including sexual abuse, against women and children • Addressing the burden of mental illness	• Increase public understanding and the practice of healthy lifestyles and key risk behaviours with a special focus on vulnerable groups and disadvantaged communities • Improve the health and well-being of children under six years and those at risk due to poverty • Improve the nutritional status of vulnerable groups, with special emphasis on people with chronic and debilitating conditions • Reduce preventable causes of maternal deaths • Improve early detection and intervention for cervical and breast cancer • Reduce high risk behaviour among youth with a focus on teenage pregnancy, smoking, alcohol and drug abuse • Reduce the prevalence and complications of TB and other communicable diseases • Reduce the prevalence and complications of common non-communicable diseases • Promote mental well-being and improve early diagnosis, treatment and support for people with mental illness • Provide rehabilitation and support to people with disabilities • Interventions to reduce impact of violence against women and children

2. Effective implementation of the comprehensive HIV and AIDS strategy

Key challenges

- Ensuring that prevention remains the foundation of the management of HIV/AIDS
- Mainstreaming the HIV and AIDS strategy, while ensuring other priority programmes continue
- Successful implementation of comprehensive care and treatment programme including ART
- Managing an increased number of acutely AIDS ill patients at health care facilities
- Implementing the workplace HIV and AIDS programme and reducing the impact of AIDS in the workplace
- Ensuring adequate AIDS programme management and administrative system capacity
- Strengthening monitoring and evaluation systems
- Training and supporting community health workers through NGOs
- Improving the nutritional status of PLWAs

- Prevent and reduce new HIV infections
- Reduce the incidence of sexually transmitted infections (STIs)
- Provide HIV and AIDS comprehensive care and treatment including ART in all sub districts by 2009
- Implement effective HIV and AIDS workplace programme in 100% of service delivery units
- Provide universal access to palliative care (home based care, hospice, step down facilities) to the population of Gauteng

3. Strengthen the district health system and provide caring, responsive and quality health services at all levels

Key challenges

- Higher than average growth in the Gauteng population largely due to in-migration with concomitant pressures on health service provision
- Implementation of the provisions of the National Health Act
- Weaknesses in the implementation of the District Health System and insufficient joint activities in the key areas of service delivery, human resources and financing between different spheres of government
- Implementation of community based services and those activities that will result in the greatest health returns
- Implementation of the Departmental Service Improvement Plan to ensure appropriate utilisation of services
- Providing effective emergency services for the entire population
- Greater demands for quality assurance with special focus on improving perception and actual quality of frontline service
- Reduction in waiting times
- Ensuring implementation of Batho Pele principles and that poor people are not further disadvantaged by the system
- Improving the ethos of health care, politeness and ethics
- Overcoming bureaucratic inertia and impotence and disempowering impact thereof especially on the poor and vulnerable
- Weaknesses in hospital management, accountability and responsibility
- Transfer of South African Police Services (SAPS) mortuaries to the Department
- Ensuring that various levels of health system function as an integrated whole
- Finalisation of Service Level Agreement between Local

- Ensure appropriate planning and monitoring of district health services at sub-district level
- Improve the quality and efficiency of primary health care service provision
- Provide 24 hour access to PHC and emergency medical services in all sub-districts
- Re-organise the District Health System for improved efficiencies and health outcomes
- Provide people centred care that recognises the dignity and uniqueness of each person
- Specific interventions to reduce waiting times at pharmacies and out-patient departments
- Ensure all hospital and clinics have full accreditation
- Position public emergency medical services as the preferred service provider for the 2010 soccer world cup
- Ensure the provision of rapid, effective and quality emergency medical services
- Ensure 100% access to ambulance services for obstetric emergencies
- Modernisation, re-organisation and re-vitalisation of all public hospitals into cost effective referral centres according to the service plan
- Strengthen the management of state aided hospitals and monitor compliance with SLAs
- Provide efficient and effective clinical support services (allied, laboratory, pharmaceuticals, blood services, radiology etc)
- Monitor compliance with norms and standards

4. Implement the people's contract through effective leadership and governance

Key challenges

- Ensuring that managers provide leadership and strategic direction to achieve departmental goals
- Clarify roles, responsibilities and accountability among central office, regions and all institutions
- Fostering partnerships between the department and academic institutions, the health professional councils, hospital boards, ward committees, non-governmental and community based organisations, the private sector, etc
- Ensure optimal departmental configuration of structure, people, systems and processes to support the execution of the strategy
- Leveraging the potential benefits of public and private partnerships, without sacrificing public sector goals of equity and redress
- Capacity to provide support to local government in playing a leadership role in service delivery
- Increased innovation around value adding processes within the department e.g. increasing share of African health tourism market

- Improve the capacity of managers and staff to manage and steer health sector transformation
- Build a broad coalition for change and forge partnerships between the department and academic institutions, the health professional councils, unions, hospital boards, ward committees, non-governmental and community based organisations, the private sector, etc
- Implementation of a comprehensive community health worker programme
- Strengthen community participation at all levels of the health system
- Ensure responsiveness to the Legislature
- Ensure implementation of relevant policies and legislative framework

5. Become a leader in human resource development and management for health

Key challenges

- Mainstreaming of gender and disability as part of the employment equity plan
- Retention of scarce and highly skilled professionals in public sector
- Recruitment and deployment of human resources that effectively addresses the needs of poor and vulnerable groups
- Implementation of a culture and practice of performance management
- Improving relationships with unions and professionals organizations
- Regain the pride in, and re-commitment to, the oaths of the health profession and getting all staff to live by the Batho Pele principles
- Impact of HIV/AIDS on staff and the workplace at large
- Low staff morale and productivity
- Senior management feeling overwhelmed due to inadequate middle management capacity
- Ensuring the desired return on training investment (including from academic institutions)
- Developing an affordable service and teaching platform at all levels of the health system
- Implementation of learnership/internship programmes

- Revised staff establishment
- Ensure the recruitment and retention of human resources
- Provide the service platform for high quality training and development and clinical research that is responsive to the needs of the country
- Implementation of the learnership/internship programme
- Implement an effective Performance Management System
- Ensure adherence to recognised human resource and labour relations management standards
- Implement strategies to achieve employment equity and to manage a diverse work force
- Implementation of the Gauteng health integrated wellness programme (EAP, HIV and AIDS work place and Occupational health and safety programmes)
- Building capacity of frontline managers

6. Operate smarter and invest in health technology, communication and management information systems

Key challenges

- Development of an Integrated Management Information System (MIS) to support decision-making, monitoring and clinical care
- Need to re-gear the communication strategies to be responsive to the needs of poor people
- Internal communication needs significant development and strengthening
- Inherited backlog of equipment exacerbated by high costs and lack of cost-effective procurement practices
- Medical inflation and currency fluctuations
- Reduction in certain national conditional grants and shifts of money for health from municipalities
- Planning processes linked to budgets and implementation capacity
- Increased leverage of preferential procurement to contribute towards BBEE
- Management of migration to the GSSC and monitoring of SLAs to institutions that has already migrated
- Implementing Cost Centre management strategy to reinforce allocation of equitable and appropriate budgets
- Re-enforcing a culture of cost consciousness to ensure alignment of expenditure with budget
- Financial management capacity (skills and

- Establish an integrated Management Information System (MIS)
- Ensure the implementation of an effective internal communication strategy to encourage staff participation, support and commitment
- Ensure the implementation of an effective external communication strategy that achieves community participation, and engagement of poor and vulnerable groups
- Improve financial management
- Ensure implementation and management of an efficient and cost effective supply chain management system
- Ensure the construction, rehabilitation, upgrading and maintenance of infrastructure
- Reduce the backlog of infrastructure and equipment

Within the environment at large and each of the strategic priorities, there are a number of challenges which have informed the manner in which the programme plans have been designed.

The Service Improvement Plan forms a basis for development of major components of the strategic plan and aligned to the 2014 vision and strategy of the Department.

4.6 A summary of the Service Improvement Plan (SIP)

The Service Improvement Plan represents a plan to establish appropriate service delivery mechanisms that represent sustainable quality care to realise healthy communities. It will result in the alignment of services for improved health outcomes and affordability, and will affect the human resource, finance and capex business drivers. Areas that are to be addressed by the plan include the higher capita cost, service organization, and appropriate health sector management of HIV and AIDS, academic service issues and psychiatric services.

The strategy is centred on two major, interlinking strands:

Service re-organisation for improved health status and affordability, notably:

- Significant increases in district health services (primary health care and district hospitals);
- Strengthening of regional hospitals;
- Smaller and more cost-effective central hospitals, with centres of excellence;
- A much stronger reliance on referral networks as against off-the street care.

Affordable and equitable staff establishments

- More realistic and affordable staff establishment, linked to service changes.
- Addressing critical staff and skills shortages in district health services, including hospitals
- Ensuring that there are more generalist doctors in terms of the skills distribution profile
- An overall increase in the number of nurses, especially mid level nurses
- Recruitment and retention of scarce skills especially allied health professionals
- Strengthening management across all institutions
- Fewer but appropriate number of posts for support staff.

The Service Improvement Plan brings to a logical conclusion the work previously done within the Department, while taking into account transformation initiatives at a national level.

The GDH is committed to the successful implementation of this plan, in a phased approach with effective change management within the organisation over a period of nine years. Implementation of phase 1 of the plan has commenced. Revised staff establishments formed the first part of the change process and have already been approved.

5. Past expenditure trends and reconciliation of MTEF projections with plan

Table 4. Trends in provincial public health expenditure {R million}

Expenditure	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF Projection
Current prices`1							
Total	6 837 576	7 688 039	8 189 984	8 943 840	-	-	-
Total per person	774	870	927	1 012	-	-	-
Total per uninsured person	1 067	1 200	1 278	1 395	-	-	-
Constant (2004/05) prices							
Total	8 328 168	8 526 035	8 615 863	8 943 840	9 257 806	9 899 554	10 355 396
Total per person	942	965	975	1 012	1 048	1 120	1 172
Total per uninsured person	1 299	1 330	1 344	1 395	1 444	1 545	1 616
% of Total spent on							
DHS	19%	20%	22%	22%	24241%	24164%	25%
PHS	20%	28%	30%	28%	28%	28%	28%
CHS	45%	37%	33%	32%	32%	29%	28%
All personnel	54%	51%	51%	51%	52%	50%	51%
Capital	**491 915**	**470 285**	**463 473**	**495 947**	**463 207**	**631 577**	**569 847**
Health as % of total public expenditure	2.60%	2.92%	2.60%	2.42%	2.22%	2.17%	2.09%

PART B. 2005-08 BUDGET PROGRAMMES AND SUB-PROGRAMMES STRATEGIC PLANS

PROGRAMME 1: ADMINISTRATION

The purpose of this programme is to:

- Provide political and strategic direction and leadership;
- Develop policies and legislation on health care provision;
- Provide leaderships and support for policy framework and guidelines in the implementation of priority programmes and
- Ensure implementation according to accepted governance practices.

Health Administration has two sub-programmes:

- Office of the Provincial Minister (or MEC)
- Management

Health Administration developed its plans for the MTEF from the platform created by the Department's strategic goals, and, specifically:

- *Strategic goal 4*: To implement the people's contract through effective leadership and governance;
- *Strategic goal 5*: To become a leader in human resource development and management for health; and
- *Strategic goal 6*: To operate smarter and invest in health technology, communication and management information systems.
- Provide support to strategic *goals 1, 2 and 3*

Situation Analysis for programme Administration

Gauteng's network of health institutions is managed through a central office in Johannesburg, and three regional offices, each covering a metropolitan and district council municipality.

The central office coordinates the work of the department by:

- Providing overall strategic direction;
- Allocating resources;
- Developing policies, norms and standards, and management systems such as financial and health information;
- Managing the inter-sectoral AIDS programme;
- Providing monitoring and evaluation;
- Liaising and coordinating internationally, nationally with other provinces and between provincial health departments, and with organisations within the province; and
- Overseeing cross-cutting issues such as gender and disability.

The regional offices:

- Lead and ensure strategic support closer to delivery units;
- Act as agents for decentralisation by assessing and building capacity of healthcare institutions;
- Ensure compliance with overall strategic direction, policies, norms and standards;
- Ensure delivery of provincial/regional services and priorities; and
- Liaise coordination with relevant organisations in their region.

Appraisal of existing services and performance

The central and regional offices have facilitated major changes in a number of critical areas over the past year, namely:

Ensuring delivery of key priority health programmes

The central office ensures delivery through project management, training, systems development and co-ordination of key department priority health programmes. These programmes include the Expanded Programme on Immunisation (EPI) which is aimed at reducing the risk of children dying from vaccine-preventable conditions, The rest of the departments activities detailed under Programme 2, and public health programmes for TB control, and women and child health.

Reducing Maternal Mortality

The Department has established a new Peri-Partum unit headed by an obstetrician. The unit is tasked with implementing strategies for the prevention and reduction of avoidable maternal deaths and avoidable deaths of babies younger than 1 month. A Task Team was established at the central office to ensure implementation.

Effective implementation of the comprehensive HIV and AIDS strategy

The Department participates in, and co-ordinate the annual HIV survey of women attending antenatal services annually, which is one of the indicators, used to track the epidemic. The 2003 HIV sero-prevalence rate among pregnant women in Gauteng shows 2% reduction, from 31.6% in 2002, to 29.6% in 2003.

Strengthen the district health system and provide caring, responsive and quality health services at all levels

The previous financial year saw six Memorandums of Understanding signed between the MEC for Health and the Executive Mayors of the three metropolitans and the three District Councils. We are in the process of developing service level agreements with Local Government.

Become a leader in human resource development and management for health

The new GPG uniform performance management system that came into effect on 1 April 2003 is being implemented in all the institutions. More than 30 000 staff members received in-house training on the revised GPG performance management system. 96% of staff members were assessed for the 2003/04 financial year and the programme is continuing. SMS performance management system training sessions are currently conducted in all the regions and central office in order to improve the quality of the reports. Human Resource managers at institutional level were also trained on the SMS performance management system to ensure improvements in the implementation of the system.

A broad *Human Resource Strategy has* been developed. The strategy focuses on people management, recruitment and retention. The process of transforming the public sector through Resolution 7 ended in September 2003 and no staff was declared to be in excess. A new staff establishment in line with service delivery needs with an appropriate skills mix at all levels has been approved and is currently being implemented on the PERSAL system. More Senior Management posts have been created to strengthen the organisation and institutional support.

Road shows on human resource management practices were completed at 50 institutions. A student exchange programme with Kings College Hospital in the United Kingdom started in August 2003, with a group of 18 nurses. The nurses are guaranteed jobs on their return to SA and are expected to serve the Department for at least three years, assisting with staff retention.

The payment of scarce skills allowances in line with the National guidelines has been rolled out. The Department has also identified institutions that have problems in attracting and retaining skills to qualify for inhospitable allowances that will address the challenge of improving the morale as well as of attraction and retention of skills in such under-serviced areas.

The *Employment Equity Act* has been popularised and the charter is displayed at all institutions. Our staff composition is 81% black and 77% female, and women constitute 40% of senior and middle management posts. Although the Department employ 110 people with disabilities, it is still a challenge to attract an adequate number of such people into the organisation. We have also established a post of a Gender Focal Point in the Transformation & Special Programmes' unit to address gender and other transformation related issues in the department. The gender steering committee was established in December 2004.

Performance management is implemented through continued application of the Department of Public Service and Administration framework for the Senior Management Service; 96% of senior managers signed the Performance Management Agreements for 2003/04 financial year and 100% of hospitals and clinics implement the performance management system for levels 1-12.

We are poised to implement an integrated health and wellness programme, covering both HIV/AIDS in the Workplace and Occupational Health and Safety. A provincial wellness committee has been established according to the national standards. 25% of

the staffing complement of the Department has access to an Employee Assistance Programme. The process of reviewing and developing a policy for and integrated health and wellness programme is underway. The Department has built healthy social partnerships with organised labour that enhances service delivery as well as morale.

The adherence to the principles of Batho Pele and the wearing of appropriate uniform whilst on duty, including the display of name badges has been enforced in all the institutions.

Table 5: Provincial Public health personnel in 2003/04[1]

Categories	Number employed	% of total employed	Number per 1000 people[2]	Number per 1000 uninsured people[2]	Vacancy rate[5]	National average	
						% of total employed	Number per 1000 uninsured people[2]
Medical officers[3]	**1966**	**4.6%**	**0.26**	**0.21**	**35.3%**	N/A	N/A
Medical specialists	**1652**	**3.9%**	**0.22**	**0.17**	**15.3%**	N/A	N/A
Dentists[3]	**160**	**0.4%**	**0.02**	**0.02**	**63.5%**	N/A	N/A
Dental specialists	**63**	**0.1%**	**0.01**	**0.01**	**44.0%**	N/A	N/A
Professional nurses	**8120**	**19.1%**	**1.09**	**0.85**	**27.1%**	N/A	N/A
Staff nurses	**2756**	**6.5%**	**0.37**	**0.29**	**33.0%**	N/A	N/A
Nursing assistants	**5171**	**12.1%**	**0.70**	**0.54**	**18.7%**	N/A	N/A
Student nurses	**2142**	**5.0%**	**0.29**	**0.22**	**31.3%**	N/A	N/A
Pharmacists[3]	**290**	**0.7%**	**0.04**	**0.03**	**52.2%**	N/A	N/A
Nutritionists and dieticians[3]	**95**	**0.2%**	**0.01**	**0.01**	**35.4%**	N/A	N/A
Other allied health professionals and technical staff[3,4]	**1850**	**4.3%**	**0.25**	**0.19**	**67.9%**	N/A	N/A
Managers, administrators and all other support staff	**18308**	**43.0%**	**2.47**	**1.92**	**34.6%**	N/A	N/A
Total	**42573**	**100.0%**			**34.1%**	100	

1. *Provincial health personnel. local government personnel data not available*
2. *2001 projected Populations*
3. *Include interns and community service*
4. *This group comprises 'health therapists' (e.g. physiotherapists, speech therapists, occupational therapists, clinical psychologists, radiographers, environmental health practitioners, dental therapists) and specialised auxiliary service staff.*
5. *Against establishment*

N/A= Not applicable

Operating smarter and investing in health technology, communication and management information systems

Health Information and Communication

The national minimum data set has been implemented in all hospitals and clinics. A Computerised Patient Information System (MEDICOM system) was installed in nine hospitals and five clinics, and is being maintained by the State Information Technology Agency (SITA). The Patient Administration and Billing (PAAB) system and Pharm-Assist is implemented in all hospitals that have not implemented the MEDICOM system. The departmental information technology and management information system is being developed, and a marketing and communication strategy is implemented across the Department.

Improving revenue collection and capacity

A total of R198,7 million was collected for the 2003/2004 financial year, mainly from patient fees. This was an increase of 19.6% over the last financial year. The Department has entered into an agreement with Provincial Treasury on Revenue Retention, so that institutions have an incentive to improve revenue collection. The Revised 2005 Uniform Patient Fee Schedule tariffs have been implemented from the 1 March 2005. A debt management project has been implemented, and a debt management team from Central Office works with provincial institutions for periods of three months, to improve debt management procedures including patient administration and collection rates.

The Folateng initiative to attract private patients to public facilities has been implemented at Johannesburg, Helen Joseph, and Pretoria West hospitals, and Sebokeng Hospital will be operational from 1 April 2005. This will continue to be used as a strategy to generate revenue and encourage and improve revenue collection at institutions.

Financial Management

Gauteng received an unqualified audit report from the Auditor-General for 2002/3, which bears testimony to the strides made in financial management and improved budgetary controls. For 2003/4, the Medical Supplies Depot received an unqualified report, while a qualification was received on the updating of the asset register. The new Standard Chart of Accounts (SCOA) has been implemented successfully and an electronic asset register system implemented in 85% of institutions. A risk management policy and draft strategy and plan has been submitted to Treasury. Risk management committee established. Control Self Assessment (CSA) and risk management management roll-out has been initiated.

Community participation and Partnerships

There are functional hospital boards in 96% of hospitals and 60% of ward health committees are functional. The process of realigning ward health sub-committees in line with legislation is underway in partnership with the Local Government. The MEC's roving meetings are continuing and are held in all districts once a month.

Evening public meetings with community members conclude the roving meetings where direct inputs from the community members are obtained under constitutional principle of public participation in policy making

Strategic Goals, Objectives and Key Actions and Projects

The table below provides an outline of the Strategic Goals, Objectives (2004/09) and Key Actions and Projects for (2005/06) which form the platform for activities within this programme.

Table 6. Strategic goals, Strategic Objectives and Key Actions and Projects for Programme 1: Administration.

Strategic Goal	Five year strategic objectives (2004/09)	Key actions and projects
Strengthen the district health system and provide caring, responsive and quality health services at all levels	• Ensure all hospital and CHCs have full accreditation	• Accreditation process • Quality assurance
Implement the people's contract through effective leadership and governance	• Improve capacity of managers and staff to manage and steer health sector transformation	• Implement middle managers and CEO capacity building/ leadership programme
	• Build a broad coalition for change and forge partnerships between the department and academic institutions, the health professions council, unions, hospital boards, ward based health committees, NGOs, CBOs and the private sector.	• Develop and implement a programme for engagement with NGOs, CBOs, Local Government, traditional healers, other Departments, etc • Sign and implement revised memorandums of understanding with universities

Strategic Goal	Five year strategic objectives (2004/09)	Key actions and projects
Implement the people's contract through effective leadership and governance	• Implement a comprehensive community health worker programme	• Appoint dedicated project manager at central office • Establish steering committees at central and district level • Select and train Community Health Workers • Monitoring and evaluation
	• Strengthen community participation at all levels of the health system.	• Establish, maintain and capacitate community participation structures with special focus on hospital boards and Ward Based Health Communities through development of guidelines and training
	• Ensure responsiveness to the Legislature	• Define and implement target response times for legislature and public enquiries
	• Ensure implementation of relevant policies and legislative framework.	• Develop capacity to analyse implications of new legislation • Ensure compliance with legislation (Mental Health Act, Pharmacy Act, and New Employment equity, PFMA, New Health Act etc.) through planning and education of health care personnel

Strategic Goal	Five year strategic objectives (2004/09)	Key actions and projects
Become a leader in human resource development and management for health	• Revised staff establishment	• Revised staff establishment linked to service plans and in line with new mandate
	• Ensure the recruitment and retention of human resources	• Implement Service Improvement Plan in phased manner to increase number of health professionals • Induction programme and focus on values and code of service of the public service • Scarce skills allowance • Improved management systems, including communication • Upgrading and/or revitalisation of facilities and equipment • Exchange programmes and agreements with other countries • Implementation of career development plans for all levels of staff • Comprehensive retention strategy to reduce attrition rate of health professional in line with national norms
	• Implement an effective Performance Management system	• Improved marketing of performance management system • Staff training • Implement performance Management System that incorporates clear rewards and sanctions and enforcement of discipline • Dedicated CEO and other management training and capacity building

Strategic Goal	Five year strategic objectives (2004/09)	Key actions and projects
	• Ensure adherence to recognised human resource and labour relations management standards	• Improve strategic analytical capacity in department Training and capacity building of staff and managers • Relationship building exercises and partnerships with organized labour
	• Implement strategies to achieve employment equity and to manage a diverse work force	• Further increase appointment of women in management positions • Achieve employment equity targets set by the public sector 70% black; 30-50% women; 2% people with disability through a combination of recruitment, training and other strategies • Dedicated transformation unit • Monitoring of employment equity targets • Gender training for all senior management staff • Gender friendly environment through development of guidelines • Strategies to integrate disabled people in the workforce • Wider training and capacity building in diversity management
	• Implementation of the Gauteng health integrated wellness programme (EAP, HIV and AIDS work place and Occupational health and safety programmes	• Dedicated programme manager to focus on implementation in all health facilities • Implement International Labour Organisation (ILO) standards • Monitoring of the programme

Strategic Goal	Five year strategic objectives (2004/09)	Key actions and projects
Operate smarter and invest in health technology, communication and management information systems	• Establish integrated Management Information System (MIS)	• Develop and implement Information Management Strategic Plan • Budget prioritization • Provide training to support the increased utilization of accurate and timely information to aid decision making processes • Participate in the implementation of the e-governance framework
	• Ensure the implementation of an effective internal communication strategy to encourage staff participation, support and commitment	• Implement best practice models as follow-up to the social audit • Training and orientation to Batho Pele • Road shows and forums to enhance communication • Implement systems to achieve a decentralized and effective organization • Promote the corporate image of the Department
	• Ensure the implementation of an effective external communication strategy that achieves community participation, and engagement of poor and vulnerable groups	• Re-gearing the communication strategy with a focus on the poor and (other) vulnerable groups and our key stakeholders • Media training and management
	• Improve financial management	• Improve Financial Management by ensuring PFMA reporting through cost centres and strengthening financial controls • Ensure alignment between the service plan and the budget • Ongoing training and mentoring • Implement a risk management strategy • Align planning with budget processes
	• Ensure implementation and management of an efficient and cost effective supply chain management system	• Implement the preferential procurement strategy and the broad based black economic empowerment policy • Development and implementation of guidelines

Key 2005/2006 Priorities for programme Administration

Strengthen the district health system and provide caring, responsive and quality health services at all levels

- Continue with accreditation process
- Continue with implementation best practice strategies to address attitudes and improve morale of frontline staff
- Implementation of Pharmacy Act and Medicine and Related Substance Control Act

Become a leader in human resource development and management for health

- Realignment and refocusing of head office structure
  - alignment of HR architecture with Departmental strategy
- Implementation of Retention Strategy
- Improve employee morale
- Build management and leadership capacity
  - Coaching and mentoring
- Redeployment of staff
- Implementation of PMDS

Operate smarter and invest in health technology, communication and management information systems

- Improving financial management
  - Strengthening of NGO's in financial management
- Strengthening internal controls
- Roll-out of csa and risk management to 25% of sites
- Strengthening revenue and contract management in all hospitals
- Implementation of public private partnerships initiative – G4
  - Revitalisation of Chris Hani Baragwanath Hospital
- Implementation of cost centre accounting system

Operate smarter and invest in health technology, communication and management information systems

- Re-gearing the communication strategy with a focus on the poor and (other) vulnerable groups and our key stakeholders
- Implementation of the internal communication strategy
- Implementation of MIS and IT strategic plan
- Development and implementation of monitoring and evaluation system and (Dashboard system)

Analysis of constraints and measures planned to overcome them

Health Administration faces a number of constraints in achieving its strategic objectives. These are summarised below, with strategies to overcome them.

Constraint	Strategies
Lack of appropriate capacity to deal with multiple change initiatives taking place and challenges faced	• Prioritisation and focus • Implement the Service Improvement Plan • Provide a coordinating/streamlining service to align initiatives and leverage internal (and external) expertise to address challenges
Lack of accurate management information	• Ensure appointment IM and IT Chief Information Officer • Upgrade training of key personnel in the management information value chain • Training of staff • Enforce reporting
Non-optimal use of existing systems	• Orientate Departmental members on the role of IM in the department and role each person plays in contributing towards high quality information management.
Continuous restructuring/transformation initiatives	• Stabilise and consolidate initiatives
Slow implementation of cost centres	• Accelerate implementation of cost centre project plan

Quality Improvement Measures

The purpose of the Quality Assurance Directorate is to coordinate and encourage the improvement of quality of care in the health care institutions of Gauteng. After the establishment of the Directorate in October 2002 three sub-directorates were formed viz. Customer Care, Clinical Audit and Accreditation Support.
Quality Assurance involves taking positive action to assess and evaluate performance against agreed, defined standards. Gauteng's quality assurance framework is based on the belief that:

- Quality is the responsibility of all staff members;
- Quality improvement efforts must focus on the site where care is received;
- Quality of structures, processes and outcomes are equally important; and
- Batho Pele principles, including consultation, service standards, access, courtesy, information openness, transparency, and redress, remain mandatory.

In a quest to deliver quality care at all levels of the district health system, the Gauteng Health Department's Quality Assurance Programme is based on the belief that all members of staff at all levels carry an individual and corporate responsibility for providing quality care, that quality improvement efforts must be focused on the sites where care is received and that structure, process and outcome issues are equally important.

Activities are coordinated by the Quality Assurance Directorate which focuses on implementing structures and processes to support Gauteng's quality assurance programme; consolidating and supporting the accreditation system, introducing the clinical audit programme and expanding the customer care system, including communication.

Measurable objectives and performance indicators for Administration

Table 7. Provincial measurable objectives and evolution of performance Indicators for Administration

Strategic Objectives	Measurable Objective	Indicator	2002/03 (actual)	2003/04 (actual)	2004/05 (target)	2005/06 (target)	2006/07 (target)	2007/08 (target)
	Sign district health plans in all districts according to the district health planning guidelines	Percentage districts with district health plans according to the district health planning guidelines	#	#	100	100	100	100
Ensure all hospital and CHCs have full accreditation	Implement a patient-focused quality accreditation system in all clinics and hospital	Percentage of provincial hospitals and community health centres evaluated	49	87	100	100	100	100
Provide rehabilitation and support to people with disabilities	Provide assistive devices to people with disabilities	Number of assistive devices issued.	2803	3512	3820	2500	4000	4000
Provide efficient and effective clinical support services (allied, laboratory, pharmaceuticals, blood services, radiology etc)	Improve pharmaceutical management	Percentage compliance of hospital pharmacies with annual stocktaking	#	100	100	100	100	100
	Ensure availability of medicines on the EDL	Percentage of hospitals and regional pharmacies with EDL medicines	#	80	98	98	100	100
Establish an integrated Management Information System (MIS)	Implement the Management Information System (MIS) in all hospitals and clinics	Percentage of provincial hospitals and clinics implementing the national minimum data set	#	80	100	100	100	100

Strategic Objectives	Measurable Objective	Indicator	2002/03 (actual)	2003/04 (actual)	2004/05 (target)	2005/06 (target)	2006/07 (target)	2007/08 (target)
Implement an effective Performance Management system	Implementation and maintenance of the prescribed staff performance management system	Percentage of provincial hospitals and clinics implementing the prescribed system	#	70	100	100	100	100
Implement and manage efficient and cost effective supply chain management system	Inventory and asset recording system	Percentage of hospitals and districts with asset management system and register (BAUD)	70	80	85	100	100	100
Improve financial management	Cost centres implemented in all hospitals	Percentage of hospitals implementing cost centres and approved cost centre accounting systems	#	#	5	25	50	75
Implementation of the Gauteng Health integrated wellness programme (EAP, HIV and AIDS work place and occupational health and safety programmes	Implementation of integrated Health Wellness programme	Percentage institutions with a dedicated Health and Wellness programme champion	#	#	100	100	100	100
Ensure Recruitment and Retention of Human Resources	Develop policy framework/guidelines for appointment of retired nurses.	Number of appointed retired nurses	#	#	50 nurses	100	150	200

Strategic Objectives	Measurable Objective	Indicator	2002/03 (actual)	2003/04 (actual)	2004/05 (target)	2005/06 (target)	2006/07 (target)	2007/08 (target)
	Recruitment and retention of staff	Attrition rate for • Permanent Doctors (excluding interns and community service medical officers • Professional nurses	#	#	34.4% 9.8%	30.0% 7 %	29.9% 6.5%	27.5% 6%
	Employment equity	Percentage women in senior management positions	#	#	40	42	45	48
		Percentage disabled people in the department	#	#	0.05	1	2	2
	Health Promotion programme to address key risk factors	Number of hospitals and PHC facilities with multimedia health promotion programme	#	#	6	12	To be determined	To be determined

#New indicator, data not available

Table 8. Situational analysis and projected performance for human resources (excluding health sciences and training)

Indicator	Type	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/08
Input									
1. Medical officers per 100,000 people	No	41.89	41.90	33.70	28.61	31.87	30.64	31.47	18.7
2. Professional nurses per 100,000 people	No	121.74	115.3	97.77	66.22	73.95	78.55	82.68	105
3. Pharmacists per 100,000 people	No	4.51	3.78	3.03	2.82	2.91	2.98	3.04	34
Process									
4. Vacancy rate for professional nurses	%	26.40%	27.40%	36.10%	26.87%	17.45%	8.81%	0.17%	15
5. Attrition rate for doctors	%	30.97%	43.08%	35.82%	33.81%	33.00%	30.00%	27.50%	25
6. Attrition rate for professional nurses	%	8.11%	10.58%	8.50%	11.44%	9.50%	7.25%	6.00%	25
7. Absenteeism for professional nurses	%			2%	2.8%	2.7%	2.6%	2.5%	5
Efficiency									
8. Nurse clinical workload (PHC)	No	#	#	**3.73**	**5.6**	**5.8**	**6.0**	**6.2**	
9. Doctor clinical workload (PHC)	No	#	#	**0.20**	**0.31**	**0.32**	**0.33**	**0.34**	
Outcome									
10. Supernumary staff as a percentage of establishment	%	0	0	0	0	0	0	0	

Past expenditure trends and reconciliation of MTEF projections with plan

Table 9. Trends in provincial public health expenditure for Administration(R million)

Expenditure	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF Projection
Current prices`1							
Total	328 675	271 790	263 215	257 836	-	-	-
Total per person	37	31	30	29	-	-	-
Total per uninsured person	51	42	41	40	-	-	-
Constant (2004/05) prices							
Total	400 326	301 415	276 902	257 836	267 090	280 250	292 500
Total per person	45	34	31	29	30	32	33
Total per uninsured person	62	47	43	40	42	44	46
Capital	61 845	20 940	16 946	18 460	20 000	21 000	22 000
Health as % of total public expenditure	0.13%	0.10%	0.08%	0.07%	0.06%	0.06%	0.06%

PROGRAMME 2: DISTRICT HEALTH SERVICES

The purpose of the programme is to manage District Health Services (DHS) and render comprehensive Primary Health Care (PHC) services

District Health Services have five sub-programmes:

- District management and Primary Health Care Facilities;
- District hospitals;
- HIV and AIDS, Sexual transmitted Infections (STI) and Tuberculosis (TB) control programme;
- Mother and Child and Women's Health (MCWH) and nutrition and
- Diseases prevention and control

District Health Services developed its plans for the MTEF from the platform created by the Department's six Strategic Goals.

Sub-Programme 2.1: District Management and PHC Facilities

Situational Analysis for Sub-Programme District Management and PHC Facilities

The District Health System (DHS) is the cornerstone of the National Health System. It is the vehicle to strengthen Primary Health Care services by improving access to quality and cost effective health care services, with community participation and its inter-sectoral collaboration.

Co-operative governance

PHC Services are currently provided jointly by Province and Local Government. However services are being rationalised and functionally integrated as Gauteng has undertaken to delegate the provision of PHC services in the province to Local Government authorities.

The Department has signed Memoranda of Understanding with all six municipalities. The details of how services are to be provided will be made concrete in a Service Level Agreement (SLA); these are being negotiated by representatives of each Metropolitan and District Council with the Health Regions and Central Office, and must be in place prior to delegation of services.

Joint political and administrative structures are already in place at provincial and local level, and are consistent with the provision of the National Health Act.

The Provincial Health Authority (PHA) is chaired by the MEC for Health and includes members of the Mayoral Council responsible for health (MMCs) in each district, and South African Local Government Association (SALGA) councillor responsible for health and welfare.

The Provincial Health Advisory Committee (PHAC) is chaired by the Head of Department, and includes heads of the health municipalities. This structure provides technical advice and support to the political structure.

Joint district management structures are being established throughout the province. There is also liaison with the National Department of Health, and the Department of Local Government.

Gauteng's Service Improvement Plan (SIP) indicates that services and resources should be shifted from hospitals to PHC services in the District Health System over the MTEF period. This will ensure sustainability and cost containment. Examples of the planned shift include the expansion of home-based care (HBC) and step- down beds and the de-institutionalisation of mental patients in line with the new Mental Health Care Act. The Plan also proposes to remove polyclinics from Central and Regional hospitals, and building a stronger referral pathway, so that patients will enter and be treated at the appropriate level in the health systems.

Below is a more detailed analysis for key areas of the sub-programme.

Appraisal of existing services and performance during the past year

Strengthening Primary Health Care (PHC)

Free primary health care services have improved Gauteng residents' access to care and visits have increased from 10.4m to almost 12.5 million in 2003/04. Working hours have been extended at many clinics, to ensure improved accessibility and to offer after-hour services. A rationalisation process is being implemented in all health districts, through joint planning with Local Government.

Referral to other levels of care and decentralisation of polyclinics will relieve pressure on the central and regional hospitals.

The Community Health Worker (CHW) programme including CHW training, support and reimbursement is being implemented. NGOs are being supported to implement outreach programmes for TB direct observed treatment (DOTS), prevention of mother-to-child-transmission (PMTCT) and voluntary counselling and testing (VCT) for the HIV and AIDS programme.

PHC is being strengthened by implementation of the Clinic Supervisory Manual (CSM). Since April 2004 the full manual was rolled out to all sub-districts. Monthly monitoring and reports are submitted for PHC services, priority programmes and drug supply. Quarterly reviews are undertaken per district.

The revised and rationalised Primary Health Care Minimum Data set in line with the National District Health Information System (DHIS) is being implemented in all the PHC facilities. Approximately 60% of managers have been trained on the system.

District Health Expenditure Reviews (DHER) and Primary Health Care service audits were completed jointly for all six health districts in 2003, culminating in joint district health service plans in line with the National Health Planning Guidelines. The process of PHC package audit and DHER 2003/04 analysis are underway and this will be used to develop District Health Plans for 2005/06

Ward-based health committees are being established in accordance with the Municipal Structures Act of 1998 and is been implemented in 60% of municipal Wards.

Functional integration of the Provincial and Local Government PHC services in Ekurhuleni and West Rand is well established, and there is a move towards rationalisation and integration in all Metro and District Council areas. Functional integration of services has numerous benefits, specifically:

- Local authority and provincial staff work together and coordinate activities to provide comprehensive care to communities;
- Improving the geographical accessibility and range of services available to many communities. Secondment of staff will continue after delegation in 2004 until 2006, or until one Public Service is in place.

Referral pathways

Building and promoting stronger referral pathways between primary health and secondary or tertiary facilities will help ensure patients have equal access to appropriate levels of care, be it specialised care at secondary or tertiary level services, or home-based care in the community. It will also help relieve pressure on central and regional hospitals. Patients should enter the health system at nurse-based clinics, and, if required, be referred up the system to Community Health Centres, and then to hospital (District or Regional), depending on level of expertise needed. Similarly, patients needing non-specialised home-care should be referred down to the system, to nurse based clinics, or CHWs.

Table 10 : District health service facilities by health district

Health district[1]	Facility type	No.	Population[2]	Population per PHC facility[2] or per hospital bed
City of Johannesburg	Non fixed clinics	54	3 578 392	-
	Fixed Clinics[4]	95		-
	CHCs	9		-
	Sub-total clinics + CHCs	104		344 076
	District hospitals	1		
Ekurhuleni	Non fixed clinics	81	2 752 678	-
	Fixed Clinics[4]	80		-
	CHCs	5		-
	Sub-total clinics + CHCs	85		32 007
	District hospitals	1		
West Rand	Non fixed clinics	81	589 468	-
	Fixed Clinics[4]	29		-
	CHCs	3		-
	Sub-total clinics + CHCs	32		17 337
	District hospitals	2		
Sedibeng	Non fixed clinics[3]	83	840 825	-
	Fixed Clinics[4]	33		-
	CHCs	5		-
	Sub-total clinics + CHCs	37		21 559.6
	District hospitals	2		
City of Tshwane	Non fixed clinics[3]	43	1 683 356	-
	Fixed Clinics[4]	32		-
	CHCs	3		-
	Sub-total clinics + CHCs	35		45 496
	District hospitals	2		
Metsweding	Non fixed clinics[3]	4	153 109	-
	Fixed Clinics[4]	6		-
	CHCs	0		-
	Sub-total clinics + CHCs	6		25 518

Health district[1]	Facility type	No.	Population[2]	Population per PHC facility[2] or per hospital bed
	District hospitals	20 beds leased from Netcare		
Total Province DHS	Non fixed clinics[3]	300	9 597 828	-
	Fixed Clinics[4]	276		-
	CHCs	24		-
	Sub-total clinics + CHCs	300		31 161
	District hospitals	8		

1. *Data per districts*
2. *Population per uninsured people – midyears estimates from DHIS*
3. *Non fixed clinics includes mobile and satellite clinics*
4. *Fixed clinics includes both provincial and local government facilities*

District Health Service Facilities and Infrastructure

Gauteng has 276 fixed clinics and health centres, both provincial and local government, as well as 24 Community Health Centres and 300 visiting points. Satellite clinics are included in the number of visiting points. There are Urban Renewal Nodes in Alexandra and Kliptown (City of Johannesburg) and Bekkersdal (West Rand District Council). The province has 8 district hospitals with 1 321 approved beds of which 1 246 beds are being used to provide services within the district health system.

There are four cross-boundary areas in Gauteng Province: two large areas cross boundary with North West Province, one in City of Tshwane with Odi/Moretele and Mabopane (NW), and the other in West Rand District Council area with Fochville and Wedela (NW). The other two cross-boundary areas are small, with Mpumalanga, namely Etwatwa Ext 17 (Ekurhuleni) and Ekangala (Metsweding).

Table 11 : Situation analysis national indicators for district health services

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	City of Jo'burg 2003/04	West Rand 2003/04	Ekurhuleni 2003/04	Sedibeng 2003/04	Tshwane 2003/04	Metsweding 2003/04	National Target
INPUT											
1. Uninsured population served per fixed public PHC facility	No	27679	32728	30145	36245	26258	32211	21470	43631	21057	<12,200
2. PHC expenditure (provincial plus Local Government) per uninsured person	R	151.89	181.16	195.87	229.38	#	143.44		151.64	#	**N/A**
4. Sub-districts offering full package of PHC services	%	#	#	85	85	100	83	85	85	72	**60**
5. Provincial EHS expenditure per uninsured person	R	0.33	0.26	0.13	0.18		0.03		0.48	0.33	**9**
PROCESS											
6. Health districts with appointed manager	%	83	100	100	100	100	100	100	100	100	**92**
7. Health districts with plan as per DHP guidelines	%	50	60	100	100	100	100	100	100	100	**48**
8. Fixed PHC facilities with functioning community participation structure	%	75	75 old	51 new	55	45	60	58	65	20	**69**

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	City of Jo'burg 2003/04	West Rand 2003/04	Ekurhuleni 2003/04	Sedibeng 2003/04	Tshwane 2003/04	Metsweding 2003/04	National Target
9. Facility data timeliness rate for all PHC facilities	%	50	55	60	60	60	60	60	60	60	**80**
OUTPUT											
10 PHC total headcount	No	10m	10.4m	12 749 586	5 176 110	890 913	3 500 873	1 309 194	1 738 156	134 340	**N/A**
11. Utilisation rate - PHC	No	1.9	1.3	1.18	1.28	1.13	1.15	1.43	0.97	0.73	**2.3**
12. Utilisation rate – PHC under 5 years	No	2.77	2.77	3.0	3.23	2.21	2.89	3.12	2.83	1.67	**3.8**
QUALITY											
13. Supervision rate	%	30	50	70	65	54	52	75	95	70	**78**
14. Fixed PHC facilities supported by a doctor at least once a week	%	13	13	13	#	#	#	#	#	#	**31**
EFFICIENCY											
15. Provincial PHC expenditure per headcount at provincial PHC facilities	R	97.35	111.64	98.46	105.17	#	73.36	#	94.55	97.35	**99**
16. Expenditure (provincial plus local government) per headcount at public PHC facilities	R	97.35	111.64	98.46	105.17		73.36		94.55	97.35	**99**

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	City of Jo'burg 2003/04	West Rand 2003/04	Ekurhuleni 2003/04	Sedibeng 2003/04	Tshwane 2003/04	Metsweding 2003/04	National Target
OUTCOME											
17. Health districts with a single provider of PHC services	%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**50**

N/A = not applicable in Gauteng
 # new indicator data not available
NB: Information for Local Government not included

Policies, priorities and strategic goals for Sub-Programme District Health Management and PHC services

The District Health Service programme draws its mandate from the following:

- National Health Act
- National DHS policy and
- Gauteng District Health Service Act, Number 8 of 2000.

Broad strategic objectives for 2004/09 are guided by Gauteng's Strategic Goals, and are, specifically, to:

- Ensure appropriate planning and monitoring of district health services at sub-district
- Improve the quality and efficiency of primary health care service provision
- Provide 24 hour access to PHC and emergency medical services in all sub-districts.
- Re-organise the District Health System for improved efficiencies and health outcomes
- Provide people centered care that recognize the dignity and uniqueness of each person
- Improving down-referral management of appropriate patients to clinics, community health centres, community-based centres and non-governmental organization for continuation of therapy
- Increase step down and palliative beds (including TB beds) in these hospitals.

Priority actions for the sub-programme for 2005/06 are informed by the key actions required to implement the Strategic Goals, and the Service Improvement Plan, and include to**:**

- Finalise Service Level Agreements with Metro/District Councils;
- Implement a District Health Plan for each district;
- Improve integration between province and local government;
- Support the establishment of Ward Health Sub-Committees; and
- Provide at least one 24-hour PHC facility in each sub-district or access
- Improve access to mental health care services and access for people with disabilities;
- Strengthen capacity of NGOs through donor funding;
- Consolidate home-based care programmes into an overall community health worker programme, and improve the quality of care provided by CHWs, through NGOs;

Analysis of constraints and measures planned to overcome them

Constraints identified	Measures to overcome constraints
Increasing HIV and AIDS case load	- Decentralise comprehensive TB, HIV and AIDS care with ART through clinics, step-down units and home-based care by CHW through NGOs
Improving resource mobilisation to address equity	- Joint District Health Plans - Service Improvement Plan - Rationalise clinics in line with norms - Build financial capacity - Decentralise through gateway clinics at district hospitals - Community Health Worker Programme - Market Primary Health Care (PHC)
Poor functional integration with local government	- Build joint structures - Implement MOUs and Service Level Agreements - Rationalise provincial/LG facilities - Engage Municipalities and unions
Morbidity and mortality	- Build epidemiological analysis capacity - Improve EPI and priority programmes
Inadequate community participation	- Ensure establishment of Ward Health Sub-Committees and volunteerism through CHW
Improving access to PHC	- Set up one 24-hour facility per sub-district - Market PHC - Train more PHC nurses
Improving the quality of care	- Patient surveys - Quality assurance programme - Clinic supervision visits
Funding the Local Government contribution gap* *(refer narrative below)*	- National and Prov Health, Treasury & DPLG - Service Level Agreements - Decentralise resources to District Health Services - Phased withdrawal of Local Government own funds
Shortage of PHC nurses	- Deploy newly qualified nurses to PHC - Incentives for rural/peri-urban nurses Retired nurses or agency nurses to release professional nurses for PHC training/ Best practice awards

Constraints identified	Measures to overcome constraints
Poor information on districts	- Purchase additional support for District Health Information System (DHIS) for training - Clinic supervisory visits - Monitor progress through reports and training - Ensure utilisation of information for planning and management of services

*Financial formula for devolution and the implication on Municipal Health Services - The Department has subsidised local government's contribution to provision of PHC through cash transfer payments, supplying EDL drugs and surgical sundries, paying for certain laboratory investigations and seconding personnel to work in local government facilities. The annual allocation of financial resources to districts has increased by between 6-8 % every year. A financial task team has been established and a risk analysis undertaken and, together with the DHERs and the Regional budget process, these guide the development of a financial formula to devolve PHC services to local government. However, the definition of Municipal Health Services in the National Health Act has cost implications for national and provincial spheres of government as the local government funding is gradually withdrawn. Gauteng Health will need additional funds to cover this in the first year. The National Department of Health, Treasury and DPLG are discussing the issue.

Specification of measurable objectives and performance indicators

Table 12 : Provincial objectives and performance indicators for district health services

Strategic Objectives	Measurable objectives	Indicator	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)
Ensure appropriate planning and monitoring of district health services at sub-district level	Develop high level business plan for strengthening of the District Health system through Senior DHS forum	Availability of high level business plan	#	#	#	1	1	1	1
	Train district managers on use of information for planning and decision making	Percentage district and program managers trained on information management	#	#	40	55	65	85	100
	Ensure functional integration between local government and province	Percentage of sub-districts that are functionally integrated	#	#	#	50	60	80	100

Strategic Objectives	Measurable objectives	Indicator	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)
	Conduct DHER in all districts	Number of District Health Expenditure Review per District available annually	#	#	#	6	6	6	6
Improve the quality and efficiency of primary health care service provision	Conduct PHC service audit annually	Percentage of sub-districts with PHC services audited	#	#	100	100	100	100	100
	Develop an integrated District Service Plan (DHP)	Percentage districts with formal plan	#	#	62	100	100	100	100
	Implement provisions of the Memorundum of Understanding with Local Government	Percentage of MOU objectives implemented	#	#	#	50	80	100	100
	Implement the clinic supervisory manual at all PHC facilities	Percentage of PHC facilities with monthly supervisory visits	#	#	60	80	85	100	100

Strategic Objectives	Measurable objectives	Indicator	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)
	Service Level Agreement in place for each district	Number of Service Level Agreements signed		#	#	#	2	4	6
Provide 24 hour access to PHC and emergency medical services in all sub-districts	Ensure 24 access to PHC in designated sub-districts	Percentage of sub-districts with access to extended hours of service	60	65	80	70	75	100	100
Re-organise the District Health System for improved efficiencies and health outcomes	Strengthen management at community health centres	Percentage of CHC with appointed facility managers	#	#	#	#	80	100	100
Provide people centred care that recognises the dignity and uniqueness of each person	Ensure shorter waiting times for patients	Percentage reduction in overall waiting times	#	5	6	5	10	25	25
	Monitor complaints in all districts	Percentage of complaints attended to	#	#	80	100	100	100	100
Implement a comprehensive community health worker programme	Increase access to Primary Health Care	Numbers of Community Health Workers trained (cumulative)		#	#	1000	2000	3000	3500

Strategic Objectives	Measurable objectives	Indicator	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)
Provide efficient and effective clinical support services (allied, laboratory, pharmaceuticals, blood services, radiology etc)	Ensure availability of drugs on EDL	Percentage of essential drugs out of stock at PHC facilities	#	5	5	2	2	1.5	1.5
Promote mental well-being and improve early diagnosis, treatment and support for people with mental illness and disabilities	Improve access to mental health care and support	Percentage of fixed PHC facilities with mental health service	#	32	34	35	38	40	45
	Improve access to health care services for people with disabilities	Percentage of PHC facilities with community based rehabilitation services	#	#	#	50	70	100	100
Strengthen community participation at all levels of the health system	Capacitate community participation structures	Percentage of Ward based health committees trained	#	#	#	#	100	-	-

 # new indicator data not available

Table 13: National Performance indicators for district health services

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/08
INPUT							
1. Uninsured population served per fixed public PHC facility	No	30 145	31 161	31784	32419	33067	**<10,000**
2. Provincial PHC expenditure per uninsured person	R	195.87	*200	*205	*210	*215	**N/A**
3. Local government PHC expenditure per uninsured person	R	**#**	#	#	#	#	**N/A**
5. Professional nurses in fixed PHC facilities per 100,000 uninsured person	No	0.6	0.6	0.6	0.6	0.6	**130**
6. Sub-districts offering full package of PHC services	%	85	85	90	100	100	**100**
7. EHS expenditure (provincial plus local government) per uninsured person	R	0.13	0.19	0.20	0.21	0.22	**13**
PROCESS							
8. Health districts with appointed manager	%	100	100	100	100	100	**100**
9. Health districts with plan as per DHP guidelines	%	100	100	100	100	100	**100**
10. Fixed PHC facilities with functioning community participation structure	%	51	60	80	100	100	**100**
11. Facility data timeliness rate for all PHC facilities	%	#	60	75	100	100	**100**
OUTPUT							
12. PHC total headcount	No	12 749 596	12.5m	13.8m	14m	14.5	**N/A**
13. Utilisation rate - PHC	No	1.18	1.5	2.0	2.5	3.0	**3.5**
14. Utilisation rate – PHC under 5 years	No	3.0	3.5	4	4.5	5.0	**5.0**
QUALITY							
15. Supervision rate	%	70	80	100	100	100	**100**
16. Fixed PHC facilities supported by a doctor at least once a week	%	13	20	50	65	75	**100**

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/08
EFFICIENCY							
17. Provincial PHC expenditure per headcount at provincial PHC facilities	R	98.46	103.19	101.04	104.72	106.34	**78**
18. Expenditure (provincial plus local government) per headcount at public PHC facilities	R	98.46	103.19	101.04	104.72	106.34	**78**
OUTCOME							
19. Health districts with a single provider of PHC services	%	0'	0'	0'	0'	0'	**100**

 # New indicator data not available

**estimates only*

Provincial expenditure based on DHER 2003/04 and District Service Plans

Data for 2003/4 indicates cost per uninsured population, based on the District Health Expenditure Review (DHER), and shows that many of the clinics are being under utilised. This is being addressed through joint District Health Service Plans and the Service Improvement Plan. Utilisation figures have increased dramatically: visits per capita in the province are 1.8 overall. This excludes utilization at hospital outpatient departments. But. Costs per visit and per capita will be addressed through the rationalisation process. As Gauteng is largely urban, except for Metsweding, the first referral point is mainly doctors in Community Health Centers. As mandated by National Department of Health, a full DHER and audit of the Primary Health Care Package was completed by each district during 2003.

Service Level Agreements and transfers to Municipalities and NGOs (non-governmental organisations) (Payments)

The District Health Services Department receives additional funding from the EU of an amount of R 5 million. The funds are used for the Partnerships for Development of PHC (PDPHC) for NGO capacity building including HIV and AIDS care.

Table 14: Transfers to Local Government by Municipality (R'000)

MUNCIPALITY		2002/03 (Actual)	2003/04 (Actual)	2004/05 (BUDGET)	2005/06 (MTEF PROJECTION)	2006/07 (MTEF PROJECTION)	2007/08
		R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**
District Municipalities	West Rand	9 413	11 216	15 480	17 150	18 010	18 910
	Sedibeng	25 570	21 856	28 280	31 320	32 890	34 540
	Metsweding	1 005	3 008	1 900	2 100	2 210	2 320
Local municipalities	Johannesburg City Metro	46 103	40 092	56 050	62 110	65 220	68 480
	Ekurhuleni Metro	58 017	62 770	75 000	83 050	87 200	91 560
	City of Tswane Metro	13 470	6 714	23 630	26 190	27 500	28 880
Total: Transfers to LG by Municipality		**153 578**	**145 656**	**200 340**	**221 920**	**233 030**	244 690

Table 15: Transfers to Private Institutions (R'000)

PUBLIC ENTITY	2002/03 (ACTUAL)	2003/04 (ACTUAL)	2004/05 (ESTIMATE)	2005/06 (MTEF PROJECTION)	2006/07 (MTEF PROJECTION)	2007/08 (MTEF PROJECTION)
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**
Lifecare - Tuberculosis hospitals	49 852	24 571	33 100	36 000	37 500	**39 500**
SANTA - Tuberculosis hospitals	5 588	44 122	29 860	32 200	33 800	**35 500**
Alexandra Health Care Centre	18 000	19 000	20 000	21 600	22 700	**23 800**
Witkoppen Clinic	1 100	1 300	1 000	1 520	1 600	**1 700**
Phillip Moyo Clinic	4 877	6 160	4 520	7 040	7 390	**7 760**
Total: Transfers to Public Entities	**79 417**	**95 153**	**90 880**	**98 360**	**102 990**	**108 260**

Table 16: Donations and Subsidies Non Governmental Organisations

INSTITUTION	2002/03 (ACTUAL)	2003/04 (ACTUAL)	2004/05 (ESTIMATE)	2005/06 (MTEF PROJECTION)	2006/07 (MTEF PROJECTION)	2007/08 (MTEF PROJECTION)
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**
NGO's - AIDS	29 900	29 117	70 000	75 000	80 000	**85 000**
NGO's - Integrated Nutrition Programme	49 227	54 673	10 307	11 333	0	**0**
NGO's - Mental Health	17 300	20 095	21 250	22 400	23 677	**24 900**
Total: Donations and Subsidies	**96 427**	**103 885**	**101 557**	**108 733**	**103 677**	**109 900**

Table 17. Trends in provincial public health expenditure for District Health Service(R million)

Expenditure	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF Projection
Current prices`1							
Total	1 306 577	1 573 435	1 743 927	1 972 643	-	-	-
Total per person	148	178	197	223	-	-	-
Total per uninsured person	204	245	272	308	-	-	-
Constant (2004/05) prices							
Total	1 591 411	1 744 939	1 834 611	1 972 643	2 351 981	2 474 906	2 602 500
Total per person	180	197	208	223	266	280	294
Total per uninsured person	248	272	286	308	367	386	406
Capital	13 784	14 011	19 812	29 410	38 876	34 800	30 800
Health as % of total public expenditure	0.50%	0.60%	0.55%	0.53%	0.56%	0.54%	0.53%

SUB-PROGRAMME 2.2: DISTRICT HOSPITALS

Purpose of the Programme

- Rendering of a hospital service at primary health care level
- Develop step down and palliative care to address the impact of HIV/AIDS
- Strengthening primary health care through provision of first level hospital care
- Playing a gate-keeping role to secondary and tertiary levels of care

Situation Analysis

Gauteng province has 8 district hospitals with 1 321 approved beds of which 1 246 beds are being used to provide care. There are 3 district hospitals in Ekurhuleni-Sedibeng, 2 in Tshwane-Metsweding and 3 in Johannesburg-West Rand health regions. According to the SIP the decentralization process to district hospitals will lead to an increase in the number of district hospital beds.

The performance of the hospitals for financial year, 2003/2004 includes the average cost per PDE of R698, average bed occupancy rate (BOR) of 72%, average length of stay of 3.3 days, 101 648 admissions and over 531 025 Patient Day Equivalent (PDE). Some of the treasury targets have already been exceeded by the hospitals including the Hospital boards, clinical audit meetings, appointment of CEO's. The average length of stay seems to be well below the national target of 4.2 days and this is positive.

The key challenges for district hospitals is to reduce cost per patient day equivalent, contain maternal mortality, linkage of hospitals with neighbouring primary care facilities in management of ambulatory care patients, reduce ALOS up to 3 days, target an 80% BOR and increase the PDE (appropriate actual workload) and address the AIDS epidemic

Table 18: National - Situational Analysis for District Hospitals sub-programme -

Indicator	Type	Province Wide Value 2001/02	Province wide value 2002/03	Province Wide Value 2003/04	COJ/ 2003/04	Ekurhuleni 2003/04	Tshwane 2003/04	Metsweding	National Target 3003/04
Input									
1. Expenditure on hospital staff as a % of district hospital expenditure	%	68.9	68.4	66.6	63.5	62.3	40.5	@	
2. Expenditure on drugs for hospital use as of % district hospital expenditure	%	9.9	8.1	10.2	10.4	9.2	5.9	@	11%
3. Expenditure by district hospitals per uninsured person	R	51.97	54.24	57.81	53.31	54.87	74.72	@	
Process									
4. District hospital with operational hospital board	%	100%	94%	87%	100%	67%	100%	@	76%
5. District hospitals with appointed (not Acting CEO) in the post	%	62%	75%	87%	100%	67%	100%	@	69%
6. Facility data timelines rate for district hospitals	%	100%	100%	100	#	#	#	@	34%
Output									
7. Caesarean section rate for district hospitals	%	13.9%	10.2%	11.9%	8.3%	14.8%	7.5%		12.5%

Indicator	Type	Province Wide Value 2001/02	Province wide value 2002/03	Province Wide Value 2003/04	COJ/ 2003/04	Ekurhuleni 2003/04	Tshwane 2003/04	Metsweding	National Target 3003/04
Quality									
8. District hospitals with patient satisfaction survey using DoH template	%	50%	62%	75%	100%	33%	100%	@	10%
9. District hospitals with clinical audit (M & M) meeting every month	%	62%	87%	100	27%	86%	100%	@	36%
Efficiency									
10. Average length of stay in the district hospitals	Days	3.4	3.3	3.1	3.5	3.4	2.6		4.2
11. Bed utilization rate (based on useable beds) in the district hospitals	%	75%	80%	67%	77%	73%	78%	@	68%
12. Expenditure per patient day equivalent in the district hospitals	R	R731.7	R597.4	R695	R792.85	R654.26	R635.56	@	R814

@ no hospital at Meetsweding district, data not available
NB: Information for WestRand and Sedibeng district not available
#new indicator, information not available

Policies, Priorities and Broad Strategic Objectives

Policies

- District Health System (DHS) Act
- White paper on transformation of health sector
- Batho Pele Principles
- Strategic Position Statement (SPS)
- National integrated planning framework

Priorities and Strategic objectives

- Increasing the number of district hospitals through building of new hospitals over the MTEF period
- Modernization, reorganization and re-vitalisation of all public hospitals into cost effective referral centers according to the service plan
- Provide efficient and effective clinical support services (allied, laboratory, pharmaceutical, blood services, radiology etc)
- Strengthening reliance on referral networks as against off-the street care
- Improving down-referral management of appropriate patients to clinics, community health centres, community-based centres and non-governmental organization for continuation of therapy
- Increase step down and palliative beds (including TB beds) in these hospitals.
- Ensuring EDL drugs supply
- Improving perception and actual quality of frontline service and reduction in waiting time
- Establishing multi-disciplinary health information management team to monitor quality of data
- Transfer of TB beds to district hospitals over three years

Analysis of constraints and measures to overcome them

Constraints	Measures planned to overcome constraints
Caesarean section exceeds 6% of accepted limit	Audit monthly caesarean cases above 6%
Lack of finalized human resource plans	• Staffing norms to be agreed upon and finalized • Increase support from the Regional and Central Offices
Perceived low staff morale, motivation and commitment	• Motivational procedure (i.e. organizing cultural events, encourage achievers, support potential, give praise where it is due, etc) • Involvement of staff in decision-making • Ensure the incentives and performance management • Address HIV and AIDS and its impact
Cost centering	• Cost centre management to be linked with quality and performance management measures
High cost per patient day equivalent (Cost/PDE)	• Cost centre management • Improve hospital inefficiency
Implementing the fraud prevention plan (FPP) and improving management of losses	• Continuous workshops and training on FPP and finalization of delegations to Unit Managers with loss control strategies outlined
Case overload as a result of HIV and AIDS	• Implement comprehensive TB/HIV/AIDS care with ART and refer patients to CHCs

Table 19: Provincial Objectives and Performance Indicators for District Hospitals sub-programme

Strategic objectives	Objective	Indicator	2001/02 (Actual)	2002/03 (Actual)	2003/04 (Actual)	2004/05 (Estimate)	2005/06 (Target)	2006/07 (Target)	2007/08 (Target)
Provide efficient and effective clinical support services (allied, laboratory, pharmaceutical, blood services, radiology etc)	Ensure availability of EDL drugs in all institutions	Percentage of Hospitals with all EDL drugs available	80	80	80	100	100	100	100
	Ensure availability of emergency bloods in all hospitals	Percentage of hospitals with emergency bloods	#	#	#	85	100	100	100
Provide people centred care that recognizes the dignity and uniqueness of each person	Ensure shorter waiting times	Percentage reduction in waiting times for pharmacy, casualty and outpatients department	#	5	6	5	10	20	30

new indicator data not available

Table 20: National Performance indicators for District Hospital services

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08
Input						
1. Expenditure on hospital staff as a % of district hospital expenditure	%	66.6	66.1	68.3	68.1	68.1
2. Expenditure on drugs for hospital use as of % district hospital expend	%	10.2	9.0	9.0	9.0	9.0
3. Expenditure by district hospitals per uninsured person	R	38.49	41.99	55.67	58.67	61.66
Process						
4. District hospital with operational hospital board	%	87.5	87.5	100	100	100
5. District hospitals with appointed CEO's AD: Nursing, AD: Admin and Medical Superintendents (not Acting) in the post	%	87	100	100	100	100
6. Facility data timelines rate for district hospitals	%	#	70	100	100	100
Output						
7. Caesarean section rate for district hospitals	%	10.2	11.6	11	11	11
Quality						
8. District hospitals with patient satisfaction survey using DoH template	%	75	85	100	100	100
9. District hospitals with clinical audit (M & M) meeting every month	%	100	100	100	100	100
Efficiency						
10. Average length of stay in the district hospitals	Days	3.1	3	3	3.2	3.2
11. Bed utilization rate (based on useable beds) in the district hospitals	%	67	70	75	72	72

12. Expenditure per patient day equivalent in the district hospitals	R	R695	700	750	800	R814
Outcome						
13. Case fatality rate in the district hospitals for surgery separations	%	0.3	2.1	2.0	2.0	3.5

new indicator data not available

Sub-Programme 2.3: Mother and Child, Women's Health (MCWH) & Nutrition

The purpose of the programme is to render Mother and Child, Women health services and Nutrition to the vulnerable groups

Situational analysis

Appraisal of existing services since 2001

Child care
The province held a successful Mass Immunisation campaign in May 2004, coverage of 90% for measles and 91% for polio was achieved as part of fulfilling the goal of declaring South Africa "Polio Free" by 2005

The Integrated Management of Childhood Illness (IMCI) programme has helped to reduce childhood illnesses and prevent deaths. For example, diarrhoea among children less than 5 years decreased from 204/1000 in 1998 to59.4/1000 in 2002. About 600 child minders have been trained in relevant components of IMCI and in child accident prevention. Two medical schools and 2 nursing colleges have integrated IMCI training in their curricula. The training programme is aimed at improving competency skills of our health workers to assess children correctly and to ensure that appropriate treatment is given for the identified condition.

The Perinatal Problem Identification Programme (PPIP) and Kangaroo Mother Care have been implemented in hospitals in order to reduce the preventable causes of perinatal morbidity and mortality. The programme has been implemented in 19 public hospitals (91%) and training has taken place on all of them in PPIP. To date each district holds quarterly Mortality and Morbidity meetings to review progress and discuss possible solution to problems.

Kangaroo Mother Care which started in 2001, is now being implemented in 15 hospitals and has lead to reduction in the perinatal mortality rate, the average length of stay in hospitals and hospital costs. This has also improved bonding between mothers and babies

Women's health

Programmes such as cervical cancer screening programme, campaigns on the prevention of violence against women, breast cancer awareness and the pregnancy termination services have contributed to an improvement of the health of women.

Nutrition programme

The Primary School Nutrition programme (PSNP) was transferred to Department of Education in 2004/05 financial year. However the GDH continued to provide technical support to PSNP and implement feeding scheme in 1718 crèches reaching 58219 children.

Vitamin A supplement is provided to all children and post-partum women in all facilities in the province. To date we have 8 facilities accredited with the WHO Baby Friendly hospital Initiative (BFHI) and celebrated the WHO/UNICEF Baby Friendly Hospital Initiative awards at some of our facilities in February 2005.

Table 21: Situation analysis indicators for MCWH & Nutrition

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	City of Jo'burg 2003 /04	West Rand 2003 /04	Ekurhuleni 2003/04	Sedibeng 2003/04	Tshwane 2003/04	Metsweding 2003/04	National target 2003/4
Incidence											
1. Hospitals offering TOP services	%	53.6	64.3	64.3	66.7	33.3	66.7	66.7	66.7	No hospital	**100**
2. CHCs offering TOP services	%	20.8	33	66.6	66.6	No CHC	66.6	33.3	50	No CHC	**50**
Process											
3. Fixed PHC facilities with DTP-Hib vaccine stock out	%	0	0	0	0	0	0	0	0	0	
4. AFP detection rate	%	#	0,7	1,3	0,8	2,3	0,4	0	0,4	0	**1**
5. AFP stool adequacy rate	%		81	83	75	33	100	0	100	0	**80**
Output											
6. (Full) Immunisation coverage under 1 year	%	76	79	79	75.4	55.8	73.9	78.3	81.8	59.9	**90**
7. Antenatal coverage	%	69.5	72.5	77.6	72.2	77	69.1	93.4	100	55	**80**
8. Vitamin A coverage	%	#	#	31.8	23	26	38	1.9	68	50	**80**

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	City of Jo'burg 2003/04	West Rand 2003/04	Ekurhuleni 2003/04	Sedibeng 2003/04	Tshwane 2003/04	Metsweding 2003/04	National target 2003/4
under 1 year											
9. Measles coverage under 1 year	%	77.6	76.1	79	79	57	79	86	83	61	**90**
10. Cervical cancer screening coverage	%	3.8	4.0	4.9	5.8	2.8	3.9	4.2	2.4	6.2	**15**
Quality											
12. Facilities certified as baby friendly	No.	#	5	8	4	4	0	0	0	0	**20**
13. Fixed PHC facilities certified as youth friendly	%	23	31	36	9	4	11	20	5	0	**20**
14. Fixed PHC facilities implementing IMCI	%	20	20	62*	55*	53*	56*	52*	80*	78*	
Outcome											
15 Institutional delivery rate for women under 18 years	%	#	10.07	9.72	8.04	8.89	8.38	17.23	6.35	No MOU	**13**
16.Children under 5 years not gaining weight	%	#	#	0.45	0.36	0.37	0.47	0.61	1.12	0.85	

source of data – Gauteng PHC services audit 2003
 # new indicator data not available

Policies

- Implementation of the 10 (ten) recommendations of Saving Mothers
- Implementation of Clinical Guidelines on Common Conditions Causing Maternal Death
- Antenatal Care Policy
- Better Birth Initiative
- Contraceptive Policy/FP
- Cervical Cancer (and Breasts) Screening Policy
- Choice on Termination of Pregnancy Act
- Programme Prevention of Mother –to-Child transmission (PMTCT)
- Post-Exposure Prophylaxis Programme
- Sterilization Act
- Integrated Management of Childhood Illnesses (IMCI)
- Expanded Programme on Immunization (EPI)
- Perinatal Problem Identification Programme (PPIP)
- Kangaroo Mother Care (KMC)
- Vitamin A Supplementation Programme
- Free Primary Health Care for under 6 Children
- Perinatal Education Programme (PEP)
- Programme Prevention of Mother –to-Child transmission (PMTCT)
- School health policy

Priorities and Strategic Goals

- Improve the health and well-being of children under six years
- Improve the nutritional status of vulnerable groups with special emphasis on people with chronic diseases and debilitating conditions i.e. Growth monitoring and promotion and reducing and controlling micronutrient deficiencies and integrated food security programme
- Reduce preventable causes of maternal deaths;
- Improve early detection and intervention for cervical and breast cancer
- Reduce high risk behaviour among youth with a focus on teenage pregnancy, smoking, alcohol and drug abuse
- Interventions to reduce violence against women and children
- Strengthen strategies and programmes to reduce infant and maternal morbidity
- Strengthen child health through IMCI programmes across the province

Analysis of constraints and measures planned to overcome them

This constraints analysis should include as a minimum:

Constraints	Measures to overcome
• Understanding and responding to the needs of the poor and vulnerable	• Improve relations with the public through use of campaigns and media so as to emphasise key risk factors that contribute to disease and deaths
• Training of health professionals to deal with burden of disease	• Decentralise training of priority programmes and motivate for integration in the health professionals training curricula
• Shortage of staff due to high turn over of staff trained in priority programmes	• Retention and recruitment strategy to be implemented
• Poor quality of information or poor performance	• Facilitate reviews of programmes in the districts

Specification of measurable objectives and performance indicators

Table 22 : Provincial objectives and performance indicators for MCWH & Nutrion

Objective	Measurable objectives	Indicator	2001/02 (actual)	2002/03 (actual	2003/04 (actual)	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)
Improve nutritional status of vulnerable groups, with special emphasis on people with chronic and debilitating conditions	Implement an integrated food security programme in conjunction with other departments through improving school feedings for Early Childhood Development Centres and provision of dietary support and monitoring and food safety in primary schools	No. crèches funded	1 244	1 890	2 700	1695	1800	1800	1800
		No. of pre-school children fed	90 133	66 579	61 113	58 404	58500	58500	58500
		No. of patients on nutrition supplements	#	#	#	10,000	20000	25000	30000
3. Reduce preventable causes of maternal deaths	Implement key recommendations of the Saving Mothers Report	Percentage maternity units implementing NCCEMD recommendations	#	#	#	100	100	100	100

Objective	Measurable objectives	Indicator	2001/02 (actual)	2002/03 (actual	2003/04 (actual)	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)
Improve early detection and intervention for cervical and breast cancer	Ensure early detection of breast cancer	No of mammograms performed	#	#	#	7506	7590	7600	7610

 # new indicator data not available

Table 23: National Performance indicators for MCWH & Nutrition

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target
Incidence							
1. Incidence of severe malnutrition under 5 years	%	0.68	0.5	0.4	0.3	0.2	-
2. Incidence of pneumonia under 5 years	%	3.11	3	2.5	2	1	-
3. Incidence of diarrhoea with dehydration under 5 years	%	0.81	0.6	0.4	0.2	0.1	-
Input							
4. Hospitals offering TOP services	%	64.3	65	67	70	70	-
5. CHCs offering TOP services	%	33	40	45	50	55	80
Process							
6. Fixed PHC facilities with DTP-Hib vaccine stock out	%	0	0	Less than 2%	0	0	-
7. AFP detection rate	%	1,3	1	1	1	1	1
8. AFP stool adequacy rate	%	83	85	85	85	85	80
Output							
9. Schools at which phase 1 health services are being rendered	%	#	#	75	75	80	
10. (Full) Immunisation coverage under 1 year	%	79	89	90	90	90	90
11. Antenatal coverage	%	77.6	80	80	80	80	80
12. Vitamin A coverage under 1 year	%	31.8	40	60(55)	70	80	80
13. Measles coverage under 1 year	%	79	80	80(90)	80	90	90
14. Cervical cancer screening coverage	%	4.9	5.5	8.5	11.5	15	15
Quality							
15. Facilities certified as baby friendly	%	4	5	8	10	13	30
16. Fixed PHC facilities certified as youth friendly	%	11.3	11.3	15	20	30	30
17. Fixed PHC facilities implementing IMCI	%	56	62	65	70	80	

Outcome							
18. Institutional delivery rate for women under 18 years[n]	%	3.3	5	7.5	10	13	13
19. Not gaining weight under 5 years	%	0.45	0.30	0.25	0.20	0.10	

The rate of women under 18 giving birth in institutions (MOU's, hospitals etc) [n]

Past expenditure trends and reconciliation of MTEF projections with plan

Table 24: Trends in provincial public health expenditure for INP conditional grant(R million)

Expenditure	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF Projection
Current prices`1							
Total	54 673	65 598	74 273	10 307	-	-	-
Total per person	6	7	8	1	-	-	-
Total per uninsured person	9	10	12	2	-	-	-
Constant (2004/05) prices							
Total	66 592	72 748	78 135	10 307	11 333	0	0
Total per person	8	8	9*	1*	1	-	-
Total per uninsured person	10	11	12*	2*	2	-	-

****The reduction in expenditure is due to the reduction in conditional grants. No funds is available for 2006/08***

Sub-Programme 2.4: HIV & AIDS, STI & TB Control programme

Gauteng's response to the HIV and AIDS epidemic has two components:

- The Gauteng Inter-Sectoral HIV and AIDS Strategy;
- The Department of Health's HIV, AIDS and Sexual Transmitted Infections (STI) and Tuberculosis (TB) control programme; and

Component One: Gauteng Inter- Sectoral HIV and AIDS Strategy

The Inter-Sectoral HIV and AIDS Strategy guides and coordinates the response to the epidemic of all departments and sectors in the province. The strategy is implemented by the Inter-Sectoral HIV and AIDS unit, which reports to the Premier through the Head of Department and the MEC for Health. Key provincial AIDS policies are adopted by the Provincial Executive Council. Provincial Departments are responsible for department specific policies and guidelines, consistent with departmental strategy.

The Inter-Sectoral HIV and AIDS Strategy was informed by:

- The National AIDS Strategy and Plan of 1994, reviewed in 1997;
- The National Strategic Plan on HIV and AIDS/STD 2000-2004;
- Two Reviews conducted in 2001/2, which highlighted strengths and weaknesses of the Gauteng AIDS response and provided detailed guidance on strengthening the health sector's response; and
- The Gauteng AIDS Summit in October 2002, which identified key priorities, including intensifying prevention interventions and providing comprehensive TB/HIV and AIDS care with ART.

Gauteng Health is a lead Department for implementing the programme defined by this strategy, and has financial and programmatic responsibilities.

The budget for the HIV and AIDS programme forms part of the Health vote in the province. Other provincial Departments and sectors are allocated funds for implementing the programme from the approved HIV and AIDS Budget. The programme is implemented through all government departments and sectors, including NGOs and organisations for people living with HIV and AIDS, and monitored by the IDU

The Department of Health's particular programmatic functions are covered in this Sub-Programme, but also in other sections of this Strategic Plan, where appropriate.

The Inter Sectoral HIV and AIDS Strategy is summarised below; a detailed version can be found in the Gauteng HIV and AIDS Strategic Plan for 2005/06 attached as Annexure1.

Component two: sub – programme: GDH HIV & AIDS, STI & TB control programme

The purpose of the programme is to implement an effective comprehensive strategy AIDS Strategy to reduce HIV infection rates, increase length of productive life of those infected with HIV and support children and families affected by AIDS in order to reduce the impact of AIDS on society.

The AIDS programme goals for 2014 are:

- Dramatic reduction of new HIV infections with a major drop in HIV prevalence for babies and youth and some decrease for adults over 25 years.
- Significant and visible increase in the length of productive life for people infected with HIV, including those ill with AIDS.
- The children of families affected by AIDS achieve good psycho-social and educational development.
- AIDS impact on the economy, government service delivery and local communities is "contained" so that development is at least sustained and if possible accelerated.

Control of this group of related infections should be planned and implemented in an integrated manner and the information presented here is for an integrated HIV & AIDS/STI/TB control programme.

Situation Analysis

Appraisal of existing services and performance

The programme continues to record progress since the beginning of most of the sub-programmes in 2001. The major highlights of the achievement of the programme are as follows:

Prevention

Since its inception in 2001, the number of facilities that provide Voluntary Counselling and Testing for HIV (VCT) have increased from 10 to 275. The average VCT uptake amongst people who have received pre-test counselling is 65%, and the seroprevalance in this group is 32%. These rates are fairly constant each year since the beginning of the programme.

The prevention-of-mother-to- child transmission (PMTCT) programme, which started in May 2001 with two pilot sites, has been expanded. To date, all hospitals and large community health centres with maternity services and 60% of clinics with antenatal care (ANC) services, provide comprehensive PMTCT programme. The number of women reached with group counselling had increased from 67000 in 2003 to about 151 000 in 2004. The VCT uptake rates range from 58% to 68%. Nevirapine uptake

for women has increased from 69% in 2002 to 80%. It varies from district to district. The number of infants that received Nevirapine increased from 11 000 to about 26 000 in 2004.

Sexually transmitted infections (STIs) are managed now in 95% of the clinics in the province as a standard practice. The number of master trainers of service providers on syndromic management has increased from 13 in 2002 to 27 in 2003. The prevalence of syphilis among pregnant women had gone down to by 83% between 1999 and 2001 to 2.1% in 2003.

Male condom distribution increased from 3.6million per month in 2002 to the average of 8 million condoms per months in 2004/05 financial year. The Femidome distribution introduced in September 2001 increased from 57000 in 2001 to 30000 in 2003/04 financial year.

Since the inception of the post-exposure-prophylaxis (PEP) for victims of sexual violence in July 2002 the programme is implemented in 51 facilities including 26 medico-legal centres with 50.9% of facilities providing 24 hour service

Treatment, Care, and Support for HIV and AIDS

The management of opportunistic infections and prevention thereof is implemented in 90% of health facilities in the province. Clinical guidelines had been developed and 10 000 health professional have been trained since January 2002. A circular to enforce implementation was also released in March 2004. The provincial business plan for the provision of ART that form part of the national comprehensive plan for the management, care, and treatment of HIV and AIDS was developed and approved. Out of 23 facilities that had been identified for the 2004/5 financial year, 19 are currently operational after an intense process of accreditation and a total of 23 facilities are functional by end of 2004/05 financial year. About 103 000 clients had been assessed by end of February 2005. Of these, 11000 were started on ART and 1346 are children. A total of 737 service providers of all categories were trained for the programme and training continues. 1596 clients are on food supplements.

The diflucan donation partnership programme (DPPP) which was introduced in 2002 continues to expand. All hospitals and CHCs in the province are on the programme. Health professionals are trained on the management of opportunistic infections through this programme.

A retrospective records review study to assess the impact of HIV and AIDS on hospitals in the province was conducted in 2003/4, and it confirms some anecdotal reports from clinicians and managers that about 50-60% of admissions in medical and paediatric wards at hospitals in the sample are for HIV and AIDS related conditions. This is mainly in the age-group 30-39 for adults. This study provides valuable information for further planning and budgeting in the province.

The number of step-down beds was increased from 200 in 2002/03 to 278 in 2003/4 with aim of reducing the load in acute hospital beds and reduces hospitalisation costs. NGOs are the backbone for the delivery of HIV and AIDS projects. A total of funded NGOs increased from 207 in 2002/3 to 245 in 2003/4, and 226 were funded in 2004/5 financial year. About 500 hospice beds are funded through the programme since 2001. A community health worker (CHW) programme was started following the announcement by the Minister in 2003. Training of a multi-skilled cadre of health service provider started with a target to train 1000 Community Health Workers in this financial year. Coupled with this is the introduction of uniform remuneration for all, DOT supporters, VCT, PEP, PMTCT, home carers, home birth attendants, ART adherence supporters, etc.

TB Control

The key challenges facing the programme are to collaborate with all role players, and in particular to integrate the TB and HIV programmes, and to develop and implement an integrated social mobilisation and advocacy plan. TB beds need to be provincialised and the electronic patient record be implemented in all sub districts.

Table 25: National- Situation analysis indicators for HIV & AIDS, STIs and TB control

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	City of Jo'burg 2003/04	West Rand 2003/04	Ekurhuleni 2003/04	Sedibeng 2003/04	Tshwane 2003/04	Metsweding 2003/04	National target 2003/4
Input											
1. Hospitals offering PEP for occupational HIV exposure	%	100	100	100	100	100	100	100	100	100	100
2. Hospitals offering PEP for sexual abuse	%	100	100	100	100	100	100	100	100	100	100
Process											
3. TB cases with a DOT supporter	%	94	94	89	91.1	57.05	85.25	75.75	66.73	#	100
4. Male condom distribution rate from public sector health facilities	No	7m	8m	8.5m	#	#	#	#	#	#	7
5. Fixed facilities with any ARV drug stock out	%	0	0	0	0	0	0	0	0	0	0
Output											
6. STI partner treatment rate	%	#	#	13.5	14.6	20	29.2	27.2	26	32	27
7. Clients HIV pre-test counselled rate in fixed PHC facilities	%	#	#	26	33	20	15	27	29	14	80
8. TB treatment interruption rate	%	13	12	11	15	5	7	15	14	7	10

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	City of Jo'burg 2003/04	West Rand 2003/04	Ekurhuleni 2003/04	Sedibeng 2003/04	Tshwane 2003/04	Metsweding 2003/04	National target 2003/4
Quality											
9. TB sputa specimens with turnaround time > 48 hours	%	61	60	49	47	55	48	89	55	35	-
Efficiency											
10. Dedicated HIV/AIDS budget spent	%	N/A	63	102	199	193	116	79	101	#	
Outcome											
11. New smear positive PTB cases cured at first attempt	%	68	45	57	57	62	57	60	49	34	65

new indicator data not available

Policies, priorities and strategic goals

The table below summarises the various policies and strategies which guide the province's HIV, AIDS, STI and TB control programmes.

- Strategic plan for HIV/AIDS and STI for South Africa 2000-2005
- Gauteng AIDS Strategy
- WHO DOTS strategy adopted in 1996
- National TB strategy and guidelines
- Clinical guidelines on STI, condom distribution, VCT, PMTCT, PEP and Medical care
- Operational plan for comprehensive HIV and AIDS care, management, and treatment
- Home-based care
- Hospice beds and step down beds

The HIV, AIDS, STI and TB control programmes control programme falls under the Gauteng's strategic goal 1 and 2, and the **priorities for 2005/06 are to:**

- Intensify all prevention services with universal access for VCT, STI management, PMTCT, PEP, and expansion of the female condom programme for the empowerment of women
- Linking PMTCT to the comprehensive care and treatment and ARV programme with a special focus on pregnant women
- Collaborate with maternal and child health services, nutrition unit, health promotion and other stakeholders to improve the follow up of babies on the PMTCT programme and testing babies PCR at 6 weeks to improve follow up of infants
- Strengthen the implementation of the new STI sentinel surveillance system so that the old system is replaced completely and information is used for improvement in delivery of STI services
- Improved access of HIV and AIDS comprehensive care, management, and treatment programme through expansion to 40 sites and a target of 25 000 patients on treatment by March 2006.
- Ensure effective utilisation of partnerships to expand access to ART
- Strengthening monitoring and evaluation and set up an ongoing sentinel surveillance system to monitor the impact of the epidemic on the health care system
- Strengthen the TB control programme
- Develop and implement an integrated social mobilisation and advocacy programme, to improve detection, cure rates, and to reduce treatment interruption rates
- Ensure training, monitoring and integration of DOT supporters in line with the provincial community health worker (CHW) policy,
- Ensure DOT support for TB patients for the entire treatment period
- Implement the provincialisation of TB beds plan

Analysis of constraints and measures planned to overcome them:

CONSTRAINT	MEASURES PLANNED TO OVERCOME CONSTRAINT
Financial management systems	- Increase human resource capacity at central office, recruit financial manager at deputy director level. - Decentralise budgets to functional units, regions, facilities, and NGOs
Human resource capacity mainly at facility level	- Monitor service impact of new programmes and beef up staff according to need - NGO's with partners
Inadequate management capacity for NGO system	Continue training of NGO managers on financial and project management. Implement the provincial NGO monitoring tool. Set up a mentoring system for NGOs.
High demand for services because of the extent of the HIV and AIDS epidemic	- Expand services at the highest rate possible. Work with stakeholder groups to ensure appropriate utilisation of services by those affected. Market primary health care services for HAST - IEC
Pressure on hospitals for acute care	- Strengthen primary health care and the referral system - Ensure effective implementation of step-down beds plan - Strengthen the HIV/TB collaboration programme
Voluntary DOT supporters not sustainable	Integrate all DOT supporters into the provincial community health worker programme
Late TB case finding	- Implement focused awareness through "hot spot" campaigns - Train health workers on screening for PTB - Ensure implementation of the suspect register in all facilities
TB training not sustainable	Resuscitate the train the trainer programme

Specification of measurable objectives and performance indicators

Table 26: Provincial objectives and performance indicators for HIV & AIDS, STI and TB control

Strategic objective	Objective	Indicator	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
Prevent and reduce new HIV infections	Reduce new infections among antenatal care women	Antenatal sero prevalence rate (%)	29.8	31.6	29.6	29.6	Maintain 27.1-32.1 30*	Maintain 27.1-32.1 30*	Maintain 27.1-32.1 30*
		HIV prevalence rate for under 20yrs (15-24)	#	#	#	15	14.6	14.5	14
		Percentage infants tested	#	#	#	20	25	30	40
		Number of male condoms distributed per month	#	7m	8m	8.5m	8.5m	9m	9m
		Number of female condoms supplied per month	#	#	25 000	25 000	25 000	30000	35000

Strategic objective	Objective	Indicator	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
		Percentage of provincial hospitals and fixed clinics offering VCT	#	30	65	80	90	95	100
	Improve integrated collaboration between HIV and AIDS and TB programmes	Number of sub districts with TB/HIV training	#	#	#	12	15	20	25
Reduce the incidence of sexually transmitted infections	Syndromic management of STIs	Incidence of male urethral discharge	#	#	#	18.5	18.5	17	17
		Percentage of facilities offering syndromic management	80	80	85	95	97	98	98
		Antenatal sero prevalence rate (%) for syphilis	#	#	#	2.0	1.95	1.8	1.5

Strategic objective	Objective	Indicator	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
Intervention to reduce impact of violence against women and children	Complete rollout of PEP in all health facilities	No of hospitals and crisis centers offering PEP	26	34	47	47	55	60	60
	Improvement of treatment completion rates	Average completion rate of clients on PEP	#	#	#	30	40	50	60
Provide HIV and AIDS comprehensive care and treatment including ART in all sub districts by 2009	Provide HIV and AIDS comprehensive care and treatment including ART in all sub districts	Percentage implementation in - Public hospitals - CHCs - Districts	#	#	#	38 45 83	90 70 100	100 80 100	100 95 100

Strategic objective	Objective	Indicator	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
	PMTCT access	Percentage implementation of the programme in - Hospitals, - CHCs and - Clinics with antenatal care services	 # # # #	 # # # #	 # # # #	 100 100 100 60	 100 100 100 65	 100 100 100 68	 100 100 100 70
Provide HIV and AIDS comprehensive care and treatment including ART in all sub-districts by 2009	Rollout HIV and AIDS comprehensive care and treatment programmed in public health facilities, and investigate practical, effective and more efficient	No of health facilities offering ART	#	#	#	23	40	50	60

Strategic objective	Objective	Indicator	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
		Number of people on ART	#	#	#	10 000	20 000	45 000	60 000
Provide universal access to palliative care (home based care, hospice, step down facilities) to the population of Gauteng	Implement Community Health Worker programmes	No. of home bound people cared for	#	#	#	30000	35000	35000	35000
	Improve TB cure rate in new smear positive cases, strengthen Directly Observed Therapy Short course (DOTS) in facilities and in the communities	Smear positive cases as a percentage of all PTB cases	#	#	72	75	65	80	85
		New smear positive PTB cases as percentage of expected number of cases	#	#	#	70	80	82	82

Strategic objective	Objective	Indicator	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
		Percentage of TB cases who are re-treated	#	#	#	10	8	8	5
		PTB smear conversion rates at 3 months for retreated cases	#	#	#	70	80	80	85
		Percentage of TB cases that are MDR	#	#	#	1	1	1	<1

#new indicator, information not available

Table 27: National Performance indicators for HIV & AIDS, STI and TB control

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2008
Input							
1. ARV treatment service points compared to plan	%	#	100	100	100	100	100
2. Fixed PHC facilities offering PMTCT (offering ANC and MOU)	%	#	#	100	100	100	100
3. Fixed PHC facilities offering VCT	%	30	65	80	100	100	100
4. Hospitals offering PEP for occupational HIV exposure	%	100	100	100	100	100	100
5. Hospitals offering PEP for sexual abuse	%	100	100	100	100	100	100
Process							
6. TB cases with a DOT supporter	%	89	100	100	100	100	100
7. Male condom distribution rate from public sector health facilities	No	8m	8.5m	8.5m	9m	10.5m	11
8. Male condom distribution rate from primary distribution sites	No	#	#	15	20	25	32
9. Fixed facilities with any ARV drug stock out	%	#	0	0	0	0	0
10. Hospitals drawing blood for CD4 testing	%	#	100	100	100	100	100
13.Fixed facilities referring patients to ARV treatment points assessment	%	#	10	10	10	10	10
Output							
14. STI partner treatment rate	%	13.5	15	25	35	40	40
16.Clients HIV pre-test counselled rate in fixed PHC	%	100	100	100	100	100	100

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2008
facilities							
17.Patients registered for ART compared to target	%	#	100	100	100	100	100
18.TB treatment interruption rate	%	11	9	6	5	4	4
Quality							
19.CD4 test at ARV treatment service points with turnaround time >6 days	%	#	0	0	0	0	0
20.TB sputa specimens with turnaround time > 48 hours	%	49	48	48	48	48	0
Efficiency							
21.Dedicated HIV/AIDS budget spent	%	100	100	100	100	100	100
Outcome							
22.New smear positive PTB cases cured at first attempt	%	57	58	65	66	70	85
23.New MDR TB cases reported - annual % change	%	#	2	>2.5	>2.5	>2.5	
24.STI treated new episode among ART patients - annual % change	%	#	#	10	8	5	
25.ART monitoring visits measured at WHO performance scale 1 or 2	%	#	#	60	75	90	

 # new indicator data not available

Past expenditure trends and reconciliation of MTEF projections with plan

Table 28: Trends in provincial public health expenditure for HIV/AIDS conditional grant(R million)

Expenditure	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF Projection
Current prices`1							
Total	5 630	32 249	55 275	134 231	-	-	-
Total per person	1	4	6	15	-	-	-
Total per uninsured person	1	5	9	21	-	-	-
Constant (2004/05) prices							
Total	6 857	35 764	58 149	134 231	185 048	252 695	265 330
Total per person	1	4	7	15	21	29	30
Total per uninsured person	1	6	9	21	29	39	41

Sub-Programme 2.5: Disease Prevention & Control

The purpose of the programme is to render oral health and communicable diseases services *excluding HIV and AIDS, STIs and TB, chronic diseases, geriatrics and disabilities)*

Situation analysis for Disease Prevention & Control

Immunisation coverage for the under one population is at 79% while the target is 90%. Pockets of low immunisation coverage still exist and this puts the province at risk of disease importation and retards elimination and eradication strategies.
Gauteng has had a serious measles outbreak since August 2003 to date, though a slow decline of confirmed measles cases has been noticed towards the end of October 2004.
The National immunisation campaign was held in July and August 2004, 1st round 26th - 30th July; 2nd round 30th August - 3rd September 2004. The coverage was as follows 102% for the first round and 78% for the second round. The AFP stool adequacy is at 71% and the target is 80%. Each district and local municipality has an outbreak response team to deal effectively with all outbreaks.

Since 1999 the Department's prevention of blindness campaign has benefited 28 000 people through cataract surgery and corneal transplants.

Health promoting schools training for health promoters has been finalised. Each district has been requested to identify at least one school to ensure that this programmes takes off in Gauteng. This has been done and several district health promoters have come up with more than one school. The target of 6 schools has been set for 2004/05, and will probably be exceeded.
Chronic non-communicable diseases accounted for over 2.2 million in the PHC facilities in the province. In the City of Jo'burg metro these services are managed through a Primary Prevention Programme coordinated with the Renal Unit at CH Baragwanath hospital for 16 PHC facilities. The programme focuses on awareness campaigns at clinics to promote healthy living amongst the elderly and old age homes are also visited by medical officers to provide care and treatment

Table 29: National- Situation analysis indicators for disease prevention and control

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	City of Jo'burg	West Rand	Ekurhuleni	Sedibeng	Tshwane	Metsweding	National target
Input											
1. Trauma Centres for victims of violence	No of Medico Legal services sites	26	26	47	7	-	3	3	11	-	**N/A**
	No of hospital casualties	23	23	23	6	3	6	3	5	-	**N/A**
Process											
2. CHCs with fast queues for elderly persons	%	#	#	23*	#	#	#	#	#	#	**10**
Output											
3. Health districts with health care waste management plan implemented	No	6	6	6	1	1	1	1	1	1	**N/A**
4. Integrated epidemic preparedness and response plans implemented	Y/N	Y	Y	Y	Y	Y	Y	Y	Y	Y	**Yes**
5. Integrated communicable disease control plans implemented	Y/N	Y	Y	Y	Y	Y	Y	Y	Y	Y	**Yes**
Quality											
6. Outbreak response time	Days	2	2	2	2	2	2	2	2	2	2
Outcome											
7. .Dental extraction to restoration rate	No	0.15	0.14	0.13	0.11	0.13	0.15	0.09	0.19	0.40	0.5
8. Cataract surgery rate	No	#		5684	#	#	#	#	#	#	950

 # new indicator data not available

** source PHC services audit 2003 malaria deaths*

Policies, priorities and strategic goals for Disease Prevention & Control

Policies

Immunisation

- Multidose Open Vial Policy
- Tetanus Toxoid Policy
- Manuals –Cold Chain
- Field Guide

Health Promoting Schools.

To implement this programmes as rapidly as possible, the Provincial office is requiring Districts to take responsibility and implement the National Guidelines as stated below:

- National Guidelines For The Development Of Health Promoting Schools/Sites In South Africa (Draft 4 October 2000)

Strategic goals

- Ensure basic prevention and care of common childhood illnesses through EPI
- Establish and implement social mobilization and health promotion programmes to address key risk factors associated with preventable disease and deaths.
- Maintain smoke free work environments
- Implement programmes to reduce or alleviate the impact on the health sector of trauma and violence
- Implement Health Promoting Schools guidelines
- Partner with the Education Department to sustain Life skills programmes
- Enhance youth programmes to address the prevalence of HIV and AIDS and STIs, teenage pregnancies, smoking, alcohol and drug abuse
- Reduce prevalence and complications of common non-communicable diseases

Analysis of constraints and measures planned to overcome them

Constraints	Measures
Low immunisation coverage	Conduct mop-up campaigns Reach the far-rural communities by strengthening outreach programmes Provide immunisation on a daily basis Raising community awareness through print and electronic media Reduce missed opportunities by: 1. screening on visits 2. eliminating false contraindications Monitor and evaluate services through maps, info system, routine reporting
Unavailability of Road To Health Card (RTHC)	Monitor orders and utilisation of RTHC
Inadequate cold chain maintenance, equipment Staff shortages.	Districts to budget for cold chain equipment Maintenance and repair of equipment Prompt staffing improvements
Resistance of the GDE to implement Health Promoting Schools .	Meetings to continue at provincial level Meetings to start at District level Suggest that the National Education be asked to commit to this programme
No final Health Promoting Schools guidelines from National Dept. Still in Draft format - October 2000	Recommend finalisation of this document and endorsement by the Minister of Education.

Specification of measurable objectives and performance indicators for Disease Prevention & Control

Table 30: Provincial objectives and performance indicators for disease prevention and control

Objective	Key Actions/Projects	Indicator	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimated)	2005/06 (estimate)	2006/07 (estimate)	2007/08 (target)
Increase public understanding and the practice of healthy lifestyles and key risk behaviours with special focus on vulnerable groups and disadvantaged communities.	Maintain smoke free environment in all health institutions	Percentage institutions with smoke free policy in place	50	70	90	100	100	100	100
		Percentage of districts with disaster management plans	#	#	#	100	100	100	100
Reduce the prevalence and complications of common non-communicable diseases	Ensure chronic care support groups are functioning and supported	Percentage of sub-districts with support groups	#	100	100	100	100	100	
	Training of nurses and doctors	Number of health care workers trained in Sexual Assault Care Practice (clinical forensics) per year	#	#	#	40	40	40	40
Promote mental well-being and improve early diagnosis, treatment and support for people with mental illness	Improve early detection, treatment and care in order to minimize the long-term effects of mental disorder	Percentage of sub-districts with mental health services DHS	#	#	#	100	100	100	100
		Number of support groups in all districts	#	#	#	25	30	35	40

	Improve mental health services for children and adolescents	Number of beds for child and adolescents	#	#	#	25	Bara 35	Tara 45	Tara 50
	Reduction of beds in private institutions for patients with chronic mental illness	Number of beds for patients with chronic mental illness (contracted care)	#	#	#	3000	2900	2800	2700
	Reduce institutional care for people with chronic mental disorder and increase community -based care	Number of acute beds in hospitals	#	#	#	391	399	407	415
		Number of NGOs funded for mental illnesses	#	#	#	65	68	72	75
		Number of acute psych units in general hospitals	#	#	#	8	9	10	11
Provide rehabilitation and support to people with disabilities	Improve services of people with disabilities focusing on provision of free health care for people with disabilities, assistive devices and access for disabled in all health facilities	Percentage hospitals implementing free health care for PWD	#	#	#	100	100	100	100
		Number of vocational rehab assessments done of PWD	#	#	#	100	150	180	200
		Number of patients receiving Orthotic & Prosthetic services	#	#	#	10000	11000	12000	13000
		Number of funded NGOs providing services for PWD	#	#	#	3	3	4	4

Table 31: National Performance indicators for disease prevention and control

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/08
Input							
1. Trauma centres for victims of violence	No	26(all districts)	6	6	6	6	1 per district
Process							
2. CHCs with fast queues for elder persons	%	23	25	30	50	60	20
Output							
3. Health districts with health care waste management plan implemented	No	6	6	6	6	6	All districts
4. Hospitals providing occupational health programmes	%	#					100
5. Schools implementing Health Promoting Schools Programme (HPSP)	%	#	0.3	0.5	1	1.5	
6. Integrated epidemic preparedness and response plans implemented	Y/N	Y	Y	Y	Y	Y	Yes
7. Integrated communicable disease control plans implemented	Y/N	Y	Y	Y	Y	Y	Yes
Quality							
8. Schools complying with quality index requirements for HPSP	%	#	6	12	18	24	
9. Outbreak response time	Days	2	1	1	1	1	1
10. **Outcome**							
14. Cataract surgery rate	No	5684	10882	8000	8500	9000	1,000

PROGRAMME 3: EMERGENCY MEDICAL SERVICES AND PATIENT TRANSPORT

The purpose of this programme is to ensure rapid and effective emergency medical care and transport and efficient, planned patient transport in accordance with provincial norms and standards.

Situational analysis for Emergency Medical Services and Patient Transport

Provision of emergency medical services is the competence of provincial health departments. In Gauteng, local authorities provide the service on an agency basis. At present three District Municipalities and two Metropolitan Municipalities which deliver the service have signed a revised three-year (until 2006) Memorandum of Agreement (MoA) based on Emergency Medical Services Norms and Standards, The City of Tshwane has entered into a short-term interim agreement, pending a final decision on the three-year MoA.

EMS responded to 53.65% of calls within 15 minutes in 2003/2004. Due to difficulty in obtaining accurate data relating to the Response Times to Priority 1 cases, the response time to all cases was used. Mechanisms have been put in place to ensure more accurate collection of this critical information. All Gauteng calls were regarded as urban calls, but this policy has been reviewed and at present the surveys done also separate non-urban calls from urban calls.

Trained ambulance personnel attend more than 426 650 incidents and transport 434 128 patients, costing an average of R571 per patient transported, annually. Gauteng has a total of 317 emergency medical service vehicles (240 ambulances) travelling over 10 million kilometres per year. There are currently 1975 operational staff members of whom 1324 are registered Basic Ambulance Assistants, 594 are Ambulance Emergency Assistants and 57 are paramedics (i.e. advanced life support trained).

Table 32: Situational Analysis indicators for Emergency Medical Services

INDICATOR		PROVINCE WIDE VALUE 2001/02	PROVINCE WIDE VALUE 2002/03	PROVINCE WIDE VALUE 2003/04	PER DISTRICT 2003/2004						NATIONAL TARGET 2003/2004
					Ekurhuleni	City of Jo'burg	Metsweding	Sedibeng	Tshwane	West Rand	
INPUT											
1. Number of vehicles per 1000 people	Ambulance	0.027	0.027	0.027	0.035	0.014	0.095	0.031	0.023	0.038	0.2
	PRV	0.01		0.009	0.007	0.003	0.016	0.009	0.006	0.006	
	Total	0.04		0.039	0.044	0.020	0.119	0.053	0.029	0.044	
2. Hospitals with patient transporters		22	22	22	14,3	14,3	No hospital	Using private ambulances*	80	33	70
PROCESS											
3. Kilometres travelled per ambulance (per annum)		36 563	46 407	47 466	43 905	39301	75 677	60 908	42 629	50 345	-
4. Percentage of locally based staff with training in life support at basic level		Information not complete COJ was not collecting data	49.2	67	57.9	73.9	80.9	75.5	48	62.8	59
5. Percentage of locally based staff with training in life support at intermediate level			42.9	30	38.7	24.5	19.1	20.3	44.6	33.1	29
6. Percentage of locally based staff with training in life support at advanced level			7.9	3	3.4	1.6	0	4.2	7.4	4.1	15
QUALITY											
7. Percentage of response times within current national urban targets (15 min)		78.13 (excl Call Centre)	80.86 (excl Call centre)	53.65	92.7	5.7	93.3	50	49	92.9	50

8. Percentage of response times within current national rural targets (40 min)	Information not separated – process started in the current financial year									50
9..Percentage of call outs answered by single person crew	0	0	0	0	0	0	0	0	0	1.8
EFFICIENCY										
10. Ambulance journeys used for hospital transfers	No patients are transported by ambulances									30
11. Priority 3 patients transported by ambulance	45.3	38.14	42.3	55.1	51.1	25.8	56.5	35.9	0.7	
12. Cost per patient transported #		R 586.84	R 571.00	R 306.18	R 371.49	R 736.73	R 287.08	R 422.56	R 494.24	
13. Ambulances with less than 500 000 km on the clock	100	100	100	100	100	100	100	100	100	50
OUTPUT										
14. Number of patients transported per 1000 people per year	21.15	51.61	49.13	54.14	45.37	77.48	73.05	30.92	56.25	10

- Populations based on 2001 census.
- Unless otherwise specified the above table is based on the 2003-2004 financial year.
- The symbol # indicates that "Province Wide Value" was based on total budget while the "Per District" field was based on transfer budget.
- The percentages specified under trained staff (6, 7, 8) refer to the component of trained staff providing emergency care. Auxiliary staff were excluded.

Resource Allocation

The table below outlines the budget and vehicle allocation to the local authorities as determined by EMS Norms and Standards. In 2004/5 emergency medical services received a budget of R280 600 000, of which R 182 000 000 was allocated as transfer payment to Local Authorities. The remainder was used as a Central Budget to fund the vehicle fleet, medical equipment, and consumable medical supplies, communications infrastructure and specialised services, such air ambulance transport.

Table 33: Resource Allocation 2004/5

AGENT	TRANSFER BUDGET	AMBULANCE	RESPONSE VEHICLE	MINIBUS
Ekurhuleni Metropolitan Municipality	R60 995	91 [83]	18 [17]	8
Metsweding District Municipality	R7 609	8 [8]	2 [2]	1
City of Tshwane	R26 195	31 [34]	9 [7]	2
City of Johannesburg	R47 957	45 [65]	10 [13]	5
Sedibeng District Municipality	R20 933	26 [26]	7 [5]	2
West Rand District Municipality	R18 311	22 [23]	4 [5]	1

* The figures in [ ] reflect the proposed full basic Norms and Standards (based on 2001 census) quantity of vehicles.
*Vehicle numbers above include vehicles that may be written off after serious accident damage.

Policies, Priorities and Broad Strategic Objectives for Emergency Medical Services and Patient Transport

Policies

Emergency patient transport and planned patient transport are rendered on the basis of:

- Section 27 (3) of the Constitution;
- The Gauteng Ambulance Services Act, 2002;
- Memoranda of Agreement with municipalities; and
- Emergency Medical Services (EMS) Norms and Standards

Broad Strategic Objectives are guided by Gauteng's Strategic Goal 3, and are specifically to:

- Ensure the provision of rapid, effective and quality emergency medical services.
- Position public emergency medical services as the preferred service provider for the 2010 games; and
- Ensure 100% access to ambulance services for obstetric emergencies.

Priority actions for 2005/06 are informed by the key actions to implement the Strategic Goal, and are to:

- Investigate a 'flying' or fast obstetric ambulance/ emergency service;
- Ensure agents comply with the EMS Norms and Standards by:
  - Improving monitoring of response times
  - Improving reporting and compliance with PFMA and DORA
  - Increasing ambulance personnel with Intermediate and Advanced Life Support training.
- Implement Gauteng Ambulance Services Act
- Set up a quality assurance system by:
  - Establishing the Ambulance Services Board
  - Inspecting and accrediting ambulance services

Analysis of constraints and measures planned to overcome them

Constraint	Measures planned
Implementation of EMS Basic Norms and Standards Although most ambulances have been purchased, the delay in replacing the existing emergency vehicle fleet due to breakdowns is seriously hampering the ability of agents to achieve the set standards.	• Improve the availability of operational vehicles (see below) • Investigate alternative modes of transport of specific categories of patients where appropriate (e.g. use minibuses for P3 cases) • Investigate alternative methods of improving the existing fleet. • Develop a policy on equipment maintenance and replacement
Distribution of Trained Emergency Care Personnel The distribution of staff with advanced EMS qualifications is not appropriate, hampering implementation of the Norms and Standards	• Fill vacant posts with appropriately qualified personnel based on the Norms and Standards. • Increase the training of staff to Intermediate and Advanced Life Support levels (refer to Programme 6)
Implementation of a Planned Patient Transport Service There is insufficient funding to implement a co-ordinated Planned Patient Transport Service	• Allocate appropriate funding for sub-program 3.2 Planned Patient Transport within the MTEF period • Investigate possibility of sharing institutional based transport services

Specification of Measurable Objectives and Performance Indicators for Emergency Medical Services and Patient Transport

Table 34: Measurable objectives and performance indicators for Emergency Medical Services

Strategic Objectives	Measurable Objective	Indicator	2002/03 (actual)	2003/04 (actual)	2004/05 (target)	2005/06 (target)	2006/07 (target)	2007/08 (target)
Ensure the provision of rapid, effective and quality emergency medical services	Improve access to emergency medical services.	Number of vehicles	287	307	271	298	309	324
		Percentage of vehicles replaced per year	12.4	30.9	49	33	33	33
	Implement Emergency Medical Services norms and standards	Percentage of operational vehicles relative to Norms and Standards	80	80	85	90	100	100
	Implement Gauteng Ambulance Services Act	Ambulance Services Board established	#	#	#	1	1	1
		Percentage of existing Ambulance Services inspected and accredited	#	#	#	100	100	100

Strategic Objectives	Measurable Objective	Indicator	2002/03 (actual)	2003/04 (actual)	2004/05 (target)	2005/06 (target)	2006/07 (target)	2007/08 (target)
	Implement planned patient transport system	Percentage of planned patient transports managed by a coordinated planned patient transport system	#	#	#	7	20	50
	Training of staff in call centres, triage and call centre Management	Number of staff trained in call centres, triage and call centre management in each district	#	#	#	2 per district	-	-
	Annual Public campaign on EMS services	Number of Annual public campaigns conducted	#	#	#	1	1	1

New indicator, data not available

Table 35: Performance Indicators for the EMS and patient transport

INDICATOR		Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/2008
INPUT								
1. Number of vehicles per 1000 people	Ambulance	No	0.027	0.027	0.024	0.027	0.029	0.3
2. Hospitals with patient transporters		%	22	22	30	50	50	100
PROCESS								
3. Kilometres travelled per ambulance (per annum)		Km	53 515	66 000	66 000	66 000	66 000	-
4. Percentage of locally based staff with training in life support at basic level		%	67%	75	75	75	64	100
5. Percentage of locally based staff with training in life support at intermediate level		%	34%	20	20	20	27	
6. Percentage of locally based staff with training in life support at advanced level		%	5%	5	5	5	9	
QUALITY								
7. Percentage of response times within current national urban targets (15 min)		%	53.65%	80	80	80	80	100
8. Percentage of response times within current national rural targets (40 min)		%	#	80	80	80	80	100
9..Percentage of call outs answered by single person crew		%	0	0	0	0	0	0
EFFICIENCY								

INDICATOR		Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/2008
10. Ambulance journeys used for hospital transfers	EMS	%	#	#	1	1	1	0
	PPT	%			80	80	80	
11. Priority 3 patients transported by ambulance		%	42.3	40	40	30	20	
12. Cost per patient transported #		R	571	600	600	600	600	
13. Ambulances with less than 500 000 km on the clock		%	100	100	100	100	100	50
OUTPUT								
14. Number of patients transported per 1000 people per year			49.13	50	50	50	50	50

New indicator, data not available

Please note that the above indicators, except where indicated otherwise refer to Emergency Transport and not Planned Patient Transport.

The staff at Intermediate Life Support level is expected to decrease within the combined services as the services are separated from Fire and therefore staff would need to be trained to fill the gap. In addition the total number of dedicated ambulance staff is expected to increase to achieve the specified level according to the norms and standards and therefore although the percentage may decrease the actual numbers are expected to increase.

3.1 Past Expenditure Trends and Reconciliation of MTEF Projections with Plan

Table 36. Trends in Provincial public health expenditure for EMS and Planned Patient Transport (R million)[1]

Sub-programme	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF projection)
Sub Programme	**2001/02 (actual)**	**2002/03 (actual)**	**2003/04 (actual)**	**2004/05 (estimate)**	**2005/06 (MTEF projection)**	**2006/07 (MTEF projection)**	**2007/08 (MTEF Projection**
1. Emergency transport	206 714	214 475	230 743	247 820	284 150	292 045	304 100
2. Planned Patient Transport	-	-	50	100	3 000	10 000	15 000
Total Programme (Current)	206 714	214 475	230 793	247 920	287 150	302 045	319 100
Total per person	23.39	24.27	26.12	28.05	32.49	34.18	36.11
Total per uninsured person	32.25	33.46	36.01	38.68	44.80	47.13	49.79
Capital	73	5	17 107	47 680	22 622	23 055	22 000
Constant (2004/05) prices							
Total	251 778	237 853	242 794	247 920	-	-	-
Total per person	28	27	27	28	-	-	-
Total per uninsured person	39	37	38	39	-	-	-
Capital	89	6	17 997	47 680	-	-	-

1. Please note that the increase in Planned Patient Transport is to enable the service to be established at 50% for 2005 and 100% in 2006. From 2007 onwards vehicles will be replaced at 33% per year for PPT.
2. The Norms and Standards level of funding increases by 5% per year to reach 100% by 2007/08.
3. General increase of 6% used for projection

PROGRAMME 4: PROVINICIAL HOSPITAL SERVICES

The purpose of this programme is to render level two hospital services provided by specialists.

Provincial Hospital Services has four sub-programmes:

- Regional Hospitals;
- Tuberculosis Hospitals
- Psychiatric/Mental Hospitals;
- Dental training Hospitals, and Other Specialised Hospitals.

Provincial Hospital Services developed its plans for the MTEF from the platform created by the Department's Strategic Goals, and, specifically, the goals to:

- *Strategic Goal 1:* Promote health, prevent and manage illness or conditions with emphasis on poverty, lifestyle, trauma and violence, and psychosocial factors;
- *Strategic Goal 2:* Effective implementation of the comprehensive HIV and AIDS strategy
- *Strategic Goal 3:* Strengthen the district health system and provide caring responsive and quality health services at all levels;
- *Strategic Goal 4:* Implement the people's contract through effective leadership and governance; and
- Strategic Goal 5: Become a leader in human resource development and management for health.
- Also there is relevance of goal 6 around improvement of finance of all the other

The plans were also informed by the national Strategic Position Statement (SPS) and Gauteng Health Service Improvement Plan.

Situational analysis for Provincial Hospital Services

The Provincial Hospital Services provide the next level of care from the District hospitals. Gauteng currently has 11 regional hospitals, three academic oral and dental schools, four psychiatric hospitals, one infectious diseases hospital, as well as contracted TB and psychiatric beds.

In terms of the departmental *Service Improvement Plan*, the bulk of patient care is to be shifted from central to regional and district hospitals. This means Regional Hospitals will need to be strengthened to provide support for district hospitals and help to prevent unnecessary referrals to central hospitals. The *Service Improvement Plan* has two objectives, namely to:

- Re-organise services for improved health status and affordability; and
- Ensure an affordable and equitable staff establishment.

In terms of Programme Four, these objectives should be implemented through:

- Outreach programmes from Central Hospitals;
- Reducing the number of beds in regional hospitals through monitoring of admissions, (ALOS, BOR and clinical audits); and
- Shifting the ratio of Level 1: Level 2 beds per hospital.

Table 37: Public hospitals by hospital type

Hospital type	Number of hospitals	Number of beds	Beds per 1000 uninsured people[1]		
			Provincial average	Highest district (include name)	Lowest district (include name)
General (regional)	11	6638	1.1	1.86 (Ekurhuleni)	0.63 (CoJ)
Sub-total - acute hospitals					
Tuberculosis[2]			---	---	---
Psychiatric[2]	4	2253	0,34---	Tshwane/ Metsweding	Ekurhuleni/ Sedibeng
Other specialist (Trop)			---	---	---
Total public			---		
Private sector psych (Contracted Care)	7	3150	0,53	Ekurhuleni/ Sedibeng	Tswhane/ Metsweding

Table 38: Public hospitals by level of care

Hospital type	Number of hospitals providing level of care	Number of beds	Beds per 1000 uninsured people[1]		
			Provincial average	Highest district (include name)	Lowest district (include name)
Level 1	20	3221	0.49	#	#
Level 2	12	3851	0.59	#	#
Level 3	4(psych)	2253	0.34	#	#
				#	#
All acute levels		9325	1.4	#	#

#new indicator, information not available

Policies, Priorities and Broad Strategic Objectives for Provincial Hospital Services

The Provincial Hospital Services' strategic plan is based on the national Strategic Position Statement (SPS) and Gauteng's Service Improvement Plan and strategic plan of action, as well as principles of equity, access, efficiency, and quality and community involvement. The strategies envisage a shift from hospitals to primary health care and ambulatory care, and a concomitant shift of resources. Key to this process is the methodology of measuring and monitoring the cost drivers of population, admissions, hospital length of stay, level of care and costs and HIV and AIDS.

Broad Objectives for year 2005/2006, driven by the provincial strategic goals are to:

- Strengthen regional hospitals through availability of general specialists and strengthening the referral systems at all levels
- Provide efficient and effective clinical support services (allied, laboratory, pharmaceuticals, blood services, radiology);
- Strengthen management of state aided hospitals and monitor compliance with Service Level Agreements;
- Reduce waiting times at pharmacies and out-patient departments;
- Provide people-centred care that recognises individual dignity and uniqueness;
- Modernise, re-organise and re-vitalise public hospitals into cost-effective referral centres according to the SIP; and
- Provide HIV and AIDS comprehensive care and treatment including ART in all sub districts by 2009.

Priority actions

- Strengthen management at hospital level;
- Commence phase one implementation of the Service Improvement Plan;
- Improve customer care with special focus on clinical audit and reduction in waiting times;
- Implement best practice strategies to address attitudes and improve morale of frontline staff;
- Place signage with pictures of management and contact details at the entrance of all health facilities;
- Strengthen services in the large regional hospitals in the historically disadvantaged areas;
- Improve down-referral of appropriate patients to clinics, community health centers, community-based centres and NGOs;
- Strengthen implementation of financial, procurement and human resource delegations; and
- Roll-out HIV and AIDS comprehensive care and treatment including ART

Sub-Programme: Regional Hospitals

The purpose of this sub-programme is to render specialised hospital services provided by general specialists and serves as platform for the training of health workers**.**

Situation Analysis for Sub-Programme Regional Hospitals

Gauteng Province currently has 11 Regional Hospitals (7 large regional and 4 small) with generalist as well as some general specialist services. Currently there are 6 638 approved Regional hospital beds of which 5 953 are in actual use. Johannesburg-West Rand Region has 3 large regional hospitals and 2 small regional (district plus) hospitals; Ekurhuleni-Sedibeng Region has 4 large regional and 2 small regional (district plus) hospitals, Tshwane-Metsweding has 1 large regional hospital.

The key challenges for regional hospitals are to retain quality generalist specialist care, to reduce patient day cost, to reduce or contain average length of stay to about 4 day, to increase BOR to 80% and to utlise allocated level 2 beds appropriately as indicated for basic specialised care.

In order to achieve more appropriate utlisation of Regional hospitals, three of the current 11 hospitals have been earmarked as district plus hospitals, where a shift of the level of care will be phased in over the MTEF period. This shift implies an increase in the percentage of level 1 beds in exchange for a simultaneous decrease in the percentage of level 2 beds as illustrated in Table 38.

In addition to these measures another two district hospitals in the Tshwane and Ekurhuleni regions are currently being upgraded to district plus hospitals in order to achieve more equitable geographical distribution of level 2 specialist service access in previously disadvantaged areas.

Table 39: Situation analysis indicators for general (regional) hospitals

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	City of Jo'burg	West Rand	Ekurhuleni	Sedibeng	Tshwane/ Metsweding	National target 2003/4
Input										
1. Expenditure on hospital staff as % of regional hospital expenditure	%	72.4	66.3	67	62.6	#	69.3	#	70.0	66
2. Expenditure on drugs for hospital use as % of regional hospital expend	%	6.5	7.3	7.7	8.8	#	6.9	#	7.8	12
3. Expenditure by regional hospitals per uninsured person	R	141.43	255.76	273.61	212.77	#	342.71	#	268.69	
Process										
4. Regional hospitals with operational hospital board	%	70	100	100	100	100	100	100	100	80
5. Regional hospitals with appointed (not acting) CEO in post	%	30	60	80	67	100	70	100	100	75
6. Facility data timeliness rate for regional hospitals	%	#	#	#	#	#	#	#	#	43
Output										
7. Caesarean section rate for regional hospitals	%	-	-	18.2	17.6	17.3	15	30.6	33.6	22
Quality										
8. Regional hospitals with clinical audit (M&M) meetings every month	%	#	80	60	100	100	70	100	100	90

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	City of Jo'burg	West Rand	Ekurhuleni	Sedibeng	Tshwane/ Metsweding	National target 2003/4
Efficiency										
9. Average length of stay in regional hospitals	Days	3.4	4.4	4.8	3.9	4	4.6	4	6	4.8
• Bed utilisation rate (based on usable beds) in regional hospitals	%	69	72	88	80	72	78	60	72	72
10. Expenditure per patient day equivalent in regional hospitals	R (No)	#	824	818.32 (11)	979.72 (3)	664.86 (1)	663.43 (5)	667.06 (1)	1219.68 (1)	1,128
Outcome										

New indicator, data not available

Policies, Priorities and Broad Strategic Objectives for Sub-Programme Regional Hospitals

Broad Strategic Objectives are guided by Gauteng's Strategic Goals and are specifically to:

- Promote health, prevent and manage illnesses or conditions with emphasis on poverty, lifestyle, trauma and violence and psychosocial factors
- Effectively implement the comprehensive HIV and AIDS strategy;
- Strengthen the district health system and provide caring, responsive and quality health services at all levels;
- Implement the people's contract through effective leadership and governance;
- Become a leader in human resource development and management for health;
- Operate smarter and invest in health technology, communication and management information systems.

Priority actions for the sub-programme for 2005/06 are informed by the key actions required to implement the strategic goals, and the Service Improvement Plan, and include to:

- Strengthen services in large regional hospitals in historically disadvantaged areas;
- Improve down-referral management of appropriate patients to clinics, community health centres, community-based centres and NGOs;
- Roll-out HIV and AIDS comprehensive care and treatment including ART in hospitals;
- Implement the cost centre management strategy and build capacity and skills of middle management to effect cost centre management requirements;
- Strengthen implementation of Hospital minimum data set;
- Manage the impact of HIV and AIDS;
- Improve customer care through focusing on clinical audits and reduced waiting times; and
- Developing strategies to address attitude and improve morale of frontline staff.

Analysis of constraints for Sub-Programme Regional Hospitals and measures planned to overcome them

Constraints	Measures planned
The "complex burden of disease" which includes the impact of the HIV/AIDS epidemic; The impact of injury caused by trauma and violence, and adverse patients events; The increasing load of chronic diseases of lifestyle on hospital service delivery.	Develop and implement a provincial "norms and standards" package for regional hospitals; linked to the SIP Hold regular Morbidity and Mortality Clinical Audits, to review "case-mix", "cause of hospital deaths" and "adverse event management" and use information in an "evidence-based" hospital service delivery rationalisation process. Intensify public health education on healthy lifestyles
Ambulance diversions from hospitals due to non-availability of beds, especially for Obstetrics and Neonatology, General Surgery and ICU.	Creating more step-down bed facilities to free up expensive hospital beds Creating day-care elective services for minor procedures Strengthening the central Metro-Control service control responsible for diverting ambulances to appropriate hospitals with available beds; Revision of SIP with specific focus on ambulance diversions where shortage of beds and service needs are experienced.
Declining work ethics, commitment and staff morale	Create staff support counsellors at institutional level to strengthen the employee assistance programme (EAP). Implement and use a performance appraisal system. Strengthen functional Occupational Health and Safety Committees, including AIDS workplace programmes and Employees' Assistance Programme availability.
Labour instability in institutions. Central Office management and finalisation of misconduct cases lengthy and dis-empowering for hospital managers.	Increase capacity building on decentralised labor relations management for frontline and middle managers at institutional level; Decentralise management of misconduct case procedures. Focus on PFMA reporting
Inadequate capacity, especially in clinical services and information management co-ordination and data collection	Revise information management posts at facility, Regional and Head Office HIS levels to strengthen capacity and improve on information

Constraints	Measures planned
Implementation of centralised GSSC further lengthens process management and finalisation.	collection processes and availability. Consolidate management and implementation of Hospital Minimum Data Set; Speed up implementation of incentives to recruit and retain specialised skills especially in the clinical field. Review centralisation of certain administrative processes to remove current obstacles, and bureaucratic processes experienced.
Inadequate revenue generation systems	Improve billing systems
Inadequate decentralisation of functions to institutional level for to manage budget and over-expenditure	Increase decentralisation of decision making on hospital expenditure management Improve information management utilisation at institutional level re. case mix reviews and cost centre development with a move towards budget per case-mix delivery allocation and related expenditure cuts.

Specification of measurable objectives and performance indicators for Regional hospitals

Table 40: Provincial objectives and performance indicators for general (regional) hospitals

Strategic Objectives	Measurable Objective	Indicator[1]	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)	2008/09 (target
Improve the capacity of managers and staff to manage and steer health sector transformation	Strengthen and capacitate management (nursing, administration, medical) team in hospitals	Percentage hospitals with appointed CEOs, Superintendent, Nursing manager and Administrative manager	#	100	100	100	100
Implement an effective Performance Management system	Develop performance work plans for all hospital CEOs	Percentage of hospital CEOs with performance work plans	#	100	100	100	100
Provide people centred care that recognises the dignity and uniqueness of each person	Shorter waiting times for patients	Percentage reduction in overall waiting times for pharmacy, casualty and outpatient (cumulative)	5	10	20	25	30

Strategic Objectives	Measurable Objective	Indicator[1]	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)	2008/09 (target
Provide people centred care that recognises the dignity and uniqueness of each person	Ensure coordination of quality management in hospitals	Percentage of hospitals implementing quality assurance programme	#	100	100	100	100
Provide efficient and effective clinical support services (allied, laboratory, pharmaceuticals, blood services, radiology etc)	Ensure availability of drugs on EDL in all institutions	Percentage of hospitals with all EDL drugs available	98	100	100	100	100
Provide HIV and AIDS comprehensive care and treatment including ART in all sub districts by 2009	Ensure provision of comprehensive TB/HIV and AIDS care including ART	Percentage of hospitals implementing ART	80	100	100	100	100

Strategic Objectives	Measurable Objective	Indicator[1]	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)	2008/09 (target
Improve the health and wellbeing of children under six years and those at risk due to poverty	Kangaroo Mother Care	Percentage of hospitals with Kangaroo Mother Care (KMC)	90	100	100	100	100
	Implementation of Perinatal Problem Identification Programme (PPIP)	Percentage of hospitals with PPIP	90	100	100	100	100

#new indicator, information not available

Table 41: National Performance indicators for general (regional) hospitals

Indicator	Type	2003/04	2004/05	2005/06	2007/08	National target 2003/4
Input						
1. Expenditure on hospital staff as % of regional hospital expenditure	%	67	67.0	66.7	67.6	66
2. Expenditure on drugs for hospital use as % of regional hospital expend	%	7.7	8.1	8.1	8.1	12
3. Expenditure by regional hospitals per uninsured person	R	273.61	273.61	295.29	310.01	
Process						
4. Regional hospitals with operational hospital board	%	100	100	100	100	80
5. Regional hospitals with appointed (not acting) CEO in post	%	80	100	100	100	75
6. Facility data timeliness rate for regional hospitals	%	#	50	60	70	43
Output						
7. Caesarean section rate for regional hospitals	%	18.2	19	18.5	18	18
Quality						
8. Regional hospitals with patient satisfaction survey using DoH template	%	#	10	25	50	100
9. Regional hospitals with clinical audit (M&M) meetings every month	%	60	90	100	100	100
Efficiency						
10. Average length of stay in regional hospitals	Days	4.8	4.4	4.3	4.3	4.8
11. Bed utilisation rate (based on usable beds) in regional hospitals	%	88	75	75	74	72
12. Expenditure per patient day equivalent in regional hospitals	R	824	783	1 128	1 128	1,128
#new indicator, information not available						

Past expenditure trends and reconciliation of MTEF projections with plan:

Table 42: Trends in provincial public health expenditure for general (regional) hospitals (R million)

Expenditure	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF Projection
Current prices`1							
Total	906 466	1 639 179	1 753 596	1 892 584	-	-	-
Total per person	103	185	198	214	-	-	-
Total per uninsured person	141	256	274	295	-	-	-
Constant (2004/05) prices							
Total	1 104 076	1 817 850	1 844 783	1 892 584	1 986 900	2 085 202	2 195 200
Total per person	125	206	209	214	225	236	248
Total per uninsured person	172	284	288	295	310	325	343
Capital	22 511	43 268	27 757	57 054	66 100	69 530	73 000

Sub-programme: Tuberculosis Hospitals (Contracted and Private-aided Hospitals)

The purpose of this Sub-Programme is to render specialist hospital service for tuberculosis patients through contracted and private-aided TB hospitals.

Situation Analysis for Sub-Programme Tuberculosis Hospitals

Gauteng's Health department provides TB care services through six private-aided and contracted hospitals. The department maintained 820 contracted TB beds in SANTA and 675 in Lifecare hospitals, during the past financial year. Hospitalisation is mainly for ill and complicated cases, as Directly Observed Treatment (DOT) has been strengthened in communities. Between 60% and 80% of hospitalised TB patients are HIV positive and most are ill because of AIDS. The challenge remains to increase the utilisation and quality of care at TB hospitals. MDR-TB cases are admitted in Sizwe Tropical Disease Hospital, a specialised Provincial hospital.

Private aided/contracted hospitals

Name	No. of Beds	Bed occupancy rate	Average length of stay	Patient days	Admissions
SANTA hospitals					
Charles Hurwitz	350	70%	63 days	87923	1395
East Rand SANTA	350	80%	90 days	101285	1118
Tshepong SANTA	120	93%	65 days	40605	566
Life CARE hospitals					
Lifemed	175	95%	50 days	60598	2040
Knights Chest	350	78%	54 days	99318	3689
Randfontein South	150	88%	55 days	47996	1820
Grand Total	**1495**	**84%**	**63days**	**437725**	**10628**

Policies, Priorities and Broad Strategic Objectives for Sub-Programme: Tuberculosis Hospitals

Tuberculosis Hospitals fall under Gauteng's Strategic Goals 2 and 3, and strategic objectives are to start a process of provincialisation of TB beds by:

- Strengthening the management of state aided hospitals;
- Monitoring compliance with Service Level Agreements;
- Achieving 90% bed occupancy at TB hospitals; and
- Improving collaboration with HIV and AIDS and TB programme.
- Determining the feasibility of TB beds in our district hospitals

Based on key actions and projects, the priority activities for 2005/06 are to:

- Finalise and implement contracts/service level agreements for TB hospitals;
- Ensure effective utilisation of TB hospitals;
- Strengthen the TB control programme by complying with treatment guidelines and standardising the TB drug regimen in funded hospitals;
- Liasing with provincial hospitals and funded and specialised hospitals for smooth transfer of patients;
- Ensuring effective down referral of patients to CHC's and clinics and other DOTS services;
- Ensuring HIV/TB collaboration and optimal HIV and AIDS care;
- Promote and provide VCT services at TB hospitals; and
- Refer to HIV and AIDS care services, to assess readiness for ART.

Analysis of constraints for Sub-Programme TB Hospitals, and measures planned to overcome them

Constraints	Measures planned to overcome constraints
A National review of Lifecare and SANTA hospitals in 2001 indicated mismanagement of funds by SANTA National.	- Develop an efficient financial monitoring system. - Implement in phased in manner the MinMEC decision to integrate TB beds into the provincial system
Under-utilisation of contracted hospitals beds	- Strengthening admission and discharge criteria and referral pathways with provincial hospitals. - Strengthening monitoring of and accuracy in utilisation reporting
Patients admitted are ill	- Strengthening training and funding for treating opportunistic infections. - Provide comprehensive AIDS care and referrals for ART to CHC

Specification of Measurable Objectives and Performance Indicators: TB hospitals

Table 43: Measurable objectives and evolution of performance indicators for TB hospitals

Strategic objectives	Measurable Objective	Indicator	2002/03 (Actual)	2003/04 (Actual)	2004/05 (Estimate)	2005/06 (Target)	2006/07 (Target	2007/08 (Target)
- Strengthen the management of state aided hospitals and monitor compliance with SLAs	Improve monitoring of SANTA and Life Care hospitals	Number of service level agreements signed	#	#	6	6	6	6
Modernisation, re-organisation and re-vitalisation of all public hospitals into cost effective referral centres according to the service plan	Ensure to Provincialise TB Beds	Number of TB beds maintained	1495	1495	1495	1435	1435	1435
	Ensure hospital efficiency	Average Length of stay (ALOS)	62	55	53	50	50	50
		Bed Occupancy Rate (BOR)	85	90	90	90	90	90

#New indicator, data not available

Past expenditure trends and reconciliation of MTEF projections with plan for TB Hospitals

Table 44: Evolution of expenditure by budget programme and sub-programme in current price (R '000) for Private Aided/Contracted hospitals

Sub-programme	2000/01 (actual)	2001/02 (actual)	2002/03 (actual)	2003/04 Adjusted budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)	2006/07 (MTEF projection)
Randfontein South	5 546 477	6 656 079	6 507 038	67 382 193	7 209 895	7 714 587	To be determined
Lifemed	6 395 022	7 208 732	75 915 434	7 861 256	8 411 543	9 000 352	To be determined
Knights	12 090 318	12 454 381	13 664 778	15 722 511	16 823 086	18 000 702	To be determined
Tshepong	3 451 425	2 567 410	3 869 730	4081 941	4 367 677	4 673 414	To be determined
Charles Hurwitz	7 221 550	7 473 455	10 692 675	11 905 661	12 739 057	13 630 790	To be determined
East Rand SANTA	8 007 384	8 609 225	10 692 675	11 905 661	12 739 057	13 630 790	To be determined

Sub-Programme : Psychiatric Hospitals

Situation analysis for Psychiatric Hospitals

Gauteng renders mental health services through a system composed of:

- Specialised psychiatric hospitals, acute psychiatric units in general hospitals, district mental health services and subsidized NGO services providing community-based day and residential care.
- four specialised psychiatric hospitals (2 253 beds); eight contracted psychiatric hospitals (3000 beds);
- acute psychiatric units in general hospitals (central and regional)
- Generalist and specialist mental health services in the district health services
- Subsidized NGOs providing community-based care for clients with severe psychiatric\disability or severe/profound intellectual disability.]

The number of acute psychiatric beds in Gauteng is in line with the national target norm of 25/100000. There is inadequate early identification of mental disorders (pick-up rate of 0.16% compared with expected 10% of cases in PHC), with patients using higher levels of care as first entry point. Contracted chronic care services remain essentially institutional. There is however some progress made with regards to deinstitutionalization. The new Mental Health Care Act which is in imprint with the following strategic objectives was promulgated in December 2004. The Gauteng Department of Health has started with the implementation.

A special case worth noting is Culminant Care & Rehabilitation Centre which has 298 active beds for the Intellectually Disabled. It is impossible to classify these individuals as either children or adults because their needs are similar to those of children irrespective of their chronological age.

Policies, Priorities and Broad Strategic Objectives for Psychiatric Hospitals

National and provincial mental health policies have been developed and approved. These are also linked to the provincial strategic plans and the five year strategic priorities for the National Health system. Basically, the provincial mental health policy spells out the need to:

- Promote mental well-being and improve early diagnosis, treatment and support to people with mental illness.
- Develop a comprehensive mental health service at all levels of care, both in the district and hospital services, and ensure that mental health services are available and accessible to the community, as close to their homes as possible.
- Improve early detection, treatment and care in order to minimize the long-term effects of mental disorders.

- Reduce institutional care for people with chronic mental disorders and increase community-based care.
- Improve mental health services for children and adolescents.
- Promote mental health and a human-rights approach to dealing with people with mental disorders.
- Implement clinical audit systems and processes across the services system with adequate support to establish a database (e.g. human resources, technical)
- Develop private psychiatric services in Folateng units (i.e. Johannesburg and Helen Joseph hospitals)

Analysis of constraints and measures planned to overcome them

Constraints	**Measures planned to overcome constraints**
Mental health services underdeveloped and marginalized, with low prioritization of mental health and mental illness;	Open 10-bed Child Psychiatry Unit at Chris Hani Bara Hospital; Open additional 10-bed Psych Unit at Tara Hospital; Re-open 40-bed Child and Adolescent Psychiatric Unit at Sterkfontein Hospital
Attrition of staff, over the last 2 years, particularly experienced staff and allied health professionals (due to emigration and movement to the private sector) has left services being run largely by inexperienced and junior staff	Support initiatives to retain experienced staff, including allied health professionals. (Possible use of scarce skills allowance to attract and retain staff, when it becomes available or when applied to psychiatric staff)
Limited number and range of resources for community-based care and inadequate to care/supervise deinstitutionalized patients.	Continue with initiatives to promote the development and expansion of community care. Strengthen Community Mental Health Service through provision of Human and Material Resources, on going capacity building and support
Stigmatization of mental illness and disability in the health services and in the community	Continue with programmes to combat stigmatization and promote integration
Impact of AIDS	Provide advisory services on psychological manifestations of AIDS. Training of PHC staff on Psychiatric manifestations of HIV/AIDS
Inappropriate institutionalisation of people at Cullinan Care and Rehab Centre	Intensify the process of deinstitutionalization at Cullinan

Specification of Measurable Objectives and Performance Indicators for Psychiatric hospitals

Table 45: Provincial objectives and performance indicators for Psychiatric hospitals

Measurable Objective	Indicator[1]	2001/02 (actual)	2002/03 (actual)	2003/04 (estimate)	2004/05 (target)	2005/06 (target)	2006/07 (target)	2007/08
Improve early detection, treatment and care to limit long-term effects of mental disorders	Detection rate (%) of acute mental disorder in PHC clinics	<1%	<1%	<1%	2%	3%	5%	7%
	Percentage of chronic stable patient with mental illness seen in PHC service for follow up treatment	1.6%	1.6%	1.6%	3%	5%	7%	8%
	Bed ratio: acute beds/100 000 pop.			25	25	25	25	25
Improve mental health services for children and adolescents	Number of operational child psychiatric in patient beds	15	15	60	60	120	120	120

Measurable Objective	Indicator[1]	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)
Reduction of beds in private institutions for patients with chronic mental illness	Number of beds for patients with chronic mental illness (contracted institutions)	3590	3400	3300	3000	2850	2700	2550
De-institutionalisation of mental health care users	Number of chronic care beds in specialized hospitals	912	900	900	850	800	750	700
Ensure Hospital Institution utilization	Number of NGO day and residential care placements for severe psychiatric disability	620	685	755 centres:20	825 centres:26	895 centres: 32	965 centres: 38✓	1035 centres: 44
	Number of NGO day residential care places for intellectual disability	2378	2400	2430 centres: 53	2460 centres: 55	2490 centres: 57	2520 centres: 59✓	2540 centres: 62
Establish hospital board in the hospital	Percentage hospitals with operational hospital board established (in terms of new legislation)	75	75%	100 (i.e. 4)	100	100	100	100
Strengthened and capacitate management team in the hospital	Percentage of managers capacitated and strengthened on financial matters	#	#	70	90	100	100	100

 # new indicator data not available

Table 46: Hospital & Community Mental Health Services budget

2001/2	2002/3	2003/4	2004/5
626 000	160 000	3 166 100	4 533 364

The budget for 2004/05 includes an additional R3 million for the establishment and implementation of Mental Health Review Boards. In The financial Year 2004/05, the process of the implementation of the Mental Health Review Boards (MHRB) started. Five MHRB's are in place and have started doing evaluation of admissions and processing of appeals, according to the Act.

Budget (derived from savings from budget for contracted care)

Table 47 :(Project on Chronic Mental Health Care)

2001/2	2002/3	2003/4	2004/5
5 673 750	9 160 097	7 989 021	7 500 000

With expenditure for 2003/04 there was still significant under-spending. The reasons for under-expenditure were largely due to the following: New NGOs still need to be developed to a stage where they are claiming full subsidies, the slow response in processing NGOs claims especially newly licensed ones as they lack administrative capacity and knowledge in this area, the difficulty in obtaining structures/ buildings for day and residential care which is far too expensive for new NGOs to rent or buy, the lack of suitable premises and funding for structures especially day care and the Projects reliance on the Districts to utilize these funds. In consequence, the budget for 2004/05 has been scaled down from previous MTEF projections.

Table 48: Contracted care payments Budget

Items	2001/2	2002/3	2003/4	2004/5
MTEF amounts (incl. Project budget)	149 000	155 000	167 000	176 000
Revised projections taking into account bed reductions (excl Project budget)	139 500	145 530	152 953	161 653
Expenditure	124 933	123 586	155 147	179 028

Lifecare payment to date reflects expenditure at 93.3% of projected expenditure over the period of April to January 2004. The occupancy figure is at 89.2% (budget calculated at occupancy=100%).

Hospital and District Health Services

Expenditure by mental health services in the district health services and in general hospitals is not recorded separately.

Table 49 Expenditure trends and budget projections (Specialized hospitals)

2002/3	2003/04	2004/05	2005/06	2006/07
(actual)	actual)	(estimate)	(MTEF projection)	
30,444	35,832	43,213	45,500	51,000

Sub- programme: Dental Training and Other Specialised Hospitals

Component for Dental Training Hospitals

The purpose of this Sub-Programme is to:

- Render oral health care services and provide a platform for the training of dental health workers;
- Generate new knowledge through appropriate research;
- Render specialised dental services or oral health services;
- Render an outreach oral health service;
- Render specialised hospital service.

Situation Analysis

Gauteng has three academic dental hospitals which provide a training platform for the production of competent and caring oral health professionals.

All three dental training hospitals provide undergraduate and postgraduate training including tertiary services in the specialised disciplines of dentistry, and in terms of the levels of care, assist in rendering services on the secondary and tertiary levels.

They also develop and support primary oral health care outreach programmes and render a consultancy service to the health professions. The dental training hospitals have established effective referral and academic links with the district oral health services in Gauteng and neighbouring provinces,

The three dental schools need to rationalise and develop a common teaching and service platforms particularly for highly specialised services.

Policies, Priorities and Broad Strategic Objectives

Although all goals are relevant, the work of this component falls largely under Gauteng's strategic goal 1, 2, 3, and 5, where the strategic objectives are to:

- Reduce the prevalence and complications of common non-communicable diseases; and
- Implement the comprehensive HIV and AIDS Strategy;
- Modernise, re-organise and revitalise all public hospitals into cost-effective referral centres, according to the service plan;
- Ensure the recruitment and retention of human resources; and
- Provide the service platform for high quality training and development that is responsive to the needs of the country.

Based on key actions and projects for these goals, priority activities are to:

- Deliver the highest quality of patient care and services to the community within affordable and available resources, measured against international standards;
- Roll out comprehensive care and treatment in public health facilities, particularly oral manifestations of HIV;
- Extend and further establish partnerships and common teaching platforms amongst the three dental training hospitals;
- Strengthen and expand on the existing relationships with the district oral health services;
- Recruit and retain high-level expertise which is often lost to the private sector; and
- Increase revenue generation through marketing of health services to medical aids

Analysis of constraints, and measures planned to overcome them for Dental Training Hospitals

Constraints	Measures planned
Shortage of skilled staff	Peer review of research presentations at the South African Division of the International Association for Dental Research. Publications of refereed scientific articles in the national and international literature form part of the continuous quality improvement measures, and inevitably, have a direct and indirect impact on the quality of service delivery by the three dental training hospitals in Gauteng
Long backlogs for patients needing dentures and elective oral surgery	Reducing waiting times for specialised dental services by including the dental hospitals in the departmental ring fencing surgical backlog fund
The lack of formal policies and agreements	Development of a national policy on oral health personnel needs of the country, and a signed memorandum of understanding between the Department and the respective universities;
Equity in post-graduate training needs to be addressed.	- EE plan - Recruitment and retention

Specification of Measurable Objectives and Performance Indicators for Component: Dental Training Hospitals

Table 50: Measurable objectives and performance indicators for [Academic] dental [training] hospitals

Strategic Objectives	Measurable Objective	Indicator	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)
Improve the capacity of managers and staff to manage and steer health sector transformation	Develop a service plan for dental school[s]	Percentage of hospitals with operational plan agreed with provincial health department	50	50	100	100	100	100
Provide people centred care that recognises the dignity and uniqueness of each person	Ensure coordination of quality management in hospitals	Percentage of hospitals with designed official responsible for coordinating quality management	0	33.3	66.6	100	100	100
Modernisation, re-organisation and re-vitalisation of all public hospitals into cost effective referral centres according to the service plan	Improve hospital utilisation	Number of outpatients	75000	89000	950000	100000	110000	115000

Component: Other Specialised Hospitals - Sizwe Infectious Diseases Hospital.

Situation Analysis for Sizwe Infectious Diseases Hospital

Sizwe Tropical Disease Hospital is a specialized hospital for the treatment of infectious diseases, mainly for the Gauteng province. Sizwe Hospital is designated as a referral hospital for the management of patients with viral haemorrhagic fever, but the hospital is currently unable to treat such patients; the only service still rendered is the quarantine of high-risk contacts of haemorrhagic fevers if they are not bleeding.

Sizwe Hospital therefore mainly serves as a referral hospital for Tuberculosis with complications, and, specifically Multi-Drug Resistant (MDR) TB patients; it also serves as the province's central supply center for out patients requiring TB MDR drugs. Most patients are HIV positive, or ill with AIDS, and the HIV and AIDS epidemic directly influences the number of complicated TB admissions, and the cost of treating them.

We continue implementing quality improvement measures that include the improvement of service delivery to Multi-drug resistant Tuberculosis patients to both in and Out Patients.

Senior positions advertised and filled are the posts of Head of Administration and the Chief Medical Officer. All Senior Positions are now filled. Vacancies for general staff were filled through the year but will always exist.

Sizwe Hospital managed to increase its bed capacity of MDR Patients from 26 beds to 79 beds. A facility opened during the past few months was the Gateway Clinic where patients are screened before being attended to in the Out-Patients Department.

The 20 bed Palliative Ward is functional as well as another 25 Bed MDR Ward (included in the 79 MDR Beds).

As a referral hospital for the treatment of TB with complications and MDR TB Sizwe Hospital beds need to have a mix of chronic, Level 1 and Level 2 beds. 79 beds are available now for MDR TB and 20 beds for Palliative Care.

Details of the bed composition are illustrated in Tables 51 and 52.

Table 51: Levels of Care (TB beds): Sizwe Tropical Disease Hospital

Levels of care	Number of Beds 2004 / 2005	Planned Number of beds according to Service Plan (2004 / 2005)*	Useable number of beds 2004 / 2005
Chronic Beds	100	203	100
Level 1	156	17	156
Level 2	60	Nil	60
TOTAL	316	220	316

Table 52: Composition for 2005 / 2006 for Sizwe Tropical Disease Hospital

Types of beds	Number of beds	Comments
Step-down Beds for Region	50	**Region: West Rand / Johannesburg ****
1.1 MDR Beds Total Surgical MDR Paediatric Male Female Male / Female	 79 6 6 26 25 16	None
Palliative Care 1.2 Total Male Female	 20 10 10	None
Pediatrics Surgery Male / Female Other TB	19 32 99	None
Other Infectious Diseases	17	Other fever patients eg. Malaria, Measles with complications etc.
1.3 Total	316	

50 Beds identified for Step down patients. The type of patients needs to fit the profile of an infectious disease environment.

Table 53: National Situation analysis indicators for Sizwe Tropical Disease Hospital

Indicator	Type	Actual 2001/2002	Actual 2002/2003	Actual 2003/2004	Estimate 2004 / 2005	National Target 2007 / 2008
Input						
1. Expenditure on hospital staff as % of regional hospital expenditure.	%	69,52%	54,6%	66.09%	50,98%	66
2. Expenditure on drugs for hospital use as % of regional hospital expend.	%	14,43%	12,08%	14.31%	11,27%	12
3. Expenditure by regional hospitals per uninsured person.	R	N/A	N/A	N/A	N/A	N/A
1.3.1 Process						
4. Regional hospitals with operational hospital Board.	%	Yes	Yes	Yes	√ Yes	80
5. Regional hospitals with appointed (not acting CEO in post.	%	No	Yes	Yes	√ Yes	75
6. Facility data timeliness rate for regional hospitals.	%	#	#	100	100	43
Quality						
7. Regional hospitals with patient satisfaction survey using DoH template.	%	No	No	No	Regional Yes	20
8. Regional hospitals with clinical audit (M&M) meetings every month.	%	No	No	No	Yes	90
Efficiency						
9. Average length of stay in regional hospitals	Days	27	29	37	38	4.8
10. Bed utilization rate (based on usable beds) in regional hospitals.	%	70	75	77	78	72

Indicator	Type	Actual 2001/2002	Actual 2002/2003	Actual 2003/2004	Estimate 2004 / 2005	National Target 2007 / 2008
11. Expenditure per patient day equivalent in regional hospitals.	R	TB-R225 MDR-R300	TB-R270 MDR-R355	TB-R225 MDR-R320	R400*	1,128

N/A = Not applicable

#new indicator information not available

Policies, Priorities and Broad Strategic Objectives for Sizwe Infectious Diseases Hospital

Although all goals are relevant, the work of this component falls largely under Gauteng's strategic goal 1, 2, 3, and 5, where the strategic objectives are to:

- Provide universal access to palliative care to the population of Gauteng;
- Modernise, re-organise and revitalize all public hospitals into cost-effective referral centres, according to the service plan;
- Ensure the recruitment and retention of Human Resources; and
- Implement the Gauteng Health integrated wellness programme (EAP, HIV and AIDS work place and Occupational Health and Safety Programmes.)
- Implement the comprehensive treatment plan and care for HIV and AIDS including ART.

Based on key actions and projects for these Goals, priority activities are to:

- Improve the efficiency and utilization of Sizwe Hospital;
- Implement an effective recruitment and retention strategy;
- Continue to implement the health integrated wellness programme;
- Upgrade the In and Out Patients service for TB MDR patients;
- Ensure provision of palliative care services and establish palliative care beds;
- Strengthen the Infection Control Programme;
- Increasing bed capacity of TB MDR patients for the province of Gauteng;
- Forge a close relationship with the Central Hospitals and Universities with respect to training and assistance.
- Establish an ART Clinic at Sizwe Tropical Disease Hospital.

Description of Planned Quality Improvement Measures for Sizwe Infectious Diseases Hospital

The following projects are in process or under way to improve the quality of service provided:

- Implementation of a clinical audit system;
- Ensuring a full-functioning Hospital Board;
- Head hunting specialists in the field of infectious diseases.
- Ensuring that National Tuberculosis protocols are adhere to.

Specification of Measurable Objectives and Performance Indicators for Sizwe Infectious Diseases Hospital

Table 54: Provincial Measurable objectives and performance indicators for Sizwe Hospital.

Strategic Objectives	Measurable Objective	Indicator	2002 / 2003 (actual)	2003 / 2004 (actual)	2004 / 2005 (estimate)	2005 / 2006 (target)	2006 / 2007 (target)	2007 / 2008 (target)
Improve the capacity of managers and staff to manage and steer health sector transformation.	Develop an operational plan for the hospital.	Availability of operational plan agreed with provincial health department	yes	yes	yes	yes	yes	yes
	Ensure delegated functions to CEO of the Hospitals.	Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level.	R100 000	R100 000	R100 000	R100 000	R100 000	R100 000

Strategic Objectives	Measurable Objective	Indicator	2002 / 2003 (actual)	2003 / 2004 (actual)	2004 / 2005 (estimate)	2005 / 2006 (target)	2006 / 2007 (target)	2007 / 2008 (target)
	Strengthened and capacitated management team in the hospital	Percentage of managers capacitated and strengthened for financial matters.	30	60	75	85	90	95
Provide people centred care that recognizes the dignity and uniqueness of each person.	Ensure co-ordination of quality management in hospitals.	Availability of designated official responsible for co-ordinating quality management.	yes	yes	yes	yes	yes	yes
Provide universal access to palliative care (home based care, hospice, step down facilities) to the population of Gauteng.	Increasing bed capacity of Palliative Care.	Number of Palliative Care Beds.	0	0	20	20	20	20

Strategic Objectives	Measurable Objective	Indicator	2002 / 2003 (actual)	2003 / 2004 (actual)	2004 / 2005 (estimate)	2005 / 2006 (target)	2006 / 2007 (target)	2007 / 2008 (target)
Reduce the prevalence and complications of TB and other communicable diseases.	Implement standard treatment guidelines / protocols for TB and TB MDR and register.	Percentage standard treatment guidelines / protocols implemented.	60	75	80	80	90	95

 # New indicator: data not available.

Table 55: National Performance indicators for Sizwe Tropical Disease Hospital

Indicator	Type	2003 / 2004	2004 / 2005	2005 / 2006	2006 / 2007	2007 / 2008	National Target 2007 / 2008
Input							
1. Expenditure on hospital staff as % of Regional hospital expenditure.	%	66.09	50.98	58,2	60%	60%	66
* 2. Expenditure on drugs for hospital use as % of regional hospital expenditure	%	14.31%	11.27%	12%	12%	12%	12%
Process							
3. Availability of operational Hospital Board	%	Yes	Yes	Yes	Yes	Yes	100
4. Regional hospitals with appointed (not acting CEO in post.	%	Yes	Yes	Yes	Yes	Yes	100
Quality							
5. Availability of patient satisfaction survey using DoH template.	%	No	Yes	Yes	Yes	Yes	100
6. Availability of clinical audit (M&M) meetings every month.		No	Yes	Yes	Yes	Yes	100

Indicator	Type	2003 / 2004	2004 / 2005	2005 / 2006	2006 / 2007	2007 / 2008	National Target 2007 / 2008
Efficiency							
7. Average length of stay in regional hospitals	Days	37	38	38	38	38	4.1
8. Bed utilization rate (based on usable beds) in regional hospitals.	**%**	77	78	75	75	75	75

PROGRAMME 5: CENTRAL HOSPITAL SERVICES

The purpose of this programme is to:

- Provide a highly specialised health care service;
- Provide a platform for the training of health workers and research; and
- Serve as specialist referral centres for regional hospitals and neighbouring provinces.

Central Hospital Services has four sub-programmes, namely:

- Dr. George Mukhari Hospital
- Pretoria Academic Hospital
- Chris Hani Baragwanath (CHB) Hospital
- Johannesburg Hospital

The plans were also informed by Gauteng's Service Improvement Plan which aims to reorganise services to improve health status and affordability, and creating affordable and equitable staff establishments.

Situation analysis for Central Hospital Services

Gauteng has four central hospitals, with 6 774 approved beds. These hospitals provide services for the provincial population and neighbouring provinces; they also serve as referral centres for many African countries and have several world-renowned Centres of Excellence, including the:

- Wound, Neurosurgery and Ophthalmology units in the Dr George Mukhari Hospital;
- Neurophysiology unit and Medical-Oncology units in the Pretoria Academic Hospital;
- Trauma and Oncology units in Johannesburg Hospital; and
- Renal and Hand units in CHB Hospital.

In practice Central Hospitals are a **"walk-in"** service for all patients in the province and from other provinces. This means that the Primary Care Support Services in the inner cities, and in much of the area covered by this cluster of hospitals, require strengthening. Departmental strategy, spelled out in the Service Improvement Plan, to shift 1 400 beds from Central Hospitals to lower levels of care in a phased approach over three financial years. Of the total beds in use in Central Hospitals, an estimated 20% are Level 1 beds.

Appraisal of existing services and performance for

The average length of stay for central hospitals is seven days, above the national average of 6.6 days. The bed occupancy rate (BOR) of 75% is within the national norm of 70-80%. Over the past two years Chief Executive Officers (CEOs) have been appointed in all central hospitals, and 94% of top management posts are filled. All hospitals have fully operational hospital boards. Outreach programmes have been

established at various districts and regional hospitals. The Department is also reorganising three additional specialised units for Cardio thoracic surgery, Oncology and Orthopaedics.

Gauteng's Folateng initiative to develop differentiated amenities for private patients started at Johannesburg hospital, where the first facility opened in May 2002. Existing, high standards of care attracted many private paying patients to 100 bed facility, and the bed occupancy rate is above 80%. Distribution of beds by discipline and level of care is illustrated in the table below.

Table 56: Numbers of beds in hospitals by level of care

Discipline/Hospital	Level 3	Level 2	Level 1	Total
Internal medicine				
Dr George Mukhari	89	67	67	223
Chris Hani Baragwanath	210	440	130	770
Johannesburg	121	95	164*	380
Pretoria Academic	198			198
Psychiatry				
Chris Hani Baragwanath	62	93		155
DGMH	48			48
Surgery				
Dr George Mukhari	64	67	48	160
Chris Hani Baragwanath	149	247	99	495
Johannesburg	99	78	53	230
Pretoria Academic	315			315
Orthopaedics				
Dr George Mukhari	72	53	54	179
Chris Hani Baragwanath	46	185	0	231
Johannesburg	45	37	0	82
Pretoria Academic	122			122
Obstetrics				
Dr George Mukhari	22	54	32	108
Chris Hani Baragwanath	46	263	0	309
Johannesburg	48	38	26	112
Pretoria Academic	113			113
Gynaecology				
Dr George Mukhari	24	60	36	120
Chris Hani Baragwanath	17	56	13	86

Johannesburg	20	16	10	46
Pretoria Academic	50			50
Paediatrics				
Dr George Mukhari	70	94	70	234
Chris Hani Baragwanath	111	223	37	371
Johannesburg	71	56	39	166
Pretoria Academic	50			50
Icu				
Dr George Mukhari	20			20
Chris Hani Baragwanath	18	10	0	28
Johannesburg	51	21	0	72
Pretoria Academic	52	20	0	72
Total	**2423**	**2273**	**714**	**5545**

Table 57: National -Situation analysis indicators for each central hospital

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	National target 2003/4
Input					
1. Expenditure on hospital staff as % of hospital expenditure	%	61.0	55.3	58.6	-
2. Expenditure on drugs for hospital use as % of hospital expenditure	%	11.0	9.8	9.8	13
Process					
3. Operational hospital board	Y/N	Y	Y	Y	Yes
4. Appointed (not acting) CEO in place	Y/N	Y	Y	Y	Yes
5. Individual hospital data timeliness rate	Months	#	#	#	Yes
Output					
6. Caesarean section rate	%	#	#	35	32
Quality					
7. Patient satisfaction survey using DoH template	Y/N	#	#	#	Yes
8. Clinical audit (M&M) meetings at least once a month	Y/N	Y	Y	Y	Yes
Efficiency					
9. Average length of stay	Days	7.5	6.2	6.15	6.8
10. Bed utilisation rate (based on usable beds)	%	74.7	75	74	75
11. Expenditure per patient day equivalent	R	1294.35	1160.27	1 401.42	1,877
Outcome					
12. Case fatality rate for surgery separations	%	#	#	4.0	3.6

 # new indicator data not available

Policies, Priorities and Broad Strategic Objectives for Central Hospital Sevices

In line with the strategic objectives of the Department's Strategic Goals, the Central Hospital Services aim to:

- Implement the comprehensive treatment plan and care for HIV and AIDS, including ART

- Modernise, re-organise and revitalise central hospitals into cost effective referral centers;
- Provide efficient and effective clinical support services so as to provide caring, responsive and quality health services;
- Improve customer care with special focus on clinical audits and reduction of waiting times;
- Provide a platform for service, teaching and research so as to continue excellence in service delivery; and
- Implement best practice strategies to improve attitude and morale of front line staff;

Priority actions for 2005/06 are informed by the key actions to implement the Strategic Goals, and are to:

- Delink Level 1 patients from central hospitals through strengthening district health services including district hospitals;
- Establish step-down beds for down referral of patients;
- Establish Gateway clinics at central hospitals and engage in a public education initiative to market the referral route to central hospitals;
- Improve efficiency of central hospital pharmacies through decentralising distribution of repeat chronic medication;
- Maintain and enhance a close relationship with universities with respect to training and research;
- Reduce surgical backlogs for elective surgery;
- Establish cost centres in hospitals, to improve financial and risk management.

Analysis of constraints for Central Hospital Services and measures planned to overcome them

CONSTRAINTS	MEASURES PLANNED TO OVERCOME CONSTRAINTS
Level 1 patient serviced at tertiary facility.	- Strengthen regional and district hospitals - market the referral system - establish gateway clinics - de-link level 1 beds from central hospitals
Shortage of health professionals (e.g. medical officers, nurses, pharmacists)	- Concerted recruitment and retention plan for scarce health professionals - Scarce skills allowance implementation - Appropriate training - Training of pharmacist assistants
Rising costs of laboratory services and pharmaceuticals	Introduce tighter protocols and better monitoring of compliance to protocols
Unsatisfactory service delivery by public works	Re-negotiate service level agreement with department of transport and public works
Budgetary constraints	Budget management plan
Low staff morale	- Scarce skills allowance - Proper implementation of performance system
Impact of HIV and AIDS	- Strengthen the employee assistance programme - Establish wellness programme - Provide comprehensive HIV and AIDS care, including art, supported by home-based and hospice

Specification of measurable objectives and performance indicators for Central Hospital Services

Table 58: Provincial objectives and performance indicators for Central hospitals

Strategic Objectives	Measurable objective	Indicator	2004/05 (actual)	2005/06 (target)	2006/07 (target)	2007/08 (target)
Provide HIV and AIDS comprehensive care and treatment including ART in all sub districts by 2009	Provide AIDS care with ART	Percentage of hospitals implementing ARV programme	100	100	100	100
Modernisation, re-organisation and re-vitalisation of all public hospitals into cost effective referral centres according to the service plan	Shift primary ambulatory care patients from central hospitals to level 1 facilities by establishing Gateway clinics at central hospitals	Number of Gateway clinics established	0	2	2	4
	Ensure provision of outreach programmes by academic medical staff to secondary and other hospitals	Number of outreach programmes maintained	10	10	10	10
	Reduce surgical backlog for surgical procedures	Percentage reduction in surgical backlog	20	30	40	60

Strategic Objectives	Measurable objective	Indicator	2004/05 (actual)	2005/06 (target)	2006/07 (target)	2007/08 (target)
Specific interventions to reduce waiting times at pharmacies and out-patient departments	Ensure shorter waiting times for patients	Percentage reduction in overall waiting times for pharmacy, casualty and outpatients departments (cumulative)	5	10	15	20
Provide efficient and effective clinical support services (allied, laboratory, pharmaceuticals, blood services, radiology etc)	Ensure availability of drugs on EDL in all institutions	Percentage of hospitals with all EDL drugs available all the time	98	100	100	100
	Strengthened and capacitated management team in hospital	Percentage of hospitals with appointed CEOs, Directors and Nursing Managers	#	100	100	100

Strategic Objectives	Measurable objective	Indicator	2004/05 (actual)	2005/06 (target)	2006/07 (target)	2007/08 (target)
	Develop a operational plan for the hospital	Availability of operational plan agreed with provincial health department	100	100	100	100
Implement an effective Performance Management System	Performance agreements for all hospital CEO's	Percentage of hospital CEO's with performance agreements	75	100	100	100
Improve the health and wellbeing of children under six years and those at risk due to poverty	Kangaroo Mother Care	Percentage of hospitals with Kangaroo Mother Care (KMC)	75	100	100	100
	Implementation of Perinatal Problem Identification Programme (PPIP)	Percentage of hospitals with PPIP	100	100	100	100

Past expenditure trends and reconciliation of MTEF projections with plan for Central Hospital Services

Table 59 : Trends in provincial public health expenditure for central hospitals(R million)

Expenditure	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF Projection
Current prices							
Total	3 092 936	2 831 224	2 857 212	2 999 335	-	-	-
Total per person	350	320	323	339	-	-	-
Total per uninsured person	483	442	446	468	-	-	-
Constant (2004/05) prices							
Total	3 767 196	3 139 827	3 005 787	2 999 335	2 970 988	3 119 950	3 239 710
Total per person	426	355	340	339	336	353	367
Total per uninsured person	588	490	469	468	464	487	505
Capital	56 595	77 282	19 313	110 753	61 500	62 000	62 000

Sub Programme: Chris Hani Baragwanath Hospital (CBH)

Situational Analysis for CHB

Chris Hani Baragwanath is the only public hospital directly serving the people of Soweto, which has a population in excess of 1.5 million; this situation presents a major challenge for the provision of primary and secondary in-patient care in the area. CBH is also a major referral centre for Central, Southern and Western Gauteng, and provides tertiary services for other provinces. The hospital provides facilities for under- and post-graduate training in association with the University of the Witwatersrand. It is the site for a number of research projects, and also has a strong association with NGOs.

CBH is approved for 2888 beds, and has average bed occupancy of 80%. It treats 150 000 inpatients, 550 000 outpatients and delivers more than 28 000 babies per year. More than 46 000 operations are performed annually, and CBH attends to about 350 emergency cases per day, of which an average of nine per day are gunshot wounds. The hospital employs approximately 549 doctors, 2150 nursing staff; and 85 professionals in Allied Disciplines, as illustrated below.

Table 60: Current Staff establishment

Category	Number Employed	Vacant Funded Posts	Vacant Unfunded Posts	Costs per annum
Medical Interns	68	0	0	R8'673'840.00
Medical Officers/Sen./Chief	109	0	0	R19'574'678.00
Medical Officers Princ.	75	0	0	R11'751'552.00
Registrars	147	16	2	R35'661'048.00
Specialist & Senior Specialist	98	1	2	R26'193'216.00
Principal & Chief Specialist	32	1	17	R18'349'797.00
Nursing Assistants	821	60	315	R92'968'354.00
Staff Nurses	193	22	60	R25'207'758.00
Professional Nurses/Senior	296	29	409	R87'709'833.00
Chief Professional Nurses	783	41	264	R168'098'512.00
Pharmacy Interns	8	0	3	R1'136'812.00
Pharmacists	12	12	21	R6'345'258.00
Allied Health Professionals	184	37	119	R37'595'880.00
Managers & Administrators	35	3	27	R14'131'045.00
Directors	2	0	1	R1'069'038.00
Support Staff	1356	98	480	R123'914'424.00
Admin Staff	424	41	190	R60'273'341.00
Total	4643	361	1910	R610'024'989.00

Table 61: Bed Numbers by level of care

Discipline	Level 3	Level 2	Level 1	Total	Approved beds
Internal Medicine	210	440	130	770	885
Orthopaedics	46	185	0	231	231
Surgery	149	247	99	495	630
Obstetrics	46	263	0	309	558
Gynaecology	17	56	13	86	86
Paediatrics+Neonatology	111	223	37	371	343
ICU/HC	18	10	0	28	Incl in disciplines
St. Johns	28	45	16	89	Incl in surg.
Psychiatry	62	93	0	155	155
TOTAL	687	1562	295	2534*	2888

* (Excludes 307 cribs, 82 lodger beds, 130 transitional beds)

Quality management department

The CHB Quality Management Department has been in place since 1 April 2002. It comprises quality managers and patient liaison officers /queue managers. Their duties include monitoring waiting times and measuring and supporting manager to respond to patient satisfaction indicators. Waiting times are measured to improve accessibility of service to patients

Waiting times are directly proportional to number of staff serving the patients; the fewer the staff members, e.g. clerks, the longer the waiting time. It is also important that the infrastructure is adapted in a way that it is conducive to the smooth flow of patients.

Specification of measurable objectives and performance indicators for CHB

Table 62: National Performance indicators for CHB

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/08
Input							
1. Expenditure on hospital staff as % of hospital expenditure	%	58.9	61.4	61.0	61,2	61.5	70
2. Expenditure on drugs for hospital use as % of hospital expenditure	%	9.0	11.9	10.1	10.3	10.4	13
Process							
3. Operational hospital board	Y/N	Y	Y	Y	Y	Y	Yes
4. Appointed (not acting) CEO in place	Y/N	Y	Y	Y	Y	Y	Yes
5. Individual hospital data timeliness rate	Months	#	#	#	#	#	Yes
Output							
6. Caesarean section rate	%	22	23	23	24	25	25
Quality							
7. Patient satisfaction survey using DoH template	Y/N	#	#	Y	Y	Y	Yes
8. Clinical audit (M&M) meetings at least once a month	Y/N	Y	Y	Y	y	Y	Yes
Efficiency							
9. Average length of stay	Days	5.9	5.6	5.5	5.4	5.3	5.3
10. Bed utilisation rate (based on usable beds)	%	79	77				75
11. Expenditure per patient day equivalent	R	987.44	1 018.05	1447	1 877	1 877	1,877
Outcome							
12. Case fatality rate for surgery separations	%	#	4.4	4.0	3.5	3.0	3.0

Sub Programme: Dr George Mukhari Hospital (DGMH)

Situation Analysis for DGMH

Dr George Mukhari Hospital (DGMH), previously known as Ga-Rankuwa Hospital, has 1 724 approved beds with an average occupancy rate of 70%. The hospital provides a full range of services at all levels of care (Levels 1, 2 and 3), but the service plan necessitate the de-linking of Level 1 care to a district hospital in the Soshanguve area. DGMH is linked to the Medical University of Southern Africa (MEDUNSA) for all academic activities.

Services offered

The hospital provides a range of medical services including all major specialist services except Medical Oncology. It will continue to do so until the district hospital is built in Soshanguve and the surrounding North West hospitals (Odi and Brits hospitals) are able to adequately provide required services. In addition, a plan will be submitted to the region to request hospice beds for terminally ill AIDS patients.
DGMH's areas of excellence include: Ophthalmology, Spinal surgery, Valve surgery, Hand surgery, Nuclear Medicine, and a renal transplant unit

The department of cardio-thoracic surgery provides excellent service in the area of heart valve surgery, where it has developed great expertise as rheumatic fever is common amongst the population it serves.

Sharing of a Service Platform

DGMH accepts the need to rationalise expensive services and has established a good rapport with the Pretoria Academic Hospital to this effect, particularly regarding cancer treatment.

Patients with various malignancies are taken care of in the hospital; there is no dedicated medical oncology service. Patients with complicated cancer are referred to Pretoria Academic hospital for further management.

There is an outreach programme to the following hospitals: Rustenburg, Polokwane Mankweng and Odi. In addition the department of family medicine provides services at district level in Soshanguve.

In line with the Service Improvement Plan, which seeks to establish smaller, cost effective tertiary hospitals by de-linking Level 1 beds, two wards with 80 beds have been open as a first phase to accommodate Level 1 patients. The aim is to expand this to 200 beds. Level 1has been defined to include step-down, short stay and day cases.

A booking system is being piloted in two departments and should gradually expand throughout the hospital. This will reduce inappropriate referrals and allow doctors to devote sufficient time to patients, thus improving patient satisfaction. It will also streamline activities in the emergency department.

A project is underway to improve the waiting area for patients at the pharmacy. We are also exploring the possibility of opening up satellite pharmacies in order to decongest the current location.

Staff establishment

DGMH has a relatively high vacancy rate of 15% for consultants (specialists and senior specialists) and 10% for registrars. This continues to impact negatively on services, and on the capacity of departments to conduct effective outreach services to neighbouring hospitals. The number of pharmacists is inadequate to render optimum service, especially considering the imminent roll out of anti retroviral drugs.

Cross Border Flows

In the absence of a formal survey, we estimate that approximately 30% of cross-border patients are Level 1 patients (based on the overall estimate for the hospital).

Hospital efficiency

The average cost per need day is R1100.00, calculated on last financial year's actual expenditure of R530 390 000 and in consideration of 1724 approved beds. The hospital has an average length of stay of eight days with total PDE of R502 336 and cost per PDE of R843.00. Our length of stay is the highest among the four central hospitals, as many of our patients come from far, limiting their ability to be managed as outpatients. The lack of step-down beds in the region also contributes to the high length of stay.

Occupancy rate has increased slightly from 67.5 in 2001/02 to 71.9 in 2002/03. This will be improved with the creation of level 1 beds and the exclusion of more than 100 "lodger beds" in the calculation of the bed occupancy rate. We are aiming to increase the bed occupancy to 85% and to reduce the length of stay by one day.

Appointment up to one level below the CEO can be finalised in the hospital. A fully-fledged hospital board is in place. Through the board, the hospital accounts to the

public by presenting a monthly report on activities and use of resources. The board is then able to support the hospital in achieving its goals.

Review interventions to reduce waiting time at the pharmacy, and satellite dispensaries.

Specification of measurable objectives and performance indicators for DGM hospital

Table 63: National Indicators for DGM hospital

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/08
Input							
13. Expenditure on hospital staff as % of hospital expenditure	%	69.3	67.6	68.4	67.4	66.5	70
14. Expenditure on drugs for hospital use as % of hospital expenditure	%	6.2	7.2	6.4	6.4	6.4	13
Process							
15. Operational hospital board	Y/N	Y	Y	Y	Y	Y	Yes
16. Appointed (not acting) CEO in place	Y/N	Y	Y	Y	Y	Y	Yes
17. Individual hospital data timeliness rate	Months	Y	Y	Y	Y	Y	Yes
Output							
18. Caesarean section rate	%	23	32	30	28	25	25
Quality							
19. Patient satisfaction survey using DoH template	Y/N	#	#	#	#	#	Yes
20. Clinical audit (M&M) meetings at least once a month	Y/N	Y	Y	Y	y	Y	Yes
Efficiency							
21. Average length of stay	Days	5.8	5.2	5.2	5.3	5.3	5.3
22. Bed utilisation rate (based on usable beds)	%	78	79	75	75	75	75
23. Expenditure per patient day equivalent	R	1 067	1110.10	1494	1 877	1 877	1,877
Outcome							
24. Case fatality rate for surgery separations	%	4.38	4.4	4.2	4.0	3.5	3.0

Sub Programme: Johannesburg Hospital

Situational Analysis Johannesburg Hospital

The Johannesburg Hospital is a central academic hospital in the South of Gauteng with 1163 operational beds, offering a full range of tertiary, secondary and primary care services to a population of five million, mainly from the Central Wits Region but also from other provinces. The hospital is located in Parktown and also serves as a referral hospital for a number of hospitals in its referral chain.

Appraisal of existing services and performance for the past year

In practice the hospital is a "walk-in" health service for all patients in the province and from Mpumalanga, North West and Limpopo, indicating that Primary Care support services in the inner city and elsewhere require strengthening. Management and clinical teams worked hard to maintain standards while striving to stay within the agreed budget frames.

Services rendered

The Johannesburg hospital provides a full range of services, of which an estimated 20% are at Level 1, 30% at L2 and 50% at L3. To address the reduction of tertiary beds, required by the Service Improvement Plan, and to improve the efficiency of L2 and L3 beds, L1 services have been outsourced to Selby Park hospital.

Highly specialised services offered that require scarce skills, special expertise, or high tech equipment, and thus budget, are:

- Paediatric Haematology/Oncology including Thalassaemia (only service in the province) & Haemophilia;
- Cystic Fibrosis clinic.
- Child Psychiatry (Child and Adolescent unit);
- Medical Haematology/Oncology, which will become the centre of excellence in the province. An investment for equipment will be required in the next three financial years;
- Cardio-thoracic surgery – excluding heart transplants. Outcomes with Paediatric cardiac surgery are especially good;
- Trauma. Johannesburg Hospital is the country's only trauma centre that meets the criteria for accreditation by the American Trauma Society, which sets world standard for trauma quality. Trauma is highlighted as a *high cost* service;
- Renal Transplant;
- Gauchers Disease clinic; and
- Interventional Cardiology.

Table 64: Cross Border Flow

Discipline	North West		Limpopo		Mpumalanga		Free State		KZN		Other	
	OPD	In Pt	OPD	In Pt	OPD	In Pt	OPD	In Pt	OPD	In Pt	OPD	In Pt
Internal Medicine	123	35	26	2	65	10	2	3	43	29	426	257
Surgery	48	13	25	14	26	7	15	13	37	21	170	102
O&G	12	7	-	-	0	3	2	1	14	12	31	27
ICU	0	3	0	0	0	1	0	0	0	0	2	19
Other	60	13	12	3	60	25	12	10	0	0	224	109
Total	**243**	**71**	**63**	**19**	**158**	**46**	**31**	**27**	**94**	**62**	**853**	**514**

*Other includes Eastern Cape, Northern Cape, and Western Cape & Foreign patients

Description of Planned Quality Improvement Measures, for Sub-Programme: Johannesburg Hospital.

A Quality Assurance team is active in the hospital, driven by a Quality Manager and Patient liaison / queue manager. Their major project over the next year will involve training employees on quality principles and strategies, and strengthening quality programmes existing in the institution. An effective complaints system is already functional; patient surveys have been completed relating to waiting times in the Casualty and Pharmacy sections, as well as a survey on staff attitudes.

Interventions planned to improve quality are to:

- Improve Quality of Care: waiting time reduction, increased cleanliness and comfort, linen availability;
- Working procedures: processes around complaints, monitoring of waiting lists, theatre cancellations, and guidelines / protocols and standards and Ethics committees.

Specification of measurable objectives and performance indicators for Johannesburg Hospital

Table 65. Performance Indicators for Johannesburg Hospital

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/08
Input							
25. Expenditure on hospital staff as % of hospital expenditure	%	49.3	47.9	54.3	54.3	54.0	70
26. Expenditure on drugs for hospital use as % of hospital expenditure	%	14.7	16.1	14.0	14.1	14.2	13
Process							
27. Operational hospital board	Y/N	Y	Y	Y	Y	Y	Yes
28. Appointed (not acting) CEO in place	Y/N	Y	Y	Y	Y	Y	Yes
29. Individual hospital data timeliness rate	Months	#	Y	Y	Y	Y	Yes
Output							
30. Caesarean section rate	%	34	42.8	40	35.5	30	25
Quality							
31. Patient satisfaction survey using DoH template	Y/N						Yes
32. Clinical audit (M&M) meetings at least once a month	Y/N	Y	Y	Y	y	Y	Yes
Efficiency							
33. Average length of stay	Days	6.1	6.3	6	6	5.3	5.3
34. Bed utilisation rate (based on usable beds)	%	79	76	76.5	75	75	75
35. Expenditure per patient day equivalent	R	1 450 16	1 553.51	1 720	1 887	1 887	1,877
Outcome							
36. Case fatality rate for surgery separations	%	#	4.4	4.2	4.0	3.5	3.0

Sub Programme: Pretoria Academic Hospital

Situational Analysis for Sub-Programme Pretoria Academic Hospital (PAH)

Pretoria Academic Hospital (PAH) currently has 999 approved beds but this will reduce to 782 beds after relocation to its new premises towards the end of 2005. PAH serves a population of 822 804 in the Tshwane - Metsweding Health Region, as well as most of Mpumalanga province. The hospital also receives significant numbers of patient referrals from Limpopo and North-West provinces, mostly via the Dr. George Mukhari Hospital. The hospital has a Bed Occupancy Rate (BOR) of 85% to 90% and Average Length of Stay (ALOS) of 6 days.

PAH will be affected by a reduction in funding for tertiary services as funds get shifted to other provinces and District Health Services. It is extremely important that adequate planning is done to manage the transition and change, in line with the national Strategic Position Statement, the provincial Service Improvement Plan, and the MTEF allocations as determined by the Department.

There is currently one Regional hospital, Kalafong Hospital, within the Region, which refers patients to PAH. This hospital is situated 20km away; there is currently no other facility within eight kilometres of PAH that provides a 24-hour health service. This results in PAH still receiving large numbers of inappropriate non-tertiary health care patients. The ever-growing inner city population and people from surrounding suburbs have nowhere else to go, especially after-hours and during weekends.

The current hospitals premises consist of 77-year old buildings that are (in parts) still in durable condition; and are regarded as a national monument. The new Pretoria Academic Hospital which will replace it has been under construction for a number of years, adjacent to the current hospital. Equipment will cost R474m. The Department is currently working on acquisition of all loose equipment for the hospital.

The new hospital, having fewer beds than the current hospital, will be strictly a tertiary (Level 2/3) hospital and be closed to walk-in patients. To accommodate these patients, the Department has approved a plan to establish a 200-bed Level 1 District Hospital in the main building complex of the current hospital. The commissioning of this District Hospital and the move to the new academic hospital premises need to happen simultaneously, to avoid service disruptions. New structure completed, moving during 2005/06 financial year.

Outreach Programmes

Close co-operation naturally exists between the Pretoria Academic hospital and Kalafong hospital with the latter being an integral part of the academic complex.

As Pretoria Academic Hospital serves as a tertiary referral hospital for the Mpumalanga Province, the Surgical and Medicine departments have a continuous

outreach programme to and co-operation with the Witbank Hospital. As Witbank Hospital is the main gateway hospital to that province, it is of utmost importance to empower that hospital to deal effectively with as many clinical cases as possible. Outreach projects to the Philadelphia hospital complex in Mpumalanga are being developed for the same reason.

Some clinical empowerment outreach is also done to Tembisa hospital as that hospital, although not part of the Tshwane-Metsweding Health Region, falls within the Pretoria Academic hospital referral system.

Cross Border Flows

There are no facilities offering tertiary health care services in Mpumalanga and only extremely limited tertiary health care services are rendered in the Limpopo province, so Pretoria Academic hospital is subjected to a heavy load of patients from these provinces. Some patients originate from provinces as far away as the Eastern Cape, Northern Cape and Free State provinces. The N1 national road traverses Pretoria and also generates a large number of emergency cases.

The hospital's newly installed Medicom IT system can as yet not provide a percentage breakdown of Levels 1, 2 and 3 referrals from neighbouring provinces. The hospital has attended a total 21563 emergency patients, that included 13 306 trauma cases, 2 071 Gynaecology and 5857 Paediatrics in 2003. One and half percent (1.5%) of these patients died.

Table 66: Cross Boundary Flows

Discipline	North West	Limpopo	Mpumalanga	Free State	W. Cape	KZN	N.Cape	E.Cape	Other
TOTAL	857	4296	7030	73	35	107	22	45	69

Description of planned quality improvement measures for Sub-Programme PAH

The following initiatives are in place to improve quality in the hospital:

- ***'Please Rate Us'*** boxes are available in all outpatient clinics and wards with simple evaluation cards for patients to evaluate the quality of the services provided by the specific areas. Annual Patient Satisfaction Surveys are conducted with the help of the Department of Marketing, Faculty for Economic Sciences of the Tshwane University of Technology;
- Help desks assist patients and the public with enquiries. The help desks, assisted by dedicated client liaison officers (queue managers) and volunteer "floor walkers" at the Outpatient Departments and the Emergency Unit, contributed to a marked improvement in the user-friendliness of the hospital;
- An Occupational Health and Safety Unit as well as an Employee Assistance Programme (EAP) unit provide support to the staff of the hospital;
- Signage was improved where needed and within the limitation of the available budget, a facilities renovation programme was embarked on to improve the general public frontline facilities;
- Specific quality indicators are utilised to monitor quality performance on all fronts of service rendering in the hospital; these are monitored on a continuous basis and reported on to Hospital Management and the Hospital Board.

Pretoria Academic Hospital runs its own internal Service Excellence Awards programme to recognise exceptional performance by individuals (per category of staff) as well as service units. Each year's winning unit is entered for the Gauteng departmental Khanyisa awards. PAH was the winner of the prestigious Khanyisa Service Excellence Award in the Central Hospitals Category for two consecutive years now; 2002 and 2003.

Table 67. Performance Indicators: Pretoria Academic Hospital

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/08
Input							
1. Expenditure on hospital staff as % of hospital expenditure	%	62.4	58.2	67.0	66.0	66.4	70
2. Expenditure on drugs for hospital use as % of hospital expenditure	%	7.8	9.4	8.3	8.3	8.3	13
Process							
3. Operational hospital board	Y/N	Y	Y	Y	Y	Y	Yes
4. Appointed (not acting) CEO in place	Y/N	Y	Y	Y			Yes
5. Individual hospital data timeliness rate	Months	#	#	Y	Y	Y	Yes
Output							
6. Caesarean section rate	%	34	31.5	28	25	25	25
Quality							
7. Patient satisfaction survey using DoH template	Y/N	#	Y	Y	Y	Y	Yes
8. Clinical audit (M&M) meetings at least once a month	Y/N	Y	Y	Y	Y	Y	Yes
Efficiency							
9. Average length of stay	Days	6.2	6	6	5.5	5.3	5.3
10. Bed utilisation rate (based on usable beds)	%	72	77	75	75	75	75
11. Expenditure per patient day equivalent	R	1274.33	1 544.74	1 711	1 877	1 877	1,877
Outcome							
12. Case fatality rate for surgery separations	%		4.4	4.2	4.0	3.5	3.0

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

Health Sciences and Training developed its plans for the 2005-2008 MTEF from the platform created by the Department's 6 Strategic goals, the 5 Year Strategic Programme of Action and The Service Improvement Plan of 2004

The purpose of this programme is to provide education, training and development for all personnel within the Department of Health through:

- Producing appropriate levels of health professionals for different levels of services.
- Training health workers to provide an efficient primary health care service at clinics, community health centres and home-based care level;
- Providing bursaries at tertiary institutions for Nursing, Medical, Allied Personnel and scarce skills development in the Health Sciences.
- Providing bursaries for management, administrative and support personnel.
- Up-skilling Senior, Middle and Emerging Managers in Leadership and management development Programmes.
- Building the capacity of Frontline Managers and Health care Workers to strengthen service delivery.
- Special Projects for training and capacity building related to strategic priorities such as strengthening District Health Systems and Comprehensive Primary Health Care between Province and Local Government, Performance Management, HIV/AIDS, ARV, HIV/AIDS in the Workplace, Financial Management for Province and Local Government and Adult Basic Education and Training.
- Implementation of the Skills Development and Employment Equity imperatives for GDH and Learnership Programme.

Situational analysis for Health Sciences and Training

The Health Sciences and Training Programme consist of the following Sub- programmes:

- Medical Training
- Professional Development
- Nursing Education
- Emergency Medical Training
- Management and Skills Development
- Bursary Administration

Health profession training / professional development

The purpose of the professional development and training Sub- programme is to provide, and coordinate education, training and development for all health professionals and midlevel workers within Gauteng Department of Health

The Gauteng Department of Health receives a Health Professions Training & Development Grant (HPT&DG) each financial year to support the training and development of health professionals, enable the shifting of teaching from central hospitals to regional and district facilities, and to develop and recruit medical specialists in under-serviced areas. The total allocation for 2003/04 was R539,330,000. Although the fund is for all health professionals, more than 90% is spent on the recruitment, development and training of medical doctors. The three medical schools, i.e. Medunsa, Pretoria and Wits Universities reported a total of 3904 undergraduate medical students in November 2004.

Challenges in this area are:

- Community medicine and public health specialists, in particular, but not limited to Forensic pathology, Psychology, and Paediatric and Vascular surgery
- Transformation in terms of race and gender for specialists

The Department's clinical facilities are currently used by various universities, four nursing colleges, one college of emergency care and four technikons. We are currently faced with numerous requests from private training providers to use our facilities for clinical practice. A policy and guidelines have been developed to manage the use of our facilities by private nurse training providers.

In compliance with the Health Professions Training strategic focus areas, this Sub-Programme provides training and development for all GHD Health Professionals. It also coordinates and collaborates with key stakeholders and role-players on mid-level worker training. To this end we have successfully implemented the programme.

- 1000 Health Professionals were targeted in the Comprehensive HIV/AIDS/ARV Training Programme in 2004/05 and by the end of this financial year would have exceeded the target to 1052.
- We are currently training 535 in the Dispensing Course for licensing
- To date a total of 1216 mid-level workers have been admitted to the learnership and internship programme. This includes, amongst others, auxiliary nurses and pharmacist assistants.

Training needs assessment/skills audit

In accordance with the Service Delivery Plan of 2004, the Department will need to support the strengthening of primary health care and district health services. The need for community health and public health specialists has become more evident. The

implementation of the National Health Act, Medicine Control Act, Pharmacy Act and Mental Health Act are priorities for the Department.

In order to meet the demand more Pharmacist Assistants will be trained through the learnership programme. Presently 164 Pharmacist Assistants are undergoing the Basic and Post Basic and Pharmacist Assistant on 18 month training.

There is an urgent need to train Doctors, Nurses and Dentists for the acquisition of dispensing licenses (as part of the Pharmacy Act) by July 2005. Thus far 535 targeted health professionals are in training on the Dispensing course. Project teams have been established in the regions to ensure that 1000 targeted health professionals receive training by 30 June 2005.

A combination of strategies will be used in order to achieve the objectives of the service Delivery Plan – an increase in the production of health professionals, recruitment strategies and retention strategies.

Plans to address the shortfall in number of professionals being trained

The Department of Health is offering Learnerships and internships to Diagnostic Radiographers, Pharmacists Assistants, Auxilliary Nurses, Dental Assistants, Medical Doctor Programmes, and Community Health Worker to redress the shortfall of the numbers of professionals.

The one-year internship programme is being converted into a two year Internship programme for doctors and dentists as an approach to ensuring professionals being trained to meet future health service delivery standards in terms of quality.

Bursaries are also made available by the department for all categories of health professionals especially the scarce skills categories such as Orthotics and Prosthetics. The purpose of bursaries is to increase the knowledge and scarce skills available to the Department with the aim of redressing race, gender, and disability inequalities and provide financial assistance to those economically disadvantaged persons who would not otherwise be able to enter the health care professions.

For the financial year 2004/2005 the budget of R11 million was allocated for bursaries.

- R3 million was for maintenance of current bursary holders.
- R3 million will go towards South African Medical students studying in Cuba.
- R5 million is for full-time and part –time new bursary applicants.

The GHD bursary support Programme maintains a total of 860 bursaries. In the current financial year 308 new candidates were selected The bursary support programme also maintains 414 bursary holders. Additional bursaries were awarded to 14 Health Promoters, 6 middle and senior managers for advanced Labour law (from Labour

Management Directorate) and 36 Clinical engineering technicians in line with the scarce skill and retention strategy.

Nursing Education

The purpose of the Nursing Education component of Professional Development is to provide nursing education, training and development for various categories of nurses and to coordinate the activities of the four nursing colleges within the Department of Health.

- The Department liaises with higher education institutions offering nursing training for all groups of nursing professionals, the HWSETA and the South African Nursing Council.
-
- The Department manages and funds four Nursing Colleges. The recruitment of suitable student nurse cadres specialized nurse educators remains a challenge for the Department.

- Community service for Nurses who have trained in the private sector will commence in July 2005. This includes bridging course graduates who will be placed as professional nurses in the services for a period of one year. Approximately 100 nurses will be placed within the provincial clinical facilities. The provincial health graduates will commence community service in January 2006. There are approximately 413 professional nurses to be placed for community service.

Training needs assessment

According to the SAQA legislation and the SANC requirements, nurse educators have to undergo assessor training**.** A total of 197 nurse educators have been trained. It is envisaged that this training will be ongoing as new staff are appointed.

Due to the high maternal and neonatal death rates in the country, it was decided that all the midwifery tutors must attend the annual National Midwifery Conference to update their knowledge. 30 Midwifery tutors attended a National Midwifery Conference in 2004.

The implementation of the Service Improvement Plan will require the following:

- An increase in the numbers of nurses, both professional and mid-level.
- Primary health care nurses.
- Specialist nurses such as intensive care and theatre nurses.

The department is embarking on a project to increase the number of student intake and reintroduce the bridging course for enrolled nurses in an attempt to increase the number of professional nurses trained. The number of nursing students commencing the four-year nursing diploma course at the colleges in 2005 was increased to 640. In addition, approximately 150 nursing degree students commenced training at the four universities. The PHC curriculum has been reviewed by the Colleges to ensure alignment with the

Strategic Objectives of the Department. The auxiliary nursing curriculum has been submitted to SANC for approval in preparation for commencement of the Auxiliary Nurse Learnerships in March 2005. Approval is awaited. The four-year basic nursing training programme is also revised annually to ensure that it is aligned to the national and provincial strategic goals, priorities and standards.

The Recognition of Prior Learning (RPL) policy for the Nursing colleges was submitted to the SANC in March 2004. A response was received from the SANC in December. In principle the council has accepted the policy. In February 2005 the RPL committee will finalise the implementation plan. It was envisaged that the first group of RPL candidates would be selected in 2005 for commencement of training in 2006 as a pilot project. However, due to the introduction of the bridging programme in 2005/6, RPL will only be implemented in 2006.

Ambulance training college

The purpose of the Ambulance Training College is to train Ambulance Personnel for quality delivery of Emergency Medical Services as per proposed norms and standards. The College aims to optimise the utilisation of resources available for training of emergency medical personnel and to maintain, develop and implement training programs that are aligned to the strategic priorities the department and linked to the operational needs of the community of Gauteng.

Training needs assessment and gap analysis

In order to meet the requisite number of personnel needed to staff the proposed 205 ambulances and 42 primary response vehicles according to the Norms and Standards, there would have to be the availability of 191 operational ALS personnel, 328 ILS and 1528 BLS personnel. These posts will be filled by existing staff, and any deficit will then be filled by personnel recruited from non-provincial services within Gauteng, personnel from outside the province and/or those personnel produced by the College and other training institutions. There are currently 50 operational paramedics (ALS), approximately 594 operational ILS and approximately 1324 BLS in Gauteng Provincial EMS. Importantly, it can be deduced that there is a deficit of 141 ALS personnel.

Currently the College establishment comprises 7 staff members. The required staff establishment is 22. The challenge facing the College is recruitment of staff to the College – specifically doctors and paramedics. The College has embarked on a recruitment and retention strategy by utilizing non-financial incentives (such as skills, knowledge and attribute development, preferred work ethic, e.t.c..

Due to lack of human resource capacity at the College, training and development for existing staff has been a challenge. A need for instructors to attend mentorship training, assessor training, ACLS, PALS, ATLS and advanced driver training has been identified. An instructor at the College has been tasked with the role of skills development for all academic staff at the College, and the Registrar with skills development of administrative staff.

Over the past 2 years the College has positioned itself strategically to facilitate alignment of training with the S.A.Q.A. Act. Resources have been arranged so as to contribute meaningfully to the norms and standards. Training gaps have been identified and strategies formulated to address these.

Management and skills development

The purpose of Management and Skills Development programme is to provide formal, informal and continuing Skills Development for the Organisational needs/demands strategic priorities and individual performance. Management and skills development is the key strategic focus impacting individual development through Performance Management. To this end the Sub-Programmes focuses on Non-Clinical skills development for all categories of staff. In addition it coordinates and ensures upskilling in Leadership and Management Development Programmes that are both in Non-clinical and health specific related areas.

The key strategic objective of Management and Skills Development is to ensure alignment of staff skills and competencies with GHDs key strategic priorities. In order to improve management and HR practices with return on investment it is crucial for the department to ensure appropriate purchasing of training from preferred Providers. The challenge is to attract relevant and cost-effective training skills development experts for training.

In accordance with the Service Improvement Plan of 2004, there is a need for strengthening of Management Teams. During 2004/05 we have actively conducted in-service education in the new Performance Management System for about 33,782 Employees. Learnerships and Internships in the Non-clinical and management related fields MSD has successfully implemented 331 Non-medical Internships in various generic fields. workplace. We have successfully implemented a formal Orientation and Induction Programme for recently appointed Employees and new recruits in the Department. This is part of the retention strategy.

The total number of Learnerships and Internships for this financial year are 1 840. 60 ISSET Learners, 47 food services aids and 100 customer care Learnerships are being implemented in compliance to the GPG mandate and SETA requirements. ABET and training aimed at lower categories will also continue until migration to GSSC is finalised with Organized Labour.

The Skills Development Act has been mainstreamed in order to achieve the imperatives outlined and to meet the targets by 2005. HWSETA approved funding for Learnerships and bursaries an amount over R6 208 000 for this Financial Year to supports 366 Health Science and Training Learnerships and bursaries for GHD. The Memorandum of Agreements and Learnership Agreements have been submitted to HWSETA. Mentors and Assessors are in place to ensure quality of training and deliverables.

Policies, priorities and strategic goals for Health Sciences and Training

Health Science and Training is informed by, and must comply with, various legislative and policy imperatives including:

- The Higher Education Act (Act No. 101 of 1997)
- The Skills Development Act (No. 97 of 1998)
- The South African Qualifications Authority Act (No. 58 of 1995)
- The Nursing Act (No. 50 of 1978) as amended by No. 5 of 1995 and No. 19 of 1997;
- The Hospital Ordinance 15 of 1958, as amended;
- The National Skills Development Strategy
- The National Human resource Development Strategy for the public service.
- The Constitution of South Africa
- The Employment Equity Act
- The Skills Development Act
- S.A.Q.A. Act
- H.P.C.S.A. regulations
- P.B.E.C.P. regulations The PRL policy
- The ABET policy.

Table 68: Strategic Goals, objectives, key actions and 2005/06 priorities

STRATEGIC GOAL	STRATEGIC OBJECTIVE	KEY ACTIONS	KEY STRATEGIC FOCUS AREA
1. ***Promote health, prevent and manage illnesses or conditions with emphasis on poverty, lifestyle, trauma and violence and psychosocial factors***	Increase public understanding and the practice of healthy lifestyles and key risk behaviours with a special focus on vulnerable groups and disadvantaged communities.	Establish and implement social mobilization and health promotion programmes to address key risk factors associated with preventable disease and deaths	▪ Run awareness programmes against common illnesses and injuries including early recognition of emergencies and seeking early treatment **(Ambulance Training College)** ▪ Ensure appropriate levels of Health Promoters are educated and trained through bursary support (Professional Development)
	Improve the Health and well-being of children under six years and those at risk due to poverty.	Ensure basic prevention and care of common childhood illnesses through: ▪ IMCI ▪ EPI.	▪ Continuing Professional Development in the relevant Clinical Practice areas. **(Prof Dev)** ▪ IMCI & EPI included in basic nursing curriculum. ▪ Coordination of training and development for IMCI, EPI, PMTCT, PPIP and nutrition risk identification **(Prof Dev & Nursing Education)**
	Reduce the Prevalence and complications of TB and other communicable diseases	Strengthen TB advocacy and treatment programmes to improve detection, cure rates and reduce treatment interruption rate. Short courses (DOTS) in facilities and the community	▪ Continuing Professional Development in the relevant Clinical Practice areas. **(Prof Dev)** ▪ Nursing curricula aligned with strategic objectives
	Reduce the prevalence and complications of common non- communicable diseases	Ensure chronic support groups are functioning and supported.	▪ Continuing Professional Development in the relevant Clinical Practice areas. **(Prof Dev)** ▪ Nursing curricula aligned with strategic objectives
	Promote mental well being and improve early diagnosis, treatment and support for people with mental illness	Improve early detection, treatment and care in order to minimize the long-term effects of mental disorders.	▪ Continuing Professional Development in the relevant Clinical Practice areas. **(Prof Dev)** ▪ Nursing curricula aligned with strategic objectives
	Interventions to reduce impact of violence against women and children	Training of nurses and Doctors	▪ Training and development of targeted Health professionals on interventions to reduce impact of violence against women and children. ▪ Training of Health Professionals in prevention of Workplace violence

STRATEGIC GOAL	STRATEGIC OBJECTIVE	KEY ACTIONS	KEY STRATEGIC FOCUS AREA
2. ***Effective implementation of the comprehensive HIV and AIDS strategy***	Provide HIV and AIDS comprehensive care and treatment including ART in all sub-districts by 2009	Ongoing training and support of staff	▪ Contribute to and influence policy implementation, curriculum development and training of GHD health personnel in the HIV/AIDS programme generally and comprehensive HIV/AIDS care programme specifically. ▪ Train targeted health care workers for the strategic rollout of the ARV programme
	Implement effective HIV/AIDS Workplace Programme in 100% service delivery units.	▪ Implement GHD AIDS Workplace and Wellness Programme	▪ Strategic alliances with Institutions of Higher Learning. ▪ Implement Employer well being Programmes in all GHD training Institutions. ▪ Ensure targeted Managers and Health Care Workers are trained on the Integrated Health and Wellness Programme.
	Provide universal access to Palliative Care, Home-Based Care, Hospice, Step-down facilities to the population of Gauteng.	▪ Implement Home-Based and Community-Based Care Programmes within and overall Community Health Worker Programme through CBOs, NGOs in collaboration with other Departments.	▪ Implement a Learnership Programme for ± 200 Community Health Care Workers on NQF Level 4.

STRATEGIC GOAL	STRATEGIC OBJECTIVE	KEY ACTIONS	KEY STRATEGIC FOCUS AREA
3. ***Strengthen the district health system and provide caring, responsive and quality health services at all levels***	Ensure the provision of rapid , effective and quality emergency medical services	Compliance with the emergency medical services basic norms and standards by agents	▪ Train the requisite numbers of ALS, ILS and BLS personnel to meet the norms and standards (Ambulance Training College) ▪ Train Health Care Professionals in Comprehensive Primary Health Care and District Health Systems. ▪ Collaborate with PHA and Local Government.
			▪ Implement refresher courses for BLS, ILS and ALS personnel **(Ambulance Training College)**
			▪ Implement PALS and ACLS courses **(Ambulance Training College)**
			▪ Develop and implement an E.M.D. training course **(Ambulance Training College)**
			▪ Develop and implement Advanced Driver Training Course for Provincial (Ambulance Training College)
			▪ Plan for implementation of Rescue Training at the College **(Ambulance Training College)**

STRATEGIC GOAL	STRATEGIC OBJECTIVE	KEY ACTIONS	KEY STRATEGIC FOCUS AREA
4. *Implement the people's contract through effective leadership and governance*	Improve the capacity of managers and staff to manage and steer health sector transformation	▪ Implement middle managers and CEO capacity building/ leadership programme	▪ Leadership and management development training CEOs management development training, mentoring and coaching. ▪ ?Development of HR planning units
	Implementation of a comprehensive community health worker programme	▪ Select and train Community Health Workers	Development of guidelines, curricula, policies and monitoring tools.

STRATEGIC GOAL	STRATEGIC OBJECTIVE	KEY ACTIONS	KEY STRATEGIC FOCUS AREA
5. *Become a leader in human resource development and management for health*	Ensure adherence to recognised human resource and labour relations management standards	▪ Training and capacity building of staff and managers	▪ Development of policies, guidelines and monitoring tools. ▪ GHD Learnership (18.2) for 800 Community Health Workers. ▪ Non-medical Internships for 2000 Interns.
	Implement strategies to achieve employment equity and to manage a diverse work force	▪ Achieve employment equity targets set by the public sector: 70% black; 30-50% women; 2% people with disability through a combination of recruitment, training and other strategies ▪ Wider training and capacity building in diversity management	▪ Monitoring compliance. ▪ Guidelines and monitoring tools. **(Management and Skills)** ▪ Prioritise the selection of emergency care candidates in meeting the employment equity imperatives of GDOH **(Ambulance Training College)** ▪ Develop and implement mentorship program **(Ambulance Training College)**
	Building capacity of frontline managers	▪ Train about 2 000 frontline staff in customer care annually	▪ Define the service**. (Management and Skills)**

STRATEGIC GOAL	STRATEGIC OBJECTIVE	KEY ACTIONS	KEY STRATEGIC FOCUS AREA
	Provide the service platform for high quality training and development and clinical research that is responsive to the needs of the country	▪ Partnerships with universities ▪ Implement revised memorandums of agreement with the universities	▪ Formalize strategic partnerships on training and development with tertiary institutions **(Ambulance Training College)**
	Ensure the recruitment and retention of human resources	▪ Implementation of career development plans for all levels of staff ▪ Implement Service Improvement Plan in phased manner to increase number of health professionals	▪ Ensure the development of mid-level health care workers in accordance with the skills development act, the national health 10 point plan and service delivery priorities for GDH (Professional Development) ▪ Build a critical mass of people who are capacitated to meet the service delivery improvement challenge through appropriate skills development (Professional Development)
	Implementation of the Learnership Programme	▪ Provide Learnerships to staff and beneficiaries outside the public service in areas such as Auxiliary Nursing, Diagnostic Radiography, Pharmacy Assistants basic, customer care management, office administration, human resource management, public service finance and state accounting. ▪ Train 5 100 beneficiaries by 2009 (12% of the workforce).	▪ Implement Learnerships and Internships aligned to GPG / GHD Provincial priorities and NSD strategy.
6. *Operating smarter and invest in health technology, communication and management systems*	Establish an integrated Management Information System (MIS).	▪ Develop and implement HRD/Training Information Management System. ▪ Budget prioritisation. ▪ Provide training to support the increased utilization of accurate	

STRATEGIC GOAL	STRATEGIC OBJECTIVE	KEY ACTIONS	KEY STRATEGIC FOCUS AREA
		and timely information to aid decision making processes. ▪ Participate in the implementation of the e-governance framework.	
	Ensure the implementation of an effective internal communication strategy to encourage staff participation support and commitment.	▪ Training and orientation to Batho Pele. ▪ Implement systems to achieve a decentralized and effective organisation.	
	Ensure implementation of an effective external communication strategy that achieves community participation, and engagement of poor and vulnerable groups.	▪ Media training and management	
	Improve financial management	▪ Improve Financial Management by ensuring PFMA reporting through cost centres and strengthening financial controls. ▪ Ongoing training and mentoring. ▪ Align planning with budget processes.	
	Ensure the construction, rehabilitation, upgrading, and maintenance of infrastructure	▪ Revitalization of health care infrastructure and equipment through construction, renovation or rehabilitation within the overall GPG strategy of Labour.	

Analysis of constraints of and measures taken to overcome them

CONSTRAINTS	MEASURES TO OVERCOME
There is a shortage of capacity for the learnership programme for health professionals e.g. shortage of tutors, assessors and mentors for the programme ***as well as staff to administer the learnerships.***	Explore incentive options and other retention measures. Staff on a sessional basis. Appoint SDF.
There is inadequate internal and external capacity for the learnership programme.	Support from senior management and external Structures related to the learnership programme including additional capacity.
Shortage of staff in Nursing Education section	Request for the creation of additional posts to be approve of urgency
Lack of management information systems in the colleges – student administration systems to operate smarter.	Ensure development of appropriate management informa and purchase a student administration system for the coll
Difficulty in attracting suitable candidates as instructors to the Ambulance Training College leading to a severe shortage of staff. This in turn leads to a challenge in achieving priorities and strategic goals identified.	Forging of strategic partnerships and agreements in order to increase numbers of instructors and Liaison with Program 3 and establishment of a formal agreement to second Medical Officers to the College on a daily basis.
High staff turn over and concomitant loss of skills, which in turn increase training, costs.	Learner contracts to be developed, upgrade salary levels and post-levels
Applicants to course at Ambulance Training College not reflective of the demography of the Province due to stereotype of certain courses in previous government	Dispel erroneous perceptions by aggressive marketing to Emergency Personnel, graduates and the public. Innovative approaches through media and open days.

Delay in procurement leads to delay in training and obtaining materials for training	Liase with procurement to find an appropriate solution to the procurement delays and obstacles encountered. Procurement system streamlined. Three year tender as opposed to the annual tendering proces with parastatals and institutions of higher learning.
Cost of nursing education – student bursary system vs student nurse salaries	Bursaries for student nurses to be considered
High tutor turn over and concomitant loss of skills which in turn increase training costs.	Retention strategies and incentives to be developed and a ca Management Plan. Recruitment of retired nurses.
Lack of a strategic plan for nursing education and lack of clarity regarding the regarding the positioning of nursing education	National Departments to address the issue of positioning as urgency. A strategic plan to be developed for the province a urgency.
PMS for students	Introduction of a bursary system for students will define them as learners only
Lack of monitoring system for the conditional grant.	A monitoring system of the conditional grant for training and development needs to be established to ensure appropriate use of the HPT and grant. Role-clarity and capacity.
Coordination of training still a problem	Participation in the development and implementation of the HRD strategy.
GSSC not fully functional to fulfil their mandate	Coordination meeting monthly service level agreements.
Inability to release staff for long periods for training.	Find innovative ways to conduct training and to review the study leave policy and guidelines. Increase staff numbers on site, E-Learning.
Inappropriate applicant selection process such that meeting employment equity targets is a challenge.	HRD strategy developed and implemented. Identify experts in selection techniques.

The impact of HIV/AIDS in the Health Workforce is becoming a serious threat to health care in South Africa.	Career management system developed and implemented. HR competence and incapacity management, EAP & OHS.
Delay in Dispensing course Training due to Procurement and tender policies and procedures.	Each region to budget and procure their own provider for the Dispensing course and work closely with central office on targets and outcomes for strategic control purposes. However Professional Development will train Proportionally to budget allocation for dispensing.
Difficulty in attracting suitable candidates as instructors to the Ambulance Training College leading to a severe shortage of staff.	Utilisation of part-time staff in order to comply with H.P.C.S.A. criteria. Forging of strategic partnerships in order to increase numbers of instructors. Liaison with Program 3 and establishment of a formal agreement to second Medical Officers to the College on a daily basis.

Specification of measurable objectives and performance indicators

Table 69: Provincial objectives and performance indicators

Strategic Objective	Objective	Indicator	2001/02 (Actual)	2002/03 (Actual)	2003/04 (Actual)	2004/05 (Estimate)	2005/06 (Target)	2006/07 (Target)	2007/08 (Target)
Implementation of the learnership/internship programme	Implement the Learnership programme	Number of people trained on learnership /intern ship (cumulative)	#	#	#	1720	2000	3440	3440
Provide HIV and AIDS comprehensive care and treatment including ART in all sub districts by 2009	Provide HIV and AIDS comprehensive care training to all clinical practitioners.	Number of Clinical practitioners trained in comprehensive HIV/AIDS/ARV care	#	#	1000	1000	1560	2000	2500
Provide professional services for Foreign health professionals	Number of health professionals assisted.		120	160	180	200	240	280	320
Ensure the provision of rapid, effective and quality emergency medical services	Increase number of Ambulance personnel with life support training	Number of emergency care staff trained to Basic Life Support level	174	56	53	100	100**	120**	120**

Strategic Objective	Objective	Indicator	2001/02 (Actual)	2002/03 (Actual)	2003/04 (Actual)	2004/05 (Estimate)	2005/06 (Target)	2006/07 (Target)	2007/08 (Target)
		Numbers of emergency care staff trained to Intermediate Life Support Level	48	59	52	72	48	50	50
		Numbers of emergency care staff trained to Advance Life Support Level	16	17	19	18	20*	40*	40*
Provide the service platform for high quality training and development that is responsive to the needs of country	Health sciences Graduates	Number of nursing new entrants	411	544	770	718	800	870	900
		Number of nursing students all years	2260	3039	3205	3121	3 020	3400	3500
		Number of all nursing graduates	1078	1266	1213	1 148	1100-1230	1360	1490

Strategic Objective	Objective	Indicator	2001/02 (Actual)	2002/03 (Actual)	2003/04 (Actual)	2004/05 (Estimate)	2005/06 (Target)	2006/07 (Target)	2007/08 (Target)
		Number of new registrars entrants	#	#	#	200-232	200-250	200-250	200-250
		Number of medical interns	#	#	#	346	*358	358-365	358-365
	Bursaries granted	Number of bursaries granted and /or maintained	#	#	878	1 135	1 135	1373	1510
Improve the capacity of Managers and staff to manage and steer health sector transformation	Senior/middle and frontline managers trained	Percentage senior/middle and frontline managers trained	#	#	#	10	12.5	15	20

* Subject to approval by P.B.E.C.P. (EMS board) - The changes from the previous strategic plan is based on alignment with the revised norms and standards.

** Subject to requisite numbers of students passing entrance examinations and nature of association with local authority. Attrition levels to be objectively analysed to improve accuracy of target setting. The changes from the previous strategic plan are based on alignment with the revised norms and standards.

- # New indicator data not available

Table 70: National- Situational analysis and projected performance for health sciences and training

Indicator	Type	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	National target for 2007/08
Input									
1. Intake of nurse students	No	564	704	894	986	850	870	900	
2. Students with bursaries from the province	No	235	689	827	1154	1269	1395	1534	
Process									
3. Attrition rates in first year of nursing school	%	24.2	10	11.2	10	10	10	10	10
Output									
4. Basic nurse students graduating	No	618	768	611	529	609	750	750	
5. Post Basic	No	460	498	602	619	621	660	710	
Efficiency									
6. Average training cost per basic nursing graduate	R	53000	55244	59588	63461	64123	67099	71460	
7. Development component of HPT & D grant spent	%	#	#	#	#	#	#	#	100

New indicator data not available

Trends in provincial public health expenditure for HPT&R conditional grant (R million)

Table 71. Trends in provincial public health expenditure for HPT&R conditional grant (r million)

Expenditure	2001/02 (Actual)	2002/03 (Actual)	2003/04 (Actual)	2004/05 (Estimate)	2005/06 (MTEF Projection)	2006/07 (MTEF Projection)	2007/08 (MTEF Projection)
Current prices`1							
Total	529 186	528 317	539 330	560 778	-	-	-
Total per person	60	60	61	63	-	-	-
Total per uninsured person	83	82	84	87	-	-	-
Constant (2004/05) prices							
Total	644 549	585 904	567 375	560 778	554 039	554 039	581 741
Total per person	73	66	64	63	63	63	66
Total per uninsured person	101	91	89	87	86	86	91

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

The purpose of this programme is to:

- Render support services required by the Department to fulfil its aims and objectives;
- Render non-clinical services as may be applicable for research, laundry, food supply services and medical supplies depot;
- Rendering efficient and effective support services to hospitals and clinics.

Situation Analysis for Health Care Support Services

Linen Supply

Significant progress has been made in the management of linen, at all hospitals, which has contributed to quality care and services to the patients. There are seven laundries in the Department, of which two functions as autonomous units and is not part of provincial hospitals. The objective of each laundry is to ensure the adequate supply of clean linen to all Gauteng health care institutions. The laundries managed to control service level and quality of care by meeting the target of 90% of supply and management requirements for institution. A linen management system has been set up at hospitals and laundries to improve and ensure effective controls. The revitalization and modernization of laundries into cost effective support services is currently in progress on three laundries. Efficient laundry management and upgrading of equipment has resulted in shortened delivery times of linen into cost-effective support services to hospitals.

Medical Supplies Depot

The Depot's mission is to provide an efficient procurement, warehousing and distribution system for pharmaceutical and non pharmaceutical items regularly required by health care institutions, and to ensure the quality of these goods meets required standards for health care.

It provides a shared supply chain to all health care institutions in Gauteng, and supplies around 75% of medicines to institutions in the Province. The Medical Supplies Depot operates on a trading account and charges a levy of 5% on medicines and medical related items issued to institutions. The Medical Supplies Depot supplies medicines to all the provincial hospitals and regional pharmacies in the province, as well as a few local authorities and non-government orgainizations. The Medical Supplies Depot only procures medicines from contracts, which are arranged by National Treasury. National Treasury, together with National Health are responsible for pharmaceutical contracts and GSSC are doing contracts for surgical and sundries items. The Store is particularly successful managing the efficient procurement and distribution of pharmaceuticals and surgical sundries to the province. Training and development of staff, especially

Pharmacist Assistants, to comply with the Pharmacy Act (2005). Security control systems and access control have been upgraded to further ensure proper stock management and continued supply an excellent warehousing and distribution service for pharmaceuticals and surgical sundries.

Food Supply Service

The cook-freeze food supply chain has currently expanded to other Institutions with the current biggest customers being Johannesburg Hospital, Pretoria Academic (Orthopaedic) Hospital, Kalafong, Pretoria West Hospitals and four CHC's limited food service. The cook-freeze supply chain delivers a full food service of high nutritional value available on different menus which can be selected to accommodate different patients with different diets. Raw products are procured and quality tested in a fully equipped laboratory, after which products are processed (cooked), frozen and supplied to Hospitals on request. We further improved efficiency by upgrading equipment according to a higher standard of Hazard Analytical Critical Control Point (HACCP) and upgrading of equipment and appearance (packaging) to meet higher standards. The Masakhane Cookfreeze is able to meet the required standards of request from customers by proper planning process. Stock requirements are calculated three weeks in advance taking into considerations availability of stock and requirements from customers.

Policies, Priorities and Broad Strategic Objectives for Health Care Support Services

Policies

The Medicine Supply Chain Depot was established in 1992, as a trading account to serve the area covered by the previous Transvaal Provincial Administration, in terms of Guidelines issued by National Treasury to provide medicines, surgical sundries and other items to hospitals and health care institutions.

The Medical Supplies Depot is guided by the following legislation:

- Public Finance and Management Act 1 of 1999
- Preferential Procurement Policy Framework Act No. 5 of 2000
- Supply Chain Management Act
- Treasury Regulations
- Pharmacy Act (Act 53 of 1953) as amended in 1997
- Medicines and Related Substance Control Act (Act 101 of 1965) as amended in 1997.
- National Health Act
- Broad Based Black Economic Empowerment Act

Programme 7's broad strategic objectives are guided by Gauteng's Strategic goals 6, specifically to:

- Ensure implementation of an efficient and cost effective supply chain management system.
- It will also assist in achieving Strategic goals 5, to "Become a leader in human resource development and management for health".

Priorities and key activities identified to achieve these objectives are to:

- Implement the preferential procurement strategy, including a BBBEE framework.
- Sustain the decentralisation of linen management to all hospitals
- Ensure the Pre-pack Store/Pre-Packing Department at the Depot becomes operational during 2005/06, and provide support to hospitals/pharmacies with the provision of pre-pack services at depot
- Timeous renewal of expired pharmaceutical and non pharmaceutical tenders by National Health and GSSC.
- Ensure and maintain the prompt delivery of medicines, linen and food
- Further expansion of the Remote Demand Module for managing of pharmaceutical orders by institutions.
- Improve sustainability and price increases recovery from institutions
- Ensure training and development of Pharmacist Assistants through SETA learnerships.
- Develop and implement of the supply chain management guidelines

Analysis of constraints and measures to planned to overcome them

Constraints	Measures planned to overcome constraints
Potential shortage of medicines, surgical and sundry items	Effective and efficient management of contracts is in place to ensure delivery of medicines, surgical and sundry items.
Tight security system and vigilant controls over receipt and issue of stock at depot and institutions	Sustain and improve random stock checks on a regular basis and full stock counts undertaken twice a year
	Ensure efficient and appropriate management of stock at the Depot and the distribution to the healthcare institutions.
Bar coding of all medicines	Implement efficient systems for the bar coding of all medicines. Request NDOH to enhance Medsas to accommodate bar coding on procurement of medicines.
Lack of Health Information System on the supply of medicine and stock control levels	Upgrade of the MEDSAS system
Ensure Pharmacist Assistants have the appropriate skills (as per Pharmacy Act by 1st of July 2005	Ensure the provision of necessary training and development
Management of economic order quantity by hospitals.	Implementation and expansions of the Remote Demand Module to all the institutions

Specification of Measurable Objectives and Performance Indicators for Health Care Support Services

Table 72: Measurable objectives and performance indicators for Health Care Support Services

Strategic objectives	Measurable objectives	Indicator	2002/03	2003/04 (actual)	2004/05 (est. actual)	2005/06 (target)	2006/07 (target)	2007/8 (target)
Ensure implementation of an efficient and cost effective supply chain management systems	Upgrade tunnel washing machines	Number of laundries with upgraded tunnel wash machine	#	#	2	5	5	5
	Implement procurement strategy, including a BBBEE framework	Percentage spend on total actual expenditure on BBBEE	#	#	30	40	75	80
	Ensure efficient supply of pharmaceuticals and surgical sundries	Percentage orders supplied to institutions on first request	93.7	94	94	98	98	98
	Ensure benefits of bulk buying, pooling of efforts and economies of scale	Percentage expense of procurement of goods and services via tenders and contracts.	#	20	20	35	55	65
	Strengthen management at medical supplies depot	Percentage of top management posts filled	#	#	40	100	100	100
	Rationalise laundries in the province	Number of laundries in Gauteng Province	#	#	7	5	5	5
	Commission prepacked unit at Medical Supplies Depot	Percentage of bulk medication prepacked	#	#	0	60	75	85
	Implement remote Demand Module to all hospitals	Number of hospitals with Remote Demand Module implemented	#	#	18	25	28	28

	Expansion of Cook freeze food supplies to hospitals and clinics	Number of hospitals and clinics supplied with by Cook Freeze	#	#	8	12	14	16

New indicator, data not available

Past expenditure trends and reconciliation of MTEF projections

Table 73; Trends in provincial public health expenditure for support services(R million)

Expenditure	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF Projection
Current prices`1							
Total	83 566	89 056	74 637	89 771	-	-	-
Total per person	9	10	8	10	-	-	-
Total per uninsured person	13	14	12	14	-	-	-
Constant (2004/05) prices							
Total	101 783	98 763	78 518	89 771	96 000	100 020	106 320
Total per person	12	11	9	10	11	11	12
Total per uninsured person	16	15	12	14	15	16	17
Capital	835	1 123	10 320	850	1 000	1 000	1 000

PROGRAMME 8: HEALTH FACILITY MANAGEMENT

The purpose of the programme is to:

- Plan, provide and equip new facilities/assets;
- Upgrade, rehabilitate and maintain community health centres, clinics, district, provincial, specialised and academic hospitals, and other health- related facilities.

Health Facility Management developed its plans for the MTEF from the platform created by the Department's Strategic Goals, specifically:

- *Strategic Goal 3:* Strengthen the district health system and provide caring, responsive and quality health services at all levels; and
- *Strategic Goal 6:* Operate smarter and invest in health technology, communication and information management systems;

The inputs and outputs of the programme can be summarised as falling under a Capital and Health Technology Portfolio (CHTP) unit that encompasses Facility Management, Professional Services and Clinical Engineering.

Situational Analysis for Programme Health Facility Management

The Gauteng health facilities portfolio comprises: 270 fixed clinics and CHCs, 31 hospitals (including three academic dental schools), 5844 flats, statehouses and dormitories, seven laundries, four nursing colleges, one emergency care college and one cook freeze facility. The 11 government mortuaries will be added to the portfolio during April 2005. The estimated replacement cost of the Gauteng portfolio is R8, 30 billion.

General condition of Health Facilities

Condition-based assessments, including structured appraisals of the condition and maintenance requirements of all building elements and site service groups, have been completed by the Council for Scientific and Industrial Research (CSIR) on all hospitals, CHCs, laundries, nursing colleges and mortuaries, using specially designed data collection forms.

Specialist maintenance assessment teams, comprising structural, civil, electrical/mechanical engineers and quantity surveyors, evaluated the fixed asset maintenance needs by inspecting the physical condition of the assets. Most of the buildings require minor repairs, but the painting of roofs and ceilings requires urgent attention.

The current estimated maintenance budget for 2004/5 Gauteng health facilities is R331, 670,000. The budget required should have included R250, 670,000 for backlog maintenance. Based on the assumptions that the existing maintenance backlog will be

eradicated over three years (provided that an adequate budget provision is allocated), the estimated annual budget is as follows:

Table 74: MTEF Budget requirements

	2005/6	2006/07	2007/08
National Infrastructure	73 955	81 549	81 225
Revitalization	17 955	148 664	133 093
Provincial Infrastructure	151 502	170 909	124 529
Maintenance	209 673	244 229	324 319
Total	**453 085**	**645 351**	**663 166**

Transfer of Government Mortuaries to the Province

A condition-based assessment was completed on Government Mortuaries to ensure adequate provision is made for maintenance of these facilities once they are included in the Departmental facility portfolio.

Asset Registers

The asset registers have been developed for buildings and fixed assets. All buildings, plant and equipment have been assigned a unique number in these registers.

Table 75: Historic and planned capital expenditure by type

	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/7 (MTEF projection)	2007/08 (MTEF projection)
Major capital[3]	323 156	297 147	359 085	207 148	237 212	394 522	331 847
Minor capital	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maintenance	30 964	196 214	188 856	420 170	209 673	244 229	324 319
Equipment[3]	168 759	173 138	129 502	282 754	225 995	237 055	238 000
Equip maintenance[2]	71 413	62 584	79 810	104 997	110 899	116 176	121 916
Total capital[1]	491 915	470 285	488 587	490 051	463 207	631 577	569 847

1. Maintenance is classified as current expenditure under the new Standard Chart of Accounts. For the purposes of the table above it has been excluded from Capital.
2. The amounts indicated under maintenance includes all maintenance other than facilities
3. The budget for equipment and equipment maintenance is provided for under the various budget Programmes and not Programme 8.

Equipment and equipment maintenance was never before reported separately resulting in no available information in this format.

Table76: Summary of sources of funding for capital expenditure

	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/7 (MTEF projection)	2007/08 (MTEF projection)
Infrastructure grant	16 172	31 142	47 160	66 458	73 955	81 549	81 225
Equitable share	235 948	327 219	412 842	407 095	361 175	415 138	448 848
Revitalisation grant[1]	102 000	135 000	87 939	155 126	17 955	148 664	133 093
Donor funding	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0
Total capital	354 120	493 361	547 941	628 679	453 085	645 351	663 166

Table 77: Historic and planned major project completions by type

	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/7 (MTEF projection)	2007/08 (MTEF projection)
New hospitals	52 961	73 980	174 261	163 501	114 858	204 313	214 529
New clinics / CHC's	0	0	0	0	40 000	30 000	30 000
Upgraded hospitals	0	0	0	123 508	232 870	218 126	270 433
Upgraded clinics / CHC's	0	0	0	0	25 000	25 000	30 000

This is a new request and figures are based on the backlog in maintenance and 20% in changes due to modernisation, etc. A comprehensive 10 year plan will have to be developed. The Revitalisation projects for the next 15 years have been identified and the Business Cases has been submitted to National Health

Table 78: Total projected long term capital demand for health facilities management (R '000)[2]

Programme 1	Province total annualised	City of Jo'burg	West Rand	Ekurhuleni	Sedibeng	Tshwane	Metsweding
MECs office and Administration[1]	n/a	n/a	n/a	n/a	n/a	n/a	0
Programme 2							
Clinics and CHC's	310	90	10	50	50	100	10,000
Mortuaries	71	20	10	20	10	10	1
District hospitals	1,450	600	50	200	0	600	0
Programme 3							
EMS infrastructure[1]	0	0	0	0	0	0	0
Programme 4							
Regional Hospitals	1,480	400	100	800	150	30	0
Psychiatric hospitals[1]	220	50	70	0	0	100	0
TB hospitals[1]							
Other specialised hospitals[1]	200	100	0	100	0	0	50,000
Programme 5							
Provincial tertiary hospitals[1]	1,150	1,000	10	10	80	50	0

Other programmes[1,3]							
Such as nursing, EMS etc colleges	40	10	10	10	0	10	0
Total all programmes	**4,921**	**2,270**	**260**	**1,090**	**290**	**950**	**61**

1. By province only
2. Summarised from provincial Integrated Health Planning Framework (IHPF) model
3. May be added by province if appropriate – where specific capital demands are targeted at a strategic (vertical) programme and on which it is desirable to report separately
4. National annual requirement based on long term plan time horizon – maximum 20 years

Table 79: National - Situational analysis indicators for health facilities management

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/4	2003/04 COJ/WR	2003/04 EKUR/SED	2003/04 TSHW/METS	National target 2003/4
Input								
Equitable share capital programme as % of total health expenditure	%	3.5	1.2	2.4	#	#	#	1.5
Hospitals funded on revitalisation programme	%	40	12	14	11%	4%	4%	17
Expenditure on facility maintenance as % of total health expenditure	%	0.5	2.5	2.3	#	#	#	2.5
Expenditure on equipment maintenance as % of total health expenditure		1.5	3.4	3.3	#	#	#	2

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/4	2003/04 COJ/WR	2003/04 EKUR/SED	2003/04 TSHW/METS	National target 2003/4
Process								
Hospitals with up to date asset register	%	#	65	85	85	85	85	100
Health Regions with up to date PHC asset register (excl hospitals)	%	100	100	100	100	100	100	100
Quality								
Fixed PHC facilities with access to piped water	%	100	100	100	100	100	100	100
Fixed PHC facilities with access to mains electricity	%	100	100	100	100	100	100	100
Fixed PHC facilities with access to fixed line telephones	%	100	100	100	100	100	100	100
Average backlog of service platform in fixed PHC facilities	%	0	0	0	22	20	30	30
Average backlog of service platform in district hospitals	%	40%	35%	35%	COJ30.5% West Rand 6%	Ekurhuleni 17,5% Sedibeng 19%	Tshwane 19,6% Metsweding 0 %	30
Average backlog of service platform in Regional hospitals	%	30%	20%	15%	COJ 15% WR 8%	Ekurhuleni 18,6%	Tshwane 39,7% Metsweding 0%	30
Average backlog of service platform in specialised hospitals	%	20	20	20	COJ15.5% WR 21%	0	Tshwane 9% Metsweding 12%	**30**

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/4	2003/04 COJ/WR	2003/04 EKUR/SED	2003/04 TSHW/METS	National target 2003/4
Average backlog of service platform in tertiary and central hospitals	%	30	30	30	COJ 29%	0	Tshwane 4%	**30**
Average backlog of service platform in support Services (laundries, nursing colleges, mortuaries hospitals	%	20	20	17	COJ17%	Ekurhuleni 34%	Tshwane 26%	**30**
Average backlog of service platform in provincially aided hospitals	%	0	0	0	0	0	0	**-**
Efficiency								**-**
Projects completed of time	%	0	0	0	0	0	0	**-**
Project budget over run	%	100%	100%	100%	100%	100%	100%	
Outcome								
Population within 5 km of fixed PHC facility	%	85	85	85	85	85	85	**85**

#new indicator, information not available

Policies, Priorities and Broad Strategic Objectives for Programme Health Facility Management

Broad strategic objectives are guided by Gauteng's Strategic Goals 3 and 6 and are to:

- Ensure the construction, rehabilitation, upgrading and maintenance of infrastructure linked to the S.I.P.
- Reduce the backlog of infrastructure and equipment.

Key projects / actions identified to achieve these objectives are to:

- Implement a capital investment strategy (CAPEX);
- Expand the Zivuseni project to implement beautification projects at health facilities;
- Investigate and develop models of Public Private Partnerships (PPP); and
- Develop and implement an equipment management strategy

Management Policies and Strategies

The CHTP, consisting of Facility Management, Professional Services and Clinical Engineering, is developing various management policies with regards to infrastructure, maintenance, equipment and other electrical and mechanical devices in the province. These policies aim to:

- Ensure uniformity within the Department;
- Provide guidelines on the various aspects;
- Create mechanisms for accountability amongst stakeholders;
- Accelerate development of new facilities and upgrading of old facilities;
- Provide a positive working environment for staff;
- Ensure appropriate utilisation of public funds;
- Enable intersectoral collaboration within the Province;

The policies are:

Labour intensity strategy and framework policy
A large number of the tenders are awarded to labour-intensive projects, Small, Medium and Micro Enterprises (SMME) and Previously Disadvantaged Individuals (PDI) contractors, creating large numbers of jobs. Monitoring mechanisms will be implemented during 2005/06 financial year. Day-to-day projects at institutions are fairly small and many contractors from the surrounding areas are requested to quote for work. The quality of the work is relatively good and the support for the community encourages a sense of ownership in their community institution.

The project will be implemented on an incremental multi-year framework, starting at full pace and with parallel capacity building in the industry.

Capital Investment, Maintenance and Equipment Policy
Several sources of funds are now available for financing facilities in Gauteng. Most funding emanates from the budget allocated by the Provincial Treasury; additional funding comes from National Department of Health allocations, and donors.

The allocation of Conditional Grants improved the state of facilities in Gauteng from 1997 to 2004. Allocating funds to establish preventative maintenance programmes and equipment plans will ensure longer-term improvements to facilities are sustained.

Capital Investment Strategy

Background: The rate of urbanisation in Gauteng continues to be high. Some municipal suburbs in the metropolis have increased significantly resulting in a growth in demand for residential services (including clinics) far outstripping available financial resources. The health of an urban community is largely determined by (amongst other factors) the provision of municipal services including water, sewerage, drainage, electricity, etc. which in turn affects the provision and success of health services.

Motivation for projects for hospitals, including the conditional grants and revitalisation: Capital works expenditure programmes need to be planned for five, ten and 15 year periods that can be adjusted in annual budgets. See Table 80 and 81 for Specification of Measurable Objectives and Performance Indicators for a list of projects.

Budget required: The Department is not considering embarking on any Capital Projects from its equitable budget due to the urgent needs for maintenance. A comprehensive maintenance plan has been provided and was used for the allocation
of the maintenance budget. This plan will assist in the long term maintenance budgeting provided that it is updated on a regular basis. Direct allocations to the institutions have been increased to ensure participation in the management of maintenance and quicker response times to execute day-to-day maintenance.

Maintenance Strategy

Background: The perception that maintenance is the request from institutions for new or improved facilities still exists. However Programme 8 focuses on maintenance of the *existing fabric,* namely electricity, statutory aspects lifts, air-cons and boilers. Maintenance in the context of this document can be defined as the practice of coordinating the physical workplace with the people that work for the organisation. It includes:

- Estate procurement, leasing and disposal;
- Strategic, tactical planning and design;
- Space management for optimal service delivery;
- Financial management and budgeting;
- Operations and facilities maintenance management; and
- Benchmarking and best practice.

Key objectives of the Health Infrastructure and Maintenance strategy are to:

- Support delivery of health services through effective management and maintenance of health facilities;
- Ensure optimum availability of all existing health facilities and plants;
- Specify minimum requirements for the management and maintenance of health facilities;
- Ensure health facilities are adequately and effectively managed and maintained;
- Ensure that risks to the Department are effectively managed;
- Ensure the Department has the necessary information for maintenance, condition and performance of facilities; and
- Ensure there is adequate information at operational level for undertaking maintenance, including the ability to review policies and strategies, analyse life cycle costs, plan for replacements and upgrades, and improve efficiency and effectiveness of maintenance.

Motivation for projects: The emphasis for 2005/06 is to address the maintenance backlog. It is envisaged that the backlog will be eradicated and from 2006/7 we will be able to concentrate on preventative and statutory maintenance only.

*Budget required**:*** The maintenance budget is based on the condition-based assessments completed by the CSIR. A vigorous programme to decentralise day-to-day maintenance to the various institutions and health regions has been introduced. The day-to-day allocation will be made to the institutions for the 2005/06 financial year to allow the CHTP to concentrate on statutory maintenance.

Extensive training and capacity building programmes have been undertaken to assist institutions with the effective and efficient implementation of day-to-day maintenance.

A budget of **R420 000 000** was allocated for the 2004/05 financial year, and R 209 673 000 for the 2005/6 financial year as follows:

- Estimated construction/replacement cost;
- Budget required to address backlog minus infrastructure and capital expenditure from 2001-2004.
- Budget is reduced for institutions where revitalisation will take place during the next three years;
- More than half of the budget has been allocated to Statutory Maintenance, namely period contracts, the Occupational Health and Safety Act and Backlog Maintenance so that priority categories 3,4, and 5 maintenance issues don't deteriorate to category 1 or 2. This will be managed by Public Works;
- The 50 % Routine and Unplanned Maintenance budget is divided as follows:
    - 5% to Institutions for Day to Day and for store items;
    - 45% for Preventative maintenance managed by Public Works;

Management of budget: Monthly monitoring meetings are held with the Regional Works office and all institutions to ensure problems are rectified as they arise. An overall budget meeting is also held with the management of the Department of Public Transport, Roads and Works to discuss broader issues. The Department of Health will release an advance of 3 months money to the Department of Public Transport, Roads and Works and will only release more according to the expenditure and monthly accounts received. A newly appointed Portfolio Manager manages the funds.

Equipment Strategy

Background: A total lack of systematic planning in the acquisition of health technologies has resulted in inappropriate utilisation of equipment and unnecessary expenditure, as well contributing to high technology costs and resulting in inequitable, fragmented, inefficient and ineffective distribution of resources. These issues exclude the long-term cost and other implications of maintenance, safety, efficiency and effectiveness of Health Technology. The WHO has emphasised that **"**Health technology is the core of what health care has to offer and it must *be* efficacious and beneficial technology. This technology must be affordable, available, accessible and appropriately used". The acquisition of Health Technology is now guided by the Department's policy framework, which sets guidelines for operational and technical policies, and provides a long term strategy to improve standards and quality of service in line with that of the National Department of Health.

Motivation for Equipment: Well-maintained and adequate equipment is critical to service delivery and a programme for effective procurement and maintenance of medical equipment is being developed. Efficient planning, procurement and maintenance of medical equipment are vital and require:

- Integrating planning and implementation of health programmes by ensuring optimal and sustainable use of health technology resources;
- Developing an essential health technology list;
- Basing acquisition programmes on clearly defined needs, which are influenced by strategic requirements planning, evaluation and selection prior to the procurement of any equipment;
- Providing maintenance to Health Technology that demands a high investment, with substantial recurring operational expenses; and

- Establishing Technical and Clinical Advisory Committees (TCAC) at all levels of management.

Analysis of Constraints for Programme 8 and measures to planned to overcome them

Constraints	Measures planned
Lack of or no communication with internal and external clients	Regular quarterly meetings with Institutions Monthly report to Senior Management
No control over the quality of work from Public Works/Suppliers. Vandalism and theft.	• Establishing Facility Management Units/Asset Committees at each Institution. • Developing reporting mechanisms for vandalism and theft
No control over the delivery time of the service.	• SLA with the Dept of Public Transport, Roads and Works. • Monthly meetings with our Agent. Budget for each Institution and mechanisms to monitor expenditure. • Day-to-Day budget to Institutions and Regions.
Lack of concrete and verified financial and project data from DPTRW	CAPEX database programme can produce reports per Institution and per Region.
Lack of planning guide for Architects. Lack of essential equipment lists Lack of updated cost norms. Lack of capacity in preparing briefs to DPTRW	• Developing cost norms and planning guide for Architects. • Developing essential equipment lists per category. • Capacity Building for staff to develop briefs and project management of capital projects
Lack of technical expertise regarding purchasing and maintenance of equipment	Appointment of clinical engineering technicians and establishment of satellite workshops
Lack of understanding of budgetary allocations regarding equipment (i.e. procurement vs. maintenance)	Regular quarterly meetings with Institutions and Regions.

Constraints	Measures planned
Management mechanisms for equipment are fragmented and do not constitute a comprehensive system, which is critical for optimal functioning of the whole health care system.	• Enable a structured process • TCAC compile and prioritise a needs list, does costing for budgetary purposes and submit to management for approval and submission to the regional office; • Regional TCAC compiles and assess the needs lists, prioritises the needs and does costing for budgetary purposes based on the needs list from all the institutions in the region. Prioritised information is submitted to Regional management for approval and submission to the Central office; • Central Office TCAC compiles and assesses the needs lists, prioritises the needs and does costing for budgetary purposes based on the needs list from all Regional Offices. Prioritised information is then submitted to the HOD committee for approval. The approved information is returned to the Regional offices and institutions to start the procurement process; • System to be developed such that GSSC will know if budget is not overrun before purchasing additional equipment.

Specification of measurable objectives and performance indicators

Table 80: Provincial objectives and performance indicators for health facilities management

Strategic Objectives	Measurable Objectives	Indicator[1]	2003/04 (target)	2004/05 (estimate)	2005/06 (target)	2006/7 (target)	2007/8 (target)
- Ensure the construction, rehabilitation, upgrading and maintenance of infrastructure - Reduce the backlog of infrastructure and equipment	Complete phase 2 New Pretoria Academic Hospital	Percentage completed	90	95	100	-	-
	Obtain equipment needs and procurement of equipment for New Pretoria Academic Hospital	Percentage completed	10	40	80	100	-
	Construction of Tshwane district Hospital	Percentage completed	10	10	40	80	95
	Obtain equipment needs and procurement of equipment for Tshwane Central Hospital	Percentage completed	#	20	80	90	100
	Construction of Hillbrow Community Health Centre	Percentage completed	60	95	100	-	-
	Construction of New Mamelodi Hospital	Percentage completed	40	30	60	80	100
	Obtain equipment needs and procurement of equipment for New Mamelodi Hospital	Percentage completed	5	25	50	80	100
	Construction of Stanza Bopape Community Health Centre: Phase 2	Percentage completed	50	90	100	-	-
	Construction of Randfontein Community Health Centre	Percentage completed	#	5	30	60	100

Strategic Objectives	Measurable Objectives	Indicator[1]	2003/04 (target)	2004/05 (estimate)	2005/06 (target)	2006/7 (target)	2007/8 (target)
	Construction of Soshanguve Block L Community Health Centre	Percentage completed	50	90	100		-
	Construction of Sterkfontein Hospital 2 new wards	Percentage completed	20	25	50	80	100
	Construction of Weskoppies Hospital New wards Phase 2A	Percentage completed	100	-	-	-	-
	Construction of Weskoppies Hospital New wards Phase 2B	Percentage completed	35	60	70	90	100
	Construction of Weskoppies Hospital New wards Phase 3	Percentage completed	70	100	-	-	-
	Construction of Sizwe Hospital new kitchen, ventilation and electrical ringfeed	Percentage completed	70	100	-	-	-
	Construction of Stretford Community Health Centre: Phase 2	Percentage completed	70	85	100	-	-
	Construction of total revitalization of Chris Hani Baragwananth Hospital	Percentage completed	30	40	45	60	70
	Upgrading of Lillian Ngoyi CHC to level 1 hospital for Johannesburg South Area	Percentage completed	#	10	50	70	100
	Upgrading of Zola CHC to level 1 hospital for Johannesburg South Area	Percentage completed	30	45	50	70	95

Strategic Objectives	Measurable Objectives	Indicator[1]	2003/04 (target)	2004/05 (estimate)	2005/06 (target)	2006/7 (target)	2007/8 (target)
	Determine equipment need and procure equipment for New Zola Hospital	Percentage completed		10	40	80	100
	Upgrading of Lenasia CHC to level 1 hospital (cancelled due to strategic need changing)	Percentage completed	30	40	50	60	80
	Construction of new Cullinan CHC	Percentage completed	30	35	50	60	80
	Construction of new Eersterust CHC	Percentage completed	30	35	60	80	100
	Upgrading of existing and new Community Health Centres in CHB catchment area	Percentage completed	20	45	50	60	80
	Relocation of Natalspruit Hospital	Percentage completed	10	15	40	50	80
	Determine equipment need and procure equipment for Natalspruit Hospital	Percentage completed	#	#	25	30	40
	Upgrading of Germiston Hospital (planning will be completed – placed lower on list due to implementation criteria)	Percentage completed	10	25	40	To be determined	To be determined
	Determine equipment need and procure equipment for Germiston Hospital	Percentage completed	#	10	30	To be determined	To be determined

Strategic Objectives	Measurable Objectives	Indicator[1]	2003/04 (target)	2004/05 (estimate)	2005/06 (target)	2006/7 (target)	2007/8 (target)
	Plan and build new Daveyton Hospital	Percentage completed	#	0	10	15	30
	Determine equipment need and procure equipment for new Daveyton Hospital	Percentage completed	#	#	10	15	30
	Renovation of OPD and Casualty Kalafong Hospital	Percentage completed	90	95	100	-	-
	Renovation of OPD and Casualty Tembisa Hospital	Percentage completed	30	35	50	70	90
	Renovation of OPD and casualty Sebokeng Hospital	Percentage completed	30	35	50	70	90
	Renovation of OPD and casualty Leratong Hospital	Percentage completed	80	95	100	-	-
	General upgrading of Johannesburg Hospital: Pharmacy, Casualty and several Wards	Percentage completed	30	35	40	50	60
	Provide needs list and procure equipment for New Oncology Unit at Johannesburg Hospital	Percentage completed	15	50	60	80	100
	Construction of Far East Rand Hospital new maternity unit	Percentage completed	85	95	100	-	-
- Reduce the backlog of infrastructure and equipment	Modernisation of high tech equipment	Percentage of hospitals on revitalisation programme with equipment plan	#	#	100	100	100

Strategic Objectives	Measurable Objectives	Indicator[1]	2003/04 (target)	2004/05 (estimate)	2005/06 (target)	2006/7 (target)	2007/8 (target)
		Percentage of hospitals on revitalisation programme with equipment committees established	#	#	100	100	100
		Percentage reduction in backlog on high tech equipment	#	5	12	30	60
	Planned prevention maintenance budget	Percentage of budget allocated to maintenance	#	3	3	4	4
• Reduce the backlog of infrastructure and equipment • Implementation of the e-governance framework	Develop brief and procure equipment	Percentage completed	10	15	30	50	80

 # new indicator, data not available

NB: Definition of indicators and targets

10% Development of Departmental Brief
20% Sketch plans completed
25% Tender stage
30% On site
31% - 89% Progress of site
90% Final phase of building including snagging
100% Final site hand over

Table 81: National Performance indicators for health facilities management

	Indicator	Type	2003/4 Actual	2004/05 Target	2005/06 Target	2006/07 Target	2007/08 Target	National target 2007/08
	Input							
1	Equitable share capital programme as % of total health expenditure	%	2.4	-0.2	2.2	2.4	1.6	**1.5**
2	Hospitals funded on revitalisation programme	%	4	4	4	4	4	**17**
3	Expenditure on facility maintenance as % of total health expenditure	%	2.3	4.7	2.3	2.5	3.1	**2.5**
4	Expenditure on equipment maintenance as % of total health expenditure		3.3	5.9	3.5	3.6	4.3	**2**
	Process							
5	Hospitals with up to date asset register	%	85	85	100	100	100	**100**
6	Health Regions with up to date PHC asset register (excl hospitals)	%	100	100	100	100	100	**100**
	Quality							
7	Fixed PHC facilities with access to piped water	%	100	100	100	100	100	**100**
8	Fixed PHC facilities with access to mains electricity	%	100	100	100	100	100	**100**
9	Fixed PHC facilities with access to fixed line telephones	%	100	100	100	100	100	**100**
10	Average backlog of service platform in fixed PHC facilities	%	22	22	11.6	25.1	3	**30**

	Indicator	Type	2003/4 Actual	2004/05 Target	2005/06 Target	2006/07 Target	2007/08 Target	National target 2007/08
11	Average backlog of service platform in district hospitals	%	15	15	18.6	25.1	13.2	**30**
12	Average backlog of service platform in Regional hospitals	%	20	20	28.8	24.4	57.3	**30**
13	Average backlog of service platform in specialised hospitals	%	10	12	14.9	14.9	16	**30**
14	Average backlog of service platform in tertiary and central hospitals	%	30	32	35.9	0	18	**30**
15	Average backlog of service platform in support Services (laundries, nursing colleges, mortuaries hospitals	%	4	3	5.1	25.4	8.5	**30**
	Average backlog of service platform in provincially aided hospitals	%	0	0	0	0	0	**-**
	Efficiency							**-**
16	Projects completed of time	%	0	0	0	0	0	**-**
17	Project budget over run	%	100	100	100	100	100	
	Outcome							
20	Population within 5 km of fixed PHC facility	%	85	85	85	85	85	**85**

Past expenditure trends and reconciliation of MTEF projections with plan

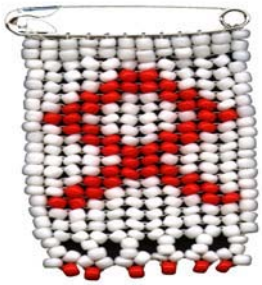
Table 82: Trends in provincial public health expenditure for health facilities management(R million)

Expenditure	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF Projection
Current prices`1							
Total	354 120	493 361	547 941	628 679	-	-	-
Total per person	40	56	62	71	-	-	-
Total per uninsured person	55	77	85	98	-	-	-
Constant (2004/05) prices							
Total	431 318	547 137	576 434	628 679	453 085	645 351	663 166
Total per person	49	62	65	71	51	73	75
Total per uninsured person	67	85	90	98	71	101	103

GAUTENG AIDS PLAN 2005/06

INTER-SECTORAL AIDS UNIT

Annexure 1



CONTENTS Pages

GAUTENG AIDS PLAN 2005/06

1. INTRODUCTION

The AIDS epidemic requires a unified effort from government and civil society where each component contributes according to its role and strengths, based on joint strategy and plans.

The **vision** of the Gauteng AIDS Programme is the implementation of an effective multi-sectoral AIDS strategy. It brings together the efforts of all government departments and civil society sectors in a joint programme to address the needs of families and local communities around HIV/AIDS prevention, care and support.
A diagram of all departments and civil society sectors involved is enclosed as Annexure A.

The **mission** is the implementation of an effective multi-sectoral AIDS Strategy to reduce new HIV infections, increase length of productive life for those infected with HIV and support children and families affected by AIDS to live normal lives in order to reduce the impact of AIDS on society.

The AIDS programme observes the following key **principles**:

- Supports the five strategic objectives for Gauteng for 2009.
- The mainstreaming of AIDS into departmental programmes including crosscutting programmes like children, youth, gender and poverty.
- De-centralisation of local co-ordination to Municipalities with the required capacity.
- Build civil society capacity to address prevention, care and support through the Partnership against AIDS.

The Gauteng **AIDS Summit Declaration** of October 2004 supported by 500 delegates from 20 government departments and 15 civil society sectors set the **Priorities** for the period 2004 – 2009 as follows: (See Annexure B for the full Declaration)

1. A multi-sectoral AIDS programme involving all departments, organized labour and civil society sectors, each playing a strategic role.
2. Reduce new HIV infections in youth and babies and focus on those at greatest risk.
3. Provide comprehensive health care for HIV/AIDS with nutrition, TB and antiretroviral treatment in partnership with communities.
4. Sustain families affected by AIDS through incorporating children into families with support, provide grants and increase access to poverty alleviation programmes.
5. Partnership, communication and co-ordination through strengthened AIDS Councils. Address stigma around AIDS involving all sectors.
6. Empower communities, CBOs and NGOs locally with the capacity to address HIV/AIDS prevention, care and support, in partnership with government as part of the overall programme. Strengthen existing co-ordination structures like ward-based multi-sectoral committees and local AIDS Councils.

7. Implement effective workplace AIDS programmes through co-ordinated action across business, labour, government and communities with effective leadership and comprehensive monitoring of progress.
8. A monitoring and evaluation system, based on international best practice by UNAIDS/WHO. Participatory processes with capacity building, combining all sources of information. Set specific programme targets.

The Gauteng Provincial Government increased the dedicated AIDS budget (the provincial grant on AIDS) from R200 million in 2004/5 to R 250 million in 2005/6. National Conditional Grants (NCG) for AIDS allocate funds to the provincial departments of Health: from R134,231 million in 2004/05 to R185,048 million in 2005/06, Social Development: from R10,315 million in 2004/05 to R20 million in 2005/06 and Education: from R17,487 in 2004/05 to R18,4 million in 2005/06. In addition departments contribute services funded from their own budgets, including social grants, health services and education of learners in lifeskills.

2. SITUATION ANALYSIS

The Annual Report for 2003/04 and a draft six-month report for 2004 provide a more detailed picture which is summarized here.

2.1 THE HIV EPIDEMIC: PREVENT NEW HIV INFECTIONS

The HIV epidemic appears to have stabilised, although at very high levels. Infection rates for Gauteng are recorded as follows:
Gauteng HIV infection rates are slightly above the national average. Antenatal ANC survey results show a possible decline in the overall infection rate with the main increase for 2003 in women above 30 years.

INFECTION RATE	SAMPLE	SOURCE OF INFORMATION
29.6%	Pregnant women	Antenatal survey by Department of Health 2003
20% 14.7% 9.2%	Adults Overall population Youth 15-24 yrs	HSRC National Household survey 2002 RHRU 2003

The following preliminary assessment is provided and an analysis of surveys has been commissioned to provide a detailed picture:

- A range of surveys in Gauteng demonstrate high levels of understanding of HIV prevention, but change in behaviour determines infection rates.
- Youth under 25 years have changed behaviour with lower HIV infection rates than expected. Selected interventions have also achieved behaviour change e.g. schools programmes, specialized projects utilizing peer education.
- The PMTCT service has reduced infection rates in babies.

- Meanwhile a range of social factors also drive HIV infection: poverty, gender imbalance, substance abuse and sexual abuse. As individuals change behaviour these factors increase in relative importance.

2.2 THE AIDS EPIDEMIC

AIDS illness and deaths are increasing rapidly. Projections for Gauteng residents estimate 1, 5 million people infected with 128,000 ill with AIDS in 2004/05 (AASA is the Actuarial Association of South Africa) but these figures are over-estimated by up to 30%.

Public understanding of care issues has progressed and 80% of people surveyed said they are willing to care for a family member with AIDS. However there is still significant stigma associated with AIDS. The TB service is making some gains against an expanding epidemic. Health provides HIV/AIDS related health services on a large scale including hospitals, clinics and home-based care and there is significant impact from AIDS on the health services.
Comprehensive health care for AIDS with anti-retroviral treatment (ART) has already met the 2004/05 target with over 10,000 people on ART through 23 specialised clinics. Access to ART has also improved the morale of PLHA and health care workers and increased the focus on active medical care for AIDS. Almost all people on ART are doing well on treatment.

2.3 ORPHANS: SUPPORT FAMILIES AFFECTED BY AIDS

Reliable projections for children affected by AIDS (ill or deceased parents or caregivers) are not available but Social Development identified 25,000 children in need of direct service support in 2003.
Services for children affected by AIDS are incorporated into overall children's services (the Gauteng Programme of Action for Children) and prioritized by Gauteng Government.
Special services for children are being provided through local NGOs for around 17,000 children in 2004 but local services are not yet accessible everywhere. A total of 676 610 children receive grants (child support and foster care). Affected families are accessing poverty relief programmes, including grants. The worst social problems were identified in informal settlements and child-headed households by door-to-door volunteers. Referrals from door-to-door campaigns to local services have dropped dramatically (by over 50%) and it appears knowledge of services has increased.

2.4. PROGRAMME MANAGEMENT

Gauteng has a relatively well-developed multi-sectoral AIDS response led by the Premier assisted by the Executive Council and the Gauteng AIDS Council (GAC). All Gauteng government departments participate and receive funds to implement internal workplace programmes. Fifteen civil society sectors participate in the Partnership against AIDS and Municipalities are making progress in supporting civil society at local level. There is significant progress in mainstreaming AIDS into departmental services and cross-cutting programmes including children, gender, youth, poverty and sexual abuse programmes.

The Gauteng AIDS effort has expanded exponentially from 1998 with new programmes coming on stream each year followed by expansion to scale. Generic management limitations affect the AIDS response disproportionately because of the rate of expansion and scope of the programme. A number of programmes need evaluation and consolidation to ensure sustainability. Programmes implemented by NGOs need better monitoring in order to sustain outputs. Financial administration of the AIDS grants is complicated.

We are able to measure outcomes and impact of our prevention interventions but are still grappling with methodology for measuring results of our care and support programmes. We also have limited expertise to manage research.

3. GOALS

1. Reduction in new HIV infections in the general public, youth and babies.
2. Increased productive life for people living with HIV and AIDS (PLHA).
3. Normal lives for children and families affected by HIV/AIDS.
4. Reduced AIDS impact on socio-economic development in Gauteng.

Logical frameworks have been developed for each of the four goals and final drafts are enclosed as Annexure C.

The strategic objectives for AIDS support the Gauteng strategy from 2009

GAUTENG STRATEGY	GAUTENG AIDS PROGRAMME: STRATEGIC OBJECTIVES
Economic growth with job creation	1. Implement effective Workplace AIDS Programmes in government, businesses and SMEs to reduce AIDS impact, sustain productivity and protect jobs and benefits for PLHA. 2. Employ community workers on learnerships through NGOs to extend social services into communities.
Fighting poverty	1. Extend children's services to all children in need to reduce the impact of AIDS on needy children. 2. Facilitate access to poverty relief measures for AIDS affected families, especially children.
Sustainable communities	1. Intensify HIV prevention efforts to reduce new HIV infections in general public, youth under 25 years and babies. 2. Prioritise people at greatest risk of HIV including migrants and people in informal settlements. 3. Develop civil societyt capacity for prevention, care and support through mobilization, mass media and education, with trained volunteers and community workers. Ensure Municipal capacity to lead, co-ordinate and support local community activities. 4. Address the social factors which drive HIV infection, including poverty, social degeneration, gender imbalance, substance abuse and sexual abuse, through integrated Gauteng strategies.
Healthy, skilled and productive people	1. Consolidate the lifeskills programme in schools. 2. Consolidate preventive health services (including VCT, STI, PMTCT, PEP and condom supply). Provide comprehensive health care with nutrition, TB and ARV treatment to improve quality and length of life of people with HIV/AIDS (including VCT, TB, ART and HBC).
People democracy	Provide specialized support for civil society partners to play their role in social regeneration, and strengthen social cohesion.
Effective implementation by government	1. Strengthen AIDS programme management capacity across government, CBO and NGOs to strengthen effective delivery, supported by monitoring research and evaluation. Ensure effective delivery by NGOs. 2. Mainstream AIDS and co-ordinate the efforts of all government departments (3 spheres) and civil society through joint strategy and plans.

4. GAUTENG AIDS STRATEGY

MOBILISATION & COMMUNICATION
To mobilise involvement and increase understanding through cultural activities, campaigns, role models, leadership and media. The content reflects the key areas of the programme: Openness, Prevention, Care and support, The Partnership against AIDS, progress with implementation.

PREVENTION

EDUCATION to change behaviour
Focused on:
❑ Youth Strategy: Lifeskills in schools Peer education for out of school youth and on campuses.
❑ Peer education for special risk settings (mining, hostels, sex-workers, prisons and others), and informal settlements.
❑ Workplace programmes with EAP services (public & private sector)
☐ Door-to-door education campaigns.
☐ Address social factors driving HIV infection: substance abuse and sexual violence, gender, poverty.

HEALTH SERVICES in support of behaviour change
❑ STI management (syndromic management)
❑ Condom Supply (free male and female condoms)
❑ Voluntary testing with counselling (VCT)
❑ Reduce transmission of HIV from infected mothers to babies (PMTCT).
❑PEP for sexual assault and occupational exposure.

CARE- "COMPREHENSIVE CARE"

SUPPORT FOR PEOPLE AND FAMILIES WITH AIDS
❑ Community support (women & men, faith-based, youth, civics, traditional healers, workplace programmes)
❑ Support groups of PLHA
❑ VCT with ongoing counseling and support.

HEALTH CARE SERVICES
❑ Comprehensive health care for HIV/AIDS (clinics, hospitals and step-down beds) including nutrition, TB and ARV treatment.
❑ Palliativecare – Home-Based Care and Hospice Beds

AFFECTED FAMILIES AND ORPHANS
❑ Social support by communities
❑ Local projects support children in their homes.
❑ Social grants and social services
❑Access to free/subsidised services: housing, water, electricity, schooling, and health services.
☐ Access to poverty alleviation programmes, (Food etc.)

SYSTEMS FOR CO-ORDINATION AND REFERRAL

ORGANISATON OF THE MULTI-SECTORAL AIDS PROGRAMME
(all departments and sectors)

MUNICIPAL	PROVINCIAL
❑Mobilise and develop communities	❑ Leadership ❑ Co-ordination ❑ Capacity Building
❑Co-ordinate plans and services	❑ Strategy ❑Provincial Plan ❑ Policy & Guidelines
❑ Monitor services	❑ Research & Development ❑ Monitoring and evaluation systems
❑ Development agenda	❑ Sectoral development programme.

NOTES:

- The strategy is consistent with the national HIV/AIDS Strategy, endorsed by experts and consulted with stakeholders through the annual Gauteng AIDS Summit.
- The AIDS impact study will be updated and Gauteng AIDS Policy reviewed in 2005.

The following policies need to be finalized in 2005/06:

1. Policy and guidelines for subsidizing indigent burials as part of the provincial package of services for indigent families: Department of Local Government.
2. Strategy and guidelines for increasing access of the AIDS affected to small, medium and micro enterprise (SMME) development programmes as part of the overall Gauteng SMME strategy: Department of Finance and Economic Affairs (DFEA).
3. Strategy and guidelines for support groups of people living with HIV/AIDS (PLHA): IDU with departments, based on the GDH draft.
4. Strategy for interventions in special risk settings including guidelines for peer education based on the project support group (PSG) methodology: IDU with all departments.
5. Strategy and programme for distributing free female condoms: GDH.
6. A new Housing policy incorporating AIDS was finalized in 2004/05.
7. Revise the HBC and CBC policies to incorporate employment of community workers.

5. STRATEGIC PRIORITIES FOR 2005/6 TO 2007/08 3 YEARS BASED ON THE DRAFT 2009 AIDS PLAN

These priorities are derived from AIDS programme objectives linked to the Gauteng strategy for 2009 through multi-sectoral planning workshops. They have been defined further through the process of developing log-frames. They will be reviewed with technical advisors on M&E in the first quarter.

5.1 REDUCE NEW HIV INFECTIONS IN THE GENERAL PUBLIC, YOUTH AND BABIES

Strategic objectives

1. Reduce risk behaviour in youth under 25 years through behaviour change interventions:
   - Media in partnership with the media and artists.
   - Lifeskills training in all schools as part of the curriculum. Evaluate the lifeskills programme.
   - Peer education for youth using best practice methodology in priority settings: tertiary education, informal settlements and organized youth.
   - Train youth leaders and make local services accessible to youth as part of the Gauteng youth strategy.

2. Reduce the transmission of HIV to babies by incorporating PMTCT measures into all ante-natal services (hospitals and clinics).

3. Reduce risk behaviour in those at greatest risk of HIV infection.
   Definition of high risk settings: Single sex-hostel residents and their partners, migrants, mining towns, sex-workers, transport workers, prisoners, gay men and people in informal settlements.
   - Peer education using best practice methodology.
   - Good access to local health services.

4. Provide accessible, effective preventive health services to support behaviour change to reduce new HIV infections:
   - Supply free male condoms for all. Provide free female condoms with access for all women and especially sex-workers.
   - Reduce the STI rate through syndromic management of STIs in all clinics.
   - Promote people's knowledge of their HIV status through providing access to VCT services in all local areas and the GPG workplace.
   - Reduce HIV transmission through rape by incorporating post-exposure prophylaxis (PEP) into all services for rape survivors (clinics and hospitals).

   Ensure the services are accessible for youth and people with high risks and provide education.

5. Increase public understanding of HIV risk and prevention measures:
   - Increase education and mobilization of men.
   - Sustain and extend door-to-door educational campaigns.
   - Sustain advertising and publicity to address current issues, including progress and new challenges. Review the media campaign.

6. Address the social factors driving HIV infection.
   Definition of social factors: poverty, gender imbalance, substance abuse, sexual abuse.
   - Facilitate access to poverty relief programmes.
   - Investigate social factors associated with the spread of HIV such as gender, substance abuse and sexual abuse and address them as part of integrated Gauteng strategies.

5.2 INCREASE PRODUCTIVE LIFE FOR PEOPLE LIVING WITH HIV AND AIDS (PLHA) AND REDUCE THE RATE OF ORPHANS

Strategic objectives

1. Provide comprehensive health care for HIV/AIDS including nutrition, TB and ARV treatment in partnership with communities in each municipal area to reduce illness and prolong productive life for PLHA.
   Definition of comprehensive care:
   Comprehensive health care for PLHA incorporates a continuum of care: public education, VCT, ongoing counseling, PLHA support with "positive living",

PMTCT, medical care with treatment of infections, TB treatment and prophylaxis, follow-up care, ART, hospital admission and palliative care.

- Continue the roll-out of dedicated HIV/AIDS services with ART for adults and children to increase ART access and coverage for PLHA.
- Facilitate appropriate nutrition for people on ART.
- Improve health care (including ART) for pregnant women with AIDS to reduce maternal deaths from AIDS.
- Monitor implementation, set up sentinel sites and collaborate with researchers on operational research to improve the results of services.

2. Educate the public and stakeholders on HIV/AIDS health care including how to utilize the services, progress and challenges.

3. Train professionals, lay health workers, PLHA and their families on health care to improve the results of services.

4. Provide a home-based care (HBC) service by community health workers (CHW) through local NGOs in all local areas. Train and employ CHWs on leaderships. Evaluate the outcomes of the service for families jointly with CBC.

5. Strengthen TB services to improve treatment outcomes: increase the TB cure rate, reduce treatment interruptions and monitor deaths. Promote VCT for TB patients and TB prophylaxis for PLHA to reduce illness.

6. Implement the workplace AIDS programme in all government departments to lengthen productive working life of PLHA in GPG:
   - Educate all employees on health care and how to utilize services.
   - Provide access to a confidential EAP service, incorporating VCT and referrals for ART and social services.
   - Monitor utilization of benefits (sick leave, boarding, death).

5.3 FACILITATE NORMAL PSYCHO-SOCIAL DEVELOPMENT FOR CHILDREN AND ECONOMIC SURVIVAL OF FAMILIES AFFECTED BY AIDS.

Strategic objectives

1. Extend children's services to all children in need with a multi-sectoral approach: the "single window" of services:
   - Provide efficient social services for fostering, adoption, and alternative placement: Social workers, children's courts, child-care centres, and safe homes.
   - Extend coverage of local community-based care (CBC) services by NGOs to all children in need with local access in over 80% of the province.
   - Evaluate the CBC service model and outcomes for families jointly with the HBC service.
   - Project future service needs and cost them in order to assess sustainability.

2. Facilitate access to poverty relief measures for affected families.
   - Ensure poverty relief and developmental programmes address the needs of AIDS affected families.
   - Access to free or subsidized services by various departments, including free schooling with school uniforms and nutrition, health care and subsidized housing, water and electricity.
   - Facilitate and co-ordinate community donations and government relief.
   - Provide social grants.
   - Promote food gardens through DACE, FBOs and PLHA groups.
   - Finalise policy and guidelines for subsidising indigent burials through Municipalities as part of the Gauteng package of indigent services.

   Note: Most of these services have criteria that target support to those of greatest need. Children have been prioritized for poverty relief measures in Gauteng.

3. Capacitate community workers, NGOs and CBOs to extend social support services into all communities (expanded public works programme in the social sector) in collaboration with the C/HBC service. Document the multi-sectoral model of community support.

4. Educate the public and stakeholders on the needs of children affected by AIDS, how to use the services available, progress and challenges.

5.4 IMPLEMENT AN EFFECTIVE MULTI-SECTORAL AIDS STRATEGY TO PROTECT SOCIO-ECONOMIC DEVELOPMENT IN GAUTENG

Strategic objectives

1. Implement an effective multi-sectoral AIDS strategy with monitoring and evaluation:
   - Finalise the Gauteng AIDS Strategy for 2009 with a revised impact study and policy review. Produce annual plans and reports.
   - Introduce the UNAIDS system for monitoring and evaluation (M&E) with minimum standards of planning, monitoring and reporting with indicators. Train managers to implement the system and extend the system to civil society partners.
   - Conduct research: Annual antenatal survey, behavioural sentinel surveys, survey of GPG employees and evaluation studies.

2. Strengthen AIDS programme implementation through mainstreaming, training, partnerships and effective NGO delivery:
   - Develop and retain staff with appropriate management expertise.
   - Provide technical support and funding for NGOs to maximize delivery.
   - Build partnerships for effective implementation.
   - Mainstream AIDS into government, business and civil society institutions for sustainability.

- Build capacity of management and union leadership to support implementation of the workplace AIDS programme.
- Strengthen implementation through advocacy, partnerships, training, research, monitoring and evaluation.

3. Facilitate implementation of effective workplace AIDS programmes in government, business and SMEs.
   - Advocate for effective implementation of workplace AIDS policy and programmes in the public and private sector.
   - Facilitate training on HIV/AIDS (including EAP) for business, organized labour and GPG employees. Investigate cost effective EAP models for large government departments.
   - Facilitate access to an EAP service for 80,000 GPG employees.
   - Increase the capacity of SMEs to implement workplace programmes.

4. Develop civil society capacity for prevention, care and support and to address the social factors associated with HIV/AIDS in partnership with government:
   - Strengthen partnership and co-ordination through AIDS Councils (provincial and local).
   - Provide training, dedicated support and selective funding for sectoral development programmes (10 sectors at provincial and local level).
   - Strengthen capacity of six Municipalities to support NGOs and CBOs (4 Departments and 6 Municipalities).
   - Sustain the provincial annual WAD door-to-door education campaign and de-centralise the campaign to Municipalities in order to extend the reach of the programme.

6. ROLES AND RESPONSIBILITIES FOR GOVERNMENT DEPARTMENTS AND CIVIL SOCIETY SECTORS

The Premier leads the Gauteng AIDS programme, assisted by the Premier's Committee on AIDS (PCA) and the Gauteng AIDS Council (GAC). The PCA is made up of Members of the Executive Committtee (MEC's) and Heads of Departments (HOD's). The GAC members are drawn from leadership of civil society across various sectors and include SALGA Gauteng.

Each department plays specific roles in the Gauteng AIDS programme related to its core business. All government departments are required to address AIDS both internally throught the workplace AIDS programmes and externally according to their core business in partnership with stakeholders from the relevant sectors. This includes funding NGOs to provide services in communities. The strategy has increasingly been integrated into other cross-cutting provincial government strategies such as youth development, care of children, gender and poverty alleviation.
Delivery is specified in priorities, objectives and programme plans for each department and are detailed in the Annual Plan. The plan is compiled through joint planning by inter-sectoral teams with submissions by departments and sectoral task teams.

6.1 HEALTH

- Accessible and effective HIV preventive health services with education: VCT, STI, condom supply (male and female), PMTCT, PEP.
- Comprehensive health care for HIV/AIDS care with nutrition, TB and ARV treatment. This includes a continuum of care for PLHA: VCT, PLHA groups, ongoing counseling, medical care, TB treatment, ART, Home-based care, step-down and hospice beds per municipal area (health sub-district).
- Workplace AIDS programme with a wellness programme, incorporating an EAP service.
- Peer education: mining towns (2).
- Selected NGO projects (youth, drama etc).
- Employment of trained Community Health Workers (CHWs) to extend services into homes.

6.2 EDUCATION

- Lifeskills programme: educator training, materials, lifeskills and other curricula, school projects, peer education, evaluation.
- Support for children affected by AIDS: free schooling, counselling, school nutrition programme and referrals.
- Workplace AIDS programme with a wellness programme incorporating an EAP service.

6.3 SOCIAL DEVELOPMENT

- Grants: child support (CSG), disability (DG) and others.
- Accessible children's services through GPAC:
  - Social worker service with placement of children (foster care, adoption, institutions and other alternatives).
  - Community based care (CBC and drop-in centres where children are supported in their homes) (food, uniforms/clothing, shelter, adult carers).
- Community training for young women, the disabled and early childhood development (EDC) workers.
- Workplace AIDS programme with EAP.
- Employment of Community Workers (CWs) to extend services into homes.

6.4 SRAC

YOUTH DIRECTORATE

- Youth out of school: peer education in informal settlements.
- AIDS is incorporated into the Youth programme: Strategy co-ordination, monitoring, research, South African Youth Council (SAYC), train youth leadership.

SRAC

- AIDS Awareness through sports, arts, culture and libraries.
- Workplace AIDS programme incorporating an EAP service.

6.5 DLG AND MUNICIPALITIES

1. Ensure Municipal capacity to co-ordinate the local multi-sectoral AIDS response:
   - Co-ordinate the local multi-sectoral AIDS response: AIDS Councils, local multi-sectoral AIDS Units, local plans, co-ordination, monitoring, reports.
   - Develop community capacity on prevention, care and support: educate, train, door-to-door campaigns, co-ordination, selective funding.
   - Poverty programmes: access to subsidized services for indigent families: burial, water and electricity, referrals.
   - Incorporate AIDS into Integrated Development Plans (IDPs).
2. Co-ordinate the Municipal AIDS response internally:
   - Workplace AIDS programme with EAP: DLG and Municipalities.
   - Mainstream AIDS into municipal services.

6.6 DPTRW

Facilitate AIDS education in the transport industry:

- Trucking against AIDS: collaborate
- Taxi Association: train peer educators
- Bus companies: train peer educators

Monitor risks e.g. taxi driver behaviour
Workplace AIDS programme with EAP.

6.7 DACE

- Workplace AIDS programme with EAP.
- Provide training and advice on food gardens through churches, PLHA groups, Municipalities, clinics and schools.
- Assist with access to farm workers and involve organizations of farmers.

6.8. HOUSING

Workplace AIDS programme with EAP. AIDS awareness as part of communications.
Finalise housing policy which addresses AIDS and train Municipalities for implementation: consider piloting the policy.

6.9 OFFICE OF THE PREMIER

Supports the Premier in leading the Gauteng AIDS response:

- Strategic planning, monitoring and evaluation across departments.
- Communications

- Secretariat and publicity for GAC and PCA. Support for key projects e.g. Workplace AIDS Indaba, GMDP training on AIDS.
- GPG workplace AIDS policy agreed with unions
- Internal workplace AIDS programme with EAP for employees.

6.10 COMMUNITY SAFETY

- Workplace AIDS programme with SAPS and Metro traffic officers, including an EAP service.
- Prevention of crime, including sexual and substance abuse.

6.11 DFEA

- Workplace AIDS programme with EAP.
- Business partnerships and economic research.
- Support SMEs on AIDS.

6.12 GSSC

EAP service provision for GPG, EAP advisory service and HR training.
Monitor benefits.
Internal workplace AIDS programme with EAP for employees.

6.13 AIDS UNIT

- Organise the multi-sectoral AIDS programme for Gauteng province: Annual plan, budget and reports, annual Gauteng AIDS Summit, co-ordination, PCA support, Local programme support.
- Provide support, technical advice and specialized training.
- Support the AIDS Council and civil society development programmes and provide technical support.
- Peer education for special risk settings (campus, prisons, hostels etc in collaboration with 5 departments).
- Strengthen workplace AIDS programmes in government and the private sector.
- Set up and manage the monitoring and evaluation system (UNAIDS guidelines). Research and development of the multi-sectoral AIDS response.
- Media campaign on AIDS.

7. CIVIL SOCIETY SECTORS

Each civil society sector has a strategic role to play in the overall strategy and plan and sectors collaborate on implementation. AIDS Councils facilitate and co-ordinate civil society efforts at provincial and municipal level. The AIDS programme provides technical support to strengthen their capacity to contribute effectively to the AIDS effort.

Key outputs are:

- Increased leadership, co-ordination and advocacy of the civil society effort on AIDS through the Gauteng and Local AIDS Councils.
- The development of sector specific strategies, part of the overall AIDS strategy.
- Train members and build sectoral capacity on prevention, care and support.
- Commitment to a programme of action with key targets in collaboration with the rest of the programme, preferably in the form of a "declaration".

In addition sectors focus on the following roles and programmes:

Youth	:	AIDS incorporated into the Gauteng Youth Strategy Peer education programmes for youth at risk not yet covered by government programmes. Advocacy for youth.
Traditional Healers	:	Train members and co-ordinate the efforts of the Sector. Collaborate on health care.
Traditional Leaders	:	Leadership role. Advocate family values and responsibility.
Women	:	Ensure womens issues are addressed effectively. Advocate against abuse.
Men	:	A joint programme with women addressing gender issues. Advocate for men's involvement and social issues related to HIV/AIDS.
Media and artists	:	Partnership projects on communication for various groups.
Children	:	Through GPAC to address the needs of vulnerable Children.
Sports	:	Role models and awareness, through SRAC.
Disability	:	Involvement in the broader AIDS response, training, address special needs as necessary with SD and O of P.
Faith-based	:	Mainstream AIDS in the sector. Support affected children, youth and carers. Advocate social values and volunteerism.
Transport	:	Peer education programme through DPTR&W for transport workers at special risk.
PLHA	:	Advocacy and mobilization on ART with GDH, address psychosocial and economic needs with SD and municipalities.
Prisons, hostel Residents	:	Partnership on peer education programmes for members at risk. Advocate for access to services (GDH, SD and others).
Civics	:	Train members, assist with local co-ordination.

AIDS NGOs	:	Strengthen capacity to deliver effectively.
Unions	:	Train leadership, especially shop stewards. Advocate for effective workplace programmes and community programmes.
Refugees	:	Access to information, education and services in relevant languages.
Business	:	Lead implementation of effective workplace programmes in collaboration with organized labour and DFEA.

8. OUTPUTS FOR 2005/06

See Annexure D for details.

9. GAUTENG AIDS BUDGET

9.1. FUNDS AVAILABLE

The budget is allocated from the Provincial Grant (PG) for AIDS and has been increased from R200 million in 2004/05 to R250 million for 2005/6. In addition departments use their own service budgets and three departments access increased National Conditional Grants (NCG) for AIDS: GDH, GDE and DSD.
(See Annexure H for budget allocation trends)

The MTEF for 2005/06 was based on a budget of R220 million so the budget allocations have been revised to reflect the budget of R250 million.

9.2. SUMMARY OF BUDGET PER PROGRAMME

PROGRAMME	BUDGET R1000	KEY OUTPUTS
YOUTH	11,350	2 mil youth access education and information.
SPECIAL RISK GROUPS	6,690	For 14 projects: hostels, prisons.
GPG WORKPLACE PGM	20,884	For >80,000 employees with EAP access for 75%. 8.5 mil condoms p.m. PEP.PMTCT, VCT
PREVENTION SERVICES	16,465	Door-to-door >2.5 mil. Radio for over 8 mil
PUBLIC EDUCATION	18,176	prevention and care. 6 Municipalities, PLHA groups, civil society
COMMUNITY SUPPORT	30,900	sectors.
HEALTH CARE WITH ART	85,635	20,000 on ART
CHILDREN'S SERVICES	39,000	20,000 children get services
ORGANISATION, M&E	20,900	Training, monitoring and evaluation, planning & co-
SECTORS / COMMUNITY		ordination. Programme mgmt (including staff).
TOTAL	**250,000**	

Budget for 2005/06 was prioritized for the following programmes:

1. Comprehensive health care for HIV/AIDS with anti-retroviral treatment (ART): GDH.
2. Extend services for children:
   - Access to local services for children affected by AIDS (DSD).
   - Access to the PMTCT service for pregnant women (GDH).
3. Strengthen community capacity for prevention, care and support. Improve local co-ordination of services.
4. Strengthen planning, reporting, monitoring and evaluation of programmes using the UNAIDS system.
5. Extend access to Employee Assistance Programme (EAP) for GPG employees (part-funding only): all Departments.

9.3. BUDGET ALLOCATIONS PER DEPARTMENT

The allocations per department are summarized as follows:

DEPT	BUDGET	ACTIVITIES
O of P	,200	Workplace
DFEA	,200	Workplace
GSSC	,284	Workplace
CS	1,200	Workplace (includes traffic police)
Housing	,700	Workplace + policy.
DPTRW	1,080	Workplace -
	,540	Transport sector -
DACE	,800	Workplace no external.
SRAC	2,900	Awareness, including workplace
	3,000	Youth out of school
DLG	,286	Workplace
	24,000	Municipal pgms (various activities)
SD	40,000	Children's services etc. + NCG
		Workplace from dept allocation
GDE	1,000	Lifeskills from NCG (R15 mil)
	4,000	Workplace
Still to be allocated	4,834	Services still to be finalised
SUBTOTAL	**85,024**	
GDH	110,000	Prevention services + NCG
		ART + NCG
		Other care + NCG (including HBC)
	5,000	Workplace programme with EAP (10,000)
		Support for PLHAs
SUBTOTAL	**115,000**	
IDU	2,900	Plan & Co-ordination
	16,176	Media campaign
	21,900	Sectors, risk groups, training.
	9,000	M+E and staff costs.
SUBTOTAL	**50,476**	
GRAND TOTAL	**250,000**	

9.4. BUDGET NOTES:

GENERAL:

1. The overall allocation per department is provided here. The final budgets will be presented in GFS format. At this stage many departments have not provided budgets in GFS format.
2. The following programmes were prioritized:
   - GDH: ART, PMTCT, EAP
   - DSD: expansion of the CBC service
   - Other depts: Municipal programmes, EAP, special risk settings
3. The allocations are based on the draft MTEF (inter-sectoral planning meeting in August with document of October 2004), submissions by departments (November 2004 and January / February 2005) and a joint planning session (January 2005). The overall budget allocation has been advised as R250 million.
4. With further work on plans and budgets, the budget available now meets all key requests. Departments also need to allocate their own funds to cover some staff costs and part of the EAP service.

SPECIFIC:

1. EAP incorporating VCT with referral for ARV.
2. Awareness avoided including special events and promotional items e.g. T-shirts.

10. MONITORING AND EVALUATION

MONITORING tells us if the PLAN is implemented properly.
EVALUATION tells us if the STRATEGY achieves the intended results.

The Gauteng AIDS programme has agreed to utilize the UNAIDS system for monitoring and evaluation and a task team is making progress on putting the system in place, starting with better planning (logical frameworks with indicators and plans with clear service delivery outputs). A manual with reporting formats will be drafted in the first quarter.
The system is compatible with government systems, including the PFMA. The addition of logical frameworks has been particularly useful. The system will be designed to be compatible with the system developed by the Office of the Premier. Problems experienced in setting up the system include weak planning skills, insufficient monitoring capacity and incomplete information systems. Extra training will be provided in 2005 to strengthen departments' capacity to implement the system, so the system will only be fully implemented in 2006/07

In 2005/6 the AIDS Unit will enforce regular reporting on the indicators contained in the plan according to the PFMA and Treasury guidelines. These indicators will be finalized in 2005 with input by departments.

The IDU will assist with evaluation projects including access to technical expertise. Good progress has been made in evaluating prevention efforts, including behaviour change and preventive health services and this is consistent with the UNAIDS system. Evaluation of care and support interventions is running well behind schedule. The

addition of ART to HIV/AIDS care provides an opportunity to measure health care service delivery and outcomes. The AIDS programme will prioritize evaluation of CBC/HBC in 2005/6 focusing on whether the services meet the needs of affected families (outcomes). Extra work will be done to project the future service needs of children affected by AIDS (DSD and IDU).

In addition the IDU will commission an update of our AIDS impact assessment and a policy review. The following surveys will be done:

1. GPG employees: biological and behavioural (IDU with GPG task team).
2. BSS for youth (IDU).
3. Annual antenatal survey (GDH).

Research and monitoring of broader social and economic factors associated with HIV and AIDS will be done in collaboration with other Gauteng programmes through the Office of the Premier.

11. ANNUAL CALENDAR (APRIL 2004 – MARCH 2005)

DATE	THEME	ACTIVITY	RESP.
March 18 - 3 April	Rand show	Stall with peer educators and material	IDU with all Depts
May 9-15	AIDS care week	Comprehensive HIV/AIDS care with ART.	GDH
May 23 June 1	Child Protection Week	Focus on abused and vulnerable children	DSD
June 7-10	S.A. AIDS conference.	Presentations, stall & media	IDU (Durban)
June 16	Youth month	Focus on youth: "Youth can win against AIDS"	YD / SRAC GAC
June 26	International Day Against Drug Abuse and Illicit Drug Trafficking	Focus on youth & social factors influencing HIV/AIDS (substance abuse and safe sex)	CS, SD, YD?
July 13	EAP conference	EAP for SMS in GPG	GSSC
August 9	Women's month Gender (focus)	Focus on women Role of men taking responsibility.	OoP GAC
September 1 -10th	Schools week Annual report	AIDS projects & media Draft – to finalise by October.	GDE IDU
October 6th -7th	Partnerships	Gauteng AIDS Summit.	GAC, IDU
Nov 2	EAP Indaba	GPG EAP Indaba	GSSC
Nov 3	National Children's day	Focus on children	GPAC (DSD)
Nov 25 – Dec 12	16 days of Activism for Prevention of Violence Against Women and Children	Support this campaign. Joint messaging for materials (sexual abuse)	OoP
November &- December	World AIDS Day Address current priorities	Door-to-door campaign. Support events Publicity at festivals	Municip, All depts IDU (to be confirmed)
Dec 3	International Day for Disabled persons	Focus on persons with disabilities (vulnerability & involvement).	O of P & DSD
February 6-14	Valentines day Condom & STI week	Focus on youth and relationships Educate on STIs	IDU/GDE/YD/GDH
March 21	Men's march/Gender Responsibilities and rights	Event to be confirmed.	IDU, OoP?

12. KEY SUCCESS FACTORS AND CONCLUSION

1. In 2005/06 Gauteng will **sustain a focus on prevention efforts** to further reduce new HIV infections:
   - Prioritize behaviour change in youth out of school in informal settlements, people in special risk settings (IDU with 5 depts) and men.
   - Extend the PMTCT service to Municipal clinics (GDH)
   - Consolidate preventive health services (GDH). Complete evaluation of the lifeskills programme in schools (GDE)
   - Address the broader socio-economic factors that increase vulnerability to HIV infection: poverty, gender, sexual abuse, substance abuse (IDU, CS and others: investigation, awareness and advocacy).

2. **Comprehensive health care** for individuals ill with AIDS will continue to be a top priority for GDH:
   - Strengthen comprehensive TB/HIV/AIDS care with public education, further rollout of the ART service and a stronger TB service.

3. **Extend access to services for children in need.**
   - Extend child support services (CBC, drop-in centres and other services to maximize access.
   - Ensure access to grants.
   - Evaluate care and support outcomes for families: joint evaluation of H/CBC outcomes (IDU with GDH and DSD), set up sentinel sites (GDH), and collaborate on operational research.

4. **Organisational priorities:**
   - Co-ordinate departmental services, ensure capacity of Municipalities to support local civil society development on AIDS and hold a decentralisation Lekgotla.
   - Strengthen programme management capacity across the board with mainstreaming of AIDS implementing the UNAIDS system for monitoring and evaluation and strengthen NGO support systems. Train programme managers and enforce reporting systems.
   - Strengthen implementation of the GPG workplace AIDS programme with roll-out of employee training and a wellness programme incorporating an EAP service in all departments (piloted in GDH and GDE).
   - Continue mainstreaming of AIDS and finalise the Gauteng AIDS strategy for 2009 with a policy review and revised impact study.

AIDS is increasingly mainstreamed into department services and integrated into broader programmes for youth, children, health care, poverty alleviation and the workplace. Delivery has increased exponentially but we need to ensure sustainability and put systems in place to measure results reliably.
Increased management expertise must be prioritized in order to sustain gains made and support further expansion in selected programmes.

Civil society is a key partner in the multi-sectoral AIDS response and significant community and private sector capacity can be leveraged with dedicated support at provincial and local level.

Gauteng should increase opportunities to share experience with implementing a multi-sectoral AIDS response. The UNAIDS system for M&E provides an opportunity to strengthen active management of programme results.

Prepared by the Inter-sectoral AIDS Unit in collaboration with the Gauteng AIDS Summit, Government Departments and civil society sectors.

March 2005

……
Mokgadi Phokojoe
Acting Director for the Inter-sectoral AIDS Unit

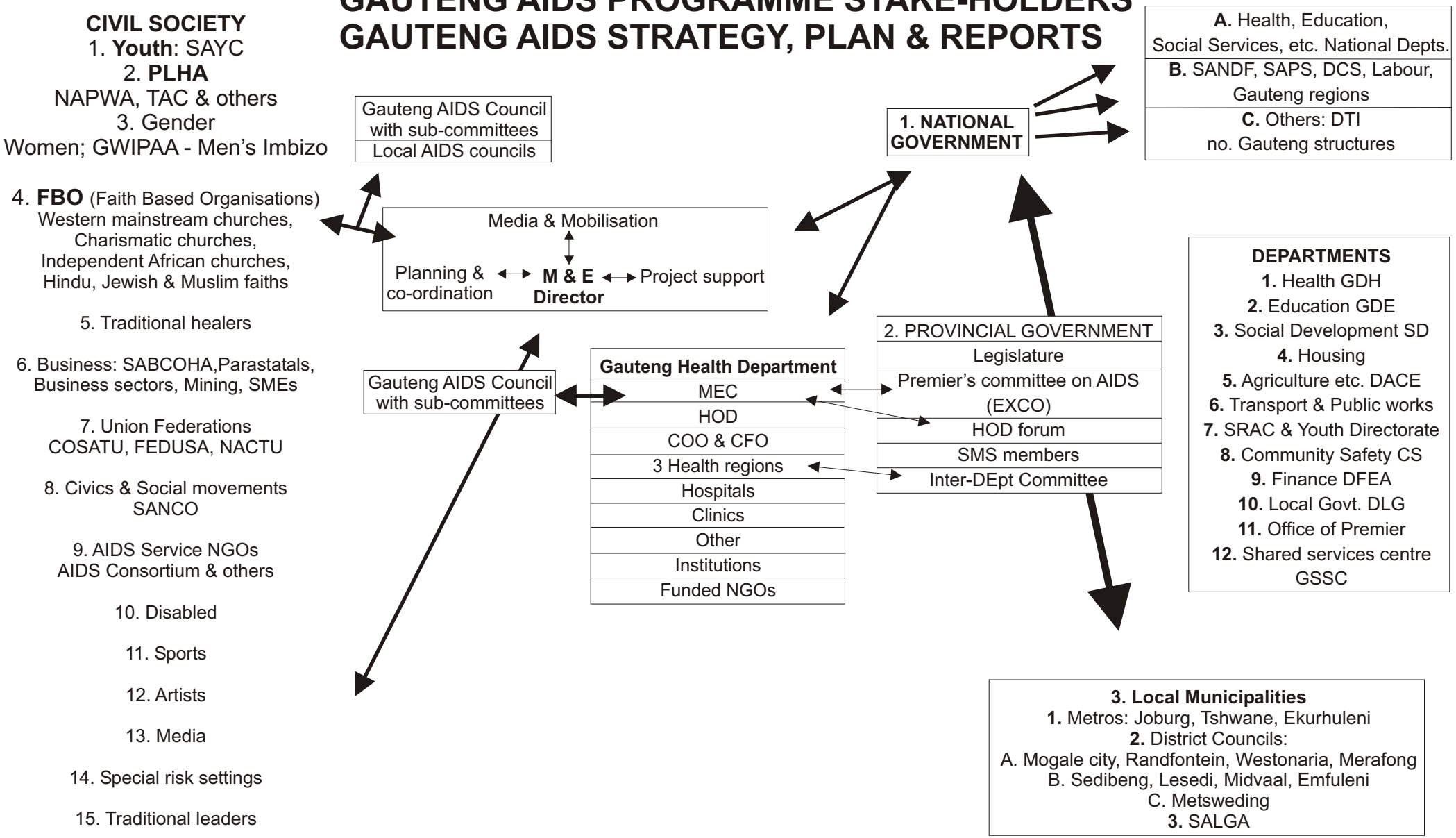
Date ……..

……
Dr. L. Rispel
Head of Department
Gauteng Department of Health

Date …….

Annexure A: See attached PDF file

GAUTENG AIDS PROGRAMME STAKE-HOLDERS
GAUTENG AIDS STRATEGY, PLAN & REPORTS



ANNEXURE B

GAUTENG AIDS SUMMIT 2004, JOHANNESBURG

DECLARATION

INTRODUCTION

Convened by the Gauteng AIDS programme. 500 delegates came together to review progress and develop a common vision for 2014.
Priorities were agreed for 2009. Delegates involved 20 government departments from 3 spheres of government, organized labour and 15 civil society sectors and a range of NGOs.

VISION 2014

An effective multi-sectoral AIDS programme with each department and sector playing its role, with co-ordination, monitoring and evaluation. Reduce new HIV infections in youth, babies and the general population, provide comprehensive health acre including nutrition, TB and ARV treatment to extend productive life, support the AIDS affected to ensure sustainable families and implement workplace programmes to sustain economic development.

PRIORITIES FOR 2004 TO 2009

1. A multi-sectoral AIDS programme involving all departments, organized labour and sectors, each playing a strategic role.

2. Partnership, communication and co-ordination through strengthened AIDS Councils.

3. Provide comprehensive health care for HIV/AIDS with nutrition, TB and antiretroviral treatment in partnership with communities.

4. A monitoring and evaluation system, based on international best practice by UNAIDS/WHO. Participatory processes with capacity building, combining all sources of information. Set specific programme targets.

5. Reduce new HIV infections in youth and babies and focus on those at greatest risk.

6. Address stigma around AIDS involving all sectors.

7. Sustain families affected by AIDS through incorporating children into families with support, provide grants and increase poverty alleviation.

8. Implement effective workplace AIDS programmes through co-ordinated action across business, labour, government and communities with effective leadership and comprehensive monitoring of progress.

9. Empower communities, CBOs and NGOs locally with the capacity to address HIV/AIDS prevention, care and support, in partnership with government as part of the overall programme. Strengthen existing structures like ward-based multi-sectoral committees and local AIDS Councils.

Prepared by the Gauteng Inter-sectoral AIDS Unit,
October 2004

ANNEXURE C

GAUTENG AIDS PROGRAMME

LOGICAL FRAMEWORK FOR CHILDREN AND FAMILIES INFECTED AND AFFECTED BY HIV/AIDS

15/02/2005

LEVEL	NARRATIVE SUMMARY	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS/RISKS
IMPACT	• "Normal" lives for children and families affected by HIV/AIDS (defn?).	• Quality of life for OVC and affected families (how to measure).	• Household surveys • Other surveys e.g. Impact assessment	• Methodology and data are reliable. Note: Get children & families to define "normal lives".
OUTCOME	• Appropriate psycho-social development of children. • Community willing and able to support OVC. • OVC attend school & pass their grades • Physical needs are met (defn: Adequate food, shelter, clothing, safety, sanitation). • Affected families access poverty relief measures (free and indigent services).	(? How to measure) • Satisfactory performance at school. • Status of nutrition and home conditions.	• Household surveys of OVC. • Demographic analysis. • Census (Statistic SA) • C/HBC evaluation studies • School records. • Reports by children's services and community workers.	• Quality of research good. • Data and information available
OUTPUTS	• Advise, train & support communities to identify and address the needs of OVC:	• Total nos and % of orphaned and vulnerable children (OVC) identified & supported	• Routine information: - Registers and service statistics (verified) • Monitoring visits:	• Services are accessible • Reliable data, statistics and reports. • Ability to identify OVC.

	• Appropriate and accessible community-based children's service (CBC or drop in centers). • Government services: - Supportive schools. - Statutory services (Children's Act). - Grants. - Free health care (according to policy). ▪ Access to free & subsidized services: - Food gardens and school feeding. - Housing. - Water &electricity. - ? burial (according to "indigent" policy).	(defn?). • Number of child headed households supported • Number of children who utilise CBC service. • Numbers of children in statutory care (new & previous) and children's homes • Number of children receiving support grants • Number of children receiving support in school including food. • Nos of community members receiving information, education and training on OVC needs and services available (group and activity).	- quality checks • Narrative reports • Surveys of OVC. • Statistics of grants (CSG, FCG). (? not collected by biological mother). • Nos reached on media (AMPS). • Training registers. • Door-to-door campaign statistics. • Poverty profiles for Gauteng.	• Difficulty of overlap of services (double-counting). • Providing services for informal settlements. • NGO capacity for project management. • Programme management capacity. • Ability to recruit, train and retain staff, community workers and volunteers.
PROCESS	• Integrated children's policy • Training of caregivers/volunteers/ Staff • Co-ordinated distribution of resources • Funding of NGOs including new services.	• Policy approved • Number of CBCs and drop-in centres • % of local areas with a service. • Number of caregivers and volunteers trained • Number of care & support services supported and funded. • % budget spent.	• Approved policy. • Narrative and financial reports • Monitoring visits • Programme reports. • Training and workshop registers. • Expenditure report.	• Procurement system. • Information accessible • Reliable reports. • Training capacity.

	• Stakeholder workshops (?planning)	• Nos attending workshops		
INPUTS	• Budget • Staff • Care givers and volunteers • Media items. • Donations (clothing, food, volunteers time)	• Budget • Number staff • Number of trained caregivers. • Number of volunteers • Number food parcels • Uniforms supplied.	• Approved budget. • Routine reports.	• Budget and supplies should meet needs. • Procurement system.

GAUTENG AIDS PROGRAMME
MONITORING AND EVALUATION
LOGICAL FRAMEWORK: CARE

15/02/2005

LEVEL	NARRATIVE SUMMARY	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS/RISKS
IMPACT	• Increased productive lives of PLHA • Decrease in projected # of orphans	• Life Expectancy • AIDS related mortality rate • ? nos of orphans	• Life expectancy and mortality rates (? Sources). • Nos orphans on grants (SD).	• Reliable record keeping • Unable to reliably project nos of orphans.
OUTCOME	• Reduced # of projected AIDS illness and deaths • Improved quality and length of life for PLHA. • Appropriate utilization of services.	• HIV related morbidity • # of admissions per person with AIDS per annum • # of years of AIDS to death • TB cure rate, default rate & death rate • % who know HIV status.	• Sentinel sites (tbd) • Programme reports • Statistical analysis. • Surveys: households, PLHA, BSS: plus. • TB Register.	• Information capturing & systems. • Functional sentinel sites. • Expertise to manage research. • Reliable projections of AIDS rates.
OUTPUTS	• Knowledge & attitudes. • Comprehensive health services in all sub-districts. • HIV testing with counseling. • Home-based care service	• # reached by media & education. • # of clients utilizing VCT, health care, referrals. • Number individuals utilizing home-based care service. • # of patients on ART • # of patients on TB treatment. • # of pregnant women on ART	• Routine information: HIS (verified). • Record reviews. • Behavioural surveys (BSS plus care issues). • Media (AMPS).	• Equitable access to facilities in health districts. • Discrimination and stigma. • Capacity of health services.
PROCESS	• Social mobilization with education.	• # and % of facilities providing services (comprehensive care).	• Routine information (HIS).	• Relevant personnel recruited, trained and

	• Training of service providers • Develop capacity of health facilities. • Policies, guidelines & procedures. • Supply systems (drugs, lab service, HBC items, rapid tests). • Management systems.	• # of facilities meeting required standards (TB & AIDS care). • % of sub-districts with an ART service • # and % of service providers trained • Implementation of policies, guidelines and procedures • % budget spent.	• Survey of facilities. • Supervisor reports. • Programme reports • Record reviews • Financial reports.	retained (HR systems). • Generic management system capacity.
INPUTS	• Budget • Staff • Lab services • Drug supply • Capital works • Media supply.	• Budget • Number and % staff appointed. • Number drugs supplied • Number of care media supplied.	• Approved budget. • Routine reports. • HR report.	• Budget and supplies should meet needs. • Staff retained • Procurement systems.

Notes:

1. Definition of "comprehensive care": comprehensive HIV/AIDS health care with nutrition, TB and ARV treatment.
   Ref: MEC for Health at the Gauteng AIDS Summit. It includes VCT and HBC.
2. Still to add TB indicators.

Definition of "BSS – plus": Questions added to the BSS to cover knowledge of care and % who know their status.

LOGICAL FRAMEWORK: PREVENTION **15/02/05**

Levels	Narrative summary	Verifiable Indicator	Means of verification	Assumption/Risks
Impact	Reduce new HIV infections in the general population (15 – 49 yrs: M&F), youth (15 – 24 years, M&F) and babies of HIV infected mothers.	• HIV prevalence among youth (15 – 24 yrs: M&F) • HIV prevalence in pregnant women including rates for women less than 25 years. • HIV prevalence in babies after PMTCT. • HIV prevalence in the general population (15 – 49 yrs M + F) **(Measure incidence if possible).**	• Household surveys (HSRC) • Annual ante-natal survey (ANC) survey of HIV in pregnant women. • Survey of babies after PMTCT	• Decrease in HIV among high risk groups. • Research gives reliable data. • Interpretation of data. • Social Factors - Poverty - Sexual abuse - Substance abuse - Gender
Outcome	• Change in attitudes towards risk. • Behaviour change per group: youth (15 – 24 yrs M&F), special risk groups, general population (15 – 49 yearsM&F). • Reduced HIV transmission through PMTCT. • HIV prevention supported by socio-economic interventions in Gauteng. • People know their HIV status. • Reduced STIs.	• BSS indicators (per group) - Knowledge and attitudes of HIV prevention (including myths). - Condom use at higher risk sex - Number of sex partners • STI rates. • % who know their HIV status per group. • HIV rates of babies after PMTCT.	• BSS surveys per group (3 yearly). • Other behavioural and household surveys. • STI rates. - ANC survey: syphilis. - Sentinel sites for STI: male urethritis. • PMTCT reports (PCR at 6 weeks). • Feedback and reports e.g. WAD, media coverage.	• Public response to interventions. • Appropriate methodology. • Interventions to scale (?80%). • Capacity for managing research. • Reliable responses from survey respondents.

Output	• Media campaign: advertising and publicity. • Sustained HIV prevention interventions for youth and other special risk groups: - Media, cultural, role-models. - Lifeskills for youth. - Peer education for special risk settings and door-to-door (with condom distribution). - Workplace education. • Preventive health services: - PMTCT service. - VCT service. - STI service. - PEP service. • Social factors addressed: through investigation, campaigns, advocacy and co-ordination across GPG. • Access to condoms (M+F) and media supply.	• Media reach • Nos and % reached per group and service (media, education or health services). • Condom distribution (special risk groups only).	• Routine information systems (verified). • BSS (exposure to interventions). • Narrative reports • Monitoring and quality checks. • Media: AMPS and circulation. • Evaluation studies.	• Quantity, quality and access to services. • Programme management, (HR, financial, info). • NGO capacity. • Ability to recruit and retain staff. • Reliable statistics
Process	• Train educators and health services providers. • Management processes (HR, financial, info). • Distribute condoms and educational materials to local areas. • Fund NGOs. • Monitoring & technical support. • Stakeholders processes:	• Numbers of people trained (per programme). • Nos peer educators in place. • Nos and % services in place. • Nos condoms distributed to local areas (Municipal areas).	• Routine reports verified with monitoring • Sentinel sites? • Registers from training. • NGO contracts. • Facility surveys (schools and clinics). • Expenditure reports (% spent).	• Quality of training. • Capacity for programme management. • NGO funding systems. • Ability to recruit and retain staff
Input	• Budget, • Staff, • Condom supply	• Resources allocated • Number of posts filled/staff turnover	• Approved budget. • Inventories of condoms, media	• Sufficient budget allocated. • Sustainable budgets.

	• Media items supply. • Other supplies: drugs, lab services.	• Numbers of condoms supplied. • Numbers of media items supplied.	supplies. • HR reports	• Procurement supply chain is effective

Definition of special risk settings: Youth in informal settlements, commercial sex work, prisons, gay men, migrants and single sex hostels with partners long distance transport and travellers. Possibly: affluent men, refugees.

THE MULTI-SECTORAL APPROACH **15/02/2005**

LEVELS	NARRATIVE SUMMARY	KEY PERFORMANCE INDICATOR	MEANS OF VERIFICATION	ASSUMPTION/RISK
IMPACT	▪ A more effective AIDS response. (AIDS prevention, care and support issues).	▪ A multi-sectoral AIDS response.	Reports Surveys	Other priorities like poverty.
OUTCOME	▪ Effective Partnerships (? defn). ▪ Civil society capacity to address HIV and AIDS. ▪ Appropriate utilization of government resources.	▪ Improved capacity of sectors ▪ Joint programmes.	Programme reports	Misinterpretation of the approach. Self interest.
OUTPUT	▪ Leadership & advocacy per sector. ▪ Strategy, plan and programme per sector ("declaration"). ▪ Leaders & members trained. ▪ Support for sectors (? defn). ▪ Joint programmes.	▪ Agreed strategy, plan and programme per sector ("declaration"). ▪ Nos of people reached by sectoral programmes (intervention & group).	Reports (verified). Media coverage. Agreed Declaration.	Effective leadership and co-ordination per sector. Governance and project management capacity. CBO capacity developed to standard Ability to recruit, train and retain volunteers.
PROCESS	▪ Co-ordination. Facilitate collaboration. ▪ Joint planning. ▪ Training and education (prevention, care & support). ▪ Access to condoms and media supplies. ▪ NGO funding & training. ▪ Access to funding and resources.	▪ No of sectors involved. ▪ Nos trained per sector. ▪ Participation in AIDS programme (Summit, WAD and others). ▪ Nos of funded NGOs and training contracts.	Research Narrative & Financial Reports (verified) Training and attendance registers. Media Reports NGO contracts	Supportive approach. Appropriate training agencies Capacity to manage funds. Attitudes and commitment. Effective NGO funding system.
INPUT	▪ Budget ▪ Staff ▪ Material ▪ Resources ▪ Condom supply	▪ Budget. Spending. ▪ No of dedicated support staff.	Financial reports (% spent). HR reports	Appropriate dedicated support staff employed and retained Budget allocated.

Note: This describes our activities. Should we have a framework which is done by the sectors themselves? – slightly different outputs.

LOGICAL FRAMEWORK: WORKPLACE PROGRAMMES

Levels	Narrative summary	Key Performance Indicator	Means of verification	Assumption/Risk
Impact	• Reduction in new HIV infections • Longer productive life for people living with HIV/AIDS • Sustain effective government services	• New HIV infection rates in GPG (Incidence) • Number of deaths reported (gender & age). • AIDS defining illness (? Medical admissions)	• GPG survey of HIV (prevalence and incidence). • Analysis of benefit claims (pension, death, sick, boarding). • AIDS impact evaluation.	• Data & information is reliable • Social determinants – stigma & discrimination • The scale of the AIDS epidemic. • Difficulty with projections.
Outcome	• Knowledge and change in attitudes • Safe sex behaviors • Improved psycho-social status and a healthy lifestyle for PLHA in GPG. • Appropriate utilization of EAP, health and support services (including ART)	• Knowledge of HIV (prevention & care) including myths. • Condom use at last risk sex • % of employees who know their HIV status. • Number of PLHA who disclose to EAP • Increased quality of life for PLHA	• GPG survey of behavior (BSS plus methodology) • EAP Reports • Surveys of infected employees.	• Data & information is reliable • Confidentiality/disclosure • Quality of public and private services • Procurement of research (all levels) • Belief systems.
Output	• Train all employees (prevention and care). • Wellness programme with EAP service for all GPG employees (including VCT). • Occupational protection: training & PEP service (mainly GDH).	• Number & % of employees trained on HIV and AIDS (prevention and care). • EAP utilization and referrals. • Number of reported accidents in GDH (HIV exposure).	• Statistics (EAP and referrals). • Routine reporting (verified). • Registers of employee training. • Records of sharps accidents (GDH) –as required by WCA.	• Scale of training implemented • Mid-level leadership and commitment (SMS & shop-stewards) • Staff expertise • Co-operation • EAP service capacity and costs.

Process	• Access to information and condoms (M&F). • Workplace, policy, plan and budget. • Efficient HR management: training, replacement and monitoring of benefits, • Distribution of media items and condoms to departments. • SMS support • Train trainers. • Contract EAP services. • Research.	• Approved policy, plans, and reports. • Number and % of employees with access to EAP services. • Number of trainers trained • Reports on benefits. • SMS member responsible • % budget spent. • Research reports.	• Approved policy, plan and reports. • EAP contracts. • Registers of training. • Expenditure reports. • Documentation of SMS responsibility. • Depts records of benefits. • Approved research reports.	• Staff turnover (contracts, re-structuring). • Leadership support. • Service suppliers with expertise. • Efficient HR administration.
Input	• Budget, • Dedicated staff, • Supply of condoms and educational material	• Approved budget. • Human resource structure (Dedicated staff member)	• Approved budget. • Reporting of structure	• Budget for EAP • Procurement systems.

ANNEXURE D

SUMMARY OF AIDS PROGRAMME OUTPUTS FOR 2005/06: FINAL DRAFT 18th MARCH 2005

GOAL 1: IMPACT: REDUCE NEW HIV INFCTIONS IN THE GENERAL POPULATION, YOUTH AND BABIES

PROGRAMME	ACTIVITY	INDICATOR	"DELIVERY"	GROUP	DEPTS	NOTES	SOURCE OF INFO
1.EDUCATE THE PUBLIC (on prevention and care)	• Advertising - radio, outdoor, print - Gender focus.	 Nos reached Nos reached	 23 million (c) 20 million (c)	 All Men & women	 IDU, M IDU		Media AMPS & circulation.
	• Peer education door-to-door. Train volunteers.	Nos reached. Nos trained	5 million (c) 12,000 +	All NGO &CBO	All IDU, M		Campaign records Training registers
	• Educate community groups on prevention and care.	Nos reached	X 2 350 +	Elderly, disabled. Women & other.	SD DLG/M		Training register
	• Analyse progress from surveys.	Final report	1	Managers	IDU		Research report.
2. YOUTH (15 – 24 yrs)	• Youth media in partnership. - Radio: YFM - Print: Ekasi comic.	 Nos listeners Nos readers	 1,8 million x months 1,5 million x months	 Youth	 IDU		Media AMPS. Circulation & readers.
	• Awareness through sport, arts, libraries	Nos reached	300,000	Youth	SRAC		Reports
LIFESKILLS IN SCHOOLS	• Lifeskills in schools (2 548 schools). Evaluation of Lifeskills programme.	% schools. Final report	90% 1	Youth	GDE		Studies
	• Focus on areas of need: informal settlements, farms/rural, FETJ, girls.	Nos schools. ? nos trained.	30 t.b.d.	Youth	GDE		Reports

YOUTH OUT OF SCHOOL (YOS) (15 – 24 yrs)	• Peer education in poverty pockets (SD), informal settlements (YD, municipalities) & campuses (IDU).	Nos reached Nos p/e trained	1 mil 3,000	Youth	SD, YD IDU DLG/M		Reports BSS
3. SPECIAL RISK SETTINGS (including HTA)	• Peer education with appropriate methodology and access to local health services.	Nos reached Nos p/e trained	3,000 t.b.d.	Migrants & partners Sex-worker	GDH, IDU		Reports per project
	• Finalise policy & programme, provide TA.			Prisoners Transport	GDH DCS		BSS
	• Distribute - appropriate media (gay men). - Male & female condoms.	Nos project assisted. Nos distributed Nos distributed	 15 200,000 t.b.d.	Gay men	DPTR&W IDU		Approved policy Reports.
4. WORKPLACE	• Educate all GPG employees on HIV prevention.	% reached	50% (c)	GPG employees	All		Reports & survey
5. PREVENTIVE HEALTH SERVICES	• Supply free male condoms & increase supply of female condoms. Finalise policy on free female condoms.	Nos male pm Nos female pm	10 mil 50,000	All All women & sex-workers	GDH		Condom stats. BSS
	• STI service (syndromic management).	% clinics	97%	All	GDH		Disca & sentinel system.
	• PMTCT in all ANC services. Improve follow-up of babies and mothers to provide treatment and assess results.	% ANC Nos women access Nos women on NVP Nos babies on NVP	80% 102,000 30,000 t.b.d. (30%)	All pregnant women	GDH		Service stats

	• Access to VCT in all local areas and the GPG workplace. Finalise strategy on non-medical VCT sites.	% clinics Non-medical sites. EAP coverage.	94% 40% 25%	All 15 – 49 yrs	GDH GDH GSSC		 Contracts.
	• PEP in all services for rape survivors. Improve completion of PEP.	Nos tested	200,000 GDH + GPG workplace		All		Service stats.
	• Train carers. Nos trained	Nos service / nos seen	51 t.b.d.	Women/men/ children	GDH		Reports
6. ADDRESS SOCIAL FACTORS	Defn: poverty, gender, sexual abuse, substance abuse. Investigate and advocate integrated strategies and campaigns.	Studies Nos reached	2 20 mil (c)	Managers Men and Women	IDU IDU		Reports Media AMPS.

NOTE:

1. This table is constructed from plans received. Some final plans may differ.

SUMMARY OF THE AIDS PROGRAMME OUTPUTS FOR 2005/06

GOAL 2: IMPACT: INCREASED PRODUCTIVE LIFE FOR PLHA

PROGRAMME	ACTIVITY	INDICATOR	"OUTPUT"	GROUP	DEPTS	SOURCE OF INFO
1. EDUCATE THE PUBLIC	As above: door-to-door & advertising. See below: civil society development	Nos reached	20 million (c)	All	IDU, M & All	Media AMPS. Campaign stats.
2. SUPPORT GROUPS	• Support PLHA with information, education, counseling, referrals & access to services.	Nos supported	16,000	PLHA	DLG/M	NGO reports (verified)
	• PLHA educate the community.	Nos reached.	t.b.d.	All	GDH	BSS
	• Finalise strategy and policy.	Policy	1	Managers	IDU/GDH	Policy document
	• Facilitate access to poverty alleviation programmes, including SMEs.	See below (goal 3)	n/a			
3. COMPRE-HENSIVE HEALTH CARE FOR TB/HIV/AIDS	1. Provide comprehensive health care with nutrition and ART in collaboration with NGOs. • Dedicated HIV/AIDS care services	Nos treated - Total - on ART % compliance Nos services % local areas	 t.b.d. 25,000 > 80% 51 100%	PLHA adults & children	GDH	Service records (verified).
	• Strengthen hospital and clinic services.	Nos on nutrition Monitor deaths	t.b.d. n/a			
	• See VCT for counselling					
	2. Improve TB treatment results - Education with DOTS - Increase VCT - Train carers	 Nos treated % on DOTS Rx interruption	 33,000 t.b.d. 8%	People with TB, including PLHA.	GDH	TB Register.

	- Monitor deaths	Success rate Nos trained Monitor deaths	81% 1,472 n/a			
	3. Provide extra beds: TB,SDC, Hospice - Step-down units for NCG - Hospice beds by NGOs Finalise strategy, policy & guidelines.	Total beds Nos clients Nos beds Length of stay Monitor deaths	510 > 6,000 236 t.b.d. n/a		GDH	Service records (verified)
	4. Provide a home-based care service in collaboration with CBC service. Joint evaluation of outcomes. Adapt policy & programme to incorporate CHWs.	Nos clients - (home-bound) - Total % local areas. Nos CHWs employed. Monitor deaths Evaluation study. Revised policy.	 20,000 t.b.d. 100% 3,090 n/a 1 1	 Managers Managers	 IDU/GDH /SD IDU	Service records (verified) Evaluate report Policy document.
	5. Referral system: database & forum. M&E systems: - sentinel sites - Operational research - Evaluation studies	% local areas Nos sites Nos studies	t.b.d. t.b.d. t.b.d.	Carers Managers	GDH	Database, minutes Reports
4. EAP SERVICE IN GPG	• Educate employees (wellness, HIV/AIDS care including VCT & ART, how to use the EAP service).	% trained. % access to EAP	t.b.d. 25%	GPG employees	All GSSC	Training registers EAP contracts
	• Access and utilization of EAP service with analysis of needs.	% using EAP EAP reports	5% 4 pa	 Managers	 All	EAP service stats EAP reports.

SUMMARY OF AIDS PROGRAMME OUTPUTS FOR 2005/06

GOAL 3: IMPACT: NORMAL LIVES FOR CHILDREN AND FAMILIES AFFECTED BY AIDS

PROGRAMME	ACTIVITY	INDICATOR	"OUTPUT"	GROUP	DEPTS	SOURCE OF INFO
1. CHILDREN'S SERVICES	Provide comprehensive services in all local areas (single window). • Extend CBC services by NGOs (CBC and drop-in services): food, home, adult support, counseling, clothing, protection.	Nos children supported. Nos local services. % local areas.	20,000 80 t.b.d.	Children	SD	Service records (verified)
	• Statutory services by social workers.	Nos children placed. - Foster care - Other	(c) t.b.d. t.b.d.		SD	Records
	• Grants: CSG.	Nos on grants.	500,000		SD	Records (verified)
	• Free services: education & health.	Nos free uniforms.	40,000			
	• Train carers from government and civil society.	Total nos trained.	t.b.d.			Training registers
	• Evaluate outcomes for families, jointly with HBC.	Evaluation report. Nos CWs.	1 830		IDU/SD	Evaluation report
2. ACCESS TO POVERTY RELIEF PROGRAMME	Ensure those at risk for HIV and affected by AIDS access poverty relief: inclusive policies, information, education, referrals, access to services, monitoring. • Information, education, referrals.	See media campaign. Nos WAD referrals	 10,000	 Households	 IDU, M	Reports (verified)

	• Free/subsidized services ("social wage") - Education with nutrition - Health care (clinics, women, children, disabled). - Housing, water & electricity.	Nos accessed	t.b.d.		GDE GDH M	
	• Grants: OAP, DG (children's grants above)				SD	
	• Food gardens	Nos households	9,000		DACE	
	• Other e.g. donations.	n/a			Civil soc	
	• Support on SMEs.	Nos trained	t.b.d.		M, DFEA, Labour	
	• Community workers employed (EPWP) with training (leaderships)	Nos CWs employed	3,920		GDH, SD	
	• Monitor access as part of evaluation of C/HBC outcomes.	See above				

SUMMARY OF AIDS PROGRAMME OUTPUTS FOR 2005/06

GOAL 4: IMPACT: REDUCED IMPACT OF AIDS ON SOCIO-ECONOMIC DEVELOPMENT OF GAUTENG

PROGRAMME	ACTIVITY	INDICATOR	"OUTPUT"	GROUP	DEPTS	SOURCE OF INFO
1. EFFECTIVE STRATEGY	1. Implement and effective AIDS strategy • Finalise 2009 strategy with research.	Research studies.	2 3	Leadership Managers	IDU	Approved strategy Research reports.
	• Annual plan, reports, Summit/Conference	Plan / reports.				Approved documents
	2. Implement UNAID M&E system. • Plan, manual, training.	Nos trained	80		IDU	
	• Research / evaluation.	Evaluations.	4		All depts.	Training registers
	• Surveys: BSS (3), ANC, GPG.	Surveys	3		IDU, GDH	Evaluation reports Survey reports.
2. IMPROVE PGM MGMT	Strengthen programme management. • Retain staff with expertise.	% posts filled.	>80%	Managers	All depts.	
	• Train managers: SMS & pgms.	Nos trained.	450			Training register.
	• Enforce standards of reporting.	PFMA stds met	>95%			
	• Database and mapping of services.	Database	1+5		IDU, M	Database.
3. WORKPLACE AIDS PGM	1. Implement government programme. • Pgm per dept: policy, plan, training, staff.	% depts.	100%	GPG employees & clients.	All depts.	Approved policy & pgms
	• Train employees on prevention & care.	% trained	t.b.d.			Training register
	• Access to an EAP service (includes VCT).	% EAP access	25%		Depts / GSSC	EAP contracts.
	• Research: evaluation, needs, HIV prevalence.	Research projects	3		IDU/GDE	Reports.

	• Develop municipal pgms.				DLG / M	
	2. Partnership with business & unions to strengthen implementation. • Joint commitment (Indaba).	Declaration	1	Business, unions & SMEs	IDU	Declaration
	• Training and collaboration.	Nos trained (all)	t.b.d.			
	• Support SMEs.	Nos projects. Nos SMEs reached.	t.b.d.		DFEA	
	• Monitor.		t.b.d.			
4. BUILD COMMUNITY CAPACITY FOR HIV/AIDS	Build civil society capacity for prevention, care and support. See media door-to-door campaigns. • Stronger AIDS Councils + local co-ordination.	Community knowledge. Nos AC trained	>80% (BSS & care) 16 (all)	Public AIDS Councils	All IDU / M	On BSS Training register
	• Train community groups: women, FBO, civil, TH etc.	Nos trained.	t.b.d.		DLG / M	
	• Sector development programmes: - Strategy, programme, co-ordination. - Training, technical support. - Selected funding.	Nos sectors Nos "Declarations" Nos projects funded.	16 6 (c) 18 prov Local	Civil society groups	 IDU DLG / M	Declaration
	• Develop & monitor the NGO funding system.	t.b.d.				
	• Local database of services.	Nos databases	5			

1. NOTES

2. Acronyms

t.b.d. : to be determined

(c) : cumulative figure

n/a : Not applicable

TA : Technical Assistance

HTA High Transmission Areas

Other acronyms are covered in the text of the plan.

3. Some outputs from GDH and Municipalities still need to be detailed. It is more difficult to quantify outputs for poverty interventions. Children's services and poverty interventions are generic and include people affected by AIDS. Service outputs for the AIDS affected cannot be separated out.

4. Several policies need to be finalized or revised.

5. Policies and definitions for service can be provided for most services to describe the standards required. However several are in draft form and need to be finalized – these are captured in the table.

6. This table of outputs provides the framework for the reporting system. Departments can add more detail and should provide copies of all existing reports (research or narrative reports).

7. A demographic profile of Gauteng is being commissioned to give a clear picture of the groups to be reached, including denominators for media and education reach per group. An analysis of behavioural studies will guide further development of behaviour change interventions.

8. The log-frames per goal provide more detail on the outcomes that these outputs should achieve.

9. These outputs summarise the services provided by government (provincial and local) in Gauteng including the NGOs and private service providers they fund from the AIDS grants (national and provincial) and departmental budgets. At this stage we are not able to quantify delivery by the private sector and NGOs/CBOs funded from other sources. This will be developed over the next few years through partnerships.

ANNEXURE E

SUMMARY OF POLICIES TO BE FINALISED IN 2005/06

PROGRAMME	DESCRIPTION	STATUS	MOTIVATION	DEPTS
1. INCOME GENERATION DFEA	Service for PLHA to set up small business: - Beneficiaries. - Service providers, access to funds. - Sustainability.	• No policy but 3 depts want funds. • DFEA setting up agency for SME devt in 2005. • Little info on existing project viability. • Demand from PLHA and women. • Previous problems experienced by SD & GDH.	• Clarify roles of AIDS pgm and budget. • Mainstream AIDS into SME support programmes. • International experience says it should be done by SME sector (not GDH and SD).	**DFEA / agency** SD GDH IDU OoP
2. SPECIAL RISK INTERVENTIONS IDU	Definition of risk. Effective methodologies. Co-ordination & monitoring. Accountability.	• 6 depts involved, led by IDU. • Draft Gauteng strategy (? NDoH strategy) • Not all co-ordinated yet. • PSG contracted for technical & training. • Research reviews: 2001 & 2005. • Some problems with accountability (researchers).	• A high priority. • Interventions need to use effective methodology. • Co-ordination & monitoring are important.	**IDU** GDH DLG/M DCS SD YD (SRAC)
3. FEMALE CONDOM SUPPLY GDH	Strategy, programme & plan: - Increase access for all women. - Ensure access for sex workers (Women's Dialogue 2005).	• A high profile issue for women. • Strategy is unclear – province is responsible. • Supplies were interrupted, not meeting needs. • Slow progress – not responsive.	• It is urgent to fix the problem. • Stakeholders must be involved.	**GDH** O of P IDU SD
4. WORKPLACE WELLNESS etc	An integrated policy & pgm covering: - Wellness with EAP (including VCT). - GPG Workplace AIDS programme.	• GPG Workplace AIDS policy is agreed but not implemented well. • EAP in place for 25% (? An approved policy). • Overlapping funding requests (VCT/EAP). • EAP includes VCT	• Lack of clarity affects implementation. • National priorities for DPSA & OHSA. • Resource utilization affected. • GPG employees to access VCT	**IDU/All** GDH O of P GDE GSSC

	- Occupational health (OHSA).	• Integration is not clear enough.	service (GDH).	
5. REVISED C/HBC GDH + SD	Revise existing C/HBC policy to accommodate community workers: models, outputs, governance, accountability.	• C/HBC policies are implemented, still to be evaluated. • CW programme changes resources models, outcomes and costing. • AIDS budget is funding broader outputs.	• Need to update the policy to ensure effective mgmt of services, including costing and evaluation.	**IDU** GDH SD
6. INDIGENT BURIAL	Policy for subsidization as part of provincial package of indigent services.	• High need confirmed by research. • Partial implementation by municipalities. • Impact on other services (C/HBC, hospice beds).	• A priority need. • DLG is addressing it.	**DLG** Municipalities. GDH SD, IDU

ANNEXURE F

DRAFT PRIORITY INDICATORS ON THE GAUTENG AIDS PROGRAMME DELIVERY

1. PREVENT NEW HIV INFECTIONS

1) Nos reached with peer education (all)
Includes:
- Youth (poor areas, informal settlements, campus)
- Special risk settings
- Door-to-door

2) Nos free male condoms supplied per month (GDH)
3) % of babies and mothers on NVP (still to be agreed, aims to assess implementation (GDH)
4) Nos tested for HIV in VCT services (GDH)

2. PROVIDE COMPREHENSIVE HEALTH CARE (GDH)

1. Monitor all deaths: includes HBC, TB Register and Hospice beds but not hospital.
2. Dedicated HIV/AIDS care services
   1) Nos treated: all and on ART (compliance if available)
   2) Access to services: nos and % local areas.
3. TB Services (outcomes)
   3) Treatment interruption
   4) Success rate
   5) Monitor deaths
4. Hospice Beds (not step down beds)
   6) Nos beds and nos of clients and length of stay
   7) Monitor deaths
5. HBC
   8) Nos clients homebound
   9) Monitor deaths
   10) Research: joint evaluation of outcomes with CBC
   11) Nos CHWs employed on learnerships
6. PLHA support groups
   12) Nos PLHA supported with activities described
7. All guidelines finalised (revised HBC, PLHA with IDU, Hospice beds)
   13) Database of services with quarterly meeting per local areas
   14) Nos sentinel sites and studies

3. NORMAL LIVES FOR AFFECTED FAMILIES/CHILDREN

1. Children Services (SD)
   1) Nos children supported by CBC services
   2) Access to local CBC services: nos and % per local areas
   3) Nos children receiving free uniform
   4) Nos children placed and nos foster care grants (FCG)
   5) Nos CWs employed on learnerships

   Research
   6) Joint evaluation of CBC outcomes
   7) Service projections with costs
2. Access to poverty relief programmes (3 departments)
   1) See above (free uniforms)
   2) Nos households with food gardens (DACE)
   3) Total nos community workers employed (GDH & SD)

4. REDUCE AIDS IMPACT ON SOCIO-ECONOMIC DEVELOPMENT

1. Strategy and plan with monitoring and evaluation system (IDU)
   1) Finalise 2009 strategy with research
   2) Annual plan and report, AIDS summit
   3) M7E system development with training of managers
   4) Research studied: 4 evaluations (1by GDE) , 3 surveys (1 by GDH)

2. Strengthen AIDS programme management
   5) Nos managers trained
   6) Quarterly reports meet PFMA standards

3. Workplace Programme GPG (All)
   7) % depts with full programme (defined)
   8) % employees trained (over past 3 years) in prevention and care
   9) EAP utilization – nos employees using EAP service
   10) Research projects: 3
   11) Private sector: Declaration from the Workplace Indaba (DFEA & IDU)
4. Build community capacity
   12) Nos community members trained (all)
   13) Nos provincial sectoral “declarations” of commitment (IDU % Depts)
   14) Nos and % Local AIDS programmes (defined) (DLG/Municipalities)

ANNEXURE G

PROGRAMME BUDGET PER DEPARTMENT 2005/06 **23/03/2005**

PROGRAMME	R '000 PG	R '000 NCG	TOTAL	DEPARTMENT	NOTES
Youth					
Lifeskills in school	1,000	18,400	19,400	GDE	Provincial Grants (PG) for evaluation
Training of leaders	3,000	0	3,000	SRAC	
Youth out of school	1,000	0	1,000	SD	
Youth out of school	2,700	0	2,700	DLG	
Tertiary campuses	750	0	750	IDU	
Awareness	2,900	0	2,900	SRAC	
Sub total	**11,350**	**18,400**	**29,750**		
SPECIAL RISK					
Peer Education:					
Transport industry	540	0	540	DPTRW	
Hostels	1,000	0	1,000	IDU	
Mines	0	3,964	3,964	GDH	GDH to clarify plan and activities for NCG
Prisons	3,000	0	3,000	IDU	
CSW and others	1,150	0	1,150	IDU	
Technical and training	1,000	0	1,000	IDU	
Sub total	**6690**	**3964**	**10654**		
PREVENTION SERVICES					
Condoms	5,014	0	5,014	GDH	GDH to provide the following:
STI	0	0	0	GDH	strategy for female condoms
VCT	0	16,554	16,554	GDH	separate budget for STI and Condoms
PMTCT	7,409	10,000	17,409	GDH	
PEP	4,042	1,014	5,056	GDH	
Sub total	**16,465**	**27,568**	**44,033**		

PROGRAMME	R '000 PG	R '000 NCG	TOTAL	DEPARTMENT	NOTES
WORKPLACE					
1. Departments					
O of P	200	0	200	O of P	From internal budget
GSSC	284	0	284	GSSC	Includes EAP service
CS	1,200	0	1,200	CS	Includes EAP service
DPTRW	1,080	0	1,080	DPTRW	Includes EAP service
DFEA	200	0	200	DFEA	Includes EAP service
DACE	800	0	800	DACE	EAP from internal budget
Housing	700	0	700	Housing	Includes EAP service
GDE	4,000	0	4,000	GDE	Includes EAP service
GDH	5,000	0	5,000	GDH	Includes EAP service
DLG	286	0	286	DLG	Includes EAP service
2. EAP support for municipalities	2,300	0	2,300	DLG	Workplace, EAP support for municipalities
3. GSSC: EAP service to departments	4,834	0	4,834	GSSC	GSSC EAP service, EAP includes VCT. GSSC budget includes GDH, GDE and Housing double funding needs clarification
Sub total	**20884**	**0**	**20884**		
CHILDREN SERVICES					
CBC Seminars	24,000	20,000	44,000	SD	Joint evaluation of C/HBC program
School uniform	7,350	18,400	25,750	SD	
Training	1,444	185,000	186,444	SD	
Nutrition support	1,500	0	1,500	SD	
Other	4,706	0	4,706	SD	
Sub total	**39,000**	**223,400**	**262,400**		
POVERTY					
Indigent burials	7,500	0	7,500	DLG	Policy pending
Sub total	**7,500**	**0**	**7,500**		

PROGRAMME	R '000 PG	R '000 NCG	TOTAL	DEPARTMENT	NOTES
PLHA SUPPORT					
PLHA groups	7,900	0	7,900	GDH	DFEA to clarify policy on SME support
Local groups	3,000	0	3,000	DLG	Policy to be revised into multi-sectoral approach
Sub total	**10,900**	**0**	**10,900**		
HEALTH CARE FOR TB/HIV/AIDS					
Care with ART	10,322	125,044	135,366	GDH	Some additional donor funds for GDH not included in this budget
TB program	11,217	564	11,781	GDH	
Hospice beds	26,451	0	26,451	GDH	Develop strategy and guidelines for Hospice beds
HBC	36,069	16,260	52,329	GDH	Revise policy to include Community Health Workers Joint evaluation of C/HBC program
Program management	1,576	6,592	8,168	GDH	Staff including costs
Sub total	**85,635**	**148,460**	**234,095**		
EDUCATE THE PUBLIC					
Advertising	6,214	0	6,214	IDU	Profiling of sectors etc.
WAD	3,305	0	3,305	IDU	Volunteers and campaing costs
Awareness	2,000	0	2,000	DLG	
Material	4,455	0	4,455	IDU	Support all programs
Other: Review, etc	2,202	0	2,202	IDU	
Sub total	**18,176**	**0**	**18,176**		
IDU MANAGEMENT					
Staff & costs	5,000	0	5,000	IDU	
M & E	4,000	0	4,000	IDU	

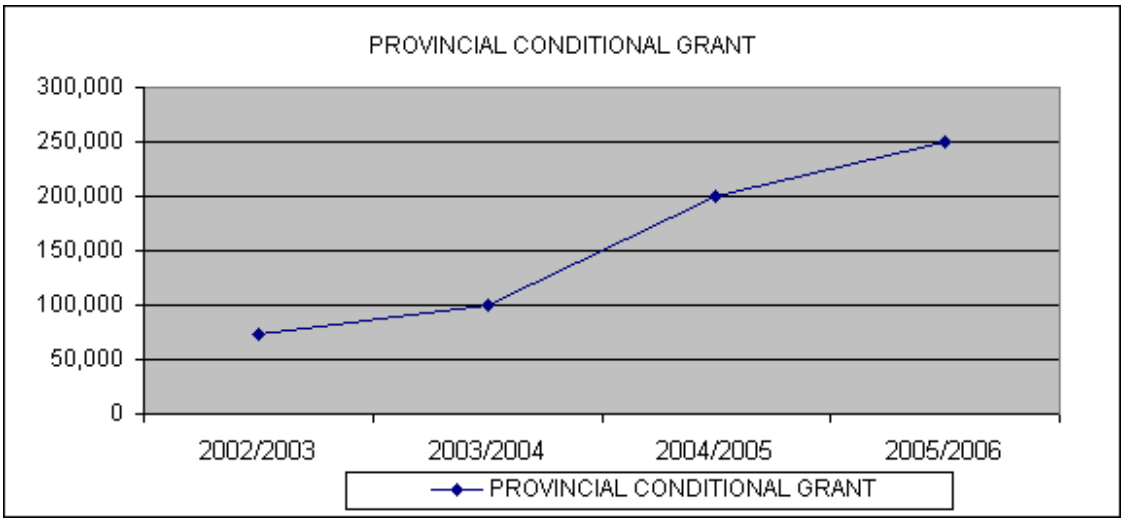
Transfers to departments	0	0	0	IDU	See department budget
Sub total	**9,000**	**0**	**9,000**		

PROGRAMME	R '000 PG	R '000 NCG	TOTAL	DEPARTMENT	NOTES
PLAN AND COORDINATION					
Training and development					Training, planning, co-ordination for all depatrments.
Coordination	2,900	0	2,900	IDU	
Sub total	**2,900**	**0**	**2900**		
PROJECT SUPPORT					
Special risk	0	0	0	IDU	See special risk budget
Workplace and GPG Survey	3,000	0	3,000	IDU	Joint program with department
Sectors include GAC	6,000	0	6,000	IDU	
Sub total	**9000**	**0**	**9000**		
LOCAL PROGRAMS					
Capacity building	6,500	0	6,500	DLG	For communities, ward committees and NGOs
GDH Local NGOs	6,000	0	6,000	IDU (DLG)	Sustain regional non-health NGOs
Sub total	**12,500**	**0**	**12,500**		
GRAND TOTAL	**250,000**	**421,792**	**671,792**		

ANNEXURE H

PROVINCIAL CONDITIONAL GRANT

	2002/2003	2003/2004	2004/2005	2005/2006
PROVINCIAL CONDITIONAL GRANT	**73,730**	**100,520**	**200,000**	**250,000**



NATIONAL CONDITIONAL GRANT

	2002/2003	2003/2004	2004/05	2005/2006
HEALTH	9,433	45,967	134,231	185,048
SOCIAL SERVICES	6,000	9,443	10,315	20,000
EDUCATION	26,560	14,500	17,487	18,400
	41,993	**69,910**	**162,033**	**223,448**