STRATEGIC PLAN
2005 - 2008

FOREWORD BY THE MEMBER OF THE EXECUTIVE COUNCIL

Human development should be the end, economic growth the means. The purpose of wealth therefore should be to enrich peoples' lives, to broaden choices, to enable every child, every women and every man to reach his or her potential. This depends on the state of health of individuals, groups and society in general.

This strategic planning document outlines our objectives and the framework for implementation. It responds to the challenges that are confronting us and the need to improve the quality of care.

As South Africans we need to transcend our differences about whose stance is the best but develop a unity of purpose to address underdevelopment as well as one of the most serious threat to development, the insidious presence of the HIV and AIDS epidemic.

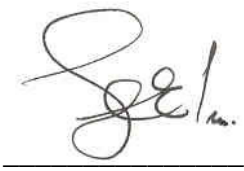
We all know that evidence suggests that the impact of HIV and AIDS at the level of the household will be catastrophic and its future impact on society likely to be devastating.

Young people grow up in a society which have cast off the hypocrisy and secrecy which characterized some people/s sexual behaviours in previous generations, but this has led many to permissive and irresponsible attitudes.

But we cannot simply shrug our shoulders in condemnation and dismissal.

We must display an attitude that will instil confidence and enthusiasm in everyone with whom we come into contact. Our people need people who will assist them to grab the opportunities availed by our democracy and provide treatment deserving their dignity.

The fulfilment of dreams lies partly in our capacity to identify opportunities and partly in the courage to grasp them before they slip away and the increase in the student intake is one of those opportunities.



Ms ES Selao
MEC for Health

INTRODUCTION BY THE HEAD OF DEPARTMENT

This department will need to remain on the cutting edge and ensure that our members are sufficiently empowered with knowledge to critically engage on important relevant issues in the strategic planning document. The plan outlines the next MTEF strategy and the important deliverables to improve the delivery of health care in this province.

Antoine d Saint says" It is not for us to forecast the future, but to shape it". We are responsible for our own destiny and this plan attempts to put the building block to shape the future of this department.

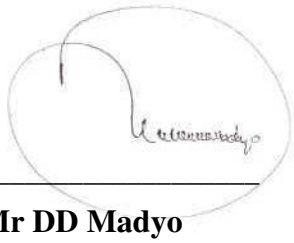
We have learnt different lessons along the way and we are re-engineering the service delivery platform. Pat Williams says " Every experience is a learning experience, every time we try something- win or loose- we learn, we grow and we attain more confidence and competence for the next time".

We need to influence our society so that we become a caring society that cares about the sick and vulnerable.

We are also going to develop the capacity of our health professionals to rise up to the challenges of the 21 Century. Development ought to mean an improvement in the quality of life such that all human beings have their basic needs met adequately, their dignity and self- respect, their freedom honoured and their potentiality given full scope for realization.

Governance is a values proposition and accountability and prudence are values that define good governance. It is therefore visionary leadership that enables and organization to embrace and advance good governance.

We need the courage to change things around us and create a new Northern Cape for the betterment of our people. A lot still needs to be done in integrating business imperatives with social imperatives.



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Mr DD Madyo

Accounting officer

1 VISION

Health service excellence for all.

2 MISSION

Empowered by the Peoples' Contract, we are committed to provide quality health care services; we will promote a healthy society in which we care for one another and take responsibility for our health; our caring, multi-skilled professionals will integrate comprehensive services, using evidence-based care-strategies and partnerships to maximise efficiencies for the benefit of all.

3 VALUES

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

4 STRATEGIC THEMES

The Areas stipulated below serve as the key priority areas for the department over the planning cycle, 2005 to 2008. The emphasis on accelerated service delivery is reflected herein.

- Improve governance and management of District Health Service
- Execute programmes that respond to the health needs and aspirations of the community
- Reduce mortality and morbidity rates
- Repositioning of District Health Services to adequately respond to challenges at local level
- Revitalisation and modernisation of hospitals
- Modernisation and realignment of financial management systems
- Provide appropriate health infrastructure in line with services package of facilities
- Revolutionize Emergency Medical Services
- Rejuvenate community health through comprehensive care, treatment and management of HIV and AIDS
- Establish comprehensive, professional clinical and pathology forensic services
- Strategic human capital management for health care excellence
- Improve health care through information and communication technology

5 INTRODUCTION

The content of this strategic plan is guided by the following documents and processes:

- Strategic Priorities for the National Health System 2004- 2009
- Provincial 5-year strategic plan
- ANC Health Plan
- State of the province address by the Premier of the Northern Cape Province on the occasion of the second session of the third legislature sitting of the Northern Cape Province 18th February 2005.
- The Budget speech by the MEC for Heath on 24th June 2004
- The Provincial SPS Document (Strategic Position Statement).
- The Provincial Strategic Plan session held on 15-16th March 2004 and 01- 03 September 2004.

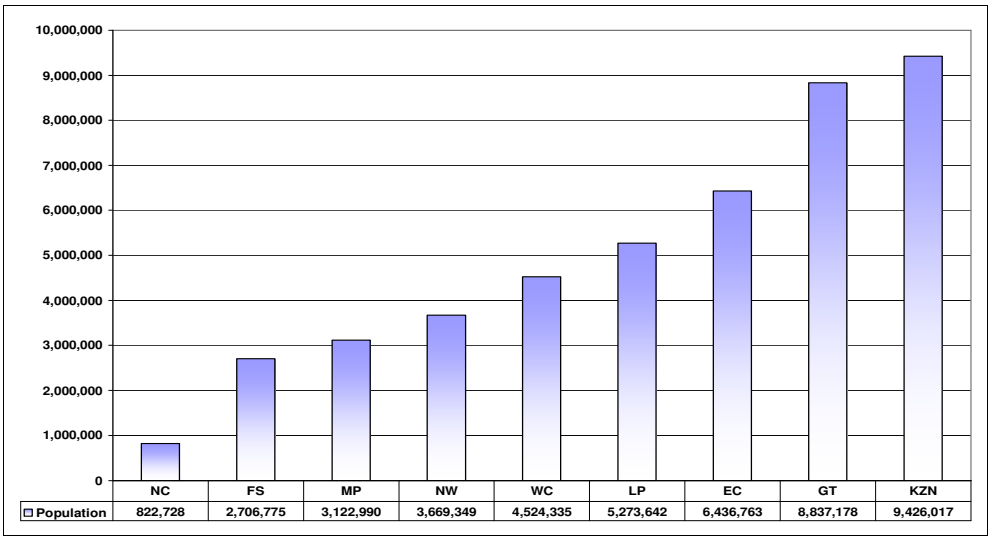
This document will serve as the broad strategic framework for this department over the next three years.

6 SITUATION ANALYSIS

6.1 DEMOGRAPHY

6.1.1 POPULATION

The population of the Northern Cape has decreased from 840'321 in 1996 to 822'728 in 2001. This reflects a 2.1% decrease in population.



The Province is renowned for its large area (it is the largest province with 29.7 % of the total land area of South Africa). It has a very low population density (only 2.3 people per km^2 , whilst the average for South Africa is 36.8 per km^2).

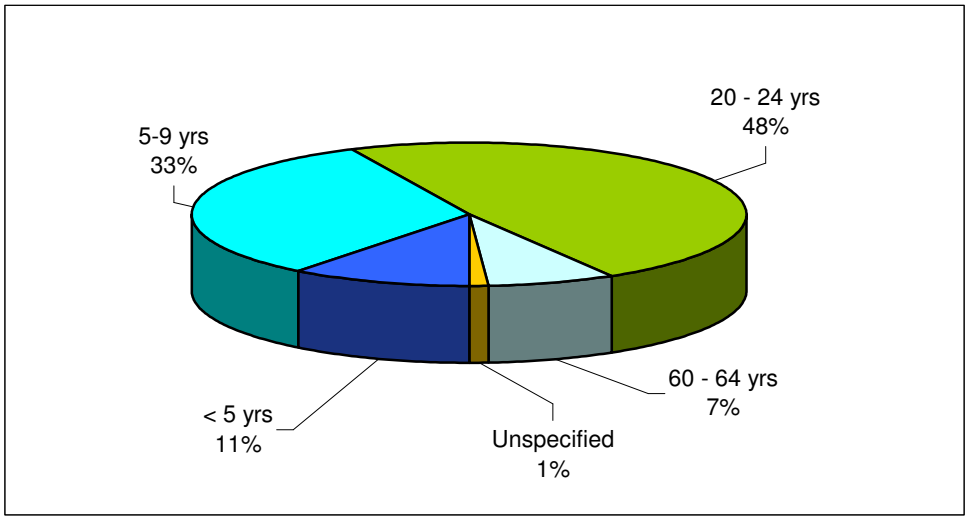
The literacy rate is below the national average, but employment however is above the national average.

Table 1: Population and population density figures

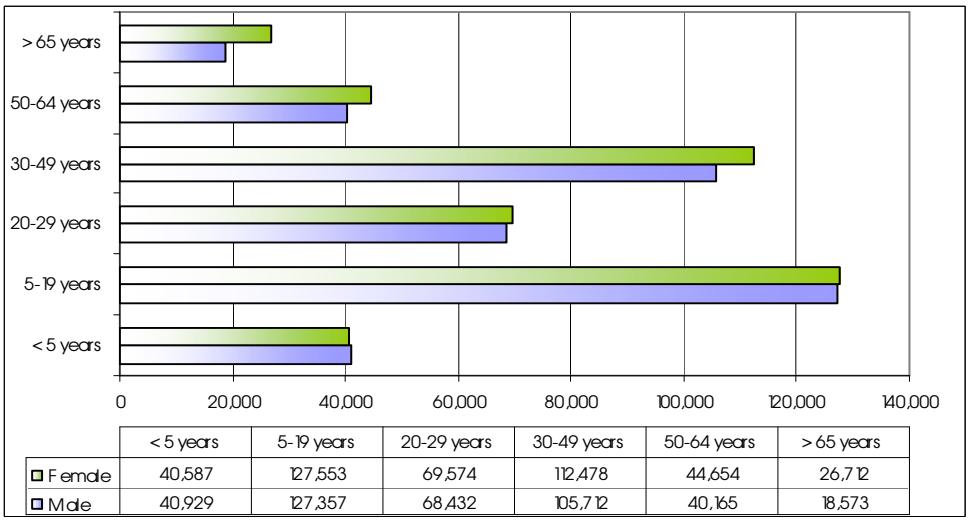
District	Population	Area (km²)	Density
Namakwa	108'111	125'884	0.86
Siyanda	209'889	103'901	2.02
Karoo	164'608	103'887	1.58
Frances Baard	303'239	9'654	31.41
Kgalagadi	36'881	17'697	2.08
Northern Cape	**822'728**	**361 023**	**2.28**

The table above shows a breakdown of the population by District excluding North West cross boundaries.

6.1.1.1 POPULATION AGE DISTRIBUTION

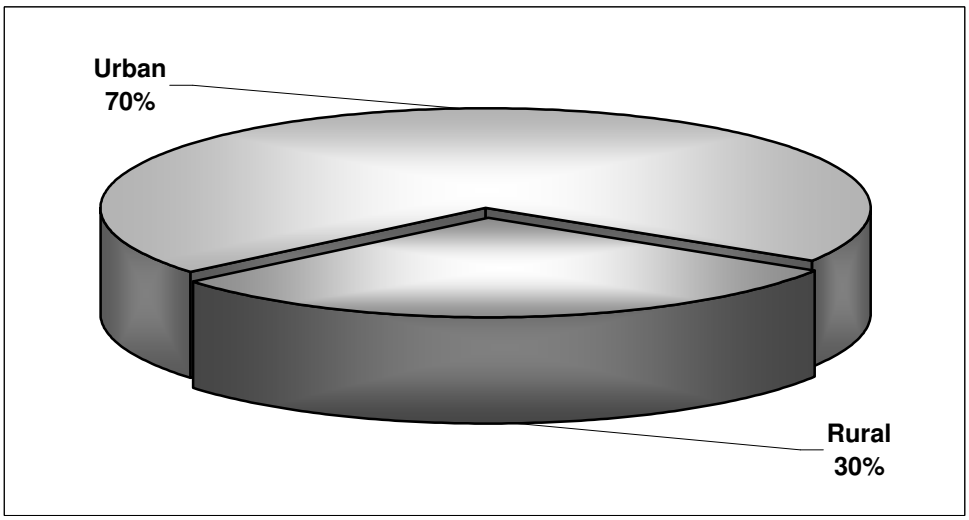


6.1.1.2 POPULATION AGE DISTRIBUTION BY GENDER



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

6.1.1.3 URBAN VERSUS RURAL POPULATION

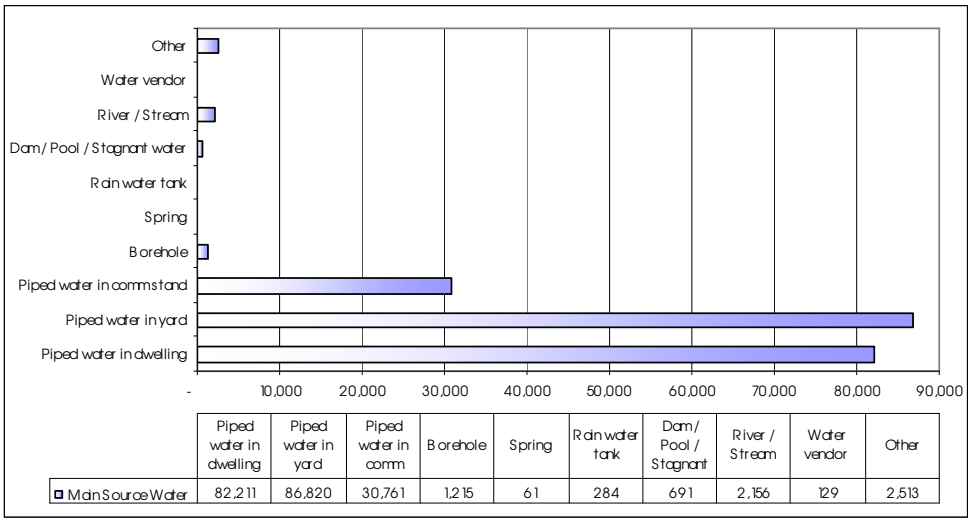


The Northern Cape population is qualified as 70% urban and 30% rural. Towns in the Northern Cape are still experiencing influx from the rural and commercial farming areas. The housing of farm employees on farms is declining in favour of small towns. This is expected to increase with the increasing importance of access to health and education facilities as pull factors. Among the push factors are technology changes in irrigation areas (mechanization), which leads to a decline in the number of jobs available.

6.1.2 HOUSING AND ENGINEERING SERVICES

According to the Census 2001, 80.2% of households lived in formal houses while almost 12.5% occupied shacks in informal settlements. There were about 11.2% of households that had no toilet facilities in 2001. Vast improvements in health have been recorded but this is being threatened by the increasing prevalence of HIV related disease, growing inequity, environmental degradation and economic crisis.

6.1.2.1 MAIN WATER SOURCE TO HOUSEHOLDS



The literacy rate is below the national average. Employment however, although low, is above the national average.

Socio- Economic Indicators for Northern Cape and South Africa

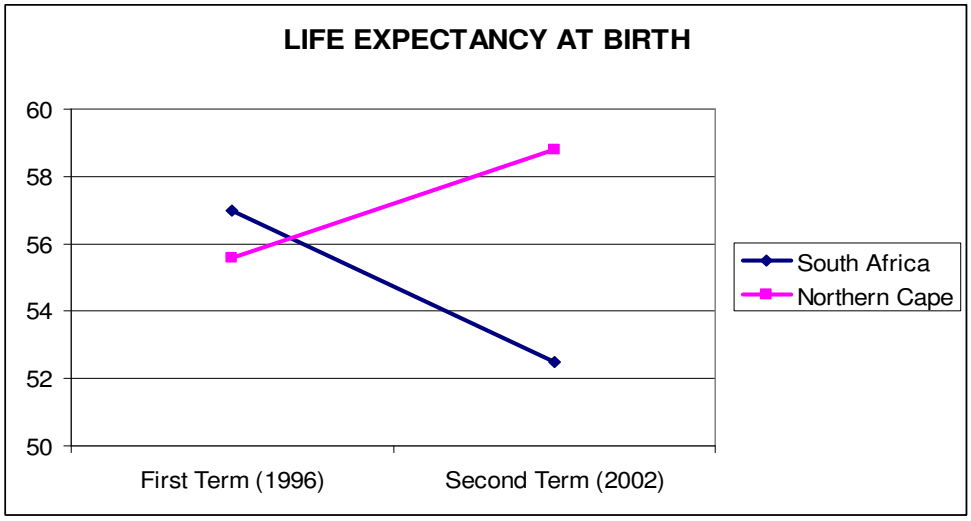
Table 2: Socio-Economic indicators for Northern Cape and South Africa

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

6.2 EPIDEMIOLOGICAL PROFILE

6.2.1 AVERAGE LIFE EXPECTANCY

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



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

6.2.2 BURDEN OF DISEASE

Bradshaw et al. (MRC, 2003) refer to a quadruple burden of disease reflected in the South African mortality profile, adding HIV/AIDS to the previously highlighted triple burden of disease. The quadruple burden covers the following four categories of disease:

- HIV&AIDS
- Pre-transitional conditions related to under-development and poverty (TB, Diarrhoeal disease), predominantly infectious disease.
- Emerging chronic conditions associated with a western lifestyle
- High rate of injuries

As shown above, these four categories of disease also plaque the Northern Cape. They will be discussed below.

6.2.2.1 HIV AND AIDS

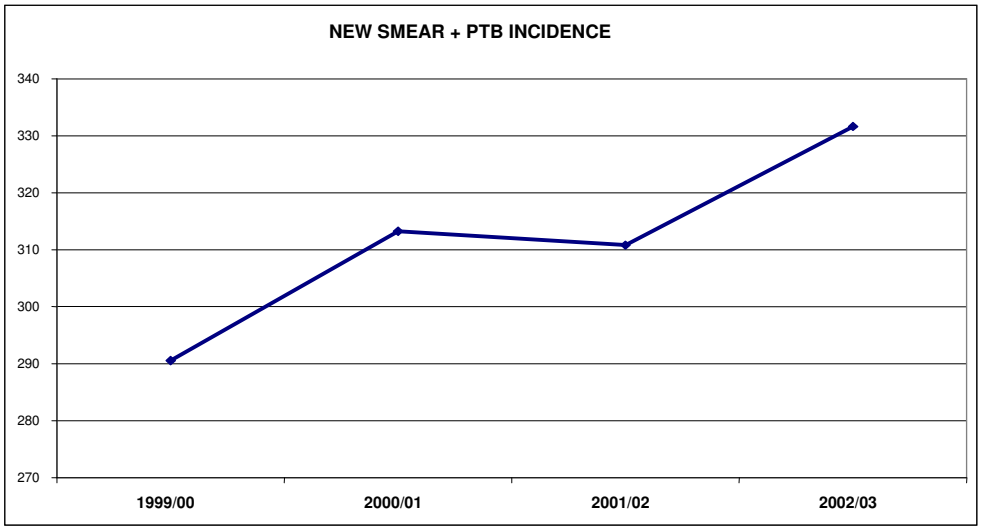
The HIV epidemic has affected all communities in the Northern Cape. The health services are particularly affected by the increased burden of disease caused by the epidemic. Health workers are confronted with progressively more patients and progressively sicker patients as the epidemic unfolds. This places an enormous challenge on all levels of staff, to continue to offer quality care and continue to manage patients with dignity. We believe the people in the health sector are striving to meet this challenge and will continue to do so.

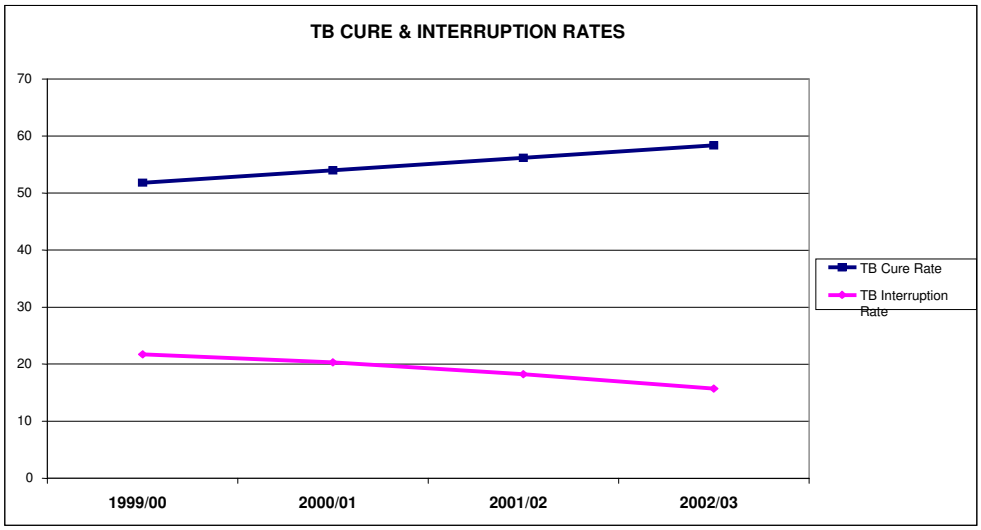
ANTENATAL PREVALENCE

Last year we presented the prevalence of 15.15% and noted a slight decrease of less than one from the previous year. This year we report an increase, from 15.15 to 16.69. Although this increase is statistically insignificant, the burden of disease will continue to be significant for some time.

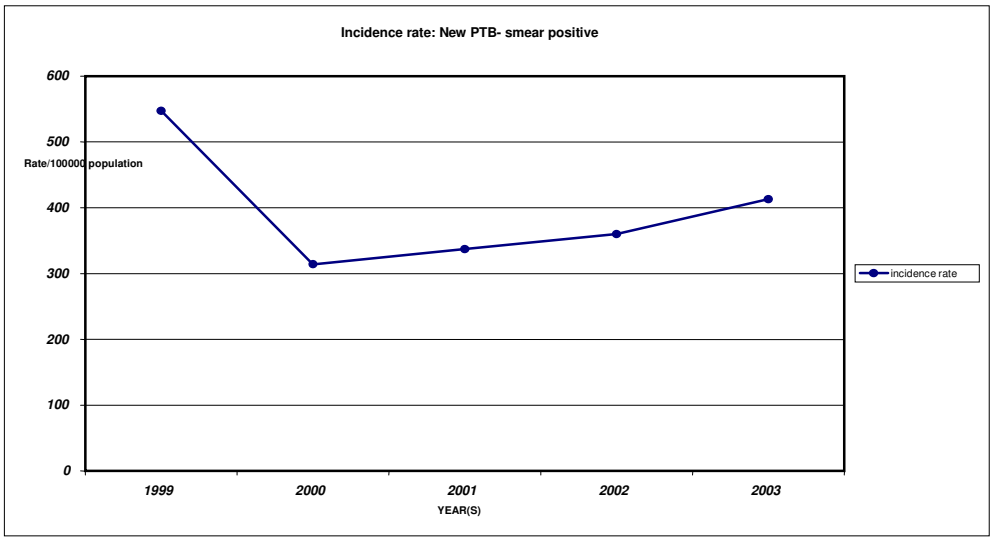
6.2.2.2 INFECTITIOUS DISEASES

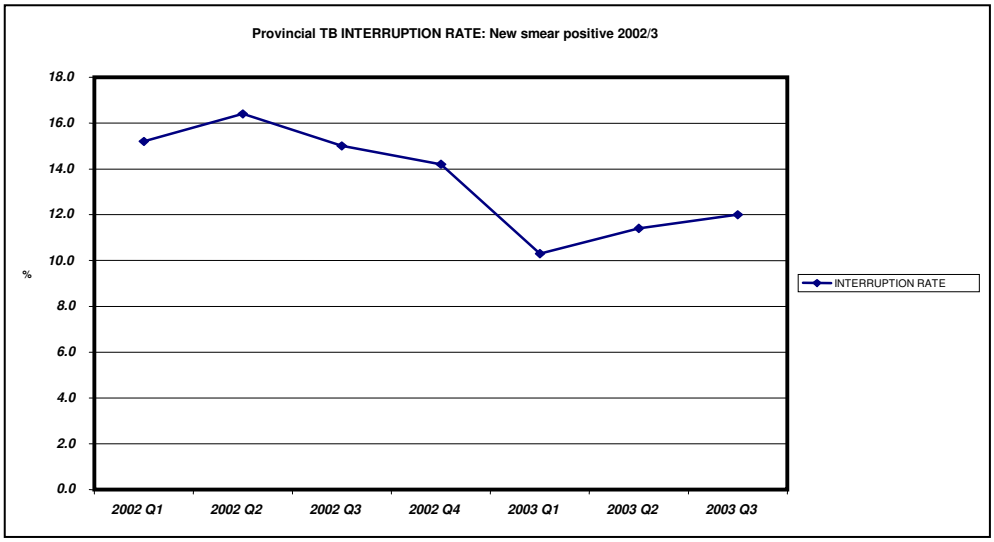
TUBERCULOSIS





The indicators show that the incidence reached its peak in 1999 to and started to decrease as a result of a massive effort from the Department of Health. The incidence rate increased again however seemed to have stabilised between 2000 and 2002.





Of concern though is the high interruption rate (which gives an indication of people who are not cured due to not completing the treatment). The provincial TB interruption rate is above the National norm of below 10%, and this is a worrying trend because it is steadily increasing across the quarters of 2003.

The other worrying factor is the low cure rate (indicating people who have completed treatment and be proven to be free of TB). The interruption rate has been brought down a little and cure rate slightly increased over the last two years, through the efforts of the Infectious Disease team. This trend will need to continue for the province to bring the problem of TB under control.

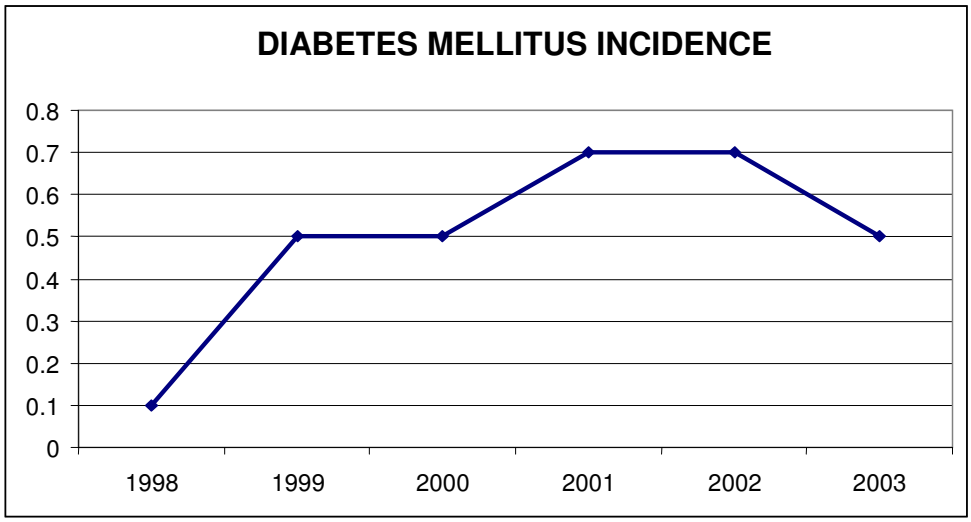
6.2.2.3 EMERGING CHRONIC CONDITIONS ASSOCIATED WITH A WESTERN LIFESTYLE

CHRONIC CONDITIONS

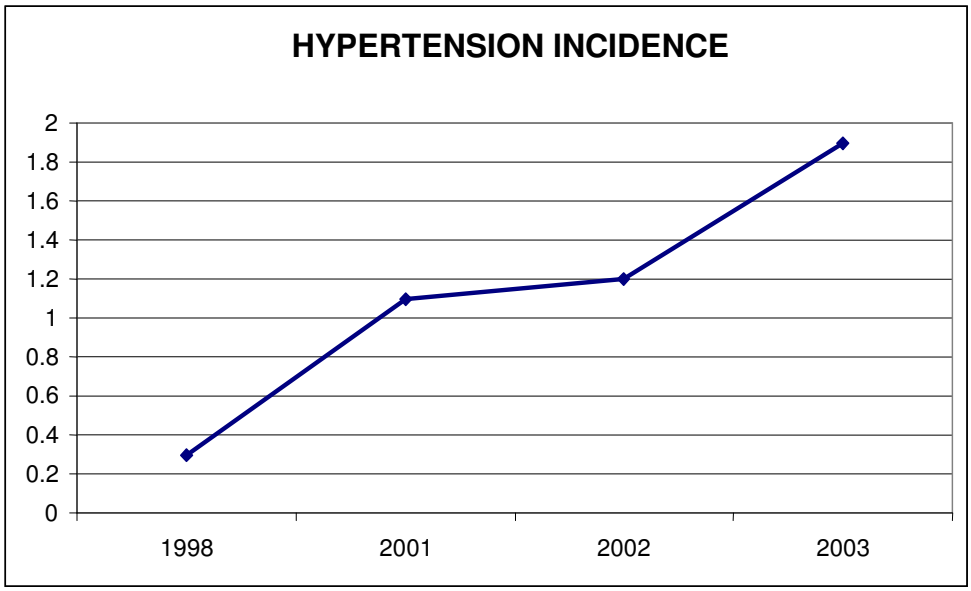
Based on self-reported chronic conditions, major conditions in the Northern Cape are blood pressure, ischemic heart disease and tuberculosis. Asthma and chronic bronchitis also appear to be particular problems for men. For women blood pressure, emphysema and tuberculosis are predominant. Men receiving treatment for hypertension in the Northern Cape is double that of the

national average (21,5% compared to 10,7%), whilst the figure for women taking medication is 35% compared to 27,7% nationally.

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



Note:
*The incidence rate is per 1000
* Age group is 45 years and older



Note:
*The incidence rate is per 1000
* Age group is 45 years and older

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

6.2.2.4 INJURIES

POST MORTEMS PERFORMED IN KIMBERELY

Review of the results of post mortems performed at the Kimberley Mortuary reveals the following trends.

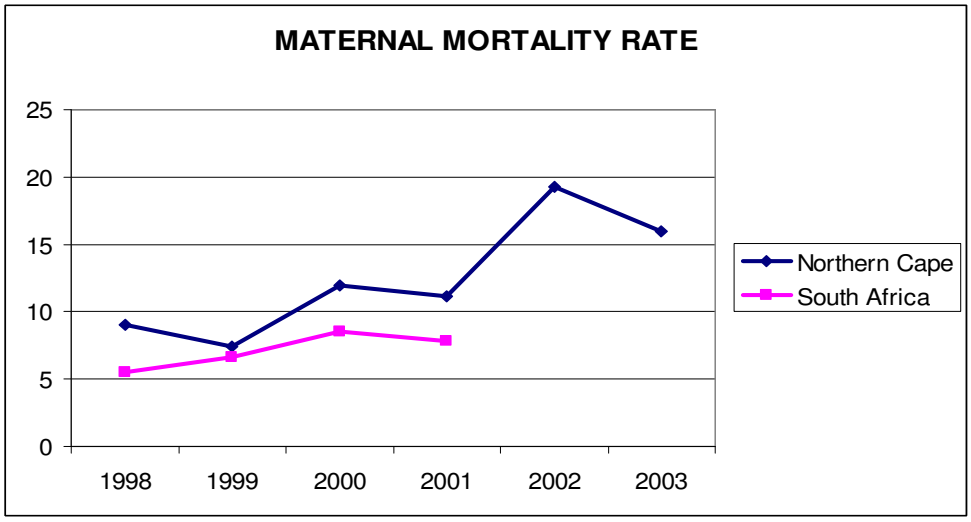
- Murder shows the most dramatic decrease

- Deaths from motor vehicle accidents and accidents are decreasing, but not significantly.
- Suicides are increasing
- Post mortems on natural deaths are increasing. This is likely due to the increase in deaths of young people from AIDS related disease.

6.2.3 WOMENS' HEALTH

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

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



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

6.2.3.1 TERMINATION OF PREGNANCY

Data for this section reflects positive investments in the facilities for termination of pregnancy (TOP), with resultant increases in access to the TOP service. There have also been improvements in the extent of condom distribution.

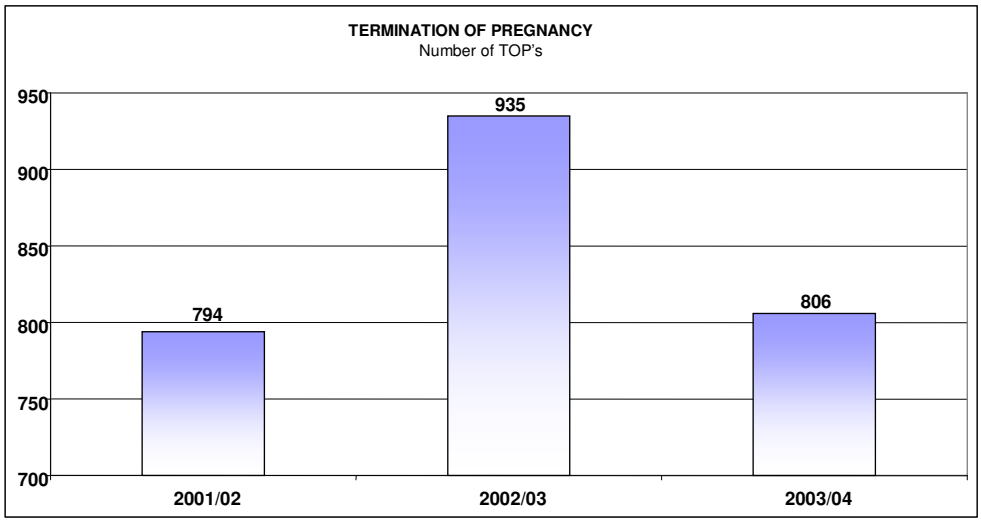


Table 3: Trends in key provincial mortality indicators

Indicator	SADHS 1998	SADHS 2003	Target[2]
Infant mortality (under 1)	41.8	46	45 per 1,000 live births by 2005
Child mortality (under 5)	14.3	14.3	59 per 1,000 live births by 2005
Maternal mortality	192.7 (2002)	167.2 (2003)	100 per 100,000 live births by 2005

Table 4: 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	1,799,145	2,061,565	1,993,900	2,224,673	2,421,992	2,100,255
PHC headcount in hospitals	12,640	25,769	14,370	2,225	2,922	11,585
Hospital separations	No Data	No Data	82,429.8	65,050.8	68,847.5	66,949.1

6.3 MAJOR SERVICE CHALLENGES

6.3.1 ACCESS TO HEALTH CARE SERVICES

Persons living in towns of the Northern Cape are all within 5km of a health facility. It is in the rural areas where this is not the case and mobiles service these areas. However, according to the National Health Care Facilities Survey 2000, the Northern Cape mobile service had the lowest frequency nationally for mobile clinic visits at once in 6.7 weeks average. The Province is the largest with regard to land mass and has 47 mobile clinics.

Access to health services has an important role to play in supporting health promotion activities, taking a lead in caring and support to people living with HIV, and in supporting appropriate home-based care.

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

However, the facility used by such youths is dependent on whether they belong to medical aid schemes or not. A high number of youth from farms use private general practitioners rather than clinics.

6.3.2 STAFF MIX AND PROVISION OF CARE

Recruitment and retention strategy has been implemented throughout the province. Rural and scarce skills allowance have been implemented as well.

6.3.3 PROBLEMS WITH REFERRAL CHAIN

Referral of patients has improved. The two crew ambulance system is being implemented and new ambulances have been purchased. Transportation of cold cases has been separated from emergency cases through the patient transport vehicles.

Cross border referrals are still posing as a challenge. Self referrals are often reported from the North West and Free State province.

6.4 HOSPITAL REVITALIZATION

Two 35 bed level 1 hospitals have been built in Coleberg and Calvinia and consist of operating theatre, accident and emergency unit and maternity unit. Colesberg Hospital is open for business and Calvinia will accept its first patients on the 17th March 2005.

The sod turning for the new psychiatric hospital has taken place.

The site for the building of Garies hospital is to be handed over to the contractor.

6.5 QUALITY OF CARE IMPROVEMENTS

The patients Rights Charter has been implemented and displayed at Institutions. Training of Health Care Workers on the Batho Pele and Patients Rights

Primary health care norms and standards have been implemented. A facility audit is currently being conducted throughout the Province.

Hospital norms and standards have been implemented, a facility audit is currently conducted at the Level I hospitals.

Provincial and District Quality Improvement Committees have been established and are fully functional

6.6 EMERGENCY MEDICAL SERVICES

The Northern Cape province known for its largest land mass boasts with one of the best road infrastructure in the country. We are on track with the implementation of the 2-crew policy.

6.7 BROAD POLICIES, PRIORITIES AND STRATEGIC GOALS

The Areas stipulated below serve as the key priority areas for the department over the planning cycle, 2005 to 2008. The emphasis on accelerated service delivery is reflected herein.

- Provide a comprehensive PHC service according to the package
- Transform priority programmes to emphasize promotion of health as an adjunct to curing disease.
- Utilize Hospital revitalization as a tool to revitalize the health care environment
- Implement a model for integrated comprehensive management of HIV and AIDS.

- To improve patient care through the appropriate use of Information and Communication Technology (ICT)
- To provide financial management leadership to the department.
- To ensure optimal utilization of Human Resources
- To ensure maximum capacitation of staff

6.8 BUDGET & EXPENDITURE TRENDS FOR HEALTH

Table 5: Summary of expenditure and estimates: Department of Health

R'000	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Programmes							
Administration	28,535	32,769	56,966	48,087	53,672	57,701	61,200
District health services	251,396	266,343	327,842	343,821	422,681	472,799	500,560
Emergency medical services	37,643	37,239	39,187	55,488	66,136	68,727	71,483
Provincial hospital services	172,591	228,729	261,626	253,714	281,333	300,355	319,362
Health sciences	6,586	8,018	11,109	19,570	26,239	20,789	21,868
Health care support services	3,881	10,204	101,812	45,107	6,598	7,188	7,664
Health facilities management	16,763	24,548	33,372	108,268	84,644	232,857	257,524
Total: Programmes	**517,395**	**607,851**	**831,914**	**874,055**	**941,303**	**1,160,416**	**1,239,661**
Statutory amount	-	657	710	784	766	815	907
Total: Health	**517,395**	**608,508**	**832,624**	**874,839**	**942,069**	**1,161,231**	**1,240,568**

Table 6: Summary of economic classification: Department of Health

R'000	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Current Expenditure							
Compensation of employees	323,730	366,105	424,852	476,576	546,148	567,276	592,137
Goods and services	141,089	187,571	336,674	251,370	271,418	322,631	351,276
Transfers and subsidies	18,366	18,231	28,001	18,626	18,372	19,910	20,632
Total: Current	**483,186**	**571,907**	**789,527**	**746,572**	**835,938**	**909,817**	**964,045**
Capital Expenditure							
Payments for capital assets	34,209	35,944	42,387	127,483	105,365	250,599	275,616
Total: Capital	**34,209**	**35,944**	**42,387**	**127,483**	**105,365**	**250,599**	**275,616**
Total economic classification	**517,395**	**607,851**	**831,914**	**874,055**	**941,303**	**1,160,416**	**1,239,661**
Statutory amount	-	657	710	784	766	815	907
Total: Health	**517,395**	**608,508**	**832,624**	**874,839**	**942,069**	**1,161,231**	**1,240,568**

Table 7: Trends in provincial public health expenditure

	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Current Prices							
Total	517,395,214	608,507,703	832,624,152	874,839,000	-	-	-
Total per person	629	740	1,012	1,063	-	-	-
Total per uninsured person	786	925	1,265	1,329	-	-	-
Total capital	34,208,884	35,943,801	42,387,072	127,483,000	-	-	-
Constant (2004/05) prices							
Total	630,187,371	674,835,043	875,920,608	874,839,000	942,069,000	1,161,231,000	1,240,568,000
Total per person	766	820	1,065	1,063	1,145	1,411	1,508
Total per uninsured person	957	1,025	1,331	1,329	1,431	1,764	1,885
% of total spent on:							
District health services	48.6%	43.8%	39.4%	39.3%	45%	41%	40%
Provincial hospital services	33.4%	37.6%	31.4%	29.0%	29.9%	25.9%	25.7%
All personnel	62.6%	60.2%	51.0%	54.5%	58.0%	48.9%	47.7%
Capital	6.6%	5.9%	5.1%	14.6%	11.2%	21.6%	22.2%
Health as % of total public expenditure	17.9%	17.5%	20.0%	19.0%	18.6%	20.7%	20.6%

7 PROGRAMME 1: ADMINISTRATION

7.1 INTRODUCTION

This programme is aimed at conducting the overall management and administration of the Department of Health.

Formulation of policy, overall management and administration of the Department and the respective Regions and Institutions within the Department in accordance with the Public Service Act, 1994 as amended, the public Finance Management Act 1 of 1999 (as amended by Act 29 of 1999) and other applicable legislation.

7.2 SITUATION ANALYSIS

The office of the MEC provides political support as well as broad strategic direction to the Health Sector. The Department of Health, under the guidance of the Head of Department is then the primary implementer of health services.

The management of the department can be broadly divided in the following manner:

- Human Resource Management
- Quality Assurance
- Communication
- Policy and Planning

7.3 HUMAN RESOURCE MANAGEMENT

7.3.1 SITUATION ANALYSIS

Capacity in Human Resource Management has been developed to Directorate level. Human Resource Development (HRD) and Administration component have been put on a trajectory from being generalist to becoming specialist as a result of a changing environment dictated by legislation. A number of consultative Committees established to co-determine outcomes in the workplace in terms of the Skills Development and the Employment Equity Acts.

A list of policies is at an advanced stage of review for implementation. Approximately 1’200 learnerships are currently undergoing training in the Department, implementing our goal of creating an environment of life-long learning in the workplace.

The department has a staff complement of 4’431 employees, spread over the Province in 5 Health districts. All functions of human resources exist at provincial office level including Kimberley Hospital Complex. Services on a small-scale are provided at district level.

In dealing with the planning for our future human resource needs, 16 students are currently studying towards a degree in medicine in Cuba. Eleven Students studying towards MBCHB have been awarded bursaries and a contract has been entered to work back years equal to the years of study.

In addressing the challenge of the skills flight, the Department has implemented the retention strategy with regard to payment of rural and scarce skills allowance. The rural allowance is applicable to all areas in the province except Kimberley and Upington. This measure has assisted the department to attract medical personnel to the rural areas.

7.3.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

- Overtime Policy
- State Housing Policy
- Education and Training Policy
- HIV and AIDS Workplace Policy

7.3.3 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 8: Provincial objectives & indicators for human resources

OBJECTIVE	INDICATOR	01/02 Actual	02/03 Actual	03/04 Estimate	04/05 Estimate	05/06 Target	06/07 Target	07/08 Target
Develop a culture of high quality life long learning by Upgrading education level of 70% low skilled employees to NQF level 4	• % of employees who obtained a General Education and Training Certificate (GETC)	25	31	40	50	60	65	70
	• % of employees who have NQF 4qualification	0	0	0	40	45	50	55
Develop fair equitable policies and procedures for training and development of employees	• % of training proposals approved against training proposals received	0	20	30	50	60	75	80
	• % of level 1-4 employees trained	0	15	15	25	45	60	70
	• % of level 5-8 employees trained	0	29	40	40	50	60	75
	• % of level 9-12 employees trained	0	40	50	50	60	70	75
	• % of EEP targets met in terms of training	0	25	30	35	40	50	80
Develop functional training committees at 17 facilities	• % of institution with training committees in place	0	10	10	25	50	80	100
	• % Of institutions that submit prescribed trained reports	0	15	5	25	50	100	100
Assist 600 new entrants into employment	• % Employment who entered for learnership	0	0	20	30	40	50	100
	• % Of students / interns into the system per year	0	0	10	20	30	80	90
Develop HR Plan in line with Service Needs	• % Staff placed appropriately according to organogram	0	0	25	50	75	100	100
	• % Staff with finalized job descriptions	0	0	25	50	75	100	100
	• Staffing norms for health facilities to inform the realignment of the organogram	0	0	0	50	100	100	
	• HR Policy manual	0	0	0	50	100	100	
Develop timeous accurate and reliable HR information for managers and staff	• % Personnel reached with information sessions	0	15	25	40	75	85	100
	• % Reduction in audit queries	0	10	40	40	75	100	100
Promote sound measures in handling discipline and grievance	• % Reduction in turn around	0	15	30	50	75	100	

7.4 COMMUNICATION

7.4.1 INTRODUCTION

In a rapidly changing social, political, economic scenario the world over and also shrinking world the media has to play a dynamic role. Dynamic in the sense that it has to be constantly changing and evolving to suit the needs and requirements of different categories of society.

The unit is assigned with the task of empowering communities through Public Education and Awareness on improved health care system and taking responsible decisions regarding their health and improved well-being. This is derived from the Department of Health's objectives of improving communication at all levels.

Establishing and strengthening working relations with various organizations in society is an ongoing challenge that has to be fulfilled to ensure that community members are empowered on health issues by the unit. This is aimed at a long term effect behavioural change towards healthy lifestyle amongst communities.

The unit is responsible for establishing and maintaining professional relations between the department and stakeholders including media through constant interaction. The interaction can be in the form of public meetings, road shows, health day events, newsletter, imbizos and media briefings.

7.4.2 SITUATIONAL ANALYSIS

7.4.2.1 MEDIA ENQUIRY

About 37 media enquiries were responded to by the department covering various health issues. The more common enquiries were on hospital revitalization programme, anthrax scare, ARVs and Kuruman sessional doctors.

The communication policy needs to be adopted to eliminate delays in response to all enquiries forwarded to the department. The members of the department who are appointed as spokespersons should be well informed of the issues to avoid any delays or giving ambiguous responses to such enquiries.

7.4.2.2 MEDIA ON ARV ROLL OUT

The roll out of ARVs was an important issue for the media and public in general. About four media statements were distributed on ARVs and because of its importance enquiries were received and dealt with on time.

7.4.2.3 CORPORATE/ NEWSLETTER

Due to lack of human resources the external newsletter could not be produced and distributed quarterly as planned. In the new financial year when the unit is fully fledged the newsletter will be distributed on time.

7.4.2.4 LINK BETWEEN DEPARTMENT AND MINISTRY

There is constant liaison between the department and the ministry as all media responses and statements are approved by the Head of the Department. The two offices interact constantly regarding the activities and events as well as visits to health institutions to ensure that there is synergy within the department and also that the two offices should complement each other.

7.4.3 CHALLENGES

- Lack of staff appointments at provincial and regional levels is a challenge to ensure that communication reaches all Northern Cape communities on health issues.
- Communication budget linked to line functions is challenging as the unit has no control over budget
- Need to train district managers on communication including telecommunication issues
- Internal communication regarding exchange and sharing of information

7.4.4 CONSTRAINTS IN IMPLEMENTING OBJECTIVES

- Communication equipment like digital cameras and other equipment is not available to capture important departmental events for archives and departmental newsletter
- Branding for corporate image is not available
- Line functions take responsibility for payments of advertisements
- Human resources to implement plans

7.4.5 PLANNED MEASURES TO OVERCOME CONSTRAINTS

- Purchasing of relevant equipment for the unit to operate optimally
- Allocation of sufficient budget for the operations of the unit like timeous production of departmental newsletter and up to date branding
- Appointment of communication staff members including the districts
- Training of district managers on communication

7.4.6 POLICIES, ACTS, PRIORITIES AND STRATEGIC GOALS

Draft communication policy has been submitted to the legal unit of the department for their inputs, currently awaiting comments and amendments. The priorities and strategic goals are derived from the departmental priorities as the unit is the support structure to all the units.

7.4.7 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 9: Provincial objectives & indicators for Communication

OBJECTIVE	INDICATOR	01/02 ACTUAL	02/03 ACTUAL	03/04 ESTIMATE	04/05 ESTIMATE	05/06 TARGET	06/07 TARGET	07/08 TARGET
To inform public on health care services/ delivery and plans	Number of quarterly newsletters printed Number of public meetings held	0 Quarterly	0	1 issue of 10'000 copies	0	40'000 30	40'000 30	40'000 30
Enhancement of good working relations with the media	Number of media invitations and releases distributed Number of community talk shows Number of national radio talk shows Number of articles written and distributed	-	-	35	30 45 3 0	25 30	30 20	30 20
To strengthen internal communication both horizontal and vertical	Number of newsletters distributed Website updates KH Radio	0	0	10 000		40'000 Monthly	40'000 Monthly	40'000 Monthly

7.5 QUALITY ASSURANCE

7.5.1 SITUATION ANALYSIS

An audit has been conducted on the implementation of the PHC District Package at 2 Districts, namely Kgalagadi and Frances Baard.

7.5.2 PROCESSING PRIVATE APPLICATIONS

Applications for the establishment of private institutions received form:

- Kuruman After Care Home – Applicant sister Cornea Smit
- Family Planning Services – De Beers Kimberley
- Taung Private Hospital – Dr Mphothulo – Taung
- Kathu Private Hospital – Extension of license till 31 December 2005

7.5.3 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 10: Provincial objectives & indicators for Quality Assurance

OBJECTIVE	INDICATOR	01/02 Actual	02/03 Actual	03/04 Estimate	04/05 Estimate	05/06 Target	06/07 Target	07/08 Target
Implement complaints procedure at the five districts by March 2005	Percentage of facilities implementing the complaints procedures in the districts.	0	60 %	100 %	100 %	100 %	100%	100%
	Percentage of complaints completed within 30 days.	0	0	50 %	75%	80%	100%	100%

7.6 BUDGET & EXPENDITURE TRENDS PROGRAMME 1: ADMINISTRATION

Table 11: Summary of expenditure and estimates: Programme 1 - Administration

R'000	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Sub-programmes							
Office of the MEC	1,172	2,844	2,505	2,424	3,114	2,930	3,121
Management	27,363	29,925	54,461	45,663	50,558	54,771	58,079
Programme Total	**28,535**	**32,769**	**56,966**	**48,087**	**53,672**	**57,701**	**61,200**

Table 12: Summary of economic classification: Programme 1 - Administration

R'000	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Current Expenditure							
Compensation of employees	14,011	17,723	21,124	25,201	32,319	33,858	35,188
Goods and services	11,659	12,727	35,113	21,966	19,965	22,723	24,733
Transfers and subsidies	43	56	68	100	88	100	109
Total: Current	**25,712**	**30,507**	**56,305**	**47,267**	**52,372**	**56,681**	**60,030**
Capital Expenditure							
Payments for capital assets	2,822	2,262	661	820	1,300	1,020	1,170
Total: Capital	**2,822**	**2,262**	**661**	**820**	**1,300**	**1,020**	**1,170**
Total economic classification	**28,535**	**32,769**	**56,966**	**48,087**	**53,672**	**57,701**	**61,200**

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

	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Current Prices							
Total	28,534,870	32,769,030	56,966,221	48,087,000	-	-	-
Total per person	35	40	69	58	-	-	-
Total per uninsured person	43	50	87	73	-	-	-
Total capital	2,822,480	2,262,265	661,168	820,000	-	-	-
Constant (2004/05) prices							
Total	34,755,630	36,340,821	59,928,232	48,087,000	53,672,000	57,701,000	61,200,000
Total per person	42	44	73	58	65	70	74
Total per uninsured person	53	55	91	73	82	88	93
Total capital	3,437,781	2,508,852	695,549	820,000	1,300,000	1,020,000	1,170,000

8 PROGRAMME 2: DISTRICT HEALTH SERVICES

8.1 INTRODUCTION AND SITUATIONAL ANALYSIS

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

The Northern Cape Province is divided into five districts namely:

- Frances Baard
- Karoo
- Kgalagadi
- Namakwa
- Siyanda

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

The main health problems in the Karoo district are tuberculoses and HIV & AIDS. Due to the fact that several roads goes through the area; the incidence seams to be especially high on that routes. A well established TB/HIV programme is in place which include VCT/CHBC and PMTCT services.Since August 2004 an Anti Retro viral treatment site have been established.

8.1.1 CROSS BOUNDARIES ISSUES

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

8.1.2 DISTRICT HOSPITALS

There are 13 Level I hospitals and 1 Level II hospital which is Gordonia Hospital. This hospital serves as a referral hospital for Siyanda and Namakwa.

8.1.3 HOSPITAL BOARDS

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

8.1.4 GORDONIA HOSPITAL

To further improve the service at the hospital, a sonar machine and a CTG machine have been purchased. This will decrease the number of referrals from Upington to Kimberley.

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

Upington has been allocated R230million for a brand new hospital to commence construction during the current financial year (2005-2006).

Table 14: Classification of institutions

DISTRICT	CLINICS F	M	S	CHC	Beds	COMMUNITY HOSPITAL	Beds	TB HOSPITALS	Beds	DISTRICT HOSPITALS	Beds
Namakwa	23	11	17	P Nolloth Brandvlei Loeriefontein Williston Fraserburg Sutherland Pofadder	6 6 6 6 6 6 6	Garies	15	-	-	Springbok Calvinia	40 35
Siyanda	12	17	20	Kenhardt Groblershoop Rietfontein Danielskuil Askham	12 3 7 6 3	Olifantshoek	12	TB Upington	38	Kakamas Keimoes Postmasburg Gordonia	36 30 40 179
Karoo	24	5	2	Vosburg Griekwastad	8 14	Victoria West Richmond Hopetown Carnavon Noupoort	21 22 22 25 12	-	-	De Aar Douglas Prieska Colesburg	51 30 25 35
Frances Baard	21	5	8	Galeshewe Day Hospital	14	Jan Kempdorp	20	Jan Kemp Dorp	30	Hartswater Warrenton Barkly West	40 30 30
Kgalagadi	6	-	3	-	-	-	-	-	-	Kuruman	64
TOTAL	**86**	**38**	**50**		**109**		**149**		**68**		**660**

8.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

8.2.1 POLICIES

- Overtime Policy
- State housing policy

8.2.2 STRATEGIC OBJECTIVES AND PRIORITIES

- Ensure accessibility of services
- Expand provision of Primary Health Care targeting full implementation of the PHC core package.
- Delegation of PHC services to District Municipalities by April 2005. Delegation to the different districts will be done in phases commencing with the Frances Baard District Municipality.
- Focus on the Batho Pele Principles.

8.2.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

- Shortage of staff especially in the Professional nurse category where there are often no applications for a post
- Lack of critical equipment at facility level
- The vastness of the province
- Costly to render service
- Difficulty to cover all areas with limited staff and vehicles
- Difficulty to supervise and monitor

Table 15: Situation analysis indicators for District Health Services

Indicator[1]	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	Frances Baard District 2003/04	Karoo District 2003/04	Kgalagadi District 2003/04	Siyanda District 2003/04	Namaqua District 2003/04	National target 2003/4
Input										
1. Sub-districts offering full package of PHC services	%	50	60	60						60
Process										
2. Health districts with appointed manager	%	100%	100%	100%	100%	100%	100%	100%	100%	92
3. Health districts with plan as per DHP guidelines	%	100%	100%	100%	100%	100%	100%	100%	100%	48
4. Fixed PHC facilities with functioning community participation structure	%	-	62%	62%						69
Output										
5. PHC total headcount	No	1,993,900	2,224,673	2,421,992						N/A
6. Utilisation rate - PHC	No	2.4	2.7	3.1						2.3
7. Utilisation rate - PHC under 5 years	No	4.2	4.5	4.9						3.8
Quality										
8. Fixed PHC facilities supported by a doctor at least once a week	%			100%	100%	100%	100%	100%	100%	31
Outcome										
9. Health districts with a single provider of PHC services	%	80	80	80						50

1 'Fixed PHC facilities' means fixed

Table 16: Situation analysis indicators for District Hospitals

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	Province wide value 2004/05	Francis Baard 2004/05	Siyanda 2004/05	Karoo 2004/05	Kgalagadi 2004/05	Namakwa 2004/05	National target
Process											
1. District hospitals with operational hospital board	%	0	0	0	0	0	0	0	0	0	76
2. District hospitals with appointed (not acting) CEO in post	%	-	-	50	50 %	7,6%	15,3%	15,3%	0%	15,3%	69
Output											
3. Caesarean section rate for district hospitals	%	13	15,2	15,2	Gilbert	38,4	11,1	9,4	16,3	16.2	12.5
Quality											
4. District hospitals with clinical audit (M and M) meetings every month	%			100%	100%	100%	100%	100%	100%	100%	36
Efficiency											
5. Average length of stay in district hospitals	Days	2,8	3,0	2,7	Gilbert	4,1	3,5	2,3	2	2,6	4.2
6. Bed utilisation rate (based on usable beds) in district hospitals	%	75,2	71,6	78,3	Gilbert	83,8	89,4	77,9	84,3	74,9	68

Table 17: Provincial objectives & indicators for District Health Services

OBJECTIVE	INDICATOR	01/02 Actual	02/03 Actual	03/04 Estimate	04/05 Estimate	05/06 Target	06/07 Target	07/08 Target
Ensure equal accessibility of PHC services for all communities	Population served per fixed PHC facility		3'638	4'018	5'820	6'250	7'250	8'000
	Number of professional nurses in fixed public PHC facilities per 1000 people		0.61	1	1	2	2	2
	Number of professional nurses in fixed public PHC facilities per 1000 uninsured people		0.77	1	1	2	2	2
Implement PHC package and establish well defined referral systems	Percentage of fixed public PHC facilities offering the full package of PHC services				60%	65%	70%	75%
Ensure appropriate management of districts	Percentage of health districts with appointed manager		100%	100%	100%	100%	100%	100%
	Percentage of health districts with formal plan		0%	0%	100%	100%	100%	100%
	Percentage of fixed public PHC facilities with functioning community participation structure				100%	100%	100%	100%

Table 18: Performance indicators for District Hospitals

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/08
Process							
1. District hospitals with operational hospital board	%	0%	0%	7.1% Gordonia Hospital	100%	-	100
2. District hospitals with appointed (not acting) CEO in post	%		46%	60%	80%	100%	100
Quality							
3. District hospitals with clinical audit (M and M) meetings every month	%		100%	100%	100%	100%	100
Efficiency							
4. Average length of stay in district hospitals	Days	4.1	4	3.5	3.2	3	3.2
5. Bed utilisation rate (based on usable beds) in district hospitals	%	78.3	75	72	70	70	72

8.3 HIV & AIDS, STI & TB CONTROL

The spirit of the HIV & AIDS Comprehensive Plan for Treatment, Care and Support is one of integration of comprehensive services to improve access for all to quality healthcare.

The Northern Cape has embraced this spirit, moulding Communicable Disease management into a single, integrated Directorate. Control of this group of related infections is now planned and implemented in an integrated manner and the information presented here is for integrated HIV & AIDS/STI/TB control.

8.3.1 SITUATION ANALYSIS

8.3.1.1 EPIDEMIOLOGY

Although the prevalence of HIV infection among ANC clinic attendees in the province has increased, levels remain far lower than the National average, with the second lowest rate in the country after the Western Cape.

Nevertheless, the spread of those people infected and affected by HIV across the vast Northern Cape poses significant logistical challenges to programme implementation.

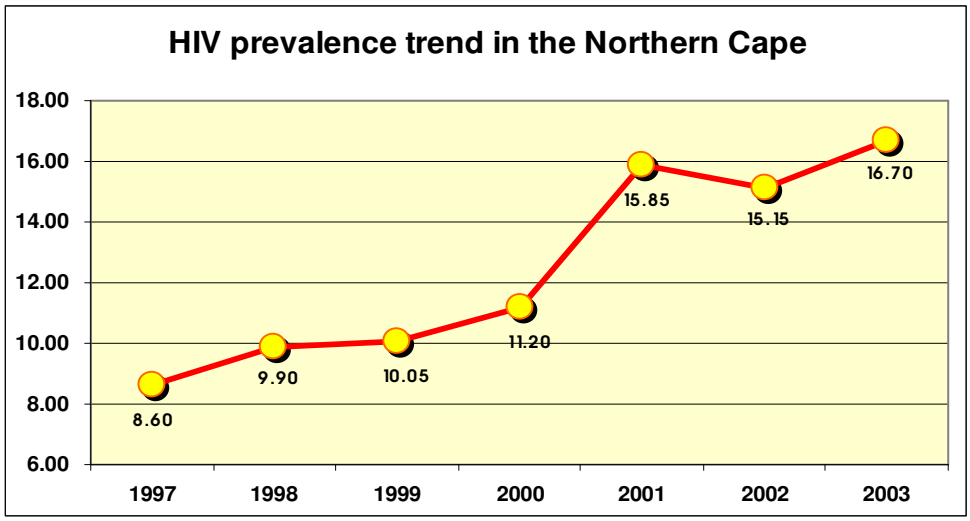


Table 19: Sero-Prevalence HIV

Year	Provincial Prevalence	Frances Baard	Karoo	Kgalagadi	Namakwa	Siyanda
1997	8.60	*No data*	*No data*	*No data*	*No data*	*No data*
1998	9.90	*No data*	*No data*	*No data*	*No data*	*No data*
1999	10.05	*No data*	*No data*	*No data*	*No data*	*No data*
2000	11.20	12.55	8.70	14.56	*No data*	7.50
2001	15.85	18.50	14.40	18.67	9.38	12.25
2002	15.15	17.41	10.14	22.67	10.00	12.09
2003	16.67					

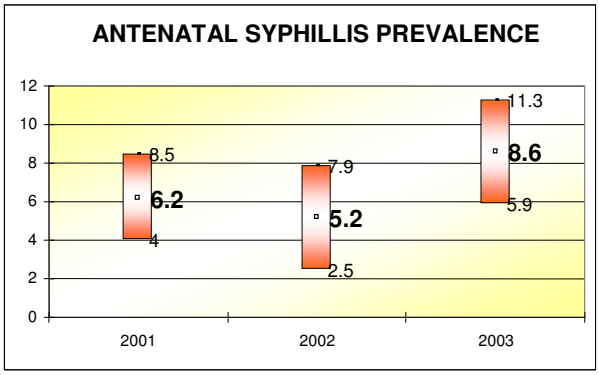
Source: South African Antenatal Sero-Prevalence Survey

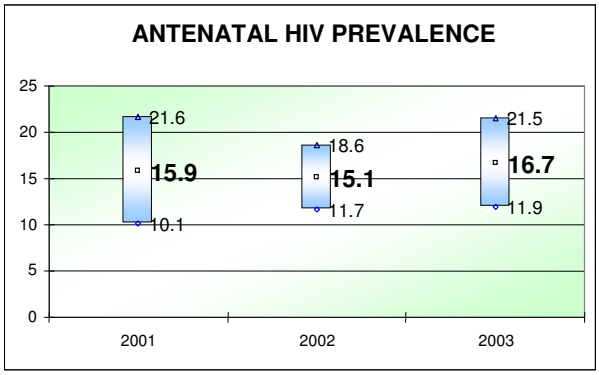
Table 20: Sero-Prevalence Syphillis

Year	Provincial Prevalence	Frances Baard	Karoo	Kgalagadi	Namakwa	Siyanda
2000	5.11	4.18	10.14	4.85	2.94	5.00
2001	6.23	5.00	4.80	4.00	9.38	11.22
2002	5.21	3.33	9.46	1.33	0	8.79
2003						

Source: South African Antenatal Sero-Prevalence Survey

A comparison of the syphilis and HIV components of the antenatal survey over the last three years reveals disproportionate increase in syphilis. The graphs below illustrate this, bars showing means with upper and lower limits of 95% Confidence Intervals.

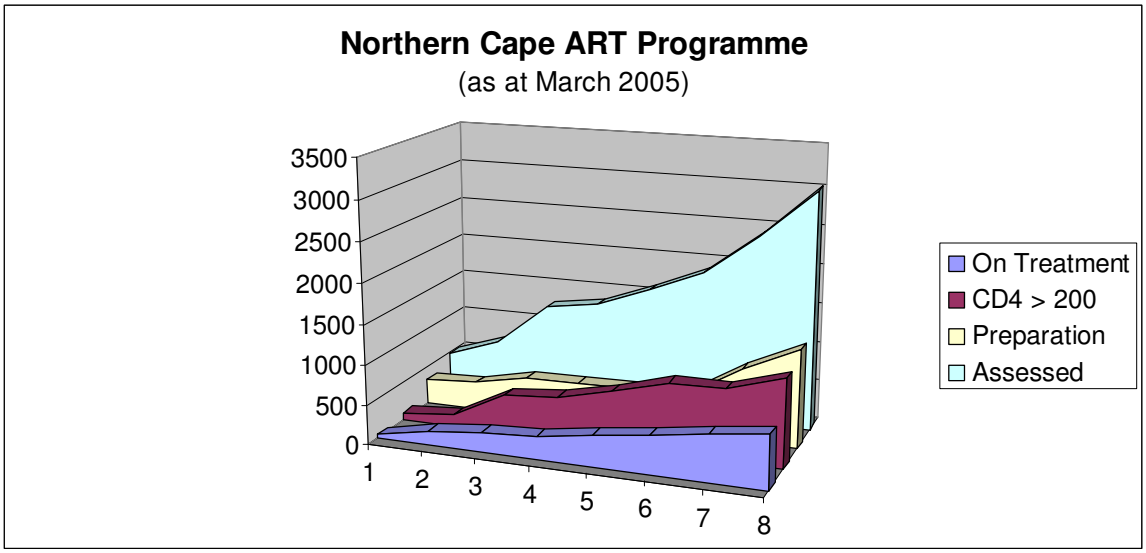




8.3.1.2 SERVICE APPRAISAL

The Comprehensive Plan, including the ART Programme launched on 26 July 2004, has breathed fresh air into many facilities. Despite concerns relating to the ability of the Province to implement this complex collection of Programmes much has been achieved in the last year.

ART Programme uptake is illustrated in the following graph:



The challenge currently being faced by the Province is to scale-up services to ensure that all patients who qualify for ART are able to complete preparation and commence treatment.

		Province Wide Values				Districts 2004/2005					National
Indicator	**Type**	**2001/02**	**2002/03**	**2003/04**	**2004/05**	**Frances Baard**	**Siyanda**	**Karoo**	**Kgalagadi**	**Namakwa**	**National target 2007/08**
Input											
ARV treatment service points compared to plan	%	N/A	N/A	N/A	100	100	100	100	100	100	100
Fixed PHC facilities offering PMTCT	%				32						50
Fixed PHC facilities offering VCT	%			98	62.5						90
Process											
TB cases with a DOT supporter	%	85,3	67,3	56,5							100
Male condom distribution rate from public sector health facilities		3,4	3,8	4,9							
Hospitals drawing blood for CD4 testing	%				20						N/A
Fixed PHC facilities drawing blood for CD4 testing	%				80						N/A
Fixed facilities referring patients to ARV treatment points assessment	%				100						N/A
Output											
STI partner treatment rate	%	0	13.8	18.1							
TB treatment interruption rate	%	17,2	14,0	11,0	10.5	18.6	10.3	14.3	12.5	16.4	10
Quality											
TB sputa specimens with turnaround time > 48 hours	%				50%	20%	0%	20%	0%	-	
Outcome											
New smear positive PTB cases cured at first attempt	%	67,1	62.3	68.8	75.2	40.5	76.6	71.5	29.8	78.9	85

8.3.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

The Northern Cape Communicable Disease Directorate recognises the following broad strategic framework for all initiatives:

- HIV/AIDS & STI strategic plan for South Africa 2000-2005
- The medium term development plan of the national tuberculosis control programme for 2002-2005
- The Comprehensive Plan for Care, Management and Treatment of HIV and AIDS

The strategic priorities identified in the Northern Cape are based primarily on those of the National Department of Health HIV/AIDS & STI Strategic Plan 2000-2005, with the following minor variations. Treatment, Care and Support have been divided into two priorities:

- Treatment and
- Care and Support
- Partnerships has been added as an additional priority

8.3.3 STRATEGIC PRIORITIES

8.3.3.1 AWARENESS AND PREVENTION

Behaviour change has been identified as a complex process that needs a range of interventions to achieve success. While awareness and information dissemination are important pre-requisites for behaviour change, there are also other elements that needs to be considered like perception of vulnerability, risk assessment, self-efficacy and access to resources, which are essential for successful, sustained behaviour change.

8.3.3.2 CARE AND SUPPORT

The provision of counselling, care and support services requires adequate infrastructures and adequately trained personnel to render the services. The counsellors that would be needed for the rendering of the services must undergo a standardized curriculum with a minimum period of supervised training.

The Home community based care programme will not only target patients with HIV/AIDS, but will be a programme that will be accessible to all chronically or terminally ill patients.

8.3.3.3 TREATMENT

Treatment is an important component of the Comprehensive Plan. It includes the following:

- Nutrition, Vitamin and Multi-nutrient support to slow down progression of the virus, prolonging the period before the patient requires Anti Retroviral Treatment.
- Prophylaxis against opportunistic infections once the immune system starts to become weaker.
- Early treatment of opportunistic infections when they occur.
- Anti Retroviral Treatment, once they are necessary, to support the immune system of a person with advanced AIDS.

8.3.3.4 HUMAN RIGHTS

The emotional and social dynamics that accompanies the epidemics of HIV & AIDS and TB frequently results in stigmatisation. Affected persons are at risk of discrimination from all spheres

of life. To support the rights enshrined in the Constitution of South Africa, all programme activities and legislator efforts should deal with discrimination with a special focus on HIV/AIDS and TB.

8.3.3.5 RESEARCH, MONITORING & EVALUATION AND SURVEILLANCE

Our planning and interventions should be based on scientifically sound research and information. A multidisciplinary, collaborative and participatory approach would be an important consideration for research funding within province. The belief is as such that research findings should be presented on a regular basis at appropriate and relevant groups.

8.3.3.6 PARTNERSHIPS

The approach to the partnership programme has been that of ensuring that the expanded, multi-sector response is the key to effective, coordinated, joint actions. The coordination of a multi-sector response would also require a process, which will seek to promote information exchange, building of alliances and programmes that are collaborative and reinforces each other.

All strategic priorities are aimed at resulting in a positive impact on disease outcome. Particular:

- Reduction of new HIV infections per year
- Reduction of new TB infections per year
- Reduction of new STI infections per year
- Reduction of morbidity and mortality relating to the above conditions

8.3.4 SPECIFIC PROGRAMME RELATED PRIORITIES

8.3.4.1 COMMUNITY AND HOME BASED CARE

- Standardize training.
- Integrate services.
- Standardize stipend payment
- Improve inter-departmental cooperation

8.3.4.2 STEP DOWN CARE

Integrate with Hospitals as well as Community and Home Based Care to provide a seamless interface between both.

8.3.4.3 VCT SERVICES

- Provide a common, primary entry point for all HIV and AIDS related services as well as other sexual health services.
- Expand to become a routine part of all Primary Health Care consultations.
- Fulfil the role of STI (including HIV) prevention and behaviour modification.

8.3.4.4 PMTCT SERVICES

- Integrate into antenatal care
- Integrate with infectious disease clinics
- Provide multi-drug therapy where ever necessary

8.3.4.5 PREVENTION

- Improve Condom distribution strategies
- Develop appropriate, effective education and awareness campaigns

8.3.4.6 DIAGNOSTIC, MANAGEMENT AND PROTOCOL DEVELOPMENT

- Circulate available guidelines and protocols
- Identify gaps and request support from National Department of Health and Trtiary Institutions

8.3.4.7 TUBERCULOSIS

- Empowerment of patients to improve treatment adherence
- Support adherence through home based support
- Utilise DOTS support for patients identified as having difficulties with adherence
- Utilise support groups to improve reporting
- Strengthen lab services and district systems to improve turn-around times

8.3.4.8 INFORMATION SYSTEMS

- Extend the roll-out of the EPRWeb Electronic Health Record.
- Recruit more support staff
- Train all health professionals and support staff on the system
- Integrate TB information system requirements with implementation of an ART module with the EPRWeb,

8.3.4.9 TREATMENT ADHERENCE

- Expand support groups using all available partners
- Integrate TB and HIV & AIDS issues into all support groups

8.3.4.10 NGO/CBO INVOLVEMENTS AND SERVICE LEVEL AGREEMENTS

- Strengthen Local AIDS Councils
- Support more active sector response to HIV & AIDS
- Provide better mentoring to NGO's

8.3.4.11 STAFF TRAINING AND SUPERVISION

- Recruit District Communicable Disease coordinators
- Recruit facility Communicable Disease coordinators
- Increase in-service training
- Better coordination of training workshops

8.3.5 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

This analysis details major constraints to the implementation of the policies and objectives identified in the previous section.

CATEGORY	CONSTRAINT	STRATEGY TO OVERCOME CONSTRAINT
HUMAN RESOURCES	Difficulty recruiting certain staff categories to rural areas	Integrated recruitment and retention package developed by HR at request of Senior Management
		Integrate all Communicable Disease services with routine medical clinics.
	No tertiary institution in the Province and little involvement of other Tertiary Institutions	Request National Department of Health to support the strengthening of the academic support for Professionals and research components of the Northern Cape programmes through a strategic relationship with an appropriate Academic institution.
SUPPORT SYSTEMS	Transport shortages in most regions.	Strengthen the general patient transport system and integrate HIV & AIDS transport requirements with routine patient transport service.
	Infrastructure weaknesses. The Projects Team managing the revitalisation has little extra capacity to take on additional responsibilities.	Integrate necessary alterations with broader Hospital and Clinic Revitalisation plans.
FINANCIAL	A significant amount of money requested from the Conditional Grant for HIV & AIDS has not been funded.	As advised by Health Finance team, the additional amounts will be sort from the Equitable Share. Unfortunately, Equitable Share allocations show no significant increase and HIV & AIDS must compete with numerous pressures. The following services are likely to remain under-funded: • Inter-facility transport services • Minor infrastructure alterations • Nutrition support

* As requested, we have marked areas where constraints may limit achievement of Provincial or National objectives in the planning period and provincial management has only limited ability to mitigate against the difficulties.

8.3.6 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 21: Provincial objectives and performance indicators for HIV & AIDS, STI and TB

STRETEGIC PRIORITY	OBJECTIVES
1. Awareness and Prevention	Prevent infection in people who are HIV negative
	Promote the health of people living with the virus
	Promote responsible, healthy sexuality through interactive campaigns
	Promote a strategic response to emerging and re-emerging infections and outbreaks
2. Care and Support	Implement effective community and home based care as part of the comprehensive plan
	Providing dignified palliative care
	Supporting compliance for life for those on treatment
3. Treatment	Providing appropriate, evidence based Anti Retroviral Treatment
	Providing appropriate, evidence based treatment of Opportunistic Infections
	Manage implementation of care packages (Nutrition and Social Services) in a responsible, accountable, transparent manner.
4. Human Rights	Respect the privacy and confidentiality of our clients
	Respect the right of our clients to non-discrimination through internal and external campaigns

STRETEGIC PRIORITY	OBJECTIVES
	Integrated HIV & AIDS care through the Employee Assistance Programme
5. Research, Monitoring & Evaluation and Surveillance	Provide appropriate, evidence based information for action
	Monitor quality and evaluate performance through standardized annual surveys and strategic academic partnerships
6. Partnerships	Support community participation in transforming the Northern Cape into a society caring for communities living with HIV and AIDS.
	Support the participation of people living with HIV & AIDS in advancing the Comprehensive Plan through coordinated partnerships around specific activities
	Support strong, sustainable inter-sector collaboration

8.4 MOTHER, CHILD, YOUTH AND WOMEN'S HEALTH

8.4.1 SITUATION ANALYSIS

In the latest Saving Mothers Report II, which was launched by the National Minister of Health on the 8th of March 2003 ,the maternal mortality rate was estimated at 175/100,000 live births in the country. The maternal mortality rate for the Northern Cape was 143,50/100,000 live births for the financial year April 2002 to March 2003.

There has been an increase in the number of maternal deaths reported in the Northern Cape, as well as in the country. The increase is mainly attributed to the improved reporting system and increase in deaths due to non-pregnancy related infections, mainly AIDS.

Deaths related to AIDS are significantly under reported because of the definition used for AIDS by the National Committee on the confidential enquiry into Maternal Deaths (NCCEMD) is that there must be positive HIV test and either a CD4 count of less than OR an AIDS defining condition such as Tuberculosis Kaposi cell Sarcoma, Pneumocystis Carri pneumonia cryptococcal meningitis

The PMTCT Programme is operational in the province at 37 clinics which are providing the PMTCT package as a whole, all the other clinics are feeder clinics which means that they refer clients to another clinic for Never pine.

Current situation of School Health Services in the Northern Cape is that it does not exist at all. Services are rendered within the primary health care system. A range of factors contributed to this including:

- -Variation in the value attached to school health services.
- -Inequity that existed within the service during the apartheid years.

8.4.2 PERINATAL TRAINING

Table 22: Perinatal health education training

Districts	No. of health workers trained
Frances Baard	4
Namaqualand	27
Karoo	18
Kgalagadi	-
Siyanda	10

8.4.3 HUMAN GENETICS

A total of 50 worker in the Northern Cape were trained in human genetics in October 2002

Table 23: Human genetics training

Districts	No. of Health Care Workers
Frances Baard	29
Namaqualand	3
Karoo	3
Kgalagadi	2
Siyanda	1

8.4.4 DIPLOMA IN ADVANCED MIDWIFERY TRAINING

The maternal child and women's health sub-directorate in the Northern Cape have trained 19 advanced midwives during in the year 2001 - 2002

district	Number of advanced midwives	Placement	No. of institutions rendering maternity and antenatal services
Frances Baard	8	Galashewe Day CHC Kimberley Hospital Hartswater Hospital Jan Kemp Hospital	29
Siyanda	6	Gordonia Hospital Kakamas Hospital Postmasburg Hospital	22
Kgalagadi	1	Kururman Hospital	7
Namaqualand	3	Fraserburg Hospital Sutherland Hospital Springbok Hospital	34
Karoo	2	Prieska Hospital De Aar Hospital	38

Table 24: Situation analysis indicators for MCWH

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	Province wide value 2004/05	Francis Baard 2004/05	Siyanda 2004/05	Karoo 2004/05	Kgalagadi 2004/05	Namakwa 2004/05	National target 2003/4
Incidence											
Hospitals offering TOP services	%	100%	100%	100%	100%	100%	100%	_	_	_	100
CHCs offering TOP services	%	0%	3.4%	3.4%	3.4%	_	_	_	_	_	50
1. Process											
Fixed PHC facilities with DTP-Hib vaccine stock out	%				0%	0%	0%	0%	0%	0%	
AFP detection rate	%	_	50%	100%	100%	100%	100%	100%	_	_	1
AFP stool adequacy rate	%	_	100%	50%	100%	100%	100%	100%	_	_	80
Output											
(Full) Immunisation coverage under 1 year	%		91,3	109,8	126,3	112	82.91	120,6	104	85,71	90
Antenatal coverage	%	97.9	108,5	109,4		91,2	106,9	133,0	206,4	92,3	80%
Vitamin A coverage under 1 year	%										80%
Measles coverage under 1 year	%		93.1%	99.3%	104.4%	95.6%	91,5%	118.4%	140%	91.5%	90
Cervical cancer screening coverage	%	0	1,9	2,6							15
Quality											
Fixed PHC facilities implementing IMCI	No.	70	80	114		28	5	37	38	-	
Outcome											
Institutional delivery rate for women under 18 years	%										13
Not gaining weight under 5 years	%	2,7	4,7	4	3,3	3.3	5,2	5,3	4	-	2.5

8.4.5 POLICIES, PRIORITIES AND STRATEGIC GOALS

8.4.5.1 POLICIES

- School Health Policy

8.4.5.2 PRIORITIES

- To reduce the maternal mortality rate from 214/100,000 p/a to 200/100,000 p/a by the end of March 2005
- To ensure that all PHC facilities have at least 60% of health care workers trained in IMCI case management by December 2008 in all districts.
- To implement the household and community component of IMCI in at least 2 sites per districts by 2005
- Improve access to HIV testing and counseling in ANC clinics.
- Extend and strengthen the District Monthly Outreach MCWH Strategy
- To implement the household and community component of IMCI at least at 2 sites per districts by 2005

8.4.6 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

- Primary Health Care coordinators at District level are co- ordinating all priority programmes at this level. Therefore no sufficient time is dedicated to the MCWH issues.

8.4.7 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Objective	Indicator	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)
Reduce the Maternal Mortality rate from 214/100,000 to 200/100,000 by the end of March 2005	Maternal MortalityRate	172/100,000 p/a	143/100,000 p/a	214/100,000 p/a	200/100,000 p/a	190/100,000 p/a	180/100,000 p/a	170/100,000 p/a
To implement the household and community component in at least 5 sites per districts	Number of Sites implementing Community IMCI in each district	0	0	5	10	5	55	25
To provide preventative and promotive services that addresses the health needs of school-going children.	% of Districts with fully functioning school health services (grade R/1)	-	-	-	30%	60%	80%	100%
Increase immunisation coverage fore children <1 year of age to 90%	90% full immunisation coverage < 1 year	91.3 %	109.8%	126.3%	90%	92%	92%	92%
To reduce the morbidity and mortality associated with cervical cancer	Percentage of women who had cervical screening done	No data available	2.6%	3.4%	8%	12%	14%	20%
To utilize all level 2 hospitals to offer TOP services by December 2005	Percentage Level2 hospitals offering TOP services	100%	100%	100%	100%	100%	100%	100%
To increase the designated TOP CHCs to 50% by March 2006	Percentage of CHCs offering TOP services	0%	3.4%	3.4%	15%	50%	75%	100%

8.5 INTEGRATED NUTRITION PROGRAMME

8.5.1 SITUATION ANALYSIS

The Integrated Nutrition Programme(INP) in the Northern Cape Province is located within the Department of Health. The Department is responsible for health services in 5 districts.

8.5.2 EPIDEMILOGY

INDICATOR	PROVINCIAL STATUS
Infant Mortality Rate	41,8/1000
Child Mortality Rate	55,5/1000
Low Birth Weight	13%
Stunting (1-9 years)	29,6%
Wasting	9,6%
Severe Underweight	8,9%
Vitamin A Deficiency	18,5%
Iron Anemic	21,5%
Obesity – Adults Female	24,8%
Male	7,6%

Malnutrition is the manifestation of interrelated causes. The above nutrition situation is typical of a poverty stricken province that is mostly rural. The high prevalence of HIV/AIDS in the province has a dramatic effect on the nutritional status of the infected individual and the population.

8.5.3 DISEASE SPECIFIC NUTRITION SUPPORT, TREATMENT AND COUNSELLING

The Food Supplementation scheme is operational at all clinics in the province. It is a nutrition intervention programme targeted at clients who attend health facilities and are found to be malnourished or at risk of becoming malnourished. These clients are then supplemented with specialised products, which include enriched cereal and a breast milk substitute. A protocol was developed for the assessment and treatment of HIV/AIDS and TB patients.

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8.5.4 GROWTH MONITORING AND PROMOTION

Regular growth monitoring and promotion is emphasized at all PHC facilities. Health workers are trained every year at district level to improve the reliability of the data that are collected. Scales and studiometres were bought for districts to improve the accuracy of the data.

8.5.5 NUTRITION PROMOTION, EDUCATION AND ADVOCACY

Nutrition counselling are given according to the National Food Based Dietary Guidelines at the Primary Health Care Facilities where nutrition advisors/ nutritionists are situated. Healthy lifestyles are promoted to all clients. Posters and pamphlets were printed on several topics.

8.5.6 MICRONUTRIENT MALNUTRITION CONTROL

High dose Vitamin A supplementation forms part of the Nutrition Intervention Policy guidelines that is revised yearly. Since October 2003 all bread flour and maize meal are fortified with vitamins and minerals according to regulations

8.5.7 FOOD SERVICE MANAGEMENT

Food service workers have been trained on the implementation of the Food Service Manangement Policy

8.5.8 PROMOTION, PROTECTION AND SUPPORT OF BREASTFEEDING

Statistics for breastfeeding rates, especially exclusive breastfeeding for the first six months of life are not available, although indications are that it is low. The transmission of HIV through breast milk does not promote the situation. Nutrition forms a strong link with the PMTCT activities to ensure proper infant and child feeding practices.

The Baby Friendly Hospital Initiative (BFHI) was launched to encourage hospitals, health care facilities, particularly maternity wards to adopt practices that fully protect, promote and support exclusive breastfeeding form birth. Eight hospitals in the province are Baby Friendly.

8.5.9 HOUSEHOLD FOOD SECURITY

To address household food security an intersectoral approach is followed. Departments of Agriculture, Social Services and Population Development and Education integrate to ensure maximum benefit for the communities. This platform is also used to coordinate the Integrated Food Security and Nutrition Programme that was developed by the Social Cluster Departments.

Department of Education took over the PSNP from April 2004.

8.5.10 HEALTH CHALLENGES

- Food security at household level
- Mother to Child Transmission of HIV through breast milk
- Promotion of healthy lifestyles

8.6 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

8.6.1 POLICIES

The Integrated Nutrition Programme (INP) in the province will be based on:

- The National INP Strategic Framework and will be implemented within the Strategic Framework of the Provincial Department of Health
- Policy Guidelines for nutrition interventions at Health Facilities
- Provincial Food Service Policy

The following acts and regulations are applicable to the Integrated Nutrition Programme:

- Health Act, 1977
- Foodstuffs, Cosmetics and Disinfectants Act, 1972
- Health Professionals Act, 1974
- Regulations:
  - Fortification of certain foodstuffs
  - Salt Regulations
  - HACCP System
  - Tolerances for fungus-produced toxins in foodstuffs
  - General hygiene requirements for food premises and transport of food
  - Constitution of Professional Board for Dietetics
- Notice:

- List of approved facilities for the purposes of performing community service by dieticians in the year 2004

8.6.2 PRIORITIES

Given the nutritional situation in the province, the following priority areas were identified:

- Baby Friendly Hospital Initiative
- Nutrition Interventions at Health Facilities
- Food Service Management

8.6.3 BROAD STRATEGIC OBJECTIVES

- To contribute to the reduction in the prevalence of Low Birth weight from 22% to 20%
- To contribute to the reduction of malnutrition in children < 5 years specifically:
- Severe malnutrition from 1,1 % to 0,8% and Growth faltering from 4,5% to 4 %
- To ensure that clients of at least 60% of public institutions receive meals that are acceptable and adequate in quality and quantity

FOCUS AREA	GOAL	OBJECTIVE
DISEASE SPECIFIC NUTRITION SUPPORT AND COUNSELLING	Contribute to the prevention and reduction of morbidity and mortality rates due to malnutrition, nutrition-related diseases of lifestyle, communicable and infectious diseases and debilitating conditions	To contribute to the reduction in the prevalence of Low Birth Weight from 22% to 20% Underweight among pregnant and lactating women To contribute to the reduction of malnutrition in children under 5 years of aged, specifically of: Severe underweight from 1,1 % to 0,8 % To contribute to the reduction of morbidity and mortality associated with communicable and infectious diseases specifaically HIV/AIDS and tuberculosis
GROWTH MONITORING AND PROMOTION	Contribute to optimal growht of infants and young children	To prevent and reduce growth faltering among children 0-60 months of age through regular growth monitoring and promotion To ensure that all new born babies are provided with a Road to Health chart
NUTRITION PROMOTION, EDUCATION AND ADVOCACY	Improved nutritional knowledge, behaviour, perceptions and attitudes of the population	To improve nutrition related knowledge, practices, perceptions and attitudes
MICRONUTRIENT MALNUTRITION CONTROL	Elimination of micronutrient deficientcies among the population, focusing on vulnerable populations or groups	To prevent, reduce and control micronutirent deficiencies
FOOD SERVICE MANAGEMENT	Contribution to institutional care of clients through food service systems for the provision of blanced nutrition	To enssure that clients of at least 60% of institutions receive meals that are acceptable and adequate in quality and quantity
PROMOTION, PROTECTION AND SUPPORT OF BREASTFEEDING	Contribute to child survival and maternal health	To increase the porportion of mothers who breastfeed their babies exclusively for six months To increase the proportion of mothers who continue to breastfeed their babies with appropriate complementary foods up to 24 months of age and beyond

		To ensure that 40% of health facilities with maternity beds are babyfriendly
CONTRIBUTION TO HOUSEHOLD FOOD SECURITY	Contribute to the improvement of household food security	To ensure that other sectors dealing with household food security receive adequate technical support and advice on nutrition

8.6.4 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

8.6.4.1 HUMAN RESOURCES

Recruitment of permanent dieticians in the province is a challenge. Dieticians were also identified as a scarce skill. Community Service Dieticians were appointed in all districts.

8.6.4.2 INFORMATION

A new management structure has been approved for the districts. Each District is to appoint Information Management Officers and they will play an important role in data capturing and coordination thereof.

8.6.5 PLANNED QUALITY IMPROVEMENT MEASURES

8.6.5.1 TRAINING

All Primary Health Care Staff will be trained on the implementation of Nutrition related policies. Food Service Workers will be trained on the implementation of the Food Service Management Policy

8.6.5.2 CUSTOMER SATISFACTION

With the support of the Quality Assurance Unit a questionnairre will be developed to measure customer's satisfaction.

8.6.5.3 MONITORING AND SUPERVISION

Customer's progress on the PEM scheme and Vit A supplement will be monitored continuously.

Indicator	Type	03/04	04/05	05/06	06/07	07/08	National target 07/08
Incidence of severe malnutrition under 5 years	%	1,5%	1,1%	0,8 %	0,5%	0%	
Vitamin A coverage under 1 year	%	30%	50%	60%	70%	80%	80%
Facilities certified as baby friendly	%	20%	35%	40%	60%	70%	30%
Not gaining weight under 5 years	%	5%	4,5%	4%	3,5%	3%	

8.7 BUDGET & EXPENDITURE TRENDS PROGRAMME 2: DISTRICT HEALTH SERVICES

Table 25: Summary of expenditure and estimates: Programme 2 - District health services

R'000	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Sub-programmes							
District management	14,076	13,494	13,979	13,452	17,156	18,457	19,655
Community health clinic services	51,233	47,723	57,040	61,794	91,631	99,197	105,602
Community health centres	26,409	28,293	39,577	43,034	66,481	71,065	75,015
Community based services	-	1,080	1,628	1,600	1,900	2,000	2,100
Other community services	20,850	19,557	22,316	18,855	22,582	24,186	25,647
HIV/AIDS	297	1,967	11,255	31,881	48,050	68,603	72,033
Nutrition	9,228	10,978	18,580	3,845	5,281	5,508	5,917
Coroner services	645	612	793	994	1,843	1,991	2,113
District hospitals	128,658	142,638	162,674	168,366	167,757	181,792	192,478
Programme Total	**251,396**	**266,343**	**327,842**	**343,821**	**422,681**	**472,799**	**500,560**

Table 26: Summary of economic classification: Programme 2 - District health services

R'000	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Current Expenditure							
Compensation of employees	164,602	179,360	204,772	222,040	258,035	272,678	284,776
Goods and services	68,477	67,031	95,485	96,068	138,277	171,381	185,707
Transfers and subsidies	17,329	17,606	26,943	16,660	17,520	18,940	19,577
Total: Current	**250,408**	**263,997**	**327,199**	**334,768**	**413,832**	**462,999**	**490,060**
Capital Expenditure							
Payments for capital assets	988	2,346	643	9,053	8,849	9,800	10,500
Total: Capital	**988**	**2,346**	**643**	**9,053**	**8,849**	**9,800**	**10,500**
Total economic classification	**251,396**	**266,343**	**327,842**	**343,821**	**422,681**	**472,799**	**500,560**

Table 27: Trends in provincial public health expenditure for Programme 2: District health services

	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Current Prices							
Total	251,396,325	266,342,739	327,841,544	343,821,000	-	-	-
Total per person	306	324	398	418	-	-	-
Total per uninsured person	382	405	498	522	-	-	-
Total capital	988,432	2,345,570	642,591	9,053,000	-	-	-
Constant (2004/05) prices							
Total	306,200,724	295,374,098	344,889,305	343,821,000	422,681,000	472,799,000	500,560,000
Total per person	372	359	419	418	514	575	608
Total per uninsured person	465	449	524	522	642	718	761
Total capital	1,203,910	2,601,237	676,006	9,053,000	8,849,000	9,800,000	10,500,000

9 PROGRAMME 3: EMERGENCY MEDICAL SERVICES

9.1 SITUATIONAL ANALYSIS

9.1.1 DEMOGRAPHICS

The Northern Cape is a province renowned for its large area (it is the largest province having 29.7 % of the total land area of South Africa).

It has a very low population density (only 2.3 people per km2, whilst the average for South Africa is 34.4) and a high urban percentage (70.1%). The population size is only 822 728. The population is distributed in relatively small concentrations with towns situated great distances from each other. Some towns in Namakwa and Kgalagadi and Siyanda districts are linked only by gravel roads.

This geographic reality presets an enormous challenge to efficient emergency medical services (EMS).

9.1.2 FINANCES

- No patient fee structure in place
- EMS budget still managed by district managers

9.1.3 HUMAN RESOURCES

- 363 emergency medical services personnel
- With the transition from the local authorities to the Department of Health, emergency care practitioners were appointed on salary levels equivalent to those in the local authority. This has resulted in staff being appointed on salary levels inappropriate to functions being performed.
- Inadequate job descriptions provided.
- Job evaluations incomplete
- 99 new Emergency Care Practitioners appointed – basic ambulance assistants

District	Personnel				Drivers Licence			Qualifications			Gender	
	Black	Coloured	White	Asian	Code 08	Code 10/11	Code 13/14	BAA	ANA	PARA	Male	Female
Namaqua	0	42	4	0	28	8	10	38	6	0	40	6
Frances Baard	94	45	10	2	54	85	5	118	26	1	105	47
Kgalagadi	21	4	2	0	13	9	5	24	3	0	17	10
Karoo	21	46	9	1	64	12	1	69	5	0	75	3
Siyanda	19	31	10	0	41	8	12	42	16	0	54	6
Total	**155**	**168**	**35**	**3**	**200**	**122**	**33**	**291**	**56**	**1**	**291**	**72**

9.1.4 MANAGEMENT

- Inadequate management structure
- Appointment of deputy director Emergency Medical Services
- EMS still under management of district managers
- Total amount of ECP's still needed to accommodate the Two men Crew system
- ECP's – 268

9.1.5 INFORMATION MANAGEMENT

- Poor information capturing in districts making decision making processes difficult.
- Need for uniformity of district data capturing forms
- Inadequate computer systems in place in districts.

9.1.6 POLICIES

- National EMS policies in draft form
- No provincial policies and protocols in place

9.1.7 TRAINING

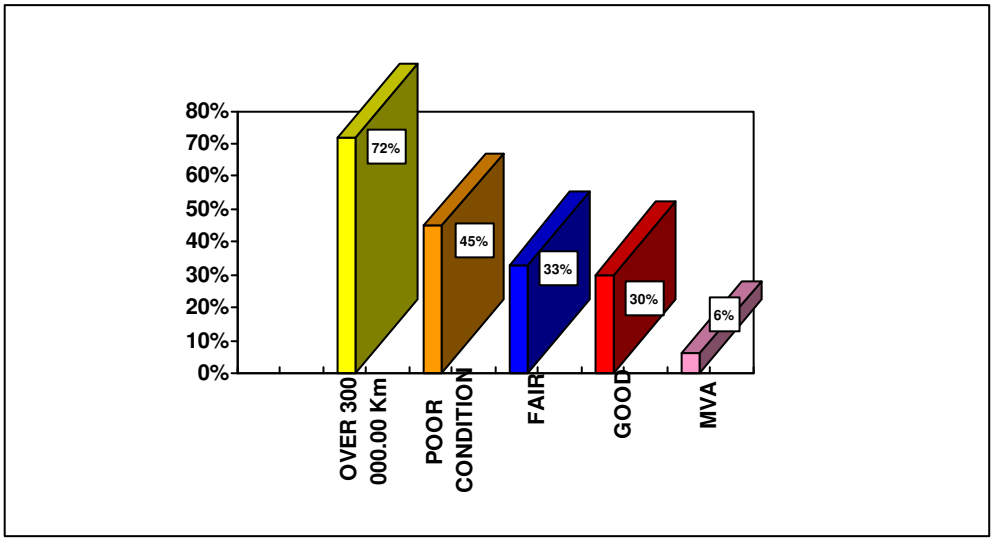
- No in-service training
- No emergency care training according to basic and intermediate level – administrative or operational

9.1.8 FLEET MANAGEMENT

PATIENT TRANSPORT VEHICLES	
DISTRICT	NO. OF VEHICLES
SIYANDA	1
KGALAGADI	0
NAMAKWA	4
FRANCIS BAARD	4
KAROO	6

- Total patient transport vehicles: 15
- All over 300 000 km
- Patient Transport Vehicles (PTV) needs
  - PTV Kombi's: 19
  - PTV Drivers: 21

- Total ambulances: 107
- 30 new ambulances purchased bringing total of ambulances to 137



9.1.9 INFRASTRUCTURE:

- Only Frances Baard and Siyanda Districts have their own control rooms functioning under EMS.
- Other districts operate from the District Municipality Disaster Management Units.
- There is an urgent need for each district EMS to have its own control room in order to co-ordinate emergency care effectively.
- Inadequate ambulance bays and washing facilities for vehicles. This will also facilitate the monitoring of ambulances and personnel movement.
- Inadequate security for vehicles

9.1.9.1 COMMUNICATIONS:

- Poor communication network in place.
- Majority of vehicles have non-operational radios

Table 28: Situation analysis indicators for emergency medical services and patient transport

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	Frances Baard 03/04	Siyanda 03/04	Karoo 03/04	Namakwa 03/04	Kgalagadi 03/04	National target 03/04
Input										
1. Ambulances per 1000 people	No			0.13	0.056	0.10	0.24	0.21	0.16	0.2
2. Hospitals with patient transporters	%			100						70
Process										
3. Kilometres travelled per ambulance (per annum)	Kms			343753						
4. Locally based staff with training in BLS	%			79.1	68.4	78.6	91.5	87.5	84.6	59
5. Locally based staff with training in ILS	%			20.5	30.3	20.3	8.5	12.5	15.4	29
6. Locally based staff with training in ALS	%			0.42	1.3	0	0	0	0	15
Quality										
7. Response times within national urban target (15 mins)	%				40	55				50
8. Response times within national rural target (40 mins)	%				40	65				50
9. Call outs serviced by a single person crew	%				60	84				1.8
Efficiency										
10. Ambulance journeys used for hospital transfers	%					2.4				30
11. Ambulances with less than 500000 km on the clock	%			70.1	12.1	15.0	20.6	82.6	83.3	50
Output										
12. Patients transported (by PTS) per 1,000 separations	No				44.6	2				10

9.2 POLICIES, PRIORITIES AND STRATEGIC GOALS:

9.2.1 STRATEGIC PRIORITIES

- Two crew system – appointment of 268 new Emergency Care Practitioner
- Vehicle purchasing – 55 ambulances per year
- Patient Transport vehicles – 19 new vehicles needed
- Fleet management system
- Communications – radiocommunications
- District control rooms
- Management organogram/ provincialisation/
- Training
- Information management Tools and computer systems in place
- Hospital emergency preparedness and response

9.2.2 FINANCES:

- Functional fee structure in place
- Provincialisation of EMS budget

9.2.3 HUMAN RESOURCES

- Staff recruitment
- Ensure equity in staff establishment
- Job evaluations and descriptions
- Establish well defined management and staff structures

9.2.4 INFORMATION MANAGEMENT:

- Evaluation of information capturing tools
- Implement new paper based data capturing forms
- Purchase necessary computer equipment
- Training in information technology and District Health Information System

9.2.5 POLICIES:

- Develop new operational policies and protocols.

9.2.6 FLEET MANAGEMENT:

9.2.6.1 EMERGENCY VEHICLES

- Purchase 55 new ambulances per year over the next three years to reach national targets per population size then can start decommissioning older vehicles
- Develop vehicle replacement policy

9.2.6.2 PLANNED PATIENT TRANSPORT

- Separation of Emergency Medical Services from Planned Patient Transport – purchase sufficient patient transport vehicles and employ adequate drivers.
- Planned patient transport policy in line with referral pathways - a policy is needed regarding the referral of patients from the various districts to Kimberley Hospital via EMS. This policy should include aspects such as good communication with the referral centre to ensure sufficient available beds as well as to enable preparation for the emergency care of the patient to be made.

9.2.7 TRAINING:

- To establish an emergency care training academy for the Northern Cape by July 2005
- To uplift the standards of the Northern Cape Emergency, Medical and Rescue services.
- Train 90 basic ambulance assistant Emergency care practitioners (ECP's) to the level of Ambulance Emergency Assistant by July 2006
- Train 90 ECP's in tertiary rescue short courses by July 2006
- Implement National Diploma of Emergency Care by July 2006
- To train the community in first aid

9.2.8 INFRASTRUCTURE:

- Incorporate EMS into accident and emergency units, with creation of undercover parking and wash bays
- Creation of district satellite service points
- Optimize emergency equipment

9.2.9 COMMUNICATIONS:

- Establish district control centres by January 2006
- Operational radio communications network by January 2006

9.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM:

- Insufficient adequately qualified emergency care practitioners in province to provide two crew system – establish training academy in province
- Insufficient number of paramedics in province – establish training academy in province
- Insufficient finances for adequate management organogram

9.4 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 29: Provincial objectives and performance indicators for EMS and patient transport

Objective	Indicator	2001/02 (actual)	2002/03 (actual)	2003/04 (estimate)	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)
Implement Two crew system	100% two crew system	-	-	40%	56%	71%	86%	100%
Response times within norms and standards	Total number of vehicles	-	-	128	161	246	311	371
	Vehicles less than 300 000km	-	-	57	64	119	184	244

Table 30: Performance indicators for the EMS and patient transport

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/08
Input							
Ambulances per 1000 people	No	0.13	0.16	0.23	0.3	0.3	0.3
Hospitals with patient transporters	%	60	44	80	100	100	100
Process							
Kilometres travelled per ambulance (per annum)	Kms	343753	340000	320000	200000	100000	
Locally based staff with training in BLS	%	79.1	83.7	66.2	54.5	46.2	
Locally based staff with training in ILS	%	20.5	16	33.1	45.5	53.8	
Locally based staff with training in ALS	%	0.42	0.29	0.66	0.9	1.1	
Quality							
Response times within national urban target (15 mins)	%			50	75	100	100
Response times within national rural target (40 mins)	%			50	75	100	100
Call outs serviced by a single person crew	%		68	25	0	0	0
Efficiency							
Ambulance journeys used for hospital transfers	%			0	0	0	0
Green code patients transported by ambulance	%			10	10	10	
Cost per patient transported by ambulance	R						
Ambulances with less than 500,000 kms on the clock	%		70.1	100	100	100	100
Output							
Patients transported (by PTS) per 1,000 separations	No					50	50

9.5 BUDGET & EXPENDITURE TRENDS PROGRAMME 3: EMERGENCY MEDICAL SERVICES

Table 31: Summary of expenditure and estimates: Programme 3 - Emergency medical services

R'000	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Sub-programmes							
Emergency transport	37,643	37,239	39,187	54,919	66,136	66,727	71,483
Planned patient transport	-	-	-	569	-	2,000	-
Programme Total	**37,643**	**37,239**	**39,187**	**55,488**	**66,136**	**68,727**	**71,483**

Table 32: Summary of economic classification: Programme 3 - Emergency medical services

R'000	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Current Expenditure							
Compensation of employees	14,749	18,262	21,879	26,880	31,651	33,136	34,628
Goods and services	11,572	13,347	16,719	17,158	22,380	25,471	27,725
Transfers and subsidies	580	90	340	450	105	120	130
Total: Current	**26,901**	**31,698**	**38,937**	**44,488**	**54,136**	**58,727**	**62,483**
Capital Expenditure							
Payments for capital assets	10,742	5,541	250	11,000	12,000	10,000	9,000
Total: Capital	**10,742**	**5,541**	**250**	**11,000**	**12,000**	**10,000**	**9,000**
Total economic classification	**37,643**	**37,239**	**39,187**	**55,488**	**66,136**	**68,727**	**71,483**

Table 33: Trends in provincial public health expenditure for Programme 3: Emergency medical services

	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Current Prices							
Total	37,642,958	37,239,351	39,187,352	55,488,000	-	-	-
Total per person	46	45	48	67	-	-	-
Total per uninsured person	57	57	60	84	-	-	-
Total capital	10,741,623	5,541,171	250,073	11,000,000	-	-	-
Constant (2004/05) prices							
Total	45,849,123	41,298,440	41,225,094	55,488,000	66,136,000	68,727,000	71,483,000
Total per person	56	50	50	67	80	84	87
Total per uninsured person	70	63	63	84	100	104	109
Total capital	13,083	6,145	263	11,000	12,000	10,000	9,000

10 PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES

Objective	Indicator	2001/02 (actual)	2002/03 (actual)	2003/04 (estimate)	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)
Provide additional support for family health services	Provide additional support for family health services in place						100%	
	Designated facility for clinical, academic and administrative purposes in place					100%		
	Referral pathways established					100%		
	Referral pathways established					100%		
Reduce inappropriate surgical referrals	protocols develop and disseminated for elective referral				100%			
	Develop and disseminate elective referral protocols					100%		
Increase surgical capacity with more day case operating	Identify dedicated day theatre capacity (incl. staff) and recovery beds				100%			
	Identify procedures to be undertaken as day case				100%			
	Open additional theatre capacity				100%			
Improve women and family centered health promotion	No. of women receiving breast-feeding advice within 8 hours of delivery, as a % of all births. b. No. of mothers who are breast-feeding 2 months after giving birth, as a % of all births.						100%	
Provide prevention of mother to child transmission (PMTCT) service to all HIV+ve mothers	No. of HIV+ve mothers receiving advice and counseling in PMTCT as % of HIV+ve mothers.						100%	
Improve women and family centered health promotion	a. Teenage Pregnancy Rate b. No. of TOPs performed, all. c. No. of TOPs performed, under 16 years. d. Pregnancy rate in women over 35.						100%	
Develop an integrated maternity	No. of outreach visits per month in					100%		

Objective	Indicator	2001/02 (actual)	2002/03 (actual)	2003/04 (estimate)	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)
service	each District.							
	Percentage of mothers in KHC practicing Kangaroo Mother Care.					100%		
	Percentage of mothers in each maternity unit practicing Kangaroo Mother Care					100%		
	No. of mothers attending referred to a high-risk clinic as a % of all antenatal attendances					100%		
	a. No. of patients in ICU who could be in maternity high care beds. b. No. of patients on maternity wards who should be in high care beds c. Bed occupancy (No. of patients in high care beds as a % of total high care beds)							
Relieve pressure on ICU by establishing High Care beds	protocols for transfer to and from High Care beds in place.					100%		
Objective 8: Increase inpatient capacity through effective bed management	No. of elective procedures per month. No. of patients awaiting elective procedures. Average length of time patients wait for elective procedures. No. of patients waiting longer than 6 months for an elective procedure. e. No. of operations cancelled per month due to management problems					100%		
Discharge Activation Protocol created and agreed to by clinical HoDs and primary	a. Average No. of days the patient remains in hospital after discharge. b. No. of primary care facilities where a discharge protocol (and re-admission protocol) has been negotiated as a percentage of primary care facilities served by KHC							

10.1 BUDGET & EXPENDITURE TRENDS PROGRAMME 4: PROVICIAL HOSPITAL SERVICES

Table 34: Summary of expenditure and estimates: Programme 4 - Provincial hospital services

R'000	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Sub-programmes							
General hospitals	157,446	212,579	244,743	234,929	261,958	279,783	297,714
TB hospitals	7,288	7,637	6,545	7,214	8,597	9,197	9,716
Psychiatric/Mental hospitals	7,857	8,513	10,338	11,571	10,778	11,375	11,932
Programme Total	**172,591**	**228,729**	**261,626**	**253,714**	**281,333**	**300,355**	**319,362**

Table 35: Summary of economic classification: Programme 4 - Provincial hospital services

R'000	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Current Expenditure							
Compensation of employees	121,291	140,375	164,523	184,533	199,061	208,031	217,048
Goods and services	46,823	87,150	88,301	65,240	76,634	88,098	97,524
Transfers and subsidies	386	449	609	750	638	726	790
Total: Current	**168,500**	**227,974**	**253,433**	**250,523**	**276,333**	**296,855**	**315,362**
Capital Expenditure							
Payments for capital assets	4,091	755	8,194	3,191	5,000	3,500	4,000
Total: Capital	**4,091**	**755**	**8,194**	**3,191**	**5,000**	**3,500**	**4,000**
Total economic classification	**172,591**	**228,729**	**261,626**	**253,714**	**281,333**	**300,355**	**319,362**

Table 36: Trends in provincial public health expenditure for Programme 4: Provincial hospital services

	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Current Prices							
Total	172,590,996	228,728,898	261,626,326	253,714,000	-	-	-
Total per person	210	278	318	308	-	-	-
Total per uninsured person	262	348	397	385	-	-	-
Total capital	4,091,202	754,877	8,193,818	3,191,000	-	-	-
Constant (2004/05) prices							
Total	210,215,833	253,660,348	275,230,895	253,714,000	281,333,000	300,355,000	319,362,000
Total per person	256	308	335	308	342	365	388
Total per uninsured person	319	385	418	385	427	456	485
Total capital	4,983,084	837,158	8,619,897	3,191,000	5,000,000	3,500,000	4,000,000

11 PROGRAMME 5: HEALTH SCIENCES AND TRAINING

11.1 HENDRIETTA STOCKDALE NURSING COLLEGE

11.1.1 INTRODUCTION

The Nursing College, the only one is the Northern Cape is the training institution for health workers mainly nurses of all races in the whole province.

11.1.2 SITUATION ANALYSIS

The capacity and intake of Henrietta Stockdale Nursing College in the Institute of Higher Education has been increased. There is an intake of 300 Four-year Nursing Course students in the new academic year. A further 600 are currently on a Nursing Auxiliary learnership.

11.1.3 STUDENT NURSES CONTRACTS

To ensure service to the communities in remote areas in the province, student who will be completing their studies are expected to sign a contract and serve the department for at least two years after completion of training.

University of the Free State will ensure and monitor training standards for the 4 year comprehensive course.

The College Senate and Council, being the highest academic and administrative bodies respectively, monitor and controls academic and administrative issues within the institution.

The South African Nursing Council, which is the statutory body for nurse training, accredits the College and associated hospitals and clinical areas where nurses are trained. It monitors and controls training standards, sets and grants examination papers, certificates and qualifications for the following courses – Bridging, Auxiliary Nursing, Midwifery, Diplomas in Clinical Nursing Science, Health Assessment, Treatment and Care and Community Health Nursing

The following programmes are offered at the college:

- Diploma in General Nursing Science (Psychiatry, Community and Midwifery)
- Diploma in Midwifery
- Diploma in Community Health Science 18/12
- Diploma in General Nursing (Bridging Course)
- Diploma in Clinical Nursing Science, Health Assessment, Treatment and Care
- Certificate in Primary Clinical Care
- Certificate - short course in Forensic Nursing
- Depam (Advanced Midwifery) (co-ordinated by the College) at MCHW
- Certificate in Pupil Auxiliary Nursing

Table 37: Provincial objectives and performance indicators for Health Sciences and Training

Objective	Indicator	Main Category	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)
Improve representation of disadvantaged groups and students of rural origin	Number (and % change) intake of students by main categories (at least medical courses, and mid level worker training	4 Year students	141	183	221	300	300	
		Enrolled Nurses (Bridging Course)	136	130	72	40	40	
		Nursing Auxiliaries	100	513	600	50	50	
		Midwifery	30	35	35	40	40	
		Post Basic Community	5	30	5	20	20	
		Primary Clinical Care	22	40	7	30	30	
		Forensic Nursing	19	25	-	25	25	
		IMCI	17	20	61	37	600	
	Promotion of mid level training programmes accredited		6	8	10	12		
		Students	23	18	21	100	50	
		Enrolled Nurses (Bridging Course)	26	153	62	140	140	
		Nursing Auxiliaries	100	120	619	600		
		Community	28	5	5	20	20	
		Primary Clinical Care	63	19	-	25	25	
		IMCI	18	17	61	37	600	
To reduce attrition rate per course per year for formal training by main category	Attrition rate per year for formal training courses by main category of course	Student Nurses	0,84%	0	0	0		
		Enrolled Nurses Bridging Course	15%	0	0	0		
		Nursing Auxiliaries	3%	0	0	0		
		Community Post Basic	None	0	0	0		
		Primary Clinical Care	9%	0	0	0		
		Forensic	None					
	I	IMCI	None					
To ensure capacity building for health managers	Percentage of managers trained per year per main category in various fields		None					
Ensure quality training	Percentage of 1st year entrants who	Student Nurses	88%	100%	97%	100%	100%	

Objective	Indicator	Main Category	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)
programmes	graduated from formal training courses by main category							
		Enrolled Nurses (Bridging Course)	77%	68%	71%	100%		
		Nursing Auxiliaries	40%	62%	100%	100%		
		Post Basic Community	40%	56%	100%	100%		
		Primary Clinical Care	100%	100%	100%	100%		
		Forensic Nursing	100%	100%	100%	100%		
		IMCI	100%	100%	100%	100%		

11.2 BUDGET & EXPENDITURE TRENDS PROGRAMME 5: HEALTH SCIENCES

Table 38: Summary of expenditure and estimates: Programme 5 - Health sciences

R'000	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Sub-programmes							
Nursing training college	6,586	8,018	9,928	11,518	16,222	16,959	17,808
Other training	-	-	1,181	8,052	10,017	3,830	4,060
Programme Total	**6,586**	**8,018**	**11,109**	**19,570**	**26,239**	**20,789**	**21,868**

Table 39: Summary of economic classification: Programme 5 - Health sciences

R'000	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Current Expenditure							
Compensation of employees	6,180	7,545	9,362	14,268	21,590	15,920	16,681
Goods and services	379	434	1,715	3,616	4,434	4,802	5,118
Transfers and subsidies	20	24	32	651	15	17	19
Total: Current	**6,578**	**8,003**	**11,109**	**18,535**	**26,039**	**20,739**	**21,818**
Capital Expenditure							
Payments for capital assets	8	15	-	1,035	200	50	50
Total: Capital	**8**	**15**	**-**	**1,035**	**200**	**50**	**50**
Total economic classification	**6,586**	**8,018**	**11,109**	**19,570**	**26,239**	**20,789**	**21,868**

Table 40: Trends in provincial public health expenditure for Programme 5: Health sciences

	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Current Prices							
Total	6,586,140	8,017,954	11,108,895	19,570,000	-	-	-
Total per person	8	10	14	24	-	-	-
Total per uninsured person	10	12	17	30	-	-	-
Total capital	7,795	15,000	-	1,035,000	-	-	-
Constant (2004/05) prices							
Total	8,021,918	8,891,911	11,686,558	19,570,000	26,239,000	20,789,000	21,868,000
Total per person	10	11	14	24	32	25	27
Total per uninsured person	12	14	18	30	40	32	33
Total capital	9,494	16,635	-	1,035,000	200,000	50,000	50,000

12 PROGRAMME 6: HEALTH CARE SUPPORT SERVICES

12.1 FORENSIC SERVICES

12.1.1 INTRODUCTION

The forensic medico-legal services are divided into pathology and clinical medicine components, the pathology services referring to medico-legal autopsies and the clinical section referring to the examination of live cases for the purpose of presentation of evidence in a court of law.

12.1.2 SITUATION ANALYSIS

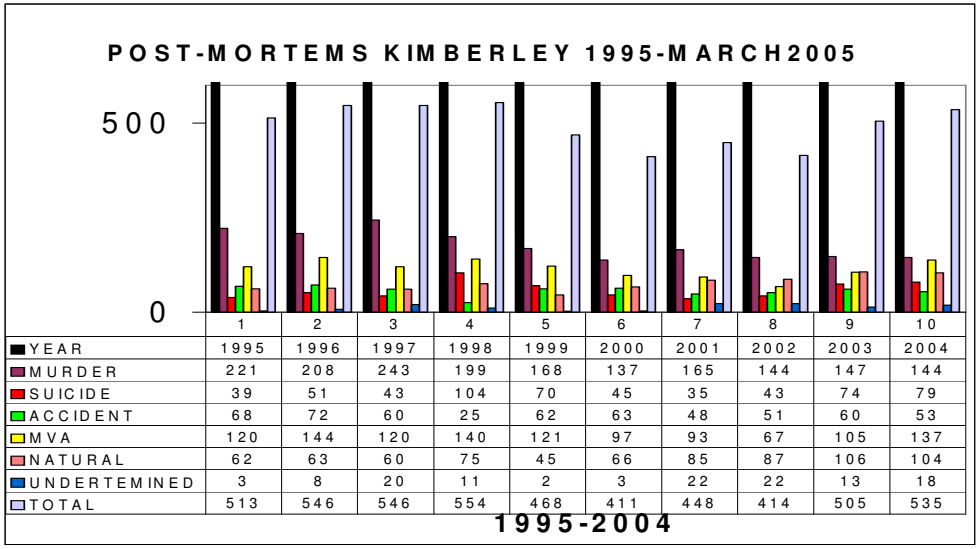
Population:	822727 (Census 2001)
Total Autopsies:	1305
Total Clinical cases:	257
Total number of trained forensic nurses:	12
Total number of doctors: full-time:	only one
Part-time:	7

12.1.3 PATHOLOGY SERVICES

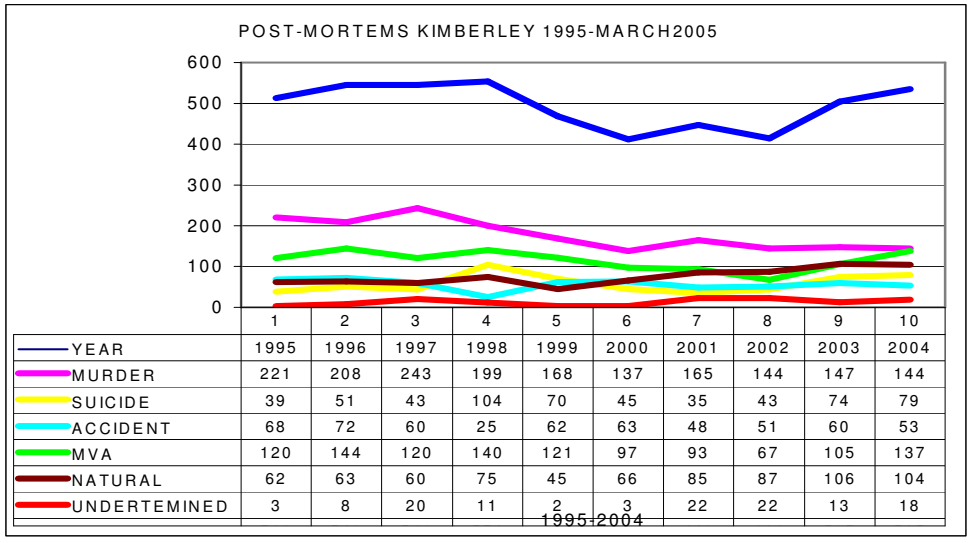
POST-MORTEM STATISTICS

Table 41: Total post-mortems in the Kimberley April 1995 – March 2005

YEAR	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Murder	221	208	243	199	168	137	165	144	147	144
Suicide	39	51	43	104	70	45	35	43	74	79
Accident	68	72	60	25	62	63	48	51	60	53
MVA	120	144	120	140	121	97	93	67	105	137
Natural	62	63	60	75	45	66	85	87	106	104
Undertemined	3	8	20	11	2	3	22	22	13	18
TOTAL	513	546	546	554	468	411	448	414	505	535



	1	2	3	4	5	6	7	8	9	10
YEAR	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
MURDER	221	208	243	199	168	137	165	144	147	144
SUICIDE	39	51	43	104	70	45	35	43	74	79
ACCIDENT	68	72	60	25	62	63	48	51	60	53
MVA	120	144	120	140	121	97	93	67	105	137
NATURAL	62	63	60	75	45	66	85	87	106	104
UNDERTEMINED	3	8	20	11	2	3	22	22	13	18
TOTAL	513	546	546	554	468	411	448	414	505	535



	1	2	3	4	5	6	7	8	9	10
YEAR	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
MURDER	221	208	243	199	168	137	165	144	147	144
SUICIDE	39	51	43	104	70	45	35	43	74	79
ACCIDENT	68	72	60	25	62	63	48	51	60	53
MVA	120	144	120	140	121	97	93	67	105	137
NATURAL	62	63	60	75	45	66	85	87	106	104
UNDERTEMINED	3	8	20	11	2	3	22	22	13	18

Table 42: Total post-mortems in Northern Cape Province April 2004-March 2005

Murders	352
Suicides	163
Accidents	437
Natural	316
Undetermined	37
TOTAL	130

Table 43: Post-mortems at other stations April 2004-March 2005

PLACE	MURDER	ACCIDENT	SUICIDE	UNDETERMINED	NATURAL	TOTAL
De Aar	35	28	12	14	14	103
Upington	120	201	45	20	178	564
Douglas	14	21	2	0	33	70
Barky West	15	24	7	0	4	50
Warrenton	6	4	5	0	0	15
Hopetown	15	8	24	0	2	49

12.1.4 TRANSFER OF MORTUARIES FORM SAPS TO HEALTH

There is currently a process underway to transfer the medico-legal autopsy services from the South African Police Services to the Department of Health. This is a countrywide process that started in 1994. There were several reasons for this transfer, including the fact that there was disquiet over the situation where the police were custodians of both corpses and evidence. Furthermore, the service was of a questionable standard then.

Germaine to the transfer was a process of nationally auditing all the forensic autopsy facilities with a view to upgrading them (and building new facilities where necessary throughout the country). The services would be rationalized and adequately trained personnel would be employed.

Currently, all relevant facilities in the Province have been audited by at first the department and, during 2004, by the provincial project team. Human resource plan has been drawn up and costed. An estimated 62 employees will be recruited over the next MTEF period to 2008. The total cost of the transfer process (Capital and recruitment) over the same period, is estimated to be R47, 18 million. (2005/06=R13, 51 million, 2006/07=R14, 86 million, 2007/08=R18, 81 million). Funding will be by way of conditional grant

NB

(i) Existing contracts between SAPS and private undertakers have been perused with a view to determining their viability and sustainability in the new system. Whether or not these will be retained depends upon the report and recommendations of public works consultants deployed nationwide.

The initial expected date of transfer was 01 April 2005. There have, however, been administrative delays at National and the national Project Manager will in due course make a presentation to National Budget Council. Thereafter the transfer can occur –expected to be in September 2005.

12.1.5 CLINICAL SERVICES

Clinical forensic services refer to live cases of sexual indecent assaults, domestic violence as well as drunken driving and assault common. Currently our database captures the sexual /indecent assaults and domestic violence cases from various points around the Province.

12.1.6 CLINICAL FORENSIC SERVICES APRIL 2004–MARCH 2005

SEXUAL OFFENCES

Male	22
Female	200
Total	**222**

0-5yrs	19	(F=16)(M=3)
6-10 yrs	26	(F=24)(M=2)
11-18 yrs	86	(F=80)(M=6)
19-25 yrs	34	(F=29)(M=5)
26-35 yrs	33	(F=28)(M=5)
36-45 yrs	19	(F=18)(M=1)
46-59yrs	5	(F=5)(M=0)

Total number of cases seen 222

All the males were reported as indecent assault and the females as rape (rape or indecent assault would be proved or disproved subsequently in court).

Domestic Violence

Domestic Violence Cases throughout the province: 3 159
Available statistics for April 2003-March2004 are:

Thutuzela Care Centre	40
Noupoort Hospital	0
Kgalagadi District	333
Siyanda District	2780
Central Karoo Hospital	6

Table 44: Forensic Services Provincial objectives and performance indicators for Forensic Services

OBJECTIVE	INDICATOR	2001/02 (Actual)	2002/03 (Actual)	2003/04 (Actual)	2004/05 (Est)	2005/06 (Target)	2006/07 (Target)	2007/08 (Target)	2006/07 (Target)	2007/08 (Target)
Transfer of medico-legal mortuaries from SAPS to Health	Transfer completed (April 05).	0%	0%	0%	100%	0	0%			
Participating in the integrated approach to combating violence against women and children	Number. of seminars to be conducted					1	5	5		
Ensure the prompt performance of forensic autopsies and accurate documentation of observations.	Total number of autopsies performed (KBY) (Stats on other stations to be added)	448	414	505	535					
Ensure that all clinical forensic personnel including sessional doctors) adequately trained	Number of medical practitioners trained					100%				
Establish a database of all forensic cases seen (clinical and pathology)	Numbers of reporting stations per month			3	3	7	8			
Engage in research contributing to crime prevention in the Province	Annual report					Draft				
Increasing the pool of trained forensic nurses	Number of trained forensic nurses and examining victims of sexual assault			3	3					
Ensure that all personnel engaged in morbid forensic services are adequately trained	Number of trained mortuary staff									

12.2 LAUNDRY SERVICES

Table 45: Provincial objectives and performance indicators for Laundry Services

Objective	Indicator	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)
Improve the laundry service By December 2005	Sluice at Kimberley Hospital to be upgraded	0	0	0	0	100%	-	-
Mini- boiler to be installed by December 2005	Mini- boiler to be available	0	0	0	0	100%	-	-

12.3 BUDGET & EXPENDITURE TRENDS PROGRAMME 6: HEALTH CARE SUPPORT SERVICES

Table 46: Summary of expenditure and estimates: Programme 6 - Health care support services

R'000	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Sub-programmes							
Laundries	2,315	2,759	2,323	2,699	2,809	2,984	3,140
Engineering	-	5,860	139	776	1,832	2,085	2,270
Orthotic and Prostetic Services	1,565	1,586	1,801	1,980	1,957	2,119	2,254
Medicine Trading Account	-	-	97,548	39,583	-	-	-
Forensic Services	-	-	-	69	-	-	-
Programme Total	**3,881**	**10,204**	**101,812**	**45,107**	**6,598**	**7,188**	**7,664**

Table 47: Summary of economic classification: Programme 6 - Health care support services

R'000	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Current Expenditure							
Compensation of employees	2,898	2,840	3,193	3,654	3,492	3,653	3,816
Goods and services	973	5,083	98,609	41,438	3,100	3,528	3,841
Transfers and subsidies	9	5	10	15	6	7	7
Total: Current	**3,881**	**7,928**	**101,812**	**45,107**	**6,598**	**7,188**	**7,664**
Capital Expenditure							
Payments for capital assets	-	2,276	-	-	-	-	-
Total: Capital	**-**	**2,276**	**-**	**-**	**-**	**-**	**-**
Total economic classification	**3,881**	**10,204**	**101,812**	**45,107**	**6,598**	**7,188**	**7,664**

Table 48: Trends in provincial public health expenditure for Programme 6: Health care support services

	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Current Prices							
Total	3,880,795	10,204,403	101,811,803	45,107,000	-	-	-
Total per person	5	12	124	55	-	-	-
Total per uninsured person	6	16	155	69	-	-	-
Total capital	-	2,276	-	-	-	-	-
Constant (2004/05) prices							
Total	4,726,809	11,316,683	107,106,017	45,107,000	6,598,000	7,188,000	7,664,000
Total per person	6	14	130	55	8	9	9
Total per uninsured person	7	17	163	69	10	11	12
Total capital	-	2,524,297	-	-	-	-	-

13 PROGRAMME 7: HEALTH FACILITIES MANAGEMENT

13.1 INTRODUCTION

This programme includes:

- District health services, including Primary Health Care facilities, Community Health Centres and District Hospitals
- Provincial health services (Kimberley Hospital Complex)

13.2 CONFIGURATION OF SERVICES

As indicated above the programme deals with infrastructure provision at all levels of care within health. The capital funding for this programme is available through the following sources:

- Hospital Revitalization Grant
- Provincial Infrastructure Grant
- Equitable share
- Donor funding

This programme includes the following areas of operation:

- Preparation of business cases in order to secure funding for capital projects.
- Managing and monitoring the implementation of the clinic-building programme.
- All major and minor capital works and upgrading.
- Provision of specific infrastructure for installation of capital equipment.
- Co-ordinating the hospital revitalization programme in the province.

13.3 KEY CHALLENGES

- Lack of technical expertise in Department of Public Works, which act as procurement and implementing agent on behalf of the Department of Health.
- Delays in procurement process administered by Department of Public Works.
- Provision of accusable health care facilities in the province with vast distances and sparse population.

13.4 STRATEGIC OBJECTIVES

- Strengthen capacity at the facilities management unit.
- Establishing maintenance and projects office under one directorate.
- Refine the long-term capital infrastructure plan.

Project	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				Colesberg Level I Calvinia Level I		Barkley West Level I Mental Health Facility	De Aar Level I&II Upington Level I&II
New clinics / CHC's	Strydenburg clinic Matjieskloof clinic	Greenpoint clinic	Lowryville clinic Kuyasa clinic Holpan container clinic	Bankara container clinic Groenwater container clinic Pniel container clinic	Garies CHC Prieska clinic Recreation clinic Phutanang clinic Eurekaville clinic Kwazamuxolo clinic Petrusville clinic	Platfontein clinic Nonzwakazi clinic Douglas clinic Phillipstown clinic	Port Nolleth CHC
Upgraded hospitals	Kimberley				Springbok		
Upgraded clinics / CHC's							

13.5 BUDGET & EXPENDITURE TRENDS PROGRAMME 7: HEALTH FACILITIES MANAGEMENT

Table 49: Summary of expenditure and estimates: Programme 7 - Health facilities management

R'000	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Sub-programmes							
District health services	-	6,425	30,469	43,094	49,909	167,922	250,589
Provincial hospital services	16,763	18,123	2,903	65,174	34,735	64,935	6,935
Programme Total	**16,763**	**24,548**	**33,372**	**108,268**	**84,644**	**232,857**	**257,524**

Table 50: Summary of economic classification: Programme 7 - Health facilities management

R'000	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Current Expenditure							
Compensation of employees	-	-	-	-	-	-	-
Goods and services	1,206	1,800	733	5,884	6,628	6,628	6,628
Transfers and subsidies	-	-	-	-	-	-	-
Total: Current	**1,206**	**1,800**	**733**	**5,884**	**6,628**	**6,628**	**6,628**
Capital Expenditure							
Payments for capital assets	15,557	22,749	32,639	102,384	78,016	226,229	250,896
Total: Capital	**15,557**	**22,749**	**32,639**	**102,384**	**78,016**	**226,229**	**250,896**
Total economic classification	**16,763**	**24,548**	**33,372**	**108,268**	**84,644**	**232,857**	**257,524**

Table 51: Trends in provincial public health expenditure for Programme 7: Health facilities management

	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Estimate	2005-06 Projection	2006-07 Projection	2007-08 Projection
Current Prices							
Total	16,763,000	24,548,356	33,372,232	108,268,000	-	-	-
Total per person	20	30	41	132	-	-	-
Total per uninsured person	25	37	51	164	-	-	-
Total capital	15,557,351	22,748,726	32,639,422	102,384,000	-	-	-
Constant (2004/05) prices							
Total	20,417,333	27,224,127	35,107,588	108,268,000	84,644,000	232,857,000	257,524,000
Total per person	25	33	43	132	103	283	313
Total per uninsured person	31	41	53	164	129	354	391
Total capital	18,948,854	25,228,337	34,336,672	102,384,000	78,016,000	226,229,000	250,896,000