Department of Health
Western Cape

Metropole District Health Services

Cape Town
2003-2004

ANNUAL REPORT

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
APH	Associated Psychiatric Hospitals
CHBC	Community Home Based Care
CHC	Community Health Centre
CHSO	Community Health Services Organisation
CMD	Cape Medical Depot
COCT	City of Cape Town (LG)
DHIS	District Health Information System
DHP	District Health Plan
DHS	District Health Services
DOH	Department of Health
DOTS	Directly Observed Treatment Short-course
DPC	District Planning Committee
DPW	Department of Public Works
ERH	EersteRiver Hospital
FBH	False Bay Hospital
FTE	Full-time Equivalent
GSH	Groote Schuur Hospital
HAART	Highly Active Antiretroviral Therapy
HBC	Home Based Care
HIV	Human Immuno-deficiency Virus
ID	Intellectual Disability
IMLC	Institutional Management and Labour committee
IMCI	Integrated Management of Childhood Illnesses
INP	Integrated Nutrition programme
Km	kilometre
LG	Local Government (COCT)
MCWH	Maternal, Child and Women's health
MDHS	Metropole District Health Services
MDR	Multi-drug Resistant TB
MMH	Mowbray Maternity Hospital
MO	Medical Officer
MOU	Midwife Obstetric Unit
MTEF	Medium-term expenditure framework
NGO	Nongovernmental organisation
NPO	Non profit Organisation
PDE	Patient Day Equivalent
PFMA	Public Finance Management Act
PGWC	Provincial Government Western Cape
PHC	Primary Health Care
PMTCT	Prevention of mother-to-child transmission of HIV
PN	Professional Nurse
PPP	Public/Private Partnership
PSNP	Primary School Nutrition Programme
PSRG	Psycho-social Rehabilitation Groups
PTB	Pulmonary tuberculosis
RHC	Reproductive Health Clinic
SLA	Service Level Agreement
STI	Sexually transmitted infection
TB	Tuberculosis
TOP	Termination of pregnancy
UCT	University of Cape Town
US	University of Stellenbosch
UWC	University of the Western Cape
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Vision

Better care for better health, all day, every day.

Mission

Our mission is to improve the health of people in the Western Cape and beyond, by ensuring the provision of a balanced health care system, in partnership with stakeholders, within the context of optimal socio-economic development.

Values

We have adopted a set of core values that will guide us in achieving our vision and mission. These values are:

Trust

Integrity

Openness and transparency

Honesty

Respect

Commitment to high quality service

5/10/2004.

My husband Robbie Hurock who started the Day Hospital Organization was very proud of the idea of serving people in their own areas rather than having to travel to the big hospitals like Groote Schuur Hospital. In the beginning when people didn't really know what the idea was, the idea was not very popular, but in time the idea caught on, and the organization has grown in strength. Robbie would have been so proud of all that the organization has become.

J Hurock.

CONTENTS

Foreword

This report is the culmination of 12 months' work of all colleagues in the MDHS who have committed themselves to the challenges of providing an accessible and quality health service in the Cape Town Metropolitan area.

A visit to our Health facilities and service outlets across the Metropole from coast to coast, Cape Point to Atlantis, brings one in contact with these dedicated colleagues who work day and night caring not only for the sick, but also ensuring that diseases are kept at bay. There are also many volunteers in our Region whose contribution to the overall goal of the Department cannot be over-emphasized.

Human resource remains the main key to effective Primary Health Care, and the most effective way to ensure that the ideals individuals and organizations hold dear are implemented, is to make sure someone takes credit for it. Without the commitment and devotion of our colleagues in the service, it would have been impossible to record the achievements outlined in this report.

My compliments to all of you.

Thank you.

DR. L.S. BITALO

REGIONAL DIRECTOR: MDHS

1. Executive Summary

METROPOLE DISTRICT HEALTH SERVICES (MDHS) REGION

Housed at both Woodstock (main office) and Parow offices, MDHS region came into existence in June 2003 following the restructuring of the Provincial Health Senior Management structure in line with Healthcare 2010 policy direction. The Region is charged with the responsibility of planning and managing Primary Health Care and to a lesser extent, above Primary Health Care services like specialised TB Hospitals, Trauma/Emergency services, Rehabilitation services, among others, across Cape Town Unicity geographical area and neighbouring Atlantis area. Almost two thirds of the population of the Western Cape Province lives in this geographical area. Seventy three percent of this population is dependent on State Health services.

POLICY INDICATORS

The Provincial Health Department has an approved Health policy – Healthcare 2010 policy. During the year under review a three-year (MTEF) MDHS Strategic plan as well as a joint MDHS – City Health District plan were developed, marketed, and approved as the key guiding documents on the implementation of Healthcare 2010 in the Metropole.

Annual operational plans for the next three-years will be based on these two documents. The strategic document lays out in detail the new 8 health sub-districts, the resource plans, the service plans, steps that will be taken to achieve the goals of Healthcare 2010 and governance model for the Metropole. Notable achievements were recorded in Quality of Care Improvement, Occupational Health and Safety Act implementation, Skills Development and Training policy requirements and adherence to the Public Finance Management Act.

The cost centre financial management system was strengthened with the decentralisation of some limited financial responsibility to the CHCs (full responsibility could not be delegated due to lack of formally appointed managers) and full responsibility to the Hospitals and Programmes.

The decision to Provincialise PHC had a profound positive impact on staff morale and a marked reduction in the number of personnel leaving the Department for City Health services.

New Health Facility Boards (Health Facility Act 2001) were established at Brooklyn TB Hospital, False Bay District Hospital, and Wes fleur Hospital. It is planned that the rest of the facilities will have their boards in place in the year 2004/05. The majority of Community Health Centres have functional Health Committees and a Cape Town Metropolitan Forum is in place. These boards and forums act as linkages between the Department and the Community.

FINANCE

For the second consecutive year, the expenditure was well within allocated funds and the revenue generated exceeded the target budget. The main sources of revenue generation are the Road Accident Fund, the Clothing Workers Union and other revenue-generated strategies. The CHCs and level 1 Hospitals also collect patient fees on behalf of level 2 and level 3 Hospitals.

HUMAN RESOURCE

HR profiler for Hospitals developed in conjunction with the Head Office HRM section. CHC profiler and MDHS organizational structure planned for 2004/05. There were no man-hours lost to labour

related stay aways. IMLC's are functioning well at all Institutions. A number of our nursing colleagues were nominated for the Cecilia Makiwane awards and Mrs. Gordon of Hout Bay CHC received the award. Long service awards and performance related rewards were given to a sizeable number of employees.

Change and people management strategies took place using both our internal expertise and outsourced consultants. These strategies were and continue to be necessary because of a continuously changing operating environment. The services of volunteers were embraced more than ever before and they have proved a very valuable resource.

PHYSICAL INFRASTRUCTURE

Although renovations and repairs were carried out on some of our Health Facilities, the backlogs remain in terms of upgrades, and new offices remain a major challenge. Similarly, the lack of IT in our CHCs (although PC's were bought and working using modems) is a key challenge that will have to be addressed. The need for level 1 beds in the Metropole is another priority that has been identified in Healthcare 2010 and prioritised in the Strategic Plan.

LIAISON AND INTERSECTORAL COLLABORATION

The relationship between City Health, Academic Institutions, NGOs and all other stakeholders continues to be excellent. Funding for NGO's was boosted teaching platforms at CHCs for Universities strengthened, and Health projects for Urban Renewal nodes in Khayelitsha and Mitchell's Plain identified.

CONCLUSION

Although there were noticeable achievements on the targets set and the foundation for the full implementation of Healthcare 2010 policy laid, the challenges of physical infrastructure, IT, lack of formal governance structure, and management posts at CHCs, sub-districts and capacity at Regional office remain major challenges.

The demand for Public Health Services by an ever-increasing State Health dependent population continues to exert pressure on the Department's resources and capacity to meet community expectations. The full implementation of the Healthcare 2010 policy will go along way in reducing this pressure. Good people management remains the catalyst to achieving an accessible and quality health care service.

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Figure 1.1 Map of the Cape Town Metropole showing the 11 Sub-districts

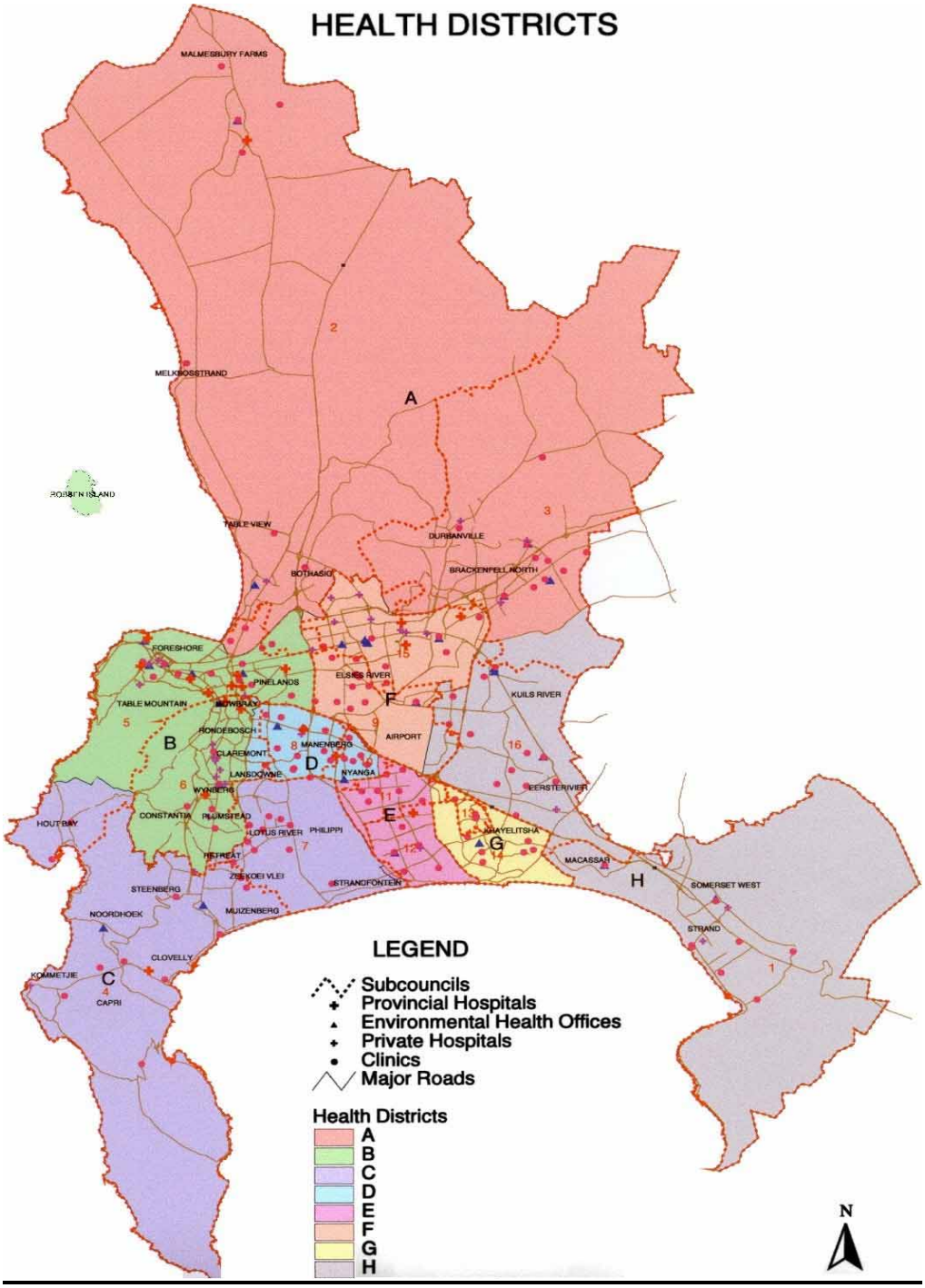


Figure 1.2 Map of the Cape Town Metropole showing the new 8 Sub-districts

KEY: A: Northern Panorama, B: Central, C: Southern, D: Klipfontein, E: Mitchells Plain, F: Tygerberg, G: Khayelitsha and H: Helderberg

2. Introduction

The past year has been a transitional period for the Metropole District Health Services (MDHS) and this Annual Report attempts to cover the services rendered by three previously separate departments Community Health Services Organisation (CHSO), District and Specialised Hospitals and Metropole Health Programmes - that came together in June 2003 as the Metropole District Health Services. The introduction will include a short profile on the hospitals that have joined the MDHS.

The format follows that recommended by the National DOH, with the emphasis on the health needs of the population and the responses of the PHC services to the burden of disease. The first section deals with demography and epidemiology, followed by reports on the physical infrastructure, package of services, human resources and expenditure. The outputs appear in the sections on service delivery and support systems. The final section is an evaluation against the planned objectives and forms the basis of the challenges for the new financial year.

The decision to change the sub-district boundaries to constitute 8 instead of 11 sub-districts has been accepted by both the Provincial and Local Authorities, but is still to be formalised. The data for this report will be presented in the 11 sub-districts as they were during most of the year of the report and where possible and where value will be added, the same data will be presented in the new 8 sub-districts.

In this first year of the MDHS, this report has focussed more on Community Health Center and community activities and unfortunately less deeply on hospital activities. However, we hope that this information will lay the basis for a more integrated report next year.

2.1 Eerste River Hospital

SMS: Dr T Visser, Nursing Manager: Mrs Strydom, Admin: Ms de Klerk
Eerste River Hospital was commissioned in September 2002 after the decommissioning of the acute services at Conradie Hospital. The hospital was previously a privately funded and run facility, but was taken over by the state, realising the dire need of a hospital in a rapidly urbanising area with 400,000 inhabitants.
The brief was initially was for the hospital to have 70 beds, but subsequently declared by the Minister of Health to be 120 beds, with the shortfalls to be made up by decanting budget and staff services from Tygerberg Hospital. There is still exists the imbalance in resources and the services needing to be delivered, notably a fully fledged Trauma and Emergency Unit. The hospital offers Internal Medicine, General Surgery, Paediatrics and a large Kangaroo Unit as well as an Out- Patient Service. The hospital acts as a referral base for Mfuleni, Delft and Klenvlei CHC.

The hospital has the exciting task of establishing a health service responding to the disease burden in an area with inadequate health services in the current financial climate. It also has the advantage of being a post apartheid hospital and thus little of the negative political, financial and collegial history has coloured the service, although the socio-political effects of an urbanizing environment is impacting the institution (e.g. 45 para-suicides per month).

2.2 False Bay Hospital

SMS: Dr K Grammer; Nursing Manager: Ms Shuttleworth
The "New" False Bay Hospital was officially opened at the present site in 17th Avenue, Fish Hoek on Monday 6 April 1965 when six patients were transferred from the Cottage Hospital located on Red Hill in Simonstown. The predecessor of the new Institution was commissioned in 1908 to "afford free medical and surgical treatment to persons in poor and indigent circumstances and further to afford treatment to patients who cannot be efficiently or conveniently treated at their own homes." False Bay Hospital was built as an 80-bed Institution at a cost of R600, 000.

Presently the hospital has 75 beds catering for paediatric, medical, surgical and obstetric patients. It has a well-differentiated Outpatients' Department that offers multiple referral clinics including general medical, paediatric, and antenatal services. Specialist orthopaedic, surgical, gynaecology and antenatal clinics are supported by outreach and sessional consultants from Groote Schuur and Victoria Hospitals. Significant service gaps exist in the Rehabilitation Service, as only one Physiotherapist is on the staff establishment, and a social worker, speech and occupational therapists are required to provide a comprehensive package of care. The Midwife Obstetric Unit and Casualty Departments are the only 24-hour services south of the Ou Kaapse Weg mountain pass and contribute to essential emergency care in the large Southern Sub-district with a population of 360, 000.

The hospital is undergoing a growth period, as it recently commissioned its independent store after many years of administrative dependency upon Victoria Hospital. Future expansion to its staff establishment is planned in line with the full package of services that a District Hospital is expected to deliver by 2010. High quality health care is delivered to our local community by a dedicated staff within a resource-constrained environment and ever-increasing demand for services. Many community-based organizations and volunteers have generously contributed their time, resources and expertise to the institution throughout the years.

2.3 Wesfleur District Hospital

Acting SMS: Dr J Gqodwana, Nursing Manager: Mrs Bouwers
Wesfleur Hospital was erected in the newly built town of Atlantis in 1977. The population served by the hospital is estimated at 150,000. It has 32 beds, 9 maternity and 23 general ward beds. Medical out patient's averages on 7,000 patients per month and 52-day theatre cases per month. Dr JW Gqodwana is the acting medical superintendent since 01 October 2003. Mrs. K. Bowers started with the opening of the hospital in 1977 and is the nursing service manager for the past four years. She serves together with the hospital acting Ms and the hospital secretary Mrs. Z. van Schoor on the Hospital management committee.

2.4 Brooklyn Chest Tb Hospital

Acting SMS : Dr S Moeti; Nursing manager: Ms A Burns.
In 1872, the first buildings were erected on the plot and named the Rentzke's Farm Hospital. It was named after a German farmer, Mr. Rentzke who farmed on this land. In 1918/19, the influenza epidemic showed that Cape Town had inadequate isolation facilities and this led to the erection of six wards in 1924. Further building then took place in 1942 and 1947. These buildings were used to house small pox patients and one was later used as a school, until 1994 when it was closed.

From 1942 - 1975 the hospital was run by the Health Department of the City of Cape Town. On 1 April 1975, the Department of National Health and Population Development took over the hospital. Since 1988 the Provincial Administration runs Brooklyn Chest Hospital. Brooklyn Chest hospital is situated in the Northern Panorama sub-district previously called the Blaauwberg sub-district. It is situated in a residential area, on bus and taxi routes that provide easy access to the communities in the surrounding areas. The communities in other sub-districts have a problem with accessibility due to the distance they have to travel, as BCH admits patients from all the Metropole sub-districts as well as the Westcoast/ Winelands Region.

Brooklyn Chest hospital provides and sustains 8 wards with a total of 305 beds and a staff complement of 180. There are 144 male beds, 102 female beds, 16 children beds and 40 baby cots. In the past year, there were 1,284 admissions, with 1000 discharges and 230 deaths.
The Registrars of Tygerberg Hospital are providing a service in Paediatric wards and Registrars from GSH render a service in 2 wards allocated for acute ill patients on a 3-month rotational basis. A Community Service Medical Officer, a Principal Medical Officer and a Sessional Medical Officer provide the service to the wards as well as an outreach service to the West Coast/ Winelands.
Two Wards are fitted with Ultra Violet Gamma Irradiation Units, where newly diagnosed MDR patients are to be admitted for the initial 4-month intensive phase treatment after which they are discharged to the sub-districts for continuation of treatment.

2.5 DP Marais TB Santa Center

Hospital manager: Dr. Mopp
The SA National Tuberculosis Association was formed in 1947 to co-ordinate and extends the work of several voluntary bodies fighting TB. Its objectives are to assist the National and Provincial health departments by means of a TB control programme and to establish and maintain TB Rehabilitation centers for bed accommodation, supplementary to public hospital facilities. DP Marais is one of 21 centers in SA and functioned since it's opening in 1957 until closure in 1974. The high TB incidence in the Western Cape and the shortage of treatment centers led to the re-opening of DP Marais in 1990. Since 2003 it has been operating as an affiliate of SANTA W Cape.

The Center provides medical, nursing, occupational therapy, health advisor and social welfare services working in a patient care team to provide a holistic approach to the treatment of TB. The service is geared to provide sufficient skills training to enable the patients to enter the open job market after successfully completing the treatment. The center has 70 beds and is located in the Southern sub-district.

2.6 Booth Memorial Hospital

Administrator: Lieut. Colonel R Trollip, Nursing Service Manager: Ms G Conradie.
Booth Memorial Hospital is one of the many Salvation Army institutions serving the public across SA. This hospital has a record of 38 years of committed service in the present building in the center of Cape Town, which previously functioned as a Maternity Hospital for over 64 years, giving a total service of 102 years.

The hospital is a sub-acute hospital to which patients are referred upon discharge from acute hospitals, institutions and homes. The service is holistic and includes – rehabilitation, convalescence, terminal/palliative care, respite care and assessment where the prognosis is uncertain. The Health Team consisting of doctors, nurses, social worker, physiotherapist, occupational and speech therapist provide the services in this 84-bed facility.

2.7 ST Lukes Pinelands Hospital

Manager: Mrs Pepper
The first organisation of St Luke's Hospice was officially established in 1980, inspired by Dame Cecily Saunders the founder of the modern hospice movement. In 1983 St Luke's started operating out of the old staff dining room of the Vincent Pallotti Hospital, but soon relocated to a house in Trill Road, Observatory with donations from the Lombardi family trust. Late in 1984 the Kenilworth in-patient facility was set up. The St Luke's Conradie was opened in January 2002 after approaching PGWC to open an in-patient unit for patients with HIV/AIDS. Due to the decommissioning of the Conradie Hospital, the HIV Palliative Care Ward was moved to the Lentegeur Hospital premises in November 2003.

St Luke's hospice movement is based on a philosophy of care focussing on the quality of life, dignity in death and support in grief. The services are provided in the home, day hospices and palliative wards by community nurses and home –based caregivers.

3. Background

3.1 Geography

The Maps of the METROPOLE divided into the old 11 and the new 8 Sub districts are shown on pages 4 and 5 (Figure 1.1 and 1.2)

3.2 Population

Almost two thirds of the Provincial population lives in the Metropole, with a much higher population density than the other 3 regions. This not only influences the disease profile in the Metropole but drives different service delivery imperatives when compared to the rural regions. An increasing number of the population -73% currently - is dependent on the public sector (Equity Gauge Project 2001) and this reflects national trends.

Table 3.1
The population distribution across the province (Census 2001 and 1996)

	Population	% of Provincial Population	Km^2	% of Prov. area	Density 2001(pop /Km^2)	Density 1996(pop /Km^2)
Westcoast /Winelands	594,856	13	33,594	26	18	18
Boland/Overberg	520,851	12	31,591	24	17	17
S Cape/Karoo	515,377	11	62,173	48	8	8
Metropole	2,893,251	64	2,169	2	1334	1321
Province	4,524,335	100	129,527	100	35	35

Table 3.2
The population distribution in 11 sub-districts.

Sub-district	Census 2001	2002	2003	2004
Athlone	198,578	201,658	204,785	207,961
Blaauwberg	144,873	147,120	149,401	151,719
Central	230,746	234,325	237,959	241,649
Helderberg	154,147	156,538	158,965	161,431
Khayelitsha	329,005	334,108	339,289	344,551
Mitchells Plain	279,776	284,115	288,521	292,996
Nyanga	287,906	292,371	296,905	301,510
Oostenberg	303,067	307,767	312,540	317,388
SPM	345,605	350,965	356,408	361,936
Tygerberg East	263,066	267,146	271,289	275,496
Tygerberg West	341,556	346,853	352,232	357,695
METROPOLE TOTAL	**2,878,325**	**2,922,965**	**2,968,29**	**3,0143,3**

As expected the re-distribution of the population across the new 8 sub-districts has resulted in most sub-districts having increased populations. However, some have doubled their figures and this will impact on local service delivery capacity. There is a concern that these figures may reflect an undercount in some sub-districts.

Table 3.3
The population distribution in 8 sub-districts over the next 6-year period

New Health Sub Districts	Census 2001	Census 2001 projected to 2010 @ 1.015508924 growth factor								
		2002	2003	2004	2005	2006	2007	2008	2009	2010
N.Panorama	389,585	395,627	401,763	407,994	414,321	420,747	427,272	433,899	440,628	447,462
Central	289,108	293,592	298,145	302,769	307,465	312,233	317,075	321,993	326,987	332,,058
Southern	307,669	312,441	317,286	322,207	327,204	332,279	337,432	342,665	347980	353,376
Klipfontein	344,735	350,081	355,511	361,024	366,624	372,309	378,084	383,947	389,902	395,949
Mitchell's Plain	401,099	407,320	413,637	420,,052	426,566	433,182	439,900	446,722	453,651	460,686
Tygerberg	415,200	421,639	428,178	434819	441,563	448,411	455,365	462,427	469,599	476,882
Khayelitsha	329,005	334,108	339,289	344,551	349,895	355,321	360,832	366,428	372,111	377,882
Eastern	401,924	408,157	414,487	420,916	427,444	434073	440,805	447,641	454,584	461,634
Metro Total	**2,878,325**	**2,922,965**	**2,96,8297**	**3,014,332**	**3,061,081**	**3,108,555**	**3,156,765**	**3,20,5723**	**3,255,441**	**3,305,929**

(Census 2001 / Dorrington/Equity Gauge figures)

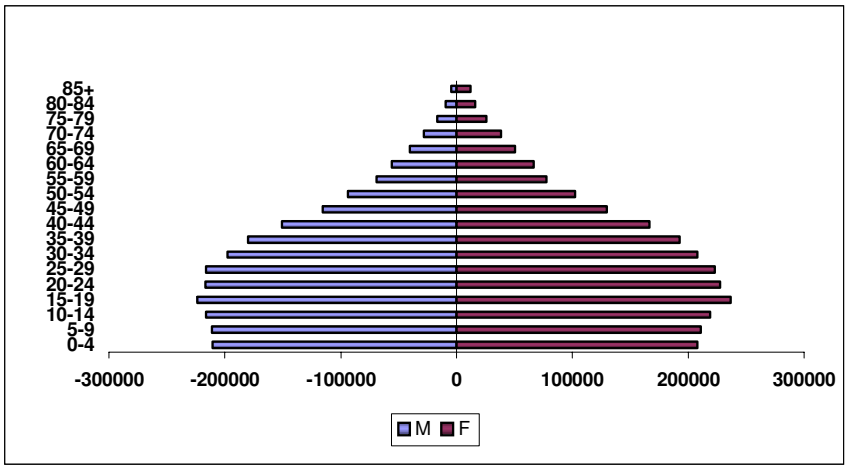


Figure 3.1 Population Pyramid for Western Cape Province.

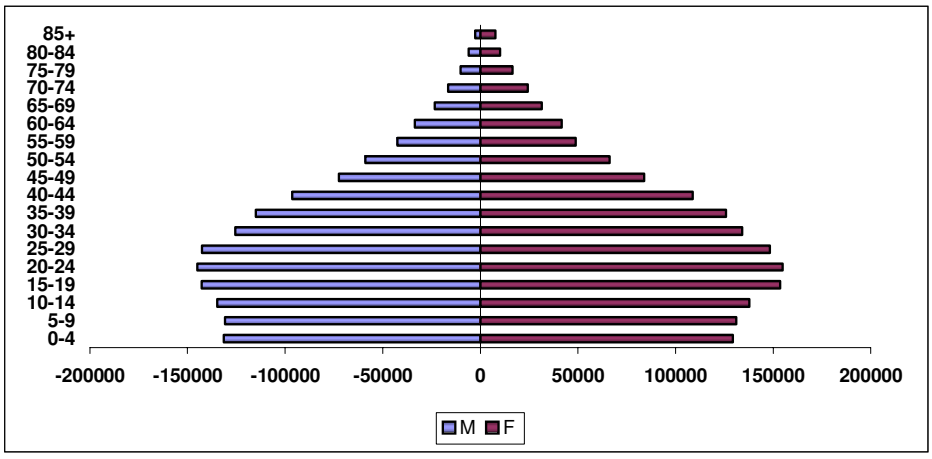


Figure 3.2 Population Pyramid for Cape Town Metropole.

The Metropole has a young and predominantly female population, factors that impact directly on the socio-economic status and disease profile of the communities – diseases associated with risk taking behaviour, teenage pregnancies, single mothers and higher Infant Mortality Rates (IMR). Nevertheless there is a large aged population, with a significant burden of disease due to chronic non-communicable diseases.

3.3 Socio-economic Status

The socio-economic profiles in Tables 3.4.1 and 3.4.2 show a divided city with extremes in wealth and poverty across the city. There are areas of extreme poverty, with many households having no stable income and little social capital. On the Cape Flats poverty results in the collapse of family life, escalating violence, substance abuse and an inability to escape the poverty trap. The new 8 sub-districts may mask this when areas are amalgamated e.g. Nyanga sub-district, which has the worst health status figures, appears to have better indicators when divided between Klipfontein and Mitchells Plain sub-districts.

Table 3.4.1
Socio-economic indicators for Cape Town (Equity Gauge Project.)

		Socioeconomic Indicators (1996)					
Subdistrict	**% on Medical Aid**	**% living in In-formal dwellings**	**% without electricity**	**% with no piped water in dwelling or on site**	**% Not Completed Matric**	**% Unemployed of the employable**	**% Households below poverty line**
Athlone	25	4	1	0.6	76	25	24
Blaauwberg	43	8	9	5	64	20	24
Central	48	7	9	5	44	17	21
Helderberg	34	14	8	8	57	18	18
Khayelitsha	4	80	32	26	86	47	55
Mitchells Plain	19	6	4	5	80	24	18
Nyanga	3	64	54	29	85	50	57
Oostenberg	43	18	13	11	67	20	18
SPM	48	7	5	4	60	17	16
Tygerberg East	45	7	6	5	54	18	16
Tygerberg West	32	4	2	0.5	69	22	17
Total	**31**	**20**	**13**	**9**	**67**	**26**	**25**

Table 3.4.2
Socio-economic indicators across the 8 Sub-district for Cape Town (Equity Gauge Project.)

		Socioeconomic Indicators (1996)					
Subdistrict	**% on Medical Aid**	**% living in In-formal dwellings**	**% without electricity**	**% with no piped water in dwelling or on site**	**% Not Completed Grade 7**	**% Unemployed of the employable**	**% Households below poverty line**
Central	55	6	7	4	8	16	19
Eastern	30	14	9	8	16	20	18
Khayelitsha	1	80	32	26	26	47	55
Klipfontein	16	23	20	15	20	36	37
Mitchell's Plain	12	41	23	21	20	33	30
N. Panorama	59	12	10	9	16	18	20
Southern	42	10	7	5	15	19	17
Tygerberg	31	4	2	0	15	22	17
Total	**31**	**20**	**13**	**10**	**17**	**26**	**25**

3.4 Health status

3.4.1 Child health

There is a paucity of national data available, but using data from 1998, the health status of children in the Western Cape appears to be better than elsewhere in South Africa. While the Metropole IMR is much lower than the provincial rate, the sub-district inequities in the Metropole (Table 3.5) show that there are sub-districts where the rates are closer to national figures and have not improved over the last 6 years. This may be a reflection of the increased HIV prevalence, socio-economic factors (especially poor sanitation) and migration to the Metropole.

Table 3.5
Infant, under -5 mortality and neonatal mortality rates in the different provinces (1998)*

Provinces	IMR	Under 5 MR	Neonatal MR
W Cape	39	30	4
Free State	53	72	9.9
Gauteng	36.3	45.3	17.8
N Province	52.3	37.2	18.3
N West	56	42	20
N Cape	55.5	41.8	20.5
Kwazulu-Natal	74.5	52.1	23.2
Mpumalanga	63.7	47.3	23.6
Eastern Cape	61.2	80	24.7

- ***Source: South African Demographic and Health Survey 1998.**

Table 3. 6
Infant mortality for 1998 - 2002 by 11 sub-districts

INFANT MORTALITY RATE	Athlone	Central	Nyanga	M. Plain	S. Penin.	Oost'berg	Helderberg	Bl'berg	T'berg. East	Tygerberg. West	Khaye.	Cape Town
1998	22	18	32	13	13	23	28	19	21	18	50	23
1999	11	15	37	11	13	31	18	13	19	15	63	22
2000	15	18	47	17	12	23	46	19	24	23	46	25
2001	14	16	49	16	15	31	26	23	24	19	44	26
2002	16	14	40	19	13	31	29	18	19	18	44	25
2003*	30	16	37	17	20	26	26	22	27	18	51	26.6

* **Jan – June 2003**

Both Nyanga and Khayelitsha sub-districts have had high Infant Mortality Rates with no real improvement over the period covered in the table above, reflecting the poor socio-economic circumstances (poverty & lack of sanitation) in those areas. With the increasing impact of HIV/AIDS on child deaths, the challenge to the health services will be to prevent worsening of the IMR.

BACKGROUND

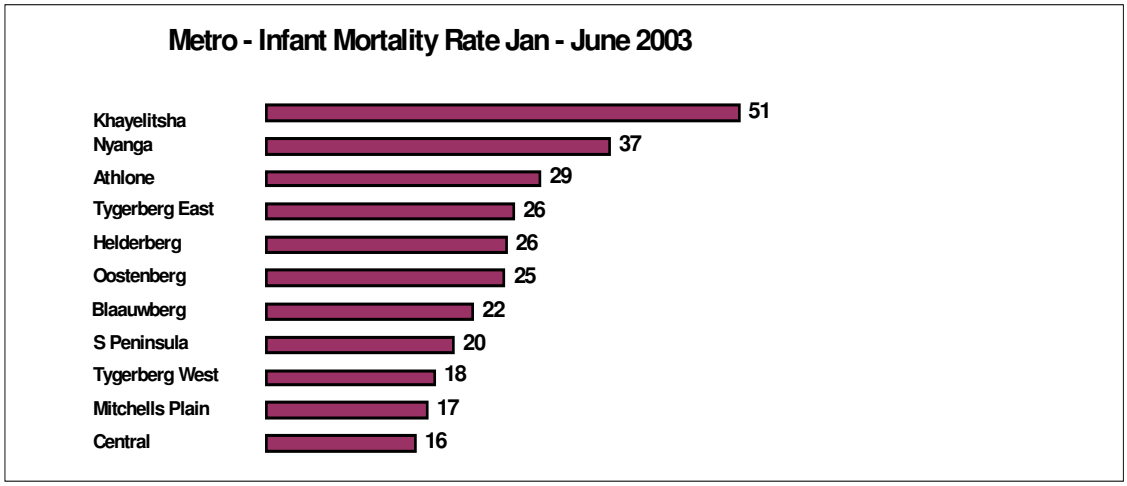


Figure 3.3 Metropole Infant Mortality Rate (Jan – June'03 MDHS Child Health March 2004)

Tables 3.6 and 3.7 illustrate how the **rearranged sub-district borders hide health status data** e.g. the high IMR of 37.41 in the Nyanga sub-district becomes less apparent when grouped within the Klipfontein or Mitchell Plain sub-districts.

Table 3.7
Infant mortality rates across 8 sub-districts

Sub-district	2000	2002
Northern Panorama	23	26
Central	16	12
Southern	13	14
Klipfontein	28	27
M Plain	26	27
Tygerberg	19	16
Khayelitsha	46	43
Helderberg	19	27

Table 3.8
Selected indicators of Nutritional status of children

Indicator		Western Cape	Gauteng	National
Low Birth weight		9.1%	7.8% (1998)	8.3%
Stunting (1-9)		14.5%	20.4% (1999)	21.6%
Wasting (1-9)		0.7%	1.2%(1999)	3.7%
Underweight:	Moderate	8.6%	8.8% (1999)	10.3%
	Severe	1%	0.5% (1999)	1.4%

Table 3.8 indicates that childhood nutritional status remains poor in Cape Town, although it compares favourably with the rest of S.A. Low birth weight in particular, is as much of a problem as elsewhere in the country.

Table 3.9
Top ten causes of death in the under – 5 population in the Metropole

	Causes	%
1	HIV/AIDS	21.6%
2	Low Birth weight & RDS	19%
3	Diarrhoeal Diseases	9.8%
4	Lower Respiratory Infections	8.7%
5	Congenital Abnormalities	3.1%
6	Septicaemia	3.1%
7	Road Traffic Accidents	2.3%
8	Meningitis –Bacterial	1.9%
9	Fires	1.7%
10	Homicide	1.6%
	TB, Drowning, Asthma, PEM and Ill-defined	27%

*MRC Report (2001)

The commonest cause of death under 5 years in Cape Town is now HIV/AIDS, Low Birth weight (prematurity) and infectious diseases together are the next commonest cause of death. The impact of trauma, including non-accidental trauma, is significant.

3.4.2 Women's Health

The Western Cape Maternal Mortality Rate is 49.8, 68.4 and 57.5 per 100,000 live births for the years 1998,2000 and 2001. Unfortunately there is no accurate national data, but comparing the reliable data from 3 provinces it appears that there is deterioration in outcomes that cannot be explained by the increase in the HIV epidemic alone. The increase in avoidable factors, missed opportunities and substandard care appear to have an added impact. (Full report: Saving Babies Report – 2002 and SAHR 2003/4). The teenage pregnancy rates are higher, at 1:6 pregnancies, in the poorer communities. This may contribute to the high prevalence of psychosocial illnesses (e.g. post-natal depression) found in these communities.

Table 3.10
Number of Maternal Deaths – 1998 –2001*

	1998	1999	2000	2001	2002
Western Cape	34	34	50	42	60
National	676	805	1035	937	

*** Saving Mothers: Second Report by DOH – 2002**

Table 3.11
Maternal Deaths 2003/4

DISTRICT	NO. OF MATERNAL DEATHS
City of Cape Town	44
Boland	5
Overberg	1
West Coast	1
Central Karoo	1
Eden	11
Total deaths in WCP:	**63**

Table 3.12
Status of Maternal Death notifications in Western Cape

Year	Maternal Deaths notified			M/D Submitted to NCCEMD	Outstanding M/D
	PUBL. FAC.	PRIV. FAC.	TOTAL		
1998	32	2	34	34	-
1999	31	3	34	34	-
2000	49	1	50	50	-
2001	41	1	42	42	-
2002	59	1	60	60	-

According to the National Cancer Register (1996-1997), in females in descending of frequency order, cancer of the cervix, breast, colorectal, oesophagus and lung were the 5 leading cancers. Cancer of the cervix compromises 13.4 % of all cancer cases in females aged 15 – 29 years and remains the leading cancer in black females.

The adult mortality rates are lower for women - 26% in women compared to 39% in men, while the life expectancy is higher in women – 66.1 years compared to 59.3 years for men.

3.4.3 Communicable Diseases – Tuberculosis

(Full report available from J Caldwell, Metropole: TB programme)

The Cape Town TB control report (1997 – 2003), shows that there has been an increase of 66% (from 13,870 in 1997 to 22,999 in 2003) in reported cases over the seven years, reflecting a growing population, migration, improved case detection and increased burden of disease. Increases in TB caseloads have been experienced across all sub-districts but mainly where the HIV epidemic is highest. The highest increase in caseloads has been in Khayelitsha with 66% and Nyanga with a 30% increase . However, in Helderberg, the sub-district with the third highest HIV prevalence the caseload only increased by 15%. The apparent high increase in South Peninsula and Blaauwberg in 2002 and 2003 can be attributed to the inclusion of data from the hospitals and correctional services in these sub-district datasets with to the implementation of the Electronic TB Register.

Table 3.13
TB incidence and caseload across the Metropole in 2003*

	Incidence/100,000	% of Caseload
Athlone	488	5%
Central	435	6%
Nyanga	1026	15%
M Plain	399	5%
Oostenberg	950	13%
South Peninsula	401	8%
Helderberg	742	6%
Blaauwberg	676	7%
Tygerberg East	617	8%
Tygerberg West	533	8%
Khayelitsha	1122	19%

*** Cape Town TB Control Report (1997-2003)**

Of the cases identified in 2003, three sub-districts – Khayelitsha (19%), Nyanga (15%) and Oostenberg (13%) carry most of the burden. This translates into these sub-districts supervising between 2473 and 1611 TB patients on an average day. To make any impact on TB outcomes these areas should receive the appropriate share of resources and support.

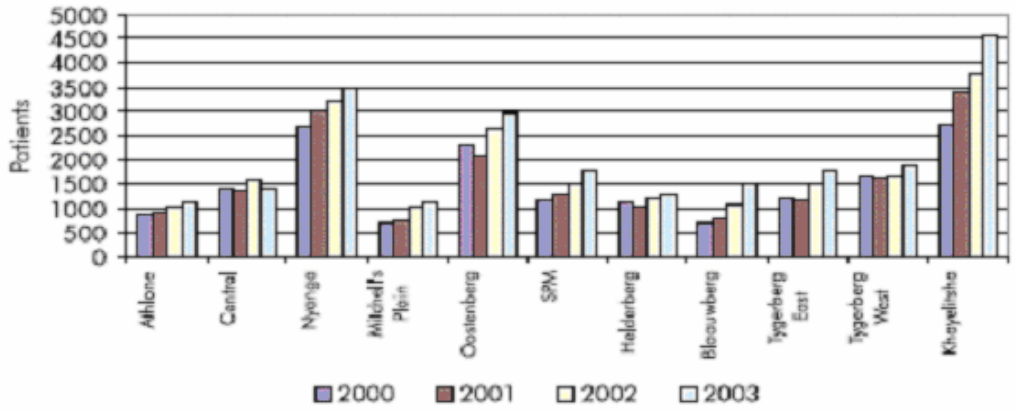


Figure 3.4: Increase in Sub-district caseloads over 4-year period (CT TB Control Report)

Multi-drug resistant Tuberculosis

The development of MDR (resistance to first line TB drugs) is largely the result of shortcomings of the following aspects in the delivery of the TB control Programme: Prescription of chemotherapy; management of drug supply; patient management and patient adherence. The Western Cape has the lowest MDR TB rate in the country, with reported rates the same as 1995: 1% of new cases and 4% of re-treatment cases and in 2003 a total of 301 new MDR TB cases were identified in the district (54 in Nyanga, 45 in Khayelitsha). As shown in Fig 3.5, there has been a steady increase in MDR since 1999 in Cape Town. Since 1990 a specialist MDR clinic has been operating from Brooklyn Chest Hospital and an improvement in the physical infrastructure has taken place at the hospital over this year.

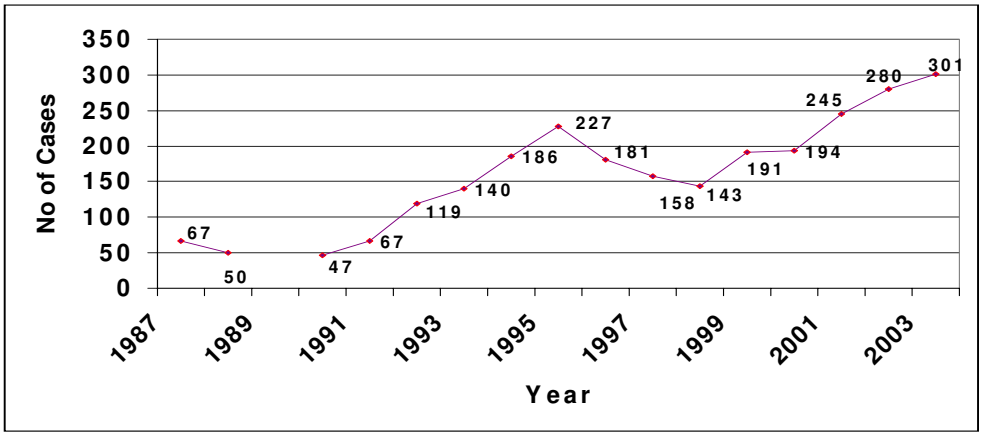


Figure 3.5: Metropole MDR caseload over the last 8 years - Karen Shean BCH

3.4.4 Communicable Diseases – HIV/AIDS/STI

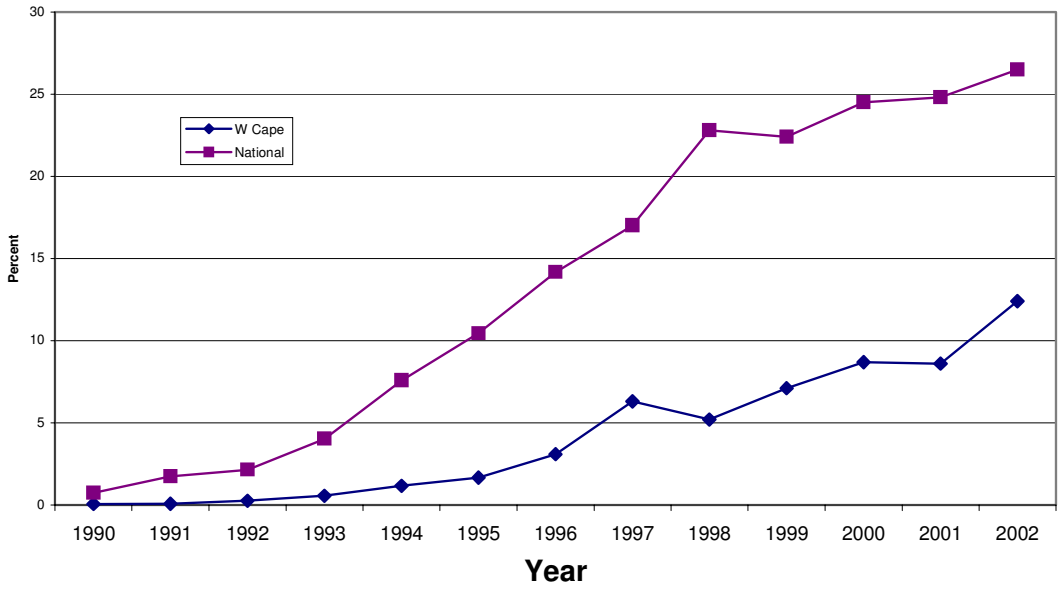


Figure 3.6: The Annual HIV prevalence as per National Antenatal survey 1990 -2000

HIV prevalence has been steadily climbing over the past 12 years nationally and provincially (Fig 3.6). At a national level, there is a plateau developing, whereas the prevalence in the Western Cape is till increasing. The latest W Cape antenatal survey results (2003) show wide variations in prevalence levels within the sub-districts: from 6.3% in Mitchell's Plain to 28.1% in Nyanga (Table 3.14). The main burden is still in the 15 –30 age group where Metro prevalence rates of up to 18% were recorded. The spiralling syphilis rates to more than double the national average (2.7%) are disturbing.

Table 3.14
HIV prevalence by sub-district (2001 and 2002 antenatal surveys)

	Athlone	Central	Nyanga	Mitchell's Plain	Oostenberg	South Peninsula	Helderberg	Blaauwberg	Tygerberg East	Tygerberg West	Khayelitsha
2001	6.8	3.7	16.1	0.7	5.7	5.9	19.0	0.6	6.1	7.9	22.0
2002	8.9	11.9	27.8	4.0	14.5	6.0	19.1	8.2	10.4	12.7	24.9
2003	10.1	11.6	28.1	6.3	16.1	9.3	19.1	4.4	7.9	8.1	27.2

BACKGROUND

3.4.5 Chronic non-communicable diseases

This group accounted for 54% (cf National: 40%) of the deaths in the Metropole (cardiovascular causes 22%, cancers 14%) and also accounts for over 50% of the visits at most CHCs. Cancer of the cervix remains the leading cancer in black females and the challenge is to find new ways of screening, preventing and treating it.

3.4.6 Violence and Trauma

The incidence of murder, assault, rape, domestic violence and road traffic accidents is high in the Metropole and impacts heavily on service delivery, CHC budgets as well as the staff morale and well being. ***Homicide is the highest cause of death*** in most sub-districts (see Table 3.12 below). The report by J Frankish (2003) indicates that between 2000 and 2002 the attendances at Trauma & Emergency units have increased by 13% across all levels of care and 36% at 24 hr Trauma units.

Violent crime is endemic in the local communities affecting the safety and security of the staff and patients attending the CHCs (e.g. death of a security guard at Khayelitsha CHC this year) and is placing severe emotional stress on the staff. The National PHC Facilities Report (2003) indicated that the Western Cape has the highest reported incidences of assaults on staff (65 cf to 18 nationally) in spite of having good security measures.

3.4.7 Mental Health

Mental health problems constitute about 8.1% of the global burden of disease, which translates to about 3-7% of the population (145,000 in the Metropole) suffering from severe mental disorders. Community based studies and RMR data have shown that there is a significant discrepancy between expected caseloads and actual patients seen at CHCs. This may be a reflection of problems related to data collection, definitions and clinical practices at PHC level.

3.4.8 Rehabilitation

The prevalence of reported disability nationally is 5% according to the national census (2001). The Western Cape Province's prevalence rate is 4.1%. These figures need to be treated cautiously as there are varying definitions and methodologies to measure disability and impairment rates. There is no national data on impairment rates, however a significantly high proportion of the population is estimated to have an impairment as indicated in a local study conducted in Mitchell's Plain sub-district in the Metrople indicate a 12.9% impairment rate (Katzenellenbogen, 1995). The causes of disability nationally are visual (1.3%, 1.7%), physical disability (1.2%, 2.0%), followed by hearing (0.7%, 1.0%) as reported by Census 2001 and National Case survey 1996 respectively.

3.4.9 Oral Health

The burden of tooth decay is higher within the lower socio-economic groups and in the Western Cape. The third National Oral Health survey (1999 –2002) shows that the percentage of caries is highest in the Western Cape - e.g. 82.3% in 6 year olds against the National weighted norm of 60.3% and the Limpopo figure of 37.2%. More than 80% of the caries go untreated and the greatest need was for preventative services, restorations and extractions in school children. A well resourced school and community dental service cannot be over emphasised.

3.4.10 Causes of Death

Compared to National trends, the Cape Metropole has a larger burden of chronic illnesses and a higher incidence of deaths due to injuries. Table 3.15 shows that homicide HIV/AIDS/TB & chronic non-communicable disease are the major causes of death in Cape Town.

Table 3.15
Causes of Death – Metropole compared to National
Source CT Mortality, 2001, MRC report - P Groenwald et al 2003 page 17

Causes of Death	Metropole	National
Pre-transitional (Infectious)	**19%** - General infections –11%, HIV/AIDS – 6%	36%
Non-communicable	**54%** - Cardio-vascular – 22%, Cancers 14%	40%
Injuries	**19%** - Intentional – 11%, Unintentional –7%	11%
Ill-defined	**8%**	13%

Table 3.16
Top 5 causes of death in Adults per sub-district (2001)

Subdistrict	1st	2nd	3rd	4th	5th
Athlone	Homicide 17%	TB 6%	Diabetes 6%	Road Acc 6%	IHD 6%
Blaauwberg	Homicide 16%	HIV/AIDS 15%	IHD 7%	Road Acc 6%	TB 4%
Central	HIV/AIDS 15%	Homicide 17%	TB 6%	IHD 5%	Road Acc 5%
Helderberg	Homicide 13%	HIV/AIDS 10%	TB 9%	LRI 7%	IHD 7%
Khayelitsha	Homicide 22%	HIV/AIDS 17%	TB 13%	Road Acc 5%	LRI 5%
Mitchell's Plain	Homicide 22%	Road Acc 7%	HIV/AIDS 15%	Hypertension 5%	IHD 4%
Nyanga	Homicide 23%	HIV/AIDS 22%	TB 10%	Road Acc 5%	Diarrhoeal 3%
Oostenberg	Homicide 20%	HIV/AIDS 14%	Road Acc 7%	TB 7%	IHD 5%
South Peninsula	Homicide 14%	IHD 7%	Diabetes 5%	Hypertension 4%	Ca Lung 4%
Tygerberg East	Homicide 16%	HIV/AIDS 8%	Road Acc 8%	TB 6%	IHD 5%
Tygerberg West	Homicide 16%	IHD 7%	Road Acc 7%	TB 6%	Diabetes 5%
CT Metropole	Homicide 18%	HIV/AIDS 12%	TB 8%	Road Acc 6%	IHD 4%

Table 3.17
Mortality trends Western Cape and Nationally

Indicator	Source: ASSA 2000		National Target
	W Cape	Nat.	
Infant mortality (under 1)	30	59	45 per 1,000 live births by 2005
Child mortality (under 5)	46	100	59 per 1,000 live births by 2005
Maternal mortality	45,1		100 per 100,000 live births by 2005
Life Expectancy	66,1	55	-

Table 3.18
Health status indicators in Cape Town

Subdistrict	IMR 2000	Under 5 mortality	Low Birth weight	TB incidence 2002	HIV prevalence (ANC 2001)
Athlone	15	63	491	443	8.9
Blaauwberg	18	51	272	512	8.2
Central	16	94	666	488	11.9
Helderberg	16	99	469	709	19.1
Khayelitsha	47	375	1015	977	24.9
Mitchell's Plain	16	122	795	376	4.0
Nyanga	45	311	738	992	27.8
Oostenberg	40	234	903	857	14.5
South Peninsula	12	86	788	351	6.0
Tygerberg East	24	102	707	532	10.4
Tygerberg West	23	114	837	483	12.7
Average	26	150	698	638	

3.5 District Health System (DHS) development in the Metropole

By definition the District Health System (DHS) exists as part of a unitary Provincial Health System that is decentralised in such a manner that it enables the center (Provincial Management) and the periphery (District or Sub-district Management) to function effectively and cooperatively. This process has evolved very slowly over this year.

The key external contextual factors in DHS development revolve around the future governance and amalgamation of PHC services within the Metropole. The National Health Act will guide national and provincial processes around this issue. The key aspects of the Act declaring PHC services a Provincial competence will have major implications for future funding and governance as from 1 July 2004. However, in the past year processes were put into place to develop joint co-operative activities. The MDHS and the City of Cape Town (COCT) continue to function within a joint co-operative framework agreement based on joint principles and joint decision making structures to be formalised through a signed service level agreement. Joint planning has resulted in the development of a draft District Health Plan linking objectives and activities to the Healthcare 2010 vision. As mentioned before the sub-district boundaries still have to be formalised.

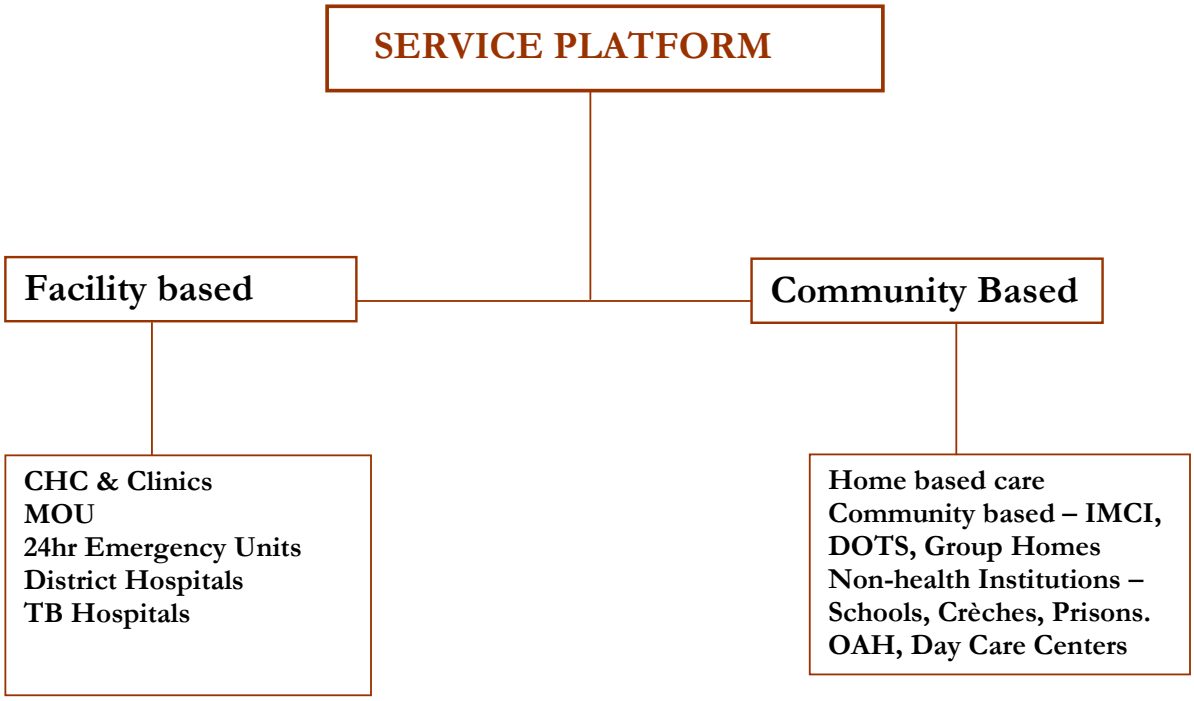
The impact on MDHS has been uneven. In June 2003 the Provincial Health Department restructuring led to the formation of the MDHS, where CHSO amalgamated with the Metropole Health Programmes division, the 3 District Hospitals (Wesfleur, False Bay, Eerste Rivier), Brooklyn Chest TB Hospital and various step-down facilities. This amalgamation was, however, not accompanied with appropriate re-structuring and strengthening of middle and lower management levels within this new organisation (see interim organogram in the annexure). The latter processes were to be completed by a Provincial work-study, which had not commenced by the end of this financial year. The interim sub-district management structures continued to function in spite of reduced capacity but this has impacted negatively on some aspects of service delivery in some sub-districts

3.6 Challenges

The **increase in the burden of disease** in all three categories (infectious, chronic and violence trauma) will challenge the PHC services to respond at points where the greatest health gains can be made.
The **sub-district inequities** in the population size, socio-economic status, environmental factors (e.g. sanitation) and consequent health status must be addressed in a substantial and sustainable manner, to improve the health of the communities concerned. These interventions must go hand-in-hand with equitable redistribution of health expenditures per sub-districts.
To **integrate all interventions** and use priority health programmes to strengthen the general PHC services rather than develop parallel services.
The **development of DHS** will have to be substantial, sustainable and at a faster pace than it was this year and in previous years. The main focus must be on the SLA with the COCT; formalisation of the structure and decentralisation with appropriate delegation.

BACKGROUND
BACKGROUND

4. Service Platform (Facilities)



4.1 Community Based Services

These services are grouped into three categories:

- Homes – Home-based care co-ordinated by Metropole HBC, through Technical Advisors, NGO's and carers (mainly EU funding), There has been a mushrooming of private training colleges as well as a variety of other NPO/NGO networks and private agencies providing these services, all of which will become a challenge for the Health Department to regulate/monitor in the future.
- Community based – These interventions are co-ordinated by various Metropole Programme managers and include – Community IMCI, DOTS, Psycho Social Rehabilitation Group (PSRG) and specific campaigns (e.g. Sensible drinking). Special facilities - Group Homes, Special Care Homes, Day Care Centers, are included
- Non-Health Institutions – Schools, crèches, old age homes and prisons, where health personnel employed by MDHS provide care and consumable supplies.

The information in Table 4.1 is self explanatory, showing the community based services across the Metropole and approximate workload and personnel.

Table 4.1. Community based service platform

	Institution			Service Delivery	Human Resources				Finances
Community Based Care Package	**No of NGOs**	**No. of Institutions**	**No of Visiting Points**	**Contacts**	**Co-ordinator/ Manager**	**CHW**	**Volunteers**	**PGWC**	**Total Budget (Rands)**
DOTS	3	-	93	18,794	11	637	-	-	1,065,000
HBC (General)	14	-		198,098	26	293	29		3,265,144
IMCI	4	-		62,640	7	102	-	-	722,675
Breast feeding peer counse	1	-	-	-	-	-	-	-	-
Integrated Nutrition Prog	-	794	794	90,481	-	-	-	10	13,617,487
School Health	-	647	647	119,025	-	-	-	51	-
Oral Health		380	380	64,599	1	-	-	17	79,655
Old Age Homes	-	53	53	4,578	-	-	-	3	1,037,300
Homes for PW Disabilities	-	10	10	731					100,800
Children's Homes	-	23	23	615					187,200
Prisons	-	2	2	5,906	-	-	-	3	54,000
Day Care Centres	19		19	8,012	-	-	-	-	2,121,000
Licensed Homes	3		3	1,920	-	-	-	-	1,494,000
Group Homes	6	-	16	252	-			0	645,500
Psychosocial Rehabilitation	3	-	35	25,518	3	-	3	6	21,010
Community based rehab	-	-	10	10,915	-	-	-	-	29,255
In home rehab	-	-	-	799	-	-	-	-	-
CBR UWC	UWC	1	1	-	-	4		2	750,000
Total	**52**	**2310**	**1312**	**632088**	**48**	**723**	**32**	**89**	**24,440,771**

HBC & IMCI: Homes are regarded as visiting points, INP: Crèches and Schools included. Staffing: 5 Community Liaison

Officers, 1 Health Promotion Officer and 4 Dieticians, Oral Health: School based oral health included. Refer to prisons for oral health, Prisons: Medical and Dental service – Pollsmoor and Goodwood Prisons

4.2 Primary Health Care Physical facilities

For the purposes of this analysis, the MDHS facilities have been combined with the Local Government (COCT) facilities, in order to give a more realistic picture of the population to facility ratios in Cape Town. The ratio is approximately half that of the National norm, when the total and not the dependent population is taken into account.

Table 4.2.
PHC service platform summary – MDHS and COCT

Sub-district	District Hospitals		Trauma Units	MOUs		RH C*		Stand Alone MDHS	Shared**	Stand Alone COCT			TOTAL Service points	Only CHCs/ Clinics	Population	Population/Service point	Population /Fixed CHC/Clinic	Population/CHC (MDHS).
	MDHS	Proposed***		MDHS	MMH	MDHS	COCT	CHCs	Clinics/CHC	Clinics	Satellites	Mobiles						
Central		1NSH	1	1		2	1	7	1	9	2	0	22	17	298,145	13,552	17,538	37,268
Eastern	1	1HHH	1	1				1	6	10	1	1	19	17	414,487	21,815	24,382	59,212
Khayelitsha	1		1	1	1		1	1	2	5	0	1	10	8	339,289	33,929	42,411	**113,096**
Klipfontein		1GFJ	2		2*	3		3	2	7	4	0	19	12	355,511	18,711	29,626	71,102
Mitchell's Plain	1		1		1	1		2	1	9	1	0	14	12	413,637	29,546	34,470	**137,879**
N. Panorama	1	1KBH	1	1				3	2	12	2	5	24	17	401,763	16,740	23,633	80,353
Southern	1	1VH	1		1			3	2	14	4	1	24	19	317,286	13,220	16,699	63,457
Tygerberg			1	2		1	1	3	6	5	4	0	20	14	428,178	21,409	30,584	47,575
Metro Total	**3**	**5**	**9**	**6**	**5**	**7**	**3**	**23**	**22**	**71**	**18**	**8**	**152**	**116**	**2,968,296**	**19,528**	**25,589**	**65,962**

* Reproductive Health Clinic
** Both Provincial and LG services are rendered in the same building and various degrees of functional integration exist.
*** Currently L2 Hospital.

4.3 District and Specialised Hospitals (including step down facilities).

Table 4.3
Hospital beds per 11 sub-districts

	Sub-District	District Hospital	Specialised/ Step-down	Beds
2	**Blaauwberg**	Wesfleur (28 + 4 added during this year)	Brooklyn Chest (305)	32 305
3	**Central**		Booth Maitland cottage Sarah Fox Life care(St Luke's)	84 85 60 180
4	**Helderberg**	-	-	-
5	**Khayelitsha**	-	-	-
6	**Mitchell's Plain**	-	-	-
7	**Nyanga**	-	-	-
8	**Oostenberg**	Eerste Rivier (112)	-	112
9	**South Peninsula**	False bay (65 + 5 Private)	DP Marais (260)	70 260
10	**Tygerberg East**	-	-	-
11	**Tygerberg West**	-	St Josephs	135

This table highlights the differences between the sub-districts and reflects historical urban planning decisions. However, the facilities vary greatly in terms of category and capacity, therefore direct comparison of numbers of facilities between sub-districts is not informative. A new 100-bed MDR ward has been commissioned at BCH and another 100 bed step-down facility for MDR patients at Brooklyn Chest Hospital (BCH) is in the planning process.

4.4 Facility infrastructure

All facilities have the basic infrastructure, including electricity, telephone, fax, water and sanitation. Each sub-district has an office with electronic connectivity via dialup modem. The recently published survey on National PHC Facilities (HST – June 2004) indicates that while the Western Cape rates favourably in relation to basic infrastructure, it has the highest reported incidence of crime (Robberies & Assaults on staff – 65 against National average of 18) and the **safety and security of staff and patients** needs to be addressed urgently.

4.5 Physical Condition of Facilities

Table 4.4
The condition of the buildings according to rapid assessment using the National Health Facility Rating

NHFA Rating	Ownership (LA)(PGWC)	MDHS CHCs (excl RHCs)
1(condemned)	0	3 (Maitland, Grassy Park, Brown Farm)
2	0	3 (Woodstock)
3	2	6
4	5	7
5 (good condition)	15	4

Table 4.4 shows that the facilities combined/shared with COCT are generally in a better condition and some of the MDHS CHCs are in need of urgent replacement or repair. Table 4.5 lists the repairs done in the past year.

Table 4.5
Maintenance, repairs and renovations costing below R10, 000 at MDHS facilities 2003/4*

Facility	Improvement done
Mamre	Upgraded power supply, Painting
Grassy Park	Painting, repair of windows and fence
Kraaifontein	Air conditioners and extractor fans
Lotus River	Upgrade of water supply and dental building
Mitchell's Plain	Air conditioners
Michael M	Air conditioners and R & R, MOU completed
Guguletu	CHC R & R completed
Retreat	Phase 1 new building in progress
Elsies River	Minor R & R, Full upgrade planned
Bishop Lavis	R &R in progress
Brooklyn	MDR wards U/V lights, Fence and Stoep
Eerste River	Upgrade in various areas
Wesfleur	R & R completed
False Bay Hospital	Private wards, Stores & Roads completed

***Source- Mr Kriedeman, Parow Office**

4.6 Challenges

The following key issues need to be considered if it is accepted that there should be improved access to fixed PHC facilities:

Population to facility ratio. (Table 12) The current ratio of "fixed PHC facility" (excluding mobiles, satellites, RHS points, dental facility) to population is 1: 26, 217 (Census 2001). This is below the national norm of 1 PHC facility: 10 000 population.

Capacity of facilities. If it is accepted that the current number of fixed PHC facilities is adequate, then it must be ensured that the physical capacity of the facility is adequate to cater for its drainage population (i.e. some facilities cater for 50 000 people instead of 10 000 people). At many of the facilities containers & prefabricated structures have been added in order to improve on available space.

Condition of facilities. Table 4.4 shows that the MDHS facilities are generally in a poorer condition compared to the COCT and the Rural facilities. This reflects the lack of a provincial facility improvement strategy for the Metropole over many years. Some facilities, like Goodhope, Ruyterwacht and Strand, are small and inadequate rented facilities. Others, like Retreat, Lotus River, and Dr. Abduraghman & Hanover Park are prefabricated buildings over 20 years old.

Equitable distribution of fixed PHC facilities per sub-district. The current population per fixed PHC facility is much higher in the Khayelitsha and Mitchell's Plain sub-districts. The Central and Southern sub-districts have the lowest population per fixed PHC facility ratios. This inequity becomes much more pronounced if Equity Gauge principles (population dependent on public sector and population weighted for health needs) are applied.

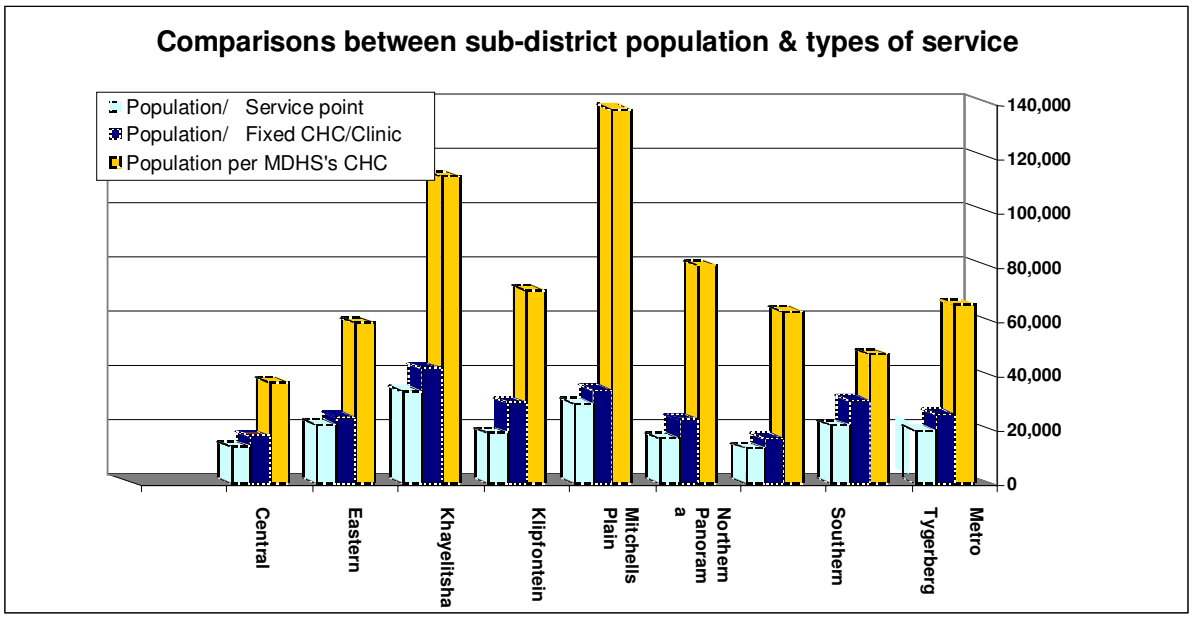


Figure 4.1: Comparison between sub-district: 3 types of service sites against sub-district population

District Hospitals: As indicated in the Health Care 2010 policy document, there is currently an absolute shortage of level 1 bed in the Metropole and the future re-designation of level 2 hospitals will go some way to address this shortage. The building of 2 additional hospitals in Khayelitsha and Mitchell's Plain sub-districts will meet the demand for beds in those areas. The Interdivisional Planning between Regional hospitals and the MDHS will start in the new financial year.

Finally, the plans for the service delivery platform, package of services and management structures that flow from it, as well as the amalgamation with the COCT, will impact on the details of the infra-structural planning and these issues need to be finalised as soon as possible.

SERVICE PLATFORM

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