5. Package of PHC services

5.1 Community based services
5.2 CHC based services
5.3 District and specialised hospitals services
5.4 Challenges

5.1 Community Home Based services

See Section 4: Table 4.1 for the list and the extent of services across the Metropole. Full reports are available on the Community Home Based Care initiatives, which are currently being financed by both earmarked EU funding and the Provincial equitable share.

5.2 CHC based services

The Table 5.1 in this section lists the package of services.

Table 5.1.
The package of primary care services delivered by CHCs & RHCs

Elements of the Package	CHC	RH	MOU	TOTAL	COMMENTS
Child Curative	44	0	0	**44**	
Nutrition	22	0	0	**22**	
ORT corners	9	0	0	**9**	Training offered, tables set up
24 hour normal deliveries	0	0	11	**11**	5 Mowbray MOUs, 6 MDHS MOUs.
Antenatal	6	0	12	**18**	4 service delivery points at LA sites
Postnatal	0	0	12	**12**	Includes Heideveld ANC/PNC
Family Planning	37	7	0	**44**	Includes 2 integrated sites where PGWC offers FP
TOP procedure (MVA)	2	0	0	**2**	Offered at Mitchell's Plain and Michael Mapongwana
TOP Counselling	44	7	0	**51**	Pre Abortion Counselling
Screening Cervical Cancer	44	7	0	**51**	
Rape Survivors: Forensic	7	0	0	**7**	Medico Legal Purposes – under review
Rape Survivors: Follow/up	9	0	0	**9**	Follow-up service for ARV etc
STI	44	7	0	**51**	
HIV/Aids: VCT	44	7	0	**51**	
PMTCT	0	0	12	**12**	
TB: Detection	44	0	0	**44**	
Treatment initiation	2	0	0	**2**	Initiated at shared facilities, provided by LA
Minor Ops	6	0	0	**6**	Vasectomies, tubal ligation and minor office surgery
Trauma & Emergency 8hr	44	0	0	**44**	
24hr	9	0	0	**9**	
Adult: Acute & Chronic	44	0	0	**44**	
Social Workers	12	0	0	**12**	In addition the Social workers visit other CHCs as well.
Mental Health	39	0	0	**39**	
Rehabilitation sites	23	0	0	**23**	13 OT sites and 21 Physiotherapy sites. .
Orthopaedic nursing	33	0	0	**33**	Visiting PN
Oral Health	28	0	0	**28**	23 CHCs and 5 Local Authority clinics Includes Hope Street Dental
Ophthalmology	3	0	0	**3**	Woodstock, Silwertown, Eerste River
Dermatology	2	0	0	**2**	Hout bay & Ocean View
X-Ray Services	15	0	0	**15**	These CHCs service the rest of he CHSO, Local Authority, Home Affairs, & Clothing industry Benefit Fund
Occupational Health	1	0	0	**1**	Provided at Reed Street

4.4 District and specialised hospitals services

Table 5.2
Summary of the current service delivery package at the Hospitals

Service Elements	District Hospitals			TB hospitals	
	FBH	ERH	WFH	BCH	DP Marais
24 hr Casualty	Yes	Limited	Yes	N/A	N/A
Maternity Unit / MOU	Yes	No	Yes	N/A	N/A
Emergency Caesars	No	No	Yes	N/A	N/A
Surgery: uncomplicated laparotomy (full package)	No	Yes – surgeon on ERH staff	No	N/A	N/A
Minor procedures / day surgery	Yes	Yes	Yes	No	No
Gynaecology: D & C	Yes	No	Yes	N/A	N/A
Psychiatry: acute care	Yes	Yes	Yes	N/A	N/A
Medicine: adult	Yes	Yes	Yes (beds limited)	Yes	Yes
Paediatrics	Yes	Yes	Yes	Yes	No
Rape Survivor services	Yes	No	Yes	Yes	N/A
Radiography (excluding barium meals / HSG)	Yes	No (private facility)	Yes	Yes	Yes
OPD	Yes – comprehensive / & PHC	Yes – limited / referrals only	Yes – comprehensive / & PHC (large)	No	No
Rehabilitation	Yes – no OT / SW/Stherapy	Yes – no OT/PT	Yes – part-time PT / require PT/OT /ST/ SW	Yes – OT / PT / OTA / PTA / audio	Yes – OT / OTA / SW
Outreach	Yes	Yes	Yes	No	No
Laboratory via NHLS	Yes	Yes	Yes	Yes	Yes

Table 5.3
Package of services at Specialised TB Hospitals

SERVICE ELEMENTS	BROOKLYN	DP MARAIS
MDR In-Patient	Yes	No
MDR Outreach	Yes	No
Rehabilitation Of Chronic TB Patient – Non-Ambulatory	Yes	No / Limited
Rehabilitation Of Chronic TB Patient - Ambulatory	No	Yes
Hospitalisation Of TB Client (Medical Cxns; Rechallenge)	Yes	Yes
Paediatric TB Clients (Includes School Service)	Yes	No
Research	Yes	No
Beds	305	260
Acute Admissions	Yes	Yes, Limited
Current Staffing Norms (Nursing)	1: 3	1: 17
Ideal Staffing Norms (Nursing)		1: 12

Table 5.4.
Package of services at SUB-ACUTE Facilities

SERVICE ELEMENTS	BOOTH (BEDS ALLOCATED)	ST LUKES (Pinelands)	CONRADIE LIFECARE
Rehabilitation (Functional Gain); Older Person	Yes	Sessional PT, no OT, SW, ST	Yes
Medical Cases	Yes **(64)**		Yes
HIV / AIDS	Yes	Yes	Yes
Non-Wt Bearing Orthopaedics	Yes		
Terminal Care	Yes	Yes	
Respite Care	Yes	Yes (Two weeks)	
Awaiting Placement	Yes **(10)**		
Wound Healing	Yes **(10)**		
Beds (Present)	84 (Cap. for 102)	20	180
Staffing Norms	1: 6		

Tables 5.2, 5.3 and 5.4 list the services provided by these facilities. ERH has no maternity and only limited casualty services and this need has to be addressed urgently.

5.5 Challenges

The services at CHC level are fragmented and duplicated between the MDHS and COCT. This will change with the decision to provincialise all PHC services, to re-designate some facilities as either clinics or CHCs and to re-configure the package of services at the new district hospitals in each sub-district. The challenge is therefore to deliver the full PHC package and District Hospital package at sites accessible to communities and under one management authority.

PACKAGE OF PHC SERVICES

6. PHC Personnel

6.1 Staff Numbers
6.1.1 Community based
6.1.2 Programme Management
6.1.3 District Management CHCs
6.1.4 District hospitals
6.1.5 TB and Specialised hospitals
6.2 Employment Equity
6.3 HR movements and activities
6.4 HRD – Skills development
6.5 HRD – Training
6.6 Employee's Assistance Programme (EAP)
6.6 Management and support personnel
6.7 Challenges

6.1 Staff numbers

6.1.1 Community based

There are a total of 752 Community Home Based Care workers in the Metropole - 295 in HBC, 376 providing Community DOTS and 81 IMCI workers. Table 6.1 reflects an inequitable distribution of carers across the sub-districts.

Table 6.1
Human resources for Home Based Care

Sub-district	Total	General HBC	Palliative HBC	PN
N. Panorama	22	19	3	2
Central	18	15	3	1
Southern	45	43	2	4
Klipfontein	54	52	2	4
Mitchell's Plain	21	19	2	2
Tygerberg	50	45	5	4
Khayeltisha	24	22	2	3
Eastern	61	63	5	5
Metropole	295	271	24	25

* U. van Vuuren

6.1.2 Programme Management (Parow Office)

This office is responsible for management supervision; monitoring and evaluation of Primary Health care programme in the Metropole. The programmes include TB, HIV/AIDS, Reproductive Health, Maternal Health, Child Health, Nutrition, Rehabilitation, Chronic Care, Oral Health, Environmental Health, Mental Health and Health Promotion. (Table 6.2)

Table 6.2
Programme Staff

Job Title	Filled	Vacant	Total
DD Programme	1	0	**1**
Aux. Serv. Officer	1	2	**3**
Community Liaison Officer	4	1	**5**
Dentist	1	0	**1**
Dietician	1	0	**1**
AD:Nursing	8	2	**10**
CPN	2	0	**2**
OT	1		**1**
Environmental HO	2	2	**4**
Total Staff	**27**	**10**	**37**

6.1.3 District Management (Woodstock office) and CHCs

Table 6.3
District Management (Woodstock office) & CHCs

Job Title	Filled	Vacant	Total
Admin	269	75	**344**
Artisan	2	2	**4**
Aux. Serv. Officer*	186	25	**211**
Cleaners	243	24	**267**
Clinical Psychologists	1	2	**3**
Community Liaison Officer	0	1	**1**
Dentists	38	6	**44**
Dieticians	5	5	**10**
Drivers	17	3	**20**
General	80	24	**104**
Medical Officers	145	45	**190**
Professional Nurses	479	99	**578**
Nursing Assistants	223	31	**254**
Staff Nurses	174	36	**210**
Occupational Therapists	6	4	**10**
Oral Hygienists	17	4	**21**
Prof. Admin Clerk	16	0	**16**
Personnel Officers	11	4	**15**
Pharmacists	51	18	**69**
Physiotherapists	15	4	**19**
Radiographers	27	6	**33**
Social Workers	13	5	**18**
State Account Senior	1	0	**1**
SASO: Therapy Assistants	1	1	**2**
Total Staff	**2021**	**423**	**2444**

*Includes HPOs, Pharmacist, Dental Assistants

6.1.4 District hospitals

Job Title	False Bay		Eerste River		Wesfleur	
	Filled	Vac	Filled	Vac	Filled	Vac
Specialist	1	0	0	0	0	0
Medical Officer (incl. SMS & Dentist)	7	0	8	3	6	1
MO Sessional	1	0	0	0	4	0
Ad Nursing	1	0	1	0	1	0
Prof Nurse	24	5	34	31	26	1
CNP	0	0	0	0	0	0
Enrolled Nurse	16	0	33	12	10	0
ENA	31	0	40	32	19	4
Pharmacist	2	0	2	0	2	0
Pharm. assistant	1	0	0	0	3	0
Radiographer	2	0	0	0	1	0
Physiotherapist	1	0	1	0	0	0
Dietician	1	0	0	0	0	0
Social worker	0	0	1	0	0	0
Food service Mx	6	0	0	0	3	1
Admin	26	3	20	12	18	7
GA, Porters, workshop, others	42	2	61	10	21	1
TOTAL STAFF	**162**	**10**	**201**	**100**	**114**	**15**

6.1.5 TB and Specialised Hospitals

Job Title	BCH		DP Marais		Booth		St Lukes	
	Filled	Vac	Filled	Vac	Filled	Vac	Filled	Vac
Specialist	0	0	0	0	0	0	0	0
Medical Officer (incl. SMS & Dentist)	3	0	.625	0	0	0	0	1
MO Sessional	0	0	0	0	.625	0	3	0
Ad Nursing	0	0	0	0	0	0	1	0
Prof Nurse	16	0	6	0	6	3	5	0
CNP	0	0	0	0	1	0	0	0
Enrolled Nurse	7	0	3	0	1	0	0	0
ENA	54	0	4	0	20	18	0	0
HB Carers	0	0	0	0	0	0	16	2
Pharmacist	1	0	0.1	0	0.8	0	0	0
Pharm. assistant	2	0	0	0	0	0	0	0
Radiographer	1	0	0	0	0	0	0	0
Physiotherapist + PA	3	0	0	0	1	0	.1	0
OT/Audiologist	0	1	.625	0	.625	0	0	0
Mid-level rehab	0	0	3	0	2	0	.2	0
Social worker + SWAux.	2	0	1.25	0	.75	0	0	0
Food service Mx	14	0	0	0	0	0	0	0
Admin	9	0	0	0	0	0	1	0
GA,Porters, workshop, others	17	0	0	0	0	0	9	0
TOTAL STAFF	**129**	**1**	**18.6**	**0**	**31**	**21**	**35**	**3**

SUB -DISTRICT	Population Census 2001 (proj 2003)	population Census 2001 PROJ 2010	Headcount 2002	Personnel Expenditure 2002	Staff 2003 Sept	Professional Nurses	Population (census 2001) per nurse	Doctors*	Population (census 2001) per doctor	EN"S	ENA's	Pharmacists	Health Promoters	HIV lay counsellors	Physio therapists	Occ. Therapists	OT Assistants
Athlone	206,196	235,233	273,608	18,621	171	39	5,287	**19**	25,774	16	16	4	7	13	2	0	1
Blaauwberg	150,431	171,616	66,592	2,633	27	7	21,490	**3**	50,144	3	2	1	3	10	0	0	0
Central	239,597	273,339	330,831	15,925	139	34	7,047	**12**	19,966	14	17	3	6	25	1	0	0
Helderberg	160,060	182,601	124,559	25,466	66	20	8,003	**5**	32,012	3	3	2	5	12	1	1	0
Khayelitsha	341,626	389,736	429,665	27,969	254	60	5,694	**26**	13,139	19	52	3	9	40	2	1	1
Mitchell's Plain	290,509	331,420	161,943	13,733	126	27	10,760	**23**	12,631	13	16	4	13	11	1	0	1
Nyanga	298,950	341,050	284,756	18,166	192	40	7,474	**28**	10,677	20	29	4	13	24	0	0	0
Oostenberg	314,693	359,009	152,835	10,475	130	36	8,741	**13**	24,207	14	14	1	12	13	1	1	1
South Peninsula	358,862	409,400	394,754	21,401	171	42	8,544	**30**	11,962	16	14	4	12	19	1	1	1
Tygerberg East	273,157	311,625	553,225	15,201	168	47	5,812	**26**	10,506	12	20	5	8	10	2	1	1
Tygerberg West	354,659	404,604	658,252	33,299	345	97	3,656	**42**	8,444	35	42	8	11	23	3	1	1
Totals CHSO	2,988,740	3,409,632	3,431,020	202,889	1,789	449	6,656	**226**	13,225	165	225	39	99	200	14	6	7
Totals CITY	2,988,740		3,534,487		916	389	7,683	17		93	482	6	0				
Totals METRO	2,988,740	3,409,632	3,431,020		2805	838	3,567	243	12,299	258	707	45	99	200	14	6	7
Total MDHS Management & Logistical Support							166										

*** Doctors expressed as FTE (40 hrs per week)**

6.2 Employment Equity across MDHS

Table 6.6
Numerical statistics for MDHS 2003 – 2669 employees

	MDHS	Demographic composition
White	9.1%	21.4%
Indian	1.9%	1.0%
Coloured	62.1%	56.0%
African	26.3%	21.6%
Female	75.9%	52%
Male	24.1%	48%
Disability	0.1%	2%

Table 6.6 reflects the average rates across all levels and occupations. The actual rates vary greatly with occupation, to be expected as this reflects historical and gender patterns of educational levels and occupational choices. The challenge would be to redistribute all categories of staff equitably across sub-districts and all levels of management.

6.3 HR movements and activities

Table 6.7
Staff movement and Merit awards at the CHSO only

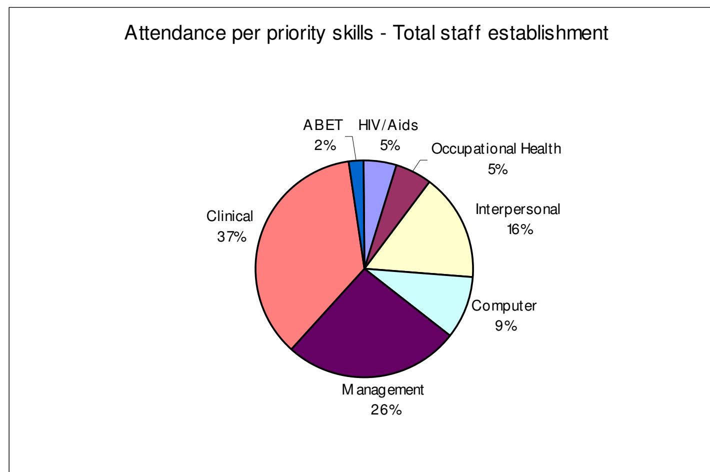
	Resignations	Early Retirement	Retirement	Medical Boarding	Deceased	Transfer	Merits applied for	Merits approved
CHSO	86	2	11	9	8	6	160	104

The staff performance management system (SPMS) was implemented from September 2003. This proved to be very challenging for managers and supervisors at all levels. Nevertheless, all staff had job descriptions & performance plans developed during the year. Performance review & assessment took place as scheduled

Approximately 6% (122) of the CHSO staff left the services in the past year (Table 6.7) The accurate report on the appointment of new staff (permanent, contract and agency) for the year has proven difficult to compile and will be an urgent task for the New Year. There is no reliable data on labour relations activities due to the absence of a MDHS labour officer.

6.4 HRD – Skills Development (CHSO only)

The HRD office at Woodstock did not duplicate the services provided at Parow, but focussed on co-ordinating and developing functions and structures within CHSO. These were: compilation of Workplace SDP; establishment of a training committee; structuring the utilisation of the SD Fund; setting up a selection process dependent upon WSP, PA and Individual development plans; developing a database and building mentorship capacity for managers. In line with the operational plan and other organisational needs, staff was sent on training as reported in figure 6.1. As expected, clinical training formed the largest component (37%), followed by management and administrative training. Challenges for the next year will be to address the low (2%) figure for ABET training.



. **Figure 6.1 Spread of CHSO staff training for 2003/4**

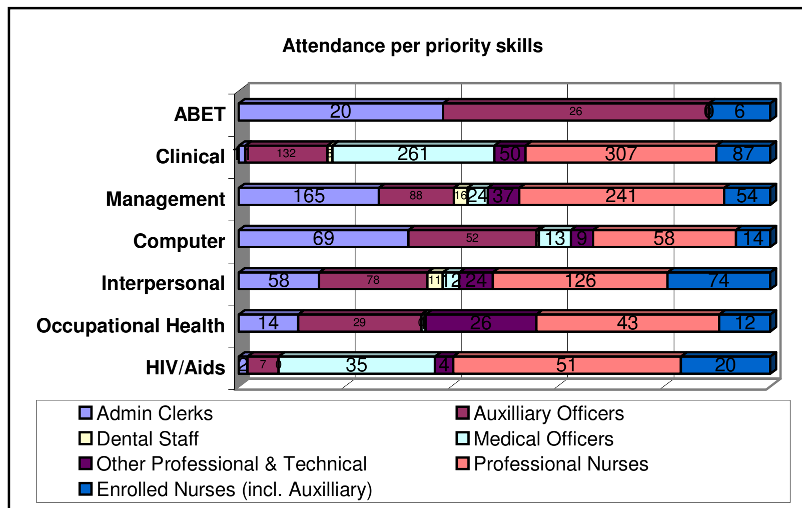


Figure 6.2 Attendances per priority skill per professional category for CHSO

Figure 6.2 shows the various categories of staff that were trained; indicating that many more non-professional staff was trained. A sustainable HRD office for MDHS to be integrated with the four District/Specialised Hospitals remains a challenge. Developing appropriate opportunities for career-pathing within the organisation; implementation of training of assessors and pharmacy assistants to meet the requirements of the Medicine & Related Substances Act; mentorship structures to enhance CNP training, re-activation & retraining and increased enrollment for ABET will form the major activities in the new year.

6.4 HRD – Training (Metropole)

The HRD department at the Karl Bremer site provided training for all health institutions in the Metropole, as well as developing skills development plans and managing the provision of EAP for the district and secondary hospitals. In November 2003 this department joined MDHS. Twenty permanently employed staff is responsible for training and coordination of courses for the whole Metropole, including hospitals and local government. The courses coordinated over the twelve months included computer training for 137 staff (CHSO = 93) and general management and administration training through the Cape Administration Academy for 232 staff members (CHSO =116). Table 6.8 lists the detail of the courses presented at the Karl Bremer Training site for staff across all services and the number of CHSO staff trained.

Table 6.8
Courses presented at HRD Karl Bremer

Courses/Workshops/Seminars	Duration	Number of staff trained	
		Total	CHSO
Curative skills for PHC	44 weeks (P/T)	16	10
IMCI (PN)	21days	7	7
IMCI (CHSO - SASSO's)	days	35	35
Maternal Mother and Child (7 courses)	1 to 5 days	359	57
Personal Development (5 courses	2 to 5 days	201	26
Mental Health (2 Courses)	2 days	120	26
Women's Health (FP,TOP,STI)	1 to 10 days	223	51
Home Based Care & Geriatric Care	10 to 12 days	11	2
CDL updates –CHSO (6 courses)	1 to 2 days	81	81
General	1 to 2 days	253	82
Total		**1,306**	**377**

6.5 Employee Assistance Programme (EAP)

The component of **EAP** (of the formerly CHSO) has been in existence since August 1997. The staff consists of an EAP co-ordinator, Community Service Psychologist, part-time supervisory Psychologist and a part- time Administrative Assistant. The main focus of this programme is to allow employees access to psychological support. This has been by individual and group sessions. Table 6.9 lists all the activities of the EAP. Strengthening of existing EAP structures and out-sourcing specific functions to an agency are the current challenges.

The focus of the work has been on changing the coping strategies of management. Most of the presenting problems were work-related adjustment problems as a result of the rapid, progressive changes undergone by health services, as well as the impact of violence on the Cape Flats and HIV/AIDS.

Table 6. 9
EAP activities for 2003/4

Service Centre	No.	Content
Interventions	73	Various issues at CHCs
Clinical	220	Individual sessions
	112	Group sessions
	20	DMT sessions
Presentations	12	Troubled employee, Communication, Ethics and Confidentiality
Projects in progress	7	Bereavement notification forms, Staff satisfaction surveys, Resilience Training (Inkhatahlo, Development Dynamics), HIV policy for workers, Child care for workers and incorporating District Hospitals into EAP

Two major interventions as part of the change management strategy, Inkathalo and Development Dynamics, were initiated. The Inkathalo intervention, which was a more reflective process, reported that the staff felt a lack of appreciation and communication by management, lack of appropriate resources, safety and security. However, the conclusion was that with the development of a common vision and good leadership at all levels of management (especially facility level), the willingness of staff to care, which was still there, could be consolidated and expanded upon.

Development Dynamics reported that:
"*Participants showed all the symptoms of people who had to deal with disruptive transformation and change with low resilience levels. Their resilience levels were low because they had not, before the workshops, reflected systematically and consciously on their responses to the changes that were brought about by the 2010 plan. As soon as they did that, they started to become more willing and able to engage productively with the demands of the changes. Whatever dysfunctional and unproductive emotions and behaviours participants displayed before the workshops also happened because the organization gave very little attention to transition management up to now. Participants' continuous attempts to sustain their own resilience, and that of their subordinates consciously, and the transition support will determine whether participants stay productive or regress to even deeper levels of dysfunction in the future.*"

These interventions will be sustained and strengthened as the need for active change management processes has been identified.

6.6 Management and support personnel

There have been a number of interim management structures and processes over the past year (see organogram in Annexure 13.1) as the planned work-study had not taken place by the end of the financial year. A description of the management follows.

a) District (Directorate): Formally appointed staff are as follows Director for Metropole, DD: DHS, DD: Programmes; SMS for Clinics and Hospitals; four AD's: Nursing, Finance, HR and Procurement (supply chain management). This component has 166 staff members working in the Stores, CSSD, Linen bank, Transport, Workshop and administrative (HR, Finance & Procurement) areas.
b) Sub-district: Informally appointed management teams for the 11 sub-districts that are aggregates of 5 CMO's, 10 Area CPN's, other health professionals and Facility Managers.
c) Facility: CPN's that have been informally appointed to positions and are often part of service delivery processes, are managing the CHCs.
d) District and specialised hospitals: These facilities have Medical Superintendents (appointed or acting) heading the management teams, with most of the administrative support structures in place.
e) Health programmes: The DD: Programmes heads this component with AD's driving the priority health programmes

The management and service delivery challenges faced by the MDHS, as well as the priority departmental initiatives, led to the setting up of the following interventions and projects:

- Drug Supply and Management Project;
- Financial and Procurement Management Project;
- Employee Assistance Programme consolidation;
- Quality of Care initiatives;
- Skills Development component of HR
- Health Information Department.

These interventions will become consolidated and move from the project stage into the mainstream of management.

6.7 Challenges

The many organisational changes that have taken place and continue to occur in an environment of increased demands and limited resources have left many employees stressed and fatigued (Change fatigue). The delays in the implementation of the DHS have compounded the situation. The challenges include:
Organisational design and structure – need for work-study to be performed and the recommendations implemented as soon as possible cannot be overstated. There must be special emphasis on management capacity and competency for sustainable **DHS development** as well as appropriate clinical workforce and skills mix with equity across the sub-districts.

General shortage of skilled clinical personnel across the province, particularly in certain sub-districts and certain sub-specialities (Mental Health, Obstetrics) will have to be addressed. This need will be partially met by increasing the number of **Clinical Nurse Practioners.**

To care for the carers by not only by developing a sustainable EAP, but also by **developing a comprehensive change management strategy for transforming the workforce,** directed by the findings of the two external interventions. The impact of the HIV/AIDS epidemic on the staff (both as caregivers and sufferers) and the threatened safety/security of staff due to high levels of violent crime need to be addressed as well.

PHC PERSONNEL
PHC PERSONNEL

7 PHC Service Delivery

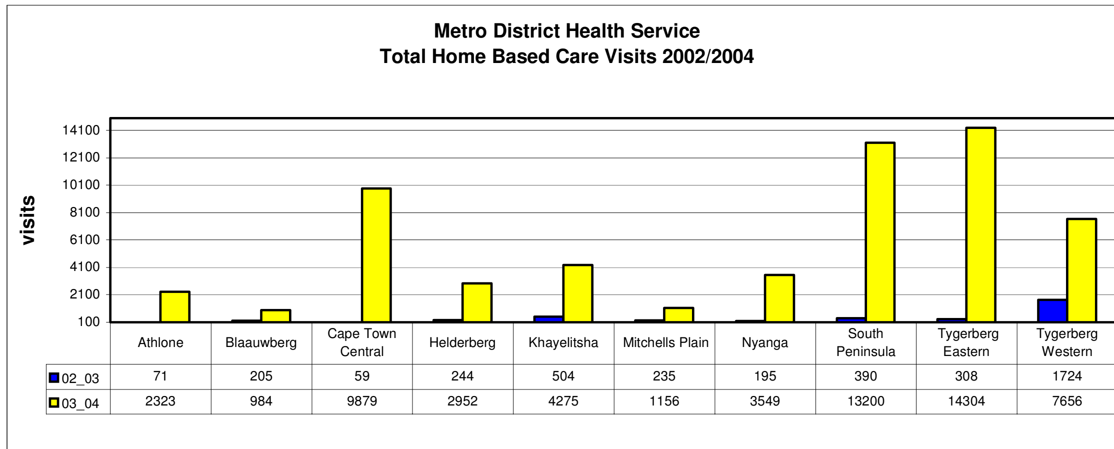
7.1 Community Home Based Care
7.1.1 Home based services
7.1.2 Home based rehabilitation
7.1.3 School Health services
7.1.4 Nutrition Services
7.2 Community Health Centers
7.3 District & Specialised Hospitals
7.4 Priority Health Programmes
7.4.1 Child Health
7.4.2 Woman's health
7.4.3 Nutrition
7.4.4 TB
7.4.5 HIV/AIDS
7.4.6 Non-communicable
7.4.7 Violence and Trauma
7.4.8 Mental Health
7.4.9 Service for the Disabled
7.4.10 Oral health
7.4.11 Health Promotion
7.4.12 Environmental Health
7.5 Challenges

7.1 Community Home Based Care

This includes services delivered at individual homes; community based health facilities (group homes, special care facilities) and non-health institutions(crèches, schools, prisons, Old Age Homes).
This report only covers four of the above services in some detail; comprehensive reports on the other activities are available.

7.1.1 Home Based Care Services

The data in Figure 7.1 indicate the activities across the sub-districts. The substantial increase from 3,935 to 60,278 visits over the 2 years is evidence of the shift to this level of service delivery, as well as better data collection systems. The uneven service provision in the Metropole (inequity) is to be addressed.



	Athlone	Blaauwberg	Cape Town Central	Helderberg	Khayelitsha	Mitchells Plain	Nyanga	South Peninsula	Tygerberg Eastern	Tygerberg Western
02_03	71	205	59	244	504	235	195	390	308	1724
03_04	2323	984	9879	2952	4275	1156	3549	13200	14304	7656

Figure: 7.1 Total home-based care visits over 2002/04

7.1.2 Home based rehabilitation services

Rehabilitation services are provided in the home, where rehabilitation therapists mainly support and train home based carers to provide basic rehabilitation. One pilot site, in the Southern sub-district, is developing support mechanisms for the provision of rehabilitation services within the existing HBC programme structures. The activities include designing individual needs based programmes, mainly exercise, correct positioning and moving for physically disabled people. This service is consistently provided by the following facilities:

Physiotherapy – Bishop Lavis, Delft and Elsies River
Occupational Therapy – Retreat, Ocean View, Hout Bay, Lotus River, Grassy Park, Maccassar, Elsies River, Delft and Kleinvlei.

There are a total of 35 Psycho-Social Rehabilitation (PSR) groups in the Metropole, of which 19 are provided by PGWC. A total of 10,562 attendances were recorded, with 35% of the clients receiving 4 sessions per month. The general group based activities include 5 back care groups, 4 CDL groups and 2 activity groups.

7.1.3 School Health services

There are 647 schools in the Metropole (Primary= 438, Secondary =160, other= 49) with a total of 416,459 learners. The school health services provide:

- assessments and screening (Table 7.1)
- individual/group/family/teacher counselling (total of 3626 sessions this year)
- health education & promotion programmes (67,770 learners exposed this year) with **HIV/AIDS/Life skills training of educators being the major activity**
- Health Promoting Schools, the joint initiative with the Department of Education according to National Policy guidelines – 75 schools are designated HPS, 291 schools are currently involved in some activities while 600 have been exposed to the concept of HPS over the years.
- In service training and support to nurses
- Multi-disciplinary interventions – Abuse Forum, Red Cross Hospital Developmental Clinic and Child Health Unit

Table 7.1
Number of assessments/Screening done during the year

	Assessments/Screenings
Grade 1	36,038
Non-Grade 1	82,987

7.1.4 Nutrition services

The Nutritionists assisted with 165 development programmes, including education and support to community-based projects such as vegetable gardens and educare activities. 333 primary schools benefited from the PSNP allocation of R13, 270,000 and the monitoring done by the nutritionists.

7.2 Community Health Centers

As seen in Table 7.2 the combined utilisation rates have steadily increased over the past 4 years and the rate remains within the national target, although private sector utilisation is not taken into account. The COCT figures include immunisation campaign data and some of the MDHS Oral Health and MOU outreach service data.

Table 7.2
PHC Service Outputs (2000 – 2003) Using Total Population figures

	2000/1		**2001/2**		**2002/3**		**2003/4**	
	Total Head count	**Utilisation rate**	**Total Head count**	**Utilisation rate**	**Total Head count**	**Utilisation rate**	**Total Head count**	**Utilisation rate**
PGWC	3799003	1.32	3844564	1.34	3913819	1.33	3,894,615	1.31
COCT	3542686	1.23	3534489	1.23	3942556	1.34	4,326,588	1.45
Combined	7,341,689	2.55	7,379,053	2.56	7,856,375	2.68	8,221,203	2.76

Table 7.3
PHC Service Outputs per 11 sub-districts

	2003/4
Central	339,738
Athlone	413,219
Mitchells Plain	221,564
Nyanga	329,025
South Peninsula	385,714
Tygerberg West	671,911
Tygerberg East	581,107
Khayelitsha	428,816
Helderberg	202,660
Oostenberg	339,060
Blaauwberg	67,021
Total	**3,894,615**

Tables 7.3 & 7.4 show the total PHC visits in the year. Almost 4 million visits are recorded for the year.

Table 7.4
PHC Service Outputs per 8 sub-districts

Sub-districts	**2003/4**
Central	597,380
Eastern	416,739
Khayelitsha	463,601
Klipfontein	712,447
Mitchell's Plain	242,781
Northern Panorama	474,489
Southern	314,973
Tygerberg	677,919
Total	3,894,615

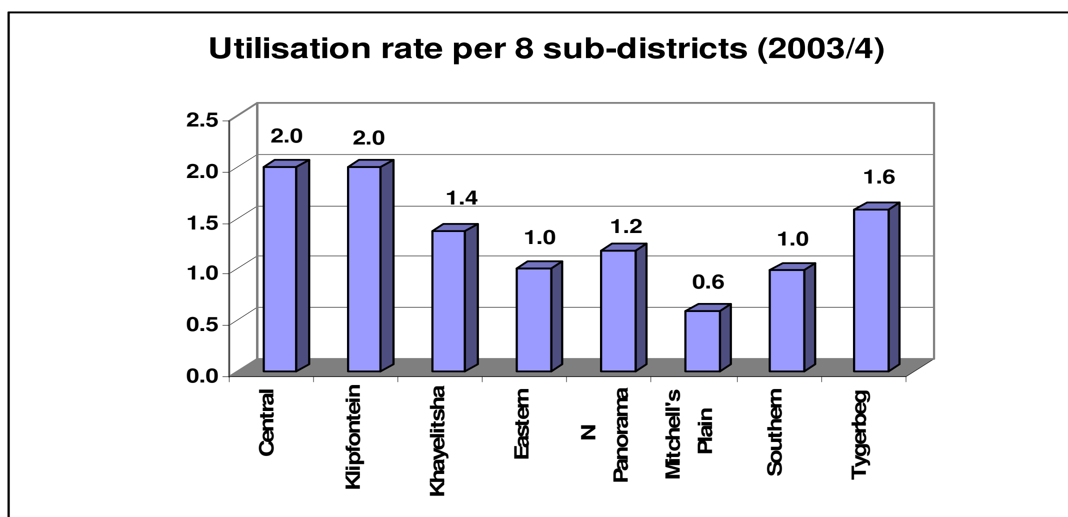


Figure 7.2: Utilisation rates at CHCs per sub-district in 2003/4

The sub-district differences in facility-based visits reflect the differences in the dependent population, socio-economic profile, burden of disease and the historical placement of facilities over the years (Fig7.2). Almost half of the districts are below the Metropole utilisation rate of 1.31.

Table 7.5
Trauma and Medical Emergency Units – After-hour Patient visits

	2001/2	**2002/2003**	**2003/4**
Delft	44,580	48,689	50,992
Elsies River	31,771	28,110	31,869
Guguletu	43,983	40,338	42,960
Hanover Park	25,693	27,507	29,013
Khayelitsha	45,618	51,692	53,988
Kraaifontein	30,712	31,038	39,332
Mitchells Plain	47,586	47,416	49,961
Retreat	30,941	26,829	28,918
Vanguard	32,794	35,463	37,501
Total	**333,678**	**337,082**	**364,534**
Secondary Hospitals (Provincial)*	275,304	251,359	291,405
Tertiary Hospitals*	124,443	164,672	162,177

* DOH Annual Report 2003/4

The number of visits to the after-hour services at the 9 Trauma Units has increased by 27,000 over the last year. The presenting problems were both medical and trauma, with over 70,000 paediatric cases seen during this period. The headcounts at the hospitals reflect a similar upward trend over the 3 year period.

The general stabilisation of attendances indicates that "saturation point" has been reached with the current staff complement. The increase in the CHBC clients, as noted above, may be contributing to this stabilisation, but the increased BOD means that the health needs of many people are not addressed at these facilities.

7.3 District & Specialised Hospitals

Table 7.6
District Hospital data

	April 2002 – March 2003			April 2003 - 2004		
	FBH*	**ERH**	**Wesfleur**	**FBH**	**ERH**	**Wesfleur**
Admissions	4,414	2,676	1,168	4,413	6,834	2,737
OPD Headcount	34,764	3 651	70 682	35,570	9,544	64,438
In patient days	17,324	13,991	2048	14,245	18,071	5,374
PDE	43,017	16,207	49,461	32,578	22,811	36,066
OPD In-Patient Day	2,00	0,26	29,06	3,06	2,35	1,35
Cost per PDE	R354.26	R1, 989.42	R286.99	R706.64	R1, 100.83	R442.41
ALOS	3,85	4,65	2,48	2,90	2,35	1,21
BOR	67.4%*	58.6%	25.7%	61.41%*	46.65%	63.27%

* FBH – 65 Public and 5 Private beds

Table 7.7
TB and Stepdown Hospital data

	April 2002 – March 2003			April 2003 – March 2004		
	BCH	Booth	St Lukes	BCH	Booth	St Lukes
Admissions	1,228	448	296	1 274	700	345
OPD Headcount	0	0	0	0	0	0
In patient days	ADD	ADD	ADD	82,580	19,173	2,177
PDE	10,0848	17,606	3,213	99,681	25,947	3,486
OPD In-Patient Day	--	--	--	--	--	--
Cost per PDE	R191.30	R350.05	R411.01	R205.98	--	--
ALOS	75,8	43,05	11,33	68,89	40,48	10,93
BOR	90.2%	84.9%	43.8%	90.78%	85.80%	48.42%

ERH was commissioned in September 2002 and therefore the apparent increase in head counts over the 2 years. Wesfleur has a much higher load of OPD headcounts compared to the other district hospitals. There has been an overall drop in the average length of stay (ALOS), but while Wesfleur more than doubled its bed occupancy rate (BOR), the general BOR is below optimal rates. The cost per PDE varies greatly across the 3 hospitals and is the result of a range of factors. Booth Memorial hospital increased its admission from 448 to 700 and is planning to increase the number of beds in the New Year.

7.4 Priority Health Programmes

7.4.1 Child Health Services

The immunisation coverage was 71% (population according to Equity Gauge Project) or 95% (population according to the 2001 census). Table 7.8 shows the total attendances of children under 5 years for care at both COCT and MDHS facilities.

Table 7.8
Head counts for under 5 services

Under -5yrs	Total	% of Total Headcount
MDHS	130,168	3.3%
COCT	1,356,121	31%

The cases managed by MDHS were exclusively curative while COCT provided mainly preventative service. Many are referred from the COCT clinics for further MO care and a significant proportion attend the after-hour service. The capacity to deliver this curative service at both the clinics and CHCs during the day needs to be addressed urgently.

Specific Adolescent Health services include the 3 accredited NAFCI sites plus 7 additional sites developed this year, 6 of which are at combined COCT/MDHS facilities. One site received a Gold and 2 sites Silver accreditation.

7.4.2 Women's Health

Obstetric

The number of visits to the MDHS MOUs has remained stable over the 3 year period averaging 130,000 per year. (Table 7.9)

Table 7.9
Total Visits (ANC, Deliveries & PNC) to the MOU service over the last 3 years

MOU	April 01 – March 02	April 02 – March 03	April 03 – March 04
Elsies River	31,002	28,816	22,973
Bishop Lavis	22,788	22,984	22,524
Kraaifontein	18,335	18,108	18,169
Vanguard	23,203	24,140	23,750
Macassar	7,794	9,411	9,399
Michael Mopangwana	31,357	31,192	33,736
Total	134,479	134,651	130,551

Table 7.10
Indicators for Ante Natal Services across the Metropole – 2003/4

Authority	Facility	First ANV < 20 wks	First ANV Total	% Bookings < 20 wks	Total ANV	No of visits per client
MDHS	B. Lavis + 2 satellites	2079	5654	37%	22,290	3.9
	E. River + 1 satellite	1742	3610	48%	17,222	4.7
	Kraaifontein + 2 satellites	1323	4184	32%	19,559	4.6
	Macassar	216	610	35%	3,181	5.2
	Michael M	636	3637	17%	23,451	6.4
	Vanguard	624	2230	28%	9,605	4.3
	False Bay	198	617	32%	2,975	4.8
	Wesfleur	608	1127	54%	6,885	6.1
TOTAL		**7426**	**21669**	**34%**	**105,168**	**4.8**
Mowbray MOUs	5 MOUs + 1 ANC	8634	22910	38%	97,937	4.2
COCT	Clinics X 7 Helderberg mainly	889	1448	61%	10,607	7.3

The MDHS average number of visits per ANC client is 4.8, well within the national norm of 3 -5 visits, NB SANC recommendation is 10 visits, Table 7.10. However, most facilities have about 30% of bookings done before 20 weeks, with Michael Mapongwana having the lowest % compared to the others, well below what is required of adequate Antenatal care. The high percentage at COCT clinics may be a reflection of the package of promotive mother-and-child services at these sites, as well as greater accessibility.

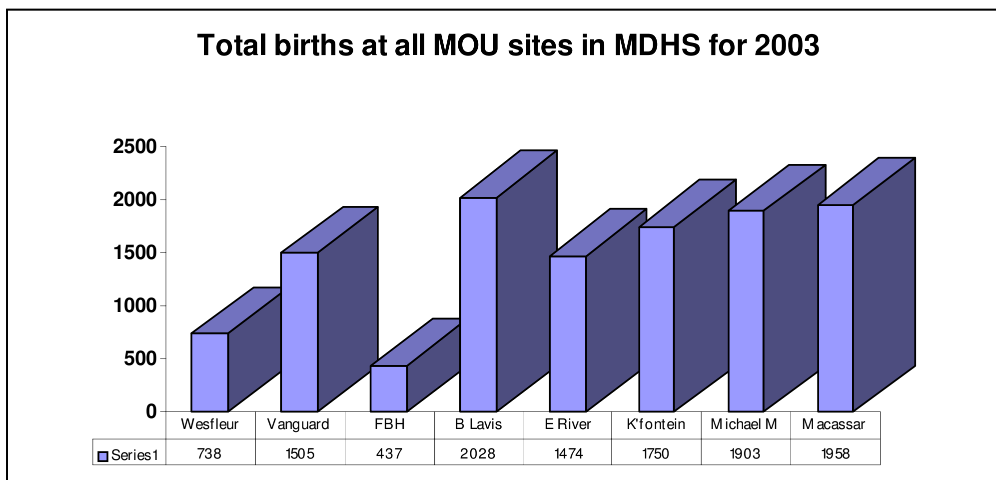


Figure 7.3 Total births at all MDHS sites for 2003

Of the 49,383 births in the Metropole 11,973 or 23.8% took place at MDHS facilities.

Termination of Pregnancy

Table 7.11
Number of TOP's done in the MDHS services Jan – Dec 2003*

	M Plain	MM*	FBH	Wesfleur	MDHS Total	Metropole Total	% done by MDHS
Jan	43	9	17	7	76	711	10.7
Feb	53	44	16	11	124	806	15.4
Mar	27	43	14	8	92	756	12.2
Apr	32	34	20	6	92	638	14.4
May	38	0	14	10	62	766	8.1
Jun	37	0	11	1	49	638	7.7
Jul	56	58	17	0	131	737	17.8
Aug	51	0	15	0	66	681	9.7
Sep	49	0	17	0	66	660	10.0
Oct	39	0	37	0	76	690	11.0
Nov	45	0	14	0	59	594	9.9
Dec	49	0	14	0	63	528	11.9
TOTAL	**519**	**188**	**206**	**43**	**956**	**8205**	**11.7**

* Data for some months from Michael Mapongwana still to be verified – data prepared by Metropole: Programmes B Smuts

Almost 12% of TOP's done in the Metropole were done at District level with a roving team and Mitchell's Plain site providing the bulk of the service (Table 7.12.) Most of the terminations are done under 12 weeks and the majority of the women treated were over 19 years. There has been some seasonal variation (February and July) but no increase over the 12-month period and the extent to which this service is responding to the need will have to be evaluated.

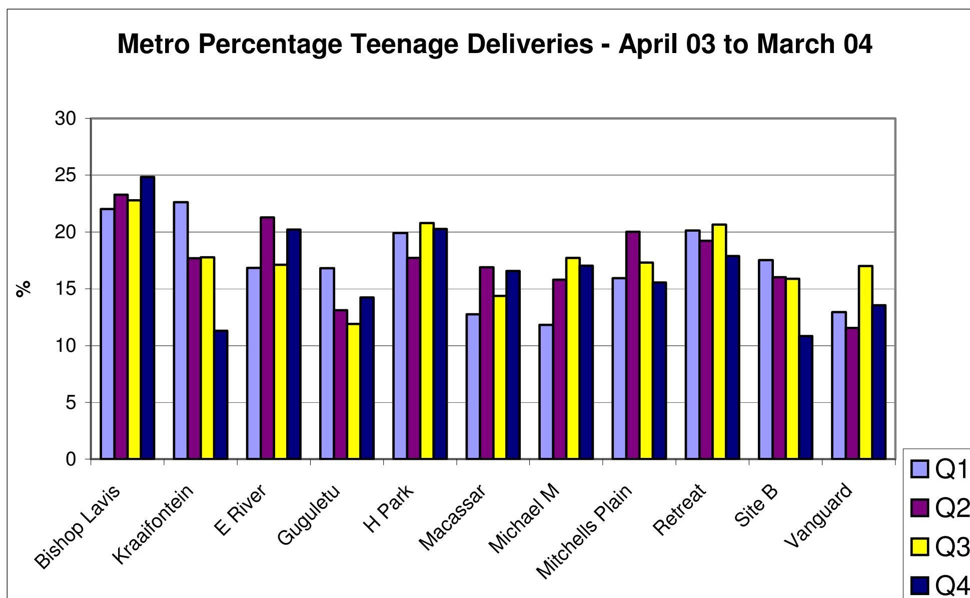


Figure 7.4 Teenage Pregnancies in the Metropole for 2003 to 2004

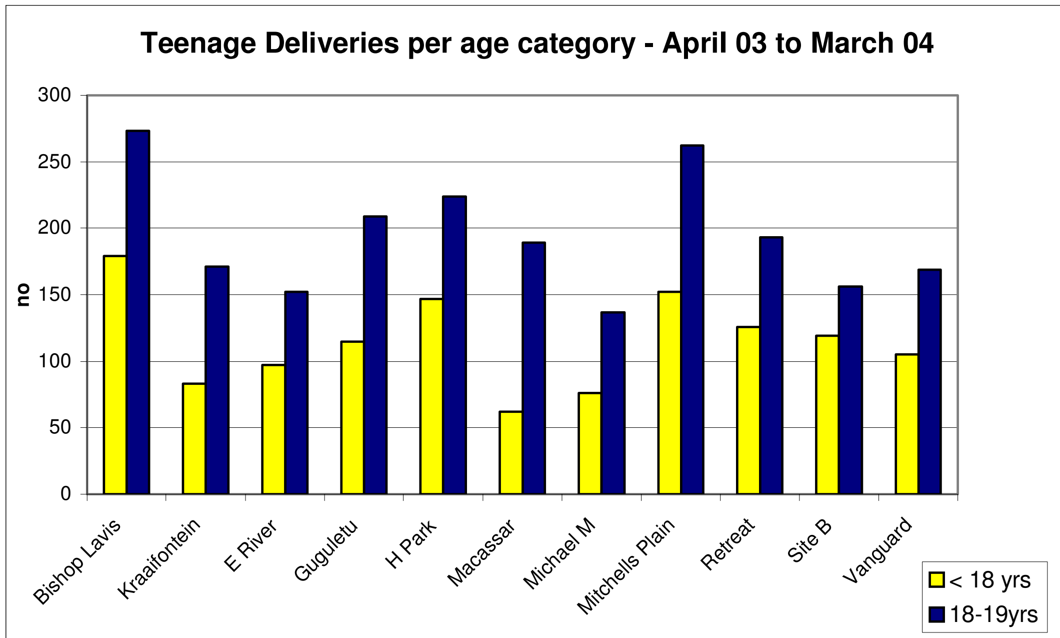


Figure 7.5 Teenage deliveries in the Metropole for 2003 to2004

Cancer of the cervix
A total of 23,019 cervical smears were done, representing 3.6% coverage of the women in the 30 – 59 age group. This represents a low coverage and a challenge for the future.

Sexual Abuse
There were a total of 4,708 cases of rape seen at the centers as listed below in the year 2002.

Table 7.12
Number of cases of rape managed at MDHS sites for 2002.

NORTHERN STRUCTURE		
DISTRICT	**TOTAL CASES (2002)**	**FOLLOW UP CENTRES**
Helderberg	326 (6.87%)	HHH/ Macassar CHC
Oostenberg	642 (13.53%)	Kraaifontein CHC/ Eerste River Hospital
Tygerberg West	567 (11.95%)	Elsies River CHC/ Dirkie Uys CHC
Tygerberg East	363 (7.65%)	Delft CHC/ Bellville South CHC
Khayelitsha	489 (10.31%)	Khayelitsha Site B CHC
Blaauwberg	227 (4.78%)	Westfleur Hospital/ Goodhope CHC
SOUTHERN STRUCTURE		
DISTRICT	**TOTAL CASES (2002)**	**FOLLOW UP CENTRES**
Cape Town Central	460 (9.70%)	Robbie Nurock CHC / Vanguard CHC
South Peninsula	426 (8.98%)	Lady Michaelis CHC/ Retreat CHC / FBHospital
Athlone	193 (4.07%)	Hanover Park CHC/ Dr Abduraghman CHC
Nyanga	618 (13.03%)	Gugulethu CHC/ Nyanga CHC
Mitchell's Plain	397 (8.37%)	Mitchell's Plain CHC

* Source : Metropole Region Management of Rape survivors Plan Sept 2003

7.4.3 Nutrition

This services are rendered at community, COCT clinics and CHCs and includes:

- Disease specific nutrition support, treatment and counselling - Individual and group counselling for CDL at 22 clinics; assessment of 3,867 children and adults; treating 3,290 malnourished children and implementing the Facility Based Nutrition Programme.
- Growth monitoring and promotion – training of clinic staff at 34 sites, training and counselling mothers and screening 8,492 under 5 year old children.
- Health promotion activities – with HP schools, community radio and TB programmes
- Micro-nutrient malnutrition control – by distributing Vit A supplements to all under 5's at clinics, MOUs and linking it to the de-worming programmes in selected sub-districts.
- Breast-feeding promotion and support - by counselling mothers and supporting the Baby Friendly initiatives.
- Household food security initiatives – training and support to community based activities
- Food services management – advisory service to institutions

Planning was done for 2 major changes in the next year, namely the transfer of funding of crèches to the Dept of Social Services and transfer of funding of the PSNP to the Dept of Education. These changes will allow this programme to focus on appropriate activities in the new year.

7.4.4 TB

The CHCs are mainly responsible for TB detection and the COCT clinics for the complete management of TB and DOTS. See caseloads in section 3.4.3. The total number of cases seen for the 2003 calendar year is 22,674 with 8,715 new smear +ve cases and the cure rate ranging between 64% and 77.1% per quarter. The drive to increase the number of persons tested (recommended – 1 positive: 10 negative smears) will increase the patient load, laboratory and drug costs and must by budgeted for. Table 7.13 once again shows the high figures for Nyanga sub-district, which will be hidden when, divided between the Athlone and Mitchell's Plain data in the new 8 sub-districts.

Table 7.13
MDR data for 2003 in the Metropole per sub-district*

Stats Per District For 2003

Sub-district	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Athlone	4	2	3	4	**13**
Central	8	9	7	6	**30**
Mitchell's Plain	2	5	5	4	**16**
Nyanga	11	13	23	7	**54**
Blaauwberg	4	2	10	4	**20**
Tygerberg East	3	5	1	6	**15**
Tygerberg West	5	3	11	14	**33**
Khayelitsha	8	12	11	14	**45**
Helderberg	2	4	3	3	**12**
Oostenberg	12	14	5	2	**33**
S Peninsula	8	9	6	7	**30**
Totals	67	78	85	71	**301**

* Source: Karen Sheen, Brooklyn Chest Hospital

7.4.5 HIV/AIDS

PMTCT: Of the 49,064 antenatal bookings, over the 12 months, 93% of the mothers were counselled, 89% accepted testing and 21% (a range of 2 –26%, Tygerberg West – Nyanga respectively) tested positive. The MOU VCT Uptake rates vary across sub-districts depending on the number of MOUs within that sub-district. Nyanga has an acceptancy rate of 74%, which is the lowest in the Metropole, see figures 7.6 and 7.7.

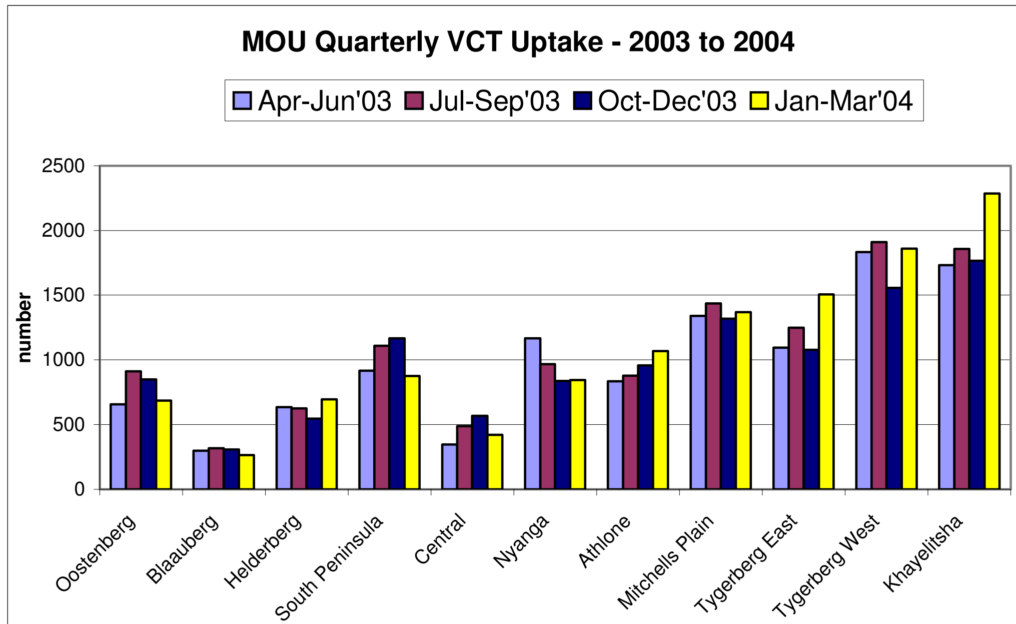


Figure 7.6 MOU VCT Uptake in the Metropole for 2003 to2004

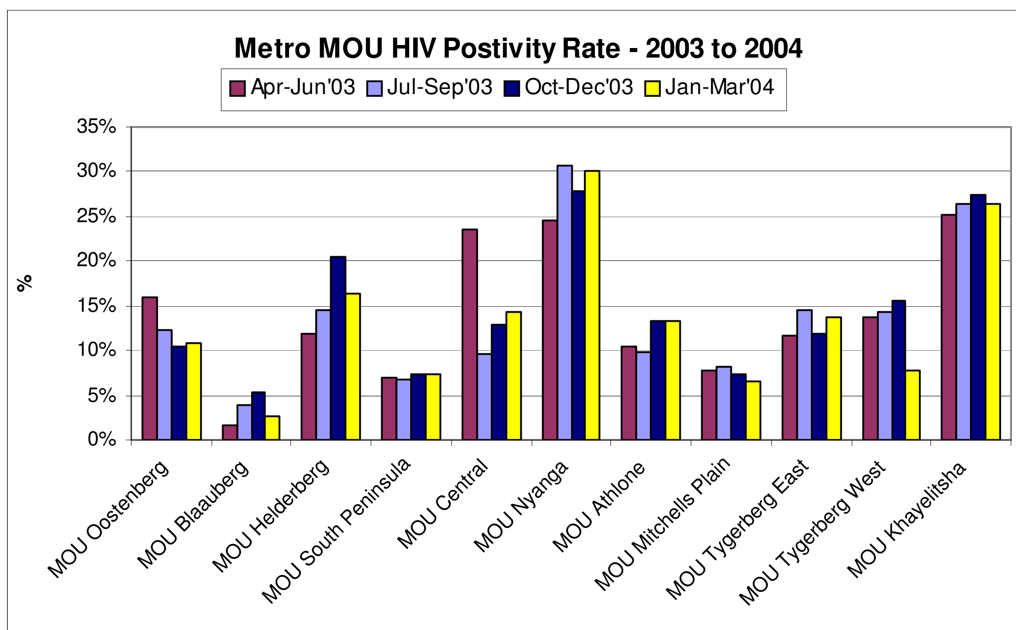


Figure 7.7 MOU HIV Positive rate in the Metropole for 2003 to2004

VCT: A total of 109,755 tests were done at CHCs and clinics, with 79,053 done for medical reasons. The annualised coverage is 3.6%, below the target of 5%. The VCT uptake has increased substantially over the 2 year period as shown in Figure 7.8. This figure excludes MOU Uptake and VCT funded sites. The uptake per district is highest in Central, Nyanga and Khayelithsa districts and the positivity rates are higher than 20% in Helderberg, Nyanga and Khayelitsha sub-districts (figures 7.9 and 7.10).

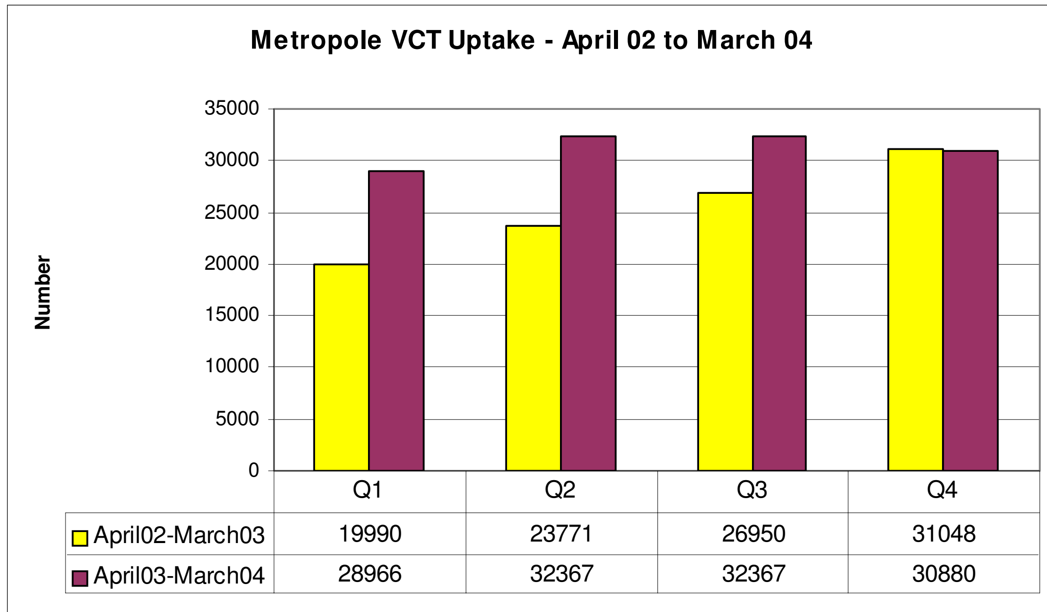


Figure 7.8 The Metropole VCT Uptake for 2 years.

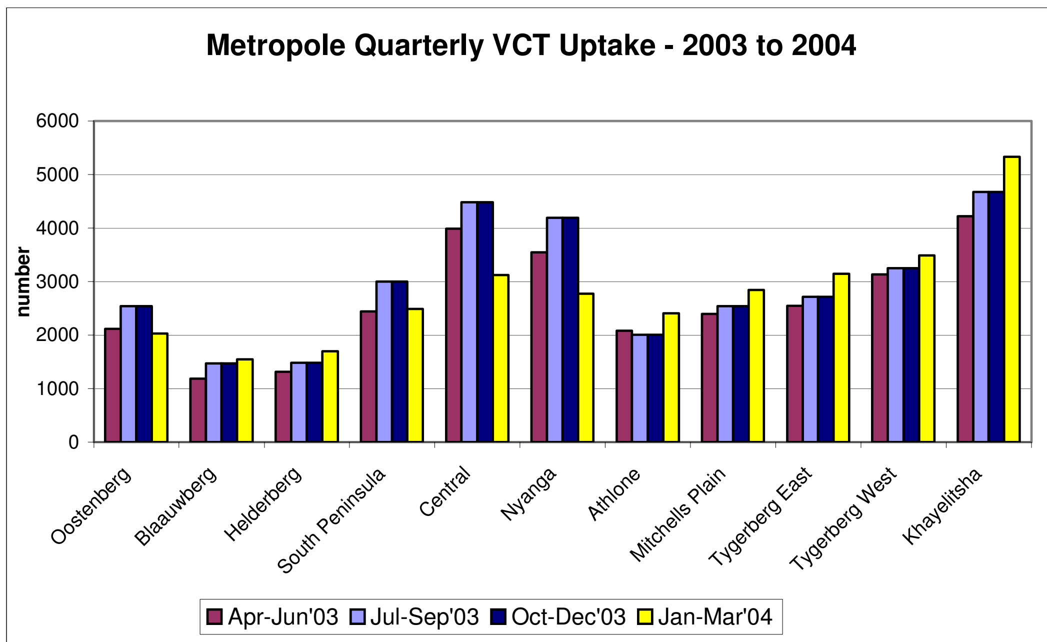


Figure 7.9 The Metropole VCT Uptake for 2003 to2004

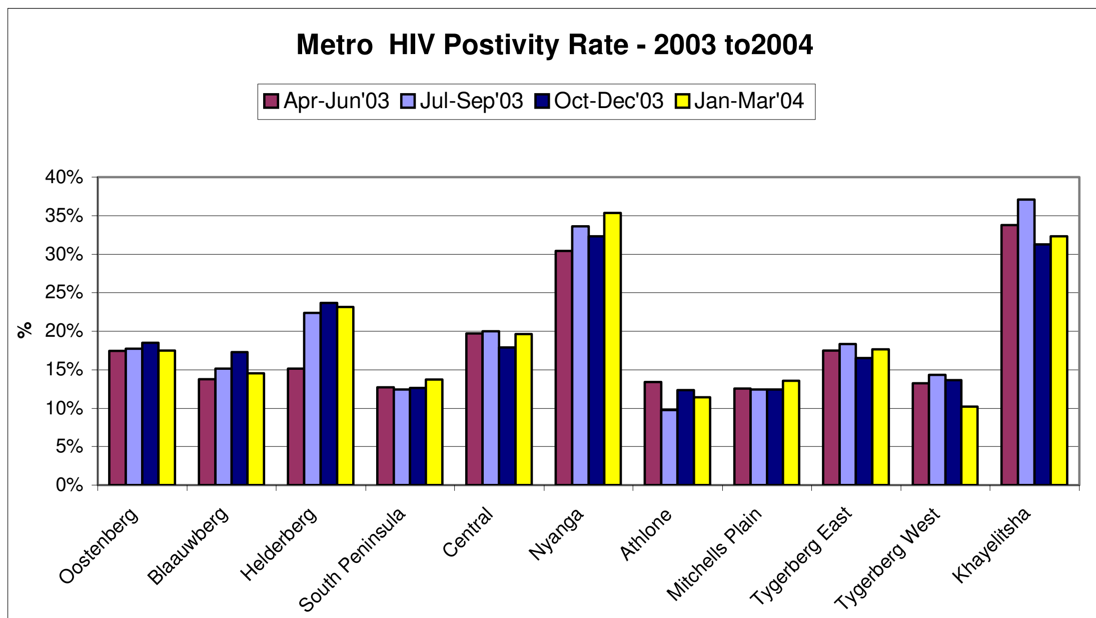


Figure 7.10 Metropole HIV Positive rates (VCT testing) 2003 to2004

ART: Four sites were administering ARVs: Khayelitsha Site B, Nolungile, Micheal Mapongwana & Gugulethu. A total of 1095 patients were registered by March 2004

Table 7.14
ART data of the four ART Sites

Sites	Total adults on ART by Mar 2004	Total children on ART by Mar 2004	Combined Total
Guguletu CHC	199	1	200
Site B	311	24	355
Nolungile	248	50	298
M Mapongwana	247	15	262
Total	**1005**	**90**	**1095**

7.4.6 Chronic non-communicable diseases

Table 7.15
Chronic non-communicable diseases

	MDHS HC per Sub-District	CHC (day) case seen by MO	Seen by PN	Combined MO and PN case load	Chronic care visit	% Chronic care case load
Central (B) Sub	513,307	149,483	37,619	187,102	75,748	40
Eastern (H) Sub	493,833	114,693	55,885	170,578	50,225	29
Khayelitsha Sub	463,601	179,498	47,903	227,401	49,051	22
Klipfontein (D) Sub	707,583	231,204	38,255	269,459	138,286	51
M Plain (E) Sub	241,931	95,885	6,043	101,928	30,632	30
N Panorama (A) Sub	47,4489	105,878	27,258	133,136	22,424	17
Southern (C) Sub	399,091	148,932	14,654	163,586	124,788	76
Tygerberg (F) Sub	677,919	173,518	30,130	203,648	83,153	41
Total	**3,497,265**	**1,199,091**	**257,747**	**1,456,838**	**574,307**	**39**

Table 7.15 indicates that the caseload for chronic non-communicable diseases is high and constitutes the

bulk of the patients seen. Significant resources are consumed in the management of these cases and the effects of these burgeoning epidemic is having a major impact on morbidity and mortality in Cape Town. One of the biggest challenges for the future is to implement high quality care for these diseases with good monitoring and evaluation activities.

7.4.7 Violence and Trauma

Table 7.5 indicates the trauma burden over the last two years at MDHS facilities. As can be seen, the number of visits has increased slightly by about 1 percentage point, compared to the increase of 36% between 2000 and 2002 demonstrated in Table 7.16. As no additional resources have been allocated, the service is probably at saturation point. The sustainability of this service is critically dependent on the availability of doctors and nurses, with substantial use of MO's from the private sector, either on a sessional basis or via locum agencies. Preliminary reports indicate that only 10% of the patients at seen CHCs are referred to hospitals and that those referrals are appropriate (up to 95% need above PHC care). A significant proportion of after-hour visits are non-emergencies and children.

Table 7.16
Metropole T & E Headcount Trends over 2 years*

Levels of Care	2nd Q 2000	3rd Q 2002	Change	Monthly Change	% Change
Units CHSO T&E	60,800	82,600	+ 21,800	+ 7,300	+ 35.9%
L1 Hospitals	9,400	9,700	+ 300	+ 100	+ 3.2%
L2 Hospitals	43,000	35,400	- 7,600	- 2,530	- 17.7%
L3 Hospitals	30,000	34,100	+ 4,100	+ 1,370	+ 13.7%
TOTAL	**143,200**	**161,800**	**+ 18,600**	**+ 6,200**	**+ 13%**

* Source: Trauma & Emergency Interim Report – J Frankish 2003

7.4.8 Mental Health

Table 7.17
Mental Health visits in the Metropole for Jan – Dec 2003

District name	Follow up PY	Follow up PM	NP PY	NP PM	Total PY	Total PM	Staffing Nurse
Khayelitsha	10,928	910	374	31	11,302	941	3
Tygerberg West	20,105	1,675	777	64	20,882	1,740	6
Mitchell's Plain	15,114	1,259	392	32	15,506	1,292	5
Tygerberg East	9,180	765	367	30	9,547	795	3
Nyanga	8,286	690	143	11	8,429	702	2
Helderberg	5,882	490	217	18	6,099	508	2
Oostenberg	9,104	758	626	52	9,730	810	3
South Peninsula	11,722	976	404	33	12,126	1,010	4
Cape Town	5,420	451	312	26	5,732	477	2
Blaauwberg	4,672	389	28.	2	4,700	391	1
Athlone	12,622	1,051	348	29	12,970	1,080	4
Grand Total	**113,035**	**9,419**	**3,988**	**332**	**117,023**	**9,751**	**39**

Table 7.17 reflects the number of visits to the dedicated Mental Health services at PHC facilities over 12 months. About 10,000 patients are seen monthly with the addition of over 300 new cases monthly. This figure should be measured against the total seen at the APH – 28,000 against 117,000 – and the proposed targets for referral of chronic stable cases to PHC facilities (Table 7.18).

Table 7.18
Comparison of OPD visits across APH platform and MDHS

	Sites	OPD Head counts	Admissions
MDHS	CHCs - Total	117,023	-
APH	Stikland	5,362	1,997
	Lentegeur	15,678	1,516
	Lentegeur (ID)	636	72
	Valkenberg	5,426	2,276
	Alexandra (ID)	979	144
	APH Total	**28,081 (Target 10,531)**	**6,005**

7.4.9 Services for the Disabled

Physiotherapy Services at CHCs

Three physiotherapy departments at Delft, Vanguard and Woodstock were opened permanently. Outreach services to Gustrouw, Hanover Park, Nolungile, Lady Michaelis and Ravensmead continue and have started at Ikwezi. The 19 sites treated 29, 152 patients for the year, with Heideveld and Mitchells Plain being the busiest clinics and treating over 4,000 cases.

The department is maintaining an up-to-date wheelchair waiting list (195 were issued) and no complaints were received from the disability sector the issuing of mobility assistive devices. The department received 78 donated wheelchairs and 6 buggies and each district stayed within their budget for assistive devices. The main constraint has been the delays in filling of posts.

Table 7.19
Total number of Assistive devices issued

Sub-district	Assistive Devices* Issued
Central	24
Blaauwberg	18
Nyanga	22
Athlone	158
Mitchell's Plain	67
South Peninsula	67
Tygerberg East	56
Tygerberg West	177
Khayelitsha	56
Oostenberg	27
Helderberg	29
Falsebay	116
TOTAL	**817**

* Includes Wheelchairs, Buggies, Crutches

Occupational Therapy Services at CHCs

There are 6 OT's spread across 5 sub-districts focussing on: clients accessing the CHCs for Rehabilitation, clients in the community needing assistance with independent living – especially mentally ill clients and programmes for clients needing occupational therapy or rehabilitation services in their homes.

Current Programmes:

Individual client management: Clients assessed and treated individually – any condition or need related to OT at PHC level including the provision of assistive devices and mobility assistive devices.

Disability Grant screening to provide functional skills assessment, referral and recommendations to work assessment units, to social service departments, to protected workshops and skills training providers. The assessment services increased from9 to 11 sites,

Group work: Rheumatoid Arthritis , Back pain, Cardio-vascular groups to provide knowledge, emotional support, peer support, prevention principles, and empowerment.

PSR: Support groups for clients with mental illness living in the community. This includes family support, skills development, broadening of life sphere, health promotion. The main purpose is to prevent relapse and promote community integration.

Day care centers: Some Day Care Centers receive consultation by our OT's for their day programmer's and individual children needing OT.

Home Based Care: This involves support to the client, client's family and Home Based Carer through in home rehabilitation and training.

Stoma- appliances

There are over 600 clients, referred from secondary and tertiary hospitals, receiving appliances from the central store at Woodstock at an annual cost of R 1,850,000. There is only one trained Stoma-therapy nurse (Khayelitsha); therefore the service is essentially a dispensing one.

Ophthalmology services - Spectacles

The MDHS provides eye testing and spectacles for school children and adults, initially only through private providers but since December 2003 through a contract with a NGO, ICEE. 430 spectacles have been issued and MDHS received a donation of 3900 ready made spectacles.

7.4.10 Oral health

The Oral Health staff provides both curative and promotive services at the dental clinics and at non-health institutions, mainly schools and prisons. The number of extractions exceeds the number of other interventions and while the preventative fissure sealant programme has proven to be a very successful intervention, the number of children receiving this service is still very low.

Table 7.2019
Oral health services for 2003/4

	Categories of Patients/Types of service	Total
Attendances	<6 years	12,976
	Schools	60,676
	Dental clinics	87,185
	Prisons	3,923
	Total	164,760
No. of Promotive & Preventative Activities	Group Education - attendees	82,999
	Fissure sealant	18,240
	Scale & Polish	13,472
No. of Procedures	Fillings	38,225
	Extraction	190,628
	Dentures	129
	Procedures under gen. anaesthetic	2,690
	Minor Surgery	2,741
	Total	234,413

7.4.11 Health promotion

The thrust of activities was to develop the infrastructure and tools for the expansion of Health Promotion in the Metropole, by developing a HP tool and training 146 staff in its use as well as working closely with the COCT to dovetail their operational plans along HP priorities. Health promoters were trained in facilitation skills; CDL and IMCI while 36 home based carers attended support workshops.

This department also assisted with the campaigns around:

- Child Accident Prevention
- TB and the production of the TB Wheel which was developed by J Caldwell
- Reproductive Health - specifically Emergency Contraception
- Nutrition – the radio campaigns around exclusive breast feeding
- Marketing of identified Health Days and issues in newspapers and on radio

The monitoring of the Sensible Drinking interventions and rolling it out to Khayelitsha, Tafelsig and Wesbank, as well as negotiating with the private sector to train shebeen owners around sensible alcohol use was achieved. The editing, printing and distribution of the Metropole Matters Newsletter formed part of additional activities.

7.4.12 Environmental Health

The main focus of activities were

- Reducing EH risks at governmental premises – inspections were done at hospitals, CHCs SAP holding cells, Regional magisterial courts.
- Improving food safety – by monitoring the School feeding scheme (aflatoxin content) and the peanut butter sampling program
- Ensuring compliance with legislation on handling of hazardous substances
- Monitoring basic service provision within the Unicity
- Support to Occupational Health services within MDHS

7.4 Challenges.

The lack of accurate information remains a challenge across all the levels of care. The ability to assess the response of the health service to the health needs has been hampered by the availability of reliable data across sub-districts as well as across services, especially the non-facility based services. This needs to be addressed urgently by setting up an integrated and comprehensive health information section within MDHS .The **use of health and management information by managers at all levels** will improve the quality of the data.

The **lack of a comprehensive HR** plan to address all the critical HR needs, especially clinical staff, as the capacity to respond to community demands has reached saturation point – this is reflected in the comparative head counts at CHCs over the last 3 years.

The need to **integrate operational and priority health programme activities**, in order to strengthen the PHC platform. The immediate challenge is to integrate and manage all the different community and home based care activities.

PHC SERVICE DELIVERY

8 PHC Support Services

8.1 Pharmaceutical Services
8.2 Transport
8.3 Equipment
8.4 Health and Management Information
8.5 Radiological Service
8.6 Laboratory Service
8.7 Referral and Outreach
8.8 Teaching and Training
8.9 Security
8.10 Challenges

8.1 Pharmaceutical services

8.1.1 Staffing:
Apart from the staff listed below, a Project Manager, was appointed to address the problems with the drug supply management system and the CMD.

Table 8.1
Staffing of MDHS Pharmaceutical services 2003/4

	Pharmaceutical services	**Number of Staff**
CHCs	Central Office	1.5 Pharmacist & 2 Admin Assistants
	Pharmacists at CHCs	59.5 (Includes Contracts & Agency staff)
	Pharmacy assistants at CHCs	49
	Storekeepers at CHCs	14
District & Specialised Hospitals	Pharmacists	6.6
	Pharmacy Assistants	6

8.1.2 Budget for pharmaceuticals (CHCs only)
The total budget for pharmaceutical items has increased to R80, 000,000 over the last years. This has been the result of an increase in the cost as well as the quantity of drugs purchased over these years.

Table 8.2
Medicine costs for CHC and Community based services over 4 years

	2000/1	**2001/2**	**2002/3**	**2003/4**
Medicine costs at MDHS – CHC & Community based	57m	64m	68m	80m

8.1.3 Outputs

Table 8.3
Number of scripts and items for 2003/4

	Scripts	**Items**	**Items/Script**
CHCs	1,792,674	6,258,757	3.49

Table 8.3 shows that the number of items per script is high (almost double that of rural clinics), reflecting the high burden of CDL with its complications and the practice of polypharmacy.

8.1.4 Referral scripts

There are 68,598 referrals per annum from secondary and tertiary hospitals, averaging 5,747 pm. The patients have access to above-PHC medication within their communities and this cost to the CHCs drug expenditure should be appropriately funded.

8.1.5 Trends, Success and challenges

There has been a 15% increase in the number of items issued to the MDHS from the CMD as compared to 2002/3 and there has been an average inflation of 6% on 2002/3 costs. The MDHS is the biggest purchaser of CMD stock. This increase, when linked to the fixed exit pricing which will come into effect next year, projects that the expenditure on drugs will more than double in the next financial year.

Regular meetings with pharmacists and storekeepers, addressing specific supply issues as well as joint meetings with medical staff have been successful in integrating clinical and administrative matters. The rational and more efficient use of specific items e.g. Fenoterol inhalers and Theophylline, has been some of the positive outcomes of these meetings. Regular meetings with the Provincial Coding committee, the Pharmacy Management committee (tertiary hospitals) and the Regional pharmacy groups are adding value to the management of patients at the most appropriate levels. The MDHS Drugs and Therapeutic committee has been working on analysis of drug usage to promote improved and cost effective clinical care (full ABC VEN analysis available)

The obvious success has been the initiation of the Special Drug Supply Management Project, which enabled the reduction in stock outs and the improved relationship with the CMD. There has also been training and implementation of stock control methods, which will improve supply management in the future.

The challenges are:

- The implementation of the new Pharmaceutical & Related Substances Act
- Increased costs and workloads.
- Appropriate staffing against a HR plan that addresses the needs across the Metropole
- To improve prescribing habits across all levels of care
- To have more co-ordinated purchasing between levels of care not to impact negatively on the ordering patterns have the CMD and thus the supply to the patients.

8.2 Transport services

The service consisting of 150 vehicles for the CHCs is co-ordinated centrally at Woodstock by 2 transport officers with support from sub-district and facility managers. There are 17 drivers providing transport for patients, staff and goods.

8.2.1 GG vehicles

The distribution and utilisation of vehicles vary greatly across the sub-districts (500 to 1100 km/pa) and improved systems of co-ordination and control need to be put in place. It is recognised that the outreach activities form a vital part of the community-based services and it should be adequately resourced. Better management and supervision in the sub-districts as well as better central control systems will result in more efficient use of this resource.

The total cost for GG vehicles for CHSO is R 3,414,801, which includes R 1,523,755 for annual km travelled and R 1,891,046 for the daily tariff. The Table 8.4 below indicates the spread of vehicles and usage across the 11 sub-districts, mindful that the central pool provides additional sub-district service.

Additional transport costs include the District Hospitals and Programme managers. The use of private vehicles must be factored into the total transport cost for PHC services.

Table 8.4
Distribution and usage of vehicles for CHSO in 2003/4 across the sub-districts

SUB-DISTRICT	NO. OF VEHICLES	AVERAGE Km's per vehicle per month	TOTAL Km's per year
Athlone	8	678	64,919
Blaauwberg	4	1,107	53,129
Central	6	830	59,761
Helderberg	13	1,005	156,781
Khayalitsha	8	691	66,370
Mitchell's Plain	7	813	68,324
Oostenberg	10	520	62,455
South Peninsula	11	735	97,045
Tydgerberg East	16	709	136,062
Tygerberg West	13	635	99,038
Nyanga	4	591	28344
Woodtsock (Transport)	50	2,311	1,386,564
TOTAL	**150**		**2,250,448**

8.2.2 Patient Transport and inter-facility transfer
Transport for Emergencies is provided by the EMS and remains problematic while the EMS is addressing their systems. There is currently no patient transport contract at MDHS.

8.3 Equipment

The CHCs spent a total of R 830,693 on ECG machines, defibrillators, incubators, one anaesthetic machine, patient trolleys and a range of smaller clinical equipment. The budget included own funds and the centrally earmarked equipment funds. The process of accessing the funds as well as the procurement processes within MDHS were problematic and delayed the acquisition of equipment. A further R 490,000 was spent on the installation of an X-ray machine at Macassar CHC.

The one employee responsible for stock control at all the CHCs resigned during this period. MDHS is in the process of setting up an Asset Management Control system as well as appoint the appropriate staff.

8.4 Information Management & Technology

The Information Management section underwent significant change during this financial year. The Directorate has recognised the vital role of information in the management of its institution. As a result, the section was developed in terms of its HR capacity. A full-time manager was appointed in a contract position to develop information systems as a project. By the end of the financial year, the section was expanded to include two additional administrative clerks in contract posts. This increase in capacity has allowed the department to expand the scope of available data.
The primary objective of the department is to provide management with timeous and relevant information. A great deal of work was done on cleaning up the data in the early part of the year. By mutual agreement, data at combined LG and PGWC facilities was split to improve management of these facilities. The database was adjusted accordingly and changes took effect as from 1 September 2003.
Datasets currently managed by the section include the following:

PHC data; District Hospital data; Midwife Obstetric Unit data; Nutrition data and Community and Home Base Care

The initial focus was to develop a comprehensive and inclusive PHC Essential dataset for the CHCs. The EDS now consists of 90 data elements incorporating aspects of both finance and oral health. Discussions were initiated with program managers to support the integration of program information with routine data. Considerable work still needs to be done in this respect. A training plan was developed and Phase 1 rolled out to all 90% facilities. The purpose of this phase was to increase awareness of data management and to put systems in place to manage data flow. Phase 2 will focus more on information use.

Reporting process for Programme 2: DHS & Health Programmes to the Provincial Monitoring and Evaluation committee was established and data submitted quarterly for the financial year. It is expected that the reporting format will change for the period 2004/2005. An information audit determined that 45 computers and 27 printers are placed at the CHCs. The critical workstations plan identified the need for 70 additional computers and 55 printers. The Woodstock office has 80 computer and 50 printers.

The immediate challenges for the new financial year is to appoint Information Officers in the Directorate and at facility level in order to ensure sustainability.

8.5 Radiological Services

There are 15 X-ray departments at CHCs across the Metropole, employing 24 Radiographers (5 vacant posts) that provided a service for a total of 109 551 patients. GSH reported on 25, 000 X-rays and a private group, Morton & Partners, reported on 22,680 X-rays. The founder of the above practice Dr H Hirschon has been rendering this service to the CHC since 1971 and continues to do it at a minimal fee of R10.22 per patient, irrespective of the number of plates read – an excellent example of a private-public partnership.

Table 8.5
Distribution of CHC X-ray departments and workload across the Metropole

Sub-district	CHC	Number of Depts.	No. of Patients seen	No. of Radiological Examinations
Blaauwberg	-	0	0	0
Helderberg	(Macassar Proposed)	0	0	0
Central	Woodstock	1	4,868	6,218
Oostenberg	Kraaifontein	1	5,168	6,108
Nyanga	Guguletu	1	8,475	10,403
Tygerberg East	Delft	1	11,943	15,492
Athlone	H Park, Heideveld, Dr Abduragman.	3	11,982	14,278
Mitchells Plain	Mitchell's Plain	1	11,983	13,947
S. Peninsula	Retreat, Lotus River	2	12,602	14,804
Tygerberg West	B. Lavis, E River, Vanguard	3	20,005	23,198
Khayelitsha	Site B, Michael M	2	22,525	25,180
Total		**15**	**109,551**	**129,628**

8.6 Laboratory Services

This service is rendered National Health Laboratory Service The cost has gone up 16% compared to the last financial year as certain investigations have increased in cost. The number of tests done has also increased for a variety of reasons e.g. service devolved to PHC level or MDHS billed for the first time for costs previously carried by hospitals. A protocol with a new laboratory investigation request form was developed for essential PHC investigations at CHCs, which resulted in some savings (e.g. thyroid profile testing), but the general increased rate of referrals to CHCs and increased cost per test overshadowed such interventions.

Table 8.6
CHC Expenditure on laboratory investigations for specific diseases over 2 years

	2002 April - March		**2003 April – Mar ***		**Comment**
	No of tests	Cost	No of Tests	Cost	
TB	16,243	880,255	51,573	1,511,863	No. of tests increased 3 fold & costs doubled
INR	12,208	664,860	38,993	971,673	No. of referred patients increased
Thyroid functions	12,174	1,333,055	13,820	1,005,516	Stopped routine Thyroid Profiling
Pap smears	23	1,948	7,291	520,889	Previously carried by GSH/TBH labs, Costs increased from R60 to R80 per smear
Antenatal tests	3	53	50,025	965,603	Previously only Direct Coombs done & carried by TBH. Now includes all blood typing & testing
Total costs	**40,651**	**2,880,171**	**161,702**	**4,975,544**	

* April to December 2003 projected for 12 months

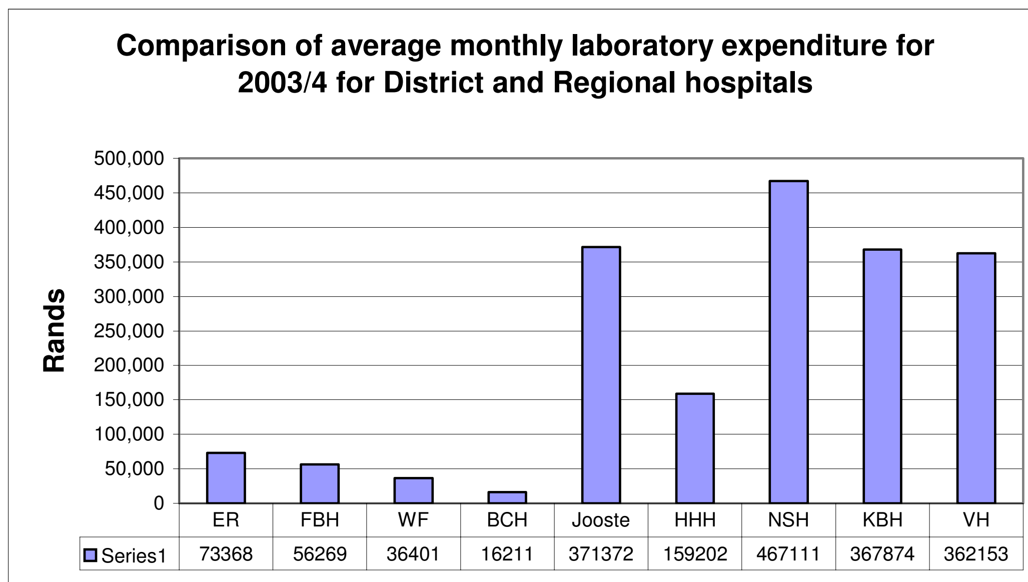


Figure 8.1 Comparisons of laboratory expenditure across types of hospitals

Special priority health programmes have resulted in increased expenditure. For instance, the WHO recommends that 10 smears for 1 positive (10% smear positive rate) should be expected in a well functioning programme in HIV-negative patients. The MRC survey in 2001-2002 reported that an average 4.8 smears were analysed for every smear positive (21% smear positive rate), which indicates that to improve the control of TB, there has to be an increased spending on these tests. Similarly, the cost of the implementation of cervical cancer management programme, involving increased cost plus increased number of tests, must be budgeted for.

8.7 Referral and outreach

Referrals from L2 and L3 hospitals to CHCs have increased significantly over the 2 years as shown in Figure 8.2 below, and this consists of stabilised patients referred back for repeat of medication or discharged to the PHC level.

Referrals to hospitals are not accurately recorded as yet, but vary across the levels of care. Referrals for non-emergencies are subject to long waiting lists and there are many defaulters due to these barriers. The emergency referrals are adversely affected by the ambulance services, availability of beds and the interim 1996 Provincial drainage protocols. The finalisation of drainage areas and referral protocols is therefore urgent.

Clinical outreach activities from the hospitals are currently unplanned, inconsistent and fragmented. However where they occur (e.g. GSH physicians to Site B) the impact upon staff and patients has been positive. The formalisation of planned co-operation will benefit all parties and most importantly the patients.

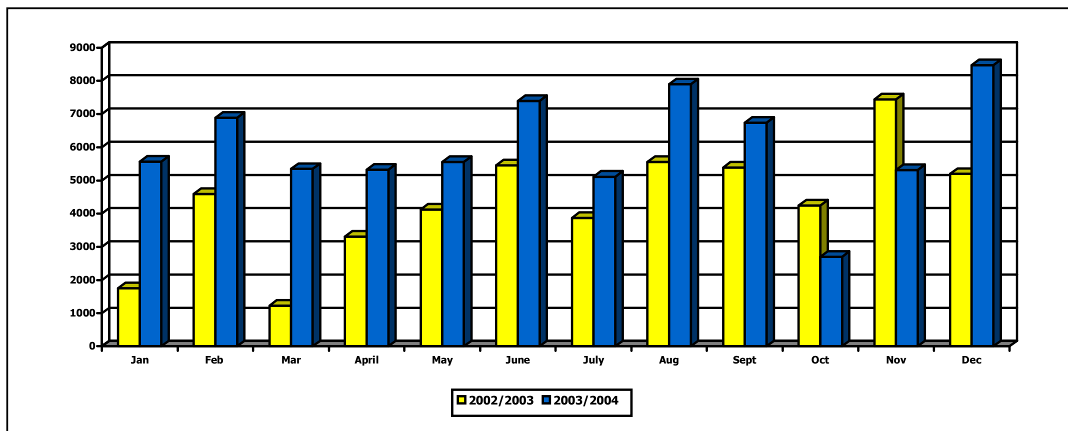


Figure 8.2 Comparison of Number of CDL Referrals from secondary & tertiary hospitals to CHCs over 2 years.

8.8 Teaching

There is a need for formalised joint agreements between the health department and all teaching institutions, to facilitate the obvious benefits to staff, patients and students from such relationships.

Table 8.
Current and future under graduate medical student learning sites for US and UCT

	CHC & DH	Tertiary Institution
1	Hanoverpark	UCT
2	Heideveld	UCT
3	Lotus River	UCT
4	M Plain	UCT
5	Greenpoint	UCT
6	Woodstock	UCT
7	Vanguard	UCT
8	Wesfleur	UCT
9	B Lavis	US
10	Delft	US
11	Durbanville	US
12	Goodwood	US
13	Michael M	US
14	Kraaifontein	US
15	Kensington	US
16	Vanguard	US
17	Eerste Rivier Hospital	US

8.9 Security

Private companies provide the service at all 24hr and some 8 hr facilities. The high numbers of attacks on staff and property, as previously stated, drives the need for guards and other security measures. Over the last 3 years guards have been shot and killed at Bishop Lavis, Retreat and Khayelitsha Site B (2003).

8.10 Challenges

The **availability of essential medicines** at all CHCs at all times by implementing a sustainable drug supply management system remains a challenge. The current systems developed by the project office with the appropriate staffing levels will greatly assist this. The need to have a computerised system to manage a medicine budget of almost R 90m cannot be over stated. The implementation of **rational prescribing habits across all levels** of care with system of appropriate referrals to PHC levels will enable more efficient usage of the medicine budget.

There is a need to develop the **rational usage of laboratory investigations** through training, protocols, and clinical audits across all the levels of care and priority health programmes. The **finalisation of the referral system**, seamless up and down the levels of care with effective emergency transport services must be addressed urgently. The **review of the agreements with the universities** and training institutions for under- and post-graduate training, to develop a mutually beneficial relationship for the organisations and students needs to be undertaken.

The development of a **fully functional information department**, with reliable health and management information to monitor and evaluate the services and the impact on the health status of the communities thus served.