Strategic Vision

Vision

To achieve optimal health status for all persons in the Province of KwaZulu-Natal

Mission Statement

To develop a sustainable, co-ordinated and comprehensive health system at all levels based on the Primary Health Care approach through the District Health System.

Core Values

Trust built on truth, integrity and reconciliation; Open communication, transparency and consultation; Commitment to performance; Courage to learn, change and innovate.

Legislative Mandate

The Department is currently functioning in terms of the Provincial Hospitals' Ordinance, 1961 (13/1961). However, the Department will be aligning itself to the Provincial Health Act, 2000 (Act 4 of 2000) which was passed on the 13th September 2000 and which will commence on a date determined by the Minister by notice in the Provincial Gazette. Regulations to the Provincial Health Act are in the process of being finalised and should be published during the 2004/2005 financial year.

Other legislation which governs the operations of the Department are:-

Health Act, 1977
Human Tissue Act, 1983
Mental Health Act, 1973
National Policy for Health Act, 1990
Provincial Hospitals' Ordinance, 1946
Provincial Hospitals' and General Services' Pensions Ordinance, 1955
Sanitary Regulations in Rural Black Areas, 1968
Provincial Hospitals' Amendment Ordinance, 1985
KwaZulu Medical and Surgical Treatment Act, 1986
Public Finance Management Act, 1999

Batho Pele Principles

Consultation

Service Standards

Access

Courtesy

Information

Openess and transparency

Redress

Giving Best Value

Encouraging Innovation and Rewarding Excellence

Customer Impact

Leadership and Strategic Direction

Patients' Rights Charter

Every patient has a right to

A healthy and safe environment

Participation in decision-making

Access to health care

Knowledge of one's health

Insurance/medical aid scheme

Choice of health services

Be Treated by a named health care provider

Confidentiality and privacy

Informed consent

Refusal of treatment

A second opinion

Continuity of care

Complaints about health services

TOP STRUCTURE - 2004

Dr ZL Mkhize
Minister of Health & Leader of Government Business

Prof. RW Green-Thompson
Head of Department

Prof. SJH Hendricks
Deputy Director General: Human Resource Management

Dr SM Zungu
Deputy Director General: Health Services Cluster

Mr HAW Conradie
Chief Financial Officer

Mrs AN Zondi
Senior Manager: Legal Services

Mr GE Mkhize
Chief Director: Human Resource Practices

Dr C Sewlal
Senior Manager: Health Services (Cluster Clinical Support & Logistics)

Dr SSS Buthelezi
Senior Manager: Health Services Cluster (Sisonke, uMgungunlovu, Umzinyathi, Amajuba, uThukela)

Dr ML Mhlongo
Senior Manager: Health Services Cluster (Ugu, eThekwini, iLembe)

Dr MLB Simelane
Senior Manager: Health Services Cluster (Zululand, Umkhanyakude, Uthungulu))

Dr ZL Mkhize
Minister of Health & Leader of Government Business

It is with a sense of pride and humility that I table the Annual Report of the Department of Health for the 2003/2004 financial year.

The report is not only a reflection of the achievements of the past financial year but it also offers an opportunity to look back at the distance we have covered in health service delivery over the past ten years.

KwaZulu-Natal Province has the largest population in the country and is amongst the worst afflicted by the wide variety of transmissible diseases such as Tuberculosis, HIV and AIDS, Cholera, Malaria and other poverty related ailments as well as non-communicable diseases.

It is the commitment and dedication of its management and staff that has ensured that the Department continues to put up a valiant fight against these diseases. This is so despite the chronic and perennial challenge of inadequate budgetary provision and the continuous haemorrhage of skilled professional staff away from our hospitals and clinics.

The Department has introduced several new categories of staff to relieve the professional staff of non-core chores to allow them to dedicate most of their time dispensing professional care that they are trained to render. The numbers of nurses in training has been increased in response to this challenge and an increasing number of scholarships have been awarded to improve the number of health care professionals in training.

The high quality of care is maintained through the quality assurance and continuous capacity building programmes of the Department. Hospital revitalization is an ongoing process, which was strengthened last year with the decision to construct two hospitals in Durban, named in memory of our icons in the liberation struggle, the Dr Pixley Seme Memorial and Dr John Dube Memorial hospitals, both of which will improve our patient referral system.

The report reflects an increasing workload and decreasing staff levels. However the increase in the number of patients who receive health services in our facilities is an indication of our success in improving accessibility of our services. The number of patients attending our Primary Health Care facilities continues to rise, reflecting the successful implementation of the Primary Health Care policy. There is evidence that our policy of targeting women and children amongst the most vulnerable groups is bearing fruit.

The report reviews the plans, which have been embarked upon for the reduction of mortality and morbidity and priority programmes focusing on Tuberculosis, with the investment in infrastructure necessary for early diagnosis and community mobilization.

The year also saw the expansion of the programmes directed at the fight against HIV and AIDS showing an increase in the Voluntary Counselling and Testing sites and integration of the PMTCT (Nevirapine Programme) into almost all the clinics and every hospital. The first few institutions that commenced with the provision of Anti-retroviral Therapy have showed a tremendous success, paving the way for the introduction of ARVs into the rest of the hospitals in the Province.

The report is a reflection of human endeavour to save lives despite prevailing challenges.

I wish to express my sincere gratitude to the Head of Department, Professor R W Green-Thompson for his leadership, members of Senior Management, heads of sections and institutions for their guidance and to the entire staff for their hard work in ensuring that millions of our people received the services they deserve.

Thank you

Dr Z L Mkhize
MEC for Health
KwaZulu-Natal

Professor RW Green-Thompson
Head of Department

The last financial year saw the end of the first ten-year period of democracy in our country. With the imminent dawn of the new decade, we are more invigorated and focussed on what we will achieve in order to continue to enhance the provision of optimal health care in our Province. We must continue to do everything to keep our people in our Province healthy. During the past five-year period, the efforts of the Department of Health were focussed on the improved access while the second five years were focussed on quality of service delivery. Our Department has also adhered to the principles of equity with regard to the distribution of our resources in order to address the imbalances of the past. These inequities especially adversely affected our rural underserved and disadvantaged communities.

The Department of Health in this Province remains to be inadequately funded when compared to other Provinces rendering similar services. Hospital expenditure per capita in this Province is the 4th highest in the country at R624,00 per capita compared to the 3rd highest which stands at R704,00 per capita. The highest per capita expenditure on hospitals is R899,00 and the lowest at R425,00 giving a National average of R615,00. The per capita expenditure on Primary Health Care for this Province is the 6th highest at R185,00 compared to the highest expenditure per capita of R246,00 and the lowest of R90,00.

This Annual Report provides a comprehensive account of the Department's achievements, outputs, outcomes, objectives, targets and challenges for the period 1st April 2003 to 31st March 2004 in accordance with the Strategic Plans for the said period.

The Department's priorities are aligned to the National Priorities, Provincial Priorities and the National Department of Health's 10-Point Plan. The Strategic Plans and objectives of the Department are premised on the aforementioned. The Strategic Plans are the backbone and framework formulating the Operational Plans of the Department, which direct the outputs and outcomes and formulate the impacts of health care in our Province. All these are achieved within the available resources. The Department's goals for the last financial year were as follows:

- Addressing the effects of poverty and to combat it in relation to health;
- Combat and control HIV and AIDS, emerging and re-emerging diseases;
- Reduce the burden of disease through decreasing morbidity and mortality by focussing on priority diseases, clinical protocols, clinical audits, catchment areas, referral patterns, definition of appropriate levels of care in concert with institutions ranging from central to district, defining entrance and exit criteria and networking;
- Promotion of good governance throughout the Department by ensuring optimum systems, audit and risk management, monitoring and evaluation, observance of Batho Pele and the Patients' Rights Charter, sound fiscal discipline in keeping with the PFMA and observance of all other relevant legislative prescripts, rules and regulations;
- Rural development and urban renewal in keeping with the nodes and developing areas of poverty and inequality with regards to health;
- Consolidation and advancement of basic infrastructure;
- Improvement of the establishment of an integrated human resource management that will result in the provision of the right people with the right skills mix working in the right place at the right time for the right reasons delivering the right services to the right people; and
- Providing a safe and secure environment for patients and staff.

The strategies cannot succeed and the objectives cannot be achieved without the necessary commitment, resources and activities. The drive to ensure a quality, caring and compassionate health care service to the people of our Province is a fundamental principle and objective of the Department.

Many achievements and accomplishments have been recorded for the year under review. Achievements have exceeded our targets in certain areas while in a few the targets have not been met. The areas of under achievement will be corrected by identifying the reasons for under performance and corrective measures put in place for the next financial year.

Towards the latter part of the reporting period, the Department reviewed its organisational structure and has further adjusted the management structure in line with its core functions and service delivery objectives. This has been done to further improve performance. It will also enhance management efficiency and service delivery. This will also take the Department further down the road of devolution of management. Effective delegation and accountability will be accomplished.

The core service delivery teams, formed by the three components, namely Hospital Services, District Health Services and the Emergency Medical Rescue Services are commended for their hard work and commendable service delivery during the year. I am certain that they will face all the challenges that present themselves in the next year with even more vigour, with the same commitment and dedication. This will ensure that quality health care in our Province will reach even more people and improve their quality of life.

With regard to the Emergency Medical Rescue Services in the Province, the last year saw a further increase in the ambulance fleet. Thirty one (31) new ambulances were added to the fleet. Whilst the Department lost a total of 57 vehicles through hijackings over the last ten years, the installation of vehicle tracker devices in all the ambulances in 2003, proved to be a major deterrent in such incidents. Only 1 attempted hijacking of an ambulance has been reported since then and 1 utility vehicle was stolen and recovered within 1 hour and 20 minutes.

HIV and AIDS, Tuberculosis, Cardiovascular diseases and Respiratory infections were the leading causes of death in the last year. During the year a total of 151 239 babies were born, (that is 1 baby was born every 3,4 minutes), 191 420 operations were performed (that is 1 operation was performed every 2,7 minutes), 232 872 ante-natal visits were recorded, 18 411 276 patients attended primary health care facilities, 1 660 788 patients attended district hospitals, 2 771 632 patients were seen at regional hospitals, 315 678 patients received tertiary level of care while 162 165 patients were provided with specialised services. This is a remarkable workload for a department, which is the largest in the country.

HIV and AIDS is still one of the greatest challenges for everyone in the Province. The Department has made visible and concerted efforts to deal with the pandemic and engaged with all stakeholders to ensure that the fight against the disease was a collective, comprehensive and strong one. Continued community involvement and empowerment will be strengthened. Great strides were made in the Voluntary Counselling and Testing (VCT) Programme, in that 465 VCT sites were fully operational and a total of 167 892 people accessed counselling up to the end of the financial year. Of this total 157 422 agreed to be tested, thus indicating that a good response and success has been achieved in changing the mindsets of our people. Behavioural change is important if we are going to overcome the HIV and AIDS epidemic, which we will overcome. Prevention is better than cure and certainly prevention is more especially the only alternative when there is no cure.

The PMTCT programme was successfully rolled out to all designated health facilities, that is, a total of 52 hospitals that provide maternity services, 11 Community Health Centres and 353 provincial PHC clinics and 45 Local Government clinics. This ensured access by pregnant women to the PMTCT programme was optimised.

The support of Community Health Workers was critical to create the relevant awareness of the community at large. A special thanks is extended to all the Community Health Workers, Lay Counsellors and volunteers.

The year 2003 also saw the introduction of anti-retrovirals for the treatment of eligible AIDS sufferers and improved HIV and AIDS care has been provided to reduce the incidence of HIV related morbidity and mortality. To complete the spectrum of comprehensive

management of HIV and AIDS, the Department also introduced its Anti-retroviral Therapy Project during the year. Much preparatory work was completed by the end of the reporting period. By September 2003, the facility needs assessments were completed and by October 2003 the identification of facilities for accreditation was finalised. The facility accreditation process commenced in January 2004 and by the end of March 2004 Anti-retroviral drugs were being provided at 5 accredited facilities. The new year will see further ARV coverage in all Districts in the Province. Such will be the capacity to provide Anti-retroviral Therapy for a further percentage of all new eligible HIV positive cases. The Department wishes to acknowledge the Global Fund and all other donors for the financial and/or other aid provided to fight the HIV and AIDS pandemic in our Province.

Limited resources, the challenges with recruitment and retention of health care professionals and the increasing attrition rate formed the backdrop against which the Department had to find innovative and entrepreneurial ways in which to ensure that it met the health care needs of the population at large. I must say the Department has done very well and this has been recognised by outside independent bodies such as the World Health Organisation (WHO). Maximising human capital investment remained a challenge during the past year especially with regard to the recruitment and retention of appropriately skilled health care professionals and support personnel. Whilst every effort was made to ensure that human resource capabilities were appropriate to the workload, the reality was that by the end of the financial year, a total of 7 364 out of 35 114 posts in critical occupation categories were still vacant, that is a 21% vacancy rate. The overall vacancies totalled 14 752 out of a total staff establishment of 66 341, that is a 22,2% vacancy rate. It must be mentioned that out of a total of 2 229 Medical Officer posts, 458 were vacant, this translating into a 20,5% vacancy rate and out of a total of 698 Medical Specialist posts, 277 were vacant, that is 39,7%. Out of a total of 12 294 Professional Nurse posts, 9 500 were filled, thus leaving a 22,7% vacancy rate. A vacancy rate of 17,9% was recorded for Enrolled Nurses at the end of the financial year, that is 1 783 posts out of a total of 9 947 remained unfilled. Of the total of 67 Dentist posts, 49 were filled with 18 remaining vacant, that is 26,9%. Closer collaboration with the tertiary education institutions will assist in addressing these challenges. The reduction of the attrition rate and the increase of our professional health worker base is a priority.

The introduction of the scarce skills and rural allowance was welcomed as a measure to ease the staffing challenges that were faced. Whilst it is still too early to assess the benefits of this initiative, I am sure that this will assist us in achieving improved staffing levels in the future. The Department will continue to support the National Department of Health to extend and improve the scarce skills and rural allowance to other occupational classes in the Department. Improved remuneration of professional health workers is important if we are going to be able to solve the human resource challenges for the Department of Health. The human resource management team must be acknowledged for their concerted efforts and performance in all aspects of human resource management.

I also wish to applaud the efforts of all the clinical support, non-core and administrative components of the Department in their efforts to ensure that the goals and objectives of the Department become a reality, even in the face of the many challenges and difficulties that they faced. It is pleasing to note the many successes that have been achieved in the support services of the Department during the last year.

The finance component of the Department must be commended for their efforts in ensuring that sound fiscal discipline prevailed and that all financial resources were effectively and efficiently utilised. The introduction of the Basic Accounting System (BAS) will bring many new challenges in the next financial year. Road shows and workshops were held to ensure that the new system would be successfully rolled out to all institutions in preparation for implementation of the BAS system in the next financial year.

The Department strengthened its management of Tuberculosis through the implementation of measures that allowed for improved access to care, early detection of cases, sputum-testing turn around time and through the involvement of the community in the DOT training programme. Our Laboratory Services must be commended for ensuring very good response times. The Laboratory Services have done well. Much more work and effort is necessary to improve our management of TB, as the disease still remains a major cause of morbidity and mortality in our Province.

During the last financial year, the Cholera incidence was drastically reduced from 3 046 cases in 2002/03 to 415 cases. This is clearly attributable to the good management of the Cholera control in the Province and the continuation of the best practices that were employed during the Cholera outbreak of 2001/2002 when a total of 43 916 cases were reported. The Province was declared as having successfully combated and controlled the epidemic in this year.

Whilst an increase in Malaria cases was experienced in the last quarter of the financial year, the Department managed to institute all the necessary controls to contain the outbreak so that by the end of the financial year, the situation had stabilised. The battle goes on and we will eradicate Malaria by the given National date of 2007.

Programmes covering chronic diseases, communicable diseases, rehabilitation, maternal, child and women's health, health promotion, oral health, environmental health, mental health, nutrition and occupational health all contributed to the well being of the people in the Province. In particular, fast queues were implemented at Community Health Centres for the chronically ill and aged patients, medical officer coverage improved at PHC clinics, cataract surgeries to prevent blindness were performed, awareness on the dangers of substance abuse was created through a district wide essay competition, and assistive devices were provided to those in need through outreach programmes. Oral health was also improved with a total of 53 083 patients having been attended to, covering a variety of oral health and dental procedures.

Partnership with the Red Cross Air Mercy services has contributed to the Flying Health Worker programme. This programme must be commended for it's continued contribution to quality and compassionate health service delivery of our people especially those in the underserved rural areas. The Italian Co-operation is also commended for their valuable contribution to our Department both in terms of financial assistance and technical expertise.

In order to meet the health needs of our people, it was important to ensure that the correct infrastructure was put in place. A total amount of R 6 510 916 has been committed for the period up to and including 2006 for health infrastructure projects. During the last financial year, a total of 60 clinic maintenance projects were embarked upon to a total value of R23 141 206, 600 building projects were undertaken to the value of R 151 574 713, 271 major maintenance projects to the value of R 35 863 052 were undertaken, a total of R36,4 million was spent on medical equipment replacement projects, R33,4 million was spent on hospital revitalisation projects and R12 million went towards community based projects in 97 clinics. Three new Community Health Centres were built at Nseleni, Hlabisa and Thembalesizwe and a total of 14 clinics were replaced. It must be noted that of the total of 353 provincial PHC clinics, 351 have piped water, all hospitals and community health centres have piped water, flush toilets, grid electricity and voice and electronic communication (telephones). Whilst improvements in infrastructure have been achieved, it must be mentioned that approximately 30% of clinics have problems with regard to access roads. Road access to our clinics is our challenge.

The Inkosi Albert Luthuli Central Hospital continued with the commissioning process such that by the end of March 2004, a total of 779 beds were commissioned, this being an increase from 406 in the previous year. A major highlight for this paperless and fully electronic hospital was the 1st kidney transplant operation that was performed on 2nd December 2003. In addition, the successful transfer of services from King Edward VIII, Wentworth and Addington hospitals was completed in October 2003. Wentworth Hospital, our previous tertiary hospital, has now been converted to a District Hospital serving the local community of the area.

In terms of the hospitals revitalisation project, the next year will see further redevelopment of King George V hospital. This will provide a TB hospital comprising 400 beds, a District Hospital of 400 beds and a Psychiatric hospital of 130 beds. In addition, two new 300-bed district hospitals will be built in the Inanda and KwaMashu area within the eThekwini metro. At the turning of the sod ceremony that took place on 21st March 2004, the Honourable Deputy State President, Mr Jacob Zuma and the National Minister of Health, Dr Manto Shabalala-Msimang honoured us with their presence.

Amidst the challenges faced, the difficulties experienced and the increased workload on our loyal and dedicated employees, there were many accolades that brought pride and honour to our Department. The

human spirit of dedication and giving is alive in our Department. Amongst others, the following special achievements are highlighted:

- Murchison Hospital received a gold award in the Premier's Pricewaterhousecooper's Good Governance Awards in 2003;
- Mrs B Cele received the Cecelia Makiwane national award in 2003;
- Mrs D R Maoela achieved finalist position in the Shoprite Checkers/SABC Woman of the Year (health category);
- Mrs N R Nkabinde received a service excellence award in the Premier's Pricewaterhousecooper's Good Governance Awards in 2003;
- Mr B Bhekumuzi received the National Department of Health's Alfred Nzo Environmental health achievement award in November 2003;
- Bethesda Hospital received the national platinum Impumelelo Innovation Award for its work on HIV/AIDS in 2003;
- Dr V G Fredlund achieved an award for Best Rural Doctor of the Year in 2003;
- EMRS staff received recognition for excellence in the Afrox Health Care EMS Challenge and the Afrox Handigas Vehicle Extrication Challenge;
- EMRS staff members received recognition for being placed in the finalists for the Heroes of the Year in 2003;
- 15 hospitals received recognition for varying levels of accreditation through the COHSASA accreditation programme; and
- 7 Health facilities achieved the Baby Friendly Health Initiative status in 2003.

In conclusion I wish to acknowledge the dedication, loyalty and commitment of all the employees of the Department, who, even in the most adverse situations, have ensured that the delivery of health services is in accordance with the Vision, Mission and Core Values of the Department. At the same time they have adhered to the principles of Batho Pele, the Patients' Rights Charter and observance of Human Rights. This has made a difference in the health status of our people and improved their quality of life.

Thank you to MANCO and the entire health family comprised of all the staff of the Department, for your support, industry and abidance of ethical principles and observance of human rights. A special thank you to our Minister, Dr Z L Mkhize, for his strength of spirit, guidance and direction over the year.
Together, we have faced our challenges. Together we have met many of them and together we will go forward to do the best we can to realise our vision of optimal health status for all persons in the Province of KwaZulu-Natal.

Situational Analysis

Overview of Health Districts and Sub-Districts

The Department of Health, in its quest to continually provide comprehensive health care to the people of the Province, ensures that compassionate and quality health care is accessible in the eleven (10+1) Districts, which are aligned to the municipal boundaries. The 10+1 Districts are:

Ugu (DC21)
uMgungundlovu (DC 22)
uThukela (DC 23)
Umzinyathi (DC 24)
Amajuba (DC 25)
Zululand (DC 26)
Umkhanyakude (DC27)
Uthungulu (DC28)
iLembe (DC29)
Sisonke (DC43)
eThekwini (Metro)

In addition to providing services in the above Districts, the Department provides health care services to communities of the Eastern Cape Province. In this regard, the cross-border flow of patients from the Eastern Cape into the KwaZulu-Natal Districts of Sisonke and Ugu is estimated at 101 661, which represents 1.67% of the total Eastern Cape population. The Mozambique and Swaziland population served by KwaZulu-Natal is estimated to be 30 000. The Province provides central level care for 50% of the population of Eastern Cape.

The map that follows represent the current health districts and all the health facilities in the Province.
Broad Structure of Public Health Service

The three core service delivery pillars of the Department are:

- District Health System (Programme 2);
- Emergency Medical Rescue Services (Programme 3); and
- Institutional Support Services (Programme 4 and 5).

These service delivery pillars are under-pinned by the following categories of services:

District Health Services

First level of Health Care

Community Health Services focus on the prevention of illness and include immunisation, health promotion, HIV/AIDS awareness, nutrition services, mother and child health services, communicable disease control, environmental health, oral and dental health, rehabilitation support, occupational health and chronic disease support. All these services are available at PHC clinics and at District Hospitals.

Provincial Health Services

Second level of Health Care

- General Hospitals cater for patients requiring admission to hospital for treatment at specialist level;
- Tuberculosis Hospitals, Psychiatric Hospitals and Chronic Medical Hospitals provide hospitalisation for patients suffering from tuberculosis, mental illness and those patients requiring long-term nursing care; and
- Dental Training Hospitals provide a platform for training in dentistry and oral hygiene.

Tertiary Health Services

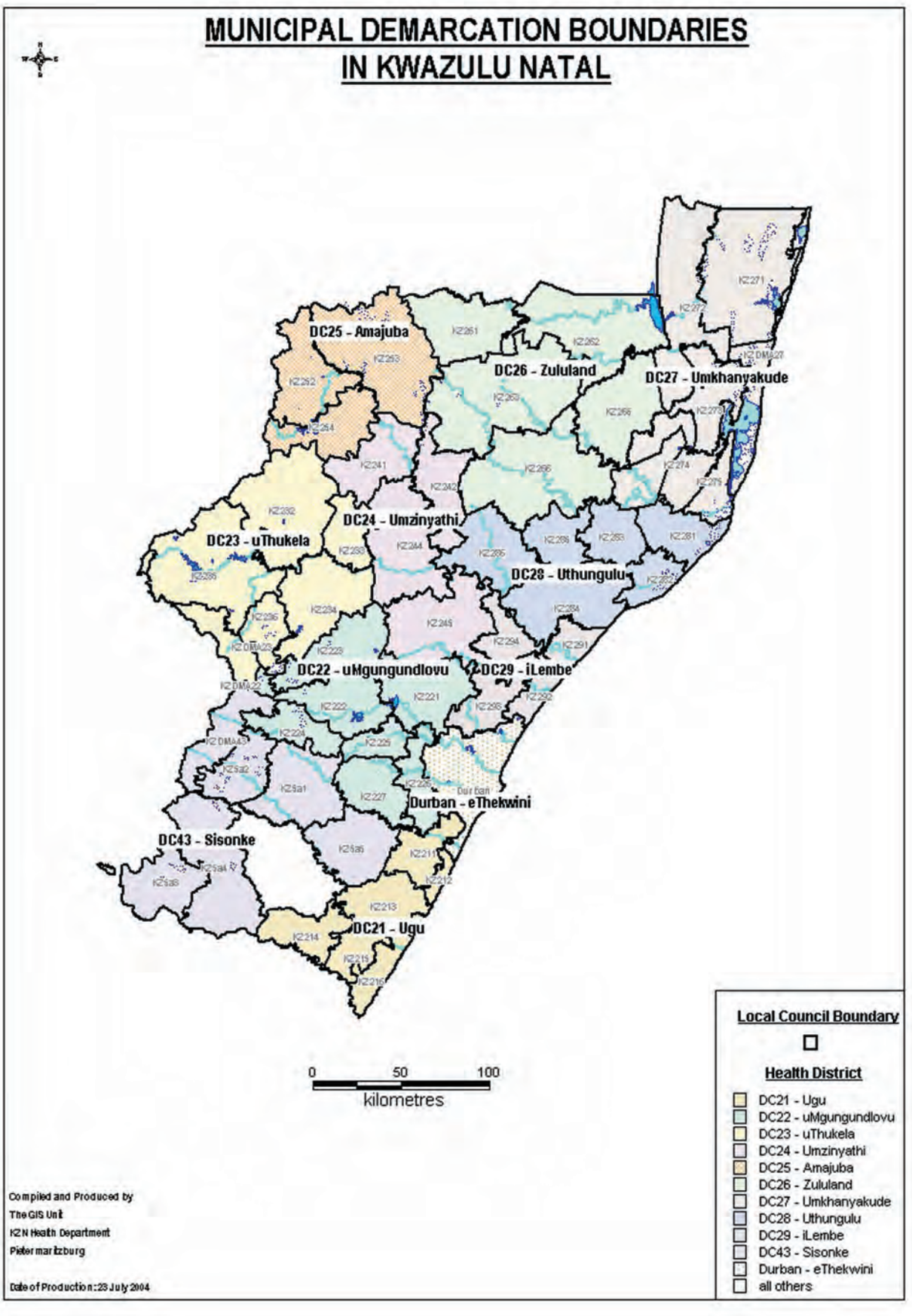
Third level of Health Care

Tertiary hospitals receive referrals from the regional hospitals. Tertiary Hospitals provide the facilities and expertise needed for sophisticated medical procedures. Should the health service required be that of services provided in central hospitals, then such referral shall be made.

Central Health Services

Fourth level of Health Care

Referrals to these hospitals are received from the tertiary hospitals. Central Hospitals provide services, which will generally be of high cost. They will provide a multi-speciality clinical service.


MUNICIPAL DEMARCATION BOUNDARIES
IN KWAZULU NATAL
DC25 - Amajuba
DC26 - Zululand
DC27 - Umkhanyakude
DC24 - Umzinyathi
DC23 - uThukela
DC28 - Uthungulu
DC22 - uMgungundlovu
DC29 - iLembe
Durban - eThekwini
DC43 - Sisonke
DC21 - Ugu
0
50
100
kilometres
Local Council Boundary
Health District
DC21 - Ugu
DC22 - uMgungundlovu
DC23 - uThukela
DC24 - Umzinyathi
DC25 - Amajuba
DC26 - Zululand
DC27 - Umkhanyakude
DC28 - Uthungulu
DC29 - iLembe
DC43 - Sisonke
Durban - eThekwini
all others
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KZN Health Department
Pietermaritzburg
Date of Production: 23 July 2004

Emergency Medical Rescue Services

- Render emergency medical services through specialised transport and paramedic personnel for victims of trauma, maternity, motor vehicle and other accidents; and
- Provide elective patient transport for indigent patients who have no other means of transport.

The Department has the following structured facilities for the provision of a comprehensive, compassionate and quality service to the people of KwaZulu-Natal:

- 14 Community Health Centres;
- 347 Clinics excluding Local Authority Clinics;
- 62 Hospitals;
- 175 Mobile Clinics;
- 15 State-Aided Clinics; and
- 14 State-Aided Hospitals.

Local Authority Clinics:

- 37 Mobile Clinics; and
- 75 Local Authority Clinics.

Table 2: Mortality trends

	1998
Infant mortality (under 1) rate	52.1 per 1000 live births
Child mortality (under 5)	
Maternal mortality	Not reported by SADHS

** Source:SADHS 1998. 2003 SADHS survey still in the field.*

Table 3: Top 10 causes of death in KwaZulu-Natal 1998-2002

Categories	% Total Mortality*	% Case Fatality**	Expected annual hospital deaths	95% CI Min Deaths	95% CI Max Deaths
AIDS	39.4%	31.5%	19200	16500	21900
TB	11.6%	13.6%	5700	3900	7500
Cardiovascular	9.6%	15.6%	4700	3050	6350
Respiratory Infections	5.5%	7.1%	2700	1450	3950
Diarrhoea	5.1%	7.1%	2500	1300	3700
Diabetes	5.1%	16.0%	2500	1300	3700
Malignant Neoplasms	4.8%	24.6%	2300	1100	3500
Intentional Injuries	4.1%	6.0%	2000	900	3100
Perinatal	3.8%	22.9%	1800	700	2900
Unintentional Injuries	2.1%	1.8%	1000	200	1800
Rest of Categories	8.9%	4.3%	4300	2700	5900
Total	**100%**		**48700**		

** % deaths caused by each category ** % within each category that die*
Source: Report on Hospital Discharge Survey in KZN 1998-2002 (Italian Cooperation).

Table 4: Notifiable conditions

	2001/02	2002/03	2003/04
Acute Flaccid Paralysis	1	2	5
Cholera	43 916	3 046	415
Malaria	7 041	1 909	2 050
Measles	5	70	117
Meningococcal infection	0	12	29
Poisoning agricultural stock remedies	0	5	0
Tuberculosis (all types)	69 250	103 976	80 547
Typhoid	12	9	3
Viral hepatitis (total)	104	115	46

* Figures denote numbers for each period

Table 5: Evolution of expenditure by budget sub-programme

Programme	2001/02	2002/03	2003/04	2003/04 Revised	Variance -% under/ (over-expenditure)
	Exp R'000	Exp R'000	Exp R'000	Budget R'000	
Programme 1: Administration	**134,002**	**143,866**	**154,176**	**154,907**	**0.47**
Programme 2: District Health Services	**3,326,700**	**3,363,876**	**3,771,028**	**3,770,364**	**(0.02)**
District management	31,689	42,178	50,409	44,750	(12.65)
Clinics	732,585	753,037	845,016	862,210	1.99
Community health centres	136,224	144,650	146,254	157,061	6.88
District hospitals	1,832,976	1,861,724	1,992,238	1,962,849	(1.50)
Community based services	64,911	81,669	46,566	73,499	36.64
Other community services	310,401	183,896	211,105	203,324	(3.83)
Coroner services	0	0	65	1000	93.50
HIV/AIDS	49,364	123,401	246,701	246,523	(0.07)
Nutrition	168,550	173,321	232,674	219,148	(6.17)
Programme 3: Emergency Medical Services	**158,336**	**196,428**	**272,046**	**272,046**	**0**
Emergency transport	147,081	193,691	268,074	264,975	(1.17)
Planned patient transport	11,255	2,737	3,972	7,071	43.83
Programme 4: Provincial Hospital Services	**2,020,760**	**2,242,949**	**2,569,622**	**2,569,322**	**(0.01)**
General hospitals (regional)	1,634,424	1,614,437	1,998,812	1,942,492	(2.90)
TB hospitals	144,556	267,065	251,263	289,201	13.12
Psychiatric hospitals	219,254	214,985	258,547	265,893	2.76
Chronic medical hospitals	15,297	139,622	53,730	63,695	15.64
Dental training hospitals	7,229	6,840	7,270	8,041	9.59
Other specialised	0	0	0	0	0
Programme 5: Central Hospital Services	**556,323**	**969,210**	**765,370**	**770,377**	**0.65**
Central hospitals	111,265	295,290	211,704	188,887	(12.08)
Provincial tertiary hospitals	445,058	673,920	553,666	581,490	4.78
Programme 6: Health Sciences and Training	**210,109**	**250,234**	**321,156**	**321,663**	**0.16**
Nurse training colleges	108,027	128,180	166,794	167,165	0.22
EMS training colleges	3,050	3,851	3,395	4,117	17.54
Bursaries	22,701	27,555	42,535	42,019	(1.23)
PHC training	32,736	37,207	41,604	41,556	(0.12)
Other training	43,595	53,441	66,828	66,806	(0.03)
Programme 7: Health Care Support Services	**0**	**5,000**	**10,400**	**10,400**	**0**
Medicines trading account	0	5,000	10,400	10,400	0
Programme 8: Health Facilities Management	**624,071**	**324,009**	**347,492**	**388,055**	**10.45**
Community health facilities	27,895	61,243	66,081	79,124	16.48
EMS	435	0	786	2,292	65.71
District hospitals	44,254	43,306	86,619	105,800	18.13
Provincial hospitals	72,459	108,051	117,599	131,322	10.45
Central hospitals	414,245	48,509	58,708	45,100	(30.17)
Other facilities	64,783	62,900	17,699	24,417	27.51
Total: Programmes	**7,030,301**	**7,495,572**	**8,211,290**	**8,257,134**	**1**

Table 6: Evolution of expenditure by budget per capita sub-programme (constant 2003/2004 prices)

	2001/02	2002/03	2003/04
Population	9,426,019	9,568,165	9,761,032
% insured	12%	12%	12%
Uninsured population	8,294,897	8,419,985	8,589,708
Conversion to constant 2003/04 prices	1.16	1.05	1.00
	Exp per capita Uninsured	**Exp per capita Uninsured**	**Exp per capita Uninsured**
Programme	R	R	R
Programme 1: Administration	18.74	17.94	17.95
Programme 2: District Health Services	465.22	419.49	439.02
Programme 3: Emergency Medical Services	22.14	24.50	31.67
Programme 4: Provincial Hospital Services	282.59	279.70	299.15
Programme 5: Central Hospital Services	77.80	120.86	89.10
Programme 6: Health Sciences and Training	29.38	31.21	37.39
Programme 7: Health Care Support Services	0	0.62	1.21
Programme 8: Health Facilities Management	87.27	40.40	40.45
Total: Programmes	**983.15**	**934.72**	**955.95**

- *Calculated by (expenditure) x (conversion factor)/(uninsured population)*

Notes

The following information is of relevance when considering the above:

1. The high income per capita in 2001/02 in Programme 2 results mainly from the inflated expenditure resulting from the cholera epidemic. This negates the apparent decrease in 2002/03.
2. The increase in 2002/03 in Central Hospital Services relates to the dual funding required to run these services at Wentworth, King Edward and Inkosi Albert Luthuli Central hospitals as a result of commissioning the latter.
3. The inflated figure for 2001/02 in Programme 8 relates mainly to the final payment for the building of Inkosi Albert Luthuli Central Hospital and accounts for the skewed per capita expenditure in this Programme.

Table 7: Expenditure on conditional grants

	2001/02	2002/03	2003/04
National Tertiary Services	427,525	488,575	551,831
HIV and AIDS	13,315	54,470	85,591
Hospital Revitalisation	87,000	111,000	34,353
Integrated Nutrition Programme	136,485	136,337	176,646
Hospital Management and Quality Improvement	957	19,000	16,375
Health Professions Training and Development	154,388	164,755	164,513
Inkosi Albert Luthuli Central Hospital	153,577	-	-
Provincial Infrastructure	23,862	43,658	70,043
Medico-Legal Mortuaries	0	0	65
TOTAL	**997,109**	**1,017,795**	**1,099,417**

Please note the above figures are based on the budget allocations for the Conditional Grants and not on the actual expenditure incurred by the relevant service.

ADMINISTRATION

This programme consists of the following sub-programmes:

- Minister
- Management

AIM

The aim of this Programme is to provide the overall strategic management of the Department in line with the Department's goals, strategic objectives and targets in order to ensure that administrative implementation focuses on meeting the health needs of the people of the Province.

The following two sub-programmes are described as follows:

Minister, with the specific objective of ensuring that the health needs of the people of the Province are met based on the constitutional mandate that is placed on the MEC and through the legislative framework that governs the Department.

Management, with the specific overall objective to ensure that the strategic leadership it provides, becomes the driving force that steers the Department towards the achievement of its overall strategic objectives and goals in line with the legislative prescripts, policies and guidelines for a quality, equitable and compassionate health care service for the people of the Province. In doing this, the Department subscribes to its vision, mission, core values, the Patients' Rights Charter and the Batho Pele Principles.

Within this Programme, a variety of clinical and non-clinical support functions exist, with the key focus on supporting the three core pillars of health service delivery, namely, the District Health Services, Hospital Services and the Emergency Medical Rescue Services.

ANALYTIC REVIEW

The period under review was indeed a challenging one for this Programme. Amongst other things, the aim was to ensure that whilst service delivery needs were being met in the broader community, there was always adequate control over the limited resources. The challenges with regard to the recruitment of skilled medical and nursing professionals, the retention of specialised skills and the impact of the HIV/AIDS epidemic on both the financial and human resources of the Department, ensured that the year was a challenging and sometimes daunting one.

A summary of highlights of components within this programme is dealt with below.

Audit and Risk Management

The Audit and Risk Management component performs a transversal function across the Department in that it deals with audit matters affecting all health institutions and ensures that risks are identified and mitigated through the implementation of internal control measures. This component works closely with the Internal Audit Unit of the Provincial Treasury and the Office of the Auditor-General in the execution of its duties.

During the reporting period, the Department was subjected to regularity audits at 7 institutions, transversal audits at 5 institutions and 2 compliance audits at the head office and one institution respectively. Computer control audits were conducted at 3 institutions. A performance audit on sick leave was also conducted at 8 institutions. The office of the Auditor-General conducted all these audits. In addition the Department's financial statements and budget were also subjected to a mandatory audit. As part of its strategy to combat fraud and corruption, the Department enlisted the services of the Internal Audit Unit of the Provincial Treasury to investigate 4 cases of alleged fraud and corruption at institutions and manage the cases emanating from Operation Cure.

The timeliness of preparing responses to the Auditor-General as well as the Internal Audit Unit is of great importance in ensuring that there is co-operation with regard to all matters raised. During the past year, the component was also involved in the compilation of risk profiles in the Department, with specific reference to systems, procedures and processes and the compliance thereof. The component was also involved in the roll out of the Department's Fraud Prevention Plan, which has also been incorporated into a training module for hospital managers.

Challenges faced by the component were mainly related to the sustainability of internal control measures that were identified and implemented as part of the risk identification processes. Non-compliance of standard policies and procedures was also highlighted in the various audits undertaken and these were addressed on an ongoing basis during the year.

Corporate Communications

This component can be seen as the window of the Department and is responsible for marketing the image, policies and programmes of the Department, building and maintaining relationships with the media and other stakeholders and serving as an information conduit between the Department and the community at large. In so doing the component also ensures that the morale of the employees is maintained at optimum levels at all times.

Based on the aforementioned, the component embarked upon a number of events and activities during the reporting period. The component worked closely with the service delivery programmes to ensure the success of the health day events on the health calendar. Amongst others, these included World Health Day, World No Tobacco Day, World AIDS Day, TB Day and Race Against Malaria. The component also ensured a visible presence of both the MEC for Health and the Head of Department at clinic openings and other formal events of the Department.

Corporate Communications was also involved with establishing the Public Relations Officers network in all provincial hospitals and assisted with skills development in this regard.

In ensuring that the morale of employees was maintained, the component organised with success, the Department's annual Choir Festival, Soccer and Netball tournaments.

The component also actively engaged with the media and kept them informed of the activities of the Department and in so doing ensured that the community were made aware of relevant health related matters on an ongoing basis.

Employee Assistance Programme

The aim of this programme is to assist employees to deal with social and emotional problems in order to sustain effective performance and remain productive members of the health care team. During the reporting period the Employee Assistance Programme continued with training of EA practitioners in all health institutions. Apart from counselling employees in areas of work related problems, the programme focussed on other problems such as financial, marital, relationship and substance abuse.

2003 Soccer Tournament Winners

However, the lack of infrastructure in terms of the counselling model contributed to the sporadic utilisation of the service especially in rural and semi-rural areas. The lack of Human Resource dedicated to EAP is still a challenge for the Department. Full response to the programme has been hindered due to the perception and fear of breach of confidentiality, especially due to the fact that EA practitioners are officials of the Department and colleagues of the clients.

Epidemiology and Health Indicator Unit

This component serves as a valuable resource for the Department in that it provides vital epidemiological information thus allowing for informed decision making in the process of health care delivery for the people across the Province. Hence the key areas of focus for the period under review were the conducting of health systems research and disease surveillance. In order to assist health planning, the Quarterly Epidemiology Bulletin was widely distributed in the Department. As a result of the survey on morbidity and mortality that was conducted in 62 hospitals, the findings were published as an executive summary, which culminated in the 6th Epidemiological Bulletin. The full technical report on the analysis of the hospital admission and discharge profile for the period 1998 to 2002 is soon to be published. The Unit also conducted capacity building workshops covering outbreak investigation and treatment, management and reporting of Rabies in all Districts.

One of the major challenges that arose during the year was the development of a monitoring and evaluation strategy for the roll out of anti-retrovirals. Critical to this process was the need to design a patient information system to satisfy the national reporting requirements against preset indicators.

Technical and financial support of the Italian Co-operation in the mainstream activities of the Epidemiological Unit was integral to the completion of the projects undertaken during the year.

Finance

The Finance Directorate was faced with a number of challenges during the 2003/04 financial year, the major one being the implementation of the Basic Accounting System (BAS). All the required targets were successfully met. The Budget Control sub-directorate successfully undertook the task of ensuring that the institutional expenditure lying against the incorrect objectives from the previous structure was allocated to the correct new objectives. Training in revenue procedures was broadened and all the hospitals have now been trained on the Uniform Patient Fee Schedule (UPFS) for assessing and setting up accounts. Training and capacity building at institutional level was undertaken in order to manage the institutional suspense and ledger accounts. The target of reducing the outstanding debts as at 31 March 2003 by some 40% was achieved, with in excess of 60% being cleared.

BAS training

Forensic and Bio-ethical Services

The aim of this component is to establish and provide forensic pathology services for the living and the dead, by the establishment of comprehensive forensic clinical services at public health institutions, and forensic autopsy services at appropriate certified mortuary facilities. In addition it focuses on the improvement of standards and quality of forensic pathology services by introducing accredited skills development and training programmes for health care professionals. The component also provided administrative support regarding medico-legal civil claims, research projects and Inspector of Anatomy functions. As a result of the Department having been designated as the pilot province for the transfer of the forensic pathology services in the country, the component was busy with the preparatory work with regard to this transfer. The component was tasked with the responsibility of facilitating the expeditious transfer of the Forensic Pathology Service from the SAPS to the Department of Health. The initial plan has been finalised and preparations for the implementation process were iniatiated.

Gender Focal Point

The main purpose of this component is to ensure that Gender Equality is effectively mainstreamed in the Department. This is achieved through the development and implementation of all policies, programmes and activities within the Department. In order to ensure that gender insensitive practices are eliminated at all levels, presentations were made to managers both at the head office level and at district level. In line with the objectives of this programme, gender sensitisation was most evident during the "16 days of no violence against women and children" during November and December 2003. In addition the Gender Focal Point interacted with all the service delivery programmes to ensure that gender issues were taken into account in the various health campaigns throughout the year.

Human Resource Management

This branch is responsible for the management of all human resources across the Department to ensure that the desired objectives are fulfilled. The branch is therefore responsible for the development of organisational post establishment, human resource planning, human resource development, staff relations and human resource practices.

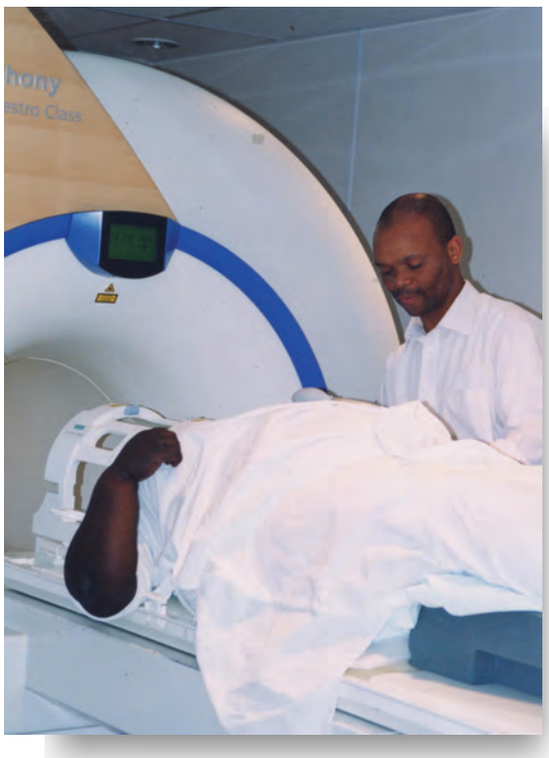
Based on the Department's strategic objectives, the organisational structure of top management was revised and implemented. This allowed for the creation of the new branches in the Department, the incumbents of which would drive the service delivery objectives in the Department.

The year saw the continuation of the decentralisation process with regard to human resource practices. This has allowed the management of institutions to exercise their delegated powers thereby ensuring the autonomy of our institutions.

The main challenges experienced were in the areas of capacity development, attrition rate, retention of scarce skills and recruitment especially in the rural areas, all of which were addressed to a certain extent.

Imaging Services

Imaging services (also termed radiological services) provides a fundamental clinical support function throughout the Department. Such services are provided at all health care facilities, inclusive of 24-hour services in certain areas. In addition the component situated in the Durban functional region is also responsible for the development of tertiary and quaternary services at the Inkosi Albert Luthuli Central Hospital. Training of health professionals in imaging is also conducted by this component.



Modern Imaging Equipment

Information Technology Component

The Information Technology component is responsible for the technical support with regard to the installation and management of the Department's computerised hardware and software. In addition it ensures that technology is upgraded in line with the prevailing trends and according to the needs of the Department. During the past year the IT component initiated the process to secure a tender for the installation of information kiosks at all provincial hospitals. It is envisaged that this will be finalised during the coming year. Steps have also been taken, in conjunction with SITA to replace the different information technology systems in use with one standardised system. Computer training centres were also established in each District. During the year 619 persons received training. The Department also managed to stabilise its network infrastructure by replacing old Cray hubs with 3 Com manageable switches. Phase 1 of the computerisation of clinics was also finalised with 50 clinics receiving

computers and printers. The technical support provided by the IT component was also improved in the Districts in that District Information Officers were appointed. During the past year all hospitals received training on the use of the new data collection tools and the new Minimum Data Set was also implemented in October 2003. In addition to the 9 existing tele-medicine/ teleconferencing sites, 6 additional hospitals were installed with these facilities.

Laboratory Services

Laboratory Services play a vital role in the provision of a comprehensive clinical support service to the core service delivery components of the Department.

Labratory Services

During the last year, in line with the WHO recommendation, a total of 34 microscopy centres were successfully established, in terms of which a total of 720 000 AFB slides were screened throughout the Province. This initiative thus ensured that services were rendered to people in the most rural areas as well as in urban areas. This service was additional to the services provided in the laboratories at the health institutions. Furthermore, the turnaround time for TB results was improved upon to reach 48 hours, whereby 8 of the 11 districts become fully compliant. Within hospitals the turnaround time for such results was within 24 hours. In order to ensure that all managers were fully trained to manage these services, training was conducted to upgrade their skills and expertise in line with the latest trends.

Challenges experienced related to the ability to recruit the requested number of trained medical technologists who qualified at tertiary institutions. This was due to the fact that the Department had to compete with the private sector when recruiting. In addition there was also a lack of appropriately qualified supervisors/ managers to manage the laboratories. This is however, being addressed through the training initiative that was embarked upon. A further challenge was the added demand on resources as a result of TB and HIV/AIDS and other related diseases.

Legal Services

The Legal Services component is an important resource for the entire Department, which incorporates legal services, contract management, medico-legal litigation and special investigations. The component was fully established towards the end of the reporting period. The Department has already reaped the benefits of having a fully-fledged legal component to ensure that all legal matters pertaining to the Department are better co-ordinated and interaction with the office of the State Attorney has been maximised.

With regard to Special Investigations, officials have been empowered in techniques to combat fraud and corruption. A total of 199 cases of alleged fraud and corruption were investigated with 103 having been completed and 96 still pending. These cases exclude the cases that were dealt with in terms of Operation Cure.

Orthotic and Prosthetic Services

This component is responsible for the provision of orthotic and prosthetic services to the entire Province. This is achieved through the main centre at Wentworth Hospital and the two satellite centres at Grey's and King Edward VIII hospitals. During the reporting period outreach clinics were conducted at 36 hospitals. Steps are being taken to achieve four fully operational orthotic and prosthetic centres in the Province with the aim of enhancing access to quality service.

One of the challenges facing this component was the budgetary constraint coupled with the exorbitant costs of imported components used in the manufacture of

such aids. Amongst other things, this component worked closely with the Rehabilitation Programme, conducted workshops for therapists and offered lectures to student therapists. During the year a total of 9 674 orthotic and prosthetic aids were provided to patients, thus ensuring that all patients were catered for and no backlog existed. Another challenge for this component was the difficulty in recruiting appropriately qualified staff.

Pharmaceutical Services

The provision of pharmaceuticals is an integral part of health care delivery to the people of the Province. Pharmaceutical Services therefore provide an important clinical support service to all health facilities in the Province, inclusive of the management of pharmaceutical services, the procurement of medicines for hospitals and clinics, the monitoring and evaluation with regard to quality of services and the development of skills to ensure effective and efficient delivery of service. During the reporting period this component faced considerable challenges in ensuring the correct stockholdings at health institutions despite severe financial constraints. However, strict adherence to the Drug Supply Management principles was essential to functioning within these constraints. In order to alleviate the problem of drug theft and wastage of medicines, security measures were tightened at the Provincial Medical Supply Centre as well as at hospitals. Intensive training was conducted on Drug Supply Management procedures. In addition to the aforementioned problems there was the continued problem of scarcity of qualified pharmacists.

Private Hospitals

The Department of Health regulates the private hospital industry in terms of development, approval and registration. As such this component ensures that the requirements of the regulations governing private hospitals and unattached operating theatre units are complied with. During the last financial year the total number of beds in private health care facilities numbered 3 534. During the past year the Department approved 5 applications for new facilities of which 2 were urban, 2 peri-urban and 1 rural. The main challenge that was encountered was the request for facilities in already well serviced areas and for specialised facilities.

Procurement

This component provides an important procurement support service to all the institutions of the Department. The main focus areas are to ensure the existence of appropriate tenders for the procurement of supplies and services required by institutions for the delivery of services to patients, the ensuring of equity and efficiency in the provisioning system and to compliance with regard to procurement legislation and the promotion of BEE in the Department's procurement activities.

Transport and Office Services

This component is responsible for ensuring that there is effective and efficient fleet management by providing support to all health facilities in the Department, including assisting with the interpretation and implementation of transport policies and guidelines. During the reporting period the component was involved with the purchasing of new vehicles, the provision of subsidised vehicles, the investigation of transport irregularities and the removal of ineffective vehicles from the system. In order to curb vehicle theft and reduce the incidence of hijackings, this component assisted with the facilitation of installation of tracking devices in the Department's ambulances.

At the end of the financial year, the Department's total pool vehicle fleet amounted to 1469. Challenges experienced during the year related to delays in receiving the RT77 contract (which created delays in the procurement of new vehicles), vehicle misuse and financial constraints which did not allow the full replacement of all ineffective and withdrawn vehicles.

Together with other provincial departments and in collaboration with TransAid, an NGO from the United Kingdom, a Transport Management Course curriculum was developed for the first time. This course will be run through a tertiary institution from July 2004.

Report Abuse of Government Vehicles

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Table 8: Programme Performance

Objective	Indicator	Target 2003/3004	Actual Performance
Audit and Risk Management			
Implementation of integrated risk management in the Department	Reduction of risks in all disciplines	20%	50% of institutions reached in order to mitigate identified risks and 5 Risk profiles were completed
	Reduction in number of audit queries	20%	Audit reports revealed a substantial decrease in the number of queries raised
Management of all audit related matters with special reference to the co-ordination of all management letters in respect of audits undertaken by the A-G as well as audit reports emanating from the Internal Audit Unit of the Provincial Treasury	Review and action on all audit reports/management letters	100% of all reports received	100% -Total of 25 audits conducted – corrective measures implemented in consultation with the institutional management
	Network with all relevant stakeholders regarding the content	100%	100% - ongoing networking took place during the year
	Ensure that action plans are in place	100%	All reports received were appropriately dealt with and action plans were drawn up by the relevant institutions
Implement fraud prevention strategy together with the fraud prevention plan	Implementation of corrective measures in areas of weakness as highlighted in audit reports	All institutions subjected to audits during the year	Research undertaken towards the compilation of a policy
Ensure the development and implementation of information security	Facilitation and conducting of risk assessment and internal control workshops	50% of all health institutions	Training has been provided and a module has been included in the Hospital management Training programme
	Security systems in place	25%	This has not yet been assessed
	Reduction in breach of security	25%	There have not been any reported cases of breach of security
Corporate Communications			
Development and implementation of an internal and external communication policy	A finalised policy that is widely distributed across the Department	100% - distribution to all health facilities	Policy has been developed. Distribution will be finalised during the next year
To build morale and improve the image of the Department	Successfully implemented public relations network at all health facilities	50% of all health facilities	20% achieved – achievement of this objective is dependent upon the creation of posts at the health care facilities

Objective	Indicator	Target 2003/3004	Actual Performance
	Reduction in negative publicity in the media	50% reduction	This cannot be realistically quantified in terms of a target as it cannot be predicted when there will be negative media publicity. All media queries were responded to timeously during the year
Promote the image of the Department to external stakeholders	Improve the relationship with the media	100%	Relationship with the media was greatly improved
	Feedback on the image of the Department	100%	Department is currently networking with the media in this regard
Employee Assistance Programme			
To ensure that an effective employee assistance programme is implemented in the Department	No. of institutions subjected to the roll out	30% of all health facilities	75% achieved
	No. of EA practitioners/co-ordinators identified	All health facilities	393 EA practitioners identified
	Degree of capacity building of EA practitioners	100% hospitals Did not target clinics/district offices/clinical support services	Hospitals – 95% achieved Clinics – 10% achieved District offices – 90% Clinical support – 20%
To facilitate the implementation and monitoring of the EAP programme	Level of functional service delivery of EAP at all health facilities	20%	21% achieved (13 out of 63 hospitals)
Ensure education on personal financial management for all officials in need	No. of officials trained	No target	200 officials received the necessary education
	No. of EA practitioners trained	100%	80% achieved - 314 out of 393 EA practitioners trained
Epidemiology and Health Indicator Unit			
To provide epidemiological information to support decision making and inform health planning	A global burden of disease profile for KZN	Final published report disseminated to all managers	4 Epidemiological Bulletins published in 2003 covering the global burden of disease
	Analysis of hospital admissions and discharges for 1998 to 2002	An executive summary disseminated to all managers	The March 2004 Epidemiological Bulletin constituted the executive summary
		A full technical report disseminated to senior managers	The report is currently in print and is soon to be distributed

Objective	Indicator	Target 2003/3004	Actual Performance
To conduct relevant disease surveillance that support prevention, treatment and control activities	Development of a spatially enabled disease data warehouse for KZN	Identification of all databases containing disease information	Disease data warehouse completed
	Investigation of all reported human deaths from Cholera and Rabies	100% of all reported deaths	23 Cholera deaths investigated (100%), 11 Rabies deaths investigated (100%)
	Development and training on Standard Operating procedures for disease surveillance	Annual ante-natal sero-prevalence survey for HIV and Syphilis	Survey completed and results submitted to the NDOH
		Implementation of the National protocol of STI Sentinel Surveillance	Training of all sentinel sites completed
	Review of provincial TB data	Analysis of data in electronic TB register and analysis of the MDR TB data at KGV	Analysis completed and results presented to CDC
Capacity building	Training of district teams in outbreak investigation and management	All districts	Training was conducted in all eleven districts
Financial Management			
Facilitate and ensure the successful implementation of the Basic Accounting System (BAS) in the Department	Introductory presentation of BAS to relevant role players	Management and district/institutional management	Fully achieved. Presentations were made to all targeted groups
	Correct structures implemented	98%	100% achieved
	Baseline BAS requirements at institutions	All institutions of the Department	Hardware and software provided at 99% of all institutions
	%age of institutions receiving introductory training on BAS	All institutions of the Department	100% achieved. Representatives from all institutions have received training
	Successful implementation of BAS	95%	98% achieved
Facilitating and ensuring that the allocation of expenditure by all health institutions is charged to the correct new expenditure objectives of the Department	%age of institutions expenditure which has been cleared	90%	95% of the incorrect expenditure has been cleared

Objective	Indicator	Target 2003/3004	Actual Performance
Embarking on the training of identified hospitals revenue staff on the procedure to effectively correct revenue	No of institutions given training	47 institutions	54 institutions covered during the year
Facilitating the control, monitoring and the clearing of all ledger and suspense accounts of the Department	%age of accounts exceeding 12 months as at 31/03/2003 cleared	40%	60% of accounts cleared
Forensic and Bio-ethical Services			
Manage Project Transfer of the Forensic Pathology Services from the SAPS to the Department of Health	Determination of the financial resource requirements to establish the Forensic Pathology Services in KZN	March 2004	Project brief completed; Activity plan has been finalised.
	Develop an implementation plan based on the recommendations of the Project Team		Implementation plan is in the process of being developed
Ensure the finalisation of draft Regulations in respect of forensic pathology services	Regulations for the Forensic Pathology Services promulgated, enabling the establishment of the Forensic Pathology Services in the Province	March 2004	Regulations both for forensic pathology services and for the transitional period pending the transfer of services from the SAPS drafted and submitted for ratification and promulgation
Skills development and training programme for health care personnel to render comprehensive forensic pathology services	Trained and competent personnel to render forensic pathology services	November 2003	Curriculum has been developed and is awaiting registration and accreditation with HWSETA and SAQA. Training materials developed
Provide medical advisory services in cases of medico-legal civil claims instituted against the Department of Health	Quick turn-around in resolving claims	Ongoing	Expeditious perusal of medical files; performance of medical/clinical audits and provision of advice and opinions on medico-legal claims
Ensuring that all applications, for projects to be conducted at public health have ethical approval and HOD approval	Ensuring a quick turn-around in assessing applications and granting approvals	Ongoing	Perusal and collation of documents relating to research projects; make recommendations for final approval
Exercise the powers, duties and functions of the Inspector of Anatomy, as defined in the National Health Act, for the Province of KwaZulu-Natal	Systems and statutory registers maintained; Authorisation for shipment of bodies granted Annual report to the National Director-General	Ongoing (Report submitted annually by the 31st December of each year)	Collation of documentation and authorisation for shipment of bodies granted within the working day; Donation of cadavers, organs and tissues for training and research authorised

Objective	Indicator	Target 2003/3004	Actual Performance
Gender Focal Point			
Building understanding of the gender policies and guidelines in the Department	Total number of institutions covered in terms of the distribution	80%	Gender policy guidelines widely distributed across 60% of institutions
	Total number of workshops held	80%	Policy presentations made for 40% of target groups
	Number of gender committees formed	50%	25% achieved - development of a provincial implementation strategy as well as the establishment of departmental workplace gender forum has commenced
Ensure the implementation of the Provincial Gender Strategy	Strengthened partnerships with other stakeholders	50%	Partnerships were particularly strengthened with all stakeholders during women's month in August 2003
Human Resource Management			
Optimise HRM by building capacity in HR practices at institutions and district offices	Total number of managers trained on: PERSAL Establishment functions Filling of entry grade posts Level of capacitation at district offices	166 officials 13 officials 30	166 officials trained 13 officials trained 30 officials trained
Decentralisation of HRM to institutions and district offices	Ability to deal with advertising and filling of posts from level 2 to 8	43 officials	43 officials trained
Ensure efficient and effective HR practices and systems	Effectively functioning registries at health institutions	96 institutions 10 + 1 districts	All targeted institutions and district offices fully operational with regard to this function
	Rectifying 2 105 out of adjustment cases at various institutions	50% of all institutions	50% achieved
	Availability of a fully functional human resource database	2 105	2 105 cases finalised
Monitoring of performance of decentralised HR practices functions	No. of audits completed in terms of rank and leg promotions	100%	100% achieved
	No. of recoveries of overpayments of personal profiles	38	38 audits completed

Objective	Indicator	Target 2003/3004	Actual Performance
	Total leave transactions completed at institutions	800 cases	800 cases finalised
	Accuracy and promptness in decision making	50%	50% achieved
Formulation, review and update of labour policies	Total no. of IMLC's established and fully operational	60%	Achieved the target fully
Establishment of fully operational institutional management and labour committees (IMLC's)	Available statistical data on backlogs	100%	99% achieved with the Head Office still outstanding
Identification and finalisation of backlog of discipline, grievance and disputes	No. of cases dealt with	100%	Achieved only 65% due to lack of Investigating and Presiding Officers
	No. of workshops conducted	100%	
	No. of trained managers	50%	50% achieved
Capacity building for hospital management and staff labour issues	Status of decentralisation in terms of discipline, grievances and labour issues	50%	35% achieved 50%
Decentralisation of identified labour relations functions	Sound labour relations between employer and employee	35%	25% achieved
Ensuring the prevention and resolution of labour unrest	Reduction in labour unrest on a comparative basis	25%	25% achieved
	Total no of managers trained on the implementation of the HR Plan	25%	30% achieved due to the delays in approval of the Plan
Ensure effective implementation of the Human Resource Plan	Total %age achieved in terms of the equity targets	100%	Achieved all the targets fully
Ensure equitable representation of people from designated groups at all levels and occupational categories			
People with disabilities	Target to be met	2%	0,09% achieved
Women of all races		50%	36 694 women (70,6%)
Africans		50%	40 464 (77,9%)

Objective	Indicator	Target 2003/3004	Actual Performance
Ensure effective implementation of skills audit system	Availability of accurate skills data		
	Completeness of reporting from institutions	100%	
	Availability of management information		
Ensure the effective determination of training needs in terms of generic, job specific and personnel training	Total no. of managers equipped with the requisite skills to determine training needs	75%	60% due to lack of training
			100% achieved against this target
Imaging Services (Radiological Services)			
To deliver imaging services to all patients requiring such services	Imaging services provided by hospital	New service at Wentworth	Service commenced in January 2004
		CT service at Prince Mshiyeni Hospital	CT scanner was installed in March 2004
		Mammography services	Awaiting finalisation of tender for new equipment
To provide 24-hr radiological service to patients	24-hour service	24-hr service for RK Khan, IALCH, Prince Mshiyeni Hospital	24-hr service available at R K Khan and IALCH. Partial service available at Prince Mshiyeni Hospital after hours
To develop the tertiary services at Grey's and IALCH and quaternary services at IALCH	Delivery of speciality services	24–hr MR services	MR services established
		Breast Imaging services	Breast Imaging services established
		Interventional services	
		Installation of MRI, neuro-angiography unit, cardiac catheterisation laboratory	Alterations for MRI scan completed and scanner delivered Installation of neuro-angiography unit ex Wentworth Hospital in progress Alterations for cardiac catheterisation laboratory will commence soon
To establish telemedicine facility	Provision of telemedicine services	Facility for consultation for outlying hospitals	Comparisons drawn between x-rays taken on digital camera and the originals – problem x-rays sent for opinions
		Communication with other centres for clinical meetings	Meetings have been held with Durban and PMB participants in surgery, anaesthetics and paediatrics

Objective	Indicator	Target 2003/3004	Actual Performance
		Distance learning	Registrars receive lectures through the telemedicine system. 2 registrars have passed the FCRad Part I
To provide quality assurance manual for general x-ray units	Availability of information	To provide information on intranet	The manual available on the intranet
Upgrading of x-ray equipment	New equipment installed	16 Institutions targeted for new and replacement imaging equipment	New equipment installed at 10 institutions and 3 are being planned: X-ray units Film processors Mobile c-arm image intensifier Upgraded ultrasound units at 6 institutions
Laboratory Services			
Provide accessible TB microscopy service	No. of functional TB microscopy centres	36 Centres	34 centres were established
Provide reliable and sustainable TB microscopy service	No. of facilities attaining 48-hour turnaround time	All districts - 90% compliance	Achieved 94% compliance – 8 districts fully compliant with 3 being addressed
Improve district and laboratory management capabilities	No. of managers trained in management and leadership skills	40% of 54 laboratory managers	Achieved 50% - 27 were trained
Build capacity and resources to support training and professional development	Functional central training unit	2 Training centres	5 Training centres in the process of being established
	No. of interns accessing training programmes	50 Interns	21 Interns accessed training programme during the year
Legal Services, Contracts and Special Investigations			
To establish a functional legal services component	All posts filled	100%	80% of all posts have been filled
Ensure an effective and efficient contract management component	Relevant policy instituted	65%	Policy has been finalised and implemented
	Compliance in terms of relevant prescripts and rules	65%	75% compliance has been achieved
	Total number of successful contracts finalised	65%	84% achieved - 1 571 contracts out of 1 871 were finalised
Provide an effective anti-fraud and corruption service	Total number of cases dealt with	75% of all cases finalised	199 of cases received 103 of cases finalised 96 cases still outstanding

Objective	Indicator	Target 2003/3004	Actual Performance
To successfully manage all medico-legal claims faced by the Department	The no. of cases successfully dealt with	100% of all cases received	327 cases received 170 were resolved 157 not yet finalised
Orthotic and Prosthetic Services			
Ensure that all patients receive their aids timeously	No. waiting list and no. backlog	All requests for aids during the year	Target was met. 9 674 aids issued to patients
Improve access to orthotic and prosthetic services	No. of hospitals, community centres and clinics where services are available	All health care facilities	36 Hospitals provide the service. Clinics and CHC's being addressed
Pharmaceutical Services			
To manage the Pharmaceutical Service in KZN	Number of posts filled Vacancy rate Percentage of hospitals visited Number of Interns appointed Number of CSP's appointed	56 post to be filled Reduce vacant posts to 40% (165) of total posts 50% (36) of hospitals All 50 intern posts to be filled 69 CSP's to be appointed	33 promotion posts filled, with the rest being advertised 54% (222) of posts vacant - difficulty in recruiting and retaining pharmacists increased 68% (49) pharmacies visited 50 Interns appointed 53 CSP's appointed in line with reduced National allocation
Ensure service delivery	Medicine availability Results of monitoring and evaluation Tracer drug availability Monthly service levels	100% 1 report per district per month 98%	82% achieved – 4 districts without pharmacists 95% drugs available at all times 93% orders filled on time at time of ordering
Quality assurance, monitoring and evaluation	No. of hospitals exceeded 50% compliance with GPP standards %age complaints satisfactorily resolved SOP's compiled	80% 20 hospitals 100% Completion of SOP's document	22 Hospitals achieved over 50% compliance 100% achieved SOP's completed
Provision of training and skills development	%age support staff trained as basic PA %age support staff trained in post-basic PA No. of interns trained	50% 20% 50%	41% of staff entered this training programme 14% trained on this programme 50% achieved

Objective	Indicator	Target 2003/3004	Actual Performance
Private Hospitals			
To ensure compliance of all private health care facilities	Total number of inspections undertaken	All private health care facilities in the Province by March 2004	Completed inspections in 37 facilities. All were compliant
Finalise the approval and registration of new private facilities	No. of applications received and finalised	All applications received during the year as well as those carried over from previous year	Dealt with 44 new and carried over applications. Finalised as follows: Approved – 14 Not approved – 14
Assessment of private facilities that are being built or upgraded	Compliance with the regulations	All projects in process	Carried over – 15 Inspected 28 projects during the year and all found to be compliant
Procurement			
To ensure an equitable and efficient provisioning system	A decentralised, equitable, effective, fair and BEE friendly procurement system (presently at 60%)	75%	Procurement delegations circulated to all institutions Procurement delegation limited to R200 000 issued to institutions Internal tender committees were appointed and policy document implemented Facilitated training on the procurement legislation – 750 delegates trained
	Ensure appropriate procurement strategies to allow BEE to participate in the Department's procurement system	To establish BEE office	BEE office was established. Large projects were unbundled to optimise BEE participation. Offered training to institutions on the application of the preferential procurement preferences legislation. Out of 289 contracts 144 awarded to BEE companies (50%)

Objective	Indicator	Target 2003/3004	Actual Performance
Transport and Office Services			
To ensure improved transport management in all institutions	No of fully trained staff at institutions and districts	20%	61% achieved (39 transport officers trained out of total of 63 health facilities)
To control the purchasing of government vehicles	Timeous purchase of vehicles adherence Adherence to policies and criteria	60% delivery of total of ordered vehicles	267 pool vehicles were ordered and 103 were delivered (39%). Delay in receiving the contract RT77 caused delay in ordering of vehicles
Facilitate the introduction of tracking system devices to all vehicles	Completion of installation by target date	40% of all vehicles	Installed tracking devices in 62 mobile clinic vehicles. This was 100% achievement for all new mobiles received
	%age reduction in no. of hijackings and theft of vehicles	61% (40 hospitals)	Facilitated the fitment of tracking devices to all new mobiles and ambulances The impact will be measured in the future
Upgrading of printing services	Cost saving in-house printing versus outsourcing	50% improvement in in-house services	Quality of printing improved by 75% as a result of new machine being installed Printing also increased from 5 082 457 to 6 156 629 copies printed (17,4% increase)
Improving control of subsidised vehicles	No. of vehicles withdrawn Compliance with policies and rules	80%	100% achieved in line with the policy
Ensuring the implementation of a vehicle replacement policy	No. of ineffective vehicles removed from the system	40% of all ineffective vehicles	62% achieved – 154 out of 250 ineffective vehicles removed from the system
Ensure control mechanisms for the prevention of misuse of vehicles	No. of new vehicles purchased	267	267 new pool vehicles purchased
	Reduction in no. of cases of misuse	50%	Total number of reported cases was 82, an increase from the previous year by 32

DISTRICT MANAGEMENT

AIM

The aim of this programme is to provide community based services through the Primary Health Care approach with the key focus being the implementation of a high quality, compassionate, accessible, seamless and comprehensive health care service for the community. This programme therefore ensures that the health status of the most vulnerable groups in all areas receive health care that serves to improve their overall health status and their quality of life. The District Health services are provided at Clinics (inclusive of local authority clinics), Community Health Centres, Mobile Clinics and at District Hospitals. Community based health programmes support the DHS by providing health promotion strategies, information, health education, counselling and community based care with regard to Communicable Diseases, HIV/AIDS, STI's, Mental Health, Chronic Diseases and Rehabilitation, Oral Health care, Nutrition, Maternal, Child and Women's Health and Health Promotion programmes.

ANALYTIC REVIEW

The National target for uninsured population per fixed PHC facility is 10 000 population per facility. The DHS Programme, in ensuring that this norm is achievable, works closely with the Clinic Upgrading and Building Programme. Whilst much progress has been made in the replacement, upgrading of existing clinics and the building of new clinics, more needs to be done to improve access at the first level of care. To this end, during the past year the average population per fixed PHC facility was reduced to 17 379 across the Province.

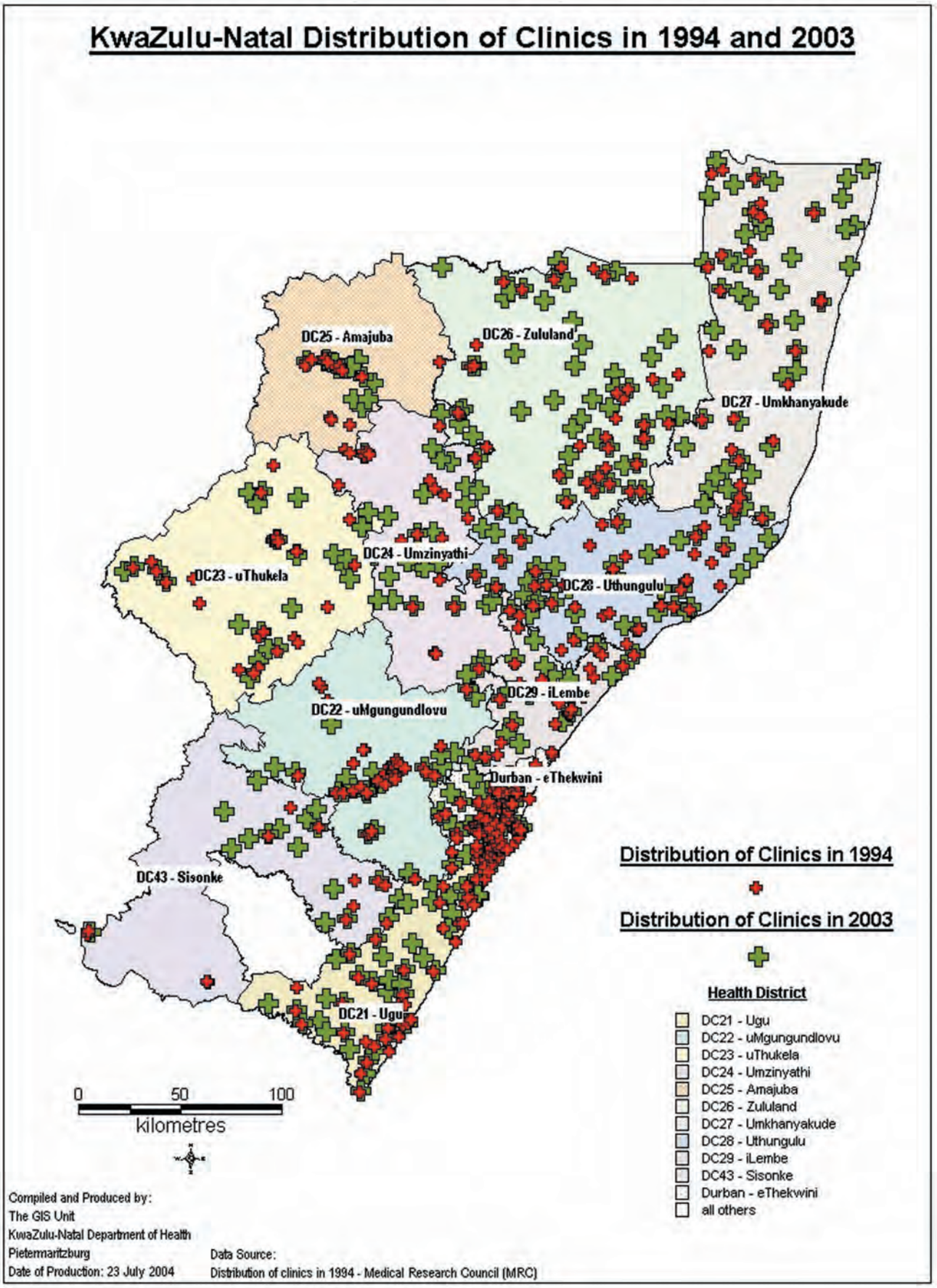
An audit of the PHC Package revealed that the National Target for staffing at PHC level (1 Professional Nurse per 1 000 population) has not been met. However all the facilities were able to offer, on average, approximately 80% of the PHC package of services during the year. The challenges faced in recruiting and retaining qualified nursing professionals prohibited the full implementation of the PHC package.

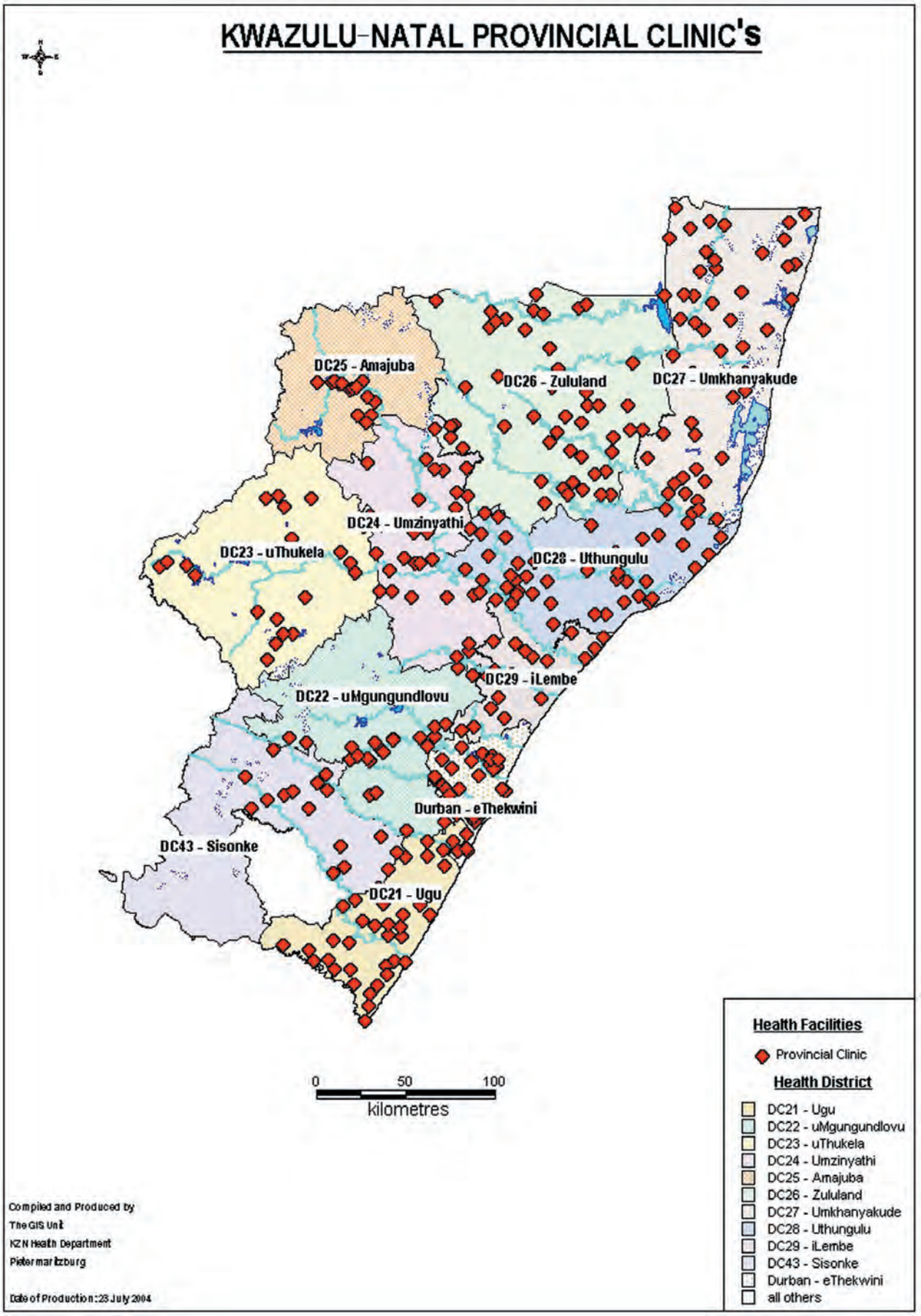
During the reporting period district development was advanced through the finalisation of the appointment of District Managers. This has resulted in improved co-ordination of primary health care in the Districts inclusive of collaboration with the local authorities towards functional integration of services.

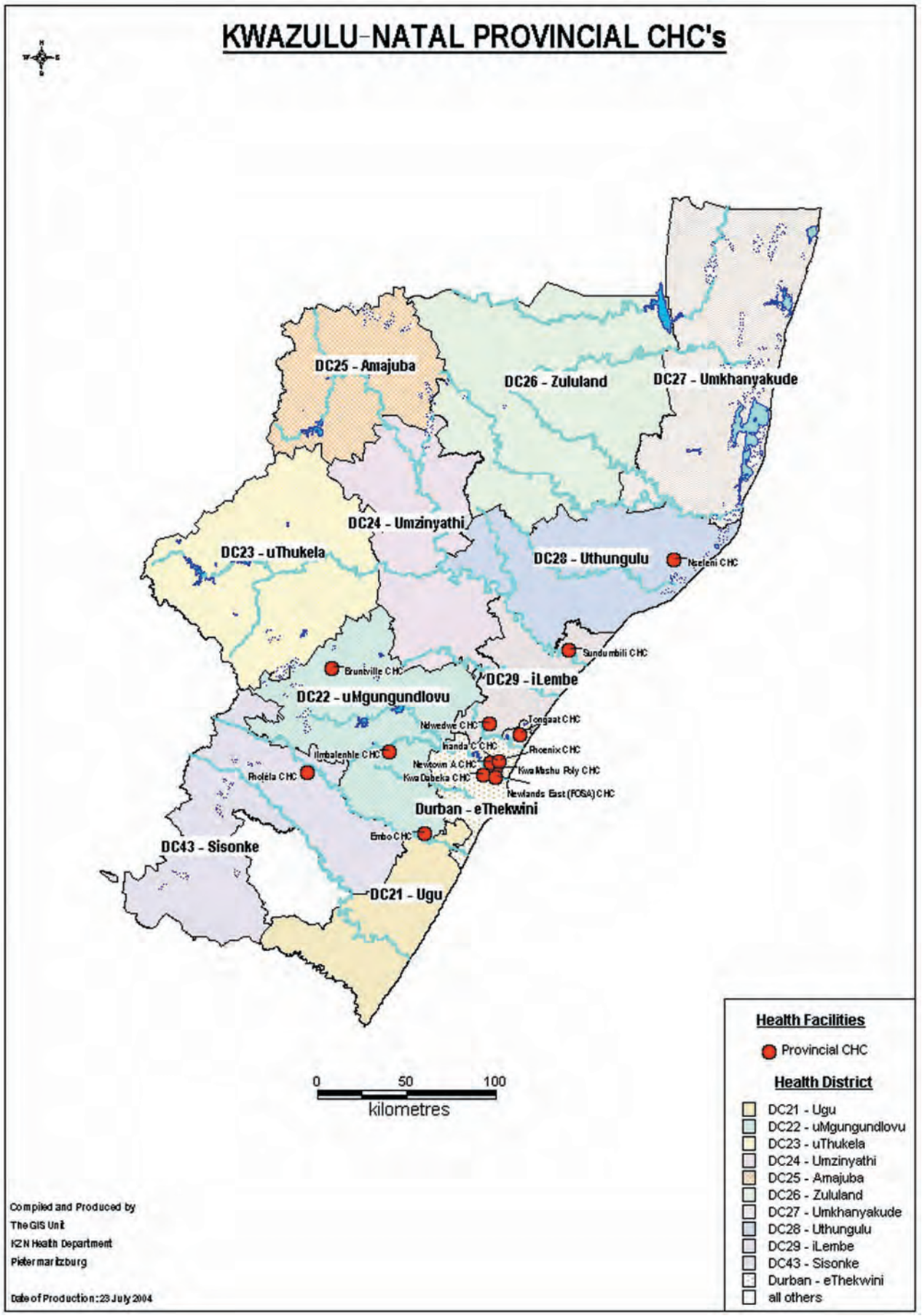
Amidst the many challenges faced by all Districts, a number of achievements were recorded for the reporting period. All Districts have developed and implemented integrated Communicable Disease Control and Health Care Waste Management plans. This has resulted in the outbreak response time being reduced to an average of one day at district level and the case fatality rates for Malaria and Cholera being within the WHO norms. With the focus on community participation in health service planning and development, governance structures at PHC facilities ranged from 34% in eThekwini to 100% in the other districts. In the absence of District Health Authorities, initiating community governance structures (Clinic Committees) at Local Authority clinics posed a challenge. Notwithstanding this, efforts to ensure community participation are ongoing.

PHC utilization rates complied with the expected norm. The under 5-year utilization rate increased, possibly due to the implementation of IMCI and the roll out of the PMTCT Programme. Mobile clinic services still accounted for an average 12% of the PHC headcount. The weekly medical coverage of the clinics across the Province remained a concern with an average of only 40% of clinics being visited weekly by a Medical Officer although this percentage was an increase from the previous year.

Factors such as poverty and high unemployment contributed significantly to the provincial morbidity and mortality profiles. Reduction of morbidity and mortality of the vulnerable groups in the Province remains a DHS priority. To this end 25 trauma centres for rape/sexually-abused clients have been established. With a focus on restoring the dignity of the elderly, fast queues have been established at all CHC's. Fast queues for collection of chronic medication have been


KwaZulu-Natal Distribution of Clinics in 1994 and 2003
DC25 - Amajuba
DC26 - Zululand
DC27 - Umkhanyakude
DC24 - Umzinyathi
DC23 - uThukela
DC28 - Uthungulu
DC29 - iLembe
DC22 - uMgungundlovu
Durban - eThekwini
DC43 - Sisonke
DC21 - Ugu
0
50
100
kilometres
Distribution of Clinics in 1994
Distribution of Clinics in 2003
Health District
DC21 - Ugu
DC22 - uMgungundlovu
DC23 - uThukela
DC24 - Umzinyathi
DC25 - Amajuba
DC26 - Zululand
DC27 - Umkhanyakude
DC28 - Uthungulu
DC29 - iLembe
DC43 - Sisonke
Durban - eThekwini
all others
Compiled and Produced by:
The GIS Unit
KwaZulu-Natal Department of Health
Pietermaritzburg
Date of Production: 23 July 2004
Data Source:
Distribution of clinics in 1994 - Medical Research Council (MRC)


KWAZULU-NATAL PROVINCIAL CLINIC's
DC25 - Amajuba
DC26 - Zululand
DC27 - Umkhanyakude
DC24 - Umzinyathi
DC23 - uThukela
DC28 - Uthungulu
DC29 - iLembe
DC22 - uMgungundlovu
Durban - eThekwini
DC43 - Sisonke
DC21 - Ugu
0
50
100
kilometres
Health Facilities
Provincial Clinic
Health District
DC21 - Ugu
DC22 - uMgungundlovu
DC23 - uThukela
DC24 - Umzinyathi
DC25 - Amajuba
DC26 - Zululand
DC27 - Umkhanyakude
DC28 - Uthungulu
DC29 - iLembe
DC43 - Sisonke
Durban - eThekwini
all others
Compiled and Produced by
The GIS Unit
KZN Health Department
Pietermaritzburg
Date of Production: 28 July 2004


KWAZULU-NATAL PROVINCIAL CHC's
DC25 - Amajuba
DC26 - Zululand
DC27 - Umkhanyakude
DC24 - Umzinyathi
DC23 - uThukela
DC28 - Uthungulu
Nseleni CHC
Sundumbili CHC
Brunville CHC
DC29 - iLembe
DC22 - uMgungundlovu
Ndwedwe CHC
Tongaat CHC
Inanda C CHC
Phoenix CHC
Ilimbalenhle CHC
Newtown A CHC
Kwa Mashu Poly CHC
Kwa Dabeka CHC
Pholela CHC
Newlands East (FOSA) CHC
Durban - eThekwini
Embo CHC
DC43 - Sisonke
DC21 - Ugu
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Compiled and Produced by
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Date of Production: 23 July 2004
Health Facilities
Provincial CHC
Health District
DC21 - Ugu
DC22 - uMgungundlovu
DC23 - uThukela
DC24 - Umzinyathi
DC25 - Amajuba
DC26 - Zululand
DC27 - Umkhanyakude
DC28 - Uthungulu
DC29 - iLembe
DC43 - Sisonke
Durban - eThekwini
all others

implemented at the majority of clinics. In partnership with the Department of Education, the Health Promoting Schools Initiative, which targets the youth at schools, has been implemented in all Districts. Accessing assistive devices for the disabled remained a challenge and the existing backlog would have to be dealt with in the coming year. The Vision 2020 Outreach Programme is ongoing and during the last financial year 54% percent of the districts exceeded the cataract surgery target set by the Department.

The performance of each District is dealt with hereunder.

Ugu – DC21

The Ugu District is one of the 13 rural nodes in the country and one of the 4 in the Province. This District is characterised by high levels of poverty and low levels of development especially in the rural areas. The district covers an area of 5 047 km^2 and serves a total population of 729 052. There are 6 local municipalities in the District. There are 4 hospitals in the District, namely 1 Regional and 3 District hospitals. Primary health care services are provided by 35 fixed clinics, 14 mobile clinics, 10 municipal clinics and 1 gateway clinic.

During the last year the District specifically focussed on strengthening PHC services and making health care more accessible. The main aim was to improve the health status of the most vulnerable groups in the District. Despite the challenges of lack of capacity and resources, staff retention and difficulty in recruiting scare skills in rural areas; good progress was made in poverty alleviation, combating the spread of communicable diseases, mother and child health and the management of chronic diseases.

One significant improvement in service delivery was in the area of drug supply and management. 90% of district health facilities were on direct supply of medicines from PMSC, that is 46 out of 50 clinics. The out of stock level decreased from 2,6% to 1,3% in comparison with the previous year. The average number of items issued per patient at PHC clinics remained below the accepted norm of 2,1 (WHO norm) and stood at 2 items per patient.

A pilot study was conducted for the adherence to the Essential Drug Programme at three different levels of care in the District, namely, Regional hospital level, District hospital level and at PHC clinic level. This was the first pilot study on this subject in the Province and was completed with the assistance of the KZN Pharmacy Technical Committee. The study provided valuable baseline data for adherence to the EDP, which was the low level of adherence to the EDP across all levels of care with the PHC level being the best performer. A follow-up survey, six months later, revealed significant improvement in compliance although the ideal level of compliance was not reached at any of the facilities.

uMgungundlovu – DC 22

The uMgungundlovu District is situated in the KwaZulu-Natal midlands and covers an area of 8 942 km^2. The total population is 960 819 of which 39% live in rural/deep rural areas and 61% in urban/peri-urban areas. Of the total population 52% are female and 60% are literate. There are 7 municipalities in the District of

Food garden as part of poverty alleviation projects

which Impendle, uMshwathi and Mooi Mpofana are the most underserved.

Services are provided by 1 Regional/Tertiary hospital, 1 District/Regional hospital, 2 District hospitals, 3 Specialised Psychiatric hospitals, 2 State subsidised TB hospitals, 3 CHC's, 33 fixed clinics (24 provincial and 9 municipal) and 12 mobile clinics.

During the reporting period, the District's contribution to poverty eradication took the form of R1, 2 million awarded to Women Owned Enterprises (WOE's) and Previously Disadvantaged Individuals (PDI's). An intensive campaign resulted in 96% of clinics initiating vegetable gardens, 11 communal gardens being established and an additional 40 499 school going children were fed on the PSNP (utilising alternative funding to the PSNP budget allocation for the year). Access to PHC services was improved by 22% in fixed clinics due to the implementation of extended hours. The Impendle Mobile clinic was re-instated and medical coverage increased to 100% to old age homes.

As a result of Transformational Leadership Programme, 100% of District Management had personal coaches and were able to enhance their managerial skills. Armed with the skills acquired through this programme the District Management team achieved a remarkable feat in that the refurbishment of the Baniyena Clinic was completed within 7 days.

The major challenge still faced by the District is facilitating further paradigm shifts towards self-reliance and self-efficacy of both the clients and the staff in the District. This will ensure that all resources within the District across all levels of care are utilised maximally for tangible returns.

uThukela – DC 23

The uThukela District covers an area of 11 329 km^2. This District serves the health needs of close to three quarters of a million people. Three hospitals, 24 fixed clinics and 13 mobile clinics, 9 municipal clinics, 3 gateway clinics, 1 State aided clinic and 272 CHW's Home Based Carers and Volunteers bring the reality of optimum health and well-being to the people of the District. The total population for this District is 680 333 with an urban/rural mix of 25% urban and 75% rural. The District is divided into 5 Municipalities.

Achievements during the reporting period included the commissioning of a Community Health Centre and upgrading of existing facilities. The District Child Survival Programme was completed, which led to improved community knowledge and practices as well as improved facility-based health care.

One of the challenges faced by this District included criminality in specific areas, which impacted negatively on access to services. In addition the inability to fill posts in the services and the District

Community participation

Office posed a problem. The attrition of Professional Nurses remained a major problem. PHC services were also affected by the limited availability of medical practitioners.

The DHER has highlighted how district resources were being distributed and utilised, thus providing a good indication of the limitations on service delivery in a limited resource environment.

Umzinyathi – DC 24

The Umzinyathi District is situated in the central part of the Province and covers an area of 8 080 km^2, of which 80% is rural. The total population in the District is 472 682, comprising 44,2% males and 55,8% females. There are 4 municipalities in this District with Msinga serving the majority of the rural population. Umzinyathi has 4 District hospitals, 30 provincial fixed clinics, 6 municipal clinics, 9 mobile clinics,1 NGO clinic and 4 gateway clinics.

During the reporting period, this District recorded a few significant achievements. Amongst others, clinic hours were extended in 11 out of 37 clinics, thus ensuring

access to PHC care for 12-hour periods, one hospital also commenced with the provision of anti-retroviral therapy towards the end of the financial year, immunisation coverage reached 90,1%, thus exceeding the National target of 90% and 2 hospitals were accorded the BFHI status.

This District like the others also experienced difficulties in terms of staff attrition, especially in the rural areas. Whilst the implementation of the scarce skills and rural allowances were seen to serve as a recruitment and retention strategy, this posed a problem in that professional nurses used this as an opportunity to move to those areas where the allowances were being offered. This created gaps in the services provided and added to the dissatisfaction of the affected staff. Another major challenge was the lack of a 24-hour PHC facility. Due to the community being confined to the more rural areas, access to health care after normal hours was not available. The co-ordination of health care services was also negatively impacted upon due to the appointment of the district management team not having been finalised early in the year. Whilst this District was identified as a Presidential rural node, progress was hampered by the resignation of the co-ordinator from the appointed NGO.

Amajuba – DC 25

The Amajuba District covers an area of 6 909 km^2 and comprises a total population of 484 673 of which 52% are females. The District has 3 municipalities, namely, Dannhauser, Uthrecht and Newcastle, with Utrecht being the biggest with 53% of the population. Services are provided by 2 Regional hospitals, 1 District hospital, 14 fixed clinics, 7 mobile clinics, 2 municipal clinics, 3 gateway clinics and 1 State aided clinic.

During the reporting period the District provided comprehensive health services in line with the Primary Health Care package of services. Based on this 47% of PHC facilities achieved a cure rate for TB of more than 60%, 57% of facilities achieved a smear conversion rate of 60% and 100% of facilities managing TB patients received their sputum results within 48 hours.

The year also saw an increase in the number of facilities offering VCT services, that is, an increase from 44% to 58% (including mobiles). Patients receiving Home Based Care in the District increased from 30 to 73. Immunisation coverage in the District increased from 80% to 94%, which is 4% above the National target. PMTCT services were offered by 15 PHC clinics. The District has also established a 24-hopur service allowing access to health services after hours. During October 2003 an awareness campaign on eye problem was held whereby 14 010 patients were screened. A total of 557 cataract operations were performed during the year.

Whilst a number of achievements were recorded for the year, certain challenges still remained. Some facilities appeared to have a high patient load with less staff, thus increasing the workload. High staff turnover could be a contributory factor in this regard. Ante-natal attendance before 20 weeks of pregnancy was a problem and requires attention. None of the hospitals in the District received the BFHI status during the year. In addition the VCT clients per counsellor per day was also lower than the District target of 5 cases per counsellor per day (National target is 8 cases per counsellor per day).

Zululand – DC 26

The Zululand District covers an area of 15 306 km^2, of which 80% is rural. The total population in this District is 833 037. The District has 7 hospitals, 54 fixed clinics, 11 mobile clinics, 1 CHC, 1 municipal clinic, 6 gateway clinics and 3 State aided clinics.

During the last year, the District piloted a project for the integration of hospital and PHC facilities in order to improve quality of service. As part of its quality initiatives, the District held a District Quality Day celebration in November 2003, where each institution displayed samples of their quality services and products. In order to ensure accurate reporting and data collection the requisite number of Facility Information Officers were appointed. In order to evaluate services being provided, suggestion boxes were installed in all health facilities. The establishment of 80% of demonstration gardens were successfully completed in order to alleviate poverty and assist the community with self-sustaining initiatives.

The challenges faced during the year included underdevelopment due to the rural situation. Access to safe water and sanitation, unemployment and HIV/AIDS exacerbated the problems and more effort is needed to make a meaningful impact on the quality of life of the people in the District. Capacity problems also resulted in the inability to deliver optimal health

care. Limited human resources, lack of skills and the lack of transport also contributed to the slow progress in certain areas.

Umkhanyakude – DC 27

The District of Umkhanyakude is one of the rural nodes of KwaZulu-Natal and covers and area of 12 818 km^2. The population in this District is 593 718 of which approximately 90% is mainly rural. Only 1% falls within the semi-urban category.

There are 5 District hospitals, 50 fixed PHC clinics, 13 mobile clinics and 1 gateway clinic providing health care to the population. The last financial year saw 75% of the population having access to a fixed clinic within a 5 km radius. However, extensive mobile services provided health care outside the 5 – 10 km radius from fixed clinics. The District recorded certain areas of good progress during the reporting period. Among others, 661 CHW's provided essential services in the District, the rehabilitation team visited all facilities, VCT and PMTCT achieved 98% coverage and all health facilities provided food supplements to patients. In addition, as part of its poverty alleviation projects, 62% of clinics established vegetable gardens and 99% of all primary school children were fed through the Protein Energy Malnutrition (PEM) scheme.

Being a very rural District, Umkhanyakude faced many challenges during the year. Whilst a target was set to ensure the provision of 1 CHC, 20 additional clinics and one 24-hour clinic, none of these were achieved. Oral health was also a challenge in that dental teams reached only 44% of clinics. Progress with regard to cataract surgery was also slow (17% only) and out of a total of 939 patients requiring eyeglasses only 156 were issued with them.

Uthungulu – DC 28

The Uthungulu District is situated in the northeast part of the Province covering an area of 8 216 km^2 and has a population of 917 451, of which approximately 83,9% live in rural settlements. The population comprises 58% females and 42% males.

The District has 6 municipalities. Health services are provided by 2 Regional/District hospitals (Ngwelezana and Lower Umfolozi District War Memorial Hospital complex), 6 District hospitals, 44 fixed provincial clinics, 13 mobile clinics, 1 CHC and 5 municipal clinics. Ngwelezana Hospital is the referral hospital for all PHC and District facilities. Lower Umfolozi District War Memorial Hospital serves mainly as a maternal and child facility.

Major health conditions that presented to the health facilities in 2003/2004 included hypertension, gastro-enteritis, pneumonia, sexually transmitted infections, malnutrition, TB and other respiratory disorders. In addition the District was hit by the outbreaks of scabies, rabies, "pink eye" and to some extent cholera and measles.

In line with the strategic objectives of the District, a number of achievements were noted during the year. The incidence of STI's decreased from 45 647 in the previous year to 39 685 during the last year. This could be attributed to the fact that all facilities introduced the syndromic management of STI's. Immunisation coverage was good and family planning coverage reached 80%. The case fatality rates for the recent outbreaks of measles and rabies were noticeably below 5% due to the District consistent environmental health, animal health and primary health responses. Whilst the District's TB cure rate was 36% it was evident that improvement in TB management strategies were still needed in order to achieve the norm of 85%. Two additional hospitals were accorded the BFHI status. Maternal mortality was 0,4% at the close of the financial year. HIV testing improved and of the 49 PHC facilities, 44 were providing VCT services.

The challenges with regard to sufficient capacity remained and supervisory visits needed to be strengthened. The District also experienced a shortage of medical officers hence routine visits to clinics were not optimal. Most gaps in the distribution of health services were identified through the DHER project. Almost half of the sub-districts were underserved and five sub-districts were generally underresourced in terms of infrastructure.

iLembe – DC 29

The iLembe District is situated in the north coast of the Province and covers an area of 3 260 km^2 and has a total population of 580 307. The District comprises 4 municipalities. There are 3 District hospitals, 1 Regional hospital, 2 CHC's, 22 fixed provincial, 7

municipal clinics, 1 gateway clinic, 137 mobile visiting points and 3 State aided health facilities.

During the reporting period the District noted a number of achievements. Amongst others, DOTS coverage was increased from 47% to 65%. This was achieved through an incentive for DOT supporters and the provision of a subsidy to the SANTA Motivation Project. Collaboration with Traditional Healers was also strengthened. VCT and PMTCT coverage was also increased to 100% at all targeted health facilities in the District. Fast queues and an appointment system were introduced especially for chronic disease clients. Towards the end of the year, referrals to the next level of care were improved in that the referral system became more effective.

During the year poverty alleviation projects were also improved upon with the increase in the number of clinic gardens from 4 to 19. In addition 23 additional schools were incorporated into the feeding schemes (PSNP) and a new NIP project was initiated at Isithundu Clinic for the provision of support to the children affected by HIV/AIDS.

The iLembe District is one of the newer districts and the coming year will see further development in terms of service delivery. Challenges that were experienced during the past year included the inability to ensure medical coverage in all sub-districts. Of the 4 sub-districts only 2 managed to achieve full medical coverage at PHC facilities. The shortage of staff also prevented the achievement of optimal service delivery. Such shortages were mainly in the medical and nursing services. Whilst the District managed to achieve 100% PMTCT coverage at all targeted facilities, the non-provision of maternity services at Local Government clinics prevented the roll out of PMTCT services to such clinics.

Sisonke – DC 43

The Sisonke District has a population of 308 999 of which 54% are females. The District covers an area of 10 109 km^2. The District is divided into 5 municipalities of which Ingwe is the most rural and most densely populated area. There are 4 District hospitals, 19 fixed provincial clinics, 2 mobile clinics, 1 CHC, 2 municipal clinics and 2 gateway clinics that provide health services in this District.

During the reporting period, the District, in keeping with the package of PHC services launched the first Health Promoting School in the Province, which did not only bring health workers together for celebration, but demonstrated the implementation of intersectoral collaboration between the Departments of Health, Education, Agriculture and farmers and community members. The District also launched a programme for the management of STI's and a programme for rehabilitation. The rehabilitation programme ensured that rehabilitation was not limited to institutions but reached the community through this outreach initiative. The services were more effective, accessible and sustainable especially with the increase in the number of therapists that were allocated to the District.

As part of its poverty alleviation initiatives, the District established 4 pilot sites (demonstration gardens at St Apollinaris Hospital, Tsatsi/Broteni Clinic, Carisbrooke and Sokhela Primary Schools), which will be rolled out to all the health facilities in the District. This initiative, led by an intersectoral team, brought together the community.

Staffing remained a challenge both in the District Office and in the health facilities. Recruitment and retention of suitably qualified staff together with the lack of suitable accommodation contributed to this and remains a challenge for the Department. In addition, due to the limited transport facilities (Planned Patient Transport) for patients optimal transporting of patients could not be realised. Delivery of the PHC package of services was also not optimal due to poor staffing and support.

eThekwini – Durban Metro

The eThekwini Metro was established in December 2000, covers an area of 2 292 km^2 and comprises 3 sub-districts, namely, North, South and West. The total population is 3 199 944, of which 52% are females. A close relationship, which was developed with the Metropolitan Unicity, allowed the facilitation for the continued devolution of provincial PHC services to the Unicity. Twelve hospitals, 1 of which is a central hospital (IALCH), 44 fixed provincial clinics, 59 municipal clinics, 9 provincial mobile clinics, 12 municipal mobile clinics, 6 CHC's and 2 gateway clinics provide services in the metropolitan area.

During the last financial year, a number of notable achievements were recorded. A major highlight was the achievement of an award for excellent planning and participation in the Red Cross Flying Doctor service. Through the efforts of the Integrated Nutrition Programme, 2 168 patients received nutritional supplementation for malnourished people in the last quarter. As part of its poverty alleviation drive, seed packs were purchased and handed out by the MEC for Health to the Umlazi community in March 2004.

There was also ongoing support for the Provincial Substance Abuse Forum and District Peri-natal Review meetings. Pharmacy Week was officially launched in IsiThumba Village in the picturesque Valley of a Thousand Hills. One of the major attractions at the site was the launch of a Mobile Clinic, a joint venture between the Department and the Pharmaceutical Society of South Africa and the Rotary Clubs of South Africa. This site was specifically selected to place emphasis on the huge and important role Pharmacy services can play in rural areas. It also served as an example of the effort the profession was making to take pharmacy to people in the rural areas where patients traditionally had very little or no access to pharmaceutical services.

One of the challenges was the increasing demand for psychiatric services as patients became enlightened about the aetiology of mental illness and possible care. Despite the acute medical and staff shortage, adequate services were provided, this having been achieved through the process of rationalisation and proper planning. Staff shortages also impacted negatively on the drug supply management at facilities. The human resource constraint is however being addressed by means of the functional integration of provincial and local authority PHC services.

Million Men March

Table 9: Programme Performance: District Management

Objective	Indicator	Target 2003/3004	Actual Performance
Ugu DC 21			
Provision of medical officer services which is accessible at all PHC facilities	Medical Officer coverage at clinics	50% of all clinics	78% of all PHC clinics were covered by MO support at least every 2 weeks
Implement direct supply of medicines to clinics	100% of PHC clinics supplied directly from PMSC	51 clinics	46 clinics directly supplied from PMSC (90%)
Reduction of morbidity and mortality amongst women and children	4 ANC visits per client	4 ANC visits per client	100% achieved
	1 PAP smear per PN per day	1 PAP smear per PN per day	47% achieved
	90% EPI coverage	90% EPI coverage	82% achieved
	1 trained IMCI nurse per clinic	1 trained IMCI nurse per clinic	100% achieved
	9 Health facilities on BFHI	9 Health facilities on BFHI	56% achieved (5 out of 9)
	Functional peri-natal mortality forums	4 forums across hospitals and clinics	4 Forums were established
To implement appropriate interventions for the management of chronic diseases	No. of eye glasses to clients	200 eye glasses	471 eye glasses provided
	No. of cataract surgeries to prioritised clients	300	211 Cataract surgeries were successfully performed
	Extent of integration of mental health at PHC level	50% of PHC clinics	100% of PHC clinics have integrated mental health care
Reduction of morbidity and mortality relating to communicable diseases including emerging and re-emerging diseases	Roll out of VCT/PMTCT	100% roll out	100% achieved
	No. of nurses trained in STI management	100% of nurses	100% of nurses trained
	Roll out of integrated TB/HIV programme	100% roll out	100% integration achieved
	TB completion rate	70%	62% TB completion achieved
	TAT reduction to less than 48 hours	100% of facilities	TAT is less than 48hrs
	DOT coverage	100%	56% coverage achieved
	Bacteriological coverage	90%	52% coverage achieved
Alleviation of poverty in the District	Established multi-sectoral project	1 Project covering skills development and food gardens	Successfully established project together with the Depts. of Agriculture and Welfare

Objective	Indicator	Target 2003/3004	Actual Performance
	PSNP in schools	235 schools	235 schools on the programme
	Establishment of clinic gardens	15 clinic gardens	15 clinics gardens were set up
	Implementation of the PEM	44 clinics and 4 hospitals	100% achieved
Implement a Quality Assurance programme for PHC services	Client satisfaction survey	Implementation in all PHC clinics	Client satisfaction survey conducted and results analysed. Baseline data being utilised to improve services
	Optimal supervisory visits to PHC clinics	1 supervisory visit per clinic per month	83% achieved
	Development of a standardised card for management of chronic diseases	Development and implementation during 2003	Standardised card developed and implemented in all PHC clinics
	Optimal functioning of all Clinic Governance Committees	80% functional Clinic and CHC Committees	32 out of 36 clinics have functional Clinic Committees (89%)
uMgungundlovu DC 22			
To develop Strategic and Implementation plans for effective co-ordination of service delivery	Strategic and Implementation plans completed	100% of health service areas, facilities and outreach teams	100% achieved as per targets
	Proportion of managers with personal coaches	100% District Office Managers and PHC Area Managers	100% of all PHC managers had personal coaches and 120 individuals trained in Transformational Leadership
To reduce poverty	Proportion of service/work contracts awarded to HDI's and PDI's	50% of all contracts	70% of work/contracts awarded to HDI's and WOE's
To ensure that all programmes have an operational plan for decreasing morbidity and mortality	Decreased morbidity and mortality of vulnerable groups: IMR PMR MMR Low birth weights ANC visits	 40/1 000 40/1 000 140/1 000 90% reduction 4 visits per client	 Not measured as yet Not measured as yet Not measured as yet Not measured as yet 3,9 visits per client
To facilitate implementation of the full PHC package	Availability of all components of the PHC package by level	90%	71% achieved overall
To ensure that all facilities have fully functional governance structures	Proportion of facilities with Clinic Committees	80% of structures	68% of facilities have Clinic Committees

Objective	Indicator	Target 2003/3004	Actual Performance
	Proportion of committees skilled in governance	All Clinic Committees	80% of Clinic Committees skilled
	Proportion of local service areas with a health forum	20% of sub-districts	100% of sub-districts have a health forum
To provide appropriate CHW human resources	Provision of sufficient CHW's to improve service delivery	267 in place	262 CHW's of which 203 trained in IMCI
To provide increased equitable access to PHC services	24-Hour clinics	2 x 24-Hour clinics	2 x 24-Hour clinics operational
	Mobile clinics	11 Mobiles	12 Mobiles (Impendle Mobile re-instated)
	Extended hours	3 Clinics	5 Clinics opened up for 12-hour period – 10 341 patients seen after 16H00
To consolidate VCT at all relevant hospitals and to roll out the service to all PHC, CHC's and clinics	%age of provincial hospitals offering VCT	100%	100% hospitals offered the VCT
	%age of PHC facilities offering VCT	100%	100% PHC facilities offered VCT
To decrease the incidence of STI's	%age of facilities offering syndromic management of STI's	100%	100%
	%age of health care workers trained in STI management	100%	100% PHC health care workers trained
To roll out the combined HIV/AIDS and TB management strategy	Proportion of facilities with integrated strategy	Entire District	100% Sub-districts have an integrated strategy
To implement a targeted youth life skills campaign using the LoveLife /NAFCI model	No. of peer master trainers	3 At district level	3 Peer master trainers trained at district level
To implement a comprehensive HBC strategy	Proportion of facilities with database for home based carers and beneficiaries	7 Facilities	2 Facilities have set up database
	Proportion of facilities providing free HBC kits	100%	100% Facilities - 360 HB carers linked to PHC clinics
To roll out the PMTCT programme to all health facilities in the District	Proportion of hospitals with PMTCT services	100%	PMTCT available at all facilities
To initiate an integration between MCWH, IMCI and PMTCT programmes	Proportion of facilities with integrated services	25%	25% Integration was achieved

Objective	Indicator	Target 2003/3004	Actual Performance
To provide support to lay counsellors	Proportion of lay counsellors on mentorship programme	100%	66% of lay counsellors on mentorship programme
Improve TB management in the District	DOT coverage	60%	68% achieved
	%age staff trained on TB management	75%	87% achieved
	%age clinics with <48 hour TAT	100%	75% have achieved <48 hour TAT
	TB cure rate	85%	30% cure rate noted
	Smear conversion rate	60%	40% achieved
uThukela DC 23			
To ensure the development of Strategic and Implementation plans for the delivery of services	District Strategic Plan developed	100%	100% - plans completed
Ensure the implementation of a clear policy for the DHS in the District	District Plan distributed to all health facilities	100% availability of District Plan	100% achieved
Ensure the availability of PHC services throughout the District	Distribution and implementation of package of services for PHC	100% implementation	100% achieved
To ensure that all programmes have an operational plan for decreasing morbidity and mortality	Operational and business plans developed and distributed throughout the District	100% availability of plans	All plans available in health facilities
Monitoring and evaluation of implementation plans	Continuous monitoring of progress through: Collation of statistics by DIO	Complete monthly statistics across all programmes	100% monthly reporting achieved
	Monthly meetings	100% representation at meetings	All programmes represented at meetings
	Utilisation of DHER as a quality assurance measurement tool	100% availability of DHER to District management	DHER available and utilised appropriately
Ensure community participation in the governance structures	Community co-ordinators identified and placed in each municipality	5 Personnel	5 Co-ordinators identified and performing the functions
	CHW availability	Each ward with CHW	272 CHW's appointed and functioning in the District
Integrated health promotion strategy implementation for all DHS programmes	Decreased peri-natal mortality rate	<30 per 1 000	Peri-natal mortality reduced to 36 per 1 000

Objective	Indicator	Target 2003/3004	Actual Performance
	Improved diarrhoeal disease control measures	<15 per 1 000	Achieved 11 per 1 000
	Increased TB cure rate	50% of TB cases cured	33% cure rate with bacteriological coverage increasing from 50% to 86% amongst PTB cases
	Improved ante-natal services	75% of facilities	Monthly peri-natal review conducted at all 3 hospitals
	NAFCI initiated	24 PHC clinics	2 Youth friendly clinics identified per municipality – total of 10
	TOP services	3 Hospitals	1 Hospital offered TOP services
Ensure appropriate management of chronic diseases	Improved clinical management of Hypertension and Diabetes	100% of facilities	100% achieved – 40 clinics, 3 hospitals, 12 mobile clinics offered these services
	Number of cataract surgeries performed	400 Cases	272 Cases dealt with
	No. of PHC nurses trained	100% - 65 nurses	65 PHC nurses and 56 community members trained
Adequate supply of well trained human resources	Extent of training according to needs	Personnel in all health facilities	Training undertaken accordingly in medical waste management, environmental surveillance, health and safety, EAP, Introduction to BAS
Provision of medical officer services to PHC clinics	Medical coverage at all clinics at least twice monthly	All PHC clinics (40)	10 PHC clinics visited once a week, 6 clinics visited bi-weekly and 24 clinics visited once monthly
Umzinyathi DC 24			
Improvement of TB management	Increase in TB cure rate	60% of patients diagnosed through sputum testing	54% TB cure rate achieved
	Sputum TAT	24-Hour TAT	100% of Health facilities have achieved 24-hour TAT
Improvement management of MCWH	EPI coverage	90% of children under one year immunised	90.1% Children under one year immunised
	IMCI implementation	37 Fixed PHC's facilities with one trained nurse on IMCI	All facilities have IMCI trained nurses - 47 nurses trained on IMCI
		All community based health workers	100% achieved with 216 community based health workers having been trained

Objective	Indicator	Target 2003/3004	Actual Performance
	BFHI status	4 District hospitals awarded baby friendly status	2 District hospitals were awarded baby friendly status
	No. of health facilities offering VCT/PMTCT	All health facilities	37 out of 41 facilities provided VCT/PMTCT (90.2%)
To improve management of HIV/AIDS	No. of volunteers trained on HBC	500 volunteers	562 Volunteers were trained
	No. of PHC clinicians trained on HIV/AIDS counselling	40 Clinicians	55 Clinicians were trained
Increase community participation in governance structures	Clinic Committees in each facility	All PHC facilities	Clinic Committees in place in 25 out of 37 clinics
	Hospital Boards	4 District hospitals	3 Hospital Boards established
Ensure Medical Officer coverage in PHC facilities	Coverage of every facility at least twice monthly	50% of all PHC facilities (18)	10 facilities achieved the appropriate coverage (27%)
Improve quality of care	Complaint mechanism	All facilities to have complaint mechanism	Complaints mechanism fully operational at all health facilities
	Customer satisfaction survey	All PHC facilities	Survey completed and results analysed, issues identified and being addressed
	Supervision of clinics	All clinics	All clinics were visited by supervisors at least once monthly
	Comprehensive PHC package of services	All PHC facilities	25 out of 37 PHC clinics offered the full package of services
	Equipment improvement	All PHC facilities to have basic equipment	This was fully achieved
	Availability of protocols and essential guidelines	All PHC facilities	Relevant protocols and guidelines were made available at 90% of PHC facilities
Amajuba DC 25			
To improve TB management	TB cure rate	60%	The cure rate improved from 44% to 58%
	TB treatment interruption rate	<5%	Reduced from 13% to 8%
	TB smear conversion rate Sputum TAT	60%	Improvement from 52% to 63% was achieved

Objective	Indicator	Target 2003/3004	Actual Performance
		<48 hours	Average TAT is 48 hours with 76% of facilities achieving 24 hour TAT
To improve the management of HIV/AIDS services	%age Facilities offering VCT services	100%	16 of the 17 facilities offered VCT services
	%age Counselling rooms with STG's for STI's	100%	100% have STG's for STI's in the consulting rooms
	%age STI prescriptions that follow a syndromic approach	100%	This has improved from 78% to 82%
	%age Clinicians trained in HIV/AIDS counselling	100%	More than 61% clinicians trained
To improve the management of MCWH services	%age Facilities with HIV/AIDS material in local language	100%	100% facilities have HIV/AIDS material in the local language
	Immunisation coverage rate	90%	Immunisation coverage increased by 14% from 80% to 94%
	%age RTHC plotted correctly	80%	RTHC improved from 65% to 72% with an 8% gap. Target affected by cross border flow of patients
	%age Facility staff practising IMCI	40%	78% of facilities have 48% of staff practising IMCI
	%age of facilities offering ante-natal services	100%	100% facilities offered ANC services
	%age of ANC visits before 20 weeks	50%	20% of first ANC visits were before 20 weeks
	Availability of a youth friendly facility in each sub-district	1 Youth friendly facility per sub-district	None of the targeted clinics were accredited as youth friendly but youth friendly forums have been formed
	%age Facilities offering PMTCT service	100%	All but 1 clinic offered PMTCT services during the year
To improve the quality of care	Availability of a 24-hour facility	1 facility to render a 24-hour service	1 Facility, Nellies Farm Clinic offers 24-hour PHC services
	Availability of essential guidelines in all facilities	100%	100% of facilities had essential guidelines available

Objective	Indicator	Target 2003/3004	Actual Performance
	Availability of vital equipment in all facilities	All facilities	100% Facilities had working vital equipment available
	Availability of customer satisfaction report	Annual customer satisfaction survey for PHC	PHC customer satisfaction survey done and report available
Improve the quality of life of the community	Availability of Optometrist in the District	1 Optometrist to be appointed	1 Optometrist was appointed during the year
	Availability of transport for eye care programme	3 Vehicles to be purchased	3 vehicles were purchased
	%age PHC nurses trained in primary eye care	100% PHC nurses	Each PHC facility had nurse trained on primary eye care
	No. of patients screened	No target	14 010 patients screened for eye problems
	No. of cataract operations	500 per annum	557 cataract operations performed during the year and in excess of 660 received glasses
Improve community involvement	%age Facilities with Clinic Committees	100% of facilities	100% of facilities have Clinic Committees in place
To establish trauma centres for victims of violence	No. of trauma centres	3 Trauma centres	Each of the 3 hospitals has a trauma centre
Zululand DC 26			
To develop a Strategic Plan for the delivery of services	Completion of Strategic plan	100%	Strategic Plan developed
To implement an effective health management information system	Train FIO's	100%	All FIO's were trained
	Communication links	100%	71% of facilities have computer communication links
To ensure proper delinking of PHC services	Separate budget for PHC	100%	Separate budget allocated for PHC services
To improve human resource management in the District	Development of integrated HR plans for all facilities	100%	90% achieved against the target
To improve communication in the District	Appoint a PRO in each hospital	50%	Not achieved
Ensure that PHC nurses have formal PHC training and relevant skills and competencies	%age PN's trained and qualified in clinical assessment, treatment and care	50%	25% achieved

Objective	Indicator	Target 2003/3004	Actual Performance
To develop strategies to ensure relationship between the DHS and institutions at all levels	All PHC services integrated for the delivery of care between clinics, CHC's and hospitals	100% integration	80% of PHC services were integrated across all levels
Poverty alleviation	%age clinics with demonstration gardens	50%	80% of clinics with clinics gardens in place
To improve water supply for clinics in the District	%age clinics with standard water supply	100%	94% of all facilities have standard water supply
	%age clinics using tankers	0%	6% were still using water supplied by tankers
To train PHC nurses	No. of nurses trained in: Mental Health Ophthalmic Advanced Reflection course Reproductive Health IMCI case management TB management VCT and PMTCT	 54 (1 per PHC clinic) 7 30 74 nurses 142 (2 per facility/mobile) VCT - 54 (1 per clinic) PMTCT – 7 (1 per hospital)	 68 nurses trained 3 completed the course 45 nurses trained 57 nurses trained 156 nurses trained 54 nurses + 7 hospitals completed training All 7 hospitals completed PMTCT training – 100% coverage
To ensure drug availability in all clinics	No. of clinics that comply with EDL	54 PHC clinics	52 PHC clinics fully compliant
Health promotion at schools	No. of schools on HP project	50 Primary schools	13 Primary schools involved in HP
To increase access to cataract surgery to the community	No. of people with access to facilities	700	200 Patients accessed the services
To improve TB TAT	No. of sputum collection per week in each facility	At least 3 sputum collections per week in each facility	All facilities have less than 48hr TAT – 54 clinics and 7 hospitals
To improve DOT coverage	No. of TB clients linked to a DOT supporter	All TB patients linked to a DOT supporter	68% of patients were linked to a DOT supporter
Umkhanyakude DC 27			
To develop a Strategic and Implementation Plan in line with the DHS vision and mission	Strategic Plan developed	Duly completed Strategic Plan for the District	Strategic Plan completed
To ensure availability of PHC services throughout the District	Access to PHC services for all members of the community	100%	75% of population had access to a fixed clinic within 5km radius

Objective	Indicator	Target 2003/3004	Actual Performance
To implement a monitoring tool for continuous monitoring of Implementation Plan	Monthly submission of data	100%	90% submission of data
	Monthly data analysis and interpretation	100%	80% bi-monthly analysis and interpretation took place
	Monthly feedback	100%	80% bi-monthly feedback obtained
To develop strategies to ensure relationship between the DHS and institutions at all levels as well as EMRS	Integration of all PHC services	100%	100% integration of services achieved
	De-linking in terms of accountability	100%	50% de-linking achieved
To ensure the existence of functional Clinic Committees and CHC Committees	No. of facilities with functional committees	100%	80% of facilities have functional committees
Develop mechanism for intersectoral collaboration	No. of joint DOH/DHS/stakeholder partnership initiatives	100% (6 meetings per year)	33% achieved
Utilisation of appropriate CHW human resources in support of DHS	Provision of sufficient CHW's	1 059 (100%)	661 (62%) CHW's provided services
	Provision of sufficient CHF's	42 (100%)	19 (45%) CHF's provided services
Ensure equitable and effective access to PHC services	Provision of sufficient additional clinics and CHC's	1 CHC 20 Additional clinics 1 24-Hour clinic 2 Mobile clinics	These targets were not achieved in the last year
Adequate supply of well trained human resources	All PHC facility nurses appropriately trained	100%	80% of all nurses trained in various skills
Provision of Medical Officer services at all clinics	Medical Officer coverage at least twice monthly per clinic	100%	78% achieved
Improvement of quality of care through health programmes	Improved access to dental care and oral health services	100%	44% achieved
	Access to rehabilitation services	100%	100% achieved
	Integration of mental health care into PHC services	100%	66% of PN's trained on basic mental health care
	Establish and maintain health promoting schools	100%	This was not achieved
	Increase the number of refractive corrections through surgery and eye glasses	100% (600 operations per year)	216 operations performed (36%) and 156 eye glasses were issued

Objective	Indicator	Target 2003/3004	Actual Performance
	Improve management of IMCI	60%	30% PHC PN's were trained
	Integration of HIV/AIDS, TB and Nutrition programmes	100%	98% of facilities offered PMTCT and VCT. 98% of facilities followed the protocols and guidelines. 100% integration between HIV and Nutrition and 60% integration between HIV and TB achieved
Decrease morbidity and mortality	PMR MMR ANC visits	30 per 1 000 140 per million 4 visits per ANC patient	32 per 1 000 achieved 167 per million achieved 4,2 visits per ANC patient
To improve the management of TB in the District	%age Facilities that meet 24-hour TAT	100%	3x per week (61%) with 9% having achieved 24hr TAT and 30% within 3 to 7 days
	TB cure rate	85%	20% of patients who were fully treated
	Smear conversion rate	85%	46% smear conversion rate
	Bacteriological coverage	90%	61% bacteriological coverage
	DOT coverage	100%	Approximately 80% DOT coverage achieved
Uthungulu DC 28			
Strengthening PHC and DHS	Immunisation coverage	90%	105% achieved
	FP coverage	No target	80% coverage reached
	No. of IMCI trained nurses	No target	30 IMCI trained nurses
	No. of CHW's	No target	267 CHW's in place
	No. of facilities with comprehensive services	100%	100%
Decrease morbidity and mortality	No. of STI's treated	100% of cases treated	39 635 cases treated
	PMTCT facilities	57	48 facilities provided PMTCT services
	%age provision of syndromic management of STI's	100%	100%
	No. of VCT sites	49 sites	44 VCT sites in place
	TB cure rate	85%	36% achieved

Objective	Indicator	Target 2003/3004	Actual Performance
Integration of care	Integration plan developed and implemented	Completion of integration plan	Plan developed and implemented
Communication and consultation	%age Facilities with Committees/Boards	100%	100% facilities had Committees/Boards in place
	%age Ffacilities with telephones and faxes	100%	93% facilities had telephones and faxes
Sufficient clinics and CHC's	No of additional clinics	2 clinics 1 CHC	2 Clinics and 1 CHC built
Improving governance structures	%age Facilities visited regularly (routine monthly supervision)	100%	Due to capacity problems only achieved 20%
Transversal health promotion programmes	Facility inspections	100%	37,5% achieved
	Schools inspected	100%	55% achieved
	Water and food samples tested	No target	80% sampling conducted
	Awareness projects	All programmes	40 awareness projects undertaken
Co-operation with Traditional Healers	Provincial traditional healers forum	Forum in place in 2003	Forum was established
Human resource training	%age Personnel trained	100%	21% of personnel trained
Ensure Medical Officer coverage at clinics	%age facilities visited by MO on weekly basis	100% of facilities	34% of facilities were visited by MO on a weekly basis
Improve quality of care	EMRS response time	Urban – 15 minutes Rural – 40 minutes	Urban – 30 minutes response time achieved Rural – 1 hour response time achieved
	%age expired drugs	0% of all drugs	0,9% of expired drugs were detected
	%age Facilities with complaints mechanism	100% of facilities	100% - all facilities had complaints mechanism in place
	Quality improvement programme and plan	100% facilities	100% programme improvement achieved
	Performance standards developed and implemented	100%	Performance standards developed (100%) with 40% compliance
Improve access to services	%age availability of drugs	100% availability	85% achieved at all facilities
Revitalisation of basic infrastructure	No. of clinics upgraded/completed	2 clinics	2 achieved

Objective	Indicator	Target 2003/3004	Actual Performance
iLembe DC 29			
To develop a Strategic Plan and ensure implementation thereof	Integrated District Plan document	100% completion of the Strategic Plan	100% DHS aspect completed, 25% hospital input received and awaiting 75%
Develop the District Health Information System	DHIS in place	100%	80% of hospitals and PHC managers trained on DHIS. FIO's still to be appointed and trained
To ensure that all Programmes have operational plan for decreasing morbidity and mortality in the District	Plan in place	100%	100% achieved 65% increase in DOTS 33% smear conversion rate TB cure rate 20% Treatment failure rate 1% Death rate 4% Default rate 14% Awareness campaign on priority communicable and non-communicable diseases was held
Strengthening of relationships between all stakeholders	Optimal co-operation between health facilities and Traditional Healers	100%	100% co-operation achieved
Provision of Medical Officer services at all PHC facilities	All clinics have Medical Officer coverage visiting once weekly	100% of PHC facilities	60% medical coverage achieved in 2 sub-districts
To ensure the existence of functional Clinic Committees at all PHC facilities	Communication strategy in place	100%	Clinic Committees established and functional in 60% of PHC facilities
To improve cold chain management and drug supply at all facilities	System in place	100%	93% achieved
	No. of clinics ordering from PMSC	All clinics	62% of clinics directly ordering from PMSC
	Installation of air conditioning systems	All clinics	80% of clinics with air conditioning units
To ensure the delivery of the full PHC package of services at all facilities	No. of clinics delivering full PHC package of services	29 clinics (100%)	23 clinics (80%) were delivering the full PHC package of services
To ensure fast queues for older persons	All CHC's to have fast queues in place	100%	Fast queues in place in both CHC's in the District

Objective	Indicator	Target 2003/3004	Actual Performance
Sisonke DC 43			
Improve service delivery in the District	Development of Service Delivery Improvement Plan	July 2003	SDIP was in place by July 2003 and was implemented in the District
	Improved clinic supervision	All clinics in the District	65% of all clinics visited (13 out of 20 clinics)
Reduction of morbidity and mortality in the District	Availability of appropriate protocols and guidelines	July/August 2003	100% of facilities have protocols and guidelines
	Increase in number of facilities offering VCT/PMTCT	December 2003	100% of facilities offering VCT/PMTCT services
	Expansion of the IMCI to all health facilities	All health facilities in the District	100% of facilities implemented IMCI. 1 PN trained per facility
	Integrated strategy for screening of HIV/AIDS, TB and STI's	August 2003	Integrated strategy successfully implemented. 41 nurses trained in STI management. 2 HBC functional teams available in each municipality
Poverty alleviation and implementation of the Integrated Nutrition Programme (INP) through PSNP, multisectoral projects, facility gardens and PEM scheme	All identified schools receiving PSNP services	100% of identified schools	77% of identified schools were put onto the programme
	Number of facility gardens established	24 facilities	4 pilot gardens were established with roll out plan to be implemented
	Availability of PEM scheme at all health facilities	All health facilities	100% achieved – 20 clinics and 4 hospitals have implemented PEM scheme
Adequate supply of well trained human resources (professionals and support staff)	Percentage of staff trained according to needs	All staff	80% of staff trained in financial management, STI management, TB management, IMCI and infection control
Improve governance at all health facilities in the district	Functional Clinic Committees and Hospital Boards	20 Clinics and 4 hospitals	All clinics and 3 hospitals have the relevant committees/boards in place. Training and capacity building will be undertaken in the coming year

Objective	Indicator	Target 2003/3004	Actual Performance
eThekwini Metro			
To implement policy on garden projects by March 2004	Facilities implementing garden projects	10 Facilities	24 Facilities had established gardens by end of March 2004
Provision of nutritional supplementation to malnourished patients	%age Identified malnourished patients receiving supplementation	100% Identified patients	2 168 Patients received nutritional supplementation
To promote, protect and support breastfeeding	%age Targeted facilities supported	100%	Support provided to 5 facilities
	%age CHW's and volunteers trained	100%	100% achieved
To increase accessibility to PMTCT and VCT services	%age Facilities offering the services	100% 5 Non-medical sites	100% Hospitals 1 State subsidised facility 100% CHC's 60% PHC clinics
To provide adequate counselling services in all facilities	%age Lay counsellors placed	100% Placement	95% Placement achieved
To train health workers on PMTCT and VCT	%age of health workers including Lay Counsellors trained	80%	20% Nurses trained All Lay Counsellors trained on VCT 80% Lay Counsellors trained on PMTCT
Reduction in mother to child transmission of HIV/AIDS	%age Babies participating in the PMTCT programme tested at 12mths and at 15mths	100%	Results have not been analysed
Prevention, early detection and proper management of STI's	%age Increase in condom distribution	40%	4,3% Increase in condom distribution
	%age Sexual partners traced and treated for STI's	40%	29% sexual partners traced and treated
	Partner notification	100%	69% achieved
To increase access to rehabilitation services	No. of facilities providing services	25 Facilities	17 Facilities provided rehabilitation services
	Participation in the Red Cross Flying Doctor service	4 Visits	Achieved 3 visits
	No. of Rehabilitation Facilitators trained Therapists trained	6 (100%) 1 Therapist	5 (83%) Rehabilitation Facilitators trained 1 Sign Language therapist trained
Improvement in cataract surgery services	No. of operations performed	1 000 Cataract operations	806 Cataract operations were performed

Objective	Indicator	Target 2003/3004	Actual Performance
Promotion of health awareness in the community	Media campaigns and radio talk shows	45 Radio slots	40 Radio presentations were done
	%age Facilities receiving IEC	100%	75% achieved
	School participation in essay competition on substance abuse	12 Schools	12 Schools participated in the essay competition
Ensure appropriate supply of medication at all facilities	%age Tracer drugs available	100%	94% achieved
	%age Facilities receiving medication directly from PMSC	100%	73% achieved
	%age Facilities implementing EDL and EDP guidelines	95%	92% achieved
To reduce health risk by facilitating improvement in waste management	%age EHP's/Infection Control Officers and Hospital Managers trained	100%	98% EHP's trained 100% Infection Control Officers trained 80% Hospital Managers trained
	%age Institutions with waste management plans	100%	100% Institutions with waste management plans in place

CHRONIC DISEASES & GERIATRICS PROGRAMME

AIM

The Chronic Diseases & Geriatrics Programme aims to facilitate a strategy to decrease the morbidity and mortality associated with chronic diseases, to improve the quality of life of older persons and address the elimination of all preventable causes of blindness.

ANALYTIC REVIEW

During the reporting period the Programme focused on creating public awareness through education on healthy life style behavior to prevent the onset of chronic diseases and to reduce the impact of such diseases on the quality of life. Additionally emphasis was placed on increasing capacity among service providers to enhance their competence in managing communities with or at risk of developing chronic diseases, older persons and the prevention of blindness Vision 2020 Programme.

District staff underwent training on related fields including the management of asthma, arthritis and to function as ophthalmic nurses and cataract case finders. The key focus areas of the Programme were implemented by all Districts using the National Guidelines and Protocols, which also created the framework for the monitoring and evaluation of service delivery.

On evaluation, it is noted that the Programme will have to address barriers preventing the Department from achieving the recommended cataract surgery rate (CSR-WHO) 2 000/million of the population. The Province achieved a CSR of 741/million due to constraints relating to infrastructure as well as the availability and optimisation of resources.

The quality of life of older persons living in rural nodes was addressed by awarding priority to poverty alleviation and protection from all forms of abuse. The overall performance is tabled hereunder.

Red Cross Air Mercy Services – ENT Clinic

Table 10(a): Programme Performance

Objective	Indicator	Target 2003/3004	Actual Performance
Chronic Diseases and Geriatrics			
To ensure that district personnel have the capacity to implement the National guidelines and protocols	Trained personnel in relevant areas	10 + 1 District personnel	A total of 30 personnel trained: 3 for management of asthma 27 for management of arthritis
	Access to National guidelines and protocols	All clinics	100% of clinics received the guidelines
	Availability of resource packs on prevention of blindness	Resource centres	Johnson and Johnson Audio-visual aids distributed to 10 resource centres
To promote healthy lifestyle behaviour	Availability of resource material	10 + 1 Districts	10 000 fliers distributed on: Epilepsy Alzheimer's Quit smoking Asthma Arthritis
	Implementation of health calendar events	10 + 1 Districts	All districts hosted awareness campaigns on relevant health days: Asthma for Africa Oct 2003 Bone and Joint Decay – Oct 2003 World Sight Day – Oct 2003 World No Tobacco Day – May 2003
To ensure optimal quality of life of older persons	Establishment of support groups	Support groups for different chronic diseases	Initiated support groups for Daibetes and Hypertension
	Availability of chronic medication	50% of all PHC facilities	Fully achieved – 50% of all PHC facilities have chronic medication
		100% of stipulated old age homes	Process not yet finalised – audit of facilties being conducted
	Implementation of fast queues	Additional 22 PHC clinics	100% achieved
	Extent to which poverty alleviation is addressed	To fund 1 income generation project/ISRD node or other site	Successfully funded – purchased sewing machines for DC43
	Availability of flu vaccine for the elderly and those at risk	16 000 elder persons and those at risk	7 375 Vaccines administered to the elderely by end of June 2003

Objective	Indicator	Target 2003/3004	Actual Performance
To facilitate the implementation of the prevention of blindness Vision 2020 programme	Contract to subsidise the Bureau for the Prevention of Blindness for Cataract Surgery	2 000/million population	Programme implemented in 12 sites – achieved 741/million population
	Availability of refraction services	Health facilities in collaboration with ICEE	4 Optometrists were recruited 5 718 patients were refracted 282 pairs of eyeglasses were dispensed
	Availability of trained ophthalmic nurses and cataract case finders	10 + 1 Districts	42 ophthalmic nurses trained in 5 districts 23 cataract case finders trained

COMMUNICABLE DISEASE CONTROL PROGRAMME

AIM

The aim of this Programme is to reduce morbidity and mortality in relation to communicable diseases by improving the surveillance and outbreak response to such diseases.

ANALYTIC REVIEW

The year saw the continued efforts to meet the objectives of the TB Medium Term Development Plan 2002-2005, to improve the rollout and performance of the Province's TB control programme, as well as improving staffing capacity and knowledge to manage TB and other communicable diseases.

With regards to the staffing capacity, a new manager was appointed to manage the programme. District and Provincial CDC Surveillance Officer posts were finalised and these assisted in improving the implementation of the programme in all districts. The year also saw more progress in unpacking the TB control programme at primary health care level with a total of 95% of clinics diagnosing and managing TB control in the Province.

Access to sputum microscopy for rural facilities achieving a 3-times-a week sputum collection service has improved to 83% of the service achieving this target. However challenges still exist with regard to the provision of vehicles and drivers.

Water testing for Cholera

Table 10 (b): Programme Performance

Objective	Indicator	Target 2003/3004	Actual Performance
Communicable Diseases			
Establish adequate and suitably trained staff at provincial and district level to manage and support the programme	Number of posts created and appointments finalised	February 2004 for the completion of the process	Managerial posts have been finalised and 18 District CDC Surveillance Officer posts have been created.
	No. of staff trained in TB and Rabies management	1 180 HCW's in TB 590 HCW's in Rabies	1 268 trained in TB 571 trained in Rabies
	No. of rural facilities achieving 3-times-a week sputum collection	80% of rural PHC facilities	83% rural facilities now achieving target
To achieve adequate and sufficient laboratory and access to microscopic services	All Districts to meet the WHO requirement of 1 AFB diagnostic centre per 150 000 of the population	100% of districts compliant	100% of districts compliant
	% of facilities implementing TB suspect register	25% of facilities implementing suspect register	41% of facilities implemented suspect registers
	No. of clinics to which TB control is unpacked	75% of clinics	95% of clinics now diagnosing and managing TB control
Improve access to TB control	Number of DOT supporters trained	2 000 trained	2 391 supporters trained in DOT
Improve TB treatment supporter programme - DOT			419 CHW's 237 HBC's 1 735 volunteers

ENVIRONMENTAL HEALTH SERVICES PROGRAMME

AIM

The aim of the Programme is to render services for the management of environmental health including Malaria, Port Health as well as community-based programmes for example, communicable diseases and health promotion.

ANALYTIC REVIEW

During 2003/2004, the Department pursued the issues surrounding the devolution of Environmental Health Services to the Metropolitan and District municipalities. This year saw the active engagement of Provincial Environmental Health Practitioners in Risk-based assessments and Risk Management inspections to ensure compliance with the minimum requirements of the relevant Environmental Health Regulations. The Department also championed the management and containment of Malaria and water-borne diseases like Cholera and other emerging diseases like SARS at Entry Points into the Province.

The main challenge faced by the Department was the increase in the number of Malaria cases reported since the beginning of January 2004. This required additional mop-up spraying to cover all areas including those not previously covered. By the end of the financial year the situation had stabilized to a certain extent.

On the job training: Malaria Control Programme

Table 10 (c): Programme Performance

Objective	Indicator	Target 2003/3004	Actual Performance
Environmental Health			
Facilitate transfer of EHS from Provincial Health Dept to District and Metropolitan Municipalities	Number of Meetings held	Consult Organized Labour	Addressed on 12 June 2003
	Audit of Assets and Resources Report	Audit finalized by September 2003	Audit was finalized by August 2003
	Guidelines Report	Guidelines compiled for approval by end of December 2003	Report on guidelines compiled and submitted - awaiting approval
Develop manual for water quality monitoring programme	Water Quality Monitoring guideline finalized	Finalize the manual and implement the water quality-monitoring programme	Manual finalized and implemented by 30 June 2003
Develop guidelines for food poisoning investigations	Guideline document	Guideline developed before end of financial year	Guidelines completed by 31 October 2003 and implemented by EHP's in all districts including the local municipalities
Develop improved assessment and monitoring tool to validate the effectiveness of information, education and communication on Malaria	Monitoring Tool developed	Final Draft Document in place by 29 August 2003	Report finalized on 29 August 2003 and in use for monitoring and evaluation
Facilitate the study of the effects of mosaic spraying and measures to minimize development of insecticide resistance	Study Report	Final Study Report by 31 December 2003	Study Report compiled and produced on 19 December 2003. Has resulted in the effective use of appropriate measures to deal with insecticide resistance
To design an updated Environmental Health Quarterly reporting format	Updated Quarterly report format	31 December 2003	Completed on 30 January 2004. Has been adopted by all stakeholders and is in use

HEALTH PROMOTION PROGRAMME

AIM

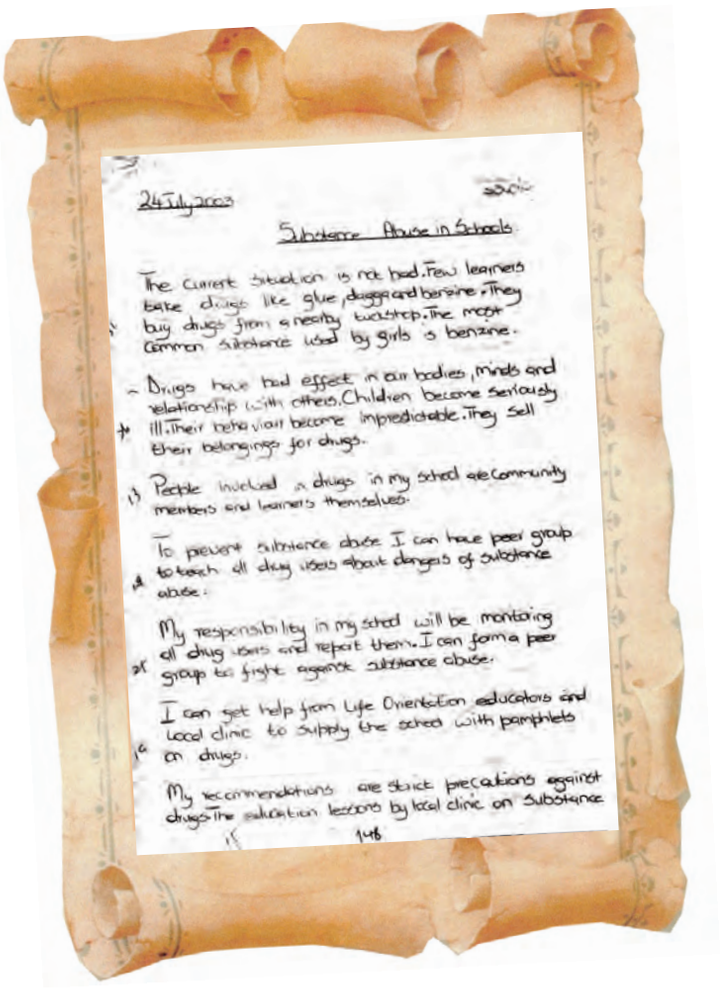
The aim of the Programme is to provide an integrated health promotion strategy for all district health system programmes by facilitating, supporting, co-ordinating and ensuring the implementation of the strategies. In addition the Programme also develops and mobilises information, education and communication (IEC) resources and services to meet the district health needs.

ANALYTIC REVIEW

During the reporting period, the Department continued with health promotion activities in all Districts. In order to ensure that the rural and urban areas were adequately covered, different fora were established (for example, District Substance Abuse Forum and Assessment Teams) to ensure that the needs of the communities were being addressed, in that sufficient information, education and communication material was distributed. Of note is the fact that a total of 132 primary schools, inclusive of urban and rural participated in an essay competition on substance abuse with the aim of fostering health lifestyles in our children and youth. One of the main challenges experienced was the slow take-off of the launching of health promoting schools. This was due to capacity problems as well as the integration with the Department of Education and Culture especially with the alignment of districts. However, the first health promoting school was launched in the Sisonke District (DC43) during the year, which paved the way for more launches in the coming year.

To enhance health promotion and promote health literacy in all communities, the Department worked closely with various sectors and with other provincial departments especially with regard to health events throughout the year. Amongst others, the Department initiated a pilot project to alleviate poverty in Sisonke (DC 43) with the Department of Agriculture, brought together the Departments of Justice, SAPS and NGO's, namely, SANCA, in the essay writing competition on substance abuse. The Department also hosted the Youth Risk Behaviour Dissemination of Information Workshop in consultation with the Departments of Education and Culture and Social Development, Planned Parenthood Association of South Africa and the Reproductive Health Unit of the Nelson R Mandela School of Medicine.

Based on the above, the overall performance with regard to health promotion is summarised in the table that follows.



24 July 2003

Substance Abuse in Schools

The current situation is not bad. Few learners take drugs like glue, dagga and benzine. They buy drugs from a nearby tuckshop. The most common substance used by girls is benzine.

- Drugs have bad effect in our bodies, minds and relationship with others. Children become seriously ill. Their behaviour become unpredictable. They sell their belongings for drugs.

People involved in drugs in my school are community members and learners themselves.

To prevent substance abuse I can have peer group to teach all drug users about dangers of substance abuse.

My responsibility in my school will be monitoring all drug users and report them. I can form a peer group to fight against substance abuse.

I can get help from Life Orientation educators and local clinic to supply the school with pamphlets on drugs.

My recommendations are strict precautions against drugs. The education lessons by local clinic on substance

Essay on Substance Abuse

Table 10 (d): Programme Performance

Objective	Indicator	Target 2003/3004	Actual Performance
Health Promotion			
To provide support and guidance to Districts in Implementing integrated Health Promotion Strategies	No. of district meetings Evaluation of district progress in line with business plans	10 + 1 Districts	10 + 1 Districts covered during the year All business plans developed and implemented in the Districts
To facilitate and monitor the implementation of Health Promoting Schools Programme	No. of meetings held by Provincial HPS Committee	12 monthly meetings including Head Office and Districts	11 meetings were held
	No. of HPS assessment teams trained	11 district HPS assessment teams established	1 provincial + 6 District HPS assessment teams established and trained
	No. of HPS schools launched	12 HP schools	1 HP school launched in DC43
	Success of Substance Abuse Programme as entry point to HP schools	12 primary schools (4 urban, 4 peri-urban and 4 rural) in each district	132 primary schools participated in the essay writing competition on substance abuse
To facilitate the continued in-service training of Health Promoters	Curriculum on HP developed for ASO's & SASO's	Completion and pilot of curriculum in 2003	Curriculum completed Awaiting audit of ASO's/SASO's before training to be implemented in accordance with SETA and NQF
	HP Assistant Managers to attend In-Service Training on HP	1 IST course per Assistant Manager	100% achieved – both AM's attended IST course at Thusano School of Public Health
	Distribution of IEC materials in all districts	100% coverage in KZN	100% achieved on wide ranging topics
Facilitate the promotion of health literacy amongst the communities	Media campaigns	80% coverage in KZN	Talk shows held on Radio Ukhozi
	Awareness events	100% coverage in KZN	All events covered in line with annual health calendar for 2003
To provide support and expertise to all role-players in implementing integrated HP Programmes	Intersectoral/ Interdepartmental Health Promotion Programmes in accordance with the Health Calendar	All sectors and departments relevant to various events on the health calendar	Relevant Departments and sectors worked together with Department in all health events during the year

INTEGRATED NUTRITION PROGRAMME

AIM

The Integrated Nutrition Programme is a programme aimed at specific target groups which combines direct nutrition interventions with indirect nutrition interventions to address malnutrition and which is implemented at different points of delivery to achieve optimal nutritional status for all people in the Province of KwaZulu-Natal.

ANALYTIC REVIEW

Priority has been given to the implementation of the Integrated Nutrition Programme in the Integrated Sustainable Rural Development Programme nodes by providing the most technical support and financial assistance to these areas.

The highlights of the Programme have been:

- The successful transfer of the Primary School Nutrition Programme to the Department of Education
- Seven health facilities achieving the Baby Friendly Hospital Initiative status bringing the total to 25 health facilities that are baby friendly in KZN
- Implementation of 115 clinic gardens in all 11 Districts
- Implementing of monitoring tool for the Vit A Supplementation Programme
- The finalization of the Health Facility Based Nutrition policy, which includes the policy on nutritional supplementation for HIV/AIDS and TB clients.

The major challenge experienced was the ability to maintain a high quality of service delivery despite 80% of the critical posts being vacant.

Growth monitoring – Road to Health Card

Table 10 (e): Programme Performance

Objective	Indicator	Target 2003/3004	Actual Performance
Disease Specific Nutrition Support, Treatment & Counselling			
To contribute to the reduction of malnutrition in children under 5 years of age, specifically of: • Underweight • Severe underweight • Stunting • Wasting To contribute to the reduction of the under-five mortality rate through strengthening nutritional management in the IMCI To contribute to the reduction of morbidity and mortality associated with nutrition-related diseases of lifestyle, specifically of: • Overweight • Obesity • Coronary heart disease • Hypertension • Diabetes mellitus To contribute to the reduction of morbidity and mortality of people living with TB, HIV/AIDS and other chronic debilitating conditions	Proportion of underweight children <5 years of age Proportion of severely underweight children <5 years of age Children <5 years of age showing undernutrition Children <5 years of age with either very low weight or marasmus or kwashiorkor	Devolve funds to all districts Receive monitoring reports Appointment of 18 CSD's and mentoring Draft and develop protocols for • HIV/AIDS and Malnutrition • Enteral Feeding • Diabetes in adults & children • Hypertension Identify health facilities for the ARV roll-out programme Train all clinical dieticians, community nutritionists and CSD's on comprehensive care of HIV patients	Policy on micronutrient food supplements for malnourished children and adults incorporated into the Health Facility Based Nutrition Programme Pilot project implemented for the distribution and evaluation of nutrition supplement for use in TB/HIV patients Placement, mentoring and support of 18 Community Service Dieticians (CSD) Developed ARV Policy document in preparation for the roll out 25 hospitals assessed and audited for equipment and products for ARV accreditation
Growth Monitoring and Promotion			
To prevent and reduce growth faltering among children 0-24 months of age through regular growth monitoring and promotion	Children < 5 years of age not gaining weight Proportion of new born babies and children with Road to Health Cards at 12 months old, 24 months old and 60 months old	Ensure that all new born babies are provided with a Road to Health Card Provide district health facilities with RtHCs and scales for growth monitoring and promotion (GMP)	Tenders have been gazetted for the purchasing of Talc scales and scales with height sticks 176 000 RtHCs procured and accessible from CPS as required

Objective	Indicator	Target 2003/3004	Actual Performance
Nutrition Promotion, Education and Advocacy			
To improve nutrition-related knowledge, practices, perceptions and attitudes To improve awareness of the INP, its focus areas and nutrition in general	Number of nutrition awareness days celebrated by 11 Districts Distribution of IEC material. Number of INP advocacy presentations held	Information, Education and Communication material available to all Districts Participation in Health Promotion activities Implementation of INP advocacy strategy	Information, Education and Communication material printed and distributed (breastfeeding, micro-nutrient, food fortification, food based dietary guidelines and HIV/AIDS nutrition guidelines) Talks on radio to promote nutrition Nutrition Campaign held in all 11 Districts in March 2004
Micro-nutrient Malnutrition Control			
Elimination of micronutrient malnutrition deficiencies among the population focusing on vulnerable population groups To decrease the proportion of children with inadequate intake of the following vitamins and minerals: • Vitamin A • Zinc • Iron • Thiamin • Riboflavin • Niacin • Vitamin B6 • Folic acid To provide information on vitamin A supplementation, fortification and dietary diversification to 11 district teams	Coverage of children age 6-60 months who receive a vitamin A capsule Coverage of at risk pregnant and lactating women who receive a vitamin A capsule No. of facilities implementing the vitamin A supplementation programme	Implementation of the Vitamin A programme at all health facilities 100% Vitamin A coverage of children 6-60 months 100% Vit A coverage of at risk pregnant & lactating women Purchase of Vitamin A capsules	Policy on Vitamin A supplementation integrated into HFBNP Monitoring tool implemented with effect from 01/09/03 73% Vitamin A coverage reached for children 6-11 months 40% Vitamin A coverage reached for children 12-60 months 11% Vitamin A coverage reached for maternal women
Food Service Management			
To implement a monitoring system for food services in KZN	Percentage of public facilities implementing the monitoring system	100% implementation of monitoring tool	Policy on food service management developed Skills development plan for Food Service workers workshopped Food Service guidelines distributed to all health facilities 50% of facilities using monitoring tool

Objective	Indicator	Target 2003/3004	Actual Performance
Promotion, Protection and Support of Breastfeeding			
To review breastfeeding practices of HIV positive mothers To ensure that mothers of infants under 24 months who are not breastfeeding, practice appropriate replacement feeding options To ensure that health facilities with maternity beds are baby-friendly	Policy review completed % Facilities that are Baby Friendly % HIV & women that breastfeed % HIV & women that formula feed	Review policy on infant feeding for HIV positive women Maintain BFHI status of 18 facilities Increase BFHI status by 10%	Code monitoring in August carried out by National /Provincial team 7 more facilities achieved the Baby Friendly Hospital Initiative status thus bringing the total to 25. 3 facilities received certificates of commitment Collaboration on the infant feeding policy for PMTCT
Contribution to Household Food Security			
Ensure the implementation of 115 clinics gardens in 11 districts Alleviation of short term hunger among Primary School learners Transfer of Primary School Nutrition Programme (PSNP) to Department of Education (DOE)	Number of clinic gardens to be implemented in the ISRDP nodal areas 63% of schools monitored DOE to implement PSNP effective 01/04/04	Clinic gardens implemented 100% monitoring of schools DOE to implement PSNP with effect from 01/04/04	115 clinic gardens funded and 117 Groundsmen trained Clustered community based projects handed to communities in Ugu, uMgungundlovu and ilembe districts 552 Farm, 2 261 Rural, 75 Informal and 247 Urban schools participated in the PSNP with 1 344 284 learners fed 1 304 schools have been monitored in this regard Transfer of Provincial staff and assets to Department of Education completed Technical support provided to the National Food Emergency Program
Nutrition Information System			
Monitor and report on the implementation of the INP at all levels	Number of INP reports produced	100% submission of reports from all Districts	Quarterly reports submitted by all Districts The 5 year Provincial Strategic Plan for Nutrition finalized, printed and distributed

Objective	Indicator	Target 2003/3004	Actual Performance
Human Resource Plan			
Provide training and education on all KRA 's within the INP to 11 district health teams	No. of workshops held No. of vacant posts filled	100% Provincial vacant post filled	40% posts filled
Liaise with the National Directorate and Districts on the implementation of the INP through regular visits and operational visits.	No. of liaison visits conducted during the year	All 11 Districts visited twice a year Workshop/ train district health teams on INP KRA's	3 out of 7 workshops on BFHI, FSM and disease specific held and 4 liaison visits conducted
Financial and Administrative Systems			
Facilitate & co-ordinate planning processes for the INP	% Improvement in expenditure Compliance with Operational plans to ensure optimal implementation	100% expenditure	123% expenditure on Conditional Grant due to payments carried over from previous financial year 80% expenditure on Poverty Alleviation

MATERNAL, CHILD AND WOMEN'S HEALTH PROGRAMME

AIM

The aim of this Programme is to ensure the optimal health status of women and children by reducing morbidity and mortality and improving the lives of women, youth and children in general.

ANALYTIC REVIEW

The activities of the Programme for the reporting period focussed on all aspects of women and children's health. The key focus areas were neonatal care, maternal health care, expanded programme of immunisation, child health, genetic services, sexual and reproductive health, cervical cancer screening, school health and youth health.

Due to the nature of this Programme, a number of challenges were encountered along the way. A situational analysis of the Districts revealed that there was a need to ensure that fully trained midwives were available to the communities. Whilst a total of 23 midwives were trained on advanced midwifery, this constituted only 41% of all health facilities. The year also saw an increase in Termination of Pregnancy cases (TOP), that is an increase of 10,6%, from 10 162 to 11 372. A further challenge was the failure of pregnant women to attend ante-natal clinics or infrequency in attendance, which resulted in 22% and 9% of maternal deaths respectively. Whilst every effort was made to ensure that the EPI programme was adequate and sustained in all the districts, a dropout rate of 11% was noted. Despite these challenges, a substantial amount of good work was carried out as evidenced in the table below.

Of note is the fact that a comprehensive, integrated Sexual & Reproductive Health Training Manual was developed and implemented and a situational analysis on Reproductive Health was published. High immunisation coverage was sustained and 22 birth defect reporting sites were established.

Maternal and child health in action

Table 10 (f): Programme Performance

Objective	Indicator	Target 2003/3004	Actual Performance
Maternal, Child and Women's Health			
Improve neonatal care in all facilities and in communities	Neonatal mortality rate (early and late)	Reduce neonatal death rate and low birth weight rate and peri-natal death rate	Neonatal Death rate: 15,4 per 1 000 Low birth weight: 10,6% Peri-natal death rate: 52,6 per 1 000
	Number of facilities implementing Kangaroo Mother Care	All hospitals implementing Kangaroo Mother Care	34 Hospitals implementing Kangaroo Care. Interim evaluation completed in May 2003
	Number of midwives completing the Peri-natal Education Programme (PEP)	Commence PEP in 10 Facilities	6 sites have PEP groups within their hospitals. 47 midwives have completed this course in this year
	Availability of Advanced midwives in midwifery services	Train 25 Advanced Midwives from Umkhanyakude, Uthungulu, Zululand	23 midwives trained (92%)
Monitor quality of neonatal care using Peri-natal Problem Identification Programme (PPIP)	Number of PPIP sites in the districts, urban and rural sites Analysis of PPIP reports	Two PPIP sites in each district (20 sites), 15 rural and 5 urban	16 PPIP sites submitted data for the Saving Babies Report. Not all districts are represented as yet
Sustain reporting of maternal deaths	Number of maternal deaths reported	Peri-natal Review committees and reporting deaths	180 deaths reported for 2003 compared to 242 in 2002
	Number of Provincial Maternal Death assessors	Maximum reporting through community based structures Deaths occurring in homes reported	Nine Provincial Maternal Death Assessors conducted assessments
	Establishment of a Provincial Quality Control team	1 Team provincially	Provincial Quality Control team established at Provincial level
Increase deaths being reported through the community based structures	Number of deaths reported through the community structures	Deaths occurring in homes reported	Only a few deaths are reported through the community based structures
		Two workshops for community health facilitators	Three workshops for community Health Facilitators completed
Release "Saving Mothers" Report and implement recommendations	Report released	Availability of recommendations in facilities	Report released by Minister of Health in June 2003
	Evidence of implementation of recommendations	Plans to implement recommendations in all facilities	District based planning workshops run in 8 of the 10 districts

Objective	Indicator	Target 2003/3004	Actual Performance
	Completed district plans	Evidence of implementation of priorities according to plan in each facility	Implementation will be surveyed during the coming National Maternal Health Situational Analysis
Make Termination of Pregnancy more available and accessible	%age Maternal deaths resulting from illegal abortions	Double number of facilities providing TOP from 8 to 16	5,8% of maternal deaths caused by abortions
	Number of facilities providing the service	100% of services	Fourteen provincial services and 5 private facilities offered TOP
	Number abortions completed		Only two services offering second trimester abortions 237 Septic abortions reported 4 669 Incomplete abortions 81% of abortions in the first trimester 6% of abortions to women under 18 years. 11 372 terminations completed (10 162 in 2002)
Improve ante-natal and post-natal care	%age Mothers accessing ante-natal care before 20 wks	35% of women attending ante-natal clinic before the 20 weeks	20 % of women delivering in provincial facilities attended ANC before 20 weeks
	%age Women accessing 5 or more visits to ANC	70% attending ante-natal clinic for 5 visits or more	59% attended 5 or more times during their pregnancies
	%age Cases of maternal deaths where there were avoidable problems during ante natal period		9% of maternal deaths had infrequent ANC visits 22% of maternal deaths had no ANC visits
	%age Coverage in all Districts	All districts with 80% coverage for the primary series of immunisation	93,5% overall coverage 3 districts are currently below 80% coverage 11% dropout between first and third doses
Expanded Programme of Immunisation (EPI)	Availability of vaccines in all Districts	Completed audit of all vaccine fridges in Districts	104 new vaccine fridges installed
	No. of adverse events following immunisation	Accurate assessments of AEFI	None of AEFI cases assessed were caused by vaccines. Total of 46 cases reported
	Detect 33 cases of Acute Flaccid Paralysis (AFP) and investigate each case with adequate stool specimens annually	33 fully investigated AFP cases, i.e. adequate stool investigation	45 cases of AFP were investigated fully. No wild Poliovirus was found

Objective	Indicator	Target 2003/3004	Actual Performance
Improve EPI disease surveillance to reach National targets:	Active AEFI team in each District	All Districts	Investigations conducted and reports submitted to NDOH
	Investigate 80% of suspected measles cases Expected number of cases in KZN: 104	All reported cases of suspected measles Detect and investigate 104 cases of suspected measles	859 suspected measles cases were investigated. Most were cause by poor BCG administrative procedures. Most cases were found to be Rubella positive
	Neonatal Tetanus: 1 case per 1 000 live births	All cases of suspected Neonatal Tetanus investigated	Only three cases of Neonatal Tetanus were reported and notified. District response was carried out in each case
Commence under 5 mortality monitoring	One site collecting and analysing child mortality data	One Child Mortality site	Infant mortality rate: 52 per 1 000 Child Mortality rate: 74,5 per 1 000
Improve the monitoring of progress of child health through accurate data collection at clinics	Data and Information verified	Accurate verified data	Northdale/Greys have collected six months data to date
Sustain and develop Integrated Management of Childhood Illnesses (IMCI) as a Child Survival Strategy	IMCI training team in each district	All districts to have a fully functional training team	8 districts have IMCI training teams
	%age of all categories of nurses trained in Clinical Case Management in each facility	All clinics to have at least one member of staff trained in clinical case management.	61% clinics with one person trained and 5 % of clinics with 60% of staff trained in clinical case management. 39% of PHC PN's trained
	%age of all CHW's trained to used the 16 Key Family Practices	50% of all community health workers trained	% of community health workers trained could not be calculated
	Number of sites implementing Community Component of IMCI	One pilot site per district	Total of 8 sites IMCI Community in 6 districts
Improve care for people with haemophilia	Identified high prevalence areas with people trained to cope with frequent bleeders	Fifteen identified high prevalence areas Fifteen trained personnel	Three nurses were trained
Reduction of unwanted teenage pregnancies, TOP's, STI/HIV Infections	Analysis of Sexual and Reproductive Health	June 2003	Situational Analysis presented in July 2003
	Comprehensive and inclusive training manual	Comprehensive and inclusive training manual	Training manual in place and training commenced in July 2003

Objective	Indicator	Target 2003/3004	Actual Performance
	Increased women year coverage rate from 18.6% in 2002	Women coverage rate of 20%	Women coverage rate: 21.1% in 2003
	No. of professional nurses trained in the comprehensive approach to sexual and reproductive health	1 PN in each facility trained	204 Professional Nurses have completed the comprehensive sexual and reproductive health training module
	Reduce births to risk groups of women, i.e. under 18years and over 35years		Teenage pregnancy rate 9,7% (was 10,4% in 2002) Birth rate to women over 35years: 11,4%
Reduce women's mortality and morbidity from Cervical Cancer	Number of people trained to take smears	Cervical screening included in training	204 Professional Nurses trained
	%age adequate smears received by laboratories	75% adequate smears received by laboratory	Intervention in cases where high % of inadequate smears were received
	Number of Districts where colposcopes are available	Women managed by colposcopy Increase number of colposcopes available	New colposcope placed at Bethesda Hospital Colposcopes available in 4 Districts
Reduce morbidity and mortality among school children	Provincial School Health Policy and Guidelines in place	Provincial School Health Policy completed by December 2003	Draft policy completed and awaiting approval
	Introduction of New School Policy to Health and Education Sectors	Policy circulated for comment Launch of new School Health Policy in March 2004	Policy will be launched in the coming year
	Introduction of parasite control child to child learning materials to schools	Distribution to schools by October 2003	Awaiting the release of funds for implementation
	Evaluation of Parasite child to child learning materials	First phase evaluation of the learning material Implementation by March 2004	Awaiting release of funds
Develop youth friendly services throughout the Province using the concepts of NAFCI	Number of sites developed and accredited	15 NAFCI sites established and accredited 20 new identified and being developed for completion in 2004	15 sites accredited 22 new sites have commenced development RHRU has continued to assist in the establishment of the sites

MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMME

AIM

The aim of the Programme is to provide optimal mental health status to all persons in the Province of KwaZulu-Natal by ensuring that mental health care is integrated into the mainstream of health care in the Province.

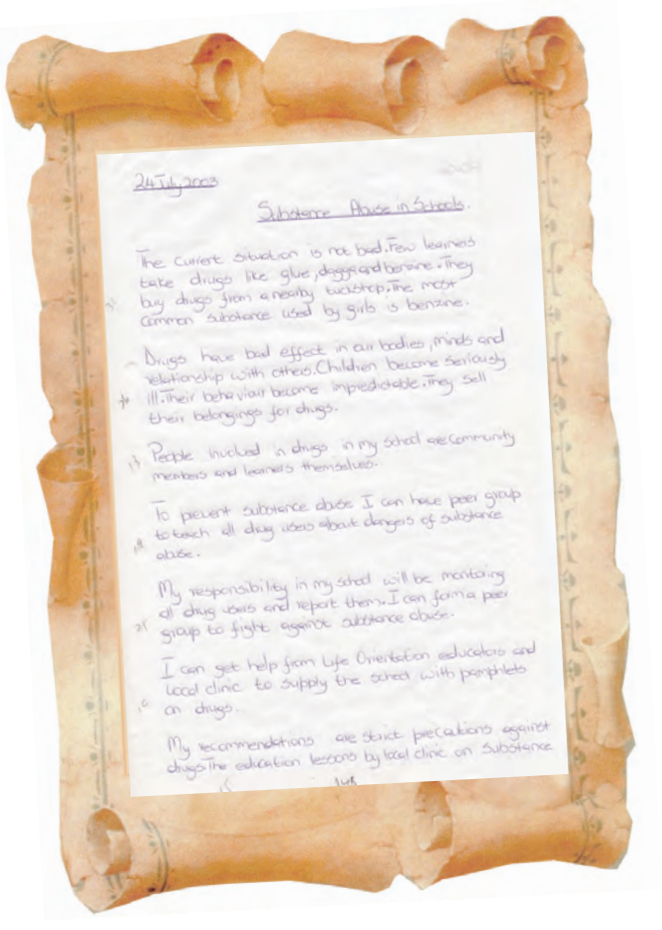
ANALYTIC REVIEW

Apart from ensuring that mental health care is integrated into the general health system, the Department also worked closely with NGO's and other organisations that render mental health services in the Province. The Department provided financial support to such institutions, to cover day care centres, halfway houses and residential institutions. A total of 33 institutions were subsidised during the year thus ensuring that the services reached the wider community in both urban and rural areas.

All activities within this Programme were in terms of the Mental Health Act, Act No. 18 of 1973, as amended. The new Mental Health Care Act, No 17 of 2002 will be implemented once the Regulations thereto have been finalised at National level.

The Mental Health Strategic and Implementation Plan for delivery of Mental Health Services in KwaZulu-Natal was approved in 2003. This policy document allowed for the implementation of comprehensive mental health care services in the Districts. In line with the objective of integrating mental health care into the District Health System, steps were taken to facilitate the closure of stand-alone psychiatric clinics so that more patients could access such services at the PHC clinics.

The main challenges with regard to reaching those people in need of mental health care lay in the non-disclosure of people in the community, hence treatment and care was limited to those cases that became known. The lack of public rehabilitation centres for people with problems of substance abuse posed a further challenge in that those people that needed such rehabilitation could not access such services. Whilst NGO organisations such as SANCA were available, these services were not free, thus placing an added financial burden on people who could not afford these services. Since this area of focus involves other departments, for example, Social Welfare, it is acknowledged that more work is required in order to decrease the incidence of substance abuse, which will assist in decreasing mental illness.


24 July 2003

Substance Abuse in Schools

The current situation is not bad. Few learners take drugs like glue, dagga and benzine. They buy drugs from a nearby tuckshop. The most common substance used by girls is benzine.

Drugs have bad effect in our bodies, minds and relationship with others. Children become seriously ill. Their behaviour become unpredictable. They sell their belongings for drugs.

People involved in drugs in my school are community members and learners themselves.

To prevent substance abuse I can have peer group to teach all drug users about dangers of substance abuse.

My responsibility in my school will be monitoring all drug users and report them. I can form a peer group to fight against substance abuse.

I can get help from Life Orientation educators and local clinic to supply the school with pamphlets on drugs.

My recommendations are strict precautions against drugs the education lessons by local clinic on substance

Essay on Substance Abuse

Table 10 (g): Programme Performance

Objective	Indicator	Target 2003/3004	Actual Performance
Mental Health and Substance Abuse			
To orientate all Districts on the Mental Health Act, 2002	Implementation of the Act once Regulations become available Establishment of Review Boards	10 + 1 Districts All health facilities Nursing Colleges Tertiary institutions Communities	All Districts and health facilities have been workshopped and are ready for implementation. Tertiary institutions and community have also been workshopped
Integration of mental health into the DHS	No. of trained PHC nurses	11 Districts and 3 429 PHC nurses	1 220 PHC nurses trained (36%)
To introduce strategies to reduce the levels of substance abuse	Increased awareness in Districts and in the community	10 + 1 Districts All KZN stakeholders	A Provincial awareness day held in June 2003 was well attended Essay competition on substance abuse together with Health promotion reached 132 primary schools
To formulate strategies of violence prevention for adults and children	Increase in communities accessing counselling More skills development	All communities dealing with victims of violence	Policy on victim empowerment drafted in consultation with stakeholders Awareness day held in Dec 2003 in collaboration with Gender Unit focussing on rights of vulnerable groups Visits undertaken with NDOH to 2 schools that were piloting the prevention of violence in schools
To improve the care of the acute and chronically mentally ill through intense care and community based Psychosocial Rehabilitation Services	Decrease of patients admitted at psychiatric institutions	Ekhuhlengeni Sanatorium Health facilities that provide mental health care	Programme on de-institutionalisation was piloted at Madadeni Hospital. Total of 34 long term patients were put onto the programme, of which 16 patients were de-institutionalised to the community Patient numbers at Ekhuhlengeni Sanatorium reduced from 1 500 to 1 100 patient intake
To set up systems and license state aided and private mental health institutions	Number of institutions licensed for psychiatric care	33 institutions	100% achieved – all 33 institutions were assessed and licensed accordingly

OCCUPATIONAL HEALTH AND SAFETY PROGRAMME

AIM

It is the duty of every Employer to provide and maintain a working environment that is safe and without risk to the health of not only the employees but also of those not directly employed by the employer. This means that the environment must be conducive to the health and safety of all those who are on the premises of the Department at any one time.

ANALYTIC REVIEW

This Programme was strengthened during the period under review with the appointment of the Programme Manager. As a result of this the importance of health and safety was conveyed to management and staff. In order to promote occupational health and safety across the Department, occupational health clinics have been established in approximately 40% of hospitals (25) with the purpose of placing all health care workers under medical surveillance. In addition 3 referral centres were opened to deal with occupational diseases.

Members of the community were also accommodated within the Programme in that those suffering from occupational diseases as a result of having worked in the mines were assessed and evaluated with regard to the degree of their affliction for the purposes of compensation by the Medical Bureau of Occupational Diseases.

Since the Programme is still in the infancy stage there is a lack of knowledge amongst all staff and more work needs to be done to sensitise them in line with their human rights. In this regard the capacity needs of the programme will be reviewed. However, with the constraints experienced the programme did achieve a measure of success for the period under review.

Safe working environment

Table 10 (h): Programme Performance

Objective	Indicator	Target 2003/3004	Actual Performance
Occupational Health and Safety Programme			
Establish and maintain a Health & Safety System	Successful appointment of: Responsible Persons at Hospitals	All Hospital Managers to be appointed	100% achieved
	Health & Safety Representatives in each Institution	1 For every 50 staff in each health facility	100% Health & Safety Representatives identified and trained
	Safety Officers in District and Hospital Level Occupational Health Nurses in District and Hospital Level	1 Post per health facility	Posts have been identified but not yet filled
Improve the reporting and recording of injuries/ accidents on duty	Develop a user friendly tool to collect all the necessary statistics	November 2003	Statistical reporting implemented successfully throughout the Department
Build capacity for the management and staff	Extent to which capacity has been built and training given	All managers trained by end March 2004	100% achieved at all health facilities
Marketing of Occupational Health & Safety Service	Dissemination of information	All hospitals, clinics and Districts	All health facilities were reached through posters and pamphlets

ORAL HEALTH PROGRAMME

AIM

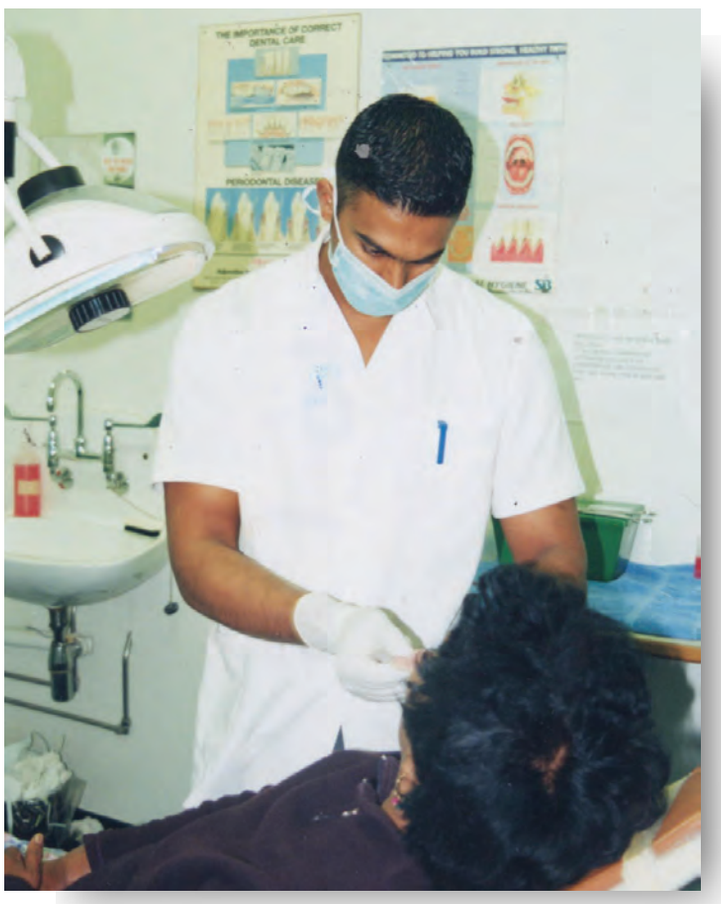
The aim of this Programme is to promote the oral health of the population of KwaZulu-Natal by providing equitable and cost effective services based on the principles of primary health care through the District Health System.

ANALYTIC REVIEW

During the period under review the Programme was instrumental in accommodating 32 compulsory Community Service Dentists, of which 60% were placed outside the urban areas. This enhanced the service delivery to the previously underserved areas of the Province.

In order to inform and educate the communities and health workers of the Oral Manifestations of HIV/AIDS, resource material was developed and distributed in all Districts. An oral health care pack for use in Home-Based Care (HBC) was produced and is ready for roll out in all Districts.

The delivery of oral health services in rural areas was a challenge in that resources were limited; accommodation needs of professional staff could not be fully met. Another challenge was that service delivery was limited to relief of pain and sepsis (extractions) and conservation measures, that is fillings and prophylaxis, was offered to a small number of patients.



Oral Health Care

Table 10 (i): Programme Performance

Objective	Indicator	Target 2003/3004	Actual Performance
Oral Health Programme			
To reduce the incidence of dental caries in the age group 5 to 6 years	Decayed, missing and filled teeth in the primary dentition	60% of teeth in the group should be caries free (WHO target is 70%)	50% of the index achieved
To reduce the incidence of dental caries in 12 year olds	Decayed, missing and filled teeth in the secondary dentition	1,5 DMFT index as per the WHO target	Index of 2,1 was noted in this age category
To ensure 5 healthy sextants in the measurement of periodontal diseases in 15 year olds	Community Peridontal Index (CPITN)	2,0 sextants	2,8 sextants as measured in the children's oral health survey
To ensure the availability of oral hygienists in all Districts	Number of Districts covered	All Districts	Oral hygienists placed in 10 Districts
The provision of oral health facilities in all sub-districts	%age coverage in all sub-districts	100%	90% of sub-districts provided with dental clinics

REHABILITATION PROGRAMME

AIM

The Rehabilitation Programme aims to promote an optimum quality of life for persons with disabilities and those at risk as well as their families in KwaZulu-Natal.

ANALYTIC REVIEW

The Programme's primary objective to create access to disability and rehabilitation services especially to rural, disadvantaged communities was highly significant with services available at 95% of institutions and at 50% of clinics. This significant outcome was the direct result of the compulsory Community Service for Therapists Programme, which commenced in January 2003.

Rural communities further accessed rehabilitation and related specialist services through the collaborative initiative with the SA Red Cross Air Mercy Service and volunteers from the private sector. Audiology/ENT Surgery Outreach Clinics were conducted at 5 sites, namely Emmaus, Benedictine, Taylor Bequest, Bethesda and Church of Scotland hospitals. Such outreach clinics benefited communities who would otherwise have been required to travel to referral hospitals at great cost and inconvenience.

While significant increase in the number of sites offering services at both institution and DHS levels was observed, the rehabilitation process continued to be compromised by the majority of persons with disabilities failing to access assistive devices due to the lack of or limited funding to purchase the devices. However, part of the existing backlog was addressed with the Province receiving 157 wheelchairs and 156 hearing aids from the National Department of Health. The Programme will directly address part of the backlog with a dedicated central allocation of funds to purchase assistive devices in the 2004/05 financial year.

The establishment of wheelchair repair and maintenance workshops, a collaborative project between the private sector, Disabled People South Africa and the Department was initially intended to create opportunity for income generation for persons with disabilities who were trained to work and run the workshops. The objective of the project has since been revised, as the majority of consumers cannot afford to pay for services. 19 workshops will now be located mainly within therapy departments at institutions, with the Provincial Programme providing funding for spare parts and labour.

The Programme observed a significant change in patient profiles at all levels of care. It is noted that an increasing number of babies, children and adults presented with inferred neuro-anatomic Sequalae of HIV/AIDS, experienced varying degrees of impaired functioning and were hence, seeking rehabilitation services. While this trend had an impact on the demand for services and related assistive devices, planning and more pertinently, appropriate clinical management was highly evident.

Rehabilition programme in action

Table 10 (j): Programme Performance

Objective	Indicator	Target 2003/3004	Actual Performance
Rehabilitation Programme			
To improve access to disability and rehabilitation services for persons with disabilities, those at risk and their families at institution and DHS levels	Availability of professional specific therapists at institutions	90% of posts filled at all institutions 50% of posts filled at all clinics	250 institutional therapists posts filled 176 therapist posts filled at all clinics
	Availability of community service therapists	60% availability of community service therapists	18 Community service therapists allocated across the 11 Districts
		40% DHS based services	Total sites established: Physiotherapy – 85 Occupational therapy – 50 Speech therapy and Audiology – 41
	Outreach rehabilitation and related specialist clinics	Rural areas where rehabilitation personnel not available	Therapists facilitated skills transfer to parent and care givers for HBC programmes, especially with regard to neurological impairment and HIV/AIDS sufferers
		Mentorship programme for community service therapists	Total of 48 mentors appointed: Physiotherapy – 21 Occupational therapy – 15 Speech therapy and Audiology – 12
		Specialist volunteers from the private sector offering outreach ENT surgery clinics at rural sites	Clinics established at: Emmaus Benedictine Taylor Bequest Bethesda Church of Scotland hospitals
To improve access to assistive devices and consumables and ensure repair and maintenance services by persons with disabilities	Availability of funds to purchase the assistive devices and consumables and spare parts for wheelchairs	No. of assistive devices and spare parts procured against the number awaited	A total of 1 048 wheelchairs and 759 hearing aids were purchased and distributed
	Availability of sponsorships	NDOH to sponsor the required items	NDOH sponsored 157 wheelchairs and 156 hearing aids
	Existence of repair and maintenance workshops	Repair and maintenance of wheelchairs at institutional workshops	A total of 19 sites identified at institutions for repairs and maintenance of wheelchairs

Objective	Indicator	Target 2003/3004	Actual Performance
To improve capacity development of rehabilitation personnel and health care workers	Relevant training programmes offered	Enhancement of quality of service in all rehabilitation programmes	181 Therapists attended the following clinical training in: Splinting procedure Management of cerebral palsy Management of neurological cases Pressure garment marking and management of burns Management of neurological child with multiple disabilities Neuro developmental techniques Sign language training 300 Therapists attended various non-clinical training
	Availability of funds to subsidise training	Funding of district and institutional level training	Successfully funded the following courses: Sign language African Rehabilitation International Conference Africa Alternate and Augmentative Communication Conference

PROVINCIAL HIV AND AIDS ACTION UNIT (PAAU)

INTRODUCTION

KwaZulu-Natal occupies about 92 000 square kilometres. It is the country's third smallest province. KwaZulu-Natal has the largest population of approximately 9.4 million. This is about 21% of the total population of the country. About 43% of KwaZulu-Natal's population live in urban centres, while the rest live in non-urban areas. In 2002 the province that recorded the highest HIV prevalence rate among ante-natal clinic attendees was KwaZulu-Natal with a rate of 36.5%. This is more than the 33.5% recorded in 2001.

AIM

The aim of PAAU is to ensure the provision of preventative, therapeutic and supportive programmes that will have a positive effect on changing people's lifestyles and perceptions on HIV and AIDS thus decreasing the incidence and the impact of the disease in KwaZulu-Natal. This is done through co-ordination of HIV and AIDS activities directed at prevention of HIV infection and care for those infected and affected by the virus. It also involves facilitating planning, implementation and evaluation of activities in the Province. Equally important is the provision of support to Non-Governmental Organisations/ Community Based Organisations/ Faith Based Organisations and other Government Departments in relation to HIV and AIDS and facilitating intersectoral collaboration and partnerships against HIV and AIDS.

The strategies to address the epidemic in the Province were implemented through the Voluntary Counselling and Testing Programme (VCT), the Home-Based Care programme (HBC), drop-in centres and community mobilisation through various media campaigns.

The greatest challenge faced during the year was the increased number of orphans as a result of the epidemic. In addition the full co-operation of all stakeholders could not be achieved for various reasons.

ANALYTIC REVIEW

Voluntary Counselling and Testing (VCT)

The implementation of the VCT programme is going very well. The Province has a total of 465 VCT sites out of which a total of 167 892 people have accessed counselling through this programme since 01 April 2002. Out of these people 157 422 agreed to be tested. A total of 1 700 Lay Counsellors were employed for the programme and this has contributed to job creation and reduction in unemployment. Out of 465 VCT sites, 43 sites are out of clinical settings which allows communities to access testing within their community centres and churches. This number is not satisfactory and hence the need for the unit to concentrate its energies in establishing more community based centres.

Amongst others the challenges that had to be addressed was the limited space especially in clinics for counselling services and the development and implementation of an effective data management system for lay counsellors.

Home Based Care (HBC)

The implementation of the Home Based Care programme was to improve the quality of life for those infected. The execution of the programme is mainly through the NGOs, hospital teams as well as through the National Integrated Drop-in centres. These centres are now executing the function of integrated home/ community based care. To date a total of 32 drop-in centres are functional in the Province. The Departments of Health and Welfare jointly funded these centres and the NGO's/CBO's manage them.

These centres provide the following services:

- Identification of vulnerable children and their families
- General assessment of both physical and social needs of the children
- Preparation of the meals at the sites
- Stimulation programmes
- Assistance of the children with their homework
- Prompt referral to other services needed
- Child care counselling
- Establishment of child care fora
- Provision of food parcels

A total of 93 400 clients received Home Based Care, 31 749 orphans benefited from these sites and 22 344 caregivers (including all Community Health Workers) have been trained.

Amongst the challenges to this programme was the increased number of orphans that had to be catered for at the drop-in centres, the payment of stipends for care givers, the provision of food supplements for clients, availability of social services and standardisation of Home Based Care training.

Sexually Transmitted Infections (STI's)

Programmes for the prevention and treatment of sexually transmitted infections have also been strengthened. The usage of protocols for the syndromic management of STI's was practised at all provincial health institutions. The promotion of the usage of barrier methods is proving successful with the increased distribution of male condoms. Condom distribution ranged between 2 million and 3 million per month and sometimes the distribution reached approximately 4,7 million per month. Female condom distribution ranged between 5 000 to 7 000 per month.

The service of treating sexually transmitted infections has been extended to the trucking industry with the opening of the roadside clinic at the Tugela Truck Stop. The second truck stop clinic is being built at Mooi River and will open before the end of this year. The unit has recently partnered with B&Q to start a mobile clinic service for STI and VCT in the Timber industry in and around the Pietermaritzburg area.

The difficulty that was experienced was the failure to adhere to syndromic management protocols especially in the private sector and the poor demand for condoms.

Community Mobilisation

In order to strengthen community mobilisation and create awareness amongst the targeted groups in the province, a total of 17 200 Traditional Healers, 187 Councillors, 95 Traditional Leaders, 330 Faith Based Master Trainers and 3 212 Faith Based Volunteers were trained during the year. In addition a total of 110 peer educators have been trained in collaboration with the Planned Parenthood of South Africa (PPASA) and RHRU. Through the NAFCI initiative, a partnership has been established with LoveLife for the provision of children's health and well being. The trained peer educators are ready for formal placements in the clinics, which will be accredited as the NAFCI sites.

In addition most Provincial Departments have appointed dedicated HIV/AIDS co-ordinators for their Departments, which also relate directly with private sector organizations. The Provincial HIV/AIDS Action Unit has trained these co-ordinators on HIV/AIDS peer education and counselling and Departments have begun funding campaigns jointly with the Unit.

Million Men March led by the MEC for Health

PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT)

AIM

The aim of this Programme is to:

- Roll out the PMTCT programme to all hospitals, CHC's and clinics which will mean that all relevant institutions are in the programme.
- Initiate an integration between MC&WH, IMCI, PMTCT in all 11 Districts.
- Establish a core training programme in all 11 district offices and 51 maternity hospitals for support to all its feeder clinics.
- Establish an effective and sustainable monitoring and evaluation system for PMTCT.
- Increase community awareness by using the existing relationships between PAAU and the relevant stakeholders and initiating novel communication channels and marketing strategies for PMTCT.

ANALYTIC REVIEW

The implementation of the Prevention of Mother to Child Transmission of HIV was expanded to all the Provincial institutions that offer a maternity service and will soon be available in all the local authority clinics. The patient monitoring system for the patients on this programme was implemented so as to improve the follow up of patients. Training of staff in this programme was robustly implemented and there was a very strong community awareness campaign undertaken, utilizing community health workers as well the media.

ANTI-RETROVIRAL THERAPY PROGRAMME (ART)

Aim

The aim of the Anti-retroviral Therapy Programme (ART) is:

To provide anti-retroviral therapy to decrease HIV related morbidity and mortality

To decrease the incidence of HIV through:

- The increased uptake in voluntary testing and counselling with more people getting to know their status and practising safer sex,
- The reduction of transmission in discordant couples, and
- Reducing the risks of HIV transmission from mother to child.

ANALYTIC REVIEW

Highly Active Anti-retroviral Therapy (HAART)

Highly Active Antiretroviral Therapy (HAART) has dramatically altered the natural history of HIV disease for those for whom potent combinations of anti-retroviral agents have been available. Cost, lack of infrastructure and political will have limited access to ARV in the developing world. The vast disparities in access to anti-retrovirals worldwide have finally become a subject of great interest and concern but programs to provide ARV in the developing world remain to be put into operation. The most severe impact of AIDS is in Sub- Saharan Africa. South Africa

is now faced with the largest and fastest growing HIV epidemic in Africa and the world. Over 4,7 million persons, or one in four adults, are currently thought to be living with HIV/AIDS in South Africa; this number is higher than in any other country in the world and is expected to double over the next decade. The HIV/AIDS epidemic has been accompanied by a severe epidemic of Tuberculosis in Africa. Tuberculosis is the major medical complication of HIV disease and the major cause of death among people with AIDS. The decrease in the cost of ARV has created new opportunities for more widespread use of these agents in Africa. An additional concern is that adherence to ARV, crucial to therapeutic success, may be inadequate, with resultant widespread development of ARV resistance. A team-based approach is therefore essential to the provision of comprehensive care of HIV infected persons including ARV. However, there is limited experience with their use and this represents one of the major obstacles to the successful implementation of ARV therapy.
Based on the above, the strategic objectives of the programme are:

- To roll-out the ART programme to district hospitals in 3 phases:
- "20% ARV coverage": Working up via phased implementation to provide capacity to provide ART for 10% of all new AIDS cases in 2004/2005
- "50% ARV coverage": Working up via phased implementation to provide capacity to provide ART for 50% of all new AIDS cases in 2005/2006. In phase 2 the remaining hospitals and healthcare centres will be strengthened to function as ART service points. In this phase it is expected that other healthcare facilities that will also be assisted and/or incorporated into the provincial HIV/AIDS care framework.
- "100% ARV coverage": Working up via phased implementation to provide capacity to provide ART for 100% of all new AIDS cases in 2006/2007. In phase 3 the following plan will be adopted:
- The remaining healthcare providers will be identified and analyzed.
- These facilities will be stratified into 2 groups:
  - Those that are able to function as ART service points
  - Those that will serve as sites that prepare patients for ARV and are able to issue ARV
- To initiate an integration between VCT and PMTCT in all 11 Districts
- To establish a rapid, intensive and a continuous training programme for health care providers with planned regional training centres
- Together develop and disseminate patient information materials related to knowledge and treatment of HIV/AIDS
- To establish an effective and sustainable monitoring and evaluation system for ART

Candle lighting

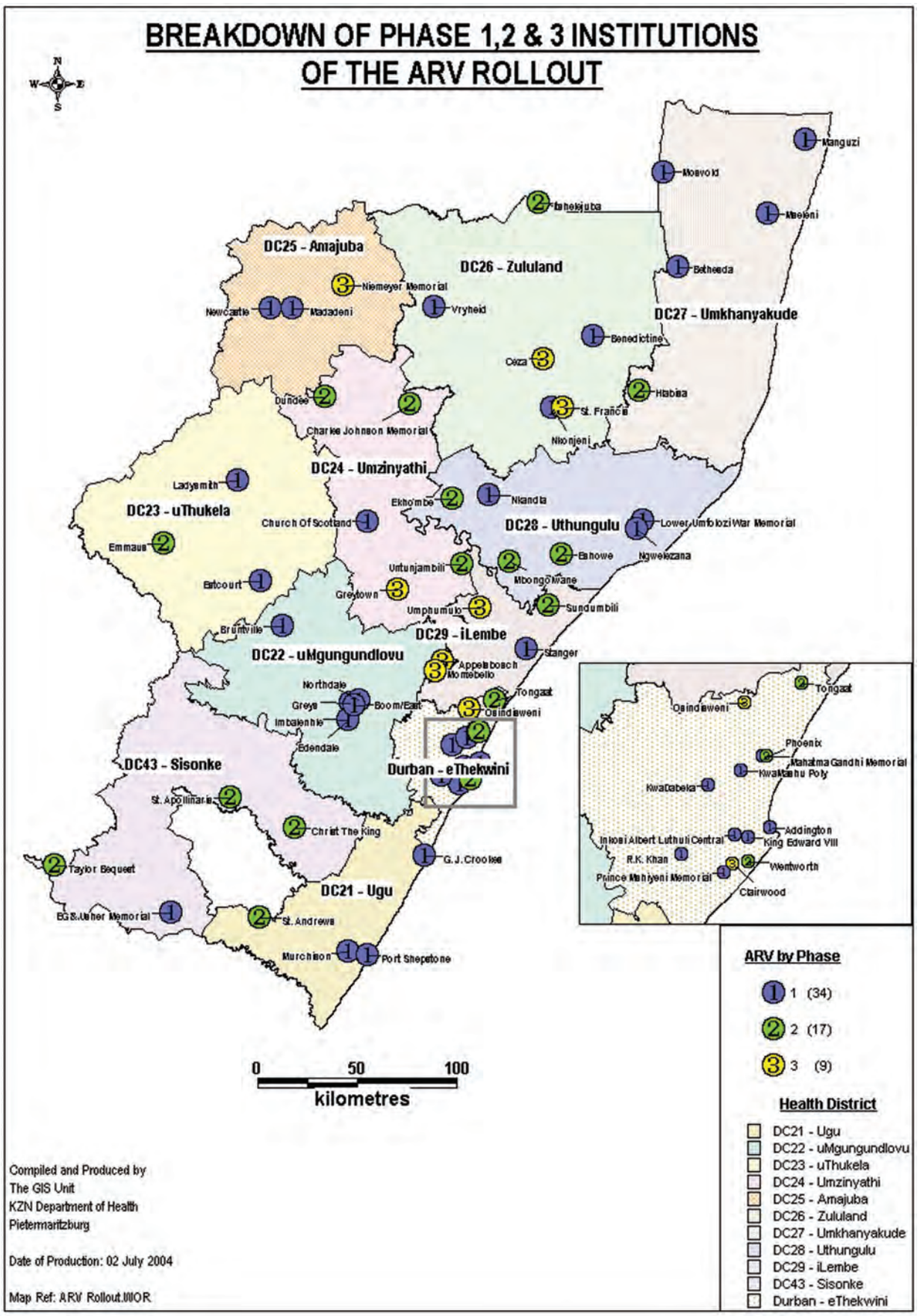

BREAKDOWN OF PHASE 1,2 & 3 INSTITUTIONS
OF THE ARV ROLLOUT
N
W
E
S
DC25 - Amajuba
DC26 - Zululand
DC27 - Umkhanyakude
DC24 - Umzinyathi
DC23 - uThukela
DC28 - Uthungulu
DC29 - iLembe
DC22 - uMgungundlovu
DC43 - Sisonke
Durban - eThekwini
DC21 - Ugu
Manguzi
Mosvold
Mseleni
Ingwavuma
Bethesda
Niemeyer Memorial
Newcastle
Madadeni
Vryheid
Benedictine
Osiza
Hlabisa
Dundee
Charles Johnson Memorial
St. Francis
Nkonjeni
Ladysmith
Ekhombe
Nkandla
Church Of Scotland
Lower Umfolozi War Memorial
Emmaus
Eshowe
Ngwelezana
Estcourt
Untunjambili
Mbongolwane
Greytown
Umphumulo
Sundumbili
Bruntville
Stanger
Appelsbosch
Mombello
Northdale
Greys
Boom/East
Tongaat
Osindisweni
Imbalenhle
Edendale
Phoenix
Mahatma Gandhi Memorial
KwaMashu Poly
KwaDabeka
Inkosi Albert Luthuli Central
Addington
King Edward VIII
R.K. Khan
Wentworth
Prince Mshiyeni Memorial
Clairwood
St. Apollinaris
Christ The King
G. J. Crookes
Taylor Bequest
BGS Usher Memorial
St. Andrews
Murchison
Port Shepstone
0
50
100
kilometres
ARV by Phase
1 (34)
2 (17)
3 (9)
Health District
DC21 - Ugu
DC22 - uMgungundlovu
DC23 - uThukela
DC24 - Umzinyathi
DC25 - Amajuba
DC26 - Zululand
DC27 - Umkhanyakude
DC28 - Uthungulu
DC29 - iLembe
DC43 - Sisonke
Durban - eThekwini
Compiled and Produced by
The GIS Unit
KZN Department of Health
Pietermaritzburg
Date of Production: 02 July 2004
Map Ref: ARV Rollout.WOR

Table 10 (k): Programme Performance

Objective	Indicator	Target 2003/3004	Actual Performance
Provincial HIV/AIDS Action Unit (PAAU)			
To design and develop an extensive, constant and effective mass media through the use of electronic and print media in the Province to raise level of HIV and AIDS awareness, understanding and promote prevention	VCT Uptake	100%	93,7% - 167 892 people received pre-test counselling
	Facilities with condom Availability	100%	100%
	Ante-natal Sero-prevalence	30%	36,5%
To consolidate VCT at all relevant hospitals and to roll out to all CHC's and PHC clinics	Percentage of provincial hospitals offering VCT	100%	100%
	Percentage of provincial fixed PHC facilities offering VCT	100%	98%
To decrease the incidence of STI's	Percentage of public PHC facilities where condoms are freely available	100%	100%
	Percentage of facilities of all types offering syndromic management of STI's.	100%	100%
	Percentage of health care workers trained in STI management	100%	100% achieved – all PHC nurses and doctors have been trained
To roll out the combined HIV/AIDS TB management from the current two sites to at least 1 site per District	Number and names of TB/HIV districts	11 Districts	4 sites have been set up
To implement a targeted youth life skills campaign in all Districts using the LoveLIfe model	Number of peer master trainers	6 in each District	10 Master Trainers were trained for each District but not formally placed as yet
To improve the quality of life for those already infected through the provision of quality and home based care services in the Province from the current 48 to 88, that is 8 in each District	Number of HBC teams	88 teams	56 (63% achieved)
	Number of Drop-in centres	24 Drop-in centres	Exceeded the target -32 Drop-in centres have been established
To ensure that all Provincial Government Departments have an HIV and AIDS plan of action	Percentage of Government Departments with HIV and AIDS plan	100%	55% achieved

Objective	Indicator	Target 2003/3004	Actual Performance
Prevention of Mother to Child Transmission Programme (PMTCT)			
Roll out the PMTCT programme to all hospitals	Number of PMTCT Hospital –Based Service Points	52 (100%)	52 (100%)
Roll out the PMTCT programme to all CHC's	Number of PMTCT CHC-Based Service Points	11 (100%)	11 (100%)
Roll out the PMTCT programme to all Clinics	Number of PMTCT provincial Clinic Based Service Points	363 (100%)	363 (100%)
Roll out the PMTCT programme to all Local Government Clinics	Number of PMTCT Local Government Clinic Based Service Points	33% of 105	45 (43%)
Roll out the PMTCT programme to all Mobile Clinics	Number of PMTCT Mobile Clinic Based Service Points	5% of 142	35 PMTCT Mobile Clinic Based Service Points were set up (25%)
Population targeted PMTCT Programme	Number of pregnant women participating in the programme	75% of 165 000	90% achieved - 149 158 women participated in the programme
To capacitate HCW's at facilities with HIV/AIDS related knowledge, skills and management development at 426 facilities	Number of nurses trained in PMTCT	852(minimum 2 per facility)	1 256 nurses were trained in PMTCT across all the facilities
To appoint skilled lay counsellors at all facilities for optimal counselling services	Number of newly appointed trained Lay Counsellors	460(min. 2 per hospital, min. 2 per CHC and 1 per clinic)	368 lay counsellors appointed and skilled (80%)
Implement a simple cost-effective patient information system to facilitate a continuum of care of women and children	Number of PMTCT facilities implementing the new patient information system	426 PMTCT facilities	426 PMTCT facilities were fully functional in this regard (100%)

Objective	Indicator	Target 2003/3004	Actual Performance
Anti-retroviral Therapy Programme (ART)			

Following a directive from the National Department of Health, the KZN DOH identified 25 sites across the 10 Districts and the Metro as facilities that will provide comprehensive care for patients infected with HIV/AIDS including anti-retroviral drugs. These facilities were identified in November 2003 following visits to all healthcare facilities within the Province.

In January 2004, provincial teams together with National Advisors visited these sites. The sites were evaluated using an accreditation tool developed by the NDOH and facilities were then provided with a detailed individualized plan to fulfil the minimum criteria for accreditation.

The formal rollout of ART in KZN occurred in April 2004 following the accreditation of 8 sites. These "ART Service Points" are located in the Metro as well as 5 Districts within the Province. At present over 2 500 patients have entered the programme and are being assessed by the criteria as set out in the National Guidelines on the treatment and care of HIV infected individuals. Over 260 patients are receiving anti-retroviral drugs via this public access programme. An additional 14 facilities are soon to be accredited.

With the accreditation of more facilities the Province will be well positioned to provide equitable access to HIV infected patients using the public healthcare facilities and will thus be in a position to achieve its target of 20 000 patients on treatment by the end of March 2005.

AIDS Helpline: 0800 01 2322

The KwaZulu-Natal Global Fund Project (KZN GF) is a 2/5-year Programme made up of a multidisciplinary team of local stakeholders in HIV/ AIDS prevention, treatment, capacity building, care and support and is funded by the Global Fund to fight AIDS, Tuberculosis and Malaria. It is dedicated to making a significant impact in the prevention, treatment, care and support of patients infected and affected by HIV/AIDS in KwaZulu-Natal.

The principles embedded in the project are based on the strength of the partnership between the private sector, NGO's, Tertiary Educational Institutions and the Provincial Department of Health. The key partners of this project are:

- KwaZulu-Natal Department of Health;
- Durban Chamber of Commerce and Industry;
- Nelson R. Mandela School of Medicine; and
- Various NGO/CBO groups.

This project is in synchrony with the mainstream activities and priorities of the KwaZulu-Natal Department of Health, in line with the National Department of Health policies and guidelines.

Service Delivery Progress

The project officially commenced on 1 February 2004 although a substantial amount of work had already commenced prior to this date. Progress achieved by the end of the 2003/2004 financial year included the following:

- Service level agreements signed with all beneficiaries;
- Administration support office for Global Fund Project established;
- Training of mentor co-ordinators completed in 2 Districts;
- 200 counsellors recruited;
- Clinic sites identified with building plans awaiting finalisation;
- District co-ordinators and trainers appointed and trained for all Districts;
- 16 patients treated on the HAART programme;
- Provided funding for an 82-bed step down facility;
- Procured anti-retrovirals for the DOTS- HAART, HAART, PEP and OPEP programmes;
- Started process for the procurement of additional laboratory equipment to carry out CD4 and viral load testing;
- Clinic at Lions River was fully set up and is functional;
- Developed training manuals for training of health care workers; and
- Trained health care workers at all accredited sites for the rollout of ARV's.

The Department acknowledges the support of the Global Fund in the fight against HIV/AIDS in our Province. Together with all relevant stakeholders the Province will reap valuable benefits during the coming years.

Table 11: District Health System

	Type	Target 2003/04	Ugu DC21	uMgungu n-dlovu DC22	uThukela DC23	Umzinyathi DC24	Amajuba DC25	Zululand DC26	Umkhanya -kude DC27	Uthungulu DC28	iLembe DC29	Sisonke DC43	eThekwini METRO
Input													
Uninsured population served per fixed public PHC facility	No.	10 000 per fixed PHC clinic	15 511	27 170	15 739	12 452	26 321	11 918	11 874	20 430	14 009	14 685	21 063
Provincial PHC expenditure per uninsured person	R	–	467	56	47.29	101.68	32.87	98	155	208	330	533.77	98.70
LG PHC expenditure per uninsured person	R	N/AV		63.20	R62	67.11	3.53***	49	Nil	265	–	63	94
PHC expenditure (provincial plus local government) per uninsured person	R	–	429	63.20	76	107.30	36.40	99	155	161.09	297	37	192.70
Professional nurses in fixed public PHC facilities per 1,000 uninsured people	No.	1	0.37	0.27	0.3	0.24	0.28	0.27	0.28	0.35	0.45	0.79	0.2
Sub-districts offering full package of PHC services	%	20	68	71	80	100	100	0	90	100	100	60	100
EHS expenditure (provincial plus local government) per uninsured person	R	–	6.82	4.16	4.27	3.42	20.07	6.45	155**	–	–	2.70	23.83
Process													
Health districts with appointed manager	%	100	100	100	100	100	100	100	100	100	100	100	100
Health districts with plan as per DHP guidelines	%	100	0*	100	100	100	100	100	0*	100	100	0*	0*
Fixed public PHC facilities with functioning community participation structure	%	80	89	68	50	100	100	94	80	100	85	95	34
Facility data timeliness rate	%	100	98	100	100	100	100	100	90	100	98	100	90

**DHP not yet implemented as per NDOH guideline.*
*** High expenditure due to Malaria Control Programme*
**** Low expenditure due to having only 1 local authority clinic*

Table 11 (continued): District Health System

	Type	Target 2003/04	Ugu DC21	uMgungun-dlovu DC22	uThukela DC23	Umzinyathi DC24	Amajuba DC25	Zululand DC26	Umkhanya-kude DC27	Uthungulu DC28	iLembe DC29	Sisonke DC43	eThekwini METRO
Output													
PHC headcount	No.	–	1 509 063	2 102 514	1 292 286	928 785	1 070 775	1 380 132	1 331 539	1 823 372	621 063	545 012	5 865 754
Utilisation rate – PHC	No.	–	2.14	2.25	1.8	2.6	2.21	1.64	1.8	2.0	3.0	2.0	1.9
Utilisation rate - PHC under 5 years	No.	–	3.39	3.8	4.0	4.24	4.65	3.36	4.5	4.13	–	4.5	3.8
Quality													
Supervision rate	%	–	67	100	100	100	100	88	90	100	100	95	60
Fixed PHC facilities supported by a doctor atleast once a week	%	–	38	35	23	27	0	33	44	15	33	100	100
Efficiency													
Provincial expenditure per visit (headcount) at provincial PHC facilities	R	–	56.16	44	67	49.17	34	47	47	62.72	–	–	43.02
Expenditure (provincial plus local government) per visit (headcount) at public PHC facilities	R	–	51.57	41	67	63.7	31.47	46	47	–	–	37	84
Outcome													
Districts with a single health provider	%	–	0	0	0	0	0	0	100	0	0	0	0
Service volumes													
Clinic headcounts	No.	–	1 295 049	1 525 106	1 038 696	780 416	970 464	1 140 378	1097566	1 609 431	424 589	372 639	4 182 445
CHC headcounts	No.	–	–	185 573	–	–	–	–	–	–	207 848	60 569	1 367 147
Mobile headcounts (Provincial mobiles)	No.	–	214 014	208 479	253 590	139 562	68 768	209 365	263 342	213 441	137 271	133 121	189 766
Mobile headcounts (Local Authority mobiles)	No.	–	–	10 337	–	–	13 633	9 453	–	–	20 450	7 493	109 221
Mobile headcount as a percentage of Total PHC headcount*	%	–	16.5	13.66	24.41	17.88	7.08	18.35	23.99	13.26	32.33	35.72	4.53

**The percentage values exclude the local authority mobile headcount*

Table 12: District Hospitals

Indicator	Type	Actual 2001/2002	Actual 2002/2003	Actual 2003/2004	Strat Plan Target 2003/2004
Input					
Expenditure on hospital staff as percentage of total hospital expenditure	%	71.82	67.87	67.98	-
Expenditure on drugs for hospital use as percentage of total hospital expenditure	%	5.71	6.48	68.28	-
Hospital expenditure per uninsured person	R	220.98	230.09	231.93	-
Process					
Hospitals with operational hospital board	%	-	-	87	100
Hospitals with appointed (not acting) CEO in place	%	-	-	89	100
Facility data timeliness rate	%	100	100	100	100
Output					
Caesarean section rate	%	17	17	16	-
Quality					
Hospitals with a published nationally mandated patient satisfaction survey in last 12 months	%	-	-	100	100
Hospitals with clinical audit (M&M) meetings at least once a month	%	-	-	85	100
Efficiency					
Average length of stay	Days	6	7	6	-
Bed utilisation rate (based on useable beds)	%	63	54	58	-
Expenditure per patient day equivalent	R	529	610	630	-
Outcome					
Case fatality rate for surgery separations	%	-	-	4.5	-
Service volumes					
Separations	No.	354 708	279 030	300 994	-
OPD headcounts	No.	1 809 692	1 929 606	1 634 195	-
Day cases (= 1 separation = ½ IPD)	No.	78 235	25 682	2 855	-
Casualty headcount	No.	212 784	267 426	343 037	-
PDE's	No.	2 909 417	2 912 430	2 446 637	-

Table 13: HIV/AIDS/STI's and TB

Indicator	Type	Actual 2001/2002	Actual 2002/2003	Actual 2003/2004	Strat Plan Target 2003/2004
Input					
Fixed PHC facilities offering PMTCT	%	2	21	100	100
Fixed PHC facilities offering VCT	%	10	80	100	100
Hospitals offering PEP for occupational HIV exposure	%	-	-	100	100
Hospitals offering PEP for sexual abuse	%	-	-	100	100
Process					
TB cases with a DOT supporter	%	-	-	60	80
Male condom distribution rate from public sector health facilities (including primary health care sites)	Per K male ≥ 15 years	5.4	8.2	6.2	8
Nevirapine stock out	%	53	65	100	100
Output					
STI partner treatment rate (STI partner tracing rate)	%	30	29	28	35
Nevirapine uptake rate among babies born to women with HIV	%	77	97	98	100
Quality					
TB sputa specimens with turnaround time > 48 hours	%	-	-	16	0
Efficiency					
Dedicated HIV / AIDS budget spent	R '000	49 364	123 401	246 701	-
HIV/AIDS Primary Health Care	%	88	86	100	100
Outcome					
New smear positive PTB cases cured at 1st attempt	%	-	-	35	50
New MDR TB cases reported – annual % change	%	-	-	-	-
Service volumes					
STI cases – new episode	%	6.3	7.7	7.2	10
Patients registered for ART*	No.	-	-	-	-
STI Partner notification slip issue rate	%	86	95	108	100

- *The data provided is for calendar year 2003 and not financial year 2003 – 2004*
- *TB sputum turnaround time is for facilities not for specimens. Next year it will be developed to the level of percentage of specimens*
- *MDR TB statistics will only be available after reporting system is in place*
- *TB patients with DOT supporters are an average of quarterly reports as they are lost to the programme quite frequently and thus the number varies*

* *Patients only registered for ART in the current financial year.*

Table 14: Maternal, Child and Women's Health including Nutrition

Indicator	Type	Actual 2001/2002	Actual 2002/2003	Actual 2003/2004	Strat Plan Target 2003/2004
Input					
Hospitals offering TOP services	%	10%(5)	13% (3)	22 %(14)	16%
CHC's offering TOP services	%	0	0	0	0
Process					
AFP detection rate	%	–	100	100	100
AFP stool adequacy rate	%	–	100	100	100
Output					
Schools at which phase 1 health services are being rendered	%	0	0	0	0
(Full) immunisation coverage under 1 year	%	82	84.2	89	80
Vitamin A coverage under 1 year	%	0	0	73	–
Measles coverage under 1 year	%	82	84.2	89	80
Quality					
Facilities certified as baby friendly	%	1.3	1.95	2.2	–
Facilities certified as youth friendly	%	–	1%(8)	2.5%(15)	18
PHC facilities implementing IMCI	%	–	6%(38)	21%(133)	25%
Outcome					
Institutional delivery rate for women under 18 yrs****	%	–	10.4	9.7	–
Not gaining weight under 5 years	%	0	0	1,2	–

DTP-Hib vaccines out of stock - Statistics not collected
Ante-natal coverage - Statistics not collected
Cervical cancer screening coverage -Statistics not collected
**** *Statistics expressed as a percentage of total births and not of population*

Table 15: Disease Prevention and Control Programme

	Type	Target 2003/04	Ugu DC21	uMgungu n-dlovu DC22	uThukela DC23	Umzinyathi DC24	Amajuba DC25	Zululand DC26	Umkhanya -kude DC27	Uthungulu DC28	iLembe DC29	Sisonke DC43	eThekwini METRO
Input													
Trauma centres for victims of violence (sexual assault, family violence)	No.	5	3	3	3	4	3	1	1	4	1	1	1
Process													
CHC's with fast queues for elder persons	%	100%	nil	66%	nil	nil	nil	nil	nil	100%	100%	nil	100%
Output													
Districts with health care waste management plan implemented	No.	all	1	1	1	1	1	1	1	1	1	1	1
Hospitals providing occupational health programmes	%	100	100	75	100	100	100	7	40	8	100	7	100
Schools implementing Health Promoting Schools Programme (HPSP)	%	10	12 schools	100	2 schools	73	9.09	12	10	4	0.5	12	10
Integrated epidemic preparedness and response plans implemented	Y/N	_	Y	Y	Y	Y	Y	Y	N	N	Y	Y	N
Integrated communicable disease control plans implemented	Y/N	_	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
Quality													
Schools complying with quality index requirements for Health Promoting Schools Programme	%	50	0	1 school	2 in process	1.77	5	1	50	4	0.3	1	10

Table 15: (continued) Disease Prevention and Control Programme

	Type	Target 2003/04	Ugu DC21	uMgungu n-dlovu DC22	uThukela DC23	Umzinyathi DC24	Amajuba DC25	Zululand DC26	Umkhanya -kude DC27	Uthungulu DC28	iLembe DC29	Sisonke DC43	eThekwini METRO
Outbreak response time	Days	1 day	1 day	1 day	1-2 days	1 day	0 days	2 wks	3 days	1 day	1 day	14 days	0 days
Waiting time for a wheelchair	Weeks	4 wks	16 to 20 wks	8-12 wks	6-8 wks	8 wks	12 wks	2 wks	6-12 wks	8 wks	6 wks	8 wks	6-8 wks
Waiting time for a hearing aid	Weeks	4 wks	8 to 12 wks	8-12 wks	6-8 wks	8 wks	6 wks	16 wks	6-12 wks	6 wks	2-3 wks	16 wks	6-8 wks
Efficiency													
Waiting time for cataract surgery	Months	1 mth	3 mths	1 wk	6-9 mths	2 mths	2 mths	6 mths	1 mth	1-2 mths	nil	6 mths	8-12 mths
Outcome													
Dental extraction to restoration rate	%	100	2.4	70	66	n/av	90.2	40	90	40	n/av	60	55
Malaria fatality rate	%	<0.5	n/app	0	0	0	0	0	0.003	0	0	0	0
Cholera fatality rate	%	-	0	0	0	0.05	0	0	1.1	0	3	0	0
Cataract surgery rate	No.	40	336	1 412	189	383	557	30	30	128	0	0	806

EMERGENCY MEDICAL RESCUE SERVICES

AIM

The broad aim of Emergency Medical Rescue Services is to provide an emergency and non-emergency medical rescue service to all the citizens of the Province of KwaZulu-Natal.

This is achieved through the following sub-programmes as described below.

Emergency Patient Transport

This service aims to meet the emergency medical and rescue needs of the Province through the provision of a high quality of pre-hospital care provided by a well-trained and highly skilled workforce. Depending on the need and/or seriousness of the call, all medical, trauma, paediatric and maternity emergencies are responded to by ambulances, ALS response units, rescue units and aero medical services.

Planned Patient Transport

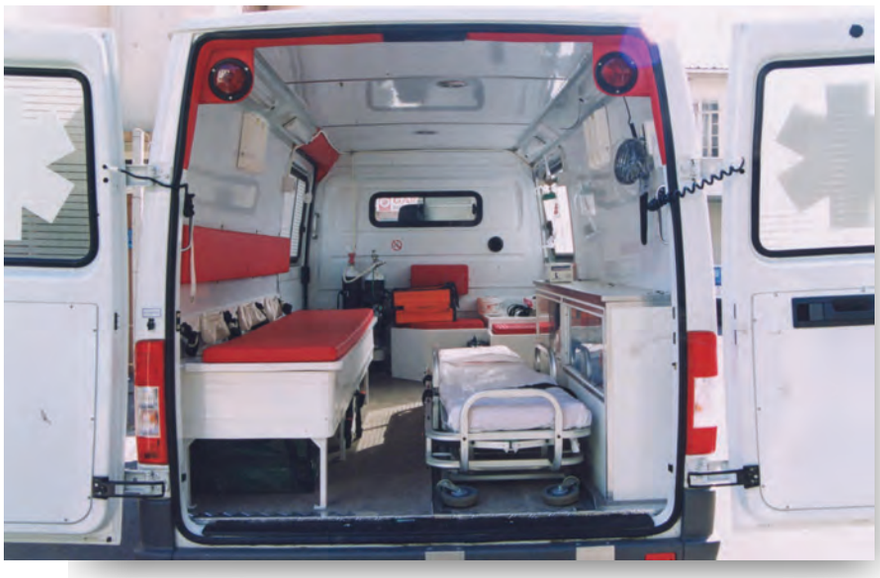
This service includes the non-emergency transport of patients referred between hospitals inter or intra district, in accordance with the referral patterns of the District Health System.

ANALYTIC REVIEW

In line with the objectives of the component, a number of improvements were achieved in the overall provision of emergency medical rescue services throughout the Province. These were especially noted in the reduction of response times, the improvement of Planned Patient Transport and the increase in the ambulance fleet. Each of these is dealt with hereunder. It must be noted that the historical under funding has hindered the optimal provision of the service, which translated into the inability to expand these services fully to previously disadvantaged areas. In addition the poor road infrastructure limited access of communities to EMRS services. More detail on the challenges experienced is included under each of the headings below.

Response Times

Although the new ambulance fleet was introduced during the last year, the improvements in the response times were not maximised in terms of the norms for urban and rural areas. A number of factors contributed to this. Most noticeable was the increase in the caseload of the last financial year. Thus although the



Inside of an ambulance

fleet status improved by 16% the caseload increased by almost 48%. This led to the situation where demand exceeded supply. Currently EMRS operates on a ratio of one ambulance per sixty thousand population (1: 60 000 average). The accepted norm for optimal operation is one ambulance per ten thousand people (1: 10 000). Despite this problem, the average response times in the rural areas of the Province improved and were within the 2003/04 targets in terms of average response times. This was indicative of the resources and emphasis that was placed on addressing the needs of the previously disadvantaged areas.

In addressing the needs of pregnant women and in an attempt to decrease the Maternal Mortality Rate (MMR), EMRS made a policy decision whereby all maternity cases were to be classified as Red Codes. This meant that requests for the transportation of maternity cases from the community and from clinics/hospitals were given greater priority.

Planned Patient Transport

The last financial year also saw the introduction of the Planned Patient Transport (PPT) programme. Due to financial constraints, implementation throughout the Province was not possible and the programme was implemented in 4 of the 10 districts requiring this service (eThekwini already had an elective transport system in place). Thirty additional posts were created and filled exclusively for PPT and the programme commenced in earnest on the 1st March 2003. During the first month 3 171 patients were transported to receiving institutions mainly in Durban and Pietermaritzburg. This figure of 3 171 patients referred from only four districts within a month indicated the dire need for this type of service to complement the District Health System and the referral system in particular. Further expansion of the PPT programme was delayed by the non-arrival of buses ordered early in the financial year. Despite these constraints however EMRS met the 2003/2004 target of covering 30% of the Province's hospitals through the PPT programme.

The programme also assisted in the facilitation of repatriation of patients to their home institutions. During the month of March 2004, 290 patients were repatriated thus releasing an equal amount of bed space in the relevant hospitals.

It is envisaged that the programme will be expanded to incorporate the transportation of patients from clinics to hospitals.

Fleet

The 2003/04 financial year saw the introduction of the new fleet of 115 Mercedes Sprinter ambulances. This had a direct impact on service delivery in that older vehicles in the fleet were replaced thus reducing maintenance costs of such vehicles. A further impact was the reduction in down times due to mechanical failure, thereby allowing more ambulances to be available for response to people's needs. By the end of March 2004 a further thirty-one 4x4 Toyota Land Cruisers had been dispatched for conversion into ambulances.

A major constraint affecting the Department and service delivery in general was the vulnerability of the fleet to hijackings. In the past 10 years EMRS lost approximately 57 vehicles due to hijackings. As the spate of hijackings increased with the resultant lives of staff being placed in jeopardy, the Department decided to install tracker devices in all ambulances, a measure that would deter hijackers and ensure the safety of the EMRS staff. The impact of this initiative will be assessed in the future.

Mercedes Sprinter Ambulances

Provincial Health Operations Centre (PHOC)

The PHOC is a vital multifunctional communication link between all the core service delivery functions of the Department. As such it is the central co-ordination point for disaster management and mass casualty incidents. As the PHOC is a fairly newly established centre, progress has been made at a steady pace. It is

envisaged that within the next five years the full potential of the PHOC will be realised.

The centre is the home of support to the Districts in the following generic fields; EMRS Provincial Operations including Major Incident Co-ordination and Air Ambulance Support, Disaster Management including Daily Status Reporting from all provincial health institutions.

During the reporting period the centre supported Districts in crucial situations that had an impact on service delivery and related issues. EMRS and Hospital Services constituted majority of the assistance (70%) required, which varied from electricity failure to security incidents. The day-to-day monitoring of Cholera and drought management related diseases was most effective in that the Department was able to be proactive in dealing with these problems.

Information and reporting is effected through the primary conduit of landlines as an entrance into the Centre therefore the toll-free line, 0800005133, has been the main route of information movement. The PHOC logged an average of 2 728 telephonic calls, 775 e-mails, 2 263 facsimiles and 527 SMS's per month during the past year. Outgoing information and messages were logged as follows: 2 219 telephonic calls, 308 e-mail's, 923 facsimiles including electronic and 211 SMS's per month.

The table below indicates the percentage breakdown of all calls/reports received by the PHOC for the reporting period.

Incidents by Type

Equipment Failure	Elect/Water	Security	Labour	Mass Casualty	Communicable Disease	Complaints	Help
19%	11%	5%	1%	31%	20%	8%	5%

Action in PHOC

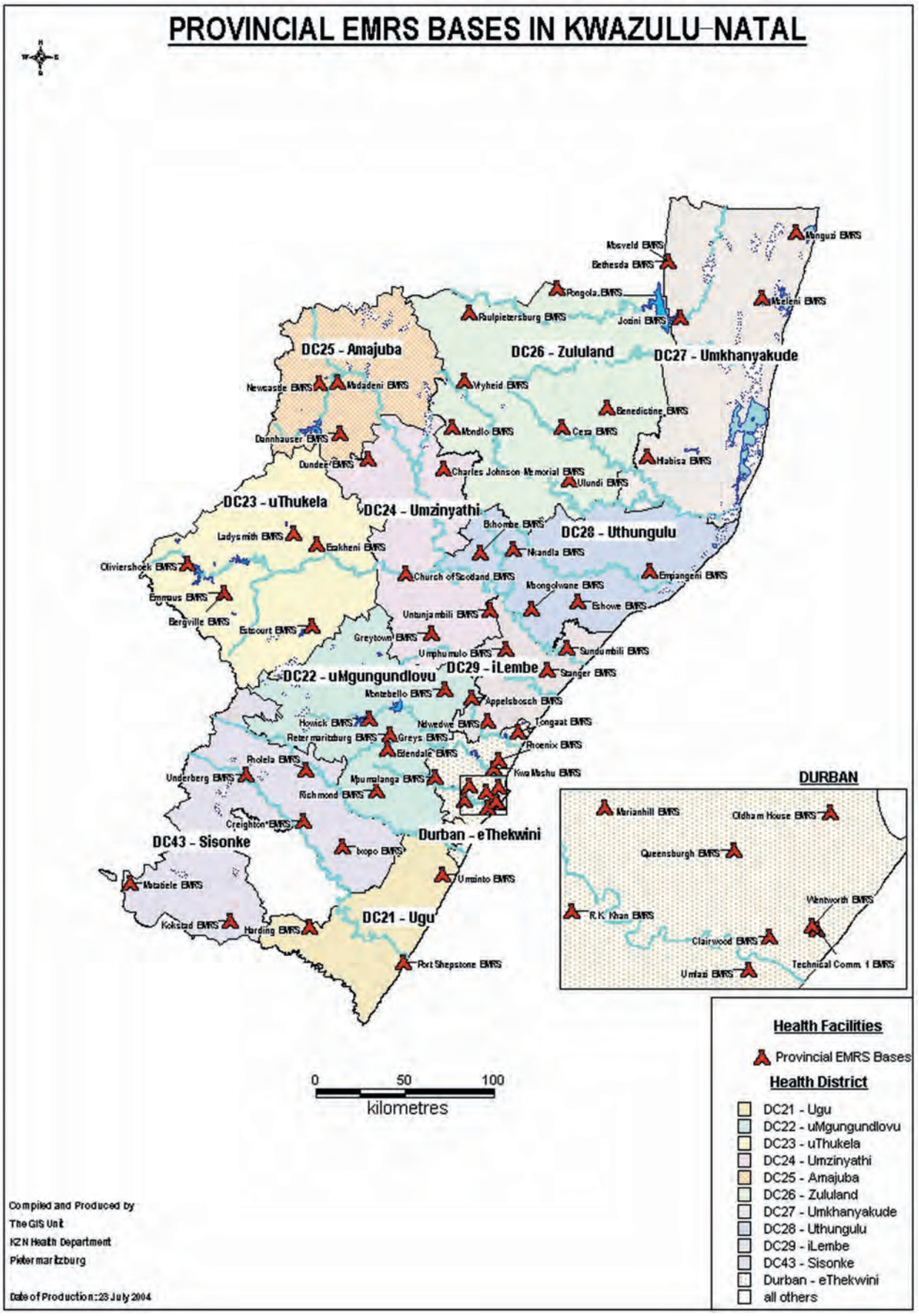

PROVINCIAL EMRS BASES IN KWAZULU-NATAL
DC25 - Amajuba
DC26 - Zululand
DC27 - Umkhanyakude
DC23 - uThukela
DC24 - Umzinyathi
DC28 - Uthungulu
DC22 - uMgungundlovu
DC29 - iLembe
DC43 - Sisonke
Durban - eThekwini
DC21 - Ugu
Mbazwana EMRS
Mbonguzi EMRS
Bethesda EMRS
Pongola EMRS
Mtubatuba EMRS
Paulpietersburg EMRS
Jozini EMRS
Newcastle EMRS
Madadeni EMRS
Vryheid EMRS
Benedictine EMRS
Dannhauser EMRS
Mondlo EMRS
Ceza EMRS
Dundee EMRS
Charles Johnson Memorial EMRS
Ulundi EMRS
Mtubatuba EMRS
Ladysmith EMRS
Ezakheni EMRS
Bhombe EMRS
Ntandla EMRS
Oliviershoek EMRS
Church of Scotland EMRS
Empangeni EMRS
Emmaus EMRS
Mpongolwane EMRS
Eshowe EMRS
Bergville EMRS
Estcourt EMRS
Untunjambili EMRS
Greytown EMRS
Umphumulo EMRS
Sundumbili EMRS
Stanger EMRS
Montebello EMRS
Appelsbosch EMRS
Howick EMRS
Ndwedwe EMRS
Tongaat EMRS
Pietermaritzburg EMRS
Greys EMRS
Phoenix EMRS
Edendale EMRS
Kwa Mashu EMRS
Underberg EMRS
Mpumalanga EMRS
Richmond EMRS
Creighton EMRS
Ixopo EMRS
Umzinto EMRS
Matatiele EMRS
Kokstad EMRS
Harding EMRS
Port Shepstone EMRS
DURBAN
Marianhill EMRS
Oldham House EMRS
Queensburgh EMRS
Wentworth EMRS
R.K. Khan EMRS
Clairwood EMRS
Umlazi EMRS
Technical Comm. 1 EMRS
0
50
100
kilometres
Health Facilities
Provincial EMRS Bases
Health District
DC21 - Ugu
DC22 - uMgungundlovu
DC23 - uThukela
DC24 - Umzinyathi
DC25 - Amajuba
DC26 - Zululand
DC27 - Umkhanyakude
DC28 - Uthungulu
DC29 - iLembe
DC43 - Sisonke
Durban - eThekwini
all others
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TABLE 16: Performance against targets from 2003/2004 Strategic Plan for the EMRS programme

Sub-programme	Objectives (Output)	Indicator	Actual Performance			
			2001/02 Actual	2002/03 Actual	2003/04 Actual	2003/04 Target
EMRS Programme	Improve quality of EMRS in the Province	No. of intensive care mobile units in Districts	0	6	11	11
	Reduce the use of ESV's for non-emergency (phase out)	%age clinics covered in the PPT programme	0%	0%	0% (lack of funds)	25%
	Capacity development of all EMRS staff	Increase number of staff to achieve equity and optimal status	1 465	1 644	1 872	1 800
		Have an agreement in place with tertiary institutions	Nil	Nil	Negotiations conducted with DIT – agreement to be finalised	Agreement with DIT
Emergency Transport	Decrease mortality and morbidity through proper management of: Trauma Children under 5 Pregnant women	Increase the number of ILS and ALS personnel	ALS – 7	ALS – 7	ALS – 12 with 10 undergoing remedial exam	16
			ILS – 93	ILS – 102	ILS – 73 (low achievement due to low pass rate)	160
	Acquire appropriate emergency support vehicles	No. of vehicles commissioned	65	55	268 (50,75%) Target not reached due to budget constraints	528 vehicles to be commissioned
	Improved access to EMRS services	No. of staff trained in EMD	0	0	88	89 (50% of 179 staff in control rooms)
		Improved response times against National norms of: Urban – 15 minutes Rural – 45 minutes	Urban 40,5% Rural 39,5%	Urban 39,5% Rural 37,5%	Urban 40,75% Rural 38,15%	
Planned Patient Transport	Increase the number of PPT (phase in)	%age of hospitals covered in the PPT programme	10%	10%	31%	30%

DISASTER MANAGEMENT

AIM

The Department's Disaster Management programme lies within the Emergency Medical Rescue Services component. The aim is to provide a sustainable Disaster Management programme within the KwaZulu-Natal Department of Health that complies with the Disaster Management Act.

The main objective of the programme is to ensure that all disasters are effectively and efficiently managed and that the programme is sustained by:

- Improving Disaster Management awareness and capacity building;
- Improving Disaster Management intersectoral collaboration;
- Improving Disaster Management communications amongst health institutions; and
- Improving Disaster Management readiness at all health institutions.

The table below indicates the performance of this programme.

Programme Performance

Objective	Indicator	Target 2003/3004	Actual Performance
To improve Disaster Management awareness amongst health care workers within the Districts	Number of workshops conducted	14 Workshops	14 Workshops conducted during the year
To conduct a disaster plan audit at all institutions within the Districts	Number of completed audits	11 Districts	Audits completed in 7 Districts
To conduct a two-way radio audit at all institutions within the Districts	Number of completed audits	11 Districts	11 Districts
To improve the skills of the Disaster Management Co-ordinators	Number of courses, conferences and seminars attended	All (6) Disaster Management Co-ordinators	6 Disaster Management Co-ordinators completed course on basic computers and basic Disaster Management
To improve disaster management through intersectoral collaboration at a Provincial and District level	Number of meetings attended	Four Provincial and eleven District intersectoral meetings	Four Provincial and three District intersectoral meetings attended

Table 17: Emergency Medical Rescue Services and Planned Patient Transport

		Actual 2001/2002	Actual 2002/2003	Actual 2003/2004	Strat Plan Target 2003/2004
Input					
Ambulances per 1000 people	No.	0.0531	0.0461	0.0539	0.0560
Hospitals with patient transporters	%	100	100	79	70
Process					
Kilometres travelled per ambulance (per annum)	Km	142.602	143.980	144.204	N/A*
Locally based staff with training in BLS	%	32,8	38,1	45,3	N/A*
Locally based staff with training in ILS	%	45,3	48,2	51	57
Locally based staff with training in ALS	%	4,5	5,9	5,7	6,9
Quality					
Response times within national urban target (15 mins)	%	40.5	39.5	40.75	45
Response times within national rural target (40 mins)	%	39.5	37.75	38.15	45
Call outs serviced by a single person crew	%	0	0	0	0
Efficiency					
Ambulance journeys used for hospital transfers	%	8.41	5.84	3.14	N/A*
Green code patients transported as % of total	%	37.5	34	33.75	N/A*
Cost per patient transported	R	257	350	461	N/A*
Ambulances with less than 500,000 km on the clock	%	100	96	92	N/A*
Output					
Patients transported per 1 000 separations	No.	**	**	**	**
Volume indicator					
Number of emergency call-outs	No.	282 240	338 851	503 782	N/A*
Patients transported (routine patient transport)	No.	271 852	318 563	483 122	N/A*

* Targets cannot be set for these indicators as they are reactive indicators and consist of a number of variables. However they are measured.

** Based on the definition provided for separations (that is patients leave the hospital in two ways, either through discharge or death) patients are not transported on discharge from hospital.

PROVINCIAL HOSPITAL SERVICES

AIM

This programme provides the second level of health care and incorporates specialised TB, Chronic Medical, Psychiatric and Dental Training Hospitals.

In addition Tertiary Hospitals provide the 3rd level of health care. For the period under review services provided by both District and Regional Hospitals are reported on in this programme.

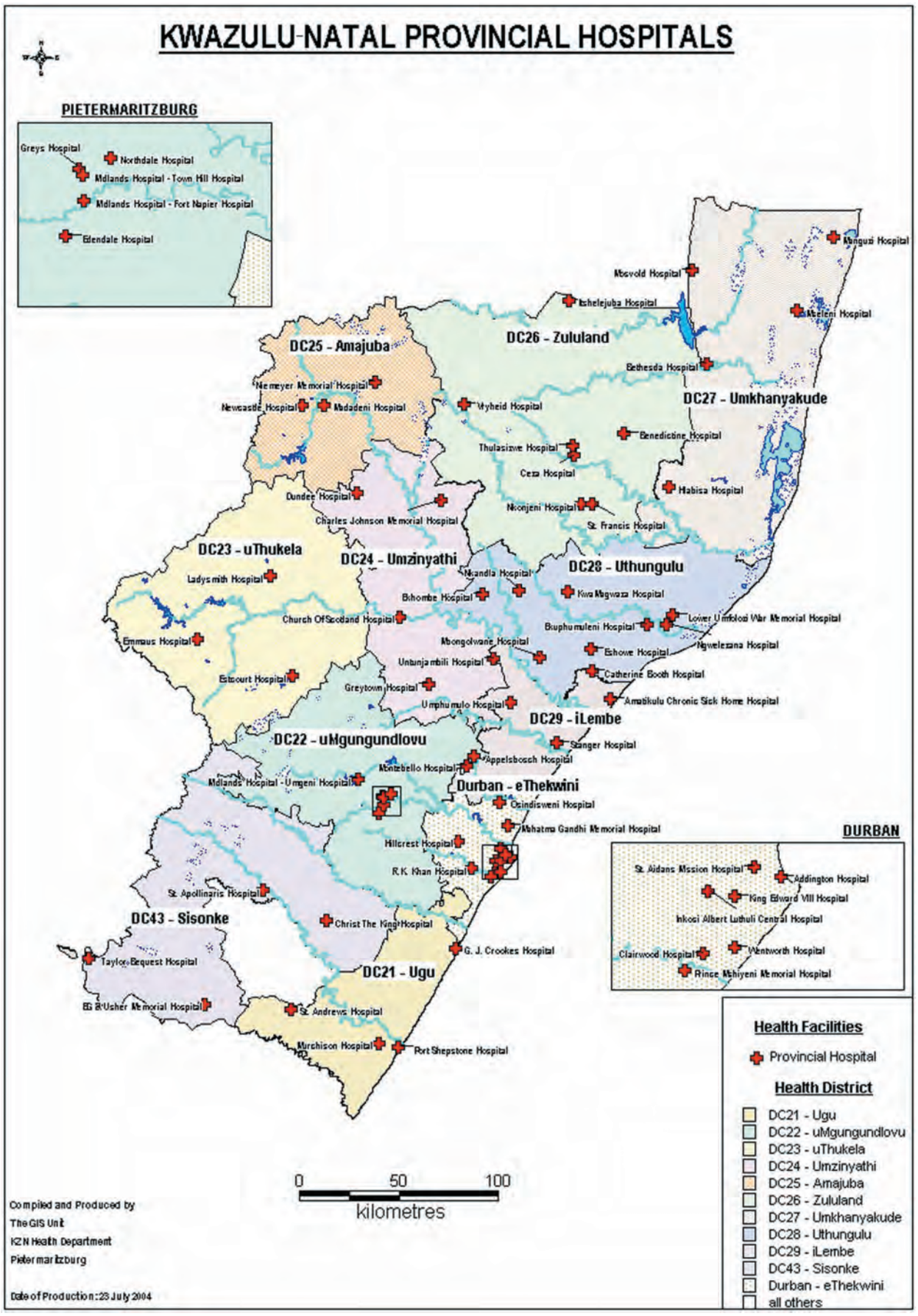
Strategic Objectives

- The Strategic Position Statement has identified incongruencies in the supply of beds in District Hospitals as well as inequities in the distribution of resources within the Province, therefore one of the objectives of this Programme was to ensure the equitable distribution of Health Resources in the Province;
- To ensure the revitalisation of Hospital Services
- Provision of a high quality, compassionate service and reduction of morbidity and mortality with emphasis on HIV/AIDS and TB; and
- The consolidation of the package of service at different levels of care and strengthening the referral system.

ANALYTIC REVIEW

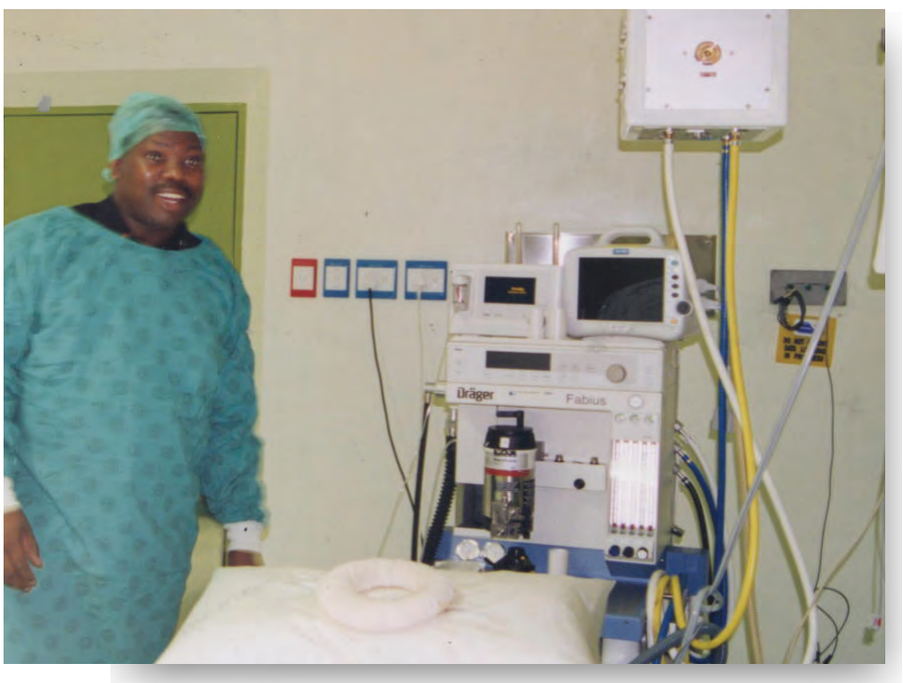
Hospitals in KwaZulu-Natal have the primary objective to provide a quality health service within the context of the District Health System. The District Hospitals provided services for the immediate surrounding population. Included in the services provided by these hospitals were short-term convalescent care (step-down facility) with a specific number of beds allocated for this purpose. In addition to serving the population of KwaZulu-Natal, these hospitals also provided services to cross-border patients, predominantly from the Eastern Cape Province. This is evidenced by admissions at Port Shepstone Hospital (15%), St. Andrew's Hospital (21%), East Griqualand and Usher Memorial Hospital (+51%) and 40% of patients admitted at Itshelejuba Hospital from Mpumalanga and Swaziland. The referral system has been reviewed provincially with all the relevant stakeholders.

The referral pattern has been revised for all levels of care and has been agreed upon by all the stakeholders. The various components of an efficient and effective referral system have been identified and guideline documents to implement these components were put in place. A package of service document at various levels of care was developed. Admission and discharge criteria as laid out in the Essential Drug List are being refined by institutions. Referral patterns both an interim functional and an ideal pattern was developed and implementation commenced. A standardized patient letter was developed and its use implemented. The standard treatment guidelines, referral protocols and criteria are available in the Essential Drug List booklets and are being contextualised by the institutions. The review of the referral system would ensure greater and more equitable access to care.


KWAZULU-NATAL PROVINCIAL HOSPITALS
PIETERMARITZBURG
Greys Hospital
Northdale Hospital
Midlands Hospital - Town Hill Hospital
Midlands Hospital - Fort Napier Hospital
Edendale Hospital
DC25 - Amajuba
DC26 - Zululand
DC27 - Umkhanyakude
DC23 - uThukela
DC24 - Umzinyathi
DC28 - Uthungulu
DC22 - uMgungundlovu
DC29 - iLembe
Durban - eThekwini
DC43 - Sisonke
DC21 - Ugu
Nongoma Hospital
Mosvold Hospital
Ekuseni Hospital
Ngwelezana Hospital
Catherine Booth Hospital
Amatikulu Chronic Sick Home Hospital
Stanger Hospital
Appelsbosch Hospital
Montebello Hospital
Osindisweni Hospital
Mahatma Gandhi Memorial Hospital
Hillcrest Hospital
R.K. Khan Hospital
Christ The King Hospital
G. J. Crookes Hospital
St. Andrews Hospital
Murchison Hospital
Port Shepstone Hospital
DURBAN
St. Aidans Mission Hospital
Addington Hospital
King Edward VIII Hospital
Inkosi Albert Luthuli Central Hospital
Clairwood Hospital
Wentworth Hospital
Prince Mshiyeni Memorial Hospital
Health Facilities
Provincial Hospital
Health District
DC21 - Ugu
DC22 - uMgungundlovu
DC23 - uThukela
DC24 - Umzinyathi
DC25 - Amajuba
DC26 - Zululand
DC27 - Umkhanyakude
DC28 - Uthungulu
DC29 - iLembe
DC43 - Sisonke
Durban - eThekwini
all others
0 50 100
kilometres
Compiled and Produced by
The GIS Unit
KZN Health Department
Pietermaritzburg
Date of Production: 23 July 2004

The vision of the Department of Health in KwaZulu-Natal is to achieve optimal health status for all persons in KwaZulu-Natal. Some progress has been made with 8 hospitals obtaining full COHSASA accreditation and 46 hospitals received graded accreditation. Murchison Hospital received the Premier's Good Governance Award during 2003. The Quality Assurance team worked throughout the Province to ensure service delivery of a high standard. The unit continues to monitor Batho Pele Principles implementation, using the tool that was developed. The results showed that seven (7) out of 10 principles have shown improvement of varying degrees and three (3) principles remained a challenge, namely courtesy, value for money & customer impact. The QA Unit will offer re-training & support around these key principles. This unit focused on specific projects to enhance Health & Human Rights implementation. The unit also attended to complaints and ensured redress by institutions. A greater percentage of complaints fell into "clinical" as well as "staff attitude" categories.

HOD with one of the last few patients at Wentworth Hospital prior to regrading of the hospital



Opening of the New Theatre at Manguzi Hospital by MEC for Health

Table 18: Programme Performance

Objective	Indicator	Target 2003/3004	Actual Performance
To ensure the provision of high quality health care by improving access			
Improvement of physical access	% Hospitals with physical access	50 % Improvement in physical access by 31/03/04	90% Hospitals with physical access. Monitoring to be continued
Reduction of waiting times in OPD and Pharmacy	% Hospitals with waiting time of less than one hour OPD and Pharmacy	Waiting time of less than one hour OPD and Pharmacy	Surveys conducted. Waiting times indicated as >4 hours
Finalisation of package of services	% Hospitals having access to finalised document	Finalised document available to 100 % of institutions on intranet	Documents placed on intranet. All institutions have access
Finalisation of referral pattern	Availability of agreed upon referral pattern document	100 % Institutions have access to the document	100 % Institutions have access to document
Service plans in all Districts aligned to service package	% Institutions providing package according to designated level	30 % Hospitals to deliver service according to their designated level of care by 31/03/04	100 % Institutions have access to agreed upon referral pattern document
To ensure the provision of high quality health care by improving clinical quality			
Establishment of clinical audit committees	% Hospitals with audit and review committees	100 % Institutions to have constituted committees	86 % Institutions have constituted review committees
Accessibility of clinical protocols for level of care	Availability of clinical protocols for commonest conditions	Clinical protocols available for 5 commonest conditions for major disciplines	Paediatric protocols for 5 commonest conditions available to all institutions - EDL has STG for all common conditions for major disciplines and available on intranet
Establishment of sustainable QIP teams	Hospitals with functioning sustainable QIP teams	Results on intranet by 30/06/03	100% Hospitals with viable sustainable QIP Teams. To offer guidance in developing Teams at Managerial, Supervisory and Unit level.
To ensure the provision of high quality health care by improving patient perception			
Implemented complaints procedures	Number of hospitals with existing complaints procedures	100 % Hospitals to have complaints procedures	100% Hospitals have complaints procedure
Establishment of help desks	Number of hospitals with helpdesks	100 % Hospitals to have help desks	85% Hospitals have help desks. 15% to be established in the coming year
Establishment of call/ info centres	Number of calls received through call centre	Functional provincial call/ info centre	Unable to establish call centres in this financial year due to logistical and financial problems

Objective	Indicator	Target 2003/3004	Actual Performance
Establishment of patient satisfaction surveys	Number of hospitals with 100 % survey results	100 % Hospitals to conduct surveys	Surveys conducted at 100 % institutions bi-annually. Areas needing attention workshopped at hospitals
Understanding of the Patients' Rights Charter	Patients complaints statistics	100 % Hospitals to understand Patient's Rights Charter	Workshops conducted on human rights with the link to patient rights
Accreditation process	Number of accredited hospitals	100 % Hospitals to obtain provincial accreditation by Sep 2005	58 Hospitals on the COHSASA programme. However funding for progress is a concern as some hospitals have poor physical facilities and therefore do not do well on programme. District Hospitals will be placed on National Quality Standards programme instead
To reduce morbidity and mortality			
Ensure maintenance of existing sites and increase availability of VCT	Number of VCT sites in hospitals	VCT sites in all hospitals and rollout to CHC's	VCT available at more than 80% of institutions. Less than 20% institutions have zero VCT. Situational analysis completed and forwarded to PAAU
Ensure implementation of treatment protocols	%age hospitals with availability of protocols	Protocols available to 100 % of hospitals	Protocols were circulated to Clinical Directors
Ensure provision of step-down beds as per SPS	Number of step-downs beds /facilities	50 % District Hospitals to have step-down beds by 2003	Target not met. 1 Step-down facility at Dream Centre was subsidised in 2003/04
Strengthen and sustain Diflucan programme and rollout to CHC's	Number of hospitals with Diflucan	100 % availability within hospitals and 50 % CHC's	100% availability at all hospitals. Rollout to CHC's still under consideration. Extended to NGO's
Proper occupational exposure management	Number of hospitals with protocols/procedures in place for management of exposure	100 % Hospitals and CHC's	Situational analysis completed. 100% of hospitals, CHC's have protocols in place
Laise with EAP structures for support of HCW's infected and affected by HIV/AIDS	Number of hospitals with support structures	100 % Hospitals	EAP rollout continuing. 100% of hospitals have EAP structure in place. Proposal submitted for expansion of basic service

Objective	Indicator	Target 2003/3004	Actual Performance
Ensure "best practice" with regards to treatment of patients with HIV/AIDS	Number of HCW's trained	50 % HCW's (with specific reference to those treating patients with HIV/AIDS attending one workshop by end of 2003)	One 3-day seminar and 5 1-day seminars held in the Province. More than 50% of health care workers attended. Training programme ongoing
Ensure high quality care of patients	Implementation of quality measurement tools at pilot sites	Complete pilot sample analysis by Dec 2003	Pilot study completed. Report forwarded to QAAU
Monitor new developments in clinical management	Number of meetings with clinical advisory group	All institutions to be advised of new developments	CAG established with input into protocols. Group disbanded through poor participation
Prevent discrimination against HIV/AIDS patients	Number of HCW's trained	25 % HCW to attend one workshop per region	One workshop held in Durban functional region. Discussions held with International Association for Physicians in Aids Care (IAPAC) to increase coverage
Ensure availability of MDR beds for TB	Burden of TB disease, number of MDR TB cases as per TB register, smear conversion rates, treatment adherence rate, cure rate, incidence and prevalence data	Reduce incidence of MDR TB < 5 %, cure rate of 85 %	Initial situational analysis of availability and evaluation of different types of treatment undertaken. Data supplied from Institutional Support Services in terms of beds available and recommendations of SPS Report forwarded to Communicable Diseases Directorate for Completion of protocols in line with National TB Control Programme
To reduce morbidity and mortality through support			
MCWH programme	Ascertain maternal mortality rate and perinatal mortality rate for each institution	Maternal mortality and perinatal mortality rates completed and available for 100 % institutions	Peri-natal mortality rates available for 95 % institutions. 69 % institutions have ascertained maternal mortality rates
Increase number of hospitals providing TOP services	Number of available TOP sites	All institutions to be able to support TOP service	12 institutions currently providing TOP services

Objective	Indicator	Target 2003/3004	Actual Performance
To reduce morbidity and mortality through effective management of trauma			
Ensure availability of crisis centres at each District	Number of Districts with crisis centres	100% Availability & accessibility by 31/03/04	100% achieved. Each District has a functional crisis centre
Ensure PEP programme availability at hospitals and clinics	%age hospitals with PEP distribution	100 % PEP availability at all institutions	100 % PEP availability at all institutions for rape/sexual abuse victims and health care workers
Effective management of emerging epidemics	%age hospitals under surveillance	100 % Hospitals covered	100% Hospitals have established surveillance systems for emerging epidemics
Management of chronic diseases	%age hospitals with guidelines	100 % Hospitals to have guidelines/protocols	100 % Hospitals have access to available guidelines on the intranet
Management of other communicable diseases	%age hospitals with guidelines	100 % Hospitals to have guidelines/protocols	100 % Hospitals have access to available guidelines on the intranet
To ensure adequate governance of health institutions			
Ensure good governance	%age hospitals with access to BAS, % hospitals with monthly budget reports	100 % hospital management trained by March 2004	100% hospitals trained on BAS and have monthly reports available
Establishment of Hospital Boards	Number of hospitals with established Hositals Boards	100 % Hospitals to have board by March 2004	86% of hospitals have Hospital Boards, with varying levels of functionality
Decentralisation of hospital management (PMA service level agreements)	%age Delegation for hospital managers	100 % Decentralisation of hospital management by March 2004	100 % hospital managers now have delegation in HR and Finance issues as per regulations
Adherence to Batho Pele principles	% Compliance to checklist	100 % compliance by 31/03/04	80% compliance. Training in view of 3 additional principles to be initiated
To ensure equitable distribution of health resources			
Improving health technology	Number of hospitals with equipment plans	All hospitals by 31/03/04	All hospitals have completed equipment audits and have identified needs for equipment

Objective	Indicator	Target 2003/3004	Actual Performance
To ensure revitalisation of hospital services			
Ensuring clean and safe hospital grounds	100 % Hospitals with accreditation on this element	100 % Hospitals complying with standards for clean, safe environment	80% Hospitals complying with standards for clean safe environment. Monitoring & guidance continued
Ensure physical facilities upgrading	% Hospitals with plans	100% Hospitals have 5-year physical facility upgrade plans	100 % Hospitals have approved master plans
Ensure establishment of health and safety committees	% Hospitals with established committees	100 % Hospitals with established committees	75% Hospitals with established committees

ORAL AND DENTAL TRAINING HOSPITAL SERVICES

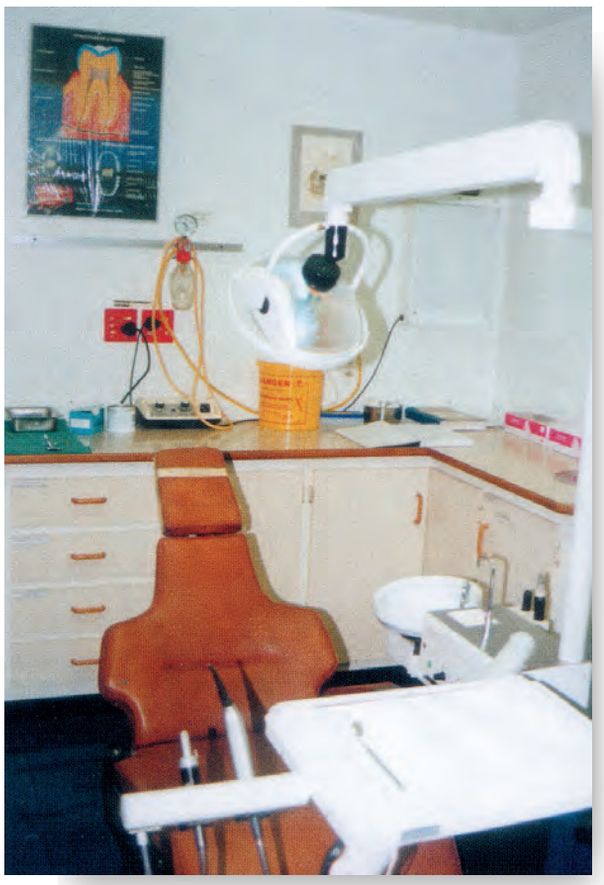
AIM

The main objectives of the Oral and Dental Training Hospital is to increase the number of dentists in the Province, enhance the dental services within the outreach programmes and to ensure improved oral health through the health education and promotion programmes of the Department.

ANALYTIC REVIEW

In line with the objectives set, the service was able to attend to a total of 53 083 patients during the last financial year. These patients were provided with services covering simple extractions to more complicated procedures involving general anaesthetic and maxillo-facial surgery. In addition the Department also provided dental services to the Department of Correctional Services in terms of which a total of 35 patients were seen. The Oral and Dental Training Hospital is the only centre in the Province that provides orthodontic (straightening of teeth using braces) and endodontic (root canal) treatment for school going children including the physically and mentally challenged pupils. The hospital also provides prosthodontic services (dentures and prosthesis) for pensioners and mentally handicapped patients.

With regard to the provision of Oral and dental training, a total of 73 students qualified as dental therapists and oral hygienists. Whist the Hospital does not train dentists, the need to do this in the Province has been identified and is currently being conceptualised. One of the major challenges facing the Hospital is the ability to increase capacity, which will allow for enhanced dental services throughout the Province.



Dental facility

Programme Performance

Objective	Indicator	Target 2003/3004	Actual Performance
Oral and Dental Training Hospital Services			
Increase the number of Dental Therapists and Oral Hygienists in the Province	No. of students qualifying	75 students	73 Students qualified. A total of 3 750 patients were attended to by students in training
Increase services through the outreach programmes	No. of patients attended to	All centres in all Districts	A total of 6 864 patients were treated in 14 out of 27 centres
Increase in oral health education and promotion	No. of patients visited and attended to	All centres in the Districts	16 795 Patients screened and provided with oral hygiene education in 27 centres. Also adapted toothbrushes for the mentally handicapped patients on an individual basis
Increase in service delivery in the Oral and Dental Training Hospital	No. of patients attended to Types of procedures carried out	All patients requiring dental treatment within the range of services available	A total of 53 083 patients were attended to including: X-rays – 2 477 Amalgams – 355 Extractions – 11 968 Dentures – 203 Root canals – 167 General anaesthetic – 437 Composite – 745 Periodontic – 150 Minor surgery – 711 Community – 2 185 Prevention – 1 314 Maxillo-facial surgery – 551 Temporary fillings – 715

Table 19: Regional, Psychiatric and Tuberculosis and Dental Training Hospitals

Indicator	Type	Actual 2001/2002	Actual 2002/2003	Actual 2003/2004	Strat Plan Target 2003/2004
Input					
Expenditure on hospital staff as percentage of total hospital expenditure (Regional)	%	74.44	68.11	68.28	-
Expenditure on drugs for hospital use as percentage of total hospital expenditure (Regional)	%	7.23	8.47	8.31	-
Hospital expenditure per uninsured person (Regional)	R	197.04	191.74	232.86	-
Expenditure on hospital staff as percentage of total hospital expenditure (Psychiatric)	%	70.19	65.38	66.48	-
Expenditure on drugs for hospital use as percentage of total hospital expenditure (Psychiatric)	%	1.07	1.69	3.39	-
Hospital expenditure per uninsured person (Psychiatric)	R	26.43	25.53	30.10	-
Expenditure on hospital staff as percentage of total hospital expenditure (Tuberculosis)	%	52.78	59.93	52.56	-
Expenditure on drugs for hospital use as percentage of total hospital expenditure (Tuberculosis)	%	2.10	5.29	6.99	-
Hospital expenditure per uninsured person (Tuberculosis)	R	17.43	31.72	29.25	-
Expenditure on hospital staff as percentage of total hospital expenditure (Medical Chronic Hospital)	%	86.44	75.42	76.64	-
Expenditure on drugs for hospital use as percentage of total hospital expenditure (Medical Chronic Hospital)	%	2.29	3.85	8.02	-
Hospital expenditure per uninsured person (Medical Chronic Hospital)	R	1.84	7.60	6.26	-
Expenditure on hospital staff as percentage of total hospital expenditure (Dental Training Hospital)	%	82.06	87.74	88.90	-
Expenditure on drugs for hospital use as percentage of total hospital expenditure (Dental Training Hospital)	%	0.93	0.55	0.79	-
Hospital expenditure per uninsured person (Dental Training Hospital)	R	0.87	0.81	0.85	-
Useable beds (Regional)	No.	6 590	6 811	6 594	4 194
Useable beds (Psychiatric)	No.	3 661	3 775	3 486	-
Useable beds (Tuberculosis)	No.	2 182	2 422	2 364	-
Process					
Hospitals with operational hospital board	%	-	-	87	100
Regional Hospitals with appointed (not acting) CEO in place	%	-	-	66.6	100
Facility data timeliness rate (Regional)	%	100	100	100	-
Facility data timeliness rate (Psychiatric)	%	100	100	100	-
Facility data timeliness rate (Tuberculosis)	%	100	100	100	-
Output					
Caesarean rate	%	25	26	25	-
Quality					
Hospitals with a published nationally mandated patient satisfaction survey in last 12 months	%	-	-	100	-
Hospitals with clinical audit (M+M) meetings at least once a month	%	-	-	85	-

Note: *Figures for useable beds have not been provided for the Dental Training Hospital, as there are no useable beds as the patients are classified only as day patients.*

QUALITY ASSURANCE AND ACCREDITATION

AIM

The aim of the unit is to assist hospitals set standards and maintain quality care in line with the prescribed norms, standards and protocols, ensure quality improvement in hospitals and to evaluate and recognise service excellence. In addition the unit is involved in ensuring that the physical environment of the hospitals is clean and poses no safety hazards to the patients and staff.

ANALYTIC REVIEW

During the year under review the QA&A unit provided support to 15 hospitals that were in the process of finalising their COHSASA accreditation programme. In terms of the 3rd phase of the accreditation programme, to date the Department has 1 fully accredited hospital, namely, Stanger Hospital, 6 hospitals that have reached pre-accreditation, intermediate level, 2 hospitals with pre-accreditation, entry-level and 1 hospital awaiting results. Two other hospitals are in the final stage of external survey and will achieve full accreditation shortly. Two psychiatric hospitals have retained their full accreditation status during 2003.

It must be mentioned that one of our hospitals, namely Murchison, received the Premier's Good Governance Gold award for Service Excellence.

To further ensure that the health and safety standards are adhered to, there has been an increase in such standards from 50 to 75%. An improvement was also made with regard to the in-service training of staff and the proper keeping of patient records. The year under review also saw a marked improvement of 30% in the hygiene and cleanliness of our hospitals, with a 50% improvement in access to health facilities, namely, access ramps, parking for the disabled and ablution facilities.

The main challenge during the year was trying to create a balance between the needs of the patient and the community and the capacity in the health facilities to ensure these optimally.

Accreditation Awards

Programme Performance

Objective	Indicator	Target 2003/3004	Actual Performance
Quality Assurance and Accreditation Unit			
To ensure provision of high quality care through continuous Quality Improvement Program To Improve Quality Service Delivery through the COHSASA Program	No. of Quality Improvement Committees at hospitals	80% out of 63 hospitals	50% of QI Committees established. The erratic turnover of staff contributed to the delay in establishing all the committees
To strengthen Quality Service Delivery through Batho Pele & Health and Human Rights	No. of hospitals that received accreditation	15 hospitals that were in the final stage of accreditation	1 Hospital – fully accredited 6 pre-accreditation-intermediate level 2 pre-accreditation – entry level 2 finalising focus surveys 1 awaiting results 3 hospitals nearing the final stage of the programme
	Level of improved access to services	85% of all hospitals	70% achieved. Other hospitals presently on the revitalisation programme Access ramps and parking have been installed for the disabled Ablution facilities have been improved to allow access for the disabled

CENTRAL HOSPITAL SERVICES

The aim of this Programme is to:

- provide a highly specialised level of health care; and
- serve as a forum for the training of medical specialists in accordance with the referral pathway.

ANALYTIC REVIEW

During the past year, Inkosi Albert Luthuli Central Hospital has taken great strides towards achieving its mission of "world-class tertiary and central hospital services through the provision of state of the art facilities and services provided by trained and competent people working together, always putting the needs of patients first."

Based on the national requirement of 2 055 central beds, the hospital will have 685 central beds (one-third) by 2010. The remaining beds will be utilised for tertiary services. In line with the health care referral system, the hospital accepts referrals from all Provincial Regional Hospitals in KwaZulu-Natal. In addition the hospital also accepts referrals from the Eastern Cape.

The successful transfer of services from hospitals such as King Edward VIII, Wentworth and Addington hospitals was completed in October 2003. The first kidney transplant in the Public Service after 3 years of buying out from the private sector was performed on 2nd December 2003. This will increase the value derived from the limited state resources. The commissioning of new services that include Red Code Trauma, Burns and Assisted Reproduction has been delayed due to shortage of medical professionals in the labour market that is gripping the whole country. Strategies are however being embarked upon for employing attractive recruitment approaches.

The process of decentralising the financial, procurement and human resource management functions to the various responsibility centres in accordance with the Department's overall decentralisation policies has been completed. However, there was still a need to build capacity at all levels of management.

The Hospital was enrolled for the COHSASA accreditation programme. 98% of the elements have achieved 90% compliance with the COHSASA quality standards. Various initiatives are still under way to ensure 100% compliance.

The number of commissioned beds was increased from 406 in 2003 to 779 by the end of the financial year – thus leaving 67 more to reach the targeted 846 beds. Most outpatient clinics were operating at full capacity. The non-commissioning of tertiary services at Grey's Hospital resulted in some clinics exceeding their planned capacity.

A general management system was introduced in the hospital to integrate management and also enable decentralisation within the hospital. This system was based on cost centres and functional units. Each cost centre had a single focus of authority and significant managerial authority, which included own budget, staff and other resources. Proper management structures, called Domain Management Teams (DMT), involving clinicians, have been put in place.

Whilst striving to achieve world-class tertiary and central hospital services, the hospital was faced with many challenges. The commissioning process has been hindered by the shortage of skilled professionals, mainly in the medical and nursing fields.

Table 20: Performance Against Targets from the 2003/2004 Strategic Plan for the Central Hospital Services Programme

Objective	Indicator	Actual 2001/2002	Actual 2002/2003	Actual 2003/2004	Strat Plan Target 2003/2004
Complete commissioning	Total number of beds commissioned	0	406	779	846
Develop management capacity for devolution	Total percentage of Managers trained	1%	6%	15%	40%
	Number of Middle Managers who have completed the management training pack	0	0	17	46
Fill vacant posts	Increase in no. of posts filled	0	1 034	1 844	2 000
Improve client satisfaction	Global quality	0	75%	80%	90%
	Process quality	0	60%	70%	85%
	Unit-Based care	0	65%	80%	90%
	Physician care	0	60%	78%	80%
	Support Services	0	75%	80%	98%
	Outcomes of care	0	75%	90%	95%
Develop relationship with other stakeholders	Hospital Board	0	0	0	1
	Increase in partnerships with tertiary institutions	0	0	50%	60%
	Increase in participation in health care forums	0	80%	90%	100%
	Increase in meetings with other provincial hospitals	60%	80%	90%	100%
Maximize value for money	Decrease in unit cost performance	0	0	-5%	-2%
	Decrease in days in inventory	0	0	90.86	75
Improve Organisational Management	Staff attrition rate	0	2.6%	3.1%	4.1%
	Management Structure alignment	0	50%	70%	100%
Improve clinical utilization	Decrease in average length of stay	0	13	11	7
	Decrease in re-admission rate	0	0	25%	18%
	Decrease in complication rate	0	0	15%	10%
	Decrease in hospital acquired infections	0	0	15%	12%

TERTIARY LEVEL GRANT

The purpose of the tertiary care service grant is to finance highly specialised medical services that are rendered at hospitals in the Province. The grant provides a welcome relief on the provincial budget in that these highly expensive medical services are not funded from the Department's equitable share. Whilst this is so, the grant is insufficient when compared to the expenditure incurred in this area. However, during the past year, the tertiary grant was utilised in 11 hospitals in the Province. These decentralised sites have had a positive impact on the access to tertiary care especially in the areas outside the eThekwini Metro.

Table 21(a): Tertiary Hospital Services

Indicator	Type	Actual 2001/2002	Actual 2002/2003	Actual 2003/2004	Strat Plan Target 2003/2004
Input					
Expenditure on hospital staff as percentage of total hospital expenditure	%	64.75	38.67	31.73	-
Expenditure on drugs for hospital use as percentage of total hospital expenditure	%	5.80	4.93	5.62	-
Hospital expenditure per uninsured person	R	53.65	80.04	64.46	-
Useable beds	No.	2 084	2 913	2 074	-
Process					
Hospitals with operational hospital board	%	100	50	50	-
Hospitals with appointed (not acting) CEO in place	%	-	-	50	-
Facility data timeliness rate	%	100	100	100	-
Output					
Caesarean section rate	%	42	45	39	-
Quality					
Hospitals with a published mandated patient satisfaction survey in last 12 months	%	100	100	100	-
Hospitals with clinical audit (M&M) meetings at least once a month	%	100	100	100	-
Efficiency					
Average length of stay	Days	7	9	7	-
Bed utilisation rate (based on useable beds)	%	66	53	70	-
Expenditure per patient day equivalent	R	1 018	1 677	2 103	-
Outcome					
Case fatality rate for surgery separations	%	-	-	6.3	-
Service volumes					
Separations	No.	77 195	66 016	56 156	-
OPD headcounts	No.	399 273	417 203	313 678	-
Day cases (= 1 separation = _ IPD)	No.	-	76	127	-
Casualty headcount	No.	50 791	46 420	38 694	-
PDE's	No.	703 144	469 085	405 115	-

Table 21(b): Central Hospital Services

Indicator	Type	Actual 2001/2002	Actual 2002/2003	Actual 2003/2004	Strat Plan Target 2003/2004
Input					
Expenditure on hospital staff as percentage of total hospital expenditure	%	21.83	7.89	20.73	31.9
Expenditure on drugs for hospital use as percentage of total hospital expenditure	%	0	2.32	3.56	3.72
Useable beds per 1 000 people	No.	0	406	779	846
Hospital expenditure per uninsured person	R	0	2 882	4 452	4 719
Process					
Hospitals with operational hospital board	%	0	0	0	100
Hospitals with appointed (not acting) CEO in place	%	100	100	0*	100
Facility data timeliness rate	%	0	100	100	100
Output					
Caesarean section rate	%	0	0	33	30
Quality					
Hospitals with a published nationally mandated patient satisfaction survey in last 12 months	%	0	0	0	0
Hospitals with clinical audit (M&M) meetings at least once a month	%	0	100	100	100
Efficiency					
Average length of stay	Days	0	3	3	3
Bed utilisation rate (based on useable beds)	%	0	48	55.6	80
Expenditure per patient day equivalent	R	0	4 884	4 628	2 410
Outcome					
Case fatality rate for surgery separations	%	0	6.07	7.3	6.9
Service volumes					
Separations	No.	0	2 803	15 151	20 420
OPD headcounts	No.	0	20 831	115 631	100 000
Day cases (=1 separation = ½ IPD)	No.	0	0	0	0
Casualty headcount	No.	0	0	0	0
PDE's	No.	0	10 011	52 635	115 677

* Acting CEO since 01/08/2003

HEALTH SCIENCES AND TRAINING

AIM

To provide for a co-ordinated and focused management of human resource development within the Department of Health, KwaZulu-Natal.

ANALYTIC REVIEW

This Programme consists of five sub-programmes, namely:

- Nurse training
- Emergency Medical Rescue Services training
- Bursaries
- Primary Health Care training
- Training Other

One of the key focus areas during the last year was the awarding of bursaries to previously disadvantaged individuals especially from rural areas. As part of its retention and recruitment strategy, the Department profiled its scare skills needs in both the urban and rural areas and granted bursaries to local students accordingly. In line with this strategy a total of 277 new bursaries were awarded to both rural and urban students bringing the total to 709 bursary holders. It must be noted that the process of selection for bursaries included the various stakeholders, amongst others, the community leaders, who played a vital role in the verification process, thus ensuring that members in their communities were considered for such bursaries. The rationale behind this initiative was to ensure that once the students qualify in their chosen field of study, they revert to their own communities to provide services and they are back home with their families thus eliminating any undue hardships.

The major challenge that was faced with regard to human resource development was the area of central selection of nurses for training. This was mainly with regard to the location of training facilities, which led to resistance from the local communities who felt that only members of their own community should attend these training facilities. The facilities were expected to provide training for the entire District and not just the area where it is located. The Department subsequently embarked on a series of negotiations with the relevant stakeholders as a result of which there was more acceptance of the concept and of the central selection process.

Based on the above the following synopsis is provided, highlighting the achievements for the period under review.

NURSING EDUCATION

- Doubling of Nurse Intake

Based on the decision taken in previous years, the doubling of nurse intake numbers were maintained for the 2003/2004 period. As a result of this a total of 2 137 students were admitted for nurse training. In addition to this, 368 students were enrolled for the bridging course against a target of 413. As a result of nurse training, 1 119 basic nurse training graduates and 307 post-basic graduates qualified. The challenges faced during the year were those of attrition due to death of students and the failure rate.

- Implementation of Nurse Training Contracts

During the reporting period, students undertaking nurse training signed a total of 1 036 study leave contracts. This showed an increase of 9,6% was achieved against the target for the year. The study leave contract also ensured that the attrition rate was kept to a minimum, that is 2,5%, the majority of which were due to death or failure to pass the examinations.

- Central Selection for Admission to all Basic Nurse Training Programmes

The Central Selection Policy was reviewed in order to ensure that it remained up to date and was also responsive to the needs of the Department. Although the target for the year was 1 464, a total of 1 389 students were centrally selected in terms of the revised policy.

- Career Pathing for Nurses

The recognition of prior learning policy was developed and was ready for implementation in the 2004 academic year.

- Amalgamation and Rationalization of Nursing Education

Based on the establishment of the KwaZulu-Natal College of Nursing, which commenced in 2002, the amalgamation and rationalization of nursing education was close to finalisation by the end of the reporting period. The new organizational structure of the KZN College of Nursing has been developed and is awaiting approval of the South African Nursing Council and will be implemented in the next academic year.

PRIMARY HEALTH CARE

Primary Health Care Nurse training was provided for 246 nurses at the University of Natal and the Natal Institute of Nursing at a cost of R1 936 000. A new task team has been formulated for PHC with the aim of integrating PHC training in KZN. The team is actively compiling educational material for health professionals in PHC services. District training plans have been formulated to analyze the training and education programmes in terms of the District needs and priorities. It is also to determine the role of Provincial Human Resource Development in this process. In this regard road shows have been carried out in the Districts. All Districts have a monitoring and reporting system in place to ensure that the objectives of this plan are met.

- Training Programmes for PHC Workers

Training has been conducted in the following areas:

- Integrated Management of Childhood Illnesses (IMCI)
- Sexually Transmitted Infections (STI's)
- Community facilitation course – to ensure successful community entry by health professionals
- Vitamin A supplementation
- Growth monitoring
- Chronic diseases
- Expanded Programme of Immunization (EPI) – Primary Medical Skills

- Recognition of Prior Learning

This concept has been tested using the current in-service package, against the Primary Health Care Diploma. As a result of this concept 20 candidates were granted the Primary Health Care Diploma. This will prove to be an important source of career pathing and recognition of relevant work experience, which aligns with the ethos of the National Qualifications Framework.

SKILLS DEVELOPMENT & CAPACITY BUILDING

- Implementation of the Work Place Skills Plan

The Workplace Skills Plan was approved and implementation commenced in all Districts. Visits to all Districts took place during the year, in order to ensure that the Workplace Skills Plan was being implemented. This was important as the Skills Development Fund was devolved to the Districts to enhance accessibility to training.

- Skills Development Core and Non-Core Functions

The policy mandate in respect of the above is the Skills Development Act. In this regard 60 Skills Development Facilitators were trained in 2003 at a cost of R90 000-00 and 35 National Qualification Framework Level 2-3 employees commenced Matriculation classes on a part-time basis and 9 are bridging between ABET and Matric, at a cost of R69 800-00.

ABET Award Function

- Computer Training

The Department entered into a Service Level Agreement with State Informatics Technology Agent (SITA) in 2003 for 2 years. SITA trained employees on all computer packages at a cost of R480 000-00 per annum. To date 107 employees have been trained.

- Management Training

Three Managers were trained in IPSP Presidential Leadership Programme, additionally 30 attended Advanced Management Development Programme (AMDP) and 29 attended the Emerging Management Development Programme (EMDP), which were co-ordinated by SAMDI (South African Management Development Institute) and funded by the European Union. A total of 64 Managers attended Discipline and Grievance courses and 29 Managers attended Diversity Management, both of which were offered by the Office of the Premier.

BURSARIES

- Bursary Database

There are currently 20 Universities/Technikons that are on the Department of Health's Bursary database catering for 15 different Health Sciences-related fields, which are funded by the Department of Health.

- KZN Department of Health Bursary Allocation

The cumulative total of bursary holders for the year 2003 was 709. However a total of 277 new Bursaries were awarded for 2003/2004. The total costs for bursaries granted in the last financial year amounted to R31 905 000.00 and included the bursaries in the following categories:

- 288 MBChB students
- 47 B Pharmacy students
- 28 Bachelor of Radiography
- 25 Dentistry students
- 37 B Cur students
- 19 B Occupational Therapy students
- 22 Biomedical Technology
- 11 BSC Dietetics
- 34 Environmental Health
- 7 Medical Technology
- 25 Speech and Hearing
- 21 Physiotherapy
- 6 Dental Therapy

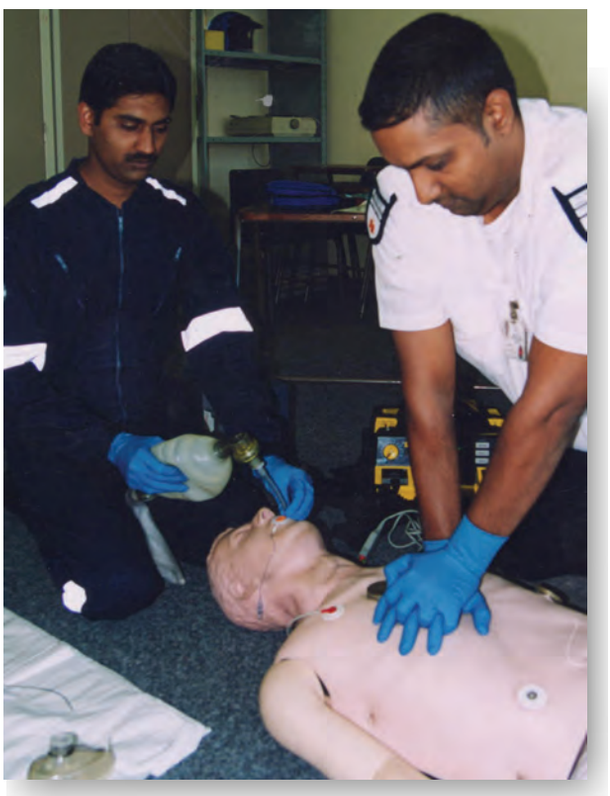
Note: The total number of bursaries in terms of the above categories is 570 and differs from the cumulative total recorded above. This is due to the difference between the academic year total and the financial year total.

Cuban Medical Programme

Whilst a total of 89 students are presently studying medicine in Cuba, due to financial constraints, the Department did not send any new students to Cuba during the last academic year.

EMRS Training

The College of Emergency Care (COEC) continued to provide training in Intermediate Life Support, Advanced Life Support and Rescue Training. While the COEC was involved in a process of transformation, the formal courses continued and this ensured that qualified personnel were available to be deployed in areas of need. Transformation included the decentralisation of the EMRS training to district level for those courses that could be run on an ongoing basis, for example, update/refresher courses and the driver training courses. During 2003 the Emergency Despatch Course was offered for the first time, in terms of which a total of 89 out of 179 staff employed in control rooms were trained. This ensured that skills were developed in dealing with the public when receiving calls for assistance and also provided technical skills with regard to two-way radio communication.



EMRS Training

Table 23: Programme Performance

Objective	Indicator	Target 2003/3004	Actual Performance
Human Resource Development			
Develop and implement HRD policies and systems to ensure effective HRD practices	Input: Central selection for nurse training implemented by all nursing campuses	100%	790 (100%) of nurses centrally selected for all Basic Programmes
	Fixed term contract for new nursing recruits developed and implemented	1 464	1 389 fixed term contracts signed
	No. of study leave contract for nurses signed in 2003	936	748 study leave contracts signed
	Development of a uniform nursing curriculum for the Province of KwaZulu-Natal	Implemented 1 January 2004	Awaiting SANC accreditation
	Recognition of prior learning policy development	Implement 2004	Policy not yet implemented
	Process: Improved selection procedure of student nurse intake	2003 Academic Year	Central Selection Policy revised
	Output: Number of centrally selected students	1 464	1 389 centrally selected students
	Quality: Attrition rate of nurses after implementation of contractual obligations	0.5% due to death/failure	2.5% due to death/failure
Provide for the cost –effective training of nurses to meet the service needs of the Department	Input: Numbers: intake of students (basic and post basic nursing admitted to nurse training)	2 829	2 137 students admitted to nurse training
Strategy: Identify formal training needs for nurse training at basic and post basic level. Quantify the numbers and categories of nurses to be trained annually, based on service delivery needs and priorities	Bridging Nurse training (ENA to EN to RN)	413	368 Bridging course students enrolled
	Basic Nurse Training	1 464	1 473 Basic Nurse training students
	Post basic Nurse Training	470	449 post basic students
	Primary Health Care Training	604 (cumulative) 250 for the year	626 PHC Nurses trained

Objective	Indicator	Target 2003/3004	Actual Performance
	Process: Improved selection procedure of student nurse intake		
A combination of in-house training at the KZN nursing schools and colleges and sponsorship of university training provided through bursaries. Monitor and evaluate nurse training programmes	Output: Numbers of graduates: basic	1 029	1 119 basic graduates
	Numbers of graduates: post-basic	410	307 post-basic graduates
	Quality: Attrition rates per year	0.5% to death/failure	2.5% due to death/failure
	Percentage of first year entrants who graduate from formal training courses	99.5%	97.5% pass rate. Attrition mainly due to death
	Efficiency: Average training cost per graduate Bridging Nurse Training	R110 000	R110 000
	Basic Nurse Training	R62 000	R62 000
	Post Basic Nurse Training (inclusive of salaries)	R140 000	R140 000
	Outcome: Percentage of graduate nurses in a Public Service post within 3 months of successful completion of basic nurse training programmes	100%	100%
Ensure appropriate development of human resources to support health service delivery	Input: Numbers in intake of students in tertiary institutions	600	709 students receiving DOH bursaries
	Students at Cuba	89	89 PDI's currently studying in Cuba
	Process: Improved representation of PDI students in intake	African: 82% Indian: 9% White: 7% Coloured: 1%	African: 75% Indian: 18% White: 6% Coloured: 0.6%
Strategy: Identify formal training needs for health professional training. Quantify the numbers and categories of health professionals to be trained annually based on service needs	Output: Numbers of Health science graduates	200	158 Health Science graduates (79%)
	Quality: Attrition rates per year of health science formal training courses.	0.5% due to death/failure	1% due to death/failure

Objective	Indicator	Target 2003/3004	Actual Performance
Assess skills gaps by comparing skills required with skills available. Provide training, bursaries and learnerships to address skills gaps, needs and priorities. Monitor and evaluate the training and allocation of bursaries and learnerships	Percentage of graduates per year of formal training courses	95%	96% pass rate
	Efficiency: Average bursary cost per graduate	R50 000 pa	R47 000 pa
	Percentage of graduating health professionals in a Public Service post within 3 months of graduation.		86% (38 of 44 placed)
	Percentage of graduating doctors in a Public Service post within 3 months of graduation		31.6% (12 of 48 Dr's placed) Recovery of debt processes instituted
Facilitate, co-ordinate, support, guide and monitor the implementation of the Departmental Workplace Skills Plan for the training and development of personnel within the Department	Input: Number of centrally co-ordinated training opportunities for personnel	8 179	10 927 training interventions conducted
	Process: Improved representation of HDI's in intake	African: 82% Indian: 9% White: 7% Coloured: 1%	African: 80% Indian: 13% White: 4% Coloured: 1%
Identify functional training needs for health personnel and quantify the numbers and categories of health personnel to be trained annually, based on service needs	Output: Numbers of Personnel trained	8 179	10 927 personnel trained
	Efficiency: Average training cost per individual	R2 300	Average cost of R820 per person trained
	Outcome: Number of personnel trained % of need	90% (8 179)	134% (10 927)
Identify management training needs for health management at senior, middle and lower levels; quantify the numbers and categories of health management to be trained annually, based on service needs and priorities	Input: Number of opportunities for managers (courses)	50	59 training opportunities for managers
	Process: Improved representation of HDI's in intake	African: 82% Indian: 9% White: 7% Coloured: 1%	African: 61% Indian: 32% White: 5% Coloured: 2%
Compare skills required with skills available. Provide training to address management skills needs	Output: Number of managers trained	1 800	621 managers trained
	Efficiency: Average training cost per manager	R3 600	Average cost of R820 per person trained

Objective	Indicator	Target 2003/3004	Actual Performance
Monitor and evaluate the management training programmes	Outcome: Target population of personnel requiring management training as at 2002 year. Number of managers trained, % of need	Nil	35%
Identify Adult Basic Education and Training (ABET) training needs for all categories of health personnel to be trained annually, based on service needs	Input: Numbers of ABET training interventions for personnel	1 930	1 773 ABET training interventions
	Process: Improved representation of HDI's in intake	100%	100%
Provide ABET training to address ABET needs. Monitor and evaluate the ABET programme	Output: Numbers of personnel trained	1 930	1 773 personnel trained. Tutor attrition impacted on training
	Efficiency: Average training cost per individual	Volunteers utilised – no cost	Nil
	Outcome: Target population of personnel requiring ABET as at 2003 year. Number of personnel trained in ABET. % of need	90% of 1 930	92% achieved (1 773)
EMRS TRAINING			
Increase the intake for Intermediate Life Support Training	No. of ILS trained	160 staff	73 ILS trained – College of Emergency Care allowed for 6 courses for the year, thus only 120 candidates could be targeted. Pass rate represents 60% which is consistent with this type of training
Intensify driver training techniques courses and decentralise it to the Districts	%age of EMRS vehicles involved in accidents	Reduce to less than 36% based on previous year's baseline	38% of EMRS vehicles involved in collisions
Provide Advanced Life Support training to areas of need	No. of ALS personnel trained	16 staff	20 staff trained in ALS

Table 24: Health Professionals Training and Development Grant

	Type	Actual 2001/2002	Actual 2002/2003	Actual 2003/2004	Strat Plan Target 2003/ 2004
INPUT					
Intake of medical students	No.	310	338	402	402
Intake of nurse students	No.	88	119	51	120
Students with bursaries from the Province	No.	328	457	453	522
PROCESS					
Attrition rates in first year of medical school	%	0.32	0	0	0
Attrition rates in first year of nursing school	%	0.4	0.4	0.4	0.4
OUTPUT					
Basic medical students graduating	No.	55	80	79	79
Basic nurse students graduating	No.	25	15	22	24
Medical registrars graduating **	No.	0	0	0	0
Advanced nurse students graduating	No.	276	373	384	409
EFFICIENCY					
Average training cost per nursing graduate	R	22 000	28 000	34 000	50 000
Development component of HPT & D grant spent	%	Nil*	Nil*	Nil*	Nil*

* *Total costs for training and development of medical and nursing students are met from Departmental budget and not from the HPT & D grant.*

** *Medical Registrars are not granted bursaries for their studies.*

Table 25: Human Resource Management

	Type	Actual 2001/2002	Actual 2002/2003	Actual 2003/2004	Strat Plan Target 2003/2004
INPUT					
Medical Officers per 1 000 people	No.	1.2	1.5	.9	1.6
Medical Officers per 1 000 people in rural districts	No.	.12	.12	.12	1
Nurses per 1 000 people	No.	9.1	9.2	0.5	11.9
Nurses per 1 000 people in rural districts	No.	1.2	1.5	1.8	2
Pharmacists per 1 000 people	No.	.3	.2	.2	.4
Pharmacists per 1 000 people in rural districts	No.	.01	.01	.02	.2
PROCESS					
Vacancy rate for nurses	%	24	21	22	8
Attrition rate for doctors	%	21	20.8	20.4	13.5
Attrition rate for nurses	%	11	10.7	10.5	14
Absenteeism for nurses	%	*	*	*	*
OUTPUT					
Doctors recruited against targets	%	41.9	51.5	55.9	65
Pharmacists recruited against target	%	34.9	34	33	55
Nurses recruited against target	%	10.8	10.2	9.9	60
Community Service doctors retained	%	18.9 (52)	18.1 (44)	32.48 (76)	100
QUALITY					
Facility with employee satisfaction survey	%	30%	40%	40%	50%
EFFICIENCY					
Nurse clinical workload (PHC)	Ratio	1 : 6735	1 : 6651	1 : 7156	2.7
Doctor clinical workload (PHC) **	No.	13 (8)	10 (12)	9 (14)	43 (14)
OUTCOME					
Surplus staff as %age of Establishment	%	0	0	0	0

* *Statistics not recorded for the reporting period*

** *The norm applied for doctors in CHC's is 1 MO in Outpatients Department and 1 MO for maternity services per CHC. As at 31/03/2004 the percentage filled posts was 20.9% in 14 CHC's. The figures in brackets indicate the total number of CHC's in the respective financial years.*

HEALTH CARE SUPPORT SERVICES

The programme deals with the Medicines Trading Account, which is managed by the Provincial Medical Supply Centre.

AIM

The Provincial Medical Supply Centre (PMSC) undertakes the procurement, warehousing and distribution of pharmaceuticals for the Department. It operates on a Trading Account and utilises a computerised stock procurement system (MEDSAS). Distribution is undertaken using the services of a contracted courier company. Deliveries are made to Hospitals, Community Health Centres and PHC Clinics. The project to deliver directly to all PHC clinics is 93% complete.

ANALYTIC REVIEW

Re-packaging of bulk supplies into patient-ready packs for both hospitals and PHC clinics was also undertaken in a strictly controlled environment. Quality of the pharmaceuticals was monitored using the on-site Quality Control Laboratory as well as monitoring results from QC facilities in the Western Cape and Gauteng.

The annual turnover of R579.2 million was an increase of 15% over the previous year and is attributable to increases in contract prices and also to large increase in volume (demand from institutions).

One of the key challenges that was faced during the year was to ensure sufficient stockholding with the available capital. March 2004 saw an increase from R32,2 million to R40 million, which allowed for a decrease in the turnover rate towards a more acceptable and safe level. This is a long-term objective that will be focussed on over the next few years. Sufficient stockholding is also necessary for the absorption of delays in delivery from suppliers thereby reducing stock outs, which would negatively impact on service delivery.

The PMSC was also able to achieve 93% success in the ability to supply requisitioned items with the delay in supplying items that were out of stock reduced to a minimal two weeks in most instances.

During the last year a new project was embarked upon to enable clinics to receive a direct supply from the PMSC instead of from the hospital pharmacy. Good progress was made with the project being 93% complete by the end of the reporting period.

Table 26: Performance against targets for 2003/2004

Objective	Indicator	Target 2003/3004	Actual Performance
Improve ability to cope with supplier stock outs	Adequate Standard Stock Account	R40 million	R40 million achieved in March 2004
Adequate stockholding	Annual Turnover	R590 million	R579 million
Sufficient stock available at end user	Successful first time filling of requisitions	95% of all requisitions filled at time of receipt	93% of requisitions filled on receipt
Direct distribution to all PHC Clinics	Percentage of PHC Clinics receiving direct deliveries from PMSC	All PHC clinics	93% of clinics received direct delivery of medicines

HEALTH FACILITIES MANAGEMENT

AIM

To render an all encompassing service to hospitals and other institutions including but not limited to:

- Maintenance – equipment, engineering installations and buildings
- Planning of new facilities – clinics, Community Health Centres, hospitals, etc
- Replacement Projects for Medical Equipment (MERP)
- Acquisition and disposal of properties – letting and leasing
- Contract administration and project support

ANALYTIC REVIEW

Whilst the Department has made considerable progress with regard to upgrading of health facilities in the Province, a number of challenges prevented the projects being achieved at the expected pace. However, within these challenges and the constraints that were experienced along the way, the successes achieved indicate that rural areas were accommodated and many major improvements were effected.

The health facilities were managed between on-site hospital management and Head Office facilitation. With a few exceptions, each institution has its own workshop to render routine day-to-day maintenance with a basic staff complement to undertake such maintenance. Larger, more complex maintenance and repair work is referred to Head Office for assistance and facilitation.

Mobile Clinic in action

Currently, there is an estimated R2.4 billion backlog of maintenance and rehabilitation of hospital infrastructure. The strategy to overcome this backlog is to maximise the available resources through a combination of in-house and outsourced work.

With reference to the 65 facilities that were subjected to the 1996 National Health Facilities Audit, and the subsequent re-evaluation by the Department in 2000/2001, the following status quo was revealed:

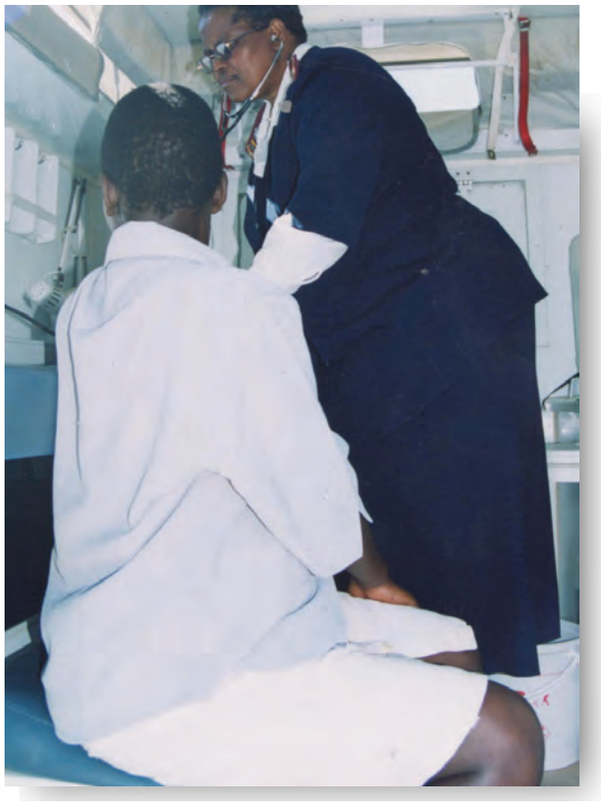
- 14 facilities were down-graded from Category 4 to Category 3;
- 1 facility was down-graded from Category 5 to Category 4;
- 1 facility was up-graded from Category 3 to Category 4;
- all other facilities, which were initially included in the 1996 audit, remained unchanged; and
- 5 new facilities, with a Category 4, were included in the 2000/2001 Departmental Audit.

Major achievements for the 2003/2004 financial year

The Clinic Upgrading & Building Programme facilitated the following major projects during the 2003/2004 financial year:

- Completion of a Community Health Centre at Nseleni funded by the Japanese Government and the construction of a departmentally funded Community Health Centre at Paulpietersberg.
- Completion of two new clinics at Hlabisa and Thembalisizwe funded by UK donors.

- A total of 14 clinics were replaced at Dududu, Mazizini, KwaDukuza, Thembusa, Nondabuya, Isandlwana, Ndumo, Ezipondweni, Molweni, Nellies Farm, Idlebe, Xulu, Matatiele and Mpola.
- Upgrading and building additions such as improved nurses accommodation, gate houses, mothers waiting lodges were completed at the following clinics – Bambanani, Maphephethweni, Maqumbi, Oqaqeni, Xhamini, Matiwaneskop, Mangeni and Masotsheni.
- Completed new standard plans for Community Health Centres for KwaZulu-Natal.
- Completion of standard plans for Health Stations that are to be used by the mobile services and community health workers.
- Clinic Maintenance Projects were ongoing and completed in 2003 as follows:
- Completed a survey of all mobile units in the Province resulting in the replacement of 67 mobile units as well as a second survey for the 2003 – 2004 order list for the replacement of mobile vehicles.
- A total of 10 Clinics and Community Health Centres were officially opened in 2003, namely, Khambi, Thembalesizwe, Zwelisha, Nseleni, KwaDukuza, Mazizini, Busingatha, Baphumile, Ndumo and Maphephethweni.
- The sum of R1 735 266.00 was allocated to projects to upgrade Medical Storerooms at clinics in 2003/2004.
- Continuation of the project to upgrade access roads to clinics.
- Designed facilities for PMTCT and VCT Programmes.
- Completed 90 investigations regarding clinic requests and enquiries received from the community and health professionals.



Patient receiving treatment in mobile clinic

- Projects were commenced in conjunction with the Department of Water Affairs and Forestry to upgrade the toilet facilities available at clinics.

Community Based Projects

97 Clinics spread throughout the Province had services such as cleaning, security and garden maintenance delivered by the community through Clinic Management Committees. The work was cycled through the community and a total sum of R12 million was spent on this. This is a direct poverty alleviation project which occurs on an annual basis.

Conversions to Electricity

To ensure cost effective usage of energy and reduce environmental pollution the programme for conversion from steam boilers to point of use electrical plant was undertaken and a further 3 hospitals were converted

FInancial Year	Total Projects	Total Estimated Value	Completed in 2003/204	Ongoing in 2003/2004
2000-2001	53	R12 504 092.62	1	10
2001-2002	59	R21 571 039.89	16	26
2003-2004	60	R23 141 206.00	0	60

during the 2003/2004 financial year bringing the total conversions to 21, which has resulted in a considerable saving.

Some of the benefits derived from these conversions are as follows:

- Reduced running costs
- Plant not dependent on a single central source of energy supply
- Environmentally more acceptable
- No costly maintenance services as required by the OHS Act.

The table below reflects the savings per annum at those hospitals that have been converted:

Institution	Savings per annum R
Applesbosch	206,328
Bethesda	192,411
Ekombe	380,152
Emmaus	101,030
GJCrookes	216,391
Greytown	595,120
Ladysmith	277,468
Mosvold	115,606
Montebello	77,000
Mseleni	110,340
Nkandla	342,509
Nkonjeni	365,643
Osindisweni	374,298
Port Shepstone	307,236
St Andrews	392,909
St Francis	202,186
Tayler Bequest	281,388
Umgeni	459,549
Wentworth	1,107,220
	R6,104,784

In addition to the above, potential savings amounting to R 3 800 000 can also be made as the result of a saving on Boiler staff salaries where they are deployed to other areas.

Clinic Electrification

After an extensive campaign to provide grid electricity to clinics, 53 clinics have been electrified to date leaving a balance of only 5 clinics to be completed in the 2004/05 financial year. As part of the electrification process, the KwaZulu-Natal Department of Health have contributed 641 kilometers of electrical distribution line to improve the infrastructure of the Province of KwaZulu-Natal.

Provision of Telephones

Following an ongoing drive to improve telephone communication at clinics 114 clinics have now been provided with telephone communication systems, leaving a balance of only 6, which are currently under investigation.

Hospital Revitalisation Programme

The following revitalisation projects have been approved and are funded from a conditional grant:

- The redevelopment of King George V Hospital, which proposes to provide:
  - A TB hospital of 400 beds
  - A District Hospital of 400 beds
  - A psychiatry hospital of 130 beds by refurbishing existing beds and building a new 30 bed closed unit.
- This project is well advanced and has resulted in extensive renovation of this hospital.
- The Department commenced with the planning of two new 300 bed District Hospitals in the Inanda, Ntuzuma, KwaMashu area of the eThekwini District. Once the land is purchased, the building will commence in the 2004/2005 financial year.
- A further project that commenced was the redevelopment of the Ngwelezane and Lower Umfolozi War Memorial Hospitals in Empangeni. These two hospitals will serve as an amalgamated Regional Hospital service that will provide a comprehensive level of care to a vast population in the northeast of KwaZulu-Natal.

Capital Investment, Maintenance and Asset Management Plan

During the 2003/2004 financial year 600 projects to the value of R151 574 713 were undertaken.

In an effort to improve the condition of health facilities 271 major maintenance projects to the value of R35 863 052 were undertaken during the past financial year.

Medical Equipment Replacement Project

A programme of planned replacement of medical equipment started in 1999 with the mandate to replace medical equipment that was due for replacement as a result of old age or poor condition. Over the past year 1185 items to the value of R 36,4 million have been purchased.

The following major items were acquired during the past financial year:

- Mobile C – arm image intensifier for King Edward VIII Hospital at a value of R508 440
- A probe for Madadeni Hospital at a value of R400 000
- A Colour Dopler Ultrasound unit for Prince Mshiyeni Hospital at a value of R499 602
- An Ultrasound Unit for RK Khan Hospital at a value of R400 000
- An MRI scanner for Grey's Hospital at a value of R13,7 million
- A CT scanner for Prince Mshiyeni Hospital at a value of R4,7 million

Major Primary Health Care Facilities Programmes Planned for the 2004/2005 financial year

The Clinic Upgrading & Building Programme have planned the following major projects for the 2004/2005 financial year:

- Completion of 17 new clinics and 14 replacement clinics.
- Completion of 11 additions to existing clinics.
- Plan a further 35 clinic projects to improve access to health care.
- Completion of 4 health stations as a pilot project.
- The planning of 3 new community health centres for the Province at Turton, Ezakheni and KwaMashu.
- Ongoing Clinic Maintenance Programmes.
- Planning of 2004 – 2005 Maintenance Programme.
- Ordering of Mobile Vehicles for 2004 plus new Mobile Survey for the 2005 mobile vehicle replacements.
- Redesign standard plans for Clinics incorporating facilities for new National Programmes.
- Fast track the building of PMTCT Facilities at 13 Hospitals (8 Community Health Centres) for the roll out of the PMTCT Programme.
- In conjunction with The Development Bank and the appointed Research Consortium assist with the survey and building of VCT Facilities at 100 clinics for the HIV/AIDS Counselling Programme.
- Complete outstanding projects to upgrade Medical Storerooms at clinics to bring them in line with the required standards by 2005.
- Appointment of consultants to assist managers to draft multi – year plans for all Community Health Centres.

Newly replaced Ndumo Clinic

TABULAR REPORTING ON PERFORMANCE AGAINST PROVINCIAL 2003/04 STRATEGIC PLAN

The table below demonstrates the Department's commitment to its provincial priority of investing in health infrastructure.

Table 26: Specification of measurable objectives and performance indicators of the Health Facilities Management Programme

New Constructions

Category/Type of Construction	Number of Projects	Total Cost R'000	2003/2004 (Budget) R'000	2004/2005 (MTEF) R'000	2005/2006 (MTEF) R'000
NEW CONSTRUCTIONS	**480**	**3 715,785**	**167,207**	**251,578**	**265,858**
New Facilities	**211**	**2,181,227**	**77,417**	**140,312**	**159,045**
Community Health Service	89	499,257	17,929	20,100	24,350
District Hospitals	99	1,411,074	49,288	99,170	99,425
Emergency Medical Services	5	17,755	1,150	1,300	2,800
Provincial Hospital Services	5	183,533	620	12,825	25,610
Central Hospital Services	3	50,500	1,200	1,460	1,860
Other Services	10	19,108	7,230	5,457	5,000
Replacements	**269**	**1,534,558**	**89,790**	**111,266**	**106,813**
Community Health Service	19	57,170	14,432	11,650	14,250
District Hospitals	170	643,241	27,353	41,436	43,456
Emergency Medical Services	-	-	-	-	-
Provincial Hospital Services	75	820,547	43,500	56,780	47,237
Central Hospital Services	-	-	-	-	-
Other Services	5	13,600	4,505	1,400	1,870
UPGRADING/REHABILITATION	**2 479**	**2,795,131**	**311,181**	**299,445**	**316,471**
Upgrading	**1 642**	**1,244,484**	**133,180**	**122,947**	**114,719**
Community Health Service	440	58,649	10,220	4,141	3,479
District Hospitals	614	549,017	27,570	27,642	27,767
Emergency Medical Services	21	12,032	5,825	1,705	1,175
Provincial Hospital Services	362	423,908	48,753	52,899	52,803
Central Hospital Services	45	35,680	12,105	4,745	3,000
Other Services	160	165,198	28,707	31,815	26,495
Rehabilitation	**837**	**1,550,647**	**178,001**	**176,498**	**201,752**
Community Health Service	185	117,331	33,951	29,075	34,029
District Hospitals	259	382,533	69,105	53,570	61,463
Emergency Medical Services	21	8,347	3,817	1,752	2,280
Provincial Hospital Services	286	403,061	21,648	41,344	48,881
Central Hospital Services	43	623,563	42,460	46,767	51,520
Other Services	43	15,812	7,020	3,990	3,579
TOTAL (Construction & Upgrade)	**2 959**	**6,510,916**	**478,388**	**551,023**	**582,329**

Table 27: Performance indicators for health facilities management

Tabular reporting in the prescribed format is not possible for this reporting period. The relevant information has however been included in a narrative format. Steps have been implemented to satisfy the format in the next Annual Report.

Performance on Hospital Revitalisation Grant

There are three projects funded through the National Revitalisation Grant namely; King George V Hospital redevelopment, Empangeni/Ngwelezane service amalgamation and the new Inanda, Ntuzuma, KwaMashu Hospitals project.

King George V Hospital

Progress made was slower than expected. This was due to various reasons. One of the major delays being caused by Tender appeals. Steps have been taken to bring the project back on track which should see a number of large contracts being awarded early in the new Financial Year.

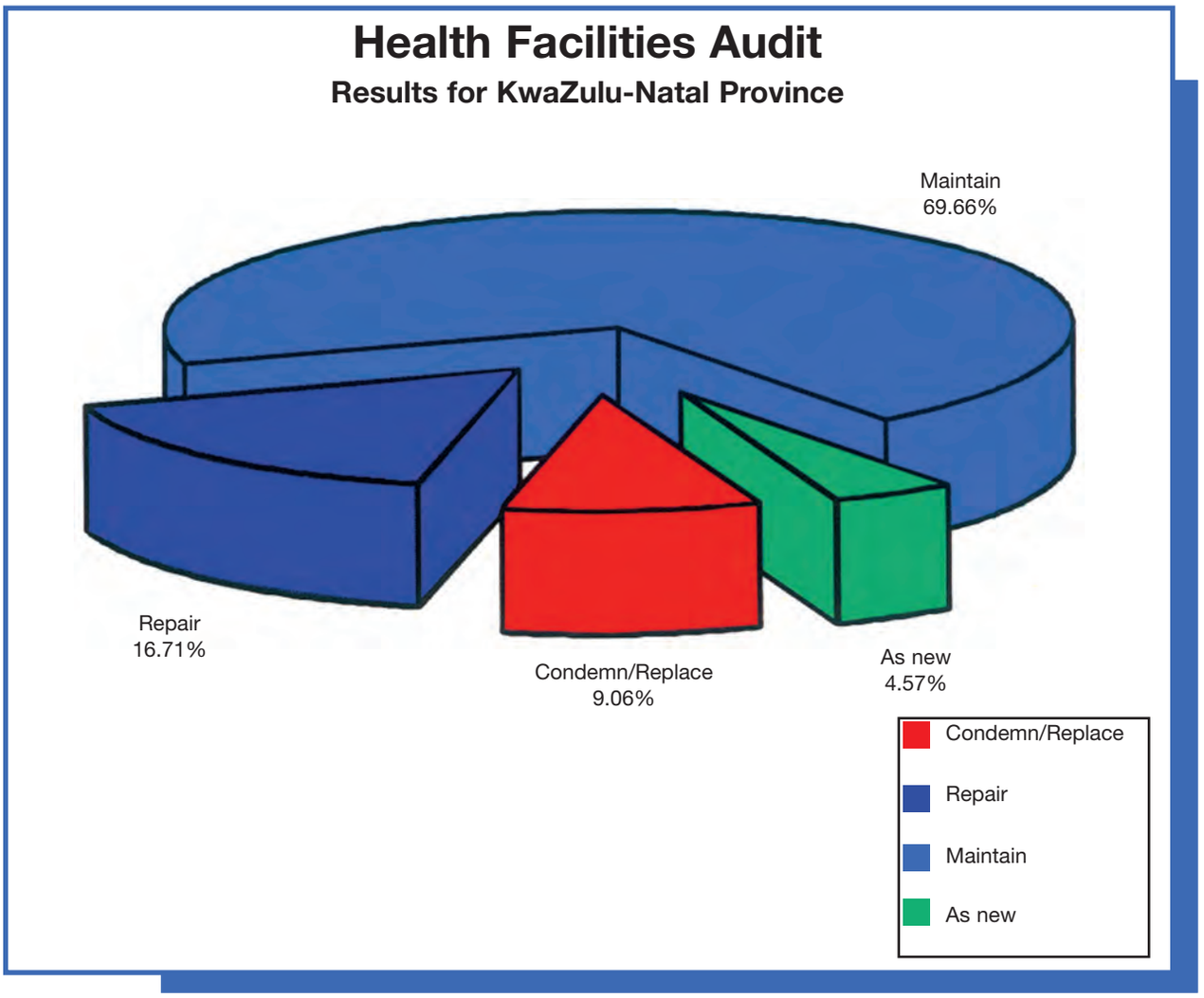
Empangeni Hospital Project

This project was still in its infancy during the 2003/2004 Financial year and the estimates and cash flows have now been refined and are more attuned to the physical position on the ground. Tenders will soon be invited for the initial phases of this project.

Inanda, Ntuzuma and KwaMashu Hospitals Project

This project has been slow off the mark due to difficulties in identifying suitable land for these developments. Suitable sites have now been identified and detailed planning will soon commence in earnest.

Total revitalization spending amounted to approximately R33.4 million during the last financial year.



The following table provides a detailed comparison of the results of the two facilities audits.

Hospitals by Type	Average 1996 NHFA Conditioning Grading	Provincial Audit Current Grading	Outline of major Rehabilitation projects since last audit
General Hospitals			
Addington Hospital	4	3	Various internal/external repairs/ renovations Replace main chiller plants
Edendale Hospital	4	4	Various external repairs/renovations Upgrade lifts New out-patients Department
Ladysmith Provincial Hospital	4	4	Convert to electricity Upgrade air conditioner Various internal/external repairs/renovations
Lower Umfolozi War Memorial Hospital	4	4	In complete re-development
Madadeni Hospital	3	3	Upgrade wards Various internal/external repairs/renovations
Newcastle Hospital	4	4	External repairs/renovations Upgrade lifts
Ngwelezane Hospital	3	3	In complete redevelopment
Prince Mshiyeni Memorial Hospital	4	3	Repair spalling concrete Various external/internal repairs/renovations Upgrade pharmacy
RK Khan Hospital	4	4	New mortuary & upgrade pharmacy Various external repairs/renovations
Chronic Disease Hospitals			
Hillcrest Hospital	3	3	New laundry Roof repairs Various external repairs/renovations
Community Health Centres			
Amatikulu Hospital and PHC Centre	3	3	Routine maintenance only
KwaDabeka Clinic	3	3	Routine maintenance only
KwaMashu Polyclinic	4	4	Upgrade mortuary
Ndwedwe Health Clinic	2	2	New facility
Phoenix Community Health Centre	5	5	Routine maintenance only
Tongaat Community Health Centre	4	4	Routine maintenance only

Hospitals by Type	Average 1996 NHFA Conditioning Grading	Provincial Audit Current Grading	Outline of major Rehabilitation projects since last audit
Community/ District Hospitals			
Appelsbosch Hospital	4	4	New kitchen & laundry block Various external/internal repairs/renovations
Bethesda Hospital	4	4	Renovate TB isolation ward Renovate staff accommodation
Benedictine Hospital	4	3	New TB & psychiatric ward Upgrade paediatric ward New therapy workshop
Charles Johnson Memorial Hospital	4	3	New staff accommodation Various external repairs/renovations Upgrade roads
Clairwood Hospital	4	3	New laundry Upgrade admissions Various external repairs/renovations
Catherine Booth	4	3	Upgrade water supply New maternity ward and store Upgrade medical. Gas
Ceza Hospital	3	3	Upgrade laundry Repairs/renovations to staff accommodation
Christ the King Hospital	4	4	New out-patients Department Upgrade wards & kitchen
Church of Scotland Hospital	4	3	Road repairs Upgrade wards
Dundee Hospital	4	3	Various external repairs/renovations Upgrade roads
East Griqualand and Usher Memorial Hospital	4	4	Extend kitchen Extend theatres New out-patients Department
Ekombe Hospital	4	4	Refurbish stores New waiting mothers accommodation Staff accommodation
Emmaus Hospital	4	4	Convert to electricity Upgrade kitchen
Estcourt Hospital	4	4	Renovate wards Various external repairs/renovations

Hospitals by Type	Average 1996 NHFA Conditioning Grading	Provincial Audit Current Grading	Outline of major Rehabilitation projects since last audit
Eshowe Hospital	4	4	Various external repairs/renovations
GJ Crookes Hospital	4	4	Upgrade laundry and mortuary Upgrade wards Various external repairs/renovations
Greytown Hospital	4	4	Upgrade roads Convert to electricity Various external repairs/renovations
Hlabisa Hospital	3	3	Various external repairs/renovations Extend mortuary
Itshelejuba Hospital	4	4	Repairs/renovations to staff housing Medical gas
Mahatma Gandhi Memorial Hospital	5	5	New neonatal ward Extend mortuary
Manguzi Hospital	4	4	New theatres New staff accommodation Upgrade wards
Mbongolwane Hospital	4	3	Upgrade wards, water, sewage
Montebello Hospital	4	4	Convert to electricity Various external repairs/renovations
Mosvold Hospital	4	4	Convert to electricity Upgrade wards
Mseleni Hospital	4	4	Repairs/renovations to wards Airstrip Convert to electricity Upgrade water plant
Murchison Hospital	4	4	New maternity ward Upgrade laundry & pharmacy Upgrade children's ward Upgrade theatres
Niemeyer Memorial Hospital	4	4	Routine maintenance only
Nkandla Hospital	3	3	Convert to electricity New staff residences
Nkonjeni Hospital	3	3	New male ward Various external repairs/renovations New staff housing

Hospitals by Type	Average 1996 NHFA Conditioning Grading	Provincial Audit Current Grading	Outline of major Rehabilitation projects since last audit
Northdale Hospital	4	4	Upgrade out-patients Department Upgrade nurse home
Port Shepstone Hospital	4	4	New laundry Convert to electricity
Stanger Hospital	4	4	Various external repairs/renovations
Osindisweni Hospital	4	3	Convert to electricity Various external repairs/renovations
St Andrew's Hospital	4	4	Convert to electricity New staff residences Upgrade water reticulation Upgrade wards Extend laundry
St Apollinaris	3	3	Upgrade sewage works Upgrade water supply Upgrade wards Upgrade roads
St Francis Hospital	4	3	Convert to electricity
KwaMagwaza Hospital	3	3	Upgrade sewage works Various external repairs/renovations
Tayler Bequest Hospital	4	3	Convert to electricity Upgrade stores Upgrade theatre
Umphumulo Hospital	4	4	New doctors' accommodation Upgrade roads
Untunjambili Hospital	5	4	New male and female wards
Vryheid Hospital	4	4	Convert to electricity
Wentworth Hospital	4	4	Upgrade air conditioner to theatres Repairs/renovations to wards Repairs/renovations to houses
Tuberculosis Hospitals			
Ekuphmuleni Hospital	3	3	Routine maintenance only
King George V Hospital	3	3	In complete redevelopment
Thulasizwe Hospital	4	3	Routine maintenance only

Hospitals by Type	Average 1996 NHFA Conditioning Grading	Provincial Audit Current Grading	Outline of major Rehabilitation projects since last audit
Stores			
Central Provincial Stores – Pietermaritzburg	-	4	Exterior repairs/renovations
Laboratory			
Provincial Laboratory Services	-	4	External repairs/renovations
Laundry			
Dundee Regional Laundry	-	4	Upgrade equipment
Regional Laundry – Durban	-	4	Upgrade equipment
Psychiatric Hospitals			
Ekuhlengeni Care Centre	-	4	Upgrade kitchen and wards
Midlands - Fort Napier Hospital	3	4	Upgrade reticulation
Midlands – Umgeni Rehabilitation Hospital	4	3	Upgrade wards Convert to electricity Repairs/renovations to staff houses
Midlands Townhill Hospital	4	4	Various internal/external repairs/renovations Upgrade water mains Fire detection Upgrade wards
Tertiary Hospitals			
Grey's Hospital	4	4	Various internal/external repairs/renovations Replace chillers Upgrade intensive care unit

Key to Grading

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

Programme Performance

Objective	Indicator	Target 2003/3004	Actual Performance
To ensure that all physical facilities of the Department are upgraded and maintained at acceptable standards	Facilities Audit Grading of grade 4	13.5% of all health facilities	13.5% was achieved
To prepare and maintain a multi-year plan for the provision of funds for capital development	No. of institutions with an approved Multi-year plan	70 %	70 %
To ensure a decentralised maintenance system at all institutions	No. of artisan posts filled at institutions.	70 %	65% of posts filled
Effective maintenance of buildings and engineering installations	Effective maintenance of buildings and engineering installations	16% of all health facilities	10% achieved
Efficient engineering installations	Cost of utilities per bed	R3 600	R3 560 (without boiler cost)

HUMAN RESOURCE OVERSIGHT REPORT

This Branch mainly deals with the management of human resources for the entire Department of Health. It deals with the creation of posts, abolition of posts, evaluation of posts, appointment of human resources, retention of human resources, service conditions of human resources, labour relations, human resource development and planning.

Table 28: Main services provided and standards

Main Services	Actual Customers	Potential Customers	Standard of Service	Actual Achievement against Standard
Creation of posts	Line function and support personnel of the Department	None	Efficient working force.	Organogram
Human resource development	All employees of the Department	Students in tertiary Institutions	Efficient working employees	The number of trained personnel
Human resource provisioning	All employees in the Department	New applicants	No of appointments	Satisfied personnel
Labour relations	All employees in the Department	All employees in the Department	Knowledgeable personnel in labour relations	Number of labour relation cases dealt with
Evaluation of posts	Employees in the Department	None	Number of posts evaluated	Number of posts evaluated
Employee Assistance Programme	Employees in the Department	None	Satisfied work force in the Department	Number of employees given assistance by the Department

Table 29: Consultation arrangement with customers

Type of Arrangement	Actual Customers	Potential Customers	Actual Achievements
Institutional Management and Labour Committees (IMLC's)	Employees	Organised Labour	Committees are in place and fully operational
Chamber	Employees	Organised Labour	Committees are in place and fully operational
Human Resource Management Forum	Employees	Organised Labour	Effective implementation of policies and integration on transversal issues

Table 30: Service Delivery Access Strategy

Access Strategy	Actual Achievements
Batho Pele principles Patients' Rights Charter	Employees and [patients have been orientated Quality assurance, monitoring and evaluation conducted

Table 31: Service Information Tool

Types of Information Tool	Actual Achievements
Information kiosks Departmental website Telemedicine Teleconferencing	Information disseminated through these mechanisms

Table 32: Complaints Mechanism

Complaints Mechanism	Actual Achievements
Grievance procedure	Fully operational
Dispute resolution mechanism	Fully operational

Table 33: Personnel costs by programme, 2003/04

Programme	Total Expenditure (R'000)	Personnel Expenditure (R'000)	Training Expenditure (R'000)	Professional and Special Services (R'000)	Personnel cost as a percent of total expenditure	Average Personnel cost per Employee (R'000)	Employment
Programme 1: Administration	154 176	88 005	0	34 388	57.1	2	51 910
Programme 2: District Health Services	3 771 090	2 247 876	0	318 179	59.6	43	51 910
Programme 3: Emergency Medical Health Services	272 046	160 963	0	13 805	59.2	3	51 910
Programme 4: Provincial Hospital Services	2 569 554	1 716 241	0	190 380	66.8	33	51 910
Programme 5: Central Hospital Services	765 378	241 768	0	240 758	31.6	5	51 910
Programme 6: Health Care Support Services	605 055	10 966	0	4 235	1.8	0	51 910
Programme 7 Health Sciences And Training	321 156	234 282	0	19 317	72.9	5	51 910
Programme 8 Health Facilities Management Programme	347 490	0	0	79 033	0	0	51 910
Total	**8 805 945**	**4 700 101**	**0**	**900 095**	**53**	**91**	**51 910**

**Please note this figure differs from the item Personal Expenditure in Table 34 as this latter table only reflects personnel expenditure recorded on PERSAL whereas this table reflects personnel expenditure as per FMS*

Table 34: Personnel costs by salary bands, 2003/ 04

Salary bands	Personnel Expenditure (R'000)	% of total personnel cost	Average personnel cost per employee (R'000)	Total Personnel expenditure	No of employees
Lower skilled (Levels 1-2)	728 291	15.7	47 526	4 635 012	15324
Skilled (Levels 3-5)	1 134 785	24.5	67 680	4 635 012	16767
Highly skilled production (Levels 6-8)	2 099 756	45.3	121 937	4 635 012	17220
Highly skilled supervision (Levels 9-12)	610 166	13.2	247 934	4 635 012	2461
Senior management (Levels 13-16)	62 014	1.3	449 377	4 635 012	138
Other					
Total	**4 635 012**	**100**	**89 289**	**4 635 012**	**51910**

**Please note this figure differs from the item Personal Expenditure in Table 33 as the former table includes personnel expenditure as recorded on FMS.*

Table 35: Salaries, Overtime, Home Owners Allowance and Medical Assistance by programme, 2003/ 04

Programme	Salaries		Overtime		Home Owners Allowance		Medical Assistance		Total Salaries, O/T, HOA & Med Ass.	Total Personnel costs
	Amount (R'000)	Salaries as % of personnel cost	Amount (R'000)	Overtime as % of personnel cost	Amount (R'000)	HOA as % of personnel cost	Amount (R'000)	MA as % of personnel cost	Amount (R'000)	Amount (R'000)
Programme 1: Administration	62 366	70.8	608	0.7	1 909	2.2	4 398	5	69 281	88 135
Programme 2: District Health Services	1 590 679	70.8	53 301	2.4	33 550	1.5	123 777	5.5	1 801 307	2 245 278
Programme 3: Emergency Medical Rescue Services	100 689	63.1	20 365	12.8	3 723	2.3	9 353	5.9	134 130	159 689
Programme 4: Provincial Hospital Services	1 130 523	69.1	68 571	4.2	35 142	2.1	84 587	5.2	1 318 823	1 637 131
Programme 5: Central Hospital Services	178 850	68.9	14 445	5.6	4 375	1.7	13 312	5.1	210 982	259 537
Programme 6: Health Care Support Services	6 875	62.7	518	4.7	222	2	481	4.4	194 207	10 968
Programme 7 Health Sciences And Training	170 666	72.8	11 388	4.9	1 339	0.6	10 814	4.6	8 096	234 274
Total	**3 240 648**	**69.9**	**169 196**	**3.7**	**80 260**	**1.7**	**242 324**	**5.2**	**3 736 826**	**4 635 012**

**Please note that the Personnel Expenditure for Programme 8 (Facilities Management) is included under Programme 1.*

Table 36: Salaries, Overtime, Home Owners Allowance and Medical Assistance by salary bands, 2003/ 04

Salary Bands	Salaries		Overtime		Home Owners Allowance		Medical Assistance		Total salaries, O/T, HOA & Med Ass.	Total Personnel costs
	Amount (R'000)	Salaries as % of personnel cost	Amount (R'000)	Overtime as % of personnel cost	Amount (R'000)	HOA as % of personnel cost	Amount (R'000)	MA as % of personnel cost	Amount (R'000)	Amount (R'000)
Lower skilled (Levels 1-2)	528 398	72.6	787	0.1	10 955	1.5	40 791	5.6	580 931	728 291
Skilled (Levels 3-5)	808 171	71.2	21 113	1.9	23 776	2.1	76 649	6.8	929 709	1 134 785
Highly skilled production (Levels 6-8)	1 511 100	72.1	26 721	1.3	40 243	1.9	107 591	5.1	1 685 655	
Highly skilled supervision (Levels 9-12)	360 403	59.1	113 101	18.5	4 737	0.8	15 543	2.5	493 784	610 166
Senior management (Levels 13-16)	32 576	49.9	7 474	11.4	549	0.8	1 754	2.7	42 353	65 282
Total	**3 240 648**	**69.9**	**169 196**	**3.7**	**80 260**	**1.7**	**242 328**	**5.2**	**3 732 432**	**4 635 012**

Table 37: Employment and vacancies by programme, 31 March 2004

Programme	Number of posts	Number of posts filled	Vacancy Rate	Number of posts filled additional to the establishment
Programme 1: Administration	1 177	792	32.7	1
Programme 2: District Health Services	35 077	26 733	23.8	
Programme 3: Emergency Medical Health Services	1 998	1 835	8.2	0
Programme 4: Provincial Hospital Services	20 091	16 553	17.6	1
Programme 5: Central Hospital Services	3 106	1 990	36	1
Programme 6: Health Care Support Services	120	113	5.8	0
Programme 7 Health Sciences And Training	4 773	3 574	25.1	0
Programme 8 Health Facilities Management				
Total	**66 342**	**51 590***	**22.2**	**4**

* Number of filled posts is different from number of employees reflected in tables 33 and 34 as those tables reflect sessional employees whereby one post is occupied by more than one employee.

Table 38: Employment and vacancies by salary bands, 31 March 2004

Salary band	Number of posts	Number of posts filled	Vacancy Rate	Number of posts filled additional to the establishment
Lower skilled (Levels 1-2)	18 576	15 063	18.9	0
Skilled (Levels 3-5)	20 924	16 597	20.7	0
Highly skilled production				
(Levels 6-8)	22 387	17 087	23.7	3
Highly skilled supervision (Levels 9-12)	4 088	2 694	34.1	1
Senior management (Levels 13-16)	366	148	59.7	0
Total	**66 341**	**51 589***	**22.2**	**4**

* *The total number of filled posts in this table differs from table 37 as the MEC for Health is excluded in this table (MEC does not fall within any of the salary bands identified)*

Table 39: Employment and vacancies by critical occupation, 31 March 2004

Critical occupations	Number of posts	Number of posts filled	Vacancy Rate	Number of posts filled additional to the establishment
Dental Practitioners,	67	49	26.9	0
Dental Specialists, Permanent	6	4	33.3	0
Dieticians and nutritionists, Permanent	90	53	41.1	0
Emergency services related, Permanent	4	0	100	0
Head of department/chief executive officer, Permanent	1	1	0	0
Medical Practitioners,	2 229	1 771	20.5	1
Medical research and related professionals, Permanent	5	2	60	0
Medical Specialists,	698	421	39.7	0
Medical Specialists,	1	1	0	0
Nursing Assistants,	7 038	5 933	15.7	0
Nursing Assistants,	2	2	0	0
Occupational therapy, Permanent	139	97	30.2	0
Optometrists and opticians, Permanent	10	5	50	0
Oral Hygiene, Permanent	34	19	44.1	0
Pharmacists, Permanent	533	302	43.3	0
Physicists, Permanent	8	5	37.5	0
Physiotherapy, Permanent	281	185	34.2	0
Professional Nurse, permanent	12 294	9 500	22.7	0
Professional nurse, Temporary	9	9	0	0
Psychologists and vocational counsellors, Permanent	125	54	56.8	0
Radiography, permanent	586	372	36.5	0
Radiography, Temporary	1	1	0	0
Speech therapy and Audiology, Permanent	79	60	24.1	0
Speech therapy and Audiology, Temporary	1	1	0	0
Staff Nurses and Pupil Nurses, permanent	9 947	8 164	17.9	0
Staff Nurses and Pupil Nurses, Permanent	9	9	0	0
Supplementary diagnostic radiographers, Permanent	17	13	23.5	0
Total	**35 114**	**27 750**	**21**	**1**

Table 40: Job Evaluation, 1 April 2003 to 31 March 2004

Salary band	Number of posts	Number of Jobs Evaluated	% of posts evaluated by	Posts Upgraded		Posts downgraded	
				Number	% of posts evaluated	Number	% of posts evaluated
Lower skilled (Levels 1-2)	18 576	39	0.2	0	0	0	0
Skilled (Levels 3-5)	20 924	1 573	7.5	0	0	0	0
Highly skilled production (Levels 6-8)	22 387	312	1.4	27	8.7	0	0
Highly skilled supervision (Levels 9-12)	4 088	485	11.9	1	0.2	0	0
Senior Management Service Band A	290	96	33.1	0	0	0	0
Senior Management Service Band B	70	12	17.1	0	0	0	0
Senior Management Service Band C	4	1	25	0	0	0	0
Senior Management Service Band D	2	0	0	0	0	0	0
Total	**66 341**	**2 518**	**3.8**	**28**	**1.1**	**0**	**0**

Table 41: Profile of employees whose salary positions were upgraded due to their posts being upgraded, 1 April 2003 to 31 March 2004

Beneficiaries	African	Asian	Coloured	White	Total
Female	12	6	1	10	29
Male	11	10	2	10	33
Employees with a disability	0	0	0	0	0
Total	**23**	**16**	**3**	**20**	**62**

Table 42: Employees with a disability 1 April 2003 to 31 March 2004

Beneficiaries	African	Asian	Coloured	White	Total
Female	12	3	0	3	18
Male	18	10	3	2	33
Total	**30**	**13**	**3**	**5**	**51**

Table 43: Employees whose salary level exceed the grade determined by job evaluation, 1 April 2003 to 31 March 2004 (in terms of PSR 1.V.C.3)* by occupation.

Occupation	Number of employees	Job evaluation level	Remuneration level	Reason for deviation
	A	B	C	D
NIL	0	0	0	0
Total Number of Employees whose salaries exceeded the level determined by job evaluation in 2003/ 04				**0**
Percentage of total employment				**0**

No table 44 in this sequence

Table 45: Profile of employees whose salary level exceed the grade determined by job evaluation, 1 April 2003 to 31 March 2004 (in terms of PSR 1.V.C.3)

Beneficiaries	African	Asian	Coloured	White	Total
Female	0	0	0	0	0
Male	0	0	0	0	0
Total	0	0	0	0	0
Employees with a disability					0

Table 46: Annual turnover rates by salary band for the period 1 April 2003 to 31 March 2004

Salary Band	Number of employees per band as on 1 April 2003	Appointments and transfers into the department	Terminations and transfers out of the department	Turnover rate
Lower skilled (Levels 1-2)				
Permanent	13 637	1 542	1 083	7.9
Temporary	956	573	226	23.6
Skilled (Levels 3-5)				
Permanent	13 751	1 510	1 134	8.2
Temporary	2 075	483	250	12
Highly skilled production(Levels 6-8)				
Permanent	15 968	1 320	2 114	13.2
Temporary	1 130	610	406	35.9
Highly skilled supervision (Levels 9-12)				
Permanent	1 392	172	261	18.8
Temporary	719	75	287	39.9
Senior Management Service Band A				
Permanent	87	3	13	14.9
Temporary	16	0	2	12.5
Senior Management Service Band B				
Permanent	7	1	0	0
Senior Management Service Band C				
Permanent	2	0	0	0
Senior Management Service Band D				
Permanent	1	0	0	0
Total	49 741	6 289	5 776	11.6

Table 47: Annual turnover rates by critical occupation for the period 1 April 2003 to 31 March 2004

Occupation:	Number of employees per occupation as on 1 April 2003	Appointments and transfers into the department	Terminations and transfers out of the department	Turnover rate (%)
Dental Practitioners, Permanent	24	14	12	50
Dental Practitioners, Temporary	26	23	23	88,5
Dental Specialists, Permanent	2	1	0	0
Dental Specialists, Temporary	1	3	1	100
Dieticians and nutritionists, Permanent	31	4	4	12,9
Dieticians and nutritionists, Temporary	24	13	17	70,8
Emergency services related, Permanent	3	0	1	33,3
Head of Department/chief executive officer, Permanent	1	0	0	0
Medical Practitioners, Permanent	539	1186	1205	223,6
Medical Practitioners, Temporary	840	297	285	33,9
Medical research and related professionals, Permanent	2	0	1	50
Medical research and related professionals, Temporary	2	0	0	0
Medical specialists, Permanent	264	206	231	87,5
Medical specialists, Temporary	101	1	18	17.8
Nursing assistants, Permanent	5 509	834	352	6,4
Nursing assistants, Temporary	349	23	48	13,8
Occupational therapy, Permanent	58	18	19	32,8
Occupational therapy, Temporary	42	37	33	78,6
Optometrists and opticians, Permanent	0	5	2	0
Optometrists and opticians, Temporary	1	0	0	0
Oral hygiene, Permanent	17	2	0	0
Pharmaceutical assistants, Permanent	310	4	14	4,5
Pharmaceutical assistants, Temporary	3	1	1	33,3
Pharmacists, Permanent	150	28	35	23,3
Pharmacists, Temporary	142	63	59	41,5
Pharmacologists, pathologists & related profession, Permanent	0	1	0	0
Physicists, Permanent	5	0	0	0
Physicists, Temporary	3	0	1	33,3
Physiotherapy, Permanent	96	38	38	39,6
Physiotherapy, Temporary	74	59	52	70,3
Professional nurse, Permanent	8 503	633	976	11,5
Professional nurse, Temporary	280	69	40	14,3
Psychologists and vocational counsellors, Permanent	20	6	11	55
Psychologists and vocational counsellors, Temporary	12	24	8	66,7
Radiography, Permanent	302	36	73	24,2
Radiography, Temporary	54	35	23	42,6
Senior managers, Permanent	51	2	4	7,8
Senior managers, Temporary	2	1	0	0
Speech therapy and audiology, Permanent	26	8	10	38,5
Speech therapy and audiology, Temporary	22	24	16	72,7
Staff nurses and pupil nurses, Permanent	6 308	640	428	6,8
Staff nurses and pupil nurses, Temporary	892	470	173	19,4
Student nurses, Permanent	209	110	46	22
Supplementary diagnostic radiographers, Permanent	20	0	3	15
Supplementary diagnostic radiographers, Temporary	1	0	0	0
TOTAL	**25 321**	**4 919**	**4 263**	**16.8**

Table 48: Reasons why staff are leaving the department

Termination Type	Number	% of total resignations	% of total employment	Total	Total Employment (01/04/2003)	Total Employment (31/03/2004)
Death, Permanent	542	9.4	1.1	5 776	49 741	51 910
Death, Temporary	31	0.5	0.1	5 776	49 741	51 910
Resignation, Permanent	3 043	52.7	6.1	5 776	49 741	51 910
Resignation, Temporary	613	10.6	1.2	5 776	49 741	51 910
Expiry of contract, Permanent	141	2.4	0.3	5 776	49 741	51 910
Expiry of contract. Temporary	425	7.4	0.9	5 776	49 741	51 910
Dismissal – operational changes, Permanent	40	0.7	0.1	5 776	49 741	51 910
Dismissal - operational changes, Temporary	1	0	0	5 776	49 741	51 910
Dismissal – misconduct, Permanent	41	0.7	0.1	5 776	49 741	51 910
Dismissal - misconduct, Temporary	12	0.2	0	5 776	49 741	51 910
Dismissal – inefficiency, Permanent	6	0.1	0	5 776	49 741	51 910
Dismissal - inefficiency, Temporary	3	0.1	0	5 776	49 741	51 910
Discharged due to ill-health, Permanent	167	2.9	0.3	5 776	49 741	51 910
Discharged due to ill-health, Temporary	6	0.1	0	5 776	49 741	51 910
Retirement, Permanent	569	9.9	1.1	5 776	49 741	51 910
Retirement, Temporary	24	0.4	0	5 776	49 741	51 910
Other, Permanent	56	1	0.1	5 776	49 741	51 910
Other, Temporary	56	1	0.1	5 776	49 741	51 910
Total	**5 776**	**100**	**11.6**	**5 776**	**49 741**	**51 910**
Total number of employees who left as a % of the total employment at the beginning of the period (01/04/2003)			**11.6**			

Table 49: Promotions by critical occupation

Occupation:	Employees as at 1 April 2003	Promotions to another salary level	Salary level promotions as a % of employees by occupation	Progressions to another notch within a salary level	Notch progressions as a % of employees by occupation
Dental Practitioners	50	0	0	17	34
Dental specialists	3	0	0	2	66.7
Dieticians and nutritionists	55	0	0	23	41.8
Emergency services related	3	0	0	0	0
Head of department/ chief executive officer	1	0	0	0	0
Medical Practitioners	1 379	78	5.7	549	39.8
Medical research and related professionals	4	0	0	2	50
Medical specialists	265	22	6	173	47.4
Medical technicians/ Technologists	441	4	0.9	362	82.1
Nursing assistants	5 858	18	0.3	4 150	70.8
Occupational therapy	100	0	0	38	38
Optometrists and opticians	1	0	0	0	0
Oral hygiene	17	0	0	16	94.1
Pharmacists	292	45	15.4	102	34.9
Physicists	8	0	0	1	12.5
Physiotherapy	170	1	0.6	62	36.5
Professional nurse	8 783	271	3.1	7 348	83.7
Psychologists and vocational counsellors	32	0	0	8	25
Radiography	356	21	5.9	248	69.7
Senior managers	53	10	18.9	13	24.5
Speech therapy and audiology	48	0	0	16	33.3
Supplementary diagnostic radiographers	21	0	0	16	76.2
TOTAL	**18 040**	**470**	**2.6**	**13 146**	**72.9**

Table 50: Promotions by salary band

Salary Band	Employees 1 April 2003	Promotions to another salary level	Salary bands promotions as % of employees by salary level	Progressions to another notch within a salary level	Notch progressions as % of employees by salary band
Lower skilled (Levels 1-2					
Permanent	13 637	12	0.1	10 849	79.6
Temporary	956	0	0	262	27.4
Skilled (Levels 3-5)					
Permanent	13 751	104	0.8	11 320	82.3
Temporary	2 075	0	0	884	42.6
Highly skilled production (Levels 6-8)					
Permanent	15 968	337	2.1	13 715	85.9
Temporary	1 130	24	2.1	221	19.6
Highly skilled supervision (Levels 9-12)					
Permanent	1 392	282	20.3	816	58.6
Temporary	719	36	5	263	36.6
Senior management (Levels13-16)					
Permanent	97	15	15.5	0	36.6
Temporary	16	4	25	0	0
Other					
Permanent	0	0	0	1	0
Total	**49 741***	**814**	**1.6**	**38 331**	**77.1**

**Total number of employees reflected as at beginning of the period (01/04/2003)*

Table 52: Total number of employees (including employees with disabilities) in each of the following occupational bands as on 31 March 2004

Occupational Bands	Male				Female				Total
	African	Coloured	Indian	White	African	Coloured	Indian	White	
Top Management	0	2	0	1	0	0	0	0	3
Senior Management	22	0	37	38	13	2	15	8	135
Professionally qualified and experienced specialists and mid-management	401	21	550	392	404	35	408	268	2 479
Skilled technical and academically qualified workers, junior management, supervisors, foremen and superintendents	1 626	105	992	380	10 683	401	1 949	1075	17 211
Semi-skilled and discretionary decision making	3 562	107	1 146	160	9 740	498	1 097	517	16 827
Unskilled and defined decision making	5 121	76	390	116	8 892	132	401	127	15 255
Total	**10 732**	**311**	**3 115**	**1 087**	**29 732**	**1 068**	**3 870**	**1 995**	**51 910**

Table 53: Recruitment for the period 1 April 2003 to 31 March 2004

Occupational Bands	Male				Female				
	African	Coloured	Indian	White	African	Coloured	Indian	White	Total
Top Management	0	0	0	0	0	0	0	0	0
Senior Management	0	0	0	1	1	0	2	0	4
Professionally qualified and experienced specialists and mid-management	29	0	64	47	21	2	28	31	222
Skilled technical and academically qualified workers, junior management, supervisors, foreman and superintendents	318	14	235	159	526	35	304	188	1 779
Semi-skilled and discretionary decision making	481	10	135	69	1 164	29	162	55	2 105
Unskilled and defined decision making	402	10	142	94	1 332	19	119	61	2 179
Total	**1 230**	**34**	**576**	**370**	**3 044**	**85**	**615**	**335**	**6 289**
Employees with disabilities	0	0	0	0	0	0	0	1	1

Table 54: Promotions for the period 1 April 2003 to 31 March 2004

Occupational Bands	Male				Female				Total
	African	Coloured	Indian	White	African	Coloured	Indian	White	
Top Management	0	0	0	0	0	0	0	0	0
Senior Management	1	0	6	3	6	0	1	2	19
Professionally qualified and experienced specialists and mid-management	210	11	297	249	215	19	244	161	1 406
Skilled technical and academically qualified workers junior management, supervisors, foreman and superintendents	1 318	92	788	248	9 294	307	1 451	845	14 343
Semi-skilled and discretionary decision making	2 553	72	949	116	7 022	397	811	439	12 359
Unskilled and defined decision making	4 120	55	306	55	6 178	93	299	69	11 175
Total	**8 202**	**230**	**2 346**	**671**	**22 715**	**816**	**2 806**	**1 516**	**39 302**
Employees with disabilities	17	3	9	2	10	0	2	1	44

Table 55: Terminations for the period 1 April 2003 to 31 March 2004

Occupational Bands	Male				Female				Total
	African	Coloured	Indian	White	African	Coloured	Indian	White	
Top Management	0	0	0	0	0	0	0	0	0
Senior Management	0	0	5	4	1	0	0	2	12
Professionally qualified and experienced specialists and mid-management	55	3	116	120	32	4	69	65	464
Skilled technical and academically qualified workers, junior management, supervisors, foreman and superintendents	346	15	272	166	1 073	59	294	233	2 458
Semi-skilled and discretionary decision making	286	8	162	83	682	45	129	99	1 494
Unskilled and defined decision making	353	11	133	98	605	9	86	53	1 348
Total	**1 040**	**37**	**688**	**471**	**2 393**	**117**	**578**	**452**	**5 776**
Employees with disabilities	1	0	0	1	0	0	0	1	3

Table 56: Disciplinary action for the period 1 April 2003 to 31 March 2004

	Male				Female				
	African	Coloured	Indian	White	African	Coloured	Indian	White	Total
Disciplinary action	142	3	85	4	95	4	27	8	368

Table 57: Skills development for the period 1 April 2003 to 31 March 2004

Occupational categories	Male				Female				
	African	Coloured	Indian	White	African	Coloured	Indian	White	Total
Legislators, senior officials and managers	115	6	47	9	172	13	38	21	421
Professionals	526	36	152	63	3 835	95	293	130	5 130
Technicians and associate professionals	187	20	109	17	788	21	179	24	1 345
Clerks	588	35	198	35	855	40	73	168	1 992
Service and sales workers	164	2	6	1	388	14	17	8	600
Skilled agriculture and fishery workers	0	0	0	0	0	0	0	0	0
Craft and related trades workers	0	0	0	0	0	0	0	0	0
Plant and machine operators and assemblers	0	0	0	0	0	0	0	0	0
Elementary occupations	423	16	28	0	764	17	29	1	1 278
Total	**2 003**	**115**	**540**	**125**	**6 802**	**200**	**629**	**352**	**10 766**
Employees with disabilities	**17**	**3**	**1**	**2**	**7**	**4**	**4**	**3**	**41**

Table 58: Performance Rewards by race, gender, and disability, 1 April 2003 to 31 March 2004

	Beneficiary Profile				
	Number of beneficiaries	Total number of employees in group	% of total within group	Cost (R'000)	Average cost per employee
African					
Male	0	10 732	0	0	0
Female	0	29 732	0	0	0
Asian					
Male	0	3 115	0	0	0
Female	0	3 870	0	0	0
Coloured					
Male	0	311	0	0	0
Female	0	1 068	0	0	0
White					
Male	0	1 087	0	0	0
Female	0	1 995	0	0	0
Employees with a disability	0	0	0	0	0
Total	**0**	**51 910**	**0**	**0**	**0**

** No performance rewards were granted due to insufficient funds.*

Table 59: Performance Rewards by salary bands for personnel below Senior Management Service, 1 April 2003 to 31 March 2004

Salary Bands	Beneficiary Profile			Cost	
	Number of beneficiaries	Number of employees	% of total within salary bands	Total Cost (R'000)	Average cost per employee
Lower skilled (Levels 1-2)	0				0
Skilled (Levels 3-5)					
Highly skilled production (Levels 6-8)	0				0
Highly skilled supervision (Levels 9-12)	0				0
Total	**0**	**51 910**			**0**

**No performance rewards were granted due to insufficient funds.*

Table 60: Performance Rewards by critical occupations, 1 April 2003 to 31 March 2004

Critical Occupations	Beneficiary Profile			Cost	
	Number of beneficiaries	Number of employees	% of total within occupation	Total Cost	Average cost per employee
Other administrative & related clerks and organisers	0			0	
Professional nurse	0			0	0
Total	**0**	**51 910**		**0**	**0**

**Due to insufficient funds no performance rewards were granted.*

Table 61: Performance related rewards (cash bonus), by salary band, for Senior Management Service

Salary Band	Beneficiary Profile			Total Cost (R'000)	Average cost per employee	Total cost as a % of the total personnel expenditure
	Number of beneficiaries	Number of employees	% of total within band			
Band A	0					
Band B	0					
Band C	0					
Band D	0					
Total	**0**	**51 910**	**0**	**0**	**0**	**0**

** Due to insufficient funds no performance rewards were granted.*

Table 62: Foreign Workers, 1 April 2003 to 31 March 2004, by salary band

Salary Band	1 April 2003		31 March 2004		Change	
	Number	% of total	Number	% of total	Number	% change
Lower skilled (Levels 1-2)	9	2.3	9	2.5	0	0
Skilled (Levels 3-5)	26	6.8	20	5.5	-6	27.3
Highly skilled production (Levels 6-8)	77	20	82	22.6	5	-22.7
Highly skilled supervision (Levels 9-12)	265	68.8	243	66.9	-22	100
Senior management (Levels 13-16)	8	2.1	9	2.5	1	-4.5
Total	**385**	**100**	**363**	**100**	**-22**	**100**

Table 63: Foreign Workers, 1 April 2003 to 31 March 2004, by major occupation

Major Occupation	1 April 2003		31 March 2004		Change	
	Number	% of total	Number	% of total	Number	% change
Administrative office workers	5	1.3	4	1.1	-1	4.5
Craft and related trades workers	7	1.8	5	1.4	-2	9.1
Elementary occupations	4	1	4	1.1	0	0
Other occupations	3	0.8	3	0.8	0	0
Professionals and managers	357	92.7	339	93.4	-18	81.8
Social natural technical and medical sciences+supp	7	1.8	5	1.4	-2	9.1
Technicians and associated professionals	2	0.5	3	0.8	1	-4.5
Total	**385**	**100**	**363**	**100**	**-22**	**100**

Table 64: Sick leave, 1 January 2003 to 31 December 2003

Salary Band	Total days	% days with medical certification	Number of Employees using sick leave	% of total employees using sick leave	Average days per employee	Est. Cost (R'000)	Total number of employees using sick leave	No. of days with med cert
Lower skilled (Levels 1-2)	51 051	84.1	6 884	26.4	7	6 636	26 105	42 929
Skilled (Levels 3-5)	60 011	80.4	8 471	32.4	7	10 899	26 105	48 269
Highly skilled production (Levels 6-8)	70 371	78.1	9 881	37.9	7	22 441	26 105	54 987
Highly skilled supervision (Levels 9-12)	5 275	71	835	3.2	6	3 059	26 105	3 744
Senior Management (Levels 13-16)	152	72.4	34	0.1	4	229	26 105	110
Total	**186 860**	**80.3**	**26 105**	**100**	**7**	**43 264**	**26 105**	**150 039**

Table 65: Disability leave (temporary and permanent), 1 January 2003 to 31 December 2003

Salary Band	Total days taken	% days with medical certification	Number of Employees using disability leave	% of total employees using disability leave	Average days per employee	Est. Cost (R'000)	No of days with med certificate	No of employees using disability leave
Lower skilled (Levels 1-2)	27 082	99.6	1 098	26.2	25	3 589	26 969	4 184
Skilled (Levels 3-5)	37 563	99.5	1 558	37.2	24	7 058	37 386	4 184
Highly skilled production (Levels 6-8)	34 821	99.4	1 462	34.9	24	11 546	34 613	4 184
Highly skilled supervision (Levels 9-12)	1 206	99.5	65	1.6	19	725	1 200	4 184
Senior management (Levels 13-16)	10	100	1	0	10	15	10	4 184
Total	**100 682**	**99.5**	**4 184**	**100**	**24**	**22 933**	**100 178**	**4 184**

Table 66: Annual Leave, 1 January 2003 to 31 December 2003

Salary Bands	Total days taken	Average per employee	Employment
Lower skilled (Levels 1-2)	266 860	22	11 966
Skilled Levels 3-5)	329 571	25	13 344
Highly skilled production (Levels 6-8)	420 524	28	15 239
Highly skilled supervision(Levels 9-12)	41 700	19	2 139
Senior management (Levels 13-16)	2 138	18	119
Total	**1 060 793**	**25**	**42 807**

Table 67: Capped leave, 1 January 2003 to 31 December 2003

Salary Bands	Total days of capped leave taken	Average number of days taken per employee	Average capped leave per employee as at 31 December 2003	No of employees	Total number of capped leave available at 31/12/03	No of employees as at 31/12/03
Lower skilled (Levels1-2)	6 248	1	53	5 397	506 935	9 598
Skilled Levels 3-5)	10 691	2	57	5 397	635 552	11 128
Highly skilled production (Levels 6-8)	17 646	3	80	5 397	1 072 857	13 490
Highly skilled supervision (Levels 9-12)	1 174	0	66	5 397	90 236	1 359
Senior management (Levels 13-16)	46	0	100	5 397	11 475	115
Total	**35 805**	**7**	**65**	**5 397**	**2 317 055**	**35 690**

Table 68: Leave payouts for the period 1 April 2003 to 31 March 2004

REASON	Total Amount (R'000)	Number of Employees	Average payment per employee
Leave payout for 2003/04 due to non-utilisation of leave for the previous cycle	1 316	482	2 730
Capped leave payouts on termination of service for 2003/4	28 797	1 187	24 260
Current leave payout on termination of service for 2003/4	2 811	928	3 029
Total	**32 924**	**2 597**	**12 678**

Table 69: Steps taken to reduce the risk of occupational exposure

Units/categories of employees identified to be at high risk of contracting related diseases (if any)	Key steps taken to reduce the risk
Doctors – all categories Nurses – all categories General Assistants Housekeeping personnel Laundry personnel Grounds personnel Laboratory personnel Phlebotomists	• Universal precautions are to be taken by all employees • Proper disposal of sharps, contaminated instruments, all body and post mortem specimens • Provision of education and training to all personnel • Provision of safety equipment ie gloves, goggles, etc

Table 70: Details of Health Promotion and HIV/AIDS Programmes
(tick the applicable boxes and provide the required information)

Question	Yes	No	Details, if yes
1. Has the department designated a member of the SMS to implement the provisions contained in Part VI E of Chapter 1 of the Public Service Regulations, 2001? If so, provide her/his name and position.		No	Managed by Ms K Naidoo Clinical Psychologist (Level 11)
2. Does the department have a dedicated unit or has it designated specific staff members to promote the health and well employees who are involved in this task and the annual budget being of your employees? If so, indicate the number of that is available for this purpose.	Yes		Dr Bagwandeen (HIV/AIDS) Ms K Naidoo (EAP) Mr C Mabaso (Occupational Health)
3. Has the department introduced an Employee Assistance or Health Promotion Programme for your employees? If so, indicate the key elements/services of this Programme.	Yes, at Head Office and at institutional level		The EAP is a worksite-based programme designed to assist in the early identification and resolution of productivity problems associated with employees impaired by personal concerns which may adversely affect employee performance. The EAP: • Facilitates lifestyle change and wellness promotion in the context of improved productivity and performance • Provides simple, quick access to help and information • Assists with attracting, motivating and retaining the best people • Incorporates assistance on a broad range of issues • Meets the specific changes facing the organisation, country and the economy • Evaluates itself and adds value to the organisation
4. Has the department established (a) committee(s) as contemplated in Part VI E.5 (e) of Chapter 1 of the Public Service Regulations, 2001? If so, please provide the names of the members of the committee and the stakeholder(s) that they represent.		No	
5. Has the department reviewed its employment policies and practices to ensure that these do not unfairly discriminate against employees on the basis of their HIV status? If so, list the employment policies/practices so reviewed.	Yes		The employment practices of the Department do not exclude anyone on the basis of their HIV status. The status of prospective employees is not requested at any stage of the recruitment process
6. Has the department introduced measures to protect HIV-positive employees or those perceived to be HIV-positive from discrimination? If so, list the key elements of these measures.	Yes		The status of HIV positive employees, if known, is confidential. These employees are also able to access confidential voluntary counselling and testing. In cases where employees become infected with the virus as a result of their work (needle stick injuries) the necessary post exposure prophylaxis is made available to them in a confidential manner.
7. Does the department encourage its employees to undergo Voluntary Counseling and Testing? If so, list the results that you have you achieved.	Yes		Results confidential
8. Has the department developed measures/indicators to monitor & evaluate the impact of its health promotion programme? If so, list these measures/indicators.		No	This response is in the context of employees only and not with regard to patients

Table 71: Collective agreements, 1 April 2003 to 31 March 2004

Total collective agreements	None*

**Collective agreements are negotiated at national level*

Table 72: Misconduct and disciplinary hearings finalised, 1 April 2003 to 31 March 2004

Outcomes of disciplinary hearings	Number	% of total
Correctional counselling	37	13
Verbal warning	53	18.6
Written warning	48	16.8
Final written warning	63	22.1
Suspended without pay	29	10.2
Fine	2	0.7
Demotion	4	1.4
Dismissal	25	8.8
Not guilty	3	1.0
Case withdrawn	21	7.4
Total	**285**	**100**

Table 73: Types of misconduct addressed at disciplinary hearings

Type of misconduct	Number	% of total
Theft	23	9.8
Fraud	11	4.7
Absent without leave	148	62.7
Insubordination	8	3.4
Alcohol abuse	10	4.2
Moonlighting	0	0
Vehicle abuse	8	3.4
Assault	10	4.2
Negligence	18	7.6
Total	**236**	**100**

Table 74: Grievances lodged for the period 1 April 2003 to 31 March 2004

	Number	% of Total
Number of grievances resolved	16	57.1
Number of grievances not resolved	12	42.9
Total number of grievances lodged	**28**	**100**

Table 75: Disputes lodged with Councils for the period 1 April 2003 to 31 March 2004

	Number	% of Total
Number of disputes upheld	22	66.7
Number of disputes dismissed	11	33.3
Total number of disputes lodged	**33**	**100**

Table 76: Strike actions for the period 1 April 2003 to 31 March 2004

Total number of person working days lost	0
Total cost (R'000) of working days lost	0
Amount (R'000) recovered as a result of no work no pay	0

Table 77: Precautionary suspensions for the period 1 April 2003 to 31 March 2004

Number of people suspended	9
Number of people whose suspension exceeded 30 days	3
Average number of days suspended	90
Cost (R'000) of suspensions	R34 663.64

Table 78: Training needs identified 1 April 2003 to 31 March 2004

Occupational Categories	Gender	Number of employees as at 1 April 2003	Training needs identified at start of reporting period			
			Learnerships	Skills Programmes & other short courses	Other forms of training	Total
Legislators, senior officials and managers	Female	242	N/A	272	N/A	272
	Male	202	N/A	199		199
Professionals	Female	10 983	N/A	3 819	N/A	3 819
	Male	3 027	N/A	516		516
Technicians and associate professionals	Female	13 538	Gen.Nursing Aux-32 Enrolled Nursing-32 Darkroom Attend-15 Pharm. Asst.-95	313	N/A	493
	Male	2 627	Gen. Nursing Aux.-5 Enrolled Nursing- 4 Darkroom Attend.-14 Pharm. Asst.-171	196		390
Clerks	Female	2 347	N/A	1 568	N/A	1 568
	Male	2 150		900		900
Plant and machine operators and assemblers	Female	393	N/A	14	N/A	14
	Male	1 068		120		120
Elementary occupations	Female	7 336	N/A	3 465	N/A	3 465
	Male	5 844		1 025		1 025
Sub Total	Female	34 839	180	9 451	N/A	9 536
	Male	14 918	194	2 956		2 979
Total		**49 757**	**374**	**12 407**	**0**	**13 274**

Table 79: Training provided 1 April 2003 to 31 March 2004

Occupational Categories	Gender	Number of employees as at 1 April 2003	Training provided within the reporting period			
			Learnerships	Skills Programmes & other short courses	Other forms of training	Total
Legislators, senior officials and managers	Female	242	0	272	0	272
	Male	202	0	199	0	199
Professionals	Female	10 983	0	3 819	0	3 819
	Male	3 027	0	516	0	516
Technicians and associate professionals	Female	13 538	162	313	0	475
	Male	2 627	180	196	0	376
Clerks	Female	2 347	0	1 568	0	1 568
	Male	2 150	0	900	0	900
Plant and machine operators and assemblers	Female	393	0	14	0	14
	Male	1 068	0	120	0	120
Elementary occupations	Female	7 336	0	3 465	0	3 465
	Male	5 844	0	1 025	0	1 025
Sub Total	Female	34 839	162	9 451	0	9 613
	Male	14 918	180	2 956	0	3 136
Total		**49 757**	**342**	**12 407**	**0**	**12 749**

Table 80: Injury on duty, 1 April 2003 to 31 March 2004

Nature of injury on duty	Number	% of total
Required basic medical attention only	256	75.5
Temporary Total Disablement	82	24.2
Permanent Disablement	0	0
Fatal	1	0.3
Total	**339**	**100**

Table 81: Report on consultant appointments using appropriated funds

Project Title	Total number of consultants that worked on the project	Duration: work days	Contract value in Rand
Strategic Management and Transformation	1 Consultancy	April 2003 to March 2004	R1 033 118.30
Human Resource matters	1 Consultancy	April 2003 to February 2004	R 810 278.95
Compilation of Departmental Strategic Plans for MTEF 2003 – 2006	1 Consultancy	4 months	R 320 903.48
Legal Advisory Services & drafting of contracts	1 Consultancy	April 2003 to March 2004	R 452 717.63
Total number of projects	**Total individual consultants**	**Total duration: Work days**	**Total contract in Rand**
Legal Services	1 Consultant	April 2003 to December 2003	R 915 216.55

Table 82: Analysis of consultant appointments using appropriated funds, in terms of Historically Disadvantaged Individuals (HDI's)

Project Title	Percentage ownership by HDI groups	Percentage management by HDI groups	Number of Consultants from HDI groups that work on the project
Strategic Management and Transformation Human Resource matters Compilation of Departmental Strategic Plans for MTEF 2003 – 2006 Legal Services	Not available	Not available	4

Table 83: Report on consultant appointments using Donor funds

Project Title	Total number of consultants that worked on the project	Duration: work days	Contract value in Rand
0	0	0	0
Total number of projects	**Total individual consultants**	**Total duration: Work days**	**Total contract in Rand**
0	0	0	0

Table 84: Analysis of consultant appointments using Donor funds, in terms of Historically Disadvantaged Individuals (HDI's)

Project Title	Percentage ownership by HDI groups	Percentage management by HDI groups	Number of Consultants from HDI groups that work on the project
NIL	0	0	0

REPORT OF THE AUDIT COMMITTEE

We are pleased to present our report for the financial year ended 31 March 2004.

Audit Committee Members and Attendance:

The Audit Committee consists of the members listed hereunder and met 4 times as per its approved terms of reference.

Name of Member	*Number of Meetings Attended*
R Morar (Chairperson)	*4*
BP Campbell	*4*
BS Khuzwayo	*4*
ADK Leisegang	*4*
DSD Shabalala	*2*
RK Sizani	*0*
RW Green-Thompson	*1*

Audit Committee Responsibility

The Audit Committee reports that it has complied with its responsibilities arising from Section 38 (1)(a) of the Public Finance Management Act and Treasury Regulation 3.1.13. The Audit Committee also reports that it has adopted appropriate formal terms of reference as its Audit Committee Charter, has regulated its affairs in compliance with this charter and has discharged all its responsibilities as contained therein.

The Effectiveness of Internal Control

Our review revealed that the Department has implemented systems of internal control for major areas of its operations. Results of Risk Analysis conducted have been raised with the Department of Health.

The quality of in year management / quarterly reports submitted in terms of the Treasury Regulations and the Division of Revenue Act

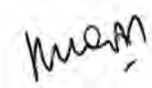
The Committee cannot at this stage comment on the content and quality of monthly and quarterly reports prepared and issued by the Accounting Officer and the Department during the year under review.

Evaluation of Financial Statements

The Audit Committee has:

- Reviewed the audited annual financial statements to be included in the annual report;
- Taken into consideration the Auditor-General's management letters and management's responses;
- Reviewed changes in accounting policies and practices;
- Reviewed significant adjustments resulting from the audit.

The Audit Committee concurs and accepts the conclusions of the Auditor-General on the annual financial statements and is of the opinion that the audited annual financial statements be accepted and read together with the report of the Auditor-General.



Chairperson of the Audit Committee
R MORAR
Date: 10/08/2004

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MANAGEMENT REPORT
for the year ended 31 MARCH 2004

Report by the Accounting Officer to the Provincial Legislature of the KwaZulu-Natal Government

1. GENERAL REVIEW OF THE STATE OF FINANCIAL AFFAIRS

Under/(Over) Spending

PROGRAMME	FINAL ALLOCATION	ACTUAL EXPENDITURE	VARIENCE
	R ' 000	R ' 000	R ' 000
1. Administration	154,300	153,449	851
2. District Health Services	3,770,364	3,771,028	(664)
3. Emergency Medical Services	272,046	272,046	-
4. Provincial Hospital Services	2,569,322	2,570,991	(1,669)
5. Central Health Services	770,377	765,370	5,007
6. Health Sciences and Training	321,663	321,156	507
7. Health Care Support Services	10,400	10,400	-
8. Facilities Management	388,055	347,492	40,563
Special Functions	-	31,884	(31,884)
Statutory Payment	607	727	(120)
Total	**8,257,134**	**8,244,543**	**12,591**

Overall Comment

During the financial year the Department continued with its primary function to provide comprehensive and quality health services at all levels of care to the population of KwaZulu-Natal in line with the provincial priorities.

The Department has focused on the provision of additional clinics and community health centres to ensure improved access to health services to the poor and underserved areas. Coupled with this is the continuing roll out of emergency medical and rescue services to the underserved and poverty stricken areas. The upgrading of the district hospitals in the drive towards equality is also continuing.

The management of both the prevention and treatment of HIV/AIDS in the province continues to pose a major challenge to the Department. The total impact of HIV/AIDS on health services is not easily identifiable in financial terms. Through its prevention programme, great strides have been made with the roll out of the Counselling and Voluntary Testing (CVT), Prevention of Mother to Child Transmission (PMTCT) of HIV/AIDS and Post Exposure Prophylactic (PEP) treatment programmes. Although the programmes have been successful, there are still areas of the province that need to be reached.

The workload of all services has increased during the

MANAGEMENT REPORT
for the year ended 31 MARCH 2004

year. The patient statistics indicate an increase in the demand for health services at a higher rate than the increase in funding and human resource provision.

Unauthorised expenditure

The Public Finance Management Act defines unauthorised expenditure as:

- "the overspending of a vote or a main division within a vote, or
- expenditure that was not made in accordance with the purpose of a vote or, in the case of a main division, not in accordance with the purpose of the main division."

The main division within the vote is at programme level. Furthermore Sec 43 (4) (c) of the PFMA does not authorise the utilisation of a saving in an amount appropriated for capital expenditure in order to defray current expenditure.

Therefore in compliance with the PFMA the Department has calculated the unauthorised expenditure as the overspending on the current expenditure of a programme and not the net overspending of the entire vote.

The unauthorised expenditure for the year is R 2,333 mil, which is overspending on District Health Services (R 664,000) and Provincial Hospital Services (R1,669 mil). This amount represents a 0.018% and 0.065% over expenditure on the respective main divisions of the Vote.

Administration

Expenditure on this programme relates to the head office functions and strict control over the spending resulted in an under expenditure which could be used by the service delivery components. After effecting the approved virements the final under expenditure is R 851,000 (0.55% of the main division allocation).

District Health Services

The over expenditure in this programme, after the approved virements have been effected, is R 664,000 (0.018% of the main division allocation), which can be attributed to incorrect allocations by institutions between current and capital expenditure.

Emergency Medical Services

This programme incurred over expenditure and after effecting the approved virements the expenditure on the main division is as authorised.

Provincial Hospital Services

The over expenditure in this programme, after the approved virements have been effected, is R 1,669 mil (0.065% of the main division allocation). R300,000 over expenditure can be attributed to incorrect allocations by institutions between current and capital expenditure. R 1,369 mil is in respect of the increase in the inventory of the Central Provincial Store, which should not be accounted for on the Balance Sheet due to the cash basis of accounting.

Central Health Services

The under expenditure in this programme, after the approved virements have been effected, is R 5,007 mil (0.64% of the main division). The reason for the under expenditure relates to delays in the purchase of equipment for Grey's Hospital and an underspending on the Professional Training Development Grant of R3,040 mil, which will be rolled over to 2004/05.

Health Sciences and Training

Expenditure on this programme relates mainly to the training of health professionals and after effecting the approved virements the final under expenditure is R 507,000 (0.16% of the main division allocation).

Health Care Support Services

Expenditure on this programme is as approved for this main division.

MANAGEMENT REPORT
for the year ended 31 MARCH 2004

Health Facilities Management

After effecting the approved virements the final under expenditure is R 40,563 mil (11.15% of the main division allocation). This resulted mainly from the delays in the process of finalising the tenders for some major capital projects. A request has been made to Provincial Treasury for the roll over of a portion of these funds.

Special Functions

During the 2002/03 financial year an exercise to analyse each of the debt accounts was undertaken mainly to identify the irrecoverable debt accounts some of which dated back to 1994 and inherited from either the National Department of Health or Provincial Treasury. The debts were considered to be irrecoverable based on the following criteria:

- Unable to trace the debtor
- Prescription period has expired
- Uneconomical to invest further funds to recover these debts
- The debtor is deceased and the recovery of the debt would cause undue hardship on the beneficiaries

The exercise was completed in the 2003/04 financial year resulting in a write off totalling R 27,911 mil made up as follows:

- Staff Debts R 18 534 000
- Nutrition Debts R 9 377 000

Amongst the debit balances were also credit balances totalling R3,473 mil, which was not offset against the debt outstanding, as the amounts could not be traced to the individual debtors. The amount was written back to revenue.

Statutory Payment

The apparent over expenditure refers to the salary increases granted to the executive authorities but not voted for as part of the statutory payments in the Adjustments Estimate. The Department funded this over expenditure.

Conditional Grants

A grant of R129,860 mil was received for hospital revitalisation. In October 2003 the Department realised that the full grant will not be spent in the 2003/04 financial year and therefore requested for a roll over of R70 mil. The rollover was granted by Provincial Treasury and suspended in the Adjustments Estimate of the Department. The funds will be included in the Adjustments Estimate in the 2004/05 financial year.

Changes in policies and strategic objectives

During the financial year the Department continued with its primary function to provide comprehensive and quality health services at all levels of care to the population of KwaZulu-Natal in terms of policies introduced since 1995, which included:

- The implementation of primary health care through the district health system.
- The continuation of the drive in respect of the comprehensive management of HIV/AIDS.
- The provision of an Integrated Nutrition Scheme.
- The immunisation of all new born babies and children.
- The drive to provide facilities in the underserved areas to improve access to health services.
- The roll out of the programme for the prevention of the transmission of HIV/AIDS from Mother-to-Child, throughout the Province.
- The provision of prophylactic use of anti-retrovirals for rape survivors.

During the financial year three new policies were implemented: -

- The implementation of the scarce skills and rural allowances for health care professionals.

- The preparation for the rollout of the provision of anti-retroviral to eligible HIV positive patients.
- The extension of the Primary School Nutrition Programme to additional rural schools, in informal settlement areas and all farm schools.

Impact on Service Delivery

Despite the constraints of limited financial resources to meet the demand for health services, during 2003/04, the Department managed to continue to provide basic services in the underserved rural areas through the primary health care approach. The first target in this regard is to provide for 2.8 visits per non-medical aid member per annum, (21 million headcounts per annum). Figures at the clinics and community health centres continue to show a steady increase, from 12,773 million in 1999/2000 to 17,139 million in 2002/03. The target set for the 2003/04 financial year is 19,231 million, an 11% increase.

In addition, the Department continued to phase in new clinics in the rural areas. A further 6 new and 7 replacement clinics have been completed in the 2003/04 financial year, bringing the total number of new and replacement clinics since 1996/97 to 145. Furthermore, two community health centres were completed one at Nseleni, which was built and equipped by Japanese Government funding and the second at Paulpietersburg, funded by the Department, in the 2003/04 financial year.

During the year the Department has vigorously expanded its Emergency Medical and Rescue Services to the vast areas where these services were non-existent.

The Department is required to further expand its services in the underserved areas but were unable to do this to the fullest extent due to the paucity of funds. This mainly refers to the eradication of backlogs in health facilities and the provision of emergency medical and rescue services in the underserved areas. The increase in demand for health services resulting from the HIV/AIDS pandemic has a major effect on the cost of treating patients as patients are returning for treatment continuously and in-patient stays are prolonged.

2. PERFORMANCE INFORMATION

The Department in its Budget Statement for 2003/04 has set targets to measure the performance of the Department on the various programmes representing its functions. It has put in place systems to collect the data in order to measure the targets. In most cases the information is available but in some cases the Department experiences problems in obtaining the accurate and timeous information due to inadequate systems in remote areas. Listed below are the estimated actual outputs for the year compared to the budget targets as per the Budget Statement.

District Health Services

- Primary Health Care facilities treated an estimated 18,973 million cases whilst the target set for the year was 19 million.
- District Hospitals admitted an estimated 384,476 patients against a target of 275,598 admissions.

Emergency Medical and Rescue Services

- Emergency Medical and Rescue Services dealt with an estimated 577,163 cases whilst the target set for the year was 387,000 cases.

Provincial Hospital Services

- Regional Hospitals admitted an estimated 365,869 patients against a target of 275,000 admissions.

Central Hospital Services

- Central and Tertiary Hospitals Services admitted an estimated 83,539 patients against a target of 71,000 admissions.

Health Sciences

- The various training functions undertaken by the Department has provided training for an estimated 10,506 persons compared to the 6,785 persons trained in 2002/03. The target set for the year was 12,792, which could not be reached due to a delay in the computer training resulting from a change in service providers.

3. SERVICES RENDERED BY THE DEPARTMENT

3.1 Tariff Policy

The main source of revenue for the Department, over and above its voted amount, is patient fees, which is based on the Uniform Patient Fee Schedule as prescribed by National Department of Health. This fee structure was updated on 1 November 2002 and will in future be adjusted as and when the National decisions on the extent of the adjustments are taken by the joint committee comprising the National and Provincial Departments of Health.

3.2 Free Services

Free services are provided in accordance with National policies to certain categories of patients, viz. pregnant women, children under five, certain communicable diseases, the aged, the poor and persons with disabilities. There are no other free services rendered by the Department.

4. CAPACITY CONSTRAINTS

Although the Department has dedicated and loyal staff to provide health services it has found that many areas of its services are inadequately staffed and that in some cases, despite repeated recruitment, it is unable to attract skilled and suitable personnel. The contributing factors are:

- The losses in nursing and other professional staff to the private sector and/or other countries
- Poor remuneration in the public service for certain categories of professional health workers
- The lack of incentives for the recruitment of professional and managerial staff particularly in remote areas and
- The recruitment of skilled financial management staff, especially in rural hospitals.

This state of affairs may improve for certain groups of professional health workers in the next financial year as a result of the scarce skills and rural allowances implemented in February 2004.

In regard to the nursing staff the Department has continued with its policy to double the student nurse intake. To ensure a supply of additional doctors, bursaries are granted. Special training programmes are being implemented to enhance managerial and financial capacity. In certain areas the lack of capacity may have serious impact on service delivery and financial management.

5. UTILISATION OF DONOR FUNDS

During the financial year under review donor funds, received by the Department, both local and foreign, totalled R12,440 mil. Expenditure totalling R 3,120 mil was incurred against these projects. The net under expenditure will be rolled over to the 2004/05 financial year. The under-spending is mainly in regard to the European Union Partnership for the development of Primary Health Care Programme, which, due to capacity problems did not perform well during the year. These problems have now been addressed and the programme will be completed in the 2004/05 financial year.

A number of small donations, totalling R6,697 mil, were received and are managed in terms of approved management plans. Because the funds are, in most cases, additional to budget the benefit of these funds to the Department is that it enables the Department to undertake special projects and investigations, which would under normal circumstances, not have been undertaken. Donor funds are normally once-off donations and for fixed periods and can therefore not be utilised for any major enhancement of service delivery.

During the year the final approval for the utilisation of USD 26,741,529 from the Global Fund for HIV/AIDS, TB and Malaria, has been granted. These funds were allocated to the Department as custodian of the funds for the partners in this project. The Provincial Treasury has received the first payment of R86,702 mil on 10 February 2004 of which R52,108 mil has been transferred on 11 February 2004 to the Health Global Fund Account for the period February 2004 to April 2004. The relevant funds have been transferred to the various beneficiaries, during February 2004 and March 2004, in accordance with their requests and submitted cashflows for February 2004 to April 2004.

6. TRADING ENTITIES

The only trading activity for the Department of Health is the Provincial Medical Supply Centre. This entity purchases pharmaceuticals from the suppliers and these are then distributed to the various institutions as requested. The pharmaceuticals are charged at actual cost plus a mark-up of 4% to 12% to cover the administrative costs. A surplus of R1,279 mil has been surrendered to Treasury in the 2003/04 financial year.

7. TRANSFER PAYMENTS

Transfer payments are made to various institutions and groups by the Department of Health. These institutions and groups are categorised as follows:

- Subsidised Hospitals providing hospital care
- School Governing Bodies for nutrition services
- Service organisations and churches providing clinic services
- Local Authorities for primary health care services
- Service organisations for HIV/AIDS campaigns
- Private entities for health services rendered in terms of a contract.

Refer to annexure 1 B & C for a detailed schedule of transfer payments made during the year. Accountability arrangements are being instituted over each entity, to ensure that funds are utilised for the purposes stipulated. Transfer payments are made based on the submission of claims by the various entities.

8. PUBLIC PRIVATE PARTNERSHIP

There was a variation to the public private partnership agreement between the Department of Health, Cowslip Investments (Pty) Ltd and Impilo Consortium for the Inkosi Albert Luthuli Central Hospital. The variation catered for the inclusion of the provision of laboratory services. Refer to note 32 for the financial obligations for the remainder of the contract.

The Department has appointed Transaction Advisors to investigate the possibility of entering into public private partnerships for the outsourcing of certain non-core functions at the hospitals. These investigations are currently in the early stages and no approvals have been granted or feasibility studies drafted, in this respect.

MANAGEMENT REPORT
for the year ended 31 MARCH 2004

9. CORPORATE GOVERNANCE ARRANGEMENTS

9.1 Risk management

In consultation with Provincial Treasury's Internal Audit Unit the Department's Audit and Risk Management component has drawn up a risk management report in accordance with the Provincial Risk Management Guidelines.

The Department's Risk Management policy is being rolled out in the form of risk management workshops with all institutional managers being involved in the identification and mitigation of risks.

9.2 Fraud prevention plan

The Department has developed a fraud prevention plan, which is currently operational and will work closely with the Provincial Treasury's Internal Audit component.

9.3 Effectiveness of Internal Audit and Audit Committees

Internal Audit and Audit Committee's in this Province has been centralised in the Provincial Treasury. The Department's Internal Audit component presently handles all management letters from the Auditor-General, all audit reports from the Provincial Treasury's Internal Audit Unit and all inspection reports from the Department's Internal Control Division.

The findings from the aforementioned reports are perused and the relevant responses compiled on behalf of the Head of the Department. On receipt of the reports the managers of the audited entities are requested to present themselves to the Departmental Internal Audit and Risk Assessment Committee (DIARAC) where the report is discussed and the relevant manager is given an opportunity to present his/her action plan on the reduction/mitigation of the identified risks.

The DIARAC also monitors the implementation process of the corrective measures at the audited entity. The Audit and Risk Management Component facilitates the monitoring by undertaking physical follow-ups at the audited entities.

9.4 Code of Conduct

The Labour Relations Directorate has conducted workshops at the institutions to roll out the Code of Conduct as issued by the Public Service Commission. Disciplinary procedures are followed if there is non compliance to the Code of Conduct.

9.5 Occupational Health and Safety

In accordance with the Occupational Health and Safety Act no. 85 of 1993 committees have been established at the institutions and regular meetings are conducted to ensure compliance with the Act.

10. PROGRESS WITH FINANCIAL MANAGEMENT IMPROVEMENTS

The Department, in its financial management improvement programme has continued to enhance financial management and financial capacity within its institutions. Although significant progress has been made to delegate functions to institutional level the Department still experiences problems in attracting appropriately skilled staff in financial management to its institutions. The Department is however convinced that the decentralisation route chosen is the correct one. Financial control over budgets has improved dramatically as most institutions are able to manage their finances monthly by performing monthly cashflow analysis. During the year financial managers have been appointed at the institutions leaving 10 institutions (12%) without a financial manager at the appropriate level. Acting financial managers have been appointed in these 10 institutions.

The Department has in place a participatory budgeting process involving all its institutions and service

MANAGEMENT REPORT
for the year ended 31 MARCH 2004

delivery components, which results in a more credible budgeting process based on actual requirements of the various districts.

The Department has finalised its procurement delegations to ensure efficiency in procurement and has rolled out these delegations to all its institutions. A major revision of the financial management delegations is being undertaken and will be finalised in the 2004/05 financial year.

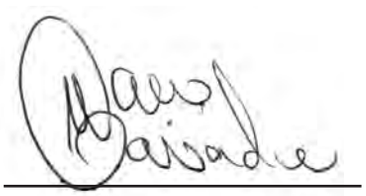
11. EVENTS AFTER THE REPORTING DATE

The full roll out of the provision of anti-retrovirals will commence in 2004/05. A conditional grant has been approved which is significantly lower than the Department's financial estimates for the period.

With effect from 1 April 2004 there is a function shift of the Primary School Nutrition Programme from the Department of Health to the Department of Education and Culture. The relevant Conditional Grant will now be received by the Department of Education.

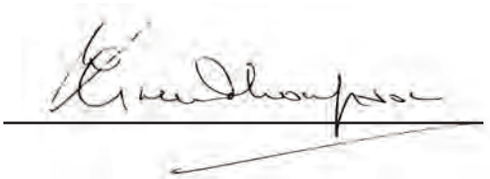
Approval

The annual financial statements set out on pages 200 to 258 is hereby recommended by the Chief Financial Officer of the Department of Health: KwaZulu-Natal.



MR. H. A. W. CONRADIE
CHIEF FINANCIAL OFFICER:
DEPARTMENT OF HEALTH
28 May 2004

The annual financial statements set out on pages 200 to 258 is hereby approved by the Accounting Officer of the Department of Health: KwaZulu-Natal.



PROFESSOR R.W. GREEN-THOMPSON
ACCOUNTING OFFICER and HEAD:
DEPARTMENT OF HEALTH
28 May 2004

REPORT OF THE AUDITOR-GENERAL TO THE KWAZULU-NATAL PROVINCIAL LEGISLATURE ON THE FINANCIAL STATEMENTS OF VOTE 7 – DEPARTMENT OF HEALTH for the year ended 31 MARCH 2004

1. AUDIT ASSIGNMENT

The financial statements as set out on pages 200 to 258, as well as the financial statements in respect of the Provincial Medical Supply Centre trading entity, as set out on pages 261 to 275, for the year ended 31 March 2004, have been audited in terms of section 188 of the Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996), read with sections 3 and 5 of the Auditor-General Act, 1995 (Act No. 12 of 1995). These financial statements, the maintenance of effective control measures and compliance with relevant laws and regulations are the responsibility of the accounting officer. My responsibility is to express an opinion on these financial statements, based on the audit.

2. NATURE AND SCOPE

The audit was conducted in accordance with Statements of South African Auditing Standards. Those standards require that I plan and perform the audit to obtain reasonable assurance that the financial statements are free of material misstatement.

An audit includes:

- examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements,
- assessing the accounting principles used and significant estimates made by management, and
- evaluating the overall financial statement presentation.

Furthermore, an audit includes an examination, on a test basis, of evidence supporting compliance in all material respects with the relevant laws and regulations, which came to my attention and are applicable to financial matters.

I believe that the audit provides a reasonable basis for my opinion.

3. AUDIT OPINION

In my opinion, the financial statements fairly present, in all material respects, the financial position of the Department of Health at 31 March 2004 and the results of its operations and cash flows for the year then ended, in accordance with prescribed accounting practice.

4. EMPHASIS OF MATTER

Without qualifying the audit opinion expressed above, attention is drawn to the following matters:

4.1 Unauthorised expenditure

As disclosed in note 13.2 to the financial statements, a total amount of R2 333 000 was overspent on programmes 2 and 4 (being over-expenditure of R664 000 on District Health Services and R1 669 000 on Provincial Hospital Services, respectively), during the year under review.

4.2 Transfer payments

Notwithstanding the fact that this matter was raised in the prior years' audit reports, entities to which transfer payments were made during the year, did not submit the written assurance, as required by section 38(1)(j) of the Public Finance Management Act, 1999 (Act No. 1 of 1999).

In terms of the aforesaid act, the accounting officer of a department, before transferring any funds to an entity, must obtain written assurance that the entity implements effective, efficient and transparent financial management and internal control systems, or, if such written assurance cannot be obtained, then render the transfer of funds subject to conditions, which compels the entity to implement the necessary remedial measures.

REPORT OF THE AUDITOR-GENERAL TO THE KWAZULU-NATAL PROVINCIAL LEGISLATURE ON THE FINANCIAL STATEMENTS OF VOTE 7 – DEPARTMENT OF HEALTH for the year ended 31 MARCH 2004

The department introduced the use of service level agreements as a means to ensuring that transfer payments were utilised for their intended purpose, however, very few of these had been signed for the 2003-2004 financial year. For those institutions for which service level agreements were in existence, these were signed after the first payment was made.

4.3 Suspense accounts

As at 31 March 2004, there were uncleared suspense accounts amounting to R11 794 000 [2002-2003: R19 672 000], as detailed below.

Suspense account	2004	2003
Debits	R1 928 000	R3 950 000
Credits	R9 866 000	R15 722 000
Total	R11 794 000	R19 672 000

In terms of Treasury regulation 17.1.2, the amounts included in clearing or suspense accounts should be cleared and correctly allocated to the relevant cost centres on a monthly basis.

4.4 Foreign employees

During the audit of the employment arrangements of foreign nationals, it was noted that there was no evidence that the department notified the Department of Home Affairs when the services of a foreigner was terminated, as required by section 19(2)(c) of the Immigration Act, 2002 (Act No. 13 of 2002).

4.5 Asset registers

It was noted that the minimum requirements for the maintenance of an assets register, as detailed in paragraph 10.1 of Practice Note 006 issued by Provincial Treasury, were not being complied with by any of the department's regional institutions audited during the year. In all instances, the assets registers were not up to date, and information regarding the description and category of the asset, unique identification number, date of purchase, location and purchase price were not recorded thereon.

4.6 Public-private partnership – Inkosi Albert Luthuli Central Hospital

The department entered into a public-private partnership (PPP) agreement with two consortiums, for the supply of equipment, information management and technology, facilities management and all associated services for the Inkosi Albert Luthuli Central Hospital (IALCH). An audit of the project agreement, output specifications and penalty regime was conducted, with a view to determining the extent of compliance therewith by both parties.

In terms of Treasury regulation 16.7, the accounting officer is responsible for ensuring that the PPP agreement is properly enforced, and must maintain mechanisms and procedures for, amongst others, measuring the outputs of the agreement, monitoring and regulating the implementation thereof, and performance in terms of the agreement, and generally overseeing the day-to-day management of the agreement.

The audit highlighted a number of areas where the project agreements and output specifications were not being complied with. These observations were brought to the attention of the department in a management letter issued to the acting Chief Executive Officer of IALCH on 21 July 2004. A crucial link and control mechanism to enforce compliance with the project agreement is the operation of the helpdesk, where the logging of complaints from staff is captured and managed, and which then filters into the penalty regime. The service fee being paid by the department to the private partner was not being adjusted, as it should be, due to the fact that the poor service, as highlighted in the aforementioned management letter, was not being adequately reported to the helpdesk. Poor monitoring by the staff was resulting in the hospital not operating at the highest standards in terms of quality, efficiency, effectiveness, and focused patient care.

REPORT OF THE AUDITOR-GENERAL TO THE KWAZULU-NATAL PROVINCIAL LEGISLATURE ON THE FINANCIAL STATEMENTS OF VOTE 7 – DEPARTMENT OF HEALTH for the year ended 31 MARCH 2004

4.7 Request for rollovers

It was noted that a request for the rollover of unspent conditional grants was submitted to Provincial Treasury on 13 May 2004. In terms of Treasury regulation 6.4.2, requests for rollovers must be submitted to the relevant treasury on or before the last working day of April. As at date of this report, Provincial Treasury has not as yet granted approval therefor.

4.8 Cheque payments

Notwithstanding the fact that this matter was reported on in the prior year, it was noted that the department still processed more than 6 000 cheque payments in excess of R2 000 during the year. This is contrary to Treasury regulation 15.12.3, which states that all payments in excess of R2 000 must be effected electronically unless otherwise approved by treasury, and any non-compliance therewith constitutes a financial misconduct.

4.9 Financial management

It was noted during the course of audit of the various components within the department, both at head office as well as at the institutions, that the policies, procedures and controls implemented by management, were not being adhered to at all times. This is evident from the wide variety of findings as detailed in the number of management letters issued during the audit. The primary root causes for these findings arising can be attributed to the lack of enforcement of policies and procedures, the lack of supervision/review, the lack of reconciliations, as well as the non-compliance with legislation.

In addition to the aforementioned, it was noted that the Province's internal audit unit (internal audit) did not perform any internal audits during the year under review, other than a risk analysis of the department, and special investigations at the request of the accounting officer. Consequently, the functions of internal audit as envisaged in Treasury regulations 3.2.11 and 3.2.12 were not fulfilled during the year under review.

4.10 Computer audits

4.10.1 An audit of the general controls at the Inkosi Albert Luthuli Central Hospital was carried out during the year. The effectiveness of the general controls were measured against the internationally accepted Control Objectives for Information and Related Technology framework and industry best practices. The most significant control weaknesses identified were the following:

(a) A comprehensive disaster recovery plan had not been developed for the IALCH.

(b) The current settings and profiles of SAP users allowed excessive access to transactions, tables, administration functions, ABAP programs and standing data.

(c) Medicom user profiles did not adequately restrict users' access to system functions that were commensurate with their job responsibilities.

(d) Detective controls to compensate for the weaknesses identified were not in place as user activities and security events were not logged and monitored.

(e) A limitation was placed on the scope of the audit due to the unavailability of crucial audit evidence.

4.10.2 A general computer controls review surrounding the MEDSAS information system at the Provincial Medical Supply Centre (PMSC) was conducted. Some of the major concerns raised are as follows:

REPORT OF THE AUDITOR-GENERAL TO THE KWAZULU-NATAL PROVINCIAL LEGISLATURE ON THE FINANCIAL STATEMENTS OF VOTE 7 – DEPARTMENT OF HEALTH for the year ended 31 MARCH 2004

(a) Although draft IT security policies, which include, software piracy policy, email security policy, Internet acceptable-use policy, and virus protection standards and procedures existed within the department, they had not been finalised and circulated for acknowledgement by all users. IT policies were originally prepared by Head Office in 2002 and have not been updated to conform to current recognised standards such as ISO17799.

(b) A formal disaster recovery plan has not been prepared for the PMSC. With the PMSC's dependence on data processing operations, the implementation, and testing of a contingency plan is essential to ensure continuity of critical business applications. In addition, the physical and environmental controls around the computer room could be improved.

(c) A risk assessment, which involves valuation of business information resources and identification and assessment of the levels of risks present, has not been performed. A risk assessment is important to ensure that the PMSC's information security architecture and IT security programs is appropriate.

(d) A formal service level agreement had not been not been finalised between the PMSC, State Information Technology Agency (SITA) and IHI. In addition, the IT strategy plan for the PMSC had not been finalised.

(e) A formal documented systems development life cycle methodology and change control process including user test plans and change control documentation were not consistently applied for all system modifications made by IHI at the PMSC.

(f) Logical access controls could be improved.

(g) To ensure a successful IT division Management must effectively manage the union between business processes and information systems. To achieve this critical success factors and key performance indicators need to be prepared by key IT stakeholders. These have not been prepared for PMSC HIS.

4.10.3 A general computer control review surrounding the Hospital Information System (HIS) at Addington Hospital was carried out. Some of the major concerns raised are as follows:

(a) A formal disaster recovery plan has not been prepared for the hospital. In addition, backups were not stored offsite. With Addington's and other hospitals' dependence on data processing operations, the implementation and testing of a contingency plan is essential to ensure continuity of critical business applications.

(b) Although draft information technology (IT) security policies, which include, software piracy policy, email security policy, Internet acceptable-use policy, and virus protection standards and procedures existed within the department, they had not been finalised and circulated for acknowledgement by all users. IT policies were originally prepared by Head Office in 2002 and have not been updated to conform to current recognised standards, such as, ISO17799.

(c) A formal service level agreement did not exist between the department and SITA. In addition, the IT strategy plan for the Hospital had not been finalised.

REPORT OF THE AUDITOR-GENERAL TO THE KWAZULU-NATAL PROVINCIAL LEGISLATURE ON THE FINANCIAL STATEMENTS OF VOTE 7 – DEPARTMENT OF HEALTH for the year ended 31 MARCH 2004

(d) A formal documented systems development life cycle methodology and change control process including user test plans and change control documentation were not consistently applied for all system modifications at the hospital.

(e) At times external contractors, approved by the department, have added network components without the knowledge of Hospital Informatics. Furthermore, up-to-date network diagrams did not exist at the hospital. No network-monitoring tool other than for the Meditech servers was used at the hospital to monitor network performance and faults on the system. As the network is fourteen years old this could compromise network availability. It is essential that there is continual monitoring and timeous upgrade of network components to ensure network stability and redundancy (availability).

(f) The Nimda worm virus was found on parts of the network and users were vulnerable when sharing files across the network. Furthermore, no firewall is in place at Addington and Internet access is via Head Office's Opennet through its firewall. All PCs at the hospital use Trend PC Cillin 2000 anti virus. Support for the current version expired in June 2004, and older versions of PC Cillin, some of which date to 2000, will no longer support new downloads of virus protection patches/pattern files. In addition, older PCs will not run the new version of the anti virus software without being upgraded.

(g) Logical access controls require improvement.

(h) To ensure a successful IT division Management must effectively manage the union between business processes and information systems. To achieve these critical success factors, key performance indicators need to be prepared by key IT stakeholders. These have not been prepared for the Addington HIS.

4.11 Performance audits

Performance audits of the department's management of primary health care and sick leave have been completed. The key findings, possible areas for improvement as well as comments of the accounting officer, arising from these audits, will be reported on in a separate report.

5. APPRECIATION

The assistance rendered by staff of the Department of Health during the audit is sincerely appreciated.

B R Wheeler
for Auditor-General
Pietermaritzburg
29 July 2004

STATEMENT OF ACCOUNTING POLICIES AND RELATED MATTERS
for the year ended 31 March 2004

The financial statements have been prepared in accordance with the following policies, which have been applied consistently in all material respects, unless otherwise indicated. However, where appropriate and meaningful, additional information has been disclosed to enhance the usefulness of the financial statements and to comply with the statutory requirements of the Public Finance Management Act, Act 1 of 1999 (as amended by Act 29 of 1999), the Treasury Regulations for Departments and Constitutional Institutions issued in terms of the Act, and the Division of Revenue Act, Act 7 of 2003.

1. Basis of preparation
The financial statements have been prepared on a modified cash basis of accounting except where stated otherwise. The modified cash basis constitutes the cash basis of accounting supplemented with additional disclosures. The reporting entity is in transition from reporting on the cash basis of accounting to reporting on an accrual basis of accounting. Under the cash basis of accounting transactions and other events are recognised when cash is received or paid. Under the accrual basis of accounting transactions and other events are recognised when incurred and not when cash is received or paid.

2. Revenue
Voted funds are the amounts appropriated to a department in accordance with the final budget known as the Adjustment Estimates of Provincial Expenditure. Unexpended voted funds are surrended to the Provincial Revenue Fund. Interest and dividends received are recognised upon receipt of the funds, and no accrual is made for interest or dividends receivable from the last receipt date to the end of the reporting period. They are recognised as revenue in the financial statements of the Department and then transferred to the Provincial Revenue Fund.

3. Donor Aid
Donor aid is recognised in the Income Statement in accordance with the cash basis of accounting.

4. Current expenditure
Current expenditure is recognised in the Income Statement when the payment is made.

5. Unauthorised, irregular, and fruitless and wasteful expenditure
Unauthorised expenditure means:

- the overspending of a vote or a main division within a vote, or
- expenditure that was not made in accordance with the purpose of a vote or, in the case of a main division, not in accordance with the purpose of the main division.

Unauthorised expenditure is treated as a current asset in the Balance Sheet until such expenditure is recovered from a third party or funded from future voted funds.

Irregular expenditure means expenditure, other than unauthorised expenditure, incurred in contravention of or not in accordance with a requirement of any applicable legislation, including:

- the Public Finance Management Act ,
- the State Tender Board Act, or any regulations made in terms of this Act, or
- any provincial legislation providing for procurement procedures in that provincial government.

Irregular expenditure is treated as expenditure in the Income Statement.

STATEMENT OF ACCOUNTING POLICIES AND RELATED MATTERS
for the year ended 31 March 2004

Fruitless and wasteful expenditure means expenditure that was made in vain and would have been avoided had reasonable care been exercised. Fruitless and wasteful expenditure must be recovered from a responsible official (a debtor account should be raised), or the vote if responsibility cannot be determined. It is treated as a current asset in the balance sheet until such expenditure is recovered from the responsible official or funded from future voted funds.

6. Debts written off
Debts are written off when identified as irrecoverable. Debts written-off are limited to the amount of surplus funds available to the Department. No provision is made for irrecoverable amounts.

7. Capital expenditure
Expenditure for physical items on hand on 31 March 2004 to be consumed in the following financial year, is written off in full when they are paid and is accounted for as expenditure in the Income Statement.

8. Receivables
Receivables are not normally recognised under the cash basis of accounting. However, receivables included in the Balance Sheet arise from cash payments that are recoverable from another party. Receivables for services delivered are not recognised in the Balance Sheet as a current asset or as income in the Income Statement, as the financial statements are prepared on a cash basis of accounting, but are disclosed separately as part of the disclosure notes to enhance the usefulness of the financial statements.

9. Payables
Payables are not normally recognised under the cash basis of accounting. However, payables included in the Balance Sheet arise from cash receipts that are due to the Provincial Revenue Fund or another party.

10. Lease commitments
Lease commitments for the period remaining from the accounting date until the end of the lease contract are disclosed as a note to the financial statements. These commitments are not recognised in the Balance Sheet as a liability or as expenditure in the Income Statement as the financial statements are prepared on the cash basis of accounting.

11. Accruals
This amount represents goods/services that have been delivered, but no invoice has been received from the supplier at the reporting date OR an invoice has been received but remains unpaid at the reporting date. These amounts are not recognised in the Balance Sheet as a liability or as expenditure in the Income Statement as the financial statements are prepared on the cash basis of accounting, but are however disclosed.

12. Employee benefits

Short-term employee benefits
The cost of short-term employee benefits is expensed in the Income Statement in the reporting period when the payment is made. Short-term employee benefits, that give rise to a present legal or constructive obligation, are deferred until they can be reliably measured and then expensed. Details of these benefits and the potential liabilities are disclosed as a disclosure note to the financial statements and are not recognised in the Income Statement.

Termination benefits
Termination benefits are recognised and expensed only when the payment is made.

STATEMENT OF ACCOUNTING POLICIES AND RELATED MATTERS
for the year ended 31 March 2004

Retirement benefits

The department provides retirement benefits for its employees through a defined benefit plan for government employees. These benefits are funded by both employer and employee contributions. Employer contributions to the fund are expensed when money is paid to the fund. No provision is made for retirement benefits in the financial statements of the department. Any potential liabilities are disclosed in the financial statements of the National/Provincial Revenue Fund and not in the financial statements of the employer department.

Medical benefits

The department provides medical benefits for its employees through defined benefit plans. These benefits are funded by employer and/or employee contributions. Employer contributions to the fund are expensed when money is paid to the fund. No provision is made for medical benefits in the financial statements of the department. Post retirement medical benefits for retired civil servants are expensed when the payment is made to the fund.

13. Comparative figures

Where necessary, comparative figures have been adjusted to conform to changes in presentation in the current year. The comparative figures shown in these financial statements are limited to the figures shown in the previous year's audited financial statements and such other comparative figures that the department may reasonably have available for reporting.

INCOME STATEMENT (Statement of Financial Performance)
for the year ended 31 March 2004

	Note	2003/04 R'000	2002/03 R'000
REVENUE			
Voted Funds			
Annual Appropriation	1	8,256,527	7,419,180
Statutory Appropriation	2	607	526
Other revenue to be surrendered to revenue fund	3	130,630	117,809
Local and foreign aid assistance (incl RDP funds)	4	12,440	1,035
TOTAL REVENUE		**8,400,204**	**7,538,550**
EXPENDITURE			
Current			
Personnel	5	4,619,621	4,222,272
Administrative		247,833	197,656
Inventories	6	1,325,681	1,178,087
Machinery and equipment	7	35,449	41,094
Land and buildings	8	6,979	7,392
Professional and special services	9	816,307	688,483
Transfer payments	10	471,129	382,842
Miscellaneous	11	6,176	6,038
Special functions: authorised losses	12	31,884	39,797
Local and foreign aid assistance	4	2,923	1,646
Total Current Expenditure		**7,563,982**	**6,765,307**
Capital			
Personnel	5	69,484	64,117
Administrative		122	567
Inventories	6	22,753	15,074
Machinery and equipment	7	356,990	186,540
Land and buildings	8	144,182	219,276
Professional and special services	9	79,553	281,134
Transfer payments	10	10,400	5,000
Local and foreign aid assistance	4	197	-
Total Capital Expenditure		**683,681**	**771,708**
TOTAL EXPENDITURE		**8,247,663**	**7,537,015**
NET SURPLUS FOR THE YEAR		**152,541**	**1,535**
Add back unauthorised & fruitless and wasteful expenditure disallowed	13	2,333	158,183
NET SURPLUS FOR THE YEAR		**154,874**	**159,718**
Reconciliation of net surplus for the year			
Voted funds to be surrendered to the Revenue Fund	16	14, 924	42,520
Other revenue to be surrendered to the Revenue Fund	17	130,630	117,809
Local and foreign aid assistance (incl. RDP funds)		9,320	(611)
NET SURPLUS FOR THE YEAR		**154,874**	**159,718**

BALANCE SHEET (Statement of Financial Position) as at 31 March 2004

	Note	2003/04 R'000	2002/03 R'000
ASSETS			
Current assets		**689,179**	**710,210**
Unauthorised, fruitless and wasteful expenditure	13	676,832	678,090
Cash and cash equivalents	14	1,270	2,309
Receivables	15	11,077	29,615
Local and foreign aid assistance receivable from donor	4	-	196
TOTAL ASSETS		**689,179**	**710,210**
LIABILITIES			
Current liabilities		**679,811**	**710,162**
Payables	18	17,984	20,996
Provincial Treasury		661,827	689,166
TOTAL LIABILITIES		**679,811**	**710,162**
NET ASSETS		**9,368**	**48**
Represented by		**9,368**	**48**
Local and foreign aid assistance (incl. RDP funds)	4	9,368	48
TOTAL		**9,368**	**48**

STATEMENT OF CHANGES IN NET ASSETS
for the year ended 31 March 2004

	Note	2003/04 R'000	2002/03 R'000
Local and foreign aid assistance (incl. RDP funds) remaining			
Opening balance	4	48	-
New advances received in the current financial year	4	12,440	-
Expenditure incurred in the current year	4	(3,120)	-
Transfers		-	48
Closing balance	4	9,368	48

CASHFLOW STATEMENT
for the year ended 31 March 2004

	Note	2003/04 R'000	2002/03 R'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Net cash flow generated from operating activities	19	838,445	931,377
Cash generated (utilised) to (increase)/decrease working capital	20	16,784	(109,243)
Voted funds and revenue funds surrendered	21	(145,554)	(160,329)
Local and foreign aid assistance (incl. RDP funds)		196	462
Net cash flow available from operating activities		**709,871**	**662,267**
CASH FLOWS FROM INVESTING ACTIVITIES		**(683,571)**	**(771,659)**
Capital expenditure		(683,681)	(771,708)
Proceeds from sale of equipment	3	110	49
Net cash flows from operating and investing activities		**26,300**	**(109,392)**
Net increase/(decrease) in cash and cash equivalents		**26,300**	**(109,392)**
Cash and cash equivalents at beginning of period	22	**(686,857)**	**(577,465)**
Cash and cash equivalents at end of period	22	**(660,557)**	**(686,857)**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2004

1 Annual appropriation

1.1 Included are funds appropriated in terms of the Appropriation Act for National Departments (Voted funds) and Provincial Departments (Equitable Share)

Programmes	Total Appropriation 2003/04 R'000	Actual Funds Received 2003/04 R'000	Variance over/(under) 2003/04 R'000	Total Appropriation 2002/03 R'000
Administration	154,300	154,300	-	144,677
District Health Services	3,770,364	3,770,364	-	3,825,571
Emergency Medical Services	272,046	272,046	-	-
Provincial Hospital Services	2,569,322	2,569,322	-	1,917,836
Central Health Services	770,377	770,377	-	928,687
Health Sciences & Training	321,663	321,663	-	198,811
Health Care Support Services	10,400	10,400	-	-
Health Facilities Management	388,055	388,055	-	403,598
	8,256,527	**8,256,527**	**-**	**7,419,180**

		2003/04 R'000	2002/03 R'000
1.2 Conditional grants			
Total grants received	Annexure 1 A	1,128,899	1,167,495

2 Statutory appropriation

Statutory payments	607	526

3 Other revenue to be surrendered to the revenue fund

Board and lodging	6,821	5,687
Domestic services	494	430
Employer contributions	285	-
Fines and forfeiture	6	22
Health services	3,077	-
Housing rental recoveries	1,781	2,404
Interest	5,169	2,254
Loss control	628	510
Meals supplied to government employees	31	-
Miscellaneous revenue – other	7,346	-
Not prescribed by law/order - other	551	-
Other	158	6,142
Patient fees	95,067	97,080
Private telephone calls, photostats & faxes	395	249
Proceeds from sale of equipment	110	49
Refunds previous year	1,381	2,486
Registration, tuition and exam fees	2,468	189
Rental: State property	1,053	-
Salaries overpaid previous financial year	3,347	-
Sale of stock	262	258
Study loans	198	-
Subsidised motor scheme	2	49
Total revenue collected	130,630	117,809
Less own revenue budgeted	(124,563)	(116,617)
Total other revenue collected	6,067	1,192

				2003/04 R'000	2002/03 R'000
3.1	**Gifts, donations and sponsorships received in kind excluding RDP funds by the department (Total not included above)**				
	Sponsorship	**Nature**	**Hospital**		
	Prior year's donations received in kind			-	5,727
	Colgate Palmolive (Pty) Ltd.	Donation of toothpaste	Various	11	
	Italian Corporation	Media projector		35	
	Eau Claire Co-operative Health Centre, South Carolina USA	Mobile unit and funding	Gateway Clinic	365	
	United Population Funds	Cervical screening Equipment		230	
	Anonymous Donor	Four televisions sets	Charles Johnson Memorial	11	
	Spec Saver South Africa	Optical chair, stand, projector and photocopier	Edendale	94	
	Grey's Hospital Board	Sr. J.H. Jones sponsorship	Grey's	12	
	Grey's Hospital Board	Refurbish swimming pool	Grey's	32	
	Alcon Laboratories SA (Pty) Ltd	Phako – Emulsification unit	Grey's	350	
	Llex, SA (Pty) Ltd.	Two Gem Premier 3000 blood gas Analyser	King Edward	326	
	Llex, Medical Systems, Rivonia	Gem Premier 3000 blood gas Analyser	King Edward	151	
	Dr C. Schmanek in Australia, Europe	Mobile C-arm Intensifier	Mseleni	20	
	Unicef via Sexual Offences & Community Affairs Unit	Furniture	Prince Mshiyeni Memorial	10	
	National Prosecuting Authority of SA	Furniture	Prince Mshiyeni Memorial	10	
	Beckman Coulter	Replace AcT 8 Haematology Analyser with AcT Haematology		220	
	Beckman Coulter	3 Epics Flow Cytometers	IALCH & Ingwelezana	1,140	

				2003/04 R'000	2002/03 R'000
3.1	**Gifts, donations and sponsorships received in kind excluding RDP funds by the department (Total not included above) continued**				
	Beckman Coulter	Upgrading of Synchron CX3 Chemistry Analyser		120	
	Beckman Coulter	Upgrading of "T" Services Heamatology Analysers to ActT 5 Diff CP Analysers	Kokstad Lab. Christ the King & King George V	540	
	Beckman Coulter	Synchron CX3 Chemistry Analyser to Emmaus	uThukela District	120	
	Beckman Coulter	Upgrading of AcT 5 Diff CP Haematology Analysers	Charles Johnson & Newcastle Laboratories	360	
	Llex (Pty) Ltd.	Blood Gas Analyser upgraded to a Gem Premier 3000 Blood Gas Analyser		87	
	Beckman Coulter	Upgraded the Synchron CX5 Chemistry Analyser	Stanger	600	
	Llex (Pty) Ltd.	Upgrade the 1640 Gas Analyser to a Gem		83	
	Calicom Trading 262 (Pty) Ltd	Selectra E Drug Analyser		325	
	Spec Saver through International Centre for Eye Care	Optometry Equipment	Port Shepstone	90	
	Beckman Coulter	Upgrading of Synchron CX3 Chemistry Analyser to CX3 Delta	KZN Provincial Lab. Services	180	
	Beckman Coulter	Replacement of MAX-M with HmX Analyser at KE Laboratory	KZN Provincial Lab. Services	350	
	Beckman Coulter	Synchron CX3 Chemistry Analyser	KwaMashu Poly Clinic	120	
	Beckman Coulter	Upgrading of Synchron CX5 Chemistry Analyser to a CX7	KZN Provincial Lab. Services	600	
	Other donations			104	
				6,697	5,727

The other donations of R104,000 consists of individual amounts less than R10,000. A detailed schedule of these donations is available from the Department's Head Office.

A detailed breakdown of prior years information can be obtained from the 31 March 2003 Annual Financial Statements.

4 Local and foreign aid assistance (including RDP funds)

4.1 Assistance received in cash

Name of Donor and purpose	Opening balance 2003/04 R'000	Revenue 2003/04 R'000	Current expenditure 2003/04 R'000	Capital expenditure 2003/04 R'000	Closing balance 2003/04 R'000
Local	43	3,115	2,898	1	259
Kaizer Chiefs HIV/AIDS	-	10	10	-	-
Uthungulu District Municipality for Management of Scabies	-	40	40	-	-
National Health – Poverty relief	-	2,785	2,785	-	-
HWSeta NurseTraining - Mseleni and Mosvold	-	161	-	-	161
HWSeta Learnership – St Aidans	-	67	30	-	37
National Health – Victim Empowerment Crisis Centre	13	-	13	-	-
Indigenous Systems for IALCH TV ICU4	-	1	-	-	1
Johnson & Johnson (Pty) Ltd. IALCH	-	2	-	-	2
Ramnarain Holdings (Pty) Ltd. – IALCH	-	1	-	-	1
Medtronic Africa (Pty) Ltd. IALCH	-	10	-	-	10
NIC – IALCH	-	7	-	-	7
Tongaat Hullet Sugar – Equipment for Catherine Booth Hospital	-	1	-	1	-
Phillips Medical Systems (Pty) Ltd. – Training of 2 Cardiologists on the Overseas Image System	30	30	20	-	40
Foreign	5	9,325	25	196	9,109
Belgian Technical Committee- Expansion of TB/HIV/STI Care	-	552	-	-	552
European Union Partnership for the Development of PHC PROG	-	8,427	24	-	8,403
European Union – Systems development and installation	-	346	-	196	150
United Kingdom Emmanuel Church – Purchase of equipment for Benedictine Hospital	1	-	1	-	-
United Kingdom International Development –Training of abortion care	4	-	-	-	4
	48	12,440	2,923	197	9,368

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2004

		2003/04 R'000	2002/03 R'000
4.1	**Assistance received in cash (continued)**		
	Analysis of balance		
	Amounts owing by donors	-	196
	Amounts to be rolled over to next financial year	9,368	(48)
		9,368	**148**
4.2	**Assistance received in kind (Value not included in the income statement) Foreign aid assistance**		
	Japanese Government – Building of Nseleni Clinic	-	86,000
		-	**86,000**
4.3	**Other assistance received in kind**		
	The Department received from various organisations and donors' human resources and other assistance that cannot be quantified. All payments are made directly by the organisations and donors. These organisations and donors include amongst others the Italian Cooperation Initiative, USAID, DFID, Islamic Association and drug companies.		
5	**Personnel**		
5.1	**Current Expenditure**	4,619,621	4,222,272
	Statutory Payment	727	577
	Basic salary costs	3,208,861	2,947,156
	Pension contributions	467,325	425,619
	Medical aid contributions	243,034	234,171
	Other salary related costs	699,674	614,749
5.2	**Capital Expenditure**	69,484	64,117
	Basic salary costs	49,290	45,687
	Pension contributions	7,495	6,693
	Medical aid contributions	3,712	3,383
	Other salary related costs	8,987	8,354
	Total Personnel Costs	**4,689,105**	**4,286,389**
	Average number of employees	**51,436**	**44,682**

		2003/04 R'000	2002/03 R'000
6	**Inventories**		
6.1	**Current Expenditure**	1,325,681	1,178,087
	Blood	61,221	56,106
	Catering	33,835	26,171
	Cleaning and pest control	23,725	21,471
	Consumables for patients	58,244	53,980
	Fuel	49,000	56,729
	Medical supplies	382,095	313,306
	Other	10,712	9,885
	Packaging and stationery	39,944	34,414
	Pharmaceuticals	633,229	574,601
	Repairs and maintenance material	18,079	19,745
	Uniforms	15,597	11,679
6.2	**Capital Expenditure**	22,753	15,074
	Blood	-	22
	Catering	-	5
	Cleaning and pest control	-	90
	Consumables for patients	1	53
	Fuel	92	489
	Medical supplies	16	111
	Other	1,680	1,172
	Packaging and stationery	17	23
	Repairs and maintenance material	20,947	13,083
	Uniforms	-	26
	Total cost of inventories	**1,348,434**	**1,193,161**
7	**Machinery and equipment**		
7.1	**Current**	35,449	41,094
	Rentals	11,456	9,259
	Maintenance	-	11,486
	Sundry	365	528
	Transport	-	2,045
	Other machinery and equipment	2,610	1,296
	Furniture and office equipment	10,304	13,297
	Medical equipment	10,277	-
	Computer equipment	437	3,045
	Other equipment	-	138
7.2	**Capital machinery and equipment expenditure analysed as follows:**	356,990	186,540
	Computer equipment	17,200	12,115
	Furniture and office equipment	11,745	9,799
	Other machinery and equipment		
	- Medical equipment	248,919	114,047
	- Other	11,398	4,391
	Transport	67,599	46,188
	Other	129	-
	Total current and capital expenditure	**392,439**	**227,634**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2004

		2003/04 R'000	2002/03 R'000
8	**Land and buildings**		
8.1	**Current**	6,979	7,392
	Maintenance	228	378
	Rental	6,514	4,629
	Construction of buildings	25	15
	Dwellings	212	2,337
	Other	-	33
8.2	**Capital land and building expenditure analysed as follows:**	144,182	219,276
	Dwellings	635	1,722
	Non residential buildings	119,176	159,598
	Improvements and maintenance	24,349	57,115
	Other	22	841
	Total current and capital expenditure	**151,161**	**226,668**
9	**Professional and special services**		
9.1	**Current**	816,307	688,483
	Auditors' remuneration		3,499
	- Regularity	2,646	-
	- Performance	594	-
	- Other	570	-
	Contractors	548,342	490,009
	Consultants and advisory services	119,698	71,832
	Commissions and committees	493	530
	Computer services	34,199	19,676
	Other	1,309	1,210
	Municipal charges	108,456	101,727
9.2	**Capital**	79,553	281,134
	Contractors	47,394	243,476
	Consultants and advisory services	31,995	37,484
	Computer services	-	41
	Other	164	9
	Municipal charges	-	124
	Total professional and special services	**895,860**	**969,617**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2004

			2003/04 R'000	2002/03 R'000
10	**Transfer payments**			
10.1	**Current**		471,129	382,842
	Transfers to municipalities	Annexure 1 B	52,455	48,104
	Transfers to institutions	Annexure 1 C	134,693	334,738
	Transfers to institutions	Annexure 1 C	283,981	-
10.2	**Capital**		10,400	5,000
	PMSC Trading Account		10,400	5,000
	Total transfer payments		**481,529**	**387,842**
11	**Miscellaneous**			
11.1	**Current**		6,176	6,038
	Bank charges		230	93
	Claims against the state		1,382	420
	Medical claims		4,466	5,502
	Ex gratia payments		7	-
	Other		91	23
			6,176	**6,038**
12	**Special functions: Authorised losses**			
	Other material losses	12.1	3,973	545
	Debts written off	12.2	27,911	39,252
			31,884	**39,797**
12.1	**Other material losses**			
	Nature of losses			
	Loss and damage to land and buildings		502	-
	Miscellaneous losses		94	-
	Supplies and equipment deficits		1,189	296
	Theft of drugs		138	1
	Theft of computers		175	10
	Vehicle collision and damages		702	151
	Vehicle theft		682	87
	Fire arms and ammunition		15	-
	Irrecoverable hospital fees		43	-
	Theft of cheques		95	-
	Theft of cellphones		20	-
	Expired drugs and medicines		260	-
	Medical supplies and equipment		42	-
	Other		16	-
			3,973	**545**

			2003/04 R'000	2002/03 R'000
12.2	**Debts written off**			
	Nutrition		9,377	33,344
	Staff debts		18,534	5,908
			27,911	**39,252**
13	**Unauthorised, fruitless and wasteful expenditure**			
	Unauthorised expenditure	13.2	675,947	673,614
	Thefts and losses awaiting approval	13.4	885	4,476
			676,832	**678,090**
13.1	**Reconciliation of unauthorised expenditure**			
	Opening balance		673,614	515,431
	Unauthorised expenditure current year		2,333	158,183
	Closing balance		**675,947**	**673,614**
13.2	**Unauthorised expenditure**			
	Prior years overspending		673,614	515,431
	Current years overspending on programmes		2,333	158,183
	District Health Services		664	-
	Provincial Hospital Services		1,669	109,977
	Central Health Services		-	47,362
	Health Sciences		-	844
			675,947	**673,614**
	Prior year balances have been restated in accordance with Provincial Treasury Guidelines			
13.3	**Reconciliation of thefts and losses awaiting approval**			
	Opening balance		4,476	4,440
	Approved in the current year		(3,973)	(545)
	Transferred in the current year		382	581
	Closing balance		**885**	**4,476**
13.4	**Thefts and losses awaiting approval**			
	Compensation claims		-	204
	Criminal and negligence (Other)		-	92
	Claims against the state		-	9
	Loss and damage to land and buildings		-	527
	Miscellaneous losses		-	94
	Other		-	28
	Other revenue		-	58
	Supplies and equipment deficits		-	1,417
	Theft of cheques		-	95
	Theft of cell phones		1	17
	Theft of computers		10	113
	Vehicle collisions and damage		110	258
	Vehicle thefts and losses		764	1,564
			885	**4,476**

			2003/04 R'000	2002/03 R'000
14	**Cash and cash equivalents**			
	Official Imprest		1,270	2,309
			1,270	**2,309**
15	**Receivables**			
	Amounts owing by other departments	15.3	3,288	1,716
	Staff debtors	15.4	7,785	18,491
	Other debtors	15.5	4	9,408
			11,077	**29,615**

15.1 Amounts of R NIL (2003: R10,895,412) included in the above figures may not be recoverable, but this has not been written off in the income statement.

		2003/04 R'000	2002/03 R'000
15.2	**Age analysis**		
	Less than one year	7,207	9,827
	One to two years	3,870	7,327
	More than two years	-	12,461
		11,077	**29,615**

		2003/04 R'000	2002/03 R'000
15.3	**Amounts owing by other departments**		
	KZN Provincial Departments	2,189	-
	Agriculture	129	-
	Economic Affairs	3	-
	Education	8	-
	Housing	332	-
	Premier	82	-
	Safety & Security	5	-
	Traditional and Local Government	87	-
	Social Welfare	546	-
	Transport	862	-
	Works	135	-
	Other Departments	1,099	1,716
	Joint Medical Establishment	1,050	-
	Mpumulanga Provincial Administration	-	20
	National Education	49	-
	National Health & Population Development	-	63
	South African Defence Force	-	811
	South African Police Services	-	3
	University of Durban Westville	-	698
	University of Natal	-	121
		3,288	**1,716**

			2003/04 R'000	2002/03 R'000
15.4	**Staff debtors**			
	Debt: Breach of contract - study		122	341
	Debt: Breach of contract - 100% housing		192	857
	Debt Control PERSAL: other		216	229
	Debt: Control tax debt		36	1,163
	Debt: Employee miscellaneous		311	1,329
	Debtor debt		3,777	7,706
	Debts: Personal		107	520
	Deduction disallowance accounts		61	443
	Housing guarantee payment		411	1,147
	Other staff debts		17	24
	Pension receipts		101	209
	PERSAL disallowance control: current and previous		64	211
	Subsistence and travel control account		567	1,016
	Salary reversal control account		1,803	3,296
			7,785	**18,491**
15.5	**Other debtors**			
	Dishonoured cheques		4	153
	Nutrition debts			
	- PEM Scheme		-	173
	- Primary School Nutrition		-	3,932
	- National Nutrition Social Development		-	4,962
	Nutrition debts from individuals		-	184
	Other		-	4
			4	**9,408**
16	**Voted funds to be surrendered to the Revenue Fund**			
	Opening balance		-	-
	Transfer from Income Statement		14,924	42,520
	Paid during the year	21	(14,924)	(42,520)
	Closing balance		**-**	**-**
17	**Revenue Funds to be surrendered to the Revenue Fund**			
	Opening balance		-	-
	Transfer from Income Statement	21	130,630	117,809
	Paid during the year		(130,630)	(117,809)
	Closing balance		**-**	**-**
18	**Payables**			
	Amounts owing to other departments	18.1	6,546	720
	Other payables	18.2	11,438	20,276
			17,984	**20,996**

		2003/04 R'000	2002/03 R'000
18.1	**Amounts owing to other departments**		
	Independent	8	-
	Legislature	6	-
	Transport	58	-
	Works	6,398	-
	Social Welfare	75	-
	Traditional and Local Government	1	-
	Department of National Education	-	358
	Durban City Health Department	-	196
	Department of Housing	-	53
	Department of Education	-	113
		6,546	**720**
18.2	**Other payables**		
	Contract deposits	-	1
	Receipt suspense	18	1,126
	Medical aid receipts	-	3,873
	Pension receipts	7,271	12,261
	Credit balances in debtors	768	6
	Salary reversal	2,575	2,335
	Sundry disallowance	2	-
	Taxation temporary employees	628	526
	UIF – temporary employees	176	148
		11,438	**20,276**
19	**Net cash flow generated by operating activities**		
	Net surplus as per Income Statement	154,874	159,718
	Adjusted for items separately disclosed	683,571	771,659
	Proceeds from sale of capital	(110)	(49)
	Capital Expenditure	683,681	771,708
	Net cash flow generated by operating activities	**838,445**	**931,377**
20	**Cash generated/ (utilised) to (increase)/ decrease working capital**		
	Decrease /(increase) in receivables	18,538	37,268
	Increase in payables	(3,012)	6,485
	(Increase) in inventories	-	5,222
	Decrease/(Increase) in thefts & losses awaiting approval	3,591	(35)
	(Increase) in unauthorised expenditure	(2,333)	(158,183)
		16,784	**(109,243)**

			2003/04 R'000	2002/03 R'000
21	**Voted and revenue funds paid during the year**			
	Voted funds	16	(14,924)	(42,520)
	Revenue funds	17	(130,630)	(117,809)
			(145,554)	**(160,329)**
22	**Cash and cash equivalents end of period**			
	Cash and cash equivalents	14	1,270	2,309
	Provincial Treasury		(661,827)	(689,166)
			(660,557)	**(686,857)**

These amounts are not recognised in the financial statements, and are disclosed to enhance the usefulness of the financial statements and to comply with the statutory requirements of the Public Finance Management Act, Act 1 of 1999 (as amended by Act 29 of 1999), the Treasury Regulations for Departments and Constitutional Institutions issued in terms of the Act and the Division of Revenue Act, (Act 7 of 2003).

			2003/04 R'000	2002/03 R'000
23	**Contingent Liabilities**			
	Housing loan guarantees	Annexure 2	55,254	52,243
	Medical Legal Claims		78,295	67,016
			133,549	**119,259**
	The majority of the housing guarantees are covered by the official's pension fund. Based on past experience and information an average of 5% to 8% of medical legal claims lodged is paid out.			
24	**Commitments**			
	Current Expenditure			
	Approved and contracted/ordered		-	26,685
	Capital Expenditure			
	Approved and contracted/ordered		387,246	103,118
	Approved but not yet contracted		1,731,701	-
			2,118,947	**129,803**
25	**Accruals**			
25.1	**Listed by standard item**			
	Personnel		-	2
	Administrative		-	8,628
	Inventories		-	9,639
	Machinery and equipment		-	1,702
	Land and buildings		-	728
	Professional and special services		-	5,606
	Transfer payments		-	612
	Other		19,833	-
	Unconfirmed balances owing to other departments	Annexure 5	131	-
			19,964	**26,917**
25.2	**Listed by programme**			
	Administration		-	987
	District Health Services		-	8,031
	Provincial Hospital Services		-	7,822
	Central Health Services		-	700
	Health Sciences		-	7,579
	Auxiliary and Associated Services		-	1,798
	Other		19,833	-
	Unconfirmed balances owing to other departments	Annexure 5	131	-
			19,964	**26,917**

		2003/04 R'000	2002/03 R'000
26	**Employee benefits**		
	Leave entitlement	862,616	884,412
	- Current Cycle	78,841	67,807
	- Previous Cycle	136,318	137,193
	- Capped Leave	647,457	679,412
	Thirteenth cheque	142,598	106,430
		1,005,214	**990,842**

The likelihood of paying out the current and previous cycle is minimal as the leave policy states that leave accrues on the 1st of January each year and an employee must utilise the leave within 18 months from this date otherwise the leave will be forfeited.

During the current year R38,614 mil leave gratuity payments were made to employees that have left the employ of the state for various reasons. This equates to 4.3% of the leave balance outstanding at the beginning of the financial year.

27 Leases

27.1 Operating leases	Property	Total	Total
Not later than 1 year	4,149	4,149	3,750
Later than 1 year and not later than 3 years	2,114	2,114	2,137
Later than 3 years	441	441	1,410
	6,704	**6,704**	**7,297**

		2003/04 R'000	2002/03 R'000
28	**Receivables for services delivered**		
	Hospitals		
	Addington	26,547	19,354
	Inkosi Albert Luthuli Central Hospital	9,914	1,413
	Fort Napier	8,455	7,730
	Newcastle	8,207	2,286
	King Edward VIII	7,616	2,576
	Grey's	5,862	2,330
	Dundee	5,364	2,229
	Utrecht	5,230	-
	Vryheid	4,037	1,428
	Wentworth	3,570	-
	Edendale	3,329	1,466
	East Griqualand and Usher Memorial	2,840	-
	Eshowe	2,435	-
	Ladysmith	2,424	-
	Port Shepstone	1,904	-
	EMRS	1,607	-
	RK Khan	1,592	-
	Madadeni	1,502	-
	Taylor Bequest	1,391	-
	Ngwelezana	1,287	-
	Clairwood	1,242	-
	Nkonjeni	1,234	-
	Osindisweni	1,100	-
	Escourt	1,086	-
	Townhill	-	1,765
	Other institutions (Less than R1mil per institution)	8,378	11,291
		118,152	**53,868**
	Less amounts estimated to be irrecoverable	(47,260)	-
	Net debts considered to be recoverable	**70,892**	**53,868**
	Total debts written off for the year	**5,740**	

The above balance represents patient fee income that has been billed to patients by the institutions, but cash has not been received. In the prior year not all institutions were recording and providing this information to head office, whilst in the current year the number of institutions reporting on this information has increased and therefore the increase is in the balance.

These accounts will be analysed in the 2004/2005 financial year to identify the specific debts which are considered to be irrecoverable as there are a number of old debts and small debts which would be uneconomical to pursue.

		2003/04 R'000	2002/03 R'000
29	**Inventories on hand at year end**		
	Hospitals	239,393	148,875
	- Consumables	142,290	93,183
	- Pharmaceuticals	97,103	55,692
	Clinics	16,385	4,514
	- Consumables	3,143	1,447
	- Pharmaceuticals	13,242	3,067
	Central Procurement Stores	16,466	15,097
	- Consumables	16,466	15,097
	- Pharmaceuticals	-	-
		272,244	168,486
	Consumables	161,899	109,727
	Pharmaceuticals	110,345	58,759
		272,244	**168,486**

The above balance represents consumables stores and pharmaceuticals that the institutions have purchased and not yet utilised as at 31 March 2004 and is physically on hand at the year end. This amount is not included in the balance sheet as the cash basis of accounting is applied. In the prior year not all institutions were recording and providing this information to head office, whilst in the current year the number of institutions reporting on this information has increased and therefore increases the balance. Inventory is valued at actual cost.

It excludes the stock at Provincial Medical Supply Centre as a separate set of financial statements has been prepared, refer to attachment.

30 Related party transactions

The Department operates a trading activity, Provincial Medical Supplies Centre (PMSC). PMSC is responsible for the purchasing of pharmaceuticals from suppliers and then selling these to the various hospitals. These are sold at cost plus a mark-up of 4% to 12% to cater for the administration costs of PMSC. The purchase of the pharmaceuticals is disclosed as part of inventories in the Department of Health's books.

31 Key management personnel

Remuneration and other allowances

Level of staff	No. of staff	R'000	No. of staff	R'000
Level 16, Accounting Officer	1	842	1	751
Level 15, Deputy Director-General	2	1,222	2	1,099
Level 14, Chief Director	10	5,188	7	3,254
Level 13, Director	125	54,810	104	40,444
	138	62,062	114	45,548

The above figures exclude the hospital managers and finance managers who are generally below level 13.

32 Public Private Partnership

The Kwazulu Natal Department of Health entered into a public private partnership with Cowslip Investments (Pty) Ltd and Impilo Consortium (Pty) Ltd. The agreement is for the supply of equipment, information management & technology, facilities management and all associated services for the Inkosi Albert Luthuli Central Hospital.

This agreement will enable the Department to deliver clinical services at the hospital and to promote the hospital as a central referral hospital operating at the highest standards in terms of quality, efficiency, effectiveness and patient focused care.

The Department is responsible for the employment of all health care staff and the administration staff and the provision of all consumables used in the provision of the health care services.

The Impilo Consortium is responsible for:

- The initial equipment i.e. both medical and non medical as well as the replacement of these assets in accordance with the asset replacement policy,
- The installation, training, management and upgrading of all information management and technology,
- Provision of all facilities management e.g. cleaning, catering, laundry, security, building maintenance etc.

The commencement date of the contract was 4 February 2002 and the final commissioning date is 31 August 2003. The contract is for a period of 15 years from the commencement date. The Department has the option to renew the agreement for a further 1 year after 15 years.

An initial amount of R360 mil was paid by the Department on the commencement date to purchase the initial equipment and surgical equipment. The initial agreement excluded the laboratory requirements. During the 2003/04 financial year, there was a variation to the agreement to include the laboratory services and this resulted in an initial payment of R44 mil for the equipment. The corresponding monthly and quarterly payments were also increased with effect from February 2004.

In terms of the agreement the Department is required to pay a monthly service fee as stipulated in the schedule of payments to cover the monthly operational costs for facilities management, information technology and maintenance of equipment and consumables that the consortium is responsible for. This service fee is then adjusted each month in accordance with the penalty regime.

The Department has to also pay a quarterly fee for the asset replacement reserve. These payments have been index linked. The commitments for the remainder of the agreement from the end of the current financial year are listed below.

During the term of the agreement the Department has full use of the assets and the consortium may not utilise the assets as security against any borrowings. Assets will only transfer to the Department at the end of the agreement.

	2003/04 R'000	2003/04 R'000	2003/04 R'000	2002/03 R'000
Future Commitments	**Monthly Service Fee**	**Quarterly Contribution**	**Total**	**Total**
Not later than 1 yr	210,844	321,391	532,235	327,329
Later than 1 yr and not later than 3 yrs	424,379	264,830	689,209	662,747
Later than 3 yrs	2,488,481	1,210,100	3,698,581	3,861,638
	3,123,704	1,796,321	4,920,025	4,851,714

ANNEXURE 1 A

STATEMENT OF CONDITIONAL GRANTS RECEIVED BY PROVINCIAL DEPARTMENTS AS AT 31 MARCH 2004

NAME OF DEPARTMENT AND GRANT	GRANT ALLOCATION				EXPENDITURE				
	Division of Revenue Act R'000	Adjustments Estimates R'000	Roll Overs R'000	Total Available R'000	Actual (1) R'000	Unspent R'000	% of Available Spent	Capital R'000	Current R'000
National Department of Health									
Health Professions Training and Development	167,553	167,553	-	167,553	164,513	3,040	98	-	164,513
HIV/AIDS Health	85,591	85,591	-	85,591	85,591	-	100	-	85,591
Hospital Management and Quality Improvement	16,375	16,375	-	16,375	16,375	-	100	-	16,375
Hospital Revitalisation	129,860	59,860	-	59,860	34,353	25,507	57	34,353	-
Integrated Nutrition Programme	176,646	176,646	-	176,646	176,646	-	100	-	176,646
National Tertiary Services	551,831	551,831	-	551,831	551,831	-	100	145,968	405,863
Medico Legal Grant	1,000	1,000	-	1,000	65	935	7	-	65
Provincial Treasury									
Provincial Infrastructure	70,043	70,043	-	70,043	70,043	-	100	70,043	-
	1,198,899	**1,128,899**	**-**	**1,128,899**	**1,099,417**	**29,482**	**92**	**250,429**	**848,988**

A roll over has been applied for the underspending of the funds on the Health Professions Training & Development and the Hospital Revitalisation.
The allocation on the Hospital Revitalisation has not been spent due to unforeseen delays in the revitalisation of King George V Hospital, Empangeni Hospital and the proposed hospital at KwaMashu.
The Medico Legal Grant was not spent as the funds were only received towards the end of the financial year. This grant has been received to assist the Department with the initial set up costs as the functions will be transferred from South African Police Services to the Department with effect from 1 April 2005.

ANNEXURE 1B

STATEMENT OF CONDITIONAL GRANT TRANSFERS TO MUNICIPALITIES BY PROVINCIAL DEPARTMENTS as at 31 March 2004

NAME OF MUNICIPALITY	GRANT ALLOCATION				EXPENDITURE				
	Division of Revenue Act R'000	Adjustments Estimate R'000	Roll Overs R'000	Total Available R'000	Actual Transfer R'000	Amount not Transferred R'000	% of Available Transferred	Capital R'000	Current R'000
For the provision of health services									
Abaqulusi	364	364	-	364	364	-	100	-	364
Dannhauser	365	365	-	365	310	55	85	-	310
eDumbe	554	554	-	554	647	(93)	117	-	647
eMnambithi	1,988	1,988	-	1,988	1,984	4	100	-	1,984
eNdumeni	1,255	1,255	-	1,255	1,382	(127)	110	-	1,382
eThekwini	24,701	24,701	-	24,701	24,491	210	99	-	24,491
Greater Kokstad Municipality	740	740	-	740	740	-	100	-	740
Hibiscus Coast	2,168	2,168	-	2,168	2,168	-	100	-	2,168
KwaDukuza	1,887	1,887	-	1,887	1,632	255	86	-	1,632
Ixopo	19	19	-	19	25	(6)	132	-	25
Mandini	725	725	-	725	723	2	100	-	723
Matatiele	787	787	-	787	737	50	94	-	737
Mooi Mpofana	562	562	-	562	533	29	95	-	533
Msunduzi	6,417	6,417	-	6,417	6,406	11	100	-	6,406
Mthonjaneni	299	299	-	299	297	2	99	-	297
Newcastle	627	627	-	627	568	59	91	-	568
Okhahlamba	591	591	-	591	518	73	88	-	518
Richmond	32	20	-	20	17	3	85	-	17
Ulundi	41	41	-	41	26	15	63	-	26
Umndoni	882	882	-	882	882	-	100	-	882
uMhlathuze	1,395	1,395	-	1,395	1,184	211	85	-	1,184
Umlalazi	1,097	1,097	-	1,097	1,159	(62)	106	-	1,159
uMngeni	806	806	-	806	803	3	100	-	803
uMshwathi	528	528	-	528	434	94	82	-	434
Umtshezi	623	623	-	623	609	14	98	-	609
uMuziwabantu	411	411	-	411	367	44	89	-	367
Umvoti	684	684	-	684	827	(143)	121	-	827
uPhongolo	22	22	-	22	16	6	73	-	16
Utrecht	17	17		17	-	17	-	-	-
	50,587	**50,575**	**-**	**50,575**	**49,849**	**726**	**99**	**-**	**49,849**

ANNEXURE 1B (continued)

STATEMENT OF CONDITIONAL GRANT TRANSFERS TO MUNICIPALITIES BY PROVINCIAL DEPARTMENTS as at 31 March 2004

NAME OF MUNICIPALITY	GRANT ALLOCATION				EXPENDITURE				
	Division of Revenue Act R'000	Adjustments Estimate R'000	Roll Overs R'000	Total Available R'000	Actual Transfer R'000	Amount not Transferred R'000	% of Available Transferred	Capital R'000	Current R'000
For the prevention/ treatment of HIV/AIDS									
eThekwini	500	500	-	500	1,229	(729)	246	-	1,229
Msunduzi	1,217	1,217	-	1,217	1,377	(160)	113	-	1,377
	1,717	**1,717**	**-**	**1,717**	**2,606**	**(889)**	**152**	**-**	**2,606**
TOTAL TO MUNICIPALITIES	**52,304**	**52,292**	**-**	**52,292**	**52,455**	**(163)**	**100**	**-**	**52,455**

The reason for the under expenditure is due to the fact that the transfers are made as and when the municipalities submit their claims.

The difference between the Division of Revenue Act and the Adjustment Estimates is R12 000 for Richmond as the allocation was reduced, as the funds were not being utilised.

ANNEXURE 1C

STATEMENT OF TRANSFERS TO PUBLIC ENTITIES AND INSTITUTIONS BY PROVINCIAL DEPARTMENTS as at 31 March 2004

NAME OF ENTITY OR INSTITUTION	TRANSFER ALLOCATION				EXPENDITURE				
	Appropriation Act R'000	Adjustments Estimate R'000	Roll Overs R'000	Total Available R'000	Actual Transfer R'000	Amount not Transferred R'000	% of Available Transferred	Capital R'000	Current R'000
Austerville Halfway House	173	173	-	173	173	-	100	-	173
Azalea House	195	195	-	195	195	-	100	-	195
Balgowan Clinic	64	64	-	64	64	-	100	-	64
Bekimpelo/Bekulwandle Trust Clinic	3,543	3,543	-	3,543	3,543	-	100	-	3,543
Benedictine Clinic	154	154	-	154	154	-	100	-	154
Charles James Hospital (Santa)	5,903	5,903	-	5,903	5,903	-	100	-	5,903
Cheshire Day Care Centre	92	92	-	92	-	92	-	-	-
Cleremont Day Care Cwentre	75	75	-	75	74	1	99	-	74
Club 47	51	51	-	51	51	-	100	-	51
Day Care Club 91	46	46	-	46	46	-	100	-	46
Day Care Club 92	64	64	-	64	64	-	100	-	64
Don Mackenzie Hospital	5,556	5,556	-	5,556	5,571	(15)	100	-	5,571
Don Mackenzie Santa Med	687	687	-	687	687	-	100	-	687
Doris Goodwin Special Hospital	3,779	3,779	-	3,779	3,779	-	100	-	3,779
Dunstan Farrel Hospital (Santa)	5,680	5,680	-	5,680	5,680	-	100	-	5,680
Durban School For The Deaf	111	111	-	111	111	-	100	-	111
Ekukhanyeni Clinic	109	109	-	109	109	-	100	-	109
Elandskop Oblate Clinic	196	196	-	196	196	-	100	-	196
Enkumane Clinic	166	166	-	166	166	-	100	-	166
Fosa Hospital (Santa)	4,399	4,399	-	4,399	4,399	-	100	-	4,399
Happy Hour Amaoti	75	75	-	75	67	8	89	-	67
Happy Hour Durban North	23	23	-	23	23	-	100	-	23
Total carried forward	31,141	31,141	-	31,141	31,055	86		-	31,141

ANNEXURE 1C (continued)

STATEMENT OF TRANSFERS TO PUBLIC ENTITIES AND INSTITUTIONS BY PROVINCIAL DEPARTMENTS as at 31 March 2004

NAME OF ENTITY OR INSTITUTION	TRANSFER ALLOCATION				EXPENDITURE				
	Appropriation Act R'000	Adjustments Estimate R'000	Roll Overs R'000	Total Available R'000	Actual Transfer R'000	Amount not Transferred R'000	% of Available Transferred	Capital R'000	Current R'000
Total brought forward	31,141	31,141	-	31,141	31,055	86		-	31,055
Happy Hour KwaXimba	35	35	-	35	35	-	100	-	35
Happy Hour Mariannhill	28	28	-	28	27	1	96	-	27
Happy Hour Merebank	31	31	-	31	-	31	-	-	-
Happy Hour Mpumalanga	87	87	-	87	86	1	99	-	86
Happy Hour Ninikhona	23	23	-	23	22	1	96	-	22
Happy Hour Nyangwini	52	52	-	52	52	-	100	-	52
Happy Hour Overport	33	33	-	33	33	-	100	-	33
Happy Hour Phoenix	31	31	-	31	30	1	97	-	30
Head Office Mental Health Support	31	31	-	31	-	31	-	-	-
Hlanganani Ngothando D C C	45	45	-	45	-	45	-	-	-
Ikhwezi Cripple Care	19	19	-	19	-	19	-	-	-
Ikhwezi Dns	99	99	-	99	99	-	100	-	99
Jewel House	44	44	-	44	43	1	98	-	43
Joan Tennant House	111	111	-	111	111	-	100	-	111
John Peattie House	409	409	-	409	408	1	100	-	408
Jona Vaughn Centre	886	886	-	886	812	74	92	-	812
Khotsong Santa Centre	240	240	-	240	240	-	100	-	240
Lynn House	179	179	-	179	179	-	100	-	179
Madeline Manor	321	321	-	321	394	(73)	123	-	394
Masada Workshop	12	12	-	12	12	-	100	-	12
Masibambeni Day Care Centre	30	30	-	30	30	-	100	-	30
Matikwe Oblate Clinic	286	286	-	286	286	-	100	-	286
McCords Hospital	40,156	40,156	-	40,156	40,156	-	100	-	40,156
Mhlumayo Oblate Clinic	326	326	-	326	326	-	100	-	326
Montebello Chronic Sick Home	2,230	2,230	-	2,230	2,230	-	100	-	2,230
Mountain View Special Hospital	2,656	2,656	-	2,656	2,656	-	-	-	2,656
Noyi Bazi Oblate Clinic	342	342	-	342	342	-	100	-	342
Total carried forward	79,883	79,883	-	79,883	79,664	219		-	79,664

ANNEXURE 1C (continued)

STATEMENT OF TRANSFERS TO PUBLIC ENTITIES AND INSTITUTIONS BY PROVINCIAL DEPARTMENTS as at 31 March 2004

NAME OF ENTITY OR INSTITUTION	TRANSFER ALLOCATION				EXPENDITURE				
	Appropriation Act R'000	Adjustments Estimate R'000	Roll Overs R'000	Total Available R'000	Actual Transfer R'000	Amount not Transferred R'000	% of Available Transferred	Capital R'000	Current R'000
Total brought forward	79,883	79,883	-	79,883	79,664	219		-	79,664
Oakford Clinic	510	510		510	315	195	62	-	315
Pongola Hospital	1,350	1,350		1,350	1,350	-	100	-	1,350
Rosary Oblate Clinic	615	615		615	615	-	100	-	615
Santa Motivators	98	98		98	98	-	100	-	98
Santa Motivators DC (21)	183	183		183	183	-	100	-	183
Santa Motivators DC (22)	226	226		226	226	-	100	-	226
Santa Motivators DC (23)	100	100		100	100	-	100	-	100
Santa Motivators DC (25)	93	93		93	93	-	100	-	93
Santa Motivators DC (28)	65	65		65	65	-	100	-	65
Scadifa Centre	318	318		318	317	1	100	-	317
Siloah Special Hospital	4,460	4,460		4,460	4,460	-	100	-	4,460
Sparks Estate	516	516		516	515	1	100	-	515
St. Lukes Home	199	199		199	198	1	99	-	198
St. Mary's Hospital Marianhill	45,631	45,631		45,631	45,631	-	100	-	45,631
Sunfield Home	72	72		72	72	-	100	-	72
The Dream Center Hospital	946	946		946	703	243	74	-	703
Umlazi Halfway House	88	88		88	88	-	100	-	88
TOTAL SUBSIDIES	135,353	135,353	-	135,353	134,693	660	100	-	134,693

Annexure 1C (continued)

STATEMENT OF TRANSFERS TO PUBLIC ENTITIES AND INSTITUTIONS BY PROVINCIAL DEPARTMENTS as at 31 March 2004

NAME OF ENTITY OR INSTITUTION	TRANSFER ALLOCATION				EXPENDITURE				
	Appropriation Act R'000	Adjustments Estimates R'000	Roll Overs R'000	Total Available R'000	Actual Transfer R'000	Amount Transferred R'000	% of Available Transferred	Capital R'000	Current R'000
Ekuhlengeni Sanitarium	43,090	43,090	-	43,090	42,498	592	99	-	42,498
Richmond Chest Special Hospital	26,142	26,142	-	26,142	25,803	339	99	-	25,803
Various Non Governmental Institutions for the treatment of HIV/AIDS	2,500	2,500	-	2,500	2,441	59	98	-	2,441
Integrated Nutrition Programme	157,321	187,912	-	187,912	213,239	(25,327)	113	-	213,239
Total Other	229,053	159,644		259,644	283,981	24,337	109		283,981
TOTAL TRANSFER PAYMENTS	**364,406**	**394,997**	**-**	**394,997**	**418,674**	**(23,677)**	**106**	**-**	**418,674**

The increase in the transfer payments from the Appropriation Act to the Adjustments Estimate is due to additional funds being allocated to the Integrated Nutrition Programme, to cater for the increase in the number of schools and children participating in the programme.

ANNEXURE 2

STATEMENT OF FINANCIAL GUARANTEES ISSUED AS AT 31 MARCH 2004

Guaranteed Institution	Guarantee in respect of	Original Guaranteed capital amount	Opening Balance 01/04/2003	Guarantees issued during the year	Guarantees released during the year	Guaranteed interest outstanding as at 31/032004	Closing balance 31/03/2004	Realised losses i.r.o. claims paid out
		R'000	R'000	R'000	R'000	R'000	R'000	R'000
ABSA	Housing	-	11,974	2,498	(624)	-	13,848	-
Cashbank	Housing	-	198	21	-	-	219	-
FBC Fidelity Bank	Housing	-	810	-	(219)	-	591	-
FirstRand Bank	Housing	-	7,132	3,828	(787)	-	10,173	-
GBS Mutual Bank	Housing	-	16	2	-	-	18	-
Green Start H/L	Housing	-	41	-	(4)	-	37	-
Ithala Limited	Housing	-	1,054	-	(12)	-	1,042	-
Nedbank (BOE Bank)	Housing	-	5,573	-	(1,608)	-	3,965	-
Nedbank (BOE Bank/Boland)	Housing	-	32	42	(37)	-	37	-
Nedbank (Permanent Bank)	Housing	-	11,112	2,245	(414)	-	12,943	-
Nedbank Limited	Housing	-	566	134	-	-	700	-
Old Mutual Bank	Housing	-	17	-	-	-	17	-
SA Home Loan	Housing	-	-	17	-	-	17	-
Saambou Bank	Housing	-	4,471	-	(1,130)	-	3,341	-
Standard Bank	Housing	-	9,203	-	(1,018)	-	8,185	-
The African Bank	Housing	-	44	77	-	-	121	-
TOTAL		-	52,243	8,864	(5,853)	-	55,254	-

Total guarantees paid during the year	1,957
Less payments recovered from the individual or the pension fund	1,546
Balance outstanding as a debtor, which is currently recovered from the individuals	411

The information is currently unavailable for the following columns:
- Original Guaranteed capital amount
- Guaranteed interest outstanding as at 31/03/2004
- Realised losses i.r.o. claims paid out

ANNEXURE 3

PHYSICAL ASSET MOVEMENT SCHEDULE (Not including inventories)

Description	Opening Balance R'000	Additions R'000	Disposals R'000	Transfers in R'000	Transfers Out R'000	Closing Balance R'000
PHYSICAL ASSETS ACQUIRED DURING FINANCIAL YEAR 2003/2004						
LAND AND BUILDINGS	**565,094**	**293,341**	**-**	**-**	**-**	**858,435**
Dwellings	1,722	635	-	-	-	2,357
Non-residential buildings	159,598	119,176	-	-	-	278,774
Improvements and maintenance	402,933	173,530	-	-	-	576,463
Other	841	-	-	-	-	841
MACHINERY AND EQUIPMENT	**186,491**	**357,187**	**(110)**	**-**	**-**	**543,568**
Computer equipment	12,115	17,397	-	-	-	29,512
Furniture and office equipment	9,750	11,745	(110)	-	-	21,385
Other machinery and equipment						
- Medical	114,047	248,919	-	-	-	362,966
- Other	4,391	11,527	-	-	-	15,918
Transport assets	46,188	67,599	-	-	-	113,787
	751,585	**650,528**	**(110)**	**-**	**-**	**1,402,003**
PHYSICAL ASSETS ACQUIRED DURING FINANCIAL YEAR 2002/2003						
LAND AND BUILDINGS	**-**	**565,094**	**-**	**-**	**-**	**565,094**
Dwellings	-	1,722	-	-	-	1,722
Non-residential buildings	-	159,598	-	-	-	159,598
Improvements and Maintenance	-	402,933	-	-	-	402,933
Other	-	841	-	-	-	841
MACHINERY AND EQUIPMENT	**-**	**186,540**	**(49)**	**-**	**-**	**186,491**
Computer equipment	-	12,115	-	-	-	12,115
Furniture and office equipment	-	9,799	(49)	-	-	9,750
Other machinery and equipment						
- Medical	-	114,047	-	-	-	114,047
- Other	-	4,391	-	-	-	4,391
Transport assets	-	46,188	-	-	-	46,188
	-	**751,634**	**(49)**	**-**	**-**	**751,585**

ANNEXURE 3 (continued)

PHYSICAL ASSET MOVEMENT SCHEDULE (Not including inventories)

NOTES

Buildings

The replacement value of the buildings is estimated to be R11,209,472,000. This has been based on the physical verification of the hospitals and clinics. An average cost per square metre was applied to the size of the buildings. This value excludes an assessment of the current status of the buildings and looks at the cost of reconstructing the hospitals from a zero base.

Machinery and Equipment

The replacement value of the equipment is estimated to be R4,162,398 000. Ratios were determined, based on past experience and information from National Department of Health, in respect to equipment value and building value. These ratios were then applied to the replacement value of the buildings and equipment and range from 20% to 40% depending on whether it is a hospital or a clinic.

ANNEXURE 4

INTER - DEPARTMENTAL RECEIVABLES - CURRENT

As Recorded in Department of Health's Books

	Confirmed balance outstanding		Unconfirmed balance outstanding	
	31/03/2004 R'000	31/03/2003 R'000	31/03/2004 R'000	31/03/2003 R'000
KZN Agriculture	-	-	129	-
KZN Economic Affairs	-	-	3	-
KZN Education	-	-	8	-
KZN Housing	-	-	332	-
KZN Premier	-	-	82	-
KZN Safety & Security	-	-	5	-
KZN Traditional and Local Government	-	-	87	-
KZN Social Welfare	-	-	546	-
KZN Transport	-	-	862	-
KZN Works	-	-	135	-
Joint Medical Establishment	-	-	1,050	-
Mpumalanga Provincial Administration	-	-	-	20
National Education	-	-	49	-
National Health & Population Development	-	-	-	63
South African Defence Force	-	-	-	811
South African Police Services	-	-	-	3
University of Durban Westville	-	-	-	698
University of Natal	-	-	-	121
	-	**-**	**3,288**	**1,716**

ANNEXURE 5

INTER - DEPARTMENTAL PAYABLES - CURRENT

As Recorded in Department of Health's Books

	Confirmed balance outstanding		Unconfirmed balance outstanding	
	31/03/2004 R'000	31/03/2003 R'000	31/03/2004 R'000	31/03/2003 R'000
Independent	-	-	8	-
Legislature	-	-	6	-
Transport	-	-	58	-
Works	-	-	6,398	-
Social Welfare	-	-	75	-
Traditional and Local Government Affairs	-	-	1	-
Department of National Education	-	-	-	358
Durban City Health Department	-	-	-	196
Department of Housing	-	-	-	53
Department of Education	-	-	-	113
	-	**-**	**6,546**	**720**

Not recorded in Department of Health's Books, balance not confirmed and accounting on the cash basis.

	Confirmed balance outstanding		Unconfirmed balance outstanding	
	31/03/2004 R'000	31/03/2003 R'000	31/03/2004 R'000	31/03/2003 R'000
South African Police Services	-	-	3	-
Western Cape Department of Health	-	-	8	-
KZN Department of Economic Development	-	-	59	-
South African Management Development Institute	-	-	61	-
	-	**-**	**131**	**-**

ENTIRE DEPARTMENT

PER PROGRAMME	2003/2004 Adjusted Appropriation	Virement	Final Allocation	Actual Expenditure	Savings/ Underspend (Excess)	Expend. as % of final allocation	2002/2003 Revised Allocation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
1 Administration	**159,437**	**(5,137)**	**154,300**	**153,449**	**851**	**99**	**144,677**	**143,289**
Current	158,187	(5,137)	153,050	153,050	-	100	144,222	143,010
Capital	1,250	-	1,250	399	851	32	455	279
2 District Health Services	**3,766,804**	**3,560**	**3,770,364**	**3,771,028**	**(664)**	**100**	**3,825,571**	**3,819,179**
Current	3,706,576	(7,078)	3,699,498	3,699,498	-	100	3,702,893	3,674,473
Capital	60,228	10,638	70,866	71,530	(664)	101	122,678	144,706
3 Emergency Medical Services	**264,043**	**8,003**	**272,046**	**272,046**	**-**	**100**	**-**	**-**
Current'	221,883	(4,534)	217,349	217,349	-	100	-	-
Capital	42,160	12,537	54,697	54,697	-	100	-	-
4 Provincial Hospital Services	**2,558,382**	**10,940**	**2,569,322**	**2,570,991**	**(1,669)**	**100**	**1,917,836**	**2,027,813**
Current	2,507,777	10,077	2,517,854	2,519,523	(1,669)	100	1,819,636	1,945,733
Capital	50,605	863	51,468	51,468	-	100	98,200	82,080
5 Central Hospital Services	**780,114**	**(9,737)**	**770,377**	**765,370**	**5,007**	**99**	**928,687**	**976,049**
Current	624,397	(6,112)	618,285	618,285	-	100	726,099	760,196
Capital	155,717	(3,625)	152,092	147,085	5,007	97	202,588	215,853
6 Health Sciences and Training	**308,959**	**12,704**	**321,663**	**321,156**	**507**	**100**	**198,811**	**199,655**
Current	307,959	12,784	320,743	320,743	-	100	198,811	199,653
Capital	1,000	(80)	920	413	507	45	-	2
7 Health Care Support Services	**10,400**	**-**	**10,400**	**10,400**	**-**	**100**	**-**	**-**
Capital	10,400	-	10,400	10,400	-	100	-	-

ENTIRE DEPARTMENT (continued)

	2003/2004						2002/2003	
	Adjusted Appropriation	Virement	Final Allocation	Actual Expenditure	Savings/ Underspend (Excess)	Expend. as % of final allocation	Revised Allocation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
8 Health Facilities Management	**408,388**	**(20,333)**	**388,055**	**347,492**	**40,563**	**90**	**403,598**	**329,010**
Capital	408,388	(20,333)	388,055	347,492	40,563	90	403,598	328,788
Special Functions	**-**	**-**	-	**31,884**	**(31,884)**	**-**	-	39,797
Statutory payment	**607**	**-**	**607**	**727**	**(120)**	**120**	**526**	**577**
TOTAL	**8,257,134**	**-**	**8,257,134**	**8,244,543**	**12,591**	**100**	**7,419,706**	**7,535,369**
Reconciliation with Income Statement								
Add: Local and foreign aid assistance (incl. RDP funds)			12,440	2,923			12,440	1,646
Add: Local and foreign aid assistance (incl. RDP funds)			-	197				
Add Other Receipts			130,630	-			130,630	-
Actual Amounts per income statement			**8,400,204**	**8,247,663**			**7,562,776**	**7,537,015**

ENTIRE DEPARTMENT (continued)

	2003/2004						2002/2003	
	Adjusted Appropriation	Virement	Final Allocation	Actual Expenditure	Savings/ Underspend (Excess)	Expend. as % of final allocation	Revised Allocation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
ECONOMIC CLASSIFICATION								
Current	**7,526,779**	**-**	**7,526,779**	**7,528,448**	**(1,669)**	**100**	**6,591,661**	**6,723,288**
Personnel	4,788,199	-	4,788,199	4,618,894	169,305	96	4,204,633	4,221,695
Transfer payments	447,289	-	447,289	471,129	(23,840)	105	371,072	382,842
Other	2,291,291	-	2,291,291	2,438,425	(147,134)	106	2,015,956	2,118,751
Capital	**729,748**	**-**	**729,748**	**683,484**	**46,264**	**94**	**827,519**	**771,707**
Transfer payments	10,400	-	10,400	10,400	-	100	5,000	5,000
Acquisition of capital assets	550,178	809	550,987	501,172	49,815	91	395,962	405,817
Other	169,170	(809)	168,361	171,912	(3,551)	102	426,557	360,890
Statutory Payment	**607**	**-**	**607**	**727**	**(120)**	**120**	**526**	**577**
Special Functions	-	-	-	31,884	(31,884)	-	-	39,797
TOTAL	**8,257,134**	**-**	**8,257,134**	**8,244,543**	**12,591**	**100**	**7,419,706**	**7,535,369**
STANDARD ITEM								
Personnel	4,856,100	-	4,856,100	4,688,378	167,722	97	4,288,050	4,285,812
Administrative	225,619	-	225,619	247,955	(22,336)	110	189,700	198,223
Inventories	1,261,495	(80)	1,261,415	1,348,434	(87,019)	107	1,147,476	1,193,161
Machinery and equipment	345,964	20,413	366,377	392,439	(26,062)	107	224,834	227,634
Land and buildings	231,738	(18,023)	213,715	151,161	62,554	71	227,327	226,668
Professional and special services	870,896	(2,310)	868,586	895,860	(27,274)	103	960,545	969,617
Transfer payments	457,689	-	457,689	481,529	(23,840)	105	376,072	387,842
Miscellaneous	7,026	-	7,026	6,176	850	88	5,176	6,038
Special functions	-	-	-	31,884	(31,884)	-	-	39,797
Statutory payment	607	-	607	727	(120)	120	526	577
TOTAL	**8,257,134**	**-**	**8,257,134**	**8,244,543**	**12,591**	**100**	**7,419,706**	**7,535,369**

DETAILS PER PROGRAMME 1: ADMINISTRATION

	2003/2004						2002/2003	
	Adjusted Appropriation	Virement	Final Allocation	Actual Expenditure	Savings/ Underspend (Excess)	Expend. as % of final allocation	Revised Allocation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
SUB-PROGRAMME								
Office of the MEC	**4,679**	**-**	**4,679**	**3,833**	**846**	**82**	**4,214**	**3,611**
Current	4,679	-	4,679	3,758	921	80	3,964	3,611
Capital	-	-	-	75	(75)	-	250	-
Management	**154,758**	**(5,137)**	**149,621**	**149,616**	**5**	**100**	**140,463**	**139,678**
Current	153,508	(5,137)	148,371	149,292	(921)	101	140,258	139,399
Capital	1,250		1,250	324	926	26	205	279
TOTAL	**159,437**	**(5,137)**	**154,300**	**153,449**	**851**	**99**	**144,677**	**143,289**
ECONOMIC CLASSIFICATION								
Current	**158,187**	**(5,137)**	**153,050**	**153,050**	**-**	**100**	**144,222**	**143,011**
Personnel	101,161	(5,137)	96,024	87,278	8,746	91	87,501	83,386
Other	57,026	-	57,026	65,772	(8,746)	115	56,721	59,625
Capital	**1,250**	**-**	**1,250**	**399**	**851**	**32**	**455**	**278**
Acquisition of capital assets	1,250	-	1,250	399	851	32	455	278
TOTAL	**159,437**	**(5,137)**	**154,300**	**153,449**	**851**	**99**	**144,677**	**143,289**

DETAILS PER PROGRAMME 1: ADMINISTRATION (continued)

	2003/2004						2002/2003	
	Adjusted Appropriation	Virement	Final Allocation	Actual Expenditure	Savings/ Underspend (Excess)	Expend. as % of final allocation	Revised Allocation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
STANDARD ITEM								
Personnel	101,161	(5,137)	96,024	87,278	8,746	91	87,501	83,386
Administration	21,437	-	21,437	23,250	(1,813)	108	17,776	19,799
Inventories	3,162	-	3,162	3,053	109	97	2,945	2,986
Machinery and equipment	3,260	-	3,260	4,310	(1,050)	132	2,498	3,002
Land and buildings	30	-	30	142	(112)	473	210	208
Professional and special services	29,223	-	29,223	34,389	(5,166)	118	29,347	28,405
Miscellaneous	1,164	-	1,164	1,027	137	88	4,400	5,503
TOTAL	**159,437**	**(5,137)**	**154,300**	**153,449**	**851**	**99**	**144,677**	**143,289**

DETAILS PER PROGRAMME 2: DISTRICT HEALTH SERVICES

	2003/2004						2002/2003	
	Adjusted Appropriation	Virement	Final Allocation	Actual Expenditure	Savings/ Underspend (Excess)	Expend. as % of final allocation	Revised Allocation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
SUB-PROGRAMME								
District Management	**44,750**	**-**	**44,750**	**50,409**	**(5,659)**	**113**	**42,856**	**42,178**
Current	44,291	-	44,291	49,050	(4,759)	111	42,413	41,799
Capital	459		459	1,359	(900)	296	443	379
Community Health Clinics	**869,288**	**(7,078)**	**862,210**	**845,016**	**17,194**	**98**	**1,519,636**	**1,477,686**
Current	863,438	(7,078)	856,360	840,821	15,539	98	1,506,308	1,467,400
Capital	5,850		5,850	4,195	1,655	72	13,328	10,286
Community Health Centres	**157,061**	**-**	**157,061**	**146,254**	**10,807**	**93**	**-**	**-**
Current	155,669	-	155,669	144,749	10,920	93	-	-
Capital	1,392	-	1,392	1,505	(113)	108	-	-
Community Based Services	**73,499**	**-**	**73,499**	**46,566**	**26,933**	**63**	**-**	**-**
Current	73,312	-	73,312	46,536	26,776	63	-	-
Capital	187	-	187	30	157	16	-	-
Other Community Services	**203,324**	**-**	**203,324**	**211,105**	**(7,781)**	**104**	**-**	**-**
Current	202,535	-	202,535	210,502	(7,967)	104	-	-
Capital	789	-	789	603	186	76	-	-
HIV/AIDS	**246,523**	**-**	**246,523**	**246,701**	**(178)**	**100**	**-**	**-**
Current	246,404	-	246,404	246,507	(103)	100	-	-
Capital	119	-	119	194	(75)	163	-	-

DETAILS PER PROGRAMME 2: DISTRICT HEALTH SERVICES (continued)

	2003/2004						2002/2003	
	Adjusted Appropriation	Virement	Final Allocation	Actual Expenditure	Savings/ Underspend (Excess)	Expend. as % of revised allocation	Revised Allocation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
SUB-PROGRAMME								
Nutrition	**219,148**	**-**	**219,148**	**232,674**	**(13,526)**	**106**	**-**	**-**
Current	219,148	-	219,148	232,674	(13,526)	106	-	-
Capital	-	-	-	-	-	-	-	-
Coroner Services	**1,000**	**-**	**1,000**	**65**	**935**	**7**	**-**	**-**
Current	1,000	-	1,000	65	935	7	-	-
Emergency Medical Rescue Services	**-**	**-**	**-**	**-**	**-**	**-**	**182,981**	**196,427**
Current	-	-	-	-	-	-	168,300	177,990
Capital	-	-	-	-	-	-	14,681	18,437
District Hospitals	**1,952,211**	**10,638**	**1,962,849**	**1,992,238**	**(29,389)**	**101**	**2,080,098**	**2,102,888**
Current	1,900,779	-	1,900,779	1,928,594	(27,815)	101	1,985,872	1,987,284
Capital	51,432	10,638	62,070	63,644	(1,574)	103	94,226	115,604
TOTAL	**3,766,804**	**3,560**	**3,770,364**	**3,771,028**	**(664)**	**100**	**3,825,571**	**3,819,179**

DETAILS PER PROGRAMME 2: DISTRICT HEALTH SERVICES (continued)

	2003/2004						2002/2003	
	Adjusted Appropriation	Virement	Final Allocation	Actual Expenditure	Savings/ Underspend (Excess)	Expend. as % of final allocation	Revised Allocation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
ECONOMIC CLASSIFICATION								
Current	**3,706,576**	**(7,078)**	**3,699,498**	**3,699,498**	**-**	**100**	**3,702,893**	**3,674,474**
Personnel	2,327,602	(7,078)	2,320,524	2,209,838	110,686	95	2,328,650	2,294,323
Transfer payments	332,445	-	332,445	356,104	(23,659)	107	271,800	282,608
Other	1,046,529	-	1,046,529	1,133,556	(87,027)	108	1,102,443	1,097,543
Capital	**60,228**	**10,638**	**70,866**	**71,530**	**(664)**	**101**	**122,678**	**144,705**
Acquisition of capital assets	24,461	10,638	35,099	33,033	2,066	94	85,995	110,399
Other	35,767	-	35,767	38,497	(2,730)	108	36,683	34,306
TOTAL	**3,766,804**	**3,560**	**3,770,364**	**3,771,028**	**(664)**	**100**	**3,825,571**	**3,819,179**
STANDARD ITEMS								
Personnel	2,363,132	(7,078)	2,356,054	2,247,849	108,205	95	2,365,322	2,327,701
Administrative	95,397	-	95,397	101,611	(6,214)	107	104,417	104,660
Inventories	644,949	-	644,949	685,942	(40,993)	106	665,617	670,397
Machinery and equipment	30,936	10,638	41,574	51,124	(9,550)	123	116,498	135,885
Land and buildings	6,417	-	6,417	6,802	(385)	106	7,659	7,186
Professional and special services	291,226	-	291,226	318,175	(26,949)	109	293,488	290,295
Transfer payments	332,445	-	332,445	356,104	(23,659)	107	271,800	282,608
Miscellaneous	2,302	-	2,302	3,421	(1,119)	149	770	447
TOTAL	**3,766,804**	**3,560**	**3,770,364**	**3,771,028**	**(664)**	**100**	**3,825,571**	**3,819,179**

DETAILS PER PROGRAMME 3: EMERGENCY MEDICAL SERVICES

	2003/2004						2002/2003	
	Adjusted Appropriation	Virement	Final Allocation	Actual Expenditure	Savings/ Underspend (Excess)	Expend. as % of final allocation	Revised Allocation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
SUB-PROGRAMME								
Emergency Transport	**256,972**	**8,003**	**264,975**	**268,074**	**(3,099)**	**101**	**-**	**-**
Current	215,812	(4,534)	211,278	214,251	(2,973)	101	-	-
Capital	41,160	12,537	53,697	53,823	(126)	100	-	-
Planned Patient Transport	**7,071**	**-**	**7,071**	**3,972**	**3,099**	**56**	**-**	**-**
Current	6,071	-	6,071	3,098	2,973	51	-	-
Capital	1,000	-	1,000	874	126	87	-	-
TOTAL	**264,043**	**8,003**	**272,046**	**272,046**	**-**	**100**	**-**	**-**
ECONOMIC CLASSIFICATION								
Current	**221,883**	**(4,534)**	**217,349**	**217,349**	**-**	**100**	**-**	**-**
Personnel	170,363	(4,534)	165,829	160,963	4,866	97	-	-
Other	51,520	-	51,520	56,386	(4,866)	109		
Capital	**42,160**	**12,537**	**54,697**	**54,697**	**-**	**100**	**-**	**-**
Acquisition of capital assets	42,160	12,396	54,556	54,556	-	100	-	-
Other	-	141	141	141	-	100		
TOTAL	**264,043**	**8,003**	**272,046**	**272,046**	**-**	**100**	**-**	**-**

DETAILS PER PROGRAMME 3: EMERGENCY MEDICAL SERVICES (continued)

	2003/2004						2002/2003	
	Adjusted Appropriation	Virement	Final Allocation	Actual Expenditure	Savings/ Underspend (Excess)	Expend. as % of final allocation	Revised Allocation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
STANDARD ITEM								
Personnel	170,363	(4,534)	165,829	160,963	4,866	97	-	-
Administrative	10,418	-	10,418	21,219	(10,801)	204	-	-
Inventories	25,425	-	25,425	21,298	4,127	84	-	-
Machinery and Equipment	42,160	12,537	54,697	54,547	150	100	-	-
Professional and special services	15,188	-	15,188	13,807	1,381	91	-	-
Miscellaneous	489	-	489	212	277	43	-	-
TOTAL	**264,043**	**8,003**	**272,046**	**272,046**	**-**	**100**	**-**	**-**

DETAILS PER PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES

	2003/2004						2002/2003	
	Adjusted Appropriation	Virement	Final Allocation	Actual Expenditure	Savings/ Underspend (Excess)	Expend. as % of final allocation	Revised Allocation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
SUB-PROGRAMME								
Provincial Regional Hospitals	**-**	**-**	**-**	**-**	**-**	**-**	**1,530,427**	**1,646,136**
Current	-	-	-	-	-	-	1,444,580	1,576,155
Capital	-	-	-	-	-	-	85,847	69,981
General Hospitals	**1,932,415**	**10,077**	**1,942,492**	**2,000,181**	**(57,689)**	**103**	**-**	**-**
Current	1,895,632	10,077	1,905,709	1,964,146	(58,437)	103	-	-
Capital	36,783		36,783	36,035	748	98	-	-
Tuberculosis Hospitals	**289,201**	**-**	**289,201**	**251,263**	**37,938**	**87**	**-**	**-**
Current	283,940	-	283,940	248,872	35,068	88	-	-
Capital	5,261	-	5,261	2,391	2,870	45	-	-
Psychiatric Hospital	**265,030**	**863**	**265,893**	**258,547**	**7,346**	**97**	**-**	**-**
Current	257,674		257,674	246,705	10,969	96	-	-
Capital	7,356	863	8,219	11,842	(3,623)	144	-	-
Chronic Medical Hospital	**63,695**	**-**	**63,695**	**53,730**	**9,965**	**84**	**-**	**-**
Current	62,506	-	62,506	52,656	9,850	84	-	-
Capital	1,189	-	1,189	1,074	115	90	-	-
Dental Training Hospitals	**8,041**	**-**	**8,041**	**7,270**	**771**	**90**	**-**	**-**
Current	8,025	-	8,025	7,144	881	89	-	-
Capital	16	-	16	126	(110)	788	-	-
Provincial Specialised Hospitals	**-**	**-**	**-**	**-**	**-**	**-**	**387,409**	**381,677**
Current	-	-	-	-	-	-	375,056	369,578
Capital	-	-	-	-	-	-	12,353	12,099
TOTAL	**2,558,382**	**10,940**	**2,569,322**	**2,570,991**	**(1,669)**	**100**	**1,917,836**	**2,027,813**

DETAILS PER PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES (continued)

	2003/2004						2002/2003	
	Adjusted Appropriation	Virement	Final Allocation	Actual Expenditure	Savings/ Underspend (Excess)	Expend. as % of final allocation	Revised Allocation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
ECONOMIC CLASSIFICATION								
Current	**2,507,777**	**10,077**	**2,517,854**	**2,519,523**	**(1,669)**	**100**	**1,819,636**	**1,945,733**
Personnel	1,710,074	10,077	1,720,151	1,685,863	34,288	98	1,262,543	1,319,947
Transfer payments	113,244	-	113,244	113,425	(181)	100	99,272	100,234
Other	684,459	-	684,459	720,235	(35,776)	105	457,821	525,552
Capital	**50,605**	**863**	**51,468**	**51,468**	**-**	**100**	**98,200**	**82,080**
Acquisition of capital assets	19,184	1,813	20,997	20,997	-	100	58,657	55,175
Other	31,421	(950)	30,471	30,471	-	100	39,543	26,905
TOTAL	**2,558,382**	**10,940**	**2,569,322**	**2,570,991**	**(1,669)**	**100**	**1,917,836**	**2,027,813**
STANDARD ITEM								
Personnel	1,741,479	10,077	1,751,556	1,716,238	35,318	98	1,302,076	1,346,309
Administrative	33,916	-	33,916	36,156	(2,240)	107	20,567	24,377
Inventories	456,092	-	456,092	482,145	(26,053)	106	305,873	355,350
Machinery and equipment	29,444	863	30,307	31,129	(822)	103	71,218	64,001
Professional and special services	181,145	-	181,145	190,382	(9,237)	105	118,830	137,541
Transfer payments	113,244	-	113,244	113,425	(181)	100	99,272	100,234
Miscellaneous	3,062	-	3,062	1,516	1,546	50	-	1
TOTAL	**2,558,382**	**10,940**	**2,569,322**	**2,570,991**	**(1,669)**	**100**	**1,917,836**	**2,027,813**

DETAILS PER PROGRAMME 5: CENTRAL HOSPITAL SERVICES

	2003/2004						2002/2003	
	Adjusted Appropriation	Virement	Final Allocation	Actual Expenditure	Savings/ Underspend (Excess)	Expend. as % of final allocation	Revised Allocation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
SUB-PROGRAMME								
Central Hospitals	**192,512**	**(3,625)**	**188,887**	**211,704**	**(22,817)**	**112**	**920,713**	**969,209**
Current	147,189	-	147,189	175,565	(28,376)	119	718,392	753,553
Capital	45,323	(3,625)	41,698	36,139	5,559	87	202,321	215,656
Tertiary Hospitals	**587,602**	**(6,112)**	**581,490**	**553,666**	**27,824**	**95**	**-**	**-**
Current	477,208	(6,112)	471,096	442,720	28,376	94	-	-
Capital	110,394		110,394	110,946	(552)	101	-	-
Central Dental Services	**-**	**-**	**-**	**-**	**-**	**-**	**7,974**	**6,840**
Current	-	-	-	-	-	-	7,707	6,643
Capital	-	-	-	-	-	-	267	197
TOTAL	**780,114**	**(9,737)**	**770,377**	**765,370**	**5,007**	**99**	**928,687**	**976,049**
ECONOMIC CLASSIFICATION								
Current	**624,397**	**(6,112)**	**618,285**	**618,285**	**-**	**100**	**726,099**	**760,195**
Personnel	259,989	(6,112)	253,877	240,670	13,207	95	377,969	373,897
Other	364,408	-	364,408	377,615	(13,207)	104	348,130	386,298
Capital	**155,717**	**(3,625)**	**152,092**	**147,085**	**5,007**	**97**	**202,588**	**215,854**
Acquisition of capital assets	154,745	(3,625)	151,120	145,968	5,152	97	17,577	16,908
Other	972	-	972	1,117	(145)	115	185,011	198,946
TOTAL	**780,114**	**(9,737)**	**770,377**	**765,370**	**5,007**	**99**	**928,687**	**976,049**

DETAILS PER PROGRAMME 5: CENTRAL HOSPITAL SERVICES (continued)

	2003/2004						2002/2003	
	Adjusted Appropriation	Virement	Final Allocation	Actual Expenditure	Savings/ Underspend (Excess)	Expend. as % of revised allocation	Revised Allocation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
STANDARD ITEM								
Personnel	260,940	(6,112)	254,828	241,768	13,060	95	385,181	378,274
Administrative	5,309	-	5,309	5,034	275	95	6,232	7,438
Inventories	104,890	-	104,890	129,481	(24,591)	123	149,141	145,616
Machinery and equipment	156,966	(3,625)	153,341	148,295	5,046	97	19,232	19,034
Land and buildings	-	-	-	35	(35)	-	-	-
Professional and special services	252,000	-	252,000	240,757	11,243	96	368,895	425,600
Miscellaneous	9	-	9	-	9	-	6	87
TOTAL	**780,114**	**(9,737)**	**770,377**	**765,370**	**5,007**	**99**	**928,687**	**976,049**

DETAILS PER PROGRAMME 6: HEALTH SCIENCES AND TRAINING

	2003/2004						2002/2003	
	Adjusted Appropriation	Virement	Final Allocation	Actual Expenditure	Savings/ Underspend (Excess)	Expend. as % of revised allocation	Revised Allocation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
SUB-PROGRAMME								
Nursing Training Colleges	**162,992**	**4,173**	**167,165**	**166,794**	**371**	**100**	**148,527**	**147,330**
Current	162,434	4,218	166,652	166,652	-	100	148,527	147,328
Capital	558	(45)	513	142	371	28	-	2
Ambulance Training College	**-**	**-**	**-**	**-**	**-**	**-**	**3,815**	**3,851**
Current	-	-	-	-	-	-	3,815	3,851
EMS Training College	**4,152**	**(35)**	**4,117**	**3,395**	**722**	**82**	**-**	**-**
Current	3,710	-	3,710	3,194	516	86	-	-
Capital	442	(35)	407	201	206	49	-	-
Primary Health Care Training	**40,031**	**1,525**	**41,556**	**41,604**	**(48)**	**100**	**-**	**-**
Current	40,031	1,525	41,556	41,556	-	100	-	-
Capital	-	-	-	48	(48)	-	-	-
Training Other	**60,384**	**6,422**	**66,806**	**66,828**	**(22)**	**100**	**19,659**	**20,919**
Current	60,384	6,422	66,806	66,806	-	100	19,659	20,919
Capital	-	-	-	22	(22)	-	-	-
Bursaries	**41,400**	**619**	**42,019**	**42,535**	**(516)**	**101**	**26,810**	**27,555**
Current	41,400	619	42,019	42,535	(516)	101	26,810	27,555
TOTAL	**308,959**	**12,704**	**321,663**	**321,156**	**507**	**100**	**198,811**	**199,655**

DETAILS PER PROGRAMME 6: HEALTH SCIENCES AND TRAINING (continued)

	2003/2004						2002/2003	
	Adjusted Appropriation	Virement	Final Allocation	Actual Expenditure	Savings/ Underspend (Excess)	Expend. as % of final allocation	Revised Allocation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
ECONOMIC CLASSIFICATION								
Current	**307,959**	**12,784**	**320,743**	**320,743**	**-**	**100**	**198,811**	**199,653**
Personnel	219,010	12,784	231,794	234,282	(2,488)	101	147,970	150,142
Transfer payments	1,600	-	1,600	1,600	-	100	-	-
Other	87,349	-	87,349	84,861	2,488	97	50,841	49,511
Capital	**1,000**	**(80)**	**920**	**413**	**507**	**45**	**-**	**2**
Acquisition of capital assets	1,000	(80)	920	408	512	44	-	2
Other	-	-	-	5	(5)	-	-	-
TOTAL	**308,959**	**12,704**	**321,663**	**321,156**	**507**	**100**	**198,811**	**199,655**
STANDARD ITEM								
Personnel	219,025	12,784	231,809	234,282	(2,473)	101	147,970	150,142
Administrative	59,142	-	59,142	60,685	(1,543)	103	40,708	41,945
Inventories	6,946	(80)	6,866	3,868	2,998	56	5,364	4,187
Machinery and equipment	1,476	-	1,476	1,405	71	95	1,568	1,868
Professional and special services	20,770	-	20,770	19,316	1,454	93	3,201	1,513
Transfer payments	1,600	-	1,600	1,600	-	100	-	-
TOTAL	**308,959**	**12,704**	**321,663**	**321,156**	**507**	**100**	**198,811**	**199,655**

DETAILS PER PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

	2003/2004						2002/2003	
	Adjusted Appropriation	Virement	Final Allocation	Actual Expenditure	Savings/ Underspend (Excess)	Expend. as % of final allocation	Revised Allocation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
SUB-PROGRAMME								
Medicine Trading Account	**10,400**	**-**	**10,400**	**10,400**	**-**	**100**	**-**	**-**
Capital	10,400	-	10,400	10,400	-	100	-	-
TOTAL	**10,400**	**-**	**10,400**	**10,400**	**-**	**100**	**-**	**-**
ECONOMIC CLASSIFICATION								
Capital	**10,400**	**-**	**10,400**	**10,400**	**-**	**100**	**-**	**-**
Transfer payments	10,400	-	10,400	10,400	-	100	-	-
TOTAL	**10,400**	**-**	**10,400**	**10,400**	**-**	**100**	**-**	**-**
STANDARD ITEM								
Transfer payments	10,400	-	10,400	10,400	-	100	-	-
TOTAL	**10,400**	**-**	**10,400**	**10,400**	**-**	**100**	**-**	**-**

DETAILS PER PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

	2003/2004						2002/2003	
	Adjusted Appropriation	Virement	Final Allocation	Actual Expenditure	Savings/ Underspend (Excess)	Expend. as % of final allocation	Revised Allocation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
SUB-PROGRAMME								
Community Health Services	**86,004**	**(6,880)**	**79,124**	**66,081**	**13,043**	**84**	**403,598**	**329,010**
Capital	86,004	(6,880)	79,124	66,081	13,043	84	403,598	328,788
District Hospitals	**115,000**	**(9,200)**	**105,800**	**86,619**	**19,181**	**82**	**-**	**-**
Capital	115,000	(9,200)	105,800	86,619	19,181	82	-	-
Emergency Medical Services	**2,292**	**-**	**2,292**	**786**	**1,506**	**34**	**-**	**-**
Capital	2,292	-	2,292	786	1,506	34	-	-
Provincial Hospital Services	**135,575**	**(4,253)**	**131,322**	**117,599**	**13,723**	**90**	**-**	**-**
Capital	135,575	(4,253)	131,322	117,599	13,723	90	-	-
Central Hospital Services	**45,100**	**-**	**45,100**	**58,708**	**(13,608)**	**130**	**-**	**-**
Capital	45,100	-	45,100	58,708	(13,608)	130	-	-
Other Services	**24,417**	**-**	**24,417**	**17,699**	**6,718**	**72**	**-**	**-**
Capital	24,417	-	24,417	17,699	6,718	72	-	-
TOTAL	**408,388**	**(20,333)**	**388,055**	**347,492**	**40,563**	**90**	**403,598**	**329,010**

DETAILS PER PROGRAMME 8: HEALTH FACILITIES MANAGEMENT (continued)

	2003/2004						2002/2003	
	Adjusted Appropriation	Virement	Final Allocation	Actual Expenditure	Savings/ Underspend (Excess)	Expend. as % of final allocation	Revised Allocation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
ECONOMIC CLASSIFICATION								
Current	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**222**
Other	-	-	-	-	-	-	-	222
Capital	**408,388**	**(20,333)**	**388,055**	**347,492**	**40,563**	**90**	**403,598**	**328,788**
Transfer payments	-	-	-	-	-	-	5,000	5,000
Acquisition of capital assets	307,378	(20,333)	287,045	245,811	41,234	86	233,278	223,055
Other	101,010	-	101,010	101,681	(671)	101	165,320	100,733
TOTAL	**408,388**	**(20,333)**	**388,055**	**347,492**	**40,563**	**90**	**403,598**	**329,010**
STANDARD ITEM								
Administrative	-	-	-	-	-	-	-	4
Inventories	20,031	-	20,031	22,647	(2,616)	113	18,536	14,625
Machinery and equipment	81,722	-	81,722	101,629	(19,907)	124	13,820	3,844
Land and buildings	225,291	(18,023)	207,268	144,182	63,086	70	219,458	219,274
Professional and special services	81,344	(2,310)	79,034	79,034	-	100	146,784	86,263
Transfer payments	-	-	-	-	-	-	5,000	5,000
TOTAL	**408,388**	**(20,333)**	**388,055**	**347,492**	**40,563**	**90**	**403,598**	**329,010**

1. **Detail of current and capital transfers as per Appropriation Act (after Virement):**
Detail of these transactions can be viewed in note 10 (Transfer payments) and Annexures 1 B and 1 C to the annual financial statements.

2. **Detail of specifically and exclusively appropriated amounts voted (after Virement):**
Detail of these transactions can be viewed in note 1 A (Annual Appropriation) to the annual financial statements.

3. **Detail of special functions (theft and losses)**
During the 2002/03 financial year an exercise to analyse each of the debt accounts was undertaken mainly to identify the irrecoverable debt accounts some of which dated back to 1994 and inherited from either the National Department of Health or Provincial Treasury. The debts were considered to be irrecoverable based on the following criteria:

- Unable to trace the debtor
- Prescription period has expired
- Uneconomical to invest further funds to recover these debts
- The debtor is deceased and the recovery of the debt would cause undue hardship on the beneficiaries

The exercise was completed in the 2003/04 financial year resulting in a write off totalling R 27,911,000 made up as follows:

- Staff Debts R 18 534 000
- Nutrition Debts R 9 377 000

Amongst the debit balances were also credit balances totalling R3,473 mil, which was not offset against the debt outstanding, as the amounts could not be traced to the individual debtors. The amount was written back to revenue.

Detail of these transactions per programme can be viewed in note 12 (Details of special functions: authorised losses) to the annual financial statements.

4. **Explanations of material variances from Amounts Voted (after virement):**

4.1 **Per programme:**

Programme1: Administration
Expenditure on this programme relates to the head office functions and strict control over the spending resulted in an under expenditure which could be used by the service delivery components. After effecting approved virements the final under expenditure is R 851 000 (0.55% of the main division allocation).

Programme 2: District Health Services
The over expenditure in this programme, after approved virements have been effected, is R 664 000 (0.018% of the main division allocation), which can be attributed to incorrect allocations by institutions between current and capital expenditure.

Programme 3: Emergency Medical Services
This programme incurred over expenditure and after effecting approved virements the expenditure on the main division is as authorised.

Programme 4: Provincial Hospital Services
The over expenditure in this programme, after approved virements have been effected, is R1,699 mil (0.65% of the main division allocation), which can be attributed to incorrect allocations by institutions between current and capital expenditure.

Programme 5: Central Health Services
The under expenditure in this programme, after approved virements have been effected, is R 5,007 mil (0.64% of the main division). The reason for the under expenditure relates to delays in the purchase of equipment for Grey's Hospital and an underspending on the Professional Training Development Grant of R3,040 mil, which will be rolled over to 2004/05.

Programme 6: Health Sciences and training
Expenditure on this programme relates mainly to the training of health professionals and after effecting approved virements the final under expenditure is R507 000 (0.16% of the main division allocation).

Programme 7: Health Care Support Services
Expenditure on this programme is as approved for this main division.

Programme 8: Health Facilities Management
After effecting approved virements the final under expenditure is R 40,563 mil (11.15% of the main division allocation). This resulted mainly from the delays in the process of finalising the tenders for some major capital projects. A request has been made to Provincial Treasury for the roll over of a portion of these funds.

4.2 Per standard item:

Personnel:
Although the Department has dedicated and loyal staff to provide health services it has found that many areas of its services are inadequately staffed and that in some cases, despite repeated recruitment, it is unable to attract skilled and suitable personnel and therefore the underspending on personnel expenditure.

Inventories
The overspending is due to the additional medical supplies being purchased to cater for the increase in the demand for health services.

Machinery and Equipment
The overspending is due to the additional medical equipment purchased.

Land and Buildings
The underspending has resulted mainly from the delays in the process of finalising the tenders for some major capital projects. A request has been made to Provincial Treasury for the roll over of a portion of these funds.

Professional and Special Services
The overspending is due to the inability to recruit and retain the appropriate staff and therefore the need to employee contractors and consultants.

Transfer Payments
The overspending on the transfer payments is due to the Integrated Nutrition Programme, to cater for the increase in the number of schools and children participating in the programme.

ANNUAL FINANCIAL STATEMENTS FOR THE PROVINCIAL MEDICAL SUPPLY CENTRE FOR THE YEAR ENDED 31st MARCH 2004

DEPARTMENT OF HEALTH: PROVINCE OF KWAZULU-NATAL VOTE 7

AUDITOR-GENERAL

AUDITOR-GENERAL

ANNUAL FINANCIAL STATEMENTS FOR THE PROVINCIAL MEDICAL SUPPLY CENTRE FOR THE YEAR ENDED 31st MARCH 2004 DEPARTMENT OF HEALTH : PROVINCE OF KWAZULU-NATAL VOTE 7

CONTENTS

PROVINCIAL MEDICAL SUPPLY CENTRE
MANAGEMENT REPORT for the year ended 31 March 2004

Report by the Accounting Officer to the Executive Authority and Parliament of the Republic of South Africa.

1. General review of the state of financial affairs

The Medical Supply Centre has shown a trading surplus of R 1,279m for the period ended 31 March 2004. This has mainly been due to the effect of increased trading activities resulting in an annual turnover of R 596 036m, being an increase of 12% over the prior year. Overheads and operating expenses also increased by 14% for the same period, due mainly to increased inventory purchases, although personnel and administrative expenses also contributed to the increased expenditure.

The surcharges levied on all items issued were reduced by 1% as detailed in item 2.0 below. The net effect therefore was a reduction in the trading surplus to R 1,279m for the financial year. The main factors contributing to the increase in trading activities were as follows :

1.1 Price increases from suppliers on inventories purchased.
1.2 A continual increase in the number of clients serviced, over the previous year.

2. Services rendered by the department

2.1 The procurement and delivery of pharmaceuticals as listed by National Health Pharmaceutical Services and Provincial Health Pharmaceutical Services
2.2 The tariff policy is structured as follows :
Surcharge of 5% – levied on all pharmaceutical items procured by and received at PMSC and thereafter delivered to the institutions.
Surcharge of 4% – levied on all pharmaceutical items procured by PMSC and delivered directly by the supplier to the said institutions.
Surcharge of 12% – levied on all pharmaceuticals that involve the use of PMSC human resources in terms of repacking, manufacturing etc.

3. Capacity constraints

The limited availability of warehousing and manufacturing space.

4. New / proposed activities

4.1 The client base currently being serviced has continued to increase over the prior year, with delivery services being extended from the existing base of 612 demanders to approximately 700 during the current financial year.
4.2 This has been a direct result of fulfilling the Health Department's mission statement, which incorporates making health services available to all.
4.3 This increase has obviously affected warehousing space and available human resources.
4.4 the financial effects have been dealt with in Note 1. above.

Approval

The annual financial statements set out on pages 261 to 275 have been approved by the Accounting Officer.

Mrs H.G. Harding
Manager : Provincial Medical Supply Centre
20 July 2004

AUDITOR-GENERAL

PROVINCIAL MEDICAL SUPPLY CENTRE
STATEMENT OF ACCOUNTING POLICIES AND RELATED MATTERS
for the year ended 31 MARCH 2004

The financial statements have been prepared in accordance with the following policies, which have been applied consistently in all material respects, unless otherwise indicated. However, where appropriate and meaningful, additional information has been disclosed to enhance the usefulness of the financial statements and to comply with the statutory requirements of the Public Finance Management Act, Act 1 of 1999 (as amended by Act 29 of 1999), the Treasury Regulations for Departments and Constitutional Institutions issued in terms of the Act and the Division of Revenue Act, Act 7 of 2003.

1. Basis of preparation

The financial statements have been prepared on a modified cash basis of accounting, except where stated otherwise. The modified cash basis constitutes the cash basis of accounting supplemented with additional disclosure items. The reporting entity is in transition from reporting on a cash basis of accounting to reporting on an accrual basis of accounting. Under the cash basis of accounting transactions and other events are recognised when cash is received or paid. Under the accrual basis of accounting transactions and other events are recognised when incurred and not when cash is received or paid.

2. Revenue

Voted funds are the amounts appropriated to a department in accordance with the final budget known as the Adjusted Estimates of National/ Provincial Expenditure. Unexpended voted funds are surrendered to the National/Provincial Revenue Fund.

Interest and dividends received are recognised upon receipt of the funds, and no accrual is made for interest or dividends receivable from the last receipt date to the end of the reporting period. They are recognised as revenue in the financial statements of the department and then transferred to the National/ Provincial Revenue Fund.

3. Donor aid

Donor aid is recognised in the income statement in accordance with the cash basis of accounting.

4. Current expenditure

Current expenditure is recognised in the income statement when the payment is made.

5. Unauthorised, irregular and fruitless and wasteful expenditure

Unauthorised expenditure means:

- the overspending of a vote or a main division within a vote, or
- expenditure that was not made in accordance with the purpose of a vote or, in the case of a main division, not in accordance with the purpose of the main division.

Unauthorised expenditure is treated as a current asset in the balance sheet until such expenditure is recovered from a third party or funded from future voted funds.

Irregular expenditure means expenditure, other than unauthorised expenditure, incurred in contravention of or not in accordance with a requirement of any applicable legislation, including:

- the Public Finance Management Act,
- the State Tender Board Act, or any regulations made in terms of this act, or
- any provincial legislation providing for procurement procedures in that provincial government.

PROVINCIAL MEDICAL SUPPLY CENTRE
STATEMENT OF ACCOUNTING POLICIES AND RELATED MATTERS
for the year ended 31 MARCH 2004

Irregular expenditure is treated as expenditure in the income statement.

Fruitless and wasteful expenditure means expenditure that was made in vain and would have been avoided had reasonable care been exercised. Fruitless and wasteful must be recovered from a responsible official (a debtor account should be raised), or the vote if responsibility cannot be determined. It is treated as a current asset in the balance sheet until such expenditure is recovered from the responsible official or funded from future voted funds.

6. Debts written off
Debts are written off when identified as irrecoverable. Debts written-off are limited to the amount of surplus funds available to the department. No provision is made for irrecoverable amounts.

7. Capital expenditure
Expenditure for physical items on hand on 31 March 2004, to be consumed in the following financial year, is written off in full when they are paid and are accounted for as expenditure in the income statement. Physical assets (fixed assets and movable assets) acquired are expensed i.e. written off in the income statement when the payment is made.

8. Investments
Non-current investments are shown at cost and adjustments are made only where in the opinion of the accounting officer, the investment is impaired. Where an investment has been impaired, it is recognised as an expense in the period in which the impairment is identified.

On disposal of an investment, the difference between the net disposal proceeds and the carrying amount is charged or credited to the income statement.

9. Investments in controlled entities
Investments in controlled entities are those entities where the reporting entity has the ability to exercise any of the following powers to govern the financial and operating policies of the entity in order to obtain benefits from its activities:

- To appoint or remove all, or the majority of, the members of that entity's board of directors or equivalent governing body;
- To appoint or remove the entity's chief executive officer;
- To cast all, or the majority of, the votes at meetings of that board of directors or equivalent governing body; or
- To control all, or the majority of, the voting rights at a general meeting of that entity.

Investments in controlled entities are shown at cost.

10. Receivables
Receivables are not normally recognised under the cash basis of accounting. However, receivables included in the balance sheet arise from cash payments that are recoverable from another party.

Receivables for services delivered are not recognised in the balance sheet as a current asset or as income in the income statement, as the financial statements are prepared on a cash basis of accounting, but are disclosed separately as part of the disclosure notes to enhance the usefulness of the financial statements.

11. Payables
Payables are not normally recognised under the cash basis of accounting. However, payables included in the balance sheet arise from cash receipts that are due to the Provincial / National Revenue Fund or another party.

12. Provisions
A provision is a liability of uncertain timing or amount. Provisions are not normally recognised under the cash basis of accounting, but are disclosed separately as part of the disclosure notes to enhance the usefulness of the financial statements.

AUDITOR-GENERAL

PROVINCIAL MEDICAL SUPPLY CENTRE
STATEMENT OF ACCOUNTING POLICIES AND RELATED MATTERS
for the year ended 31 MARCH 2004

13. Lease commitments
Lease commitments for the period remaining from the reporting date until the end of the lease contract are disclosed as part of the disclosure notes to the financial statements. These commitments are not recognised in the balance sheet as a liability or as expenditure in the income statement as the financial statements are prepared on the cash basis of accounting.

14. Accruals
This amount represents goods / services that have been delivered, but no invoice has been received from the supplier at the year end, OR an invoice has been received but remains unpaid at the year end. These amounts are not recognised in the balance sheet as a liability or as expenditure in the income statement as the financial statements are prepared on a cash basis of accounting, but are however disclosed as part of the disclosure notes.

15. Employee benefits
Short-term employee benefits
The cost of short-term employee benefits is expensed in the income statement in the reporting period when the payment is made. Short-term employee benefits, that give rise to a present legal or constructive obligation, are deferred until they can be reliably measured and then expensed. Details of these benefits and the potential liabilities are disclosed as a disclosure note to the financial statements and are not recognised in the income statement.
Termination benefits
Termination benefits are recognised and expensed only when the payment is made.

Retirement benefits
The department provides retirement benefits for its employees through a defined benefit plan for government employees. These benefits are funded by both employer and employee contributions. Employer contributions to the fund are expensed when money is paid to the fund. No provision is made for retirement benefits in the financial statements of the department. Any potential liabilities are disclosed in the financial statements of the National / Provincial Revenue Fund and not in the financial statements of the employer department.

Medical benefits
The department provides medical benefits for (certain/all) its employees through defined benefit plans. These benefits are funded by employer and / or employee contributions.

Employer contributions to the fund are expensed when money is paid to the fund. No provision is made for medical benefits in the financial statements of the department.
Post retirement medical benefits for retired members are expensed when the payment is made to the fund.

16. Capitalisation reserve
The capitalisation reserve represents an amount equal to the value held in a suspense account by Provincial Treasury on behalf of Provincial Medical Supply Centre, for the procurement of pharmaceuticals.

17. Recoverable revenue
Recoverable revenue represents payments made and recognised in the income statement as an expense in previous years due to non-performance in accordance with an agreement, which have now become recoverable from a debtor. Repayments are transferred to the Revenue Fund as and when the repayment is received.

18. Comparative figures
Where necessary, comparative figures have been restated to conform to the changes in the presentation in the current year. The comparative figures shown in these financial statements are limited to the figures shown in the previous year's audited financial statements and such other comparative figures that the department may reasonably have available for reporting.

PROVINCIAL MEDICAL SUPPLY CENTRE
APPROPRIATION STATEMENT
for the year ended 31 MARCH 2004

Programme	2003/04						2002/03	
	Adjusted Appropriation R'000	Virement R'000	Revised Allocation R'000	Actual Expenditure R'000	Savings / Underspend (Excess) R'000	Expenditure as % of revised allocation	Revised Allocation R'000	Actual Expenditure R'000
1. Administration								
Current			17,012	18,917	(1,905)	111.2%	15,370	15,559
2. Procurement Management, Financial Systems and PFMA								
Current			495,328	575,507	(80,179)	116.2%	445,829	507,685
Capital			1,632	333	1,299	20.4%	1,675	1,109
Total	-	-	513,972	594,757	(80,785)	115.7%	462,874	524,353
Reconciliation with Income Statement								
Actual amounts per Income Statement				594,757				524,353

PROVINCIAL MEDICAL SUPPLY CENTRE
APPROPRIATION STATEMENT
for the year ended 31 MARCH 2004

Direct charge against the National Revenue Fund	2003/04						2002/03	
	Adjusted Appropriation R'000	Virement R'000	Final Allocation R'000	Actual Expenditure R'000	Savings / Underspend (Excess) R'000	Expenditure as % of revised allocation	Revised Allocation R'000	Actual Expenditure R'000
Provinces Equitable Share			513,972	594,757	(80,785)	115.7%	463,039	524,353
Total			**513,972**	**594,757**	**(80,785)**	**115.7%**	**463,039**	**524,353**

Economic classification	2003/04						2002/03	
	Adjusted Appropriation R'000	Virement R'000	Final Allocation R'000	Actual Expenditure R'000	Savings / Underspend (Excess) R'000	Expenditure as % of revised allocation	Revised Allocation R'000	Actual Expenditure R'000
Current								
Personnel			11,688	10,966	722	93.8%	10,530	9,151
Other			500,652	583,458	(82,806)	116.5%	450,834	514,093
Capital								
Acquisition of capital assets			1,632	333	1,299	20.4%	1,675	1,109
Total			**513,972**	**594,757**	**(80,785)**	**115.7%**	**463,039**	**524,353**

Standard item classification	2003/04						2002/03	
	Adjusted Appropriation R'000	Virement R'000	Final Allocation R'000	Actual Expenditure R'000	Savings / Underspend (Excess) R'000	Expenditure as % of revised allocation	Revised Allocation R'000	Actual Expenditure R'000
Personnel			11,688	10,966	722	93.8%	10,530	9,151
Administrative			5,324	7,951	(2,627)	149.3%	4,840	6,408
Inventories			491,430	570,699	(79,269)	116.1%	442,450	504,168
Equipment			1,632	574	1,058	35.2%	1,675	1,109
Land and buildings			969	467	502	48.2%	881	925
Professional and special services			2,747	3,767	(1,020)	137.1%	2,498	2,592
Miscellaneous			182	-	182	0.0%	165	-
Total			**513,972**	**594,424**	**(80,452)**	**115,7%**	**463,039**	**524,353**

PROVINCIAL MEDICAL SUPPLY CENTRE
DETAIL PER PROGRAMME 7
for the year ended 31 MARCH 2004

Programme per subprogramme	2003/04						2002/03	
	Adjusted Appropriation R'000	Virement R'000	Final Allocation R'000	Actual Expenditure R'000	Savings / Underspend (Excess) R'000	Expenditure as % of revised allocation	Revised Allocation R'000	Actual Expenditure R'000
1.1 Subprogramme1								
Current			512,340	594,424	(82,084)	116.0%	461,364	523,359
Capital			1,632	333	1,299	20.4%	1,675	994
Total			**513,972**	**594,757**	**(80,785)**	**115.7%**	**463,039**	**524,353**

Economic classification	2003/04						2002/03	
	Adjusted Appropriation R'000	Virement R'000	Final Allocation R'000	Actual Expenditure R'000	Savings / Underspend (Excess) R'000	Expenditure as % of revised allocation	Revised Allocation R'000	Actual Expenditure R'000
Current								
Personnel			11,688	10,966	722	93.8%	10,530	9,151
Other			500,652	583,458	(82,806)	116.5%	450,834	514,208
Capital								
Acquisition of capital assets			1,632	333	1,299	20.4%	1,675	994
Total			**513,972**	**594,757**	**(80,785)**	**115.7%**	**463,039**	**524,353**

Standard item classification	2003/04						2002/03	
	Adjusted Appropriation R'000	Virement R'000	Final Allocation R'000	Actual Expenditure R'000	Savings / Underspend (Excess) R'000	Expenditure as % of revised allocation	Revised Allocation R'000	Actual Expenditure R'000
Personnel			11,688	10,966	722	93.8%	10,530	9,151
Administrative			5,324	7,951	(2,627)	149.3%	4,840	6,408
Inventories			491,430	570,699	(79,269)	116.1%	442,450	505,168
Equipment			1,632	574	1,058	35.2%	1,675	1,109
Land and buildings			969	467	502	48.2%	881	925
Professional and special services			2,747	3,767	(1,020)	137.1%	2,498	2,592
Miscellaneous			182	-	182	0.0%	165	-
Total			**513,972**	**594,424**	**(80,452)**	**115.7%**	**463,039**	**524,353**

PROVINCIAL MEDICAL SUPPLY CENTRE
INCOME STATEMENT (STATEMENT OF FINANCIAL PERFORMANCE)
for the year ended 31 MARCH 2004

REVENUE	Note	2003/04 R'000	2002/03 R'000
Non voted funds			
Other revenue to be surrendered to the revenue fund	1	596,036	532,708
TOTAL REVENUE		**596,036**	**532,708**
EXPENDITURE			
Current			
Personnel	2	10,966	9,151
Administrative		7,951	6,408
Inventories	3	570,699	504,168
Machinery and Equipment	4	574	115
Land and buildings	5	467	925
Professional and special services	6	3,767	2,592
Total Current Expenditure		**594,424**	**523,359**
Capital			
Machinery and Equipment	4	333	994
Total Capital Expenditure		333	994
TOTAL EXPENDITURE		**594,757**	**524,353**
NET SURPLUS / (DEFICIT)		**1,279**	**8,355**
NET SURPLUS / (DEFICIT) FOR THE YEAR	7	**1,279**	**8,355**

PROVINCIAL MEDICAL SUPPLY CENTRE
BALANCE SHEET (STATEMENT OF FINANCIAL POSITION)
at 31 MARCH 2004

ASSETS	Note	2003/04 R'000	2002/03 R'000
Current assets		**42,057**	**40,522**
Provincial Treasury	8	(1,689)	16,492
Accounts Receivable	9	3	0
Inventory	3	43,743	24,030
TOTAL ASSETS		**42,057**	**40,522**
LIABILITIES			
Current liabilities		**1,529**	**10,228**
Other revenue funds to be surrendered to the Revenue Fund	10	1,279	8,355
Accounts Payable	11	250	1,873
TOTAL LIABILITIES		**1,529**	**10,228**
NET ASSETS/LIABILITIES		**40,528**	**30,294**
Represented by:		**40,528**	**30,294**
Capitalisation reserve	15	40,400	30,000
Medvas Surpluses	15	128	294
TOTAL		**40,528**	**30,294**

PROVINCIAL MEDICAL SUPPLY CENTRE
STATEMENT OF CHANGES IN NET ASSETS
for the year ended 31 MARCH 2004

	Note	2003/04 R'000	200/03 R'000
Capitalisation reserve			
Opening balance	15	30,000	25,000
Transfers		10,400	5,000
Closing balance		**40,400**	**30,000**

PROVINCIAL MEDICAL SUPPLY CENTRE
CASH FLOW STATEMENT
for the year ended 31 MARCH 2004

	Note	2003/04 R'000	2002/03 R'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Net cash flow generated by operating activities	12	1,612	9,349
Cash generated / (utilised) to (increase) / decrease working capital	13	(11,105)	3,824
Voted funds and Revenue Funds surrendered	14	(8,355)	(416)
Net cash flow available from operating activities		**(17,848)**	**12,757**
CASH FLOWS FROM INVESTING ACTIVITIES		**333**	**994**
Capital expenditure	4	333	994
Net cash flows from operating and investing activities		(18,181)	11,763
Net increase / (decrease) in cash and cash equivalents		(18,181)	11,763
Cash and cash equivalents at beginning of period		16,492	4,729
Cash and cash equivalents at end of period	8	**(1,689)**	**16,492**

PROVINCIAL MEDICAL SUPPLY CENTRE
NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 MARCH 2004

1. Other revenue to be surrendered to revenue fund

Description	2003/04 R'000	2002/03 R'000
Other	26	5
Medvas	596,010	532,703
Total other revenue collected	**596,036**	**532,708**

2. Personnel

2.1 Current expenditure

Appropriation to Executive and Legislature		
Basic salary costs	9,447	7.746
Pension contributions	1,035	921
Medical aid contributions	481	484
Other salary related costs	3	-
Total personnel costs	**10,966**	**9,151**
Average number of employees	122	122

3. Inventories

3.1 Current expenditure

Inventories purchased during the year

Health Central Procurement Stores	570,699	504,168
Total cost of inventories	**570,699**	**504,168**

3.2 Inventories on hand at year end (for disclosure purposes only)

Health Central Procurement Stores	34,968	21,439
Manufacturing Labotatories	8,775	2,591
	43,743	**24,030**

The value of inventory on hand disclosed is for the main store.
Costing method used : Price re-averaging

4. Machinery and equipment

Current (rentals, maintenance and sundry)		574	115
Capital	4.1	333	994
Total capital and current expenditure		**907**	**1,109**

4.1 Capital machinery and equipment expenditure analysed as follows:

Computer equipment	87	509
Furniture and office equipment	78	266
Other machinery and equipment	168	77
Transport	-	142
	333	**994**

			2003/04 R'000	2002/03 R'000
5.	**Land and Buildings**			
	Current expenditure			
	Maintenance		102	50
	Leasehold improvements			
	Rental		365	875
	Total current expenditure		467	925
	Capital expenditure			
	Total current and capital expenditure		**467**	**925**
6.	**Professional and special services**			
6.1	**Current expenditure**			
	Contractors		2,813	2,043
	Computer services		-	139
	Other (specify material amounts separately)		954	410
			3,767	2,592
	Total Professional and special services		**3,767**	**2,592**
7.	**Analysis of surplus**			
	Voted funds to be surrendered to the National/Provincial Revenue Fund			
	Non voted funds			
	Other revenue to be surrendered to the Revenue Fund		1,279	8,355
			1,279	**8,355**
8.	**Cash and cash equivalents**			
	Paymaster General Account		(1,692)	16,492
	Cash on hand		3	-
			(1,689)	**16,492**
9.	**Accounts Receivable – current**			
	Amounts owing by other departments			
	Staff debtors	9.1	3	-
			3	-
9.1	**Staff debtors**			
	Personnel Debtors		3	-
			3	-
10.	**Other revenue funds to be surrendered to the Revenue Fund**			
	Opening balance		8,355	416
	Transfer from income statement for revenue to be surrendered		1,279	8,355
	Paid during the year		(8,355)	(416)
	Closing balance		**1,279**	**8,355**

PROVINCIAL MEDICAL SUPPLY CENTRE
NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 MARCH 2004

			2003/04 R'000	2002/03 R'000
11.	**Payables – current**			
	Description			
	Other payables	11.1	250	1,873
			250	**1,873**
11.1	**Other payables**			
	Creditors – Stock		241	1,873
	Debts/Disallowance Accounts		9	-
			250	**1,873**
12.	**Net cash flow generated by operating activities**			
	Net surplus as per Income Statement		1,279	8,355
	Adjusted for items separately disclosed		333	994
	Capital expenditure		333	994
	Net cash flow generated by operating activities		**1,612**	**9,349**

13.	**Cash generated (utilised) to (increase)/decrease working capital**	**2003/04 R'000**	**2002/03 R'000**
	(Increase) / decrease in accounts receivable – current	(3)	33
	(Increase) / decrease in inventory	(19,713)	1,401
	Increase / (decrease) in accounts payable – current	(1,623)	(1,358)
	Increase / (decrease) in other current liabilities	10,234	3,748
		(11,105)	**3,824**
14.	**Non-Voted funds and revenue funds surrendered**		
	Voted funds surrendered		
	Revenue funds surrendered	(8,355)	(416)
		(8,355)	**(416)**
15.	**Equity**		
	Capitalisation reserve	40,400	30,000
	Medvas Surpluses	128	294
		40,528	**30,294**

The capitalisation reserve has been increased by R 10,4m with the approval of the Provincial Treasury Department.

The Medvas surpluses are derived from price adjustments to the inventory control system.

These amounts are not recognised in the financial statements and are disclosed to enhance the usefulness of the financial statements and to comply with the statutory requirements of the Public Finance Management Act, Act 1 of 1999 (as amended by Act 29 of 1999), the Treasury Regulations for Departments and Constitutional Institutions issued in terms of the Act and the Division of Revenue Act, Act 7 of 2003.

16. Contingent liabilities

Liable to	Nature		2003/04 R'000	2002/03 R'000
Housing loan guarantees	Employees	Annexure 1	16	11
			16	**11**

17. Accruals

402103 Administrative Expenditure	209	212
	209	**212**

18. Employee benefits

	2003/04 R'000	2002/03 R'000
Leave entitlement	47	115
	47	**115**

ANNEXURE 1

STATEMENT OF FINANCIAL GUARANTEES ISSUED AS AT 31 MARCH 2004

DOMESTIC

Guaranteed institution	Guarantee in respect of	Original Guaranteed capital amount R'000	Opening Balance 01/04/2003 R'000	Guarantees issued during the year R'000	Guarantees Released during the year R'000	Guaranteed interest outstanding as at 31/03/2004 R'000	Closing Balance 31/03/2004 R'000	Realised losses i.r.o. claims paid out R'000
ABSA	Housing	11	11	-	11	-	-	11
	Housing	16	-	16	-	-	16	-
		27	11	16	11	-	16	11

Performance Audits:

2003/2004

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1. PURPOSE AND CONTENT OF THE REPORT

1 .1 The purpose of this report is to facilitate public accountability by bringing to the attention of the provincial legislature key findings regarding the performance audits of the management of primary health care and sick leave conducted at the Department of Health of the KwaZulu-Natal Provincial Administration (department). The content of the report is based mainly on the requirements of sections 3 and 5 of the Auditor-General Act, 1995 (Act No. 12 of 1995).

1.2 Sufficient audit work was performed to provide substantiating audit evidence for the findings set out herein. The findings documented in this report are supported by examples of the consequences of the deficient management measures and should not be regarded as comprehensive.

1.3 It is hoped that this report will give rise to corrective steps, which would contribute constructively to the establishment and implementation of proper management measures and controls and, consequently, to improved value for money.

2. AUDITING CONCEPTS AND APPROACH

2.1 BACKGROUND:

2.1.1 The auditing of government institutions takes place in a milieu in which, in the first instance, it is the responsibility of the accounting officer concerned to institute measures to:

(a) procure resources of the right quality in the right quantities at the right time and place at the lowest possible cost (economy);

(b) achieve the optimal relationship between the output of goods, services or other results and the resources used to produce them (efficiency); and

(c) achieve policy objectives, operational goals and other intended effects (effectiveness).

2.1.2 The promotion of economy, efficiency and effectiveness depends on adequate management measures for the planning, budgeting, authorisation, control and evaluation of the procurement and utilisation of resources. The responsibility to institute these measures rests with management. The primary objective of performance auditing is to confirm independently that these measures do exist and are effective and to provide management, Parliament and other legislative bodies with information, by means of a structured reporting process, on shortcomings in management measures and examples of the effects thereof.

2.1.3 Although the methodology of performance auditing is focused on highlighting shortcomings in management measures, this does not mean that poor or no value for money is received throughout.

2.1.4 It is not the Auditor-General's function to question policy. It is, however, his responsibility to investigate the effect of policy and the management measures that lead to policy decisions.

2.2 *MODUS OPERANDI:*

Performance audits are conducted in accordance with generally accepted government auditing standards as well as the internal guidelines for the planning, execution, reporting and follow-up of performance audits. By the very nature of things it is possible in each

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performance audit to focus only on a segment of the activities of a particular institution. In this regard preference is given to the more important aspects. The modus operandi adopted makes provision for, inter alia, the following:

2.2.1 Steering committee:

When the initial arrangements were made for the audit, the management of the department was informed in detail of the objectives and the modus operandi that would be followed during the audit and arrangements were made for the establishment of a steering committee. The main purpose of the steering committee, which consisted of the audit team and senior staff members of the department, was to secure and maintain co-operation between all parties involved. During the meetings of the steering committee efforts were made to reach consensus on matters such as audit criteria, findings and conclusions so that the eventual report would not contain any surprises for the department and it could be afforded the opportunity for timely inputs. This approach should also lead to early corrective steps where weaknesses have been noticed. It is, however, in no way the intention or practice that the steering committee should provide the institution with a veto right in respect of the nature and scope of the performance audit or the reporting thereon. A steering committee is a consultative forum seeking consensus, but the relevant statutory powers remain vested in the Auditor-General.

2.2.2 Management report:

(a) Consensus on the factual correctness of the findings in the management report on primary health care was not confirmed during a formal meeting of the steering committee owing mainly to time constraints. However, the draft report was discussed during a meeting with senior officials of the department on 25 March 2003, and certain amendments were made to the draft report. The response of the Superintendent-General was received on 23 December 2003 and incorporated into the report.

(b) Consensus on the factual correctness of the findings in the management report of sick leave was accepted in principle by means of a memorandum from the Chief Director: Human Resource Practices dated 19 December 2003. The response of the Superintendent-General was received on 8 April 2004 and incorporated into the report.

3. PRIMARY HEALTH CARE

3.1 SCOPE

3.1.1 Performance audits are conducted in accordance with generally accepted government auditing standards as well as the internal guidelines for the planning, execution, reporting and follow-up of performance audits. Performance audits are furthermore conducted on a cyclical basis at all government institutions. In view of the complexity of the environments to be audited each performance audit focuses on a delimited segment of the activities of a particular institution. Preference is naturally given to the more important aspects.

3.1.2 The performance audit focused mainly on the following aspects of primary health care services:

- Allocation of funds to community health centres and clinics.
- Infrastructure and maintenance.
- Recruitment and retention of professional nurses.
- The Tuberculosis (TB) programme.

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3.1.3 Although only the TB programme was selected, it was also necessary to include the other items above in the audit as it had an effect on the delivery of services in this regard.

3.1.4 During the audit various project files relating to infrastructure were examined and the following clinics were visited to, inter alia, conduct interviews, obtain information and evidence as well as to verify such evidence:
Jozini, Umzinto, Mkhuze, Mhlekazi, Phungashe, Mabhelani, Umlazi Section U21, Umlazi V, Nondabuya, Manyiseni, Groutville, Kearsney, Caluza, Mpumuza, Philani, Mbumbulu and Izingolweni mobile clinics.

4. OVERVIEW

4.1 The mission of the department is " to develop a sustainable, co-ordinated, integrated and comprehensive health system at all levels of care, based on the primary health care (PHC) approach through the District Health System".

4.2 According to the Budget Statement for the 2002/2003 financial year, the following percentage of the total budget of the province had been allocated to the department:

Year	Total provincial budget	Allocated to department	Percentage of total budget
2001/2002	R 25 082 billion	R 6 743 billion	26,88%
2002/2003	R 27 109 billion	R 6 995 billion	25,80%

4.3 For the 2001/2002 and 2002/2003 financial years, approximately R3 253 and R3 698 billion had been allocated, respectively, for the rendering of district health services. From the above amounts approximately R1 137 billion and R1 207 billion, respectively, had been allocated to community health services.

4.4 PHC services are provided by community health centres (CHC's), clinics and mobile clinics. The department and local authorities administer these facilities.

4.5 TUBERCULOSIS PROGRAMME:

4.5.1 Tuberculosis (TB) is a disease that originates from infection by Mycobacterium that kills more people than any other single infectious agent. Tuberculosis is a serious growing health problem in South Africa, expanded and complicated by HIV/AIDS and multiple drug-resistant TB.

4.5.2 (a) The overall objectives of the National Tuberculosis Control Programme (NTCP) are:

- To reduce mortality and morbidity attributable to TB.
- To prevent the development of drug resistance to TB treatment.
- To ensure accurate measurement and evaluation of programme performance.

(b) The short-term objectives of the NTCP are:

- To achieve smear conversion rates of at least 85 per cent among new smear positive cases and 80 per cent among re-treatment cases at the end of the intensive phase of treatment.
- Cure at least 85 per cent of new smear positive cases with short course anti TB therapy.

4.5.3 The NTCP has four levels namely the central unit or national level, the provincial level, the district level and health unit levels. The central unit level is at the National Department of

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Health. The central unit plays the role of co-ordination, facilitation and evaluation of tuberculosis services for the whole country. The provincial level is responsible for implementation and budgeting. The district level is the key level for the management of primary health care and is the most peripheral unit of the health services administration. The health unit level includes the providing of primary health care services regarding tuberculosis by clinics, health centres and dispensaries in the various districts.

4.5.4 The National Department of Health adopted a directly observed treatment supporter (DOTS) strategy to combat the spread of TB. An integral part of the strategy involves the interaction of treatment supporters whose task it is to administer and observe patients taking medication. This strategy includes the following five key elements:

- Directly observed treatment by the clinic/treatment supporter for 6 months.
- Short course chemotherapy and uninterrupted drug supplies.
- Standard reporting and recording system.
- Diagnosis based on positive sputum microscopy.
- Commitment to the DOTS programme by all.

4.5.5 Training regarding DOTS covers knowledge, attitude change and skills in communication, simple counselling and problem solving in providing correct continuous directly observed treatment. Suitable training manuals and health learning materials are provided. DOTS supporters in the community receive supportive supervision by regular contact with the clinic nurse who will also record continuity of progress in the clinic TB register. This process ensures the recording of missed treatments and the rapidity of re-establishing continuous treatment. The community health committee participates in identifying new potential DOTS supporters. This is a partnership between supporter, patient and clinic with the patient deciding whom his supporter will be. Committees may provide non-financial incentives such as community recognition of outstanding voluntary DOTS support. A norm was set to achieve a minimum community-based DOTS treatment cure rate of new sputum positive TB cases of 85 per cent.

5. KEY FINDINGS, POSSIBLE AREAS FOR IMPROVEMENT AS WELL AS COMMENTS OF THE ACCOUNTING OFFICER

5.1 ALLOCATION OF FUNDS TO COMMUNITY HEALTH CENTRES AND CLINICS:

5.1.1 In terms of the department's Strategic Position Statement (SPS) the budget is allocated to the 11 districts in relation to the district population as adjusted with a poverty factor based on the average per capita income for the district. However, owing mainly to financial constraints, the above allocation norm could not be fully implemented in the allocation of funds to CHC and clinics for the 2002/2003 financial year.

5.1.2 Owing mainly to inadequate funds being allocated to the department, the average amount per capita allocated for District Health Services is significantly lower than in certain other provinces. For example, the average per capita budget for Gauteng amounted to R92,09 for the 2001/2002 financial year compared to approximately R74,43 for the department.

5.1.3 Cross border patients from Mozambique and the Eastern Cape contributed to a significant additional financial burden on the department.

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According to the SPS the annual additional expenditure to provide services to the cross border patients amounted to approximately R76 million.

POSSIBLE AREAS FOR IMPROVEMENT:

(a) The norms determined in the SPS should also be applied during the allocation of funds to CHC and clinics.

(b) The norm based on the percentage-weighted population should be reviewed regularly to ensure that funds are allocated to districts in an equitable manner.

(c) The department should continue to monitor the cost of cross border services and should disclose it in the annual report to the Legislature with a view to ensure that adequate funds are being made available to the department.

COMMENTS OF THE ACCOUNTING OFFICER:

(a) The department has to provide health care for both first and third world economic development while at the same time moving towards equity. Resources are currently being shifted from the more advantaged urban parts of the province in order to develop the previously disadvantaged and the rural areas. The SPS model ensures the move towards equity in service provision and finance allocations.

(b) The department undertakes to monitor the patient flows from both Mozambique and the Eastern Cape and the estimated cost of cross border services will also be monitored. In addition, the disclosure of this information in the annual report of the 2003-2004 financial year will be considered.

5.2 INFRASTRUCTURE AND MAINTENANCE:

During visits to clinics it was found that some clinics rendered services from inadequate facilities and some clinics' maintenance had not been carried out on a regular basis.

5.2.1 At the Umlazi Section U21 clinic one Diagnostic Set had to be shared between 11 sisters which contributed to delays in treatment. In addition, two out of four available BP machines were not functioning for a considerable period of time.

5.2.2 Four vehicles were purchased to be used as mobile clinics in Mbumbule. However, only two were used for its intended purpose and the other two were used for administration purposes at the Prince Mshiyeni Memorial Hospital. In addition, the design of the vehicles was not conducive for the efficient and effective rendering of clinic services. There was neither air conditioning nor design space for stock and a normal height canopy resulted in the nurses working under very difficult circumstances. Furthermore, there were no storage facilities for the mobile clinic's medicine and stock at the Prince Mshiyeni Memorial Hospital.

5.2.4 Although funds were allocated for the upgrading of the Nondabuya clinic during 1997, by November 2002 it had not been done. In addition, adequate accommodation for nurses did not exist and the nurses occupied a small gatehouse, which was built for security staff.

5.2.5 At certain clinics sufficient consulting rooms did not exist which contributed to inadequate communication between patients and sisters. The following are examples:

- At the Umlazi Section U21 clinic, visited by approximately 300 patients per day, eleven sisters had to share three consulting rooms.
- At the Manyiseni clinic, visited by approximately 65 patients per day, two sisters had to share one consulting room.

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POSSIBLE AREAS FOR IMPROVEMENT:

(a) Adequate funds should be made available for maintenance and it should be spent timeously to ensure that the rendering of primary health care services is improved.

(b) During the planning of the provision of mobile clinics, the needs of the relevant sisters should be taken into account to ensure that such clinics are conducive for the efficient and effective rendering of services.

(c) The upgrading of clinics should take place more timeous.

COMMENTS OF THE ACCOUNTING OFFICER:

(a) The shortage of and non-functioning of certain equipment has been investigated and the matter has since been rectified.

(b) Mobile vehicles have been specially designed and fitted to render mobile clinic services. The vehicles described in the report appear to be ordinary vehicles, which should not have been used for the purpose of rendering a mobile service. The department will conduct a comprehensive survey amongst nursing staff to identify possible problems and their needs. Thereafter a cost-benefit analysis will be conducted to address the needs as far as possible within financial constraints.

(c) The department is aware of the problems that are being experienced at the Nondabuya clinic with regard to the accommodation of nursing personnel. In this regard the construction of a new clinic together with accommodation units for the staff was put on the programme and is presently under construction. Further, the existing clinic is being retained and upgraded for use as a mother's waiting lounge.

(d The Umlazi U21 clinic was built and staffed to render a 24-hour clinic and maternity service. However, the 24-hour maternity service has since been discontinued and therefore there is adequate facilities now available to accommodate patients and to serve as consulting rooms.

(e) The Manyiseni clinic is on the programme to be replaced and the procurement process is under way.

5.3 RECRUITMENT AND RETENTION OF PROFESSIONAL NURSES:

According to the SPS, by October 2002 the nursing shortage at district level was critical. A total number of 6 476 nurses were required and only 4 899 posts were filled which had a detrimental effect on implementing the district health system. By March 2003 the shortage of professional nurses at PHC level was still evident as indicated in the following examples:

5.3.1 Three professional nurses instead of the approved establishment of six professional nurses were employed at the Jozini clinic. This resulted in the clinic working on a call system instead of a proper night duty service.

5.3.2 The Mhlekashe clinic rendered 24-hour services with only one professional and two enrolled nurses. The establishment provided for four professional nurses.

POSSIBLE AREAS FOR IMPROVEMENT:

(a) The allocation and utilisation of staff at all PHC facilities should be investigated to identify staffing levels and norms. During such investigation at least the following should be considered:

- Professional nurses available against the number of PHC facilities.
- Surpluses and shortages of staff including productivity levels.
- Actual needs at PHC facilities.
- Types of services rendered at PHC facilities.

- Number of temporary and staff nurses.
- Impact of vacation and sick leave.
- Cost-effectiveness of training.

(b) The possibility of re-allocating possible surplus staff should be investigated to ensure a more equal workload and the efficient rendering of PHC services.

(c) The shortage of nurses at district level with specific emphasis on rural areas should be attended to as a matter of urgency.

COMMENTS OF THE ACCOUNTING OFFICER:

(a) Provision has been made in the 2003/2004 budget for incentives to attract staff to these areas but it is anticipated that the amount provided in the MTEF will be insufficient to cover all the categories of staff where shortages are experienced.

(b) The department has embarked on an improved staff structure, which will address the needs of the primary health care service in the department. A generic organisational structure for all community health centres has been approved on 7 February 2003 and is in the process of being implemented. Furthermore, the necessary job evaluation/job analysis to determine the levels of all jobs involved in the delivery of primary health care has been commenced with and the generic organisational structure for clinics is in the process of being finalised. It should also be noted that recruitment and training of personnel will be given priority.

5.4 TUBERCULOSIS PROGRAMME:

5.4.1 Turnaround time of sputum specimens:

According to paragraph 4.2.7 of the TB guideline the target of the National Tuberculosis Control Programme (NTCP) is to ensure that a sputum turnaround time of 48 hours is achieved in order for patients to be started on the correct treatment as soon as possible. However, management measures to ensure the achievement of the objective were not always adequate.

5.4.1.1 The turnaround time was not recorded and managed as a key performance indicator.

5.4.1.2 Although it is acknowledged that weekends and public holidays play a role in the sputum turnaround time, the Caluza and Mpumuza clinics achieved a turnaround time of 7 to 14 days and the Mhlekazi, Kearsney and Phungashe clinics achieved 7 to 10 days.

5.4.2 **Treatment interruption rate:**

According to information supplied by the department 47 418 patients were treated for TB during 2001 and the treatment interruption rate for the province during the same period was 21 per cent. This effectively meant that 9 957 patients interrupted their treatment. It could not be determined whether these patients were re-treated. The cost for basic TB treatment for a patient that weighs more than 50 kilograms amounts to approximately R293 per patient for the full course, while the cost of TB re-treatment per patient amounts to approximately R593 for the full course. If all 9 957 patients had been re-treated the calculated additional cost in this regard amounted to approximately R2 987 100. The actual cost in this regard could not be obtained and the information for 2002 was not available by December 2002.

5.4.3 **Multi Drug Resistant TB (MDR):**

MDR is when TB is no longer susceptible to treatment with normal TB drugs. It usually develops in patients who have been inadequately treated for TB as a result of interruption of treatment. According to the

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department the cost to treat one TB patient with MDR amounts to at least R1 520 per month excluding hospitalisation costs. The number of TB patients with MDR increased from 365 in 2001 to 430 in 2002 or 18 per cent. During 2002 approximately 260 patients with MDR were treated at a cost of approximately R395 200 per month, excluding hospitalisation cost.

5.4.4 **Record keeping:**
Adequate records for the treatment of TB was not always kept. For example, at the Jozini clinic no proper register existed and duplicate green patient cards were used. Furthermore, at various clinics it could not be determined whether the 2-month sputum test, which is vital in the treatment of TB, had been done owing mainly to inadequate record keeping.

5.4.5 **Directly Observed Treatment Short course (DOTS):**
Although the DOTS strategy should contribute to the reduction in TB cases, it was not always properly implemented. At 6 of the clinics visited, DOTS was either non existent or were not functioning properly owing mainly to workers not being compensated at all.

5.4.6 **Facilities:**
The objectives of primary health care, namely for the community to first visit a clinic before going to a hospital, was not always achieved.

5.4.6.1 The clinics in Umlazi did not take sputum samples and therefore the patients went directly to the Prince Mshiyeni Memorial Hospital where the chest clinic examined at least 350 patients per day. This process is not always in the best interest of the community. For example, a pensioner from Illovo will spend approximately R60 on transport to visit the hospital for a sputum test and a further R60 on transport to obtain the result at the hospital.

5.4.6.2 The Nondabuya and Manyiseni clinics in Ingwavuma were not involved in the TB related programmes and patients with TB symptoms were referred to hospital.

POSSIBLE AREAS FOR IMPROVEMENT:

(a) Although it is acknowledged that weekends do play a role in obtaining sputum specimen results within 48 hours, the fact that some PHC facilities do receive such results in time indicates that management measures should be improved in this regard. Improvement regarding the following management measures should be considered:

- Record keeping of sputum specimens sent for testing.
- Follow-up procedures of such specimens.
- Training of staff in this regard.

(b) Statistics regarding the TB treatment should be available timeously. In addition, the reasons for interruption should be investigated. The following should be included in such investigation:

- Record keeping of patients, the 2-month sputum test as well as patients interrupting treatment.
- Follow-up procedures of patients interrupting treatment.
- Success rate of treatment.
- The availability of resource to follow-up such cases.
- Training of staff in this regard.
- The effectiveness of DOTS.
- Strategy to reduce interruptions.

(c) Proper records regarding the number of patients that had been re-treated as well as the cost in this regard should be kept. Such statistics will enable the department to identify PHC facilities where problems exist as well as to take

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corrective steps. Reporting of statistics and information to the national Department of Health will also be more reliable.

(d) Measures should be implemented to ensure that PHC facilities are optimally utilised for the TB programme. In this regard statistics such as the number of patients referred to hospitals by PHC institutions, the number of patients and reasons why they visit the hospitals directly, could be used. Also, the needs of and the affordability of the community should be taken into account.

(e) Proper management information for MDR should be kept and should at least include the following:

- Number of MDR patients per clinic/district /region.
- Reasons why patients became MDR patients.
- Cost per patient as well as total cost in this regard.
- Success rate of treatment.

(f) Management measures implemented should enable the department to identify problem areas (hot spots) at an early stage and implement corrective steps where necessary. Timeous reporting of statistics and information to the national Department of Health will also be more accurate.

COMMENTS OF THE ACCOUNTING OFFICER:

(a) The Turn Around Time (TAT) of sputum specimens has since improved and in this regard the department has:

- Increased the number of microscopy centres to handle the workload, which has increased from 55 to currently 72.
- Improved transport to clinics, with the target being at least 3 times weekly. Currently, 62 per cent of clinics in the department are achieving this.
- Improved communications. The implementation of a functional and reliable telephone, facsimile and radio service at all clinics is an ongoing process.
- Achieved a 48-hour TAT in all facilities in four of the Districts, with one at 90 per cent, one at 82 per cent and the rest ranging from 50 to 70 per cent.
- The department is currently in the process of implementing a quarterly reporting system to monitor TAT. In this regard it should be noted that all clinics mentioned in the report are currently achieving the 48-hour TAT.

(b) The department acknowledges that the Treatment Interruption Rate (TIR) is problematic and in this regard every effort is being made to manage and reduce the TIR. The department envisages reducing the rate of interruption through the following interventions:

- Ensuring that a higher percentage of TB are enrolled on a quality assured DOT programme.
- Patient education with an emphasis on taking appropriate treatment in the prescribed way.
- Training and supervision of the health workers involved in TB management.
- Availability of active "tracer teams".

(c) The Medical Research Council (MRC) has been commissioned to conduct a study into the application of a standardised treatment regimen for MDR TB under TB control programme conditions. The study is called the DOTS Plus study, and has focussed on issues such as the effectiveness of a standardised treatment regimen, cost effectiveness, data/treatment outcomes as well as an effective model for management of MDR TB as a public health strategy. The study is currently underway, and the department is actively participating in the study.

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(d) The department has introduced the patient/ district based electronic register system at all districts throughout the Province. This initiative has relieved the workload on all clinics, and has improved the reporting and recording rates, thus providing the department with valuable information to manage the programme. Further, the department is in the process of capturing smear conversion and treatment outcome data.

(e) To monitor progress, the DOTS programme is currently operating on a quarterly reporting system. This has strengthened and allowed for the expansion of the programme.

(f)) Due to the decentralisation of TB control to primary health care clinics, the department is able to diagnose and treat TB at approximately 55 per cent of the clinics. With the success of the implementation programme, it is envisaged that one hundred per cent of clinics would be able to diagnose and treat TB by 2005. Further, it should be noted that certain clinics such as the Umlazi clinics are now taking sputum samples for diagnosis.

5.5 PERFORMANCE MANAGEMENT:

5.5.1 The following are examples of national targets which should be achieved but related critical performance measures and targets were not determined and formalised in the budget statements of the department for the 2002/2003 financial year:

- To achieve smear conversion rates of at least 85 per cent among new smear positive cases and 80 per cent among re-treatment cases at the end of the intensive phase of treatment.
- To cure at least 85 per cent of new smear positive cases with short course anti TB therapy.
- To achieve a minimum community-based DOTS treatment cure rate of new sputum positive TB cases of 85 per cent.
- To achieve full immunisation of 90 per cent of one-year olds by December 2003.
- To achieve a sputum turnaround time of 48 hours.

5.5.2 In the annual report for the 2001/2002 financial year the department only reported on the achievements of one out of the 11 districts. The report on Umgungundlovu indicated that the smear conversion was 63 per cent for re-treatment at 3 months and 61 per cent for new treatment at 2 months. However, the national target is 85 per cent.

POSSIBLE AREAS FOR IMPROVEMENT:

Critical performance measures and targets should be determined and included in the budget statements. It should be monitored regularly and achievements/non-achievements should be comprehensively reported on in the department's annual report to the Legislature.

COMMENTS OF THE ACCOUNTING OFFICER:

Cognisance has been taken of the office's comments as well as the national targets as mentioned in the report. These targets have been included in the department's strategic and operational plans for the 2004/2005 financial year. Consideration will be given for the inclusion of the most critical performance targets in the budget statements for 2005/2006. Furthermore, the department will consider the improvement of the management information system and the measurement of the actual performance against targets will be included in the department's annual report in future.

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6. SICK LEAVE

6.1 SCOPE

6.1.1 The performance audit focused mainly on the following aspects of the management of sick leave:

- Departmental policy and strategy
- Monitoring and control

6.1.2 In view of the fact that known problems exist with regard to the reliability and completeness of information obtained from the PERSAL system, the findings reflected in this report were tested at the hospitals visited (refer paragraph 6.1.5). Cases included in the sample were audited by using hard copy source documents. Reference to averages should be seen as a benchmark and not as a finding as such.

6.1.3 Sick leave taken during the period 1 January 2001 to 31 December 2002 was to be covered by the audit. However, PERSAL report 7.11.4 relating to sick leave could not be obtained for the above period and therefore data for the period 1 July 2002 to 30 June 2003 was used for reporting purposes.

6.1.4 An analysis of sick leave data (PERSAL report 4.8.9) was done and the 4 hospitals with the highest percentage of sick leave were selected for the audit. In addition, 4 management areas were randomly selected to ensure coverage of smaller areas. The following management areas were visited during the audit and reviews done on a sample basis:

Addington Hospital, Edendale Hospital, Vryheid Hospital, GJ Crookes Hospital, Natalia Security Division, CPS Division – Stores and Management, Division Office Services and Kwadabeka Community Health Centre.

6.1.5 The sick leave data was extracted and analysed using the software package Audit Command Language (ACL) and Microsoft Excel.

7. OVERVIEW

7.1 PRESCRIPTS:

The most important prescripts relevant to the management of sick leave are Paragraph 7 of Resolution 7 of 2000 of the Public Service Co-ordinating Bargaining Council (PSCBC) (Resolution 7 of 2000) which came into operation on 1 July 2000, read with PSCBC Resolution 5 of 2001 and the Directive on Leave of Absence in the Public Service as well as circulars E 1/6/2/P dated 8 April 2002 and 1/6/2/2 dated 4 November 2002 issued by the Department of Public Service and Administration. It is applicable to all employees falling within the ambit of the PSCBC, with the exception of casual employees.

7.2 NORMAL SICK LEAVE:

(a) Employees are entitled to 36 working days sick leave with full pay over a three-year cycle. Unused sick leave lapses at the expiry of the three-year cycle. The current three year leave cycle started on 1 January 2001.

(b) Employees who apply for three or more sick leave days must submit a certificate from a registered and recognised medical practitioner as defined by the Health Professional's Council of South Africa, citing the duration of absence.

(c) In cases where a pattern in the utilisation of sick leave has been established, the employer may require a medical certificate for absences of less than three working days describing the nature and extent of the illness before granting sick leave.

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7.3 TEMPORARY DISABILITY LEAVE:

An employee has to utilise first his/her normal sick leave of 36 working days, whether it is for a minor illness and/or a major operation. If such an employee has exhausted all his/her normal sick leave credits, all applications for sick leave should thereafter be treated as temporary disability leave. An employee, after the normal sick leave of 36 days have been exhausted, submits an application for sick leave each and every time that s/he requires sick leave. A medical certificate describing the nature and extent of the illness should accompany each application. The Head of Department (HOD) may grant a maximum of 30 working days temporary disability leave, during which period the Department must conduct an investigation into the nature and extent of the employee's illness. The 30 working days may be extended based upon the findings of the investigation.

7.4 PERMANENT INCAPACITY LEAVE:

If, emanating from an investigation, it transpires that an employee needs to be re-deployed, retrained, retired due to ill – health, etc. the period from the date that such a decision was made by the HOD until the process of redeployment, re-training, retirement, etc. has been finalised should be covered by permanent incapacity leave. The HOD may in this instance grant a maximum of 30 working days paid permanent incapacity leave, or such additional number of days required by the employer to finalise the process.

8. KEY FINDINGS, POSSIBLE AREAS FOR IMPROVEMENT AS WELL AS COMMENTS OF THE ACCOUNTING OFFICER

8.1 DEPARTMENTAL STRATEGY AND TARGETS FOR THE MANAGEMENT OF SICK LEAVE:

Although it was observed from the management areas visited that the department issued circulars to the hospital managers, they only focused on the administration of sick leave and didn't address the management of sick leave. The absence of a formal management strategy contributed to a lack of specific targets such as average number of sick leave days taken per employee. According to the information obtained from PERSAL report 7.11.4 for the period 1 July 2002 to 30 June 2003, 25 289 employees took a total of 176 228 sick leave days at an average of 7 sick leave days per employee and at a total cost of approximately R39 337 833.

SUGGESTED CORRECTIVE MEASURES:

(a) The department should formulate and implement a sick leave strategy to assist management in the planning, organising, co-ordinating and control over sick leave.

(b) Management should determine targets, which should be included in the sick leave strategy.

(c) Such targets and progress towards achieving the targets should form part of the monthly management information.

COMMENTS OF THE ACCOUNTING OFFICER:

(a) The department acknowledges the need for an integrated sick leave strategy and in this regard the Human Resources Practices Sub-Directorate has been tasked with the researching, developing, and drafting of the strategy. Furthermore, it should be noted that a committee/task team has been constituted and is currently reviewing the department's practices with regards to the management of sick leave. It is envisaged that the development of a macro strategy of the department concerning the management of the sick leave will take into consideration the comments and content of the institutional policies that will be developed. It is

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hoped that this strategy will be finalised within the next few months and once the draft has been finalised, your office would be forwarded a copy for perusal and comments.

(b) It must be noted that sick leave is an entitlement in terms of Resolution 7 of 2000. This contributes to difficulties being experienced by the department to manage sick leave effectively and the PSCBC should consider to revise the policy.

8. 2 RESPONSIBILITY TO MANAGE SICK LEAVE:

The responsibility to manage sick leave was not cascaded down to all management levels and no proof could be found that it was required of managers to pro-actively manage sick leave. According to the Public Service Commission Report on the Sick Leave Trends in the Public Service, dated March 2002 quarterly printouts of sick leave captured on PERSAL should be provided to line managers (through PERSAL Report 7.11.4) indicating the trends per employee in their respective components. However, from the management areas visited it was evident that managers did not make use of the information on the PERSAL system to keep a record of and monitor sick leave taken. PERSAL report 4.8.9 indicated that at 31 December 2002, for the eight management areas visited, a total of 367 employees, constituting 10 per cent of employees that took sick leave, had exhausted their 36 sick leave days while only 66 per cent of the current sick leave cycle had transpired. In addition, according to the PERSAL report 4.8.9, the above employees took 8 822 sick leave days over and above the normal 36 sick leave days at a cost of approximately R1 750 219. At least 76 per cent of the above sick leave days occurred at the Addington Hospital.

POSSIBLE AREAS FOR IMPROVEMENT:

(a) Training should be provided to managers in the use of PERSAL in order to obtain the required management information as well as how the information can be used to effectively manage sick leave.

(b) Management information should be made available to managers on a regular basis to enable them to keep a record of sick leave taken and to pro-actively monitor and manage sick leave utilisation.

(c) The responsibility to manage sick leave should be included in the performance contracts/job descriptions of managers. The actual sick leave levels for employees under their control should then be used as a performance measure during performance evaluations.

COMMENTS OF THE ACCOUNTING OFFICER:

(a) The comments of the Auditor-General are noted. The department acknowledges the importance of effectively managing leave and more importantly sick leave, and in this regard, initiatives have been taken in building capacity, both at a head office level as well as at an institutional level. The PERSAL Control Unit within the Human Resource Practices Sub-Directorate has developed the PERSAL Management Information Course, with the specific target group being the Institutional Managers, System Managers, Finance Managers and Human Resource Managers. The roll out of the course has commenced in the department and approximately 50 per cent of the targeted managers and supervisors in the department have within their mandate of managing/supervising staff, the obligation to manage the resources of the department effectively and efficiently.

(b) It should be noted that all management levels nine and above, which were evaluated since

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2001, have as part of their key responsibilities the management of all human resource matters, which include the management of sick leave. As propose by your office, consideration will be given for the responsibility of managing sick leave to be included in the performance agreement/job description of all officials entrusted with management.

8.3 CAPTURING OF SICK LEAVE FORMS:

A formal policy and procedure that clearly identifies the time period within which the submission and capturing of leave forms should take place did not exist. In addition, sufficient staff was not always available to capture leave forms. This resulted in leave forms not being captured on PERSAL in a timely manner and therefore the information on PERSAL was not reliable and up to date which could affect the proper management of sick leave. A 7-day period (instituted by 2 national departments) was used as a benchmark against which to measure the effectiveness of the capturing of sick leave applications. Approximately 77 per cent of the 19 273 sick leave days taken in the management areas visited were captured after 21 days.

POSSIBLE AREAS FOR IMPROVEMENT:

(a) The department should implement a formal policy and procedures for the capturing of sick leave. It should include, inter alia, the following:

- An acceptable period (norm) within which the submission, approval and capturing of sick leave applications has to be captured on PERSAL.
- Rotating of data capturing duties to avoid monotony through repetition of work.
- A plan for someone to take over the duties if the data capturer is not available for a specific period of time.
- The monitoring of actual data compared to the acceptable norms to identify any deviations and corrective action to be taken if needed.

(b) Attention to basic administration and management is an absolute necessity. Management should therefore perform leave audits (reviews) to ensure that sick leave taken is updated on PERSAL in a timely and accurate manner.

(c) Management should review leave files to ensure that all leave captured is supported by proper approved leave forms.

COMMENTS OF THE ACCOUNTING OFFICER:

(a) The comments of the Auditor-General are noted. As indicated, the task team has been entrusted with the development of an integrated policy on the management of sick leave and cognisance of the comments and suggested corrective measures have been taken into account in the formulation/development of the policy.

(b) The hospital managers as well as the human resource managers at the audited institutions have indicated that all measures will be taken to ensure that all leave records will be reviewed on a continued basis. Further, all leave taken will be cross-referenced with other management tools like duty rosters, attendance registers as well as management reports that are generated by PERSAL.

8.4 TEMPORARY DISABILITY LEAVE:

According to Resolution 7 read with Circular E 1/6/2/P dated 8 April 2002 an employee has to utilise first his/her normal sick leave of 36 working days, whether it is for a minor illness or a major operation. If such an employee has exhausted all his/her normal sick leave credits, all applications for sick leave should thereafter be treated as temporary disability leave. Such an application should be in respect of each

application for sick leave after the first 36 days have been exhausted and has to be finalised within 30 days of the first day of sick leave taken. During this period an investigation must be done into the nature and extent of the employee's illness. The following shortcomings in this regard existed:

8.4.1 Temporary disability leave not investigated:

Adequate procedures indicating the steps to be taken by management to determine the extent of the inability to perform normal official duties, the degree of inability and the cause thereof were not in place. Reviews at the management areas visited indicated that temporary disability leave was not investigated within the required time period of 30 days. However, it was noted that only letters informing officials that they have exhausted their normal sick leave of 36 days and that a medical certificate should support any future sick leave applications were issued. Examples of eight employees who took 824 days temporary disability leave at a cost of approximately to R146 906 and no actions being taken or investigations done were brought to the attention of the department during the audit.

8.4.2 Temporary disability granted prior to employees exhausting normal sick leave:

At 4 of the management areas visited it was found that 12 officials were granted a total of 334 days temporary disability leave prior to them exhausting their 36 normal sick leave days. A calculation based on the officials' salary at the time indicated that the cost of this temporary disability leave amounted to approximately R52 671. Management did not perform proper investigations prior to the approval of the temporary disability leave to ensure that the normal sick leave days had been exhausted.

8.4.3 Staff that was given more than 36 days normal sick leave:

According to the PERSAL help desk in the management areas visited the system has built in controls to prevent the capturing of more than 36 days normal sick leave. However, a review of PERSAL report 4.8.9 revealed that 12 officials were granted a total of 179 days more than their 36 days normal sick leave within the current leave cycle. A calculation based on the officials' salary at the time indicated that the cost of the additional days amounted to approximately R31 321. This indicated a serious lack of basic control and inadequate management of sick leave.

POSSIBLE AREAS FOR IMPROVEMENT:

(a) Temporary disability leave cases should be investigated to determine the extent of inability to perform normal duties within 30 days to avoid abuse of temporary incapacity leave. Such investigations should be properly documented on the leave file.

(b) The department should implement standard procedures within the sick leave policy which guides the institutions on which steps must be followed when an official exceeds his or her normal sick leave days to avoid any possible abuse of temporary disability leave.

(c) Management should perform an audit on cases currently under disability leave with the objective of identifying any possible sick leave abuse and corrective measures should be taken if needed.

(d) Management should investigate all the cases where temporary disability leave were approved prior to employees exhausting normal sick leave. Should the root cause be the lack of system controls it should be rectified as a matter of urgency.

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(e) The PERSAL program control should be tested to confirm that it does have controls to prevent capturing of more than 36 days normal sick leave. Should it have any deficiencies, management must implement controls to monitor sick leave balances.

COMMENTS OF THE ACCOUNTING OFFICER:

(a) The comments of the Auditor-General are noted. The Human Resource Practices Sub-Directorate within the department's Human Resource Management Cluster had undertaken a rigorous development exercise after the adoption of Resolution 7 of the PSCBC. The program had entitled intensive workshops and seminars on the provisions of the new leave directive.

(b) In view of the findings of the Auditor-General in respect of investigations that needed to be undertaken in respect of temporary disability leave, the management/institutions that were subjected to the audit, have undertaken to constitute "sick leave" committees that will be tasked with the evaluation of the sick leave forms that are submitted. A further initiative that has been taken is the drafting of internal sick leave policies in keeping with that of the conditions as contained in the sick leave directive as issued in terms of Resolution 7 of the PSCBC.

(c) With regard to the audit finding that staff was allocated more than the 36 days normal sick leave, it was discovered that this was relevant to employees who were previously appointed on contract and whose appointment was subsequently changed to that of a permanent nature. These changes required the termination and reappointment of these officials, which result in PERSAL not picking up the officials' previous sick leave status. Due to this matter being related to a systems problem on PERSAL, it has been referred to the PERSAL controller in the Office of the Premier with the recommendation that tests be conducted on PERSAL to confirm the controls that prevents more than 36 days normal sick leave from being taken. The outcome of these tests will be communicated to your office once the department receives the results.

8.5 TYPES OF ILLNESS:

An analysis of PERSAL report 7.11.4 for the period 1 July 2002 to 30 June 2003 indicated that 43 per cent of sick leave taken was captured as 'Unknown'/ 'No type of illness' / 'see medical certificate' and 13 per cent was flu related illnesses. The cost of the above sick leave amounted to approximately R16 921 686 and R5 191 663, respectively. In addition, it was noted that PERSAL has 519 codes for the type of illness and certain similar type of illnesses has more than one code. This complicated data collation and negatively affected the usability of data for the management of sick leave making it difficult to proactively reduce the level of sick leave taken.

POSSIBLE AREAS FOR IMPROVEMENT:

(a) The proposed sick leave strategy and procedures should give clear direction to staff and management on the completion and capturing of types of sick leave.

(b) Management should consider limiting the codes on PERSAL or at least limit access to certain codes.

COMMENTS OF THE ACCOUNTING OFFICER:

The comments of the Auditor-General are noted. It should be noted that the department has submitted to the PERSAL Control Unit within the Department of the Premier suggestions and recommendations to investigate and register the required System Change Controls to amend the leave codes on PERSAL as contained in Table 147 of the System.

8.6 DAYS OF THE WEEK ON WHICH MOST SICK LEAVE WERE TAKEN:

The Public Service Regulations, 2001, Part v, (F)

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(c) stipulates that the Head of Department shall "ensure that an employee does not abuse sick leave". This highlights the importance of monitoring and investigating trends to identify and deal with any possible sick leave abuse. An analysis indicates that 26 per cent of the sick leave incidences for the period July 2002 to June 2003 commenced on Mondays compared to the national average of 28 per cent, indicating a possible trend of extended weekends, which contributed to the inefficient utilisation of resources.

POSSIBLE AREAS FOR IMPROVEMENT:

The department needs to monitor this trend to avoid any possible abuse of sick leave as recommended by the Public Service Commission.

COMMENTS OF THE ACCOUNTING OFFICER:

The comments of the Auditor-General are noted and all attempts will be made to monitor the days on which sick leave is taken and the frequency of the leave taken on an individual basis. Further, the department acknowledges the seriousness of the audit finding and should there be instances where it is found that officials have abused sick leave, they will be subjected to the disciplinary process.

8.9 EMPLOYEE ASSISTANCE PROGRAMME (EAP):

Although the department implemented an EAP, it was not fully functioning to address the well being of staff and to proactively reduce sick leave levels. Furthermore, at the management areas visited no proof could be found that the information on PERSAL was used to identify and document high-risk groups and/or trends of sick leave taken to be addressed by the EAP. It is evident from paragraph 8.2 of this report that Addington Hospital should have been identified as a high-risk area where individuals could have benefited from specific interventions through the EAP.

POSSIBLE AREAS FOR IMPROVEMENT:

(a) The department should formulate an EAP policy to assist management in addressing the well being of staff and to lower the level of sick leave taken.

(b) The management information system should be used to identify high-risk areas and individuals who can be placed on the EAP.

COMMENTS OF THE ACCOUNTING OFFICER:

(a) The department's Employee Assistance Programme (EAP) is currently involved in building capacity at an Institutional level by training Employee Assistance (EA) practitioners as well as the formulation of EAP committees to ensure the creation of a conducive work environment that promotes positive employee well-being. Further, the department is in the process of developing/formulating an EAP policy that is all encompassing with its primary objective being to ensure employee well-being and to enhance productivity.

(b) A further initiative that has been embarked on relative to EAP, is the formulation of a database with information that has been extracted from the EA practitioners as well as from other tools in identifying the incidences, frequency and types of leave taken by officials. This initiative embraces the concept of EAP being proactive rather that reactive.

9. APPRECIATION

The assistance rendered by the staff of the department during the audit is sincerely appreciated.

B.R. Wheeler
for Auditor-General
Pietermaritzburg
29 July 2004

AEFI	Adverse Events Following Immunisation
AFB	Acid Fast Bacilli
AFP	Acute Flaccid Paralysis
AG	Auditor-General
AIDS	Acquired Immune Deficiency Syndrome
ALS	Advanced Life Support
AM	Assistant Manager
AMDP	Advanced Management Development Programme
ANC	Antenatal Clinic
ARV	Anti-retroviral
ASO	Auxiliary Service Officer
BAS	Basic Accounting System
BBA	Born Before Arrival
BEE	Black Employment Empowerment
BFHI	Baby Friendly Hospital Initiative
BLS	Basic Life Support
CAG	Clinical Advisory Groups
CBO	Community Based Organisation
CDC	Communicable Disease Control
CHC	Community Health Clinics
CHF	Community Health Facilitators
CHW	Community Health Workers
COEC	The College of Emergency Care
COHSASA	Council for Health Service Accreditation of Southern Africa
CPITN	Community Periodontal Index
CPS	Central Provincial Stores
CSD	Community Service Dietician
CSP	Community Service Pharmacists
CT	Computer Tomography
DFR	Durban Functional Region
DHER	District Health Expenditure Review
DHIS	District Health Information System
DHP	District Health Plan
DHS	District Health System
DIO	District Information Officer
DIT	Durban Institute of Technology
DMFT	Decayed Missing Filled Teeth
DMT	Domain Management Teams
DOE	Department of Education
DOH	Department of Health
DOT	Directly Observed Treatment
EAP	Employees' Assistance Programme
EDC	Essential Drug Programme
EDL	Essential Drug List
EHP	Environmental Health Practitioners
EHS	Environmental Health Services
EMD	Emergency Medical Despatch
EMDP	Emerging Management Development Programme
EMRS	Emergency Medical Rescue Services
ENT	Ear, Nose & Throat
EPI	Expanded Programme of Immunisation

FCRad	Fellow of the College of Radiology
FIO	Facility Information Officer
FSM	Food Service Management
ESV	Emergency Service Vehicles
FP	Family Planning
GMP	Growth Monitoring and Promotion
GPP	General Pharmacy Practices
HAART	Highly Active Antiretroviral Therapy
HBC	Home-Based Care
HCW	Health Care Workers
HDI	Historically Disadvantaged Individual
HFBNP	Health Facility Based Nutrition Programme
HIV	Human Immune Virus
HO	Head Office
HP	Health Promotion
HPS	Health Promoting Schools
HRM	Human Resource Management
HWSETA	Health and Welfare Sector Education, Training & Authority
IALCH	Inkosi Albert Luthuli Central Hospital
IAPAC	International Association of Physicians in AIDS Care
IEC	Information, Education & Communication Material
ILS	Intermediate Life Support
IMCI	Integrated Management of Childhood Illnesses
IMLCS	Institutional Management Labour Committees
INP	Integrated Nutrition Programme
IMR	Infant Mortality Rate
ISRD	Integrated Sustainable Rural Development
IST	In-Service Training
IT	Information Technology
KEH	King Edward VIII Hospital
KGV	King George V Hospital
KRA	Key Result Area
KZN	KwaZulu-Natal
MDR	Multi-Drug Resistant
MEC	Member of Executive Committee
MEDSAS	Medicine Suppliers' Administration System
MERP	Medical Equipment Replacement Programme
MO	Medical Officer
MR	Medical Rescue
MRI	Magnetic Resonance Imaging
MMR	Maternal Mortality Rate
NAFCI	National Adolescent Friendly Clinic Initiative
NDOH	National Department of Health
NDT	Neuro-Developmental Techniques
NGO	Non-Governmental Offices
NHFA	National Health Facilities Audit
NIP	National Infection Programme
NQF	National Qualification Framework
OHS	Occupational Health & Safety
OPD	Outpatient Department
OPEP	Occupational Post Exposure Prophylaxis
PA	Pharmacy Assistance
PAAU	Provincial AIDS Action Unit

PAP	Pappinicular
PDE	Patient Day Equivalent
PDI	Previously Disadvantaged Individuals
PEM	Protein Energy Malnutrition
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PHOC	Provincial Health Operations Centre
PMA	Performance Management Agreement
PMB	Pietermaritzburg
PMR	Perinatal Mortality Rate
PMSC	Provincial Medical Supply Centre
PMTCT	Prevention of Motor to Child Transmission
PN	Professional Nurse
PPASA	Planned Parenthood of South Africa
PPI	Perinatal Problem Identification Programme
PPT	Planned Patient Transport
PRO	Public Relations Officer
PSNP	Primary School Nutrition Programme
PTB	Pulmonary Tuberculosis
PTC	Pharmaceutical Therapeutic Committee
QAAU	Quality Assurance & Accreditation Unit
QC	Quality Control
QIP	Quality Improvement Programme
RHRU	Reproductive Health Research Unit
RtHC	Road to Health Card
SAMDI	South African Management Institute
SANC	South African Nursing Council
SANCA	South African National Council for Alcoholism & Drug Abuse
SANTA	South African National Tuberculosis Association
SAPS	South African Police Services
SAQA	South African Qualification Association
SARS	Severe Acute Respiratory Syndrome
SASO	Specified Auxiliary Service Officer
SDIP	Service Delivery Integration Programme
SETA	Service, Education & Training Authority
SITA	State Information Technology Agency
SOP	Standard Operating Procedures
SPS	Strategic Positioning Statement
STG	Standard Training Guidelines
STI	Sexually Transmitted Infections
TAT	Turn Around Time
TB	Tuberculosis
TOP	Termination of Pregnancy
UK	United Kingdom
UPFS	Uniform Patient Fees Structure
VCT	Voluntary Counselling and Testing
WASH	Water & Sanitation Hygiene
WHO	World Health Organisation
WOE	Women-Owned Enterprises