



CITY OF TSHWANE

HEALTH CARE

**SIXTH ANNUAL REPORT
1 JULY 2006 TO 30 JUNE 2007**



The Executive Mayor of the City of Tshwane, Dr Gwen Ramokgopa

***The leading international African capital city of
excellence that empowers the community to
prosper in a safe and healthy environment***

Message by the Member of the Mayoral Committee for Health and Social Development

It is personally enriching to be afforded the opportunity to present the 6th Annual report of the Health Services Division of the Health and Social Development Department of the City of Tshwane. We are delighted that we adopted a realisable vision and mission of the Division when we said that we want to have a healthy and an empowered community.

Significant milestone has been achieved with 98% of our households living within the five kilometre radius of access to our health facilities. We are happy to announce that we are rendering a comprehensive personal Primary Health Care package through all our clinics and this is in keeping with our strategic objectives. All our facilities have rolled out services related to TB Treatment and VCT and ARV treatments.

The report shows increase on TB cases and most of the people suffering from TB are HIV infected. We have expanded services related to children and youth. We are part of the strategy for Integrated Management of Childhood Illness that was adopted in 1996 and all our clinics are rendering the service. Women's health remains our primary aim and focus and during the period we have implemented several campaigns ranging from cervix and breast cancer. We have managed together with the Province to ensure the provision of essential drugs to all the clinics on time and to the satisfaction of both the staff and the clients.

Let me conclude by extending words of appreciation to the management of the division, nurses and the entire staff. Your commitment to the delivery of quality service is fully noticed and serves as living proof that our vision to build a better is a possible goal to achieve and it will be achieved.

Other words of appreciation are extended to the SED of the Department and the Manager responsible for Support Services.

Thank you also to the Executive Mayor Dr Gwen Ramokgopa for your sterling leadership capability, your sound political guidance and inspirations have inspired us to develop the necessary courage to roll up our sleeves and go an extra mile in providing our community with better and quality service.

I thank you



Ms Sonto Thipe
MMC for Health and Social Development
City of Tshwane

Foreword by the Strategic Executive Director for Health and Social Development

The Health Services Division of the Health and Social Development Department herewith presents to you its sixth Annual Report for the financial year 1 July 2006 to 30 June 2007.

Health is prioritised as one of the core elements for social transformation and forms an important part of improving the quality of life of the citizens of the City of Tshwane. This report highlights the contributions made to “a better life for all” through the rendering of municipal and primary health care services as well as the services rendered by City’s Multisectoral Aids Unit.

I wish to express my sincere appreciation to all those who have contributed to our Departments strategic objective namely to ensure vibrant, healthy and sustainable communities.



Ms Joan K de Beer
Strategic Executive Director:
Health and Social Development Department
City of Tshwane

TABLE OF CONTENTS

Map 1: City of Tshwane	viii
1. TSHWANE: OVERVIEW OF THE CITY AND ITS PEOPLE	1
1.1 Demography	1
1.2 Overview of income and living conditions: impact on the well-being of the community	2
2. HEALTH CARE DIVISION OF THE CITY OF TSHWANE	2
2.1 Vision and mission.....	2
2.2 Legal framework.....	2
2.3 Financial management of the Tshwane Health District.....	2
3. STRATEGIC GOALS OF THE HEALTH CARE DIVISION	3
3.1 Developing the District Health System in Tshwane	3
3.2 Ensuring that primary health care services and facilities are accessible to the community and suitable for the rendering of comprehensive primary health care	3
3.2.1 Accessible services	3
3.2.2 Accessible and suitable health facilities in Tshwane.....	4
3.2.3 Improving the quality of care.....	4
3.2.3.1 Percentage of complaints successfully resolved.....	4
3.2.3.2 Clinic supervision.....	5
3.2.3.3 In-depth programme reviews	5
3.2.3.4 Annual rating survey	5
3.2.3.5 Annual waiting time survey	5
3.2.4 Ensuring appropriately skilled staff for the health district.....	6
3.2.4.1 Staff establishment	6
3.2.4.2 Personnel development	7
3.3 Implementation of a management information system for the Health District.....	9
3.4 Provisioning of essential drugs	9
3.4.1 Area covered for the provisioning of essential drugs	9
3.4.2 Facilities and services.....	9
3.4.3 Staff establishment	10
3.4.4 Drug expenditure	10
3.4.5 Achievements and challenges	10
3.4.6 Plans for 2007/08.....	10
3.5 Provision of comprehensive primary health care services	10
3.5.1 Sexually transmitted infections	10
3.5.2 Services for children and youth	11
3.5.2.1 Integrated management of childhood illnesses.....	11
3.5.2.2 Expanded programme on immunisation	12
3.5.2.3 Interventions targeting the youth.....	12
3.5.3 Women's health	13
3.5.3.1 Cervical cancer.....	13
3.5.3.2 Antenatal care.....	14
3.5.3.3 Family planning.....	14
3.5.4 Curative, chronic and preventive services	15
3.5.5 Tuberculosis services	15
3.5.5.1 Overall objective of the collaboration between the HIV and TB programmes	15
3.5.5.2 Case-finding.....	16
3.5.5.3 Treatment outcome reports.....	17
3.5.5.4 Sputum conversion	18
3.5.5.5 Multidrug resistance centre.....	18
3.5.5.6 Coordination of TB services.....	19
3.5.6 Notifiable medical conditions	19
3.5.6.1 Prevention of the spread of notifiable medical conditions	19
3.5.6.2 Reporting of notifiable medical conditions	19
3.5.6.3 Notifiable medical conditions reported	19
3.5.7 Responding successfully to HIV and Aids	20
3.5.7.1 HIV and Aids programmes.....	20
3.5.7.2 Tshwane Aids Unit.....	21
3.5.7.3 Tshwane HIV and Aids Strategy	22
3.5.7.4 HIV and Aids Workplace Programme	22
3.5.7.5 Prevention and care	23
3.5.7.6 Candle-lighting memorial services	23
3.5.7.7 Sports heroes walk against Aids.....	24
3.5.7.8 Multisectoral seminars	25
3.5.7.9 Funding of NGOs working in the field of HIV and Aids	26

3.6	Empowering the community	26
3.6.1	Community participation	26
3.6.2	Community empowerment.....	26
3.6.3	Health-promoting programmes launched	27
3.7	Improving environmental health conditions in Tshwane	28
3.7.1	Infrastructure and surveillance	28
3.7.2	Investing in agriculture for food security	29
3.7.3	Training.....	29
3.7.4	Events management.....	30
3.7.5	Sampling management	30
	3.7.5.1 Food samples analysed.....	31
	3.7.5.2 Water quality monitoring	31
	3.7.5.3 Food safety strategy	31
3.7.6	Noise control	31
3.7.7	Information services	32
3.7.8	Environmental health outreach programme	33
3.7.9	Management information system statistics	33
3.7.10	Law enforcement	34
3.7.11	Environmental health programmes	34
3.7.12	Renewable Energy and Energy Efficiency Project (REEEP)	35
3.7.13	MHS projects	36
3.7.14	Summary of achievements	36

TABLES

Table 1:	Completed capital projects for health care	4
Table 2:	Approved capital projects for health care	4
Table 3:	Clients' satisfaction survey results	5
Table 4:	Population, PHC facilities and staff audit	6
Table 5:	City of Tshwane health care staff (category and number).....	6
Table 6:	Personnel development –Tshwane provincial staff	7
Table 7:	Personnel development – City of Tshwane health care staff	8
Table 8:	Bacteriological coverage – Tshwane 2006/07.....	17
Table 9:	Notifiable medical conditions recorded.....	19
Table 10:	Tshwane Aids Unit priorities.....	22
Table 11:	Health-promoting Programmes	27
Table 12:	MHS scope of work.....	29
Table 13:	Training: Environmental Health Practitioners	29
Table 14:	Training: students.....	30
Table 15:	Food samples analysed at ARC.....	31
Table 16:	Water samples analysed at ARC	31

FIGURES

Figure 1:	Tshwane's population	1
Figure 2:	Languages spoken in Tshwane	1
Figure 3:	Funding sources of the Tshwane Health District 2006/07	3
Figure 4:	Increase in visits to local authority clinics.....	4
Figure 5:	Average total waiting times at clinics	5
Figure 6:	Incidence of STIs and male urethral discharge.....	11
Figure 7:	Incidence of severe malnutrition in children under five years old seen in public PHC facilities in Tshwane	12
Figure 8:	Teenage pregnancy rate – public PHC clinics in the City of Tshwane	13
Figure 9:	Cervical smears of uninsured women of 30 to 59 years old in all public PHC facilities in Tshwane (2006/07)	13
Figure 10:	Cervical cancer screening analysis – City of Tshwane clinics (July 2006 to June 2007)	14
Figure 11:	Family planning methods profile	14
Figure 12:	Disease and service profile (July 2006 to June 2007).....	15
Figure 13:	Types of TB notified in Tshwane (July 2006 to June 2007)	16
Figure 14:	Age breakdown of TB patients.....	16
Figure 15:	Percentage of patients with DOT support – Tshwane (July 2006 to June 2007)	17
Figure 16:	Treatment outcomes – PTB patients in Tshwane clinics, excluding Odi subdistrict (July 2005 to June 2006).....	18
Figure 17:	Sputum conversion rate – New smear-positive patients in Tshwane: July 2006 to June 2007 ..	18
Figure 18:	ARV programme: City of Tshwane clinics (July 2006 to June 2007).....	21
Figure 19:	City of Tshwane noise complaints.....	32
Figure 20:	Complaints per region.....	33
Figure 21:	Complaints per complaint category.....	34

LIST OF ABBREVIATIONS AND ACRONYMS

Aids	Acquired immune deficiency syndrome
AFP	Acute flaccid paralysis
ANC	Antenatal care
ARC	Agriculture Research Council
ART	Antiretroviral treatment
ARV	Antiretroviral
AQMP	Air Quality Management Plan
BCG	Bacillus Calmette-Guérin (tuberculosis vaccine)
CANSA	Cancer Association of South Africa
CBO	Community-based organisation
CCP	Cities for Climate Protection
CD	Compact Disk
CD4	Cluster of differentiation 4 (A CD4 count is a test to determine the immune status of HIV-positive patients.)
CDM	Clean Development Mechanism
CER	Certified emissions reduction
CHC	Community health centre
CHW	Community Health Worker
CoT	City of Tshwane
DHER	District Health Expenditure Review
DHIS	District Health Information System
DOT	Directly observed therapy
DOTS	Directly observed therapy – short course
DTP-Hib	Diphtheria, tetanus, pertussis and Haemophilus influenzae type B
EDL	Essential Drug List
EPI	Expanded Program on Immunization
EGB	Energy Governance Board
EHP	Environmental Health Practitioners
FBO	Faith-based organisation
FP	Family Planning
GDACE	Gauteng Provincial Department of Agriculture, Conservation and Environment
HBV	Hepatitis B vaccine
HCW	Health care worker
HIV	Human immunodeficiency virus
ICD	International Classification of Diseases
IMCI	Integrated Management of Childhood Illnesses
IUCD	Intra Uterine Contraceptives Device
LA	Local Authority
MDR	Multi-drug resistance
MDS	Minimum data set
MMC	Member of the Mayoral Committee
NGO	Non-government organisation
NQF	National Qualifications Framework
OCSA	Occupational Care South Africa
PEP	Post-exposure prophylaxis
PHC	Primary health care
PLWHA	People living with HIV and Aids
PMTCT	Prevention of mother-to-child transmission
PN	Professional Nurse
PREMOS	Pretoria Municipal Training Centre (CoT's training centre)
PTB	Pulmonary tuberculosis
REEEP	Renewable Energy and Energy Efficiency Project
R & D	Research and Development
SA	South Africa
SABC	South African Broadcasting Corporation
SABS	South African Bureau of Standards
SANS	South African National Standards
SEA	Sustainable Energy Africa
Seed	Sustainable Energy for Environment and Development
Stats SA	Statistics South Africa
STI	Sexually transmitted infection
SSN	South South North
TB	Tuberculosis
TMAC	Tshwane Metropolitan Aids Council
TOPV	Trivalent Oral Polio Vaccine
UJ	University of Johannesburg
VCT	Voluntary counselling and testing
XDR TB	Extreme Drug Resistance Tuberculosis

The Director-General
Department of Health
Private Bag X282
PRETORIA
0001

2006/07 Annual Report

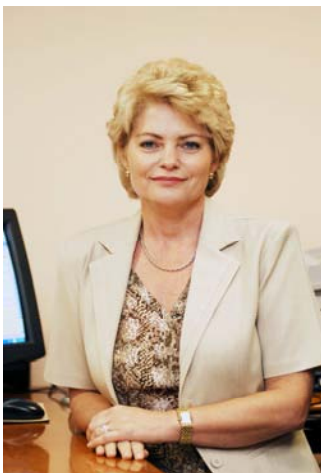
It is a privilege to present the sixth annual report on the activities of the Health Services Division and on health conditions in the City of Tshwane.

This report covers the period 1 July 2006 to 30 June 2007, which coincides with the financial year of the Municipality. The report includes combined information about the Tshwane/Metsweding Gauteng region and the former North West districts (Odi and Moretele).

I wish to express my sincere thanks to the Executive Mayor, the members of the Mayoral Committee, as well as all councillors, for their support during this period.

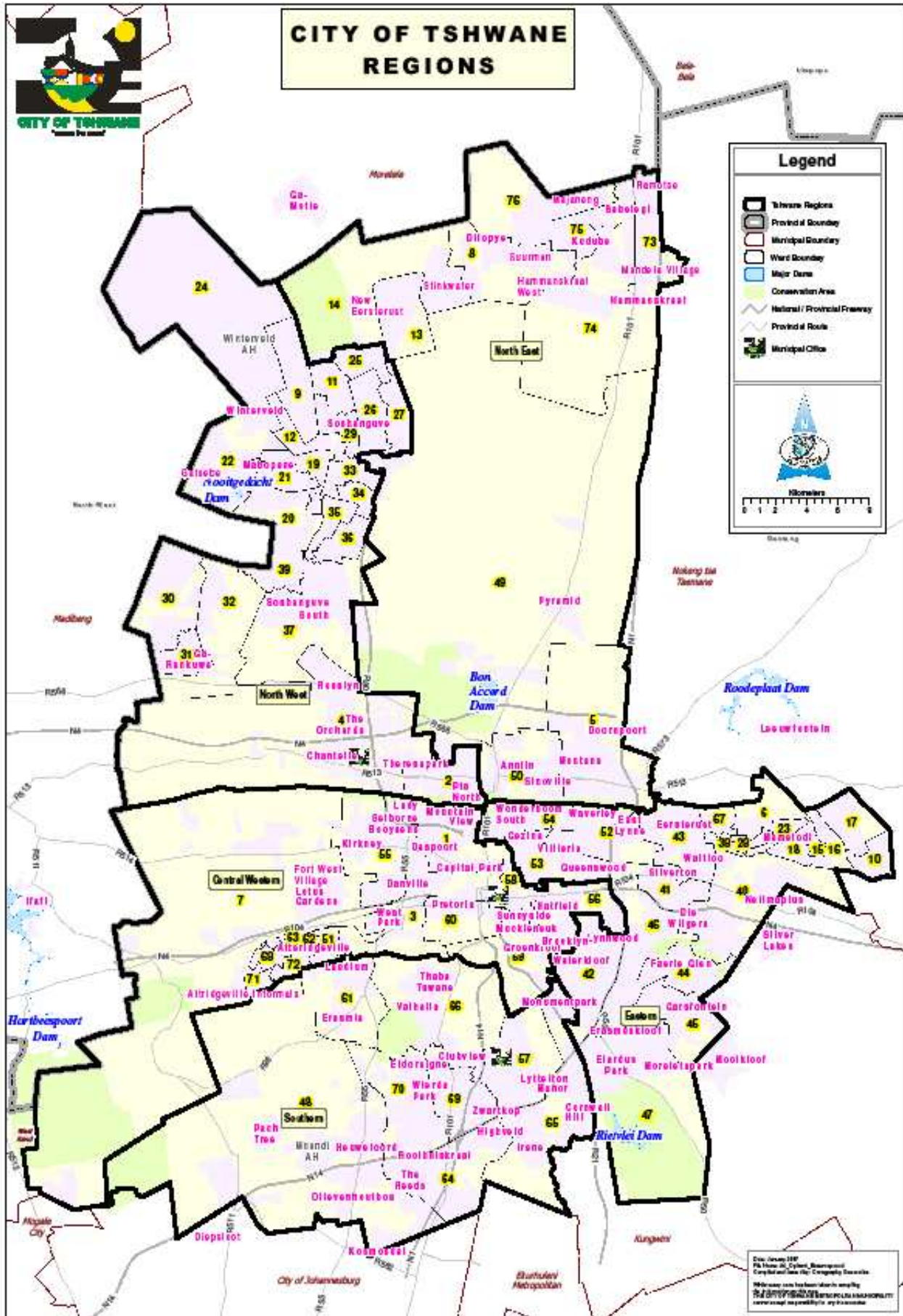
To the management and staff of the Health Services Division who had to deal with increase service delivery demands in changing and challenging times, thank you for your effort and dedication.

Yours sincerely



Ms Francis Roodt
Acting Executive Director: Health Services
Health and Social Development Department
City of Tshwane

Map 1. City of Tshwane



THE CITY OF TSHWANE: OVERVIEW OF THE CITY AND ITS PEOPLE

The City of Tshwane (CoT) is classified as a category A municipality. The CoT covers an extensive area of 3 200 km².

1.1 DEMOGRAPHY

Tshwane has an estimated population of 2,1 million (total mid-year population estimation for 2006 – Census 2001).

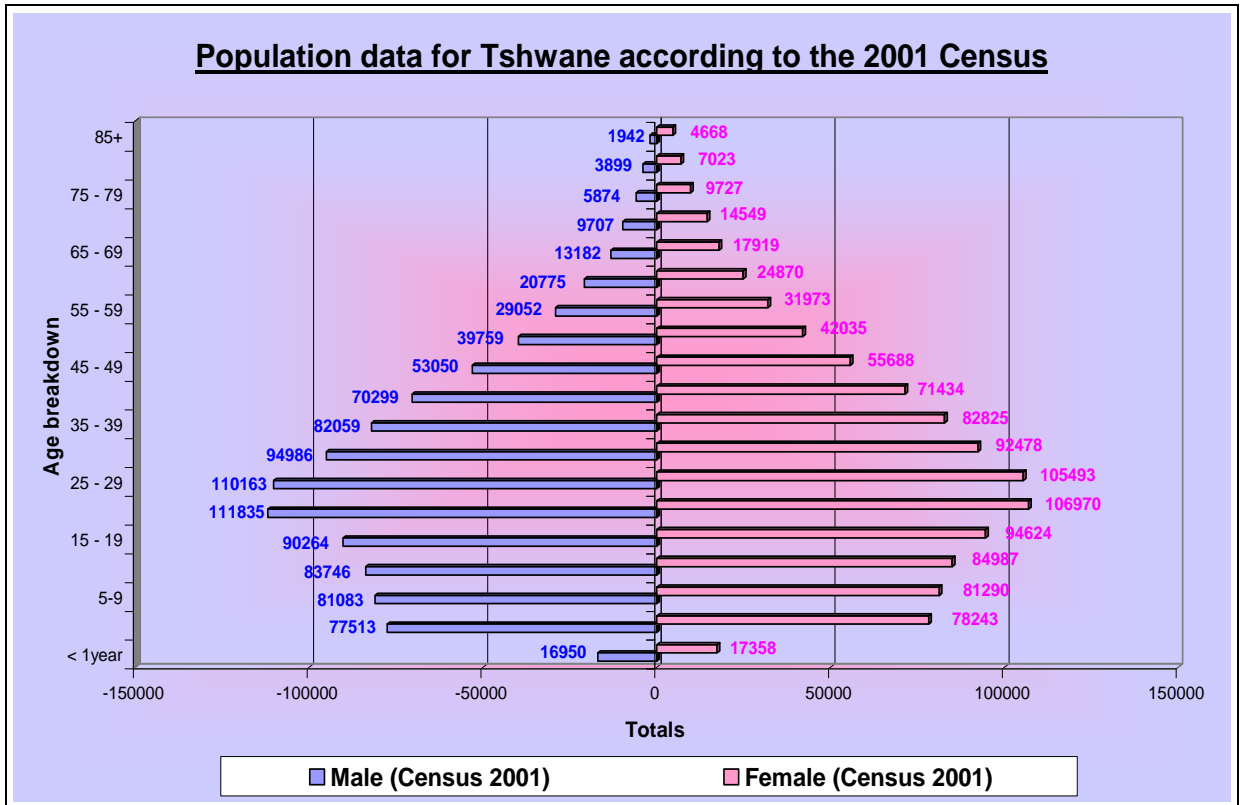


Figure 1: Tshwane's population

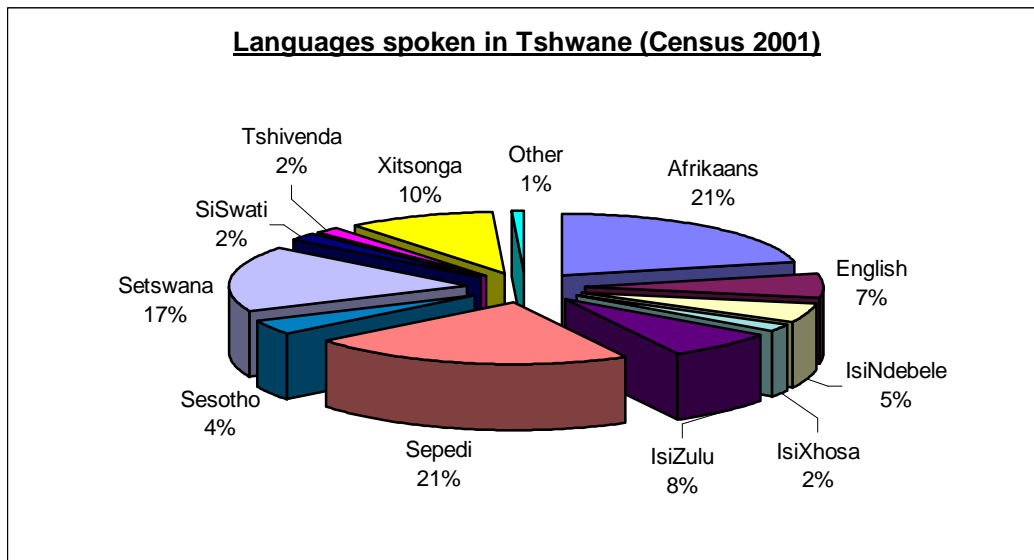


Figure 2: Languages spoken in Tshwane

1.2 OVERVIEW OF INCOME AND LIVING CONDITIONS: IMPACT ON THE WELL-BEING OF THE COMMUNITY

The levels of service to which a community has access, especially in respect of basic amenities such as safe water, sanitation, electricity and housing, have a direct impact on the health and well-being of that community. Poor living conditions and a lack of income often increase the incidence of malnutrition and lower immunity against common infections.

The number of households in Tshwane is estimated to be 568 661. Tshwane currently has an estimated 28 869 households (i.e. 5% of households) without access to a basic water service and 96 426 households (17%) without access to basic sanitation (source: Strategic Plan for the Eradication of Water and Sanitation Backlogs in Tshwane (Executive Summary), compiled by the Water and Sanitation Division of CoT, 2005).

Ninety-eight per cent of all households in Tshwane live within a five-kilometre radius of a public health facility.

2 HEALTH CARE DIVISION

2.1 VISION AND MISSION

The vision that the Health Care Division has for the city is that it should be a healthy city with an empowered community. The Division aims to realise this vision by improving the quality of life of all the people of Tshwane by promoting and protecting their health and well-being. This is being done through effective leadership and best practices and by providing efficient, quality services in a manner that builds partnerships. The services offered are designed to be accessible, affordable, sustainable and equitable.

The Health Care Division is guided by values such as commitment, integrity, teamwork, a positive attitude, the pursuit of excellence and a dedication to serving society.

The aim of the Division is to improve the health status of the city by –

- providing comprehensive primary health care (PHC) services to the communities of Tshwane;
- ensuring that the PHC services are accessible to the communities;
- empowering the communities through health promotion campaigns and programmes that promote community participation;
- responding successfully to the HIV and Aids pandemic;
- improving environmental health conditions in the city; and
- ensuring that partnerships are formed and networks are established for the implementation of health care programmes.

The Municipality currently provides PHC services in the Pretoria, Akasia and Centurion areas. The Gauteng Provincial Government provides PHC services in the Soshanguve and Hammanskraal areas, while the North West Provincial Government provides them in the Ga-Rankuwa, Mabopane, Winterveld (Odi subdistrict), Temba and Stinkwater (Moretele subdistrict) areas up to March 2007, since April 2007 Gauteng Province is responsible for health services in the former North West areas.

2.2 LEGAL FRAMEWORK

The Constitution of the Republic of South Africa, 1996, assigns the responsibility for health services to the provinces and the responsibility for municipal health services to local authorities (Schedules 4 and 5 to the Constitution). The new National Health Act, 2003 (Act 61 of 2003), as assented to by the President on 18 July 2004, defines municipal health services as a range of environmental health services.

Comprehensive PHC services are the responsibility of the provincial health departments in terms of the National Health Act, 2003. The district health system is the vehicle that has been chosen for the provision of these services. The services currently rendered by municipalities and the Gauteng Department of Health will be integrated according to a reconfiguration model that is still to be formally agreed upon.

The National Health Act, 2003, provides for transitional arrangements: it stipulates that municipalities must continue to provide the health services that they were providing in the year before the Act took effect until a service level agreement can be concluded. The Tshwane Municipality entered into an interim service level agreement with the Gauteng Department of Health on 12 June 2006. This agreement formalised the roles and responsibilities of the two parties and the relationship between them.

2.3 FINANCIAL MANAGEMENT OF THE TSHWANE HEALTH DISTRICT

District health services in the Tshwane Health District are the joint responsibility of the Tshwane Municipality and the Gauteng and North West health departments. Total expenditure by the public sector in the district amounted to R842 089 547 for the period under review.

The financial contributions of each were as follows:

- North West Department of Health (NWDH): 25%
- Gauteng Department of Health (GDH): 55%
- City of Tshwane Metropolitan Municipality: 20%
- Environmental health services expenditure were R26 393 945.

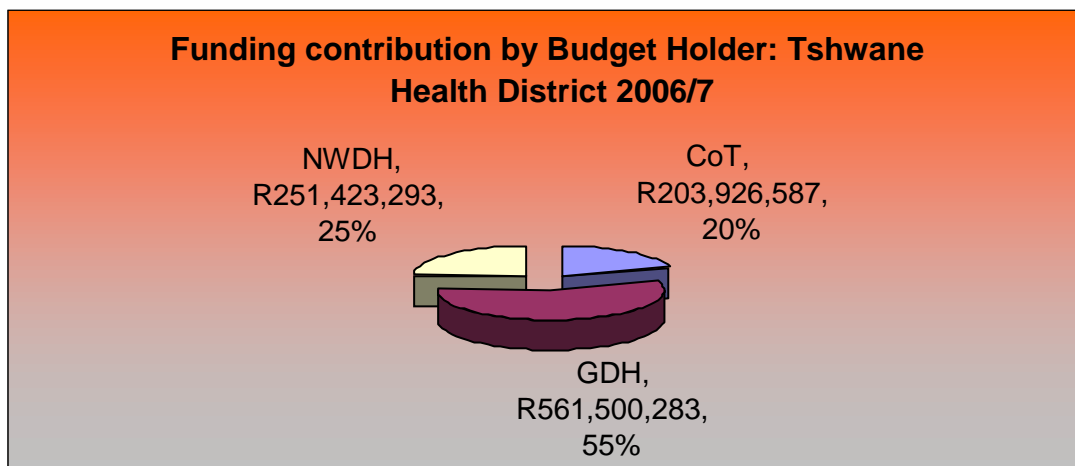


Figure 3: Funding Sources for the Tshwane Health District 2006/7

3 STRATEGIC OBJECTIVES OF HEALTH CARE DIVISION

- Provide a comprehensive personal PHC package through clinics to the citizens of Tshwane (Clinics, Programmes and Pharmacy)
- Promote a safe and healthy environment in Tshwane by delivering Municipal Health Services according to the National health Act
- Coordinate and facilitate the multisectoral response to HIV/Aids in Tshwane
- Ensure continuous quality improvement of health services through research and development

3.1 DEVELOPING THE DISTRICT HEALTH SYSTEM IN TSHWANE

The National Health Plan confirmed the district health system to be the appropriate vehicle for the delivery of PHC services. The district system provides for a single authority to be responsible for all PHC in a district. (A health district is equated to a metropolitan or district council.) The Gauteng Department of Health announced on 12 September 2005 its intention to provincialise the PHC services rendered by municipalities in the province. This decision was based on the new National Health Act, 2003, which came into effect in May 2005 and in terms of which the responsibility for PHC services rests with the provinces. (Municipal health services are defined in that Act as a range of environmental health services, and these services are now the constitutional responsibility of local government.)

PHC services in the municipal area are planned and coordinated jointly by the Tshwane Health Care Division and the Gauteng Department of Health through an interim district health advisory committee and joint subdistrict teams. A formal council, the Tshwane District Health Council, will be established under the National Health Act, 2003. In the interim, a functional integration approach has been adopted, with provincial staff being seconded to municipal clinics.

3.2 ENSURING THAT PRIMARY HEALTH CARE SERVICES AND FACILITIES ARE ACCESSIBLE TO THE COMMUNITY AND SUITABLE FOR THE RENDERING OF COMPREHENSIVE PRIMARY HEALTH CARE

3.2.1 Accessible services

PHC services are aimed at promoting health, preventing illness and curing diseases without the admission of a patient to a hospital. The services are provided from clinics, community health centres and district hospitals in the Tshwane area. A total of 3 465 028 patients visited public PHC and reporting private PHC facilities throughout Tshwane (excluding district hospitals) during the period under review. This represents 8% increase in the overall headcount compared with the previous year.

In all, 1 114 858 patients visited the local authority clinics during the 2006/07 year. This represents an increase of 7,8% in clinic attendance compared with the previous year, as indicated in Figure 4. The local authority clinics saw 32,2% of all patients seen at clinics in Tshwane.

The utilisation rate for the year under review decreased from 1.8 to 1.7 when compared to the previous year. The 1,7 uptake rate among the uninsured population (utilisation) in respect of PHC services in Tshwane is less than the World Health Organization's recommended rate of 3,5 visits a year and the national average of 2,3 visits a year.

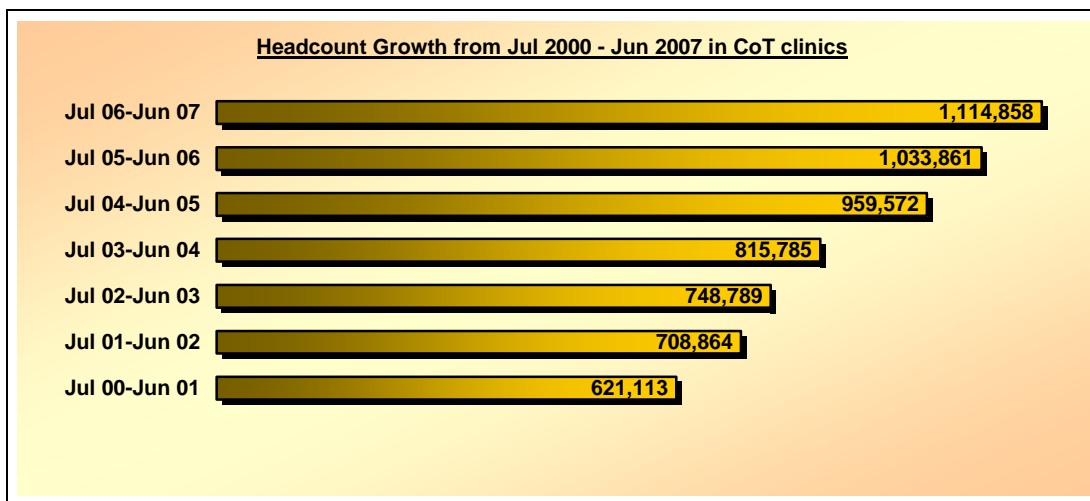


Figure 4: Increase in visits to local authority clinics

The national Department of Health has outlined a comprehensive service package for the provisioning of PHC services. This package of services is expected to be capable of tackling the leading causes of mortality and morbidity in the country, using cost-effective strategies. The Tshwane Health District is still in the process of implementing the full package of PHC services at all service points. To improve accessibility after hours, extended hours have been introduced in some clinics and a 24-hour health service has been introduced in each of the subdistricts. 24-hour health services are also provided by the district hospitals (Mamelodi West Hospital, Pretoria West Hospital and the Tshwane District Hospital).

3.2.2 Accessible and suitable health facilities in Tshwane

Ninety-six per cent of the health facilities owned by the Tshwane Municipality are suitable for the provision of PHC services. Table 1 lists the health-related projects completed during the financial year 2006/07 and table 2 lists the approved capital projects for the financial year 2007/08. The projects are derived from the Municipality's Integrated Development Plan and are funded by the Municipality.

Table 1: Completed capital projects for health care

Capital project	Output	Year commenced	Project completed
Extension of Hercules Clinic	Access to health care in central Tshwane	2006	2007
Extension of Soshanguve Block X Clinic	Access to health care in northern Tshwane	2006	2007
New Ga-Rankuwa View Clinic	Access to health care in northern Tshwane	2006	2007

Table 2: Approved capital projects for health care

Capital project	Output	Year to be commenced	Year to be completed
Extension of Stanza 2 Clinic	Access to health care in northern Tshwane	2007	2009
Extension of Lotus Garden Clinic	Access to health care in southern Tshwane	2007	2009
Extension of Pharmacy at East Lynne Clinic	Access to health care in northern Tshwane	2007	2009

3.2.3 Improving the quality of care

All clinics are displaying the Patient's Rights Charter and a service pledge for all health care workers in Tshwane. A complaints system is maintained in all clinics, and a flow chart advising patients on how to lodge a complaint is visible in all clinics.

3.2.3.1 Percentage of complaints successfully resolved

During the period under review, 95.2% of complaints were successfully resolved. A monthly complaint report is compiled to identify trends in complaints and to ensure that remedial action is taken to improve service delivery.

3.2.3.2 Clinic supervision

The Regular Review and Red Flag tools are used monthly in clinics to monitor and evaluate clinic administration and to facilitate clinic supervision. Quarterly supervisors' meetings are held with the Regional Gauteng office to discuss area supervision. The reporting rate is 100%.

3.2.3.3 In-depth programme reviews

The in-depth reviews are done jointly between Local Authority and Provincial Area and Programme Managers. The following in-depth programme reviews were done with satisfactory outcomes during the year under review and reported on the following supervisory meetings:

- Drat Tool (In-depth review TB) 23 May 2007
- Mental Health 21 February 2007
- Health Information System 23 August 2006
- Rehabilitation Tool 22 November 2006

3.2.3.4 Annual rating survey

A rating survey was done in March 2007 to determine patient satisfaction. Table 3 indicates the survey results for the past six financial years. A comparison of results of the client satisfaction survey done since Sept 2002 is detailed in Table 3.

Table 3. Client satisfaction survey results

	Sept '02	Apr '03	Mar '04	Feb '05	Apr '06	Mar '07
Percentage of clients satisfied with the clinic environment	78%	87%	87%	89%	91%	90%
Percentage of clients satisfied with the quality of care by staff	73%	80%	81%	94%	86%	84%
Percentage of clients satisfied with the waiting times and clinic hours	72%	74%	74%	84%	76%	80%

3.2.3.5 Annual waiting time survey

A waiting time survey was conducted from 26 March to 02 April 2006 in all local authority clinics. Figure 5 shows the results for the past five financial years.

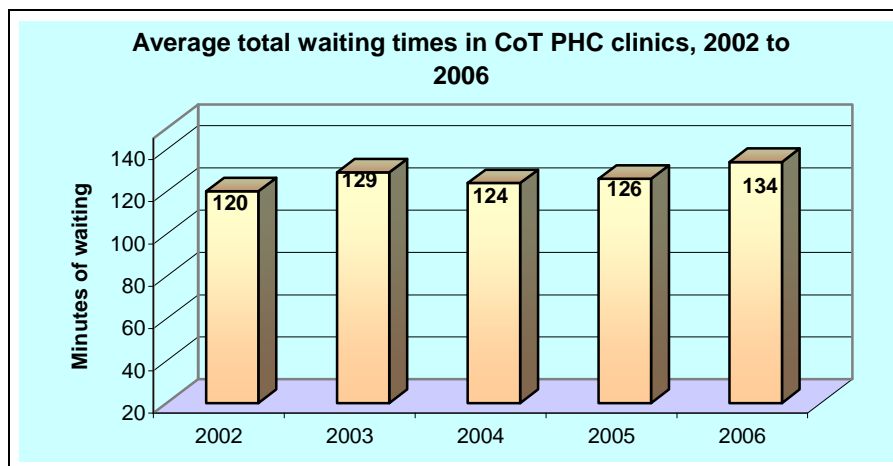


Figure 5: Average total waiting times at clinics

3.2.4 Ensuring appropriately skilled staff for the health district

3.2.4.1 Staff establishment

The staff establishment in respect of providers of health care in Tshwane is about 3 200 (including the staff in district hospitals, environmental health staff and emergency medical services staff). Table 4 lists the nursing staff numbers for PHC services per subdistrict. The following staffing ratios for PHC demonstrate the critical shortage of key health staff in the city during the year under review:

- One professional nurse served 2 687 members of the uninsured population; this is an average nurse to population ratio of 37 per 100 000. This ratio improved slightly compared with the previous year (34 per 100 000).
- One doctor served 27 140 members of the uninsured population; the average doctor to population ratio was therefore 3,7 per 100 000, compared with the national average of 19 per 100 000, indicating a decrease since the last reporting period.
- One environmental health practitioner served 48 837 members of the population, averaging the environmental practitioner to population ratio at 0,31 per 15 000 versus the target of 1 per 15 000 (EHP CoT staffing).

Table 4: Population, PHC facilities and staff audit

Sub-district	Population per sub-district	Number of facilities (clinics)	Number of professional nurses	Number of doctors
Southern	205 383	CHC (1), clinic (4), satellite (2) mobile (1)	55	7
Northern	406 173	CHC (1), clinic (8), satellite (2) mobile (2)	151	14
Central	1 013 787	CHC (2), clinic (23), satellite (1) mobile (2)	259	35
Odi	420 362	CHC (3), clinic (12), satellite (1) mobile (1)	141	4
Uninsured population	1 628 381	CHC (7), clinic (47), satellite (6) mobile (6)	606	60
TOTAL	2 045 705			

Source of population figures: DHI

Table 5: CoT Health Care Staff (category and number)

Category	Number of permanent employees	Number of contract employees
Administrative	33	
Aids unit	14	
Environmental health	71	
General workers	38	
Health programmes	10	
Managers	6	
Medical officers	12 (6 full time, 5 part time, 1 senior)	2 (session doctors)
Pharmacy	30	
Primary health care	187	1
Radiography	6	
Research and development	14	
Support services	23	
Total	444	3

3.2.4.2 Personnel development

The purpose of the training section is to:

- Management and co-ordination of training programmes to personnel, students and the community to enhance an effective and efficient service delivery.
- Fill in the gaps that are identified in order for development to have productive employees.
- Assist employees to be in line with the new developments in the department.

Achievements / Strengths

- Maintenance of partnerships and smooth working relations with tertiary institutions.
- Continuous TB training / clinical discussions with all health care providers in the city to ensure standardisation and management of the TB epidemic.
- 93% of professional nurses IMCI trained and fully implementing the strategy in clinics.

Challenges

- Mushrooming of nursing colleges in the city, placing a huge demand on experiential learning in clinical facilities.
- Failure rate for formal programmes too high.
- Financial constraints and staff shortage
- 60% of targeted health professionals at province were trained on their job specification.
- 40% of administration and support at province were trained on their job specification.
- Manage to assist Tshwane University of Technology with the placement of 3rd year students to do in-service training as a requirement for them to complete their Diplomas.
- Orientate and induct newly appointed staff members who joined the department.

Table 6: Personnel development – Tshwane provincial staff

Staff Category April 2006 – March 2007	Staff Establishment	Number of Courses	Number Attended
Legislators and senior officials	9	6	4
Professionals	212	9	101
Middle Management	102	25	83
Technicians and Associated Professionals	212	25	173
Clerks	245	8	125
Service Workers and shop market sales workers	1130	9	674
Craft related trade workers	84	4	52
Plant and machine operators and assemblers	1	0	0
Labour and related workers	623	5	326

Table7: Personnel development – CoT Health Care Staff

Key Performance Areas	Service Delivery Indicator	Target	Performance		
			2004/05	2005/06	2006/07
Workplace Skills Plan	Percentage of all staff with a workplace skills plan	100% of staff with a workplace skills plan by June to July of the year under review	99%	96%	99%
Career Plan Development	% of skilled technical and academically qualified workers, junior management staff and supervisors with a junior management qualification. (NQF4)	100% of staff at supervisory level and 20% of staff in non-supervisory positions with junior management in five years	60%	74%	74%
	% of support services staff in this category of skilled technical and academically qualified workers, junior management and supervisors with relevant technical skills courses or life skills courses. (Pharmacy-ass, nursing ass and x-ray personnel)	100% with at least relevant technical skills courses or life skills courses by June 2008	89%	92%	92%
	% of semi-skilled staff with relevant technical skills courses or life skills courses.	100% by June 2008	74%	87%	92%
Professional Development	% of PN's with a PHC Diploma	65% by the end of June 2008	51%	59%	59%
	% Managers trained in Information Management	63% by June 2008	92%	63%	63%
	% of PN exposed to formal DHIS training	38% by June 2007	33%	38%	38%
	% Implementation and compliance to targets set in approved Divisional Skills Development Plan	80% compliance by June 2007	85%	97%	97%
	% of clinics with more than two IMCI trained staff member	70% by June 2007	95%	96%	96%
	% of Professional Nurses IMCI trained	75% by June 2007	Not measured		93%
	% of clinics with more than 2 VCT nurses trained	100% by June 2007	74%	100%	100%
	% of all PN and doctors with a dispensing course.	80% by June 2008	38%	65%	65%
	% of IMCI trained staff visited by a supervisor yearly	90% of trained staff annually	0	100%	100%
	Number of TB training interventions to support the TB program	15	0	15	15
External Training	Number of students for PHC trained from tertiary institutions per year	600 per year	408	460	651
	Number of external people (private providers and provincial staff) trained per year	60 per year	48	51	262

3.3 IMPLEMENTATION OF A MANAGEMENT INFORMATION SYSTEM FOR THE HEALTH DISTRICT

Managers at all levels need appropriate and accurate information to be able to analyse the health situation and set relevant health objectives. The achievement of these health objectives needs to be monitored using predefined indicators. The Tshwane Health District is using the National approved DHIS of the district information system – the District Health Information System.

The following achievements can be reported with regard to the CoT clinics:

- 100% of the MDS data from PHC facilities and private providers of immunisation and family planning services are captured in the DHIS.
- Feedback is given and the information is used to improve the quality and coverage of services.
- One formal DHIS course was presented.
- 91% of the CoT clinics have functional e-mail facilities.
- A standardised PHC software program for the administration of patient records has been rolled out to all the CoT clinics.
- A software program for the Environmental Health Section has been developed and implemented.
- 91% of the clinics use an electronic system to order pharmaceutical stock.
- MDS for MHS has been implemented.

The following challenges exist for the health information units in the Tshwane Health District:

- Increasing the number of functioning e-mail terminals in health facilities to 100%.
- Developing integrated computerised systems to manage data related to diseases and health services.
- Replacing the current (hard copy) patient records with electronic patient records.
- Increase the quality of MHS data.

3.4 PROVISIONING OF ESSENTIAL DRUGS

The report represents the combined activities of the Tshwane Pharmaceutical Services Section and those of the Gauteng Department of Health's Regional Pharmacy.

3.4.1 Area covered for provisioning of essential drugs

The pharmaceutical services that are provided cover the Tshwane/Metsweding Region. As of April 2007, the cross-border areas that formed part the Tshwane Municipal Region but were administered by the North-West Province (Odi and Moretele Clinics) were incorporated into the Gauteng Provincial Administration as per the new provincial borders. This added 2 CHC's and 17 PHC clinics to the clinics that were previously served from the Regional Pharmacy.

3.4.2 Facilities and services

Pharmaceutical services are rendered to 5 provincial CHC's, 50 provincial PHC clinics and 23 municipal PHC clinics. The services that are rendered range from drug supply through to ensuring rational use of medicines in the clinics. The Regional Pharmacy dispenses an average of 8000 prescriptions a month to old age homes and Mental Health facilities. The pharmacy supplies family planning methods to 90 private sector providers and vaccines to 85 private providers. The Regional Pharmacy also provides home-based care supplies for the region.

A down referral system has been established and has been implemented in the provincial clinics. The down referral system involves the supply of chronic tertiary and secondary level medicines to patients via clinics that are most convenient for collection by the patients. Municipal clinics have not implemented the system because of a lack of capacity to provide the service.

The Municipal Service concentrates more on medicine utilization. Regional Pharmacists enforce rational drug prescribing, rational dispensing and utilization. This is achieved through the implementation of procedures to monitor this with the goal of ensuring that the medicine related needs of the patients are properly addressed in a safe and cost effective manner.

The dispensing of medicines in 13 the PHC clinics and 3 CHC's is done by Post Basic Pharmacists' Assistants functioning under the indirect supervision of a pharmacist and established treatment protocols. A stock control service is provided by the assistants as far as possible in the rest of the PHC clinics. Three of the CHC's have full time pharmacists that cater for the special dispensing needs of a community health centre. The PHC services are restricted to the Primary EDL and Standard Treatment Guidelines, but allowance has been made for medical doctors to make use of the Hospital and Paediatric Guidelines.

3.4.3 Staff establishment

The Tshwane Region has ten registered pharmacists and three community service pharmacists. Four of the registered pharmacists are in management positions and the community service pharmacists are deployed in the Regional Pharmacy. Pharmaceutical Services has 39 qualified and registered Post Basic Pharmacists' Assistants who are deployed to the clinics and CHC's. There are 33 Learner Basic Pharmacists' Assistants and 10 Learner Post Basic Pharmacists' Assistants. There are 16 other staff including administrative officers, data capturers, drivers and general workers who provide a supportive service to the pharmaceutical services in the region.

3.4.4 Drug expenditure

The drug figure was R50 101 236.00 for the 2006/2007 provincial financial year, which was a 2.06% increase over the previous year's expenditure (R49 088 674.00).

3.4.5 Achievements and challenges

The challenges:

- Non-adherence to the PHC level Standard Treatment Guidelines by prescribers poses a crucial problem to the service which has to ensure the safety and cost-effectiveness of the dispensing process as well as ensure that the service is provided within the guidelines of national legislation.
- Functioning within the constraints of space in the Regional Pharmacy to provide services to all clinics in the region. New facilities are currently under construction and should be ready by the end of November 2007.
- The effects of the public sector strike were a reduced flow of medicines from the Auckland Park Medicines Depot. The risk of stock out in the clinics was reduced through careful monitoring of stock levels in individual clinics and moving stock around as necessary.
- Assisting the large number of learner post basic pharmacists' assistants complete their modules was a huge challenge to the pharmacists.
- The integration of the Odi/Moretele facilities into the Regional Pharmacy processes and procedure is a challenge that is still being addressed.

The achievements:

- A study done by one of the pharmacists regarding the conditioning of ice-packs for the transportation/storage of vaccines in cooler boxes made a crucial contribution to the National EPI programme. This results of the study were presented at the annual South African Hospital and Institutional Pharmacists, conference.
- Improving the turn around time in the Regional Pharmacy for clinic orders irrespective of the increased number of clinics being supplied.
- Completion of the Learner Post Basic Pharmacists' Assistant course by 21 learners to enable their deployment to the PHC facilities.
- Achievement of an average of more than 98% medicine availability in the clinics.
- Improved acceptance of the pharmaceutical service within the health facilities.
- Drawing up and implementation of measures to monitor:
 - Rational Drug Utilization
 - Good Dispensing Practices

3.4.6 Plans for 2007/08 year

- Increased cooperation and working together between the municipal and the provincial pharmaceutical services.
- Placing the pharmacy profession in its rightful place within Health Care through the improvement of the image of the profession.
- Improving medicine availability above 99% in all the facilities.
- Completion and implementation of the Tshwane Medicine Formulary (with Standard Treatment Guidelines) to guide the utilization of medicines in the region.

3.5 PROVISION OF COMPREHENSIVE PRIMARY HEALTH CARE SERVICES

3.5.1 Sexually transmitted infections

People with sexually transmitted infections (STIs) are more likely to be infected with HIV than those without an STI. It is therefore extremely important to identify and treat anyone who has an STI.

The incidence of male urethral discharge has decreased since the last review period. A total of 8 606 new cases were reported for the year under review compared with the 11 350 cases of the previous year. The average incidence decreased from 14 per 1 000 to 11 per 1 000 of the sexually active male population treated at public health facilities within the boundaries of the CoT. The incidence of male urethral discharge is used as a proxy (equivalent) indicator to measure the disease, as it is a true STI. It is easily diagnosed and patients usually come for treatment and responds well to the treatment.

The incidence new STIs is higher in the Central subdistrict than in the other subdistricts. A possible explanation could be the influx into the area of migratory labourers who are not part of the "residential" population of the district.

The rate of STI incidence for the year under review increased from 31 per 1 000 to 33 per 1 000. In all, 52 215 new cases were reported at the public health facilities within the boundaries of the CoT. These infections are "mixed" infections comprising discharges, ulcers and herpes.

Condom distribution is an important strategy in the prevention of STIs. Over 8 million condoms (both male and female condoms) were distributed by the public health sector during the year under review. There is a significant decrease in condoms distribution by about 4 million condoms. The decrease may be attributed to inconsistent in recording, decrease usage of condoms by clients and the possible use of private health service providers. Other strategies used in the prevention and treatment of STIs included adopting a syndromic treatment approach and monitoring there of and tracing contacts. Health education programmes also focused on the prevention of sexually transmitted diseases.

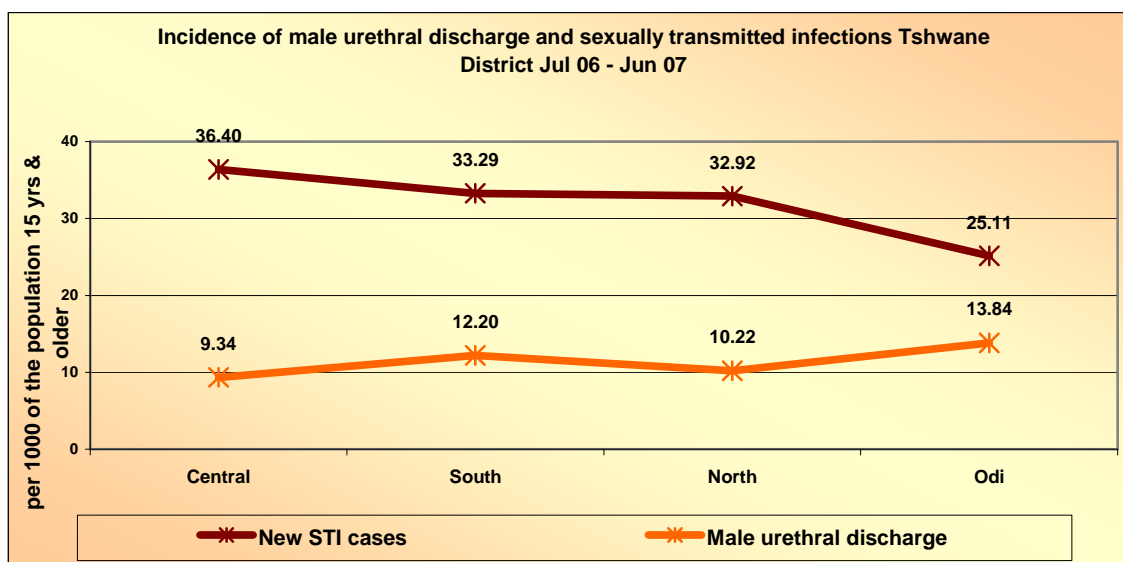


Figure 6: Incidence of STIs and male urethral discharge

3.5.2 Services for children and the youth

3.5.2.1 Integrated management of childhood illnesses

The strategy for the Integrated Management of Childhood Illnesses (IMCI) was adopted by South Africa in 1996 and is used in the PHC facilities in Tshwane. The IMCI clinical guidelines target children under the age of five (this age group bears the highest burden of deaths from common childhood diseases). The guidelines take an evidence-based, syndromic approach to case management that supports the rational, effective and affordable use of drugs and diagnostic tools.

The IMCI strategy includes both preventive and curative interventions that aim to improve practices in health facilities, the health system and at home. At the core of the strategy is the integrated case management of the most common childhood problems, with the emphasis on the most common causes of death. (Childhood vaccinations have successfully reduced deaths due to measles. Oral rehydration therapy has contributed to a significant reduction in deaths resulting from diarrhoea. Effective antibiotics have saved the lives of children with pneumonia, and improvements in breastfeeding practices have reduced the number of childhood deaths.)

The IMCI strategy has three main components:

- Improving the case-management skills of health staff by providing guidelines on the integrated management of childhood illnesses and recommending activities to promote the use of these guidelines
- Improving the overall health system in such a way that childhood illnesses can be managed effectively
- Improving family and community health care practices

The infant mortality rate can be used to help monitor survival and healthy development among children. Factors influencing infant mortality are access to safe water, sanitation, nutrition, the level of the mother's education, the quality of maternal care and the availability of vaccines.

The incidence of diarrhoea and severe malnutrition is monitored in all public health facilities. Severe malnutrition is diagnosed when a child is found to weigh less than 60% of the appropriate estimated weight for age, or to suffer from marasmus, kwashiorkor or a similar condition. Severe malnutrition might also be indicated as clinically malnourished. Of the children under five who were weighed in a PHC clinic during the year under review, 1,5 per 1 000 were found to be severely malnourished, that shows a decrease of 0,8 per 1 000 as compared to the previous year and 4,1 per 1 000 who visited the PHC clinics presented with diarrhoea with dehydration, indicating an increase

of 2,4 per 1 000. Figure 7 shows the rates per subdistrict, this important child health indicator point to a drastic deterioration in the Odi subdistrict since the last reporting period. A review will be done in that subdistrict to confirm the status and to determine the possible reasons for the deterioration. Appropriate action will then be taken.

All PHC facilities provides free milk and food supplements to underweight-for-age and severely malnourished children under the age of five. During the year under review, the IMCI principles were emphasize and an extensive health promotion programme on rehydration and the prevention of dehydration was comprehensively introduced.

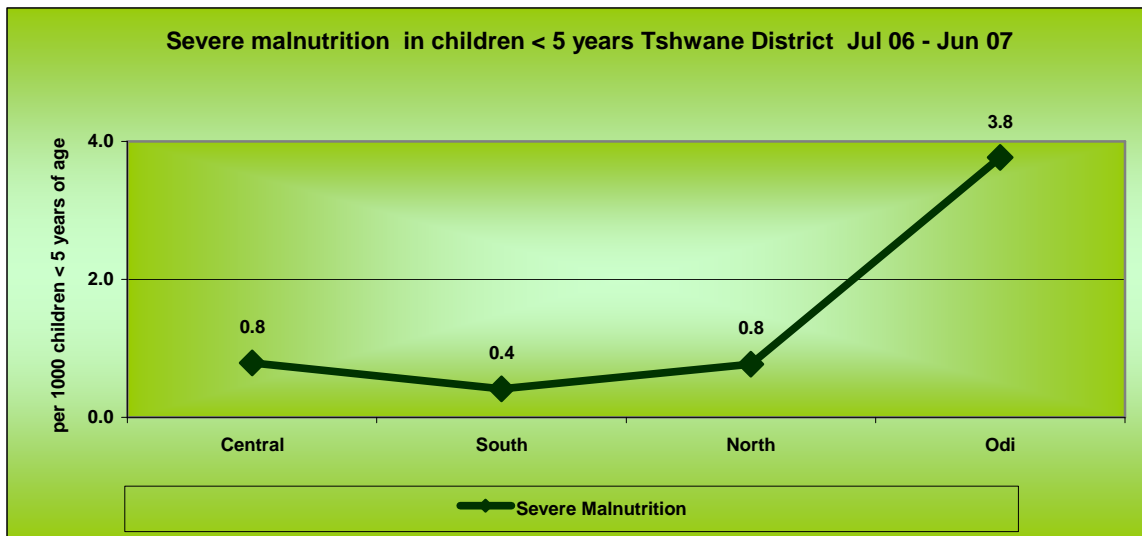


Figure 7: Incidence of severe malnutrition in children under five years of age seen in public PHC facilities in Tshwane District

3.5.2.2 Expanded Program on Immunization

The Expanded Program on Immunization (EPI) is a global programme for the control of vaccine-preventable diseases. In addition to being given a vitamin A supplement, children are immunised with:

- BCG (tuberculosis vaccine)
- TOPV (trivalent oral polio vaccine)
- DTP-Hib (combination of diphtheria, tetanus, pertussis and *Haemophilus influenzae* type B immunisation)
- Measles vaccine
- HBV (hepatitis B vaccine)

The national goal for South Africa was to reach 90% coverage for each vaccine in the primary childhood series by the year 2000. The primary series refers to the BCG, 3 polio, 3 DTP-Hib-HBV and measles vaccines. About 91% of all children under the age of one year in the City of Tshwane LA clinics are fully immunised.

3.5.2.3 Interventions targeting the youth

Although the teenage pregnancy rate dropped from 10% to 8% during the year under review, it is still cause for concern. Figure 8 shows the trend from 2000 to 2007.

Interventions targeting adolescents included the implementation of clinical guidelines for the health of young people and adolescents and measures to reduce the number of teenage pregnancies and cases of substance abuse. Fast-lane options for family planning services were introduced in most clinics.

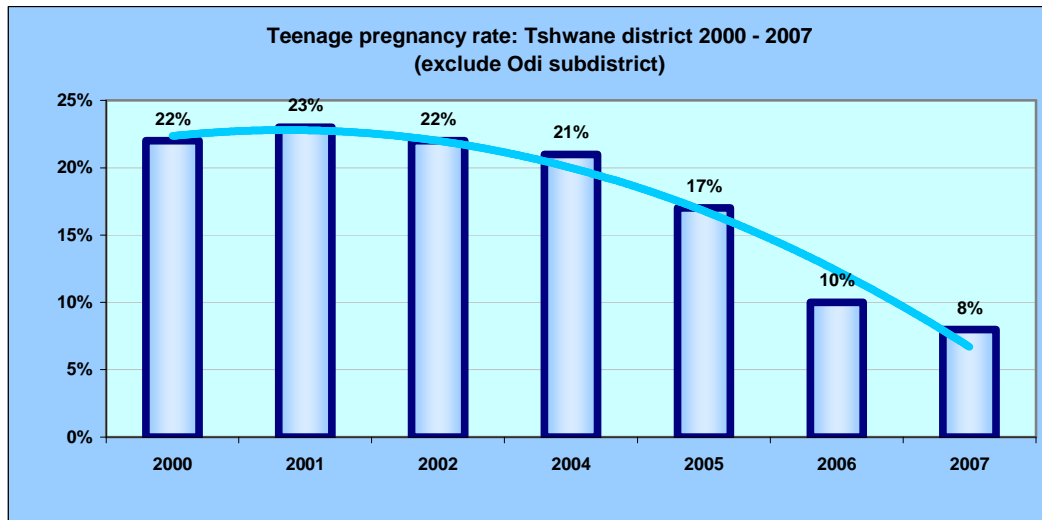


Figure 8: Teenage pregnancy rate – Public PHC clinics in the City of Tshwane

3.5.3 Women's health

3.5.3.1 Cervical Cancer

Cancer of the cervix is the most common form of gynaecological cancer in South African women. The cervical cancer screening programme is able to reduce the incidence of cervical cancer and mortality related to cervical cancer. The National Cervical Cancer Screening Policy recommends that any woman over the age of 30 who has not had a cervical smear previously should have one done. Thereafter, a smear should be done every 10 years until the age of 60.

In all, 16 807 cervical smears were done in the Tshwane district from July 2006 to June 2007. Of these, 585 showed abnormalities, bringing the rate of abnormalities to 3.5%. As indicated by Figure 9, cervical screening coverage remains a challenge, as only 7.2% of the target population (231 751) underwent a cervical screening. The results of the cervical screening done by the City of Tshwane clinics were further analysed. They indicate an abnormality rate of 9%. The abnormality rate includes the 20- to 29-year-old age group (see Figure 10).

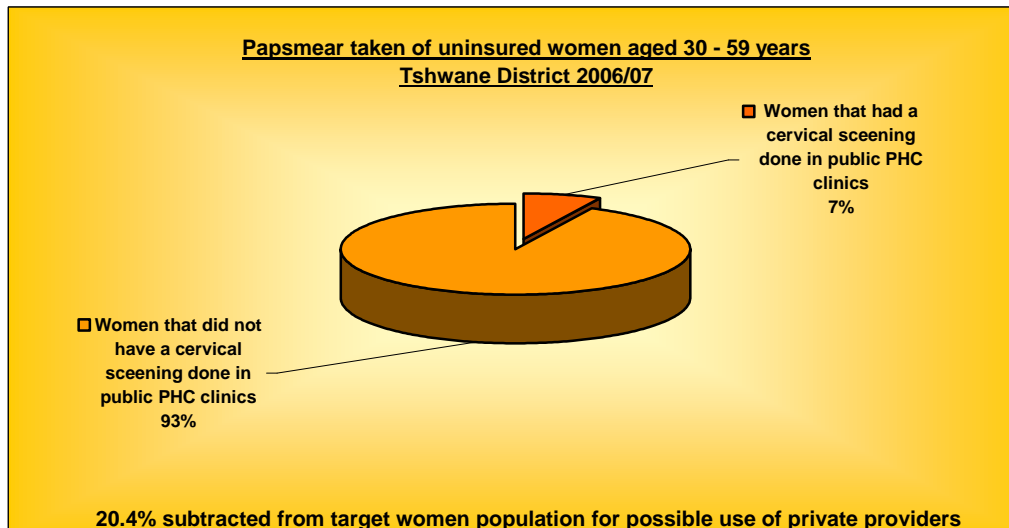


Figure 9: Cervical smears of uninsured women of 30 to 59 years of age in all public PHC facilities in Tshwane (2006/07)

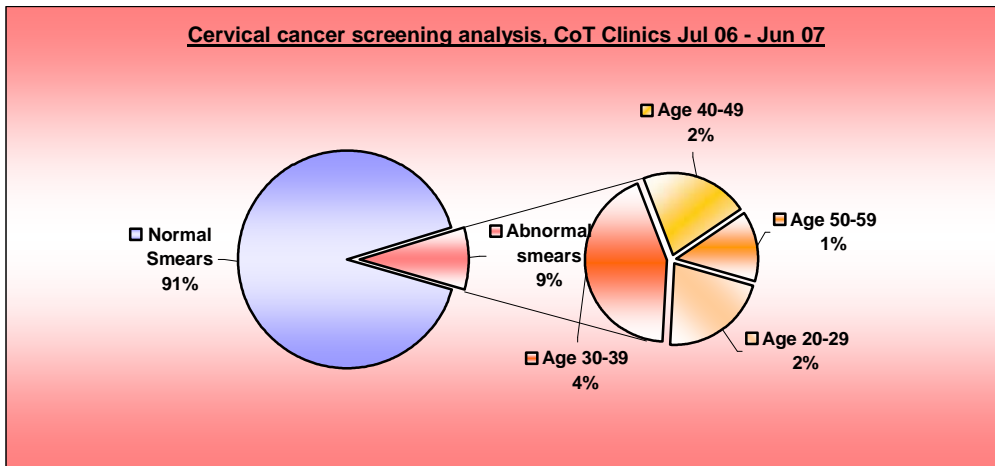


Figure 10: Cervical cancer screening analysis – CoT clinics (July 2006 – June 2007)

3.5.3.2 Antenatal care

The national target is that all pregnant women should have at least four visits to a health care facility during each pregnancy. These should start before 20 weeks' gestation. The average number of visits per antenatal client in the Tshwane Health District was 3,0 during the year under review, which represent a decrease of 1,4 visits from the previous year.

Antenatal care (ANC) coverage measures the percentage of pregnant women in a community who make use of ANC services at least once in their pregnancy. Denominator data proved to be unreliable and could not be used to calculate the coverage for the period under review. The calculation requires that population-based figures be used as a denominator. Different factors may affect the calculation of the coverage, such as the proportion of the insured population using private ANC services, the influx of women from other areas with no or poor ANC facilities, and incorrect population figures.

3.5.3.3 Family planning

Fertile female members of the community (females aged 15 to 44 years) should be protected from unwanted pregnancies. There are about 654 478 uninsured fertile females in the population of Tshwane. During the year under review, the couple year protection rate calculated to 69,5%. These figures exclude coverage through sterilisation and condom use. The national target for coverage in respect of fertile females is 65%.

A large variety of contraceptive methods, not provided by the national family planning programme, is also available from pharmacies and doctors. Private pharmacies and medical practitioners have contracts with the Tshwane Health District to provide contraceptive methods from the family planning programme.

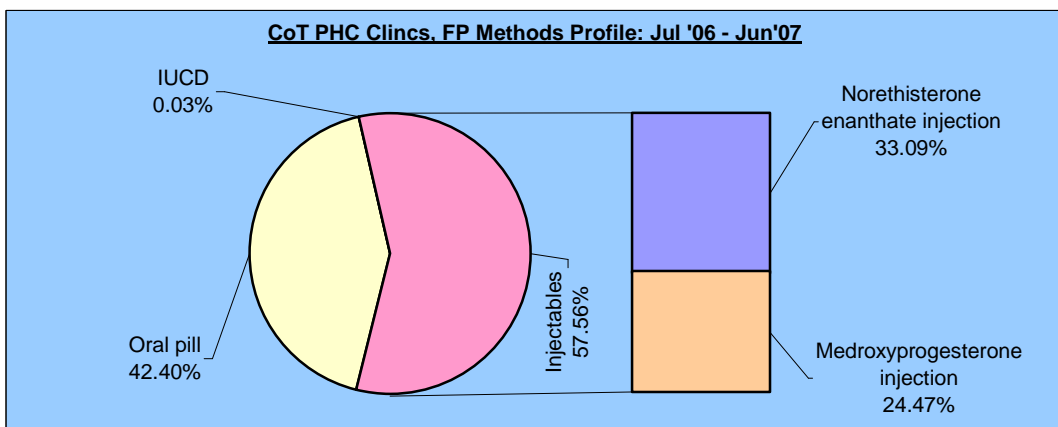


Figure 11: Family planning Methods Profile

Different methods are used at clinics to ensure that women have a variety of choices to choose from. A supportive and non prescriptive approach has to be encouraged by health personnel to ensure cooperation and commitment of a client to the chosen method of contraception. Injection types of contraception are preferred methods as compared to other methods of contraception as indicated by Figure 11. The injectables are the highest with 57.56% as compared to Oral pills and IUCD's. Condoms are also distributed at facilities for free for those who don't want to use any of the above methods. Male condoms distribution rate for the period July '06 to June '07 is 11 condoms per male client (3 049 331 condoms). Number of Female condoms distributed is 53 248 condoms.

3.5.4 Curative, chronic and preventive services

Curative and chronic health services are available at 50 out of 55 (91%) health facilities throughout the Tshwane area. All fixed facilities of the LA are now providing 100% curative service. Since the introduction of curative and chronic services in the local authority clinics, a marked increase has been experienced in the use of these services.

General curative and chronic services are provided as part of the comprehensive package of health services available at all PHC facilities. These services are being introduced incrementally through formal service level agreements with the provincial health departments. Services for chronic care are offered at 91% of the PHC facilities in Tshwane. The local authority clinics provide 62% chronic services and 100% preventive services at all facilities. Initiatives are in place to expand chronic services to other facilities.

3.5.5 Tuberculosis services

It has been said that no country can control tuberculosis (TB) without controlling HIV, and that HIV and TB are a deadly duo. TB is the most common opportunistic infection and the biggest killer of people living with HIV or Aids, as HIV-positive people who had TB earlier in life have an increased risk of developing active TB. If newly infected with TB, a person with HIV is more likely to progress to active TB. Infection with HIV is the greatest risk factor for the development of active TB.

Collaboration between the HIV and TB programmes is therefore extremely important. HIV prevalence among TB patients was 55% during the year under review, which is 5% above the rate for the previous year.

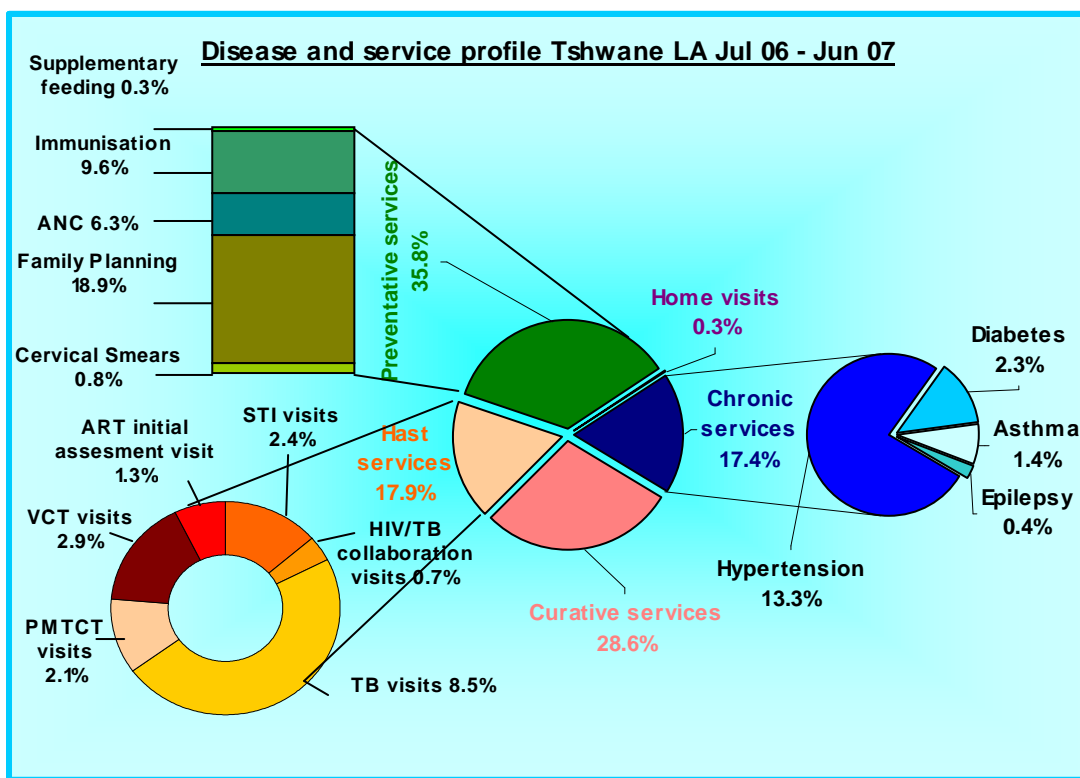


Figure 12: Disease and service profile (July 2006 – June 2007)

3.5.5.1 Overall objective of the collaboration between the HIV and TB programmes

Collaboration between the HIV and TB programmes ensures that :

- all newly diagnosed TB patients undergo routine voluntary counselling and testing;
- laboratory and clinical staging is done on all HIV-positive TB patients;
- Co-trimoxazole is supplied to all HIV-positive adult patients co-infected with TB;
- all HIV-positive adult patients are screened for active TB;
- patients are referred for antiretroviral treatment in accordance with the national guidelines;
- TB-preventive therapy is given to all eligible HIV-positive adult patients; and
- all currently functioning TB and HIV training sites report on all indicators.

Services to combat TB are provided in Tshwane according to the National Tuberculosis Control Programme. There are two subdistrict TB coordinators in the North West area and four in the Gauteng area who control and report on the services. The notification of cases, drug procurement and TB quarterly reporting are, however, still done separately for the North West and Gauteng.

Comprehensive TB services are available in 87% of clinics in Tshwane. All clinics offer DOTS (directly observed therapy – short course) services and help to diagnose TB and trace contacts.

Facilities for the admission of TB patients are available at Santa Tshepong, Jubilee Hospital, Correctional Services, 1 Military Hospital and the Pretoria West Hospital.

3.5.5.2 Case-finding

TB in children younger than seven years of age is diagnosed by means of the TB score sheet for children, skin tests and chest X-rays. People suspected of having active TB and contacts of adult TB cases are tested through sputum examinations and chest X-rays, as indicated. Children over six years of age who are suspected of having TB and adults with signs and symptoms of TB (but who cannot produce sputum) are X-rayed at clinics.

TB case finding rate for the year under review is 2.6%. The Tshwane district target is 3%, more strategies through TB crisis plans are in place to alleviate the national TB crisis. Health education is provided at firms, hospitals and old-age homes, and X-rays are taken of people suspected of having TB.

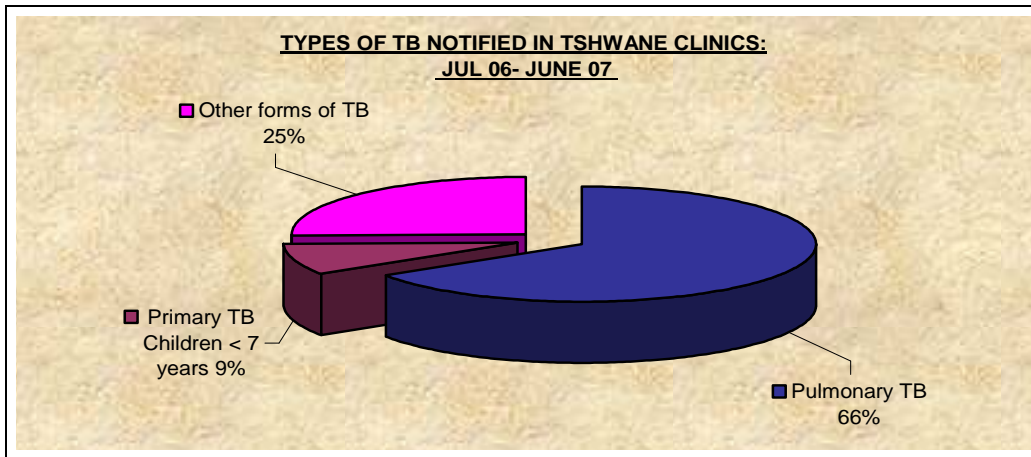


Figure 13: Types of TB notified in Tshwane (July 2006 – June 2007)

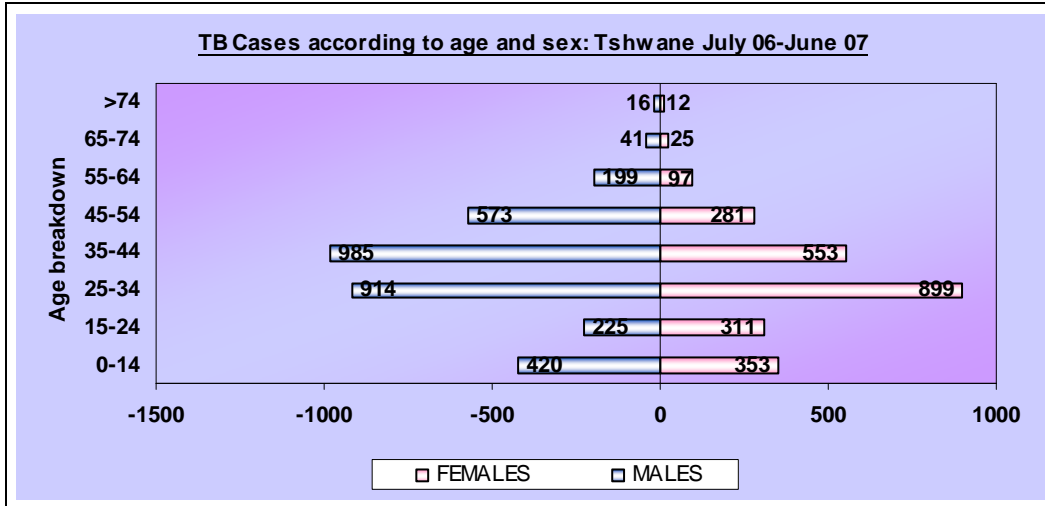


Figure 14: Age breakdown of TB patients

Bacteriological coverage indicates the percentage of pulmonary tuberculosis (PTB) cases diagnosed with sputum TB bacteriology. Ideally, all adult PTB patients should be diagnosed with sputum bacteriology. Sputum testing is the only reliable way health care workers can monitor susceptibility to the TB drugs and guarantee a TB cure at the end of the treatment.

Table 8: Bacteriological coverage: Tshwane (2006/07)

Area	Central	Northern	Southern	Odi	Total
Bacteriological coverage	89.1%	72.9%	94.6%	65.2%	78.9%
Number of PTB cases with positive sputum	2045	379	304	788	3516
Number of PTB cases with negative sputum	596	22	61	33	712
Number of adult PTB patients with no smear	322	149	21	438	930
Number of PTB cases, 0–7 years (primary TB) with no smear	307	172	36	231	746
Total number of PTB cases > 7 years (able to produce a sputum sample)	2963	550	586	1259	5358
Number of extra-PTB cases	780	560	153	719	2212
Total number of TB cases diagnosed	4050	1282	575	2209	8116

3.5.5.3 Treatment outcome reports

Patients are treated according to the national TB guidelines, with DOT (directly observed therapy) playing an important role. With DOT, someone supports the patient by actually observing the drugs being taken daily. This is a cost-effective way of ensuring treatment compliance and helps to prevent multi-drug resistance (MDR). Average Tshwane district DOTS coverage has decrease from 88.8% to 84.7%. DOTS coverage exclude Odi subdistrict because no data was submitted.

The outcome reports of PTB patients indicate the success of the patients' treatment and cure. The health district's cure rate is 61%, and its average rate of successful treatment of all new smear positive cases is 66%. The treatment outcome is evaluated a year after a patient starts his or her treatment.

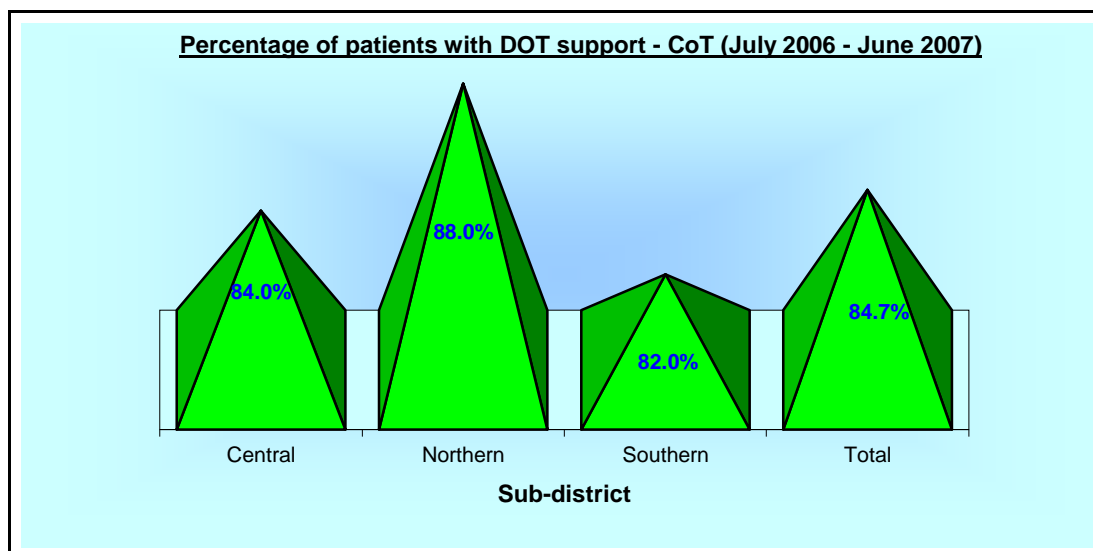


Figure 15: Percentage of patients with DOT support – Tshwane (July 2006 – June 2007)

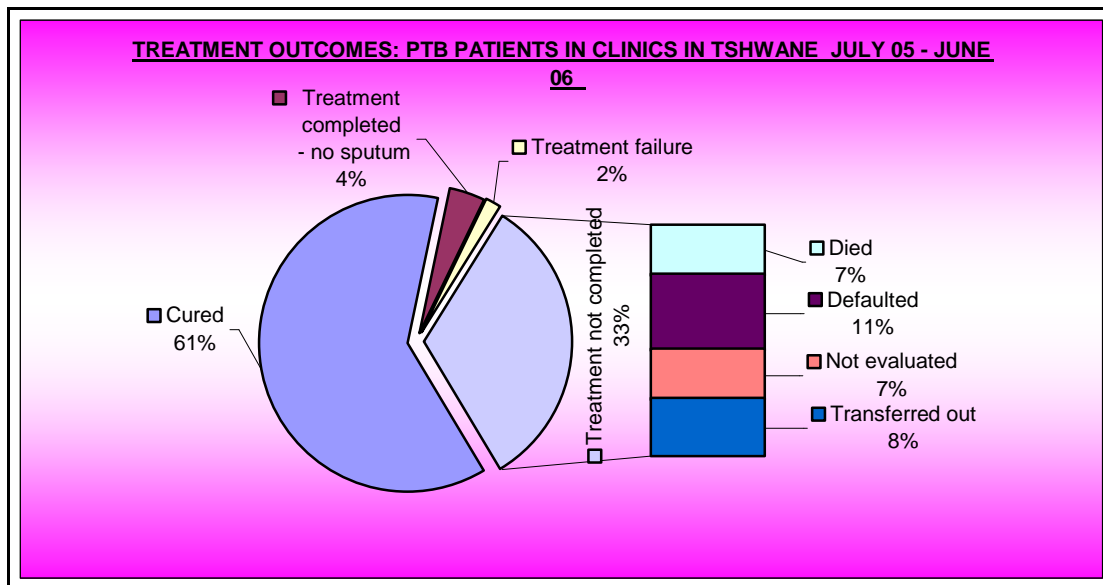


Figure 16: Treatment outcomes – PTB patients in Tshwane clinics, excluding Odi subdistrict

3.5.5.4 Sputum conversion

A PTB patient with initial smear-positive sputum should convert to smear-negative within two months of the start of the treatment. Sputum conversion confirms that the patient is susceptible to the TB antibiotics and is no longer infectious. If the patient does not convert, the sputum is tested for sensitivity to the TB antibiotics to exclude MDR. Compliance with standard treatment is very important to avoid MDR. Standard treatment for susceptible TB patients costs about R400,00 per patient, but from R27 000,00 to R30 000,00 per MDR patient, with XDR costing +R600 per patient. Turnaround times for sputum specimens during the year under review were relatively satisfactory.

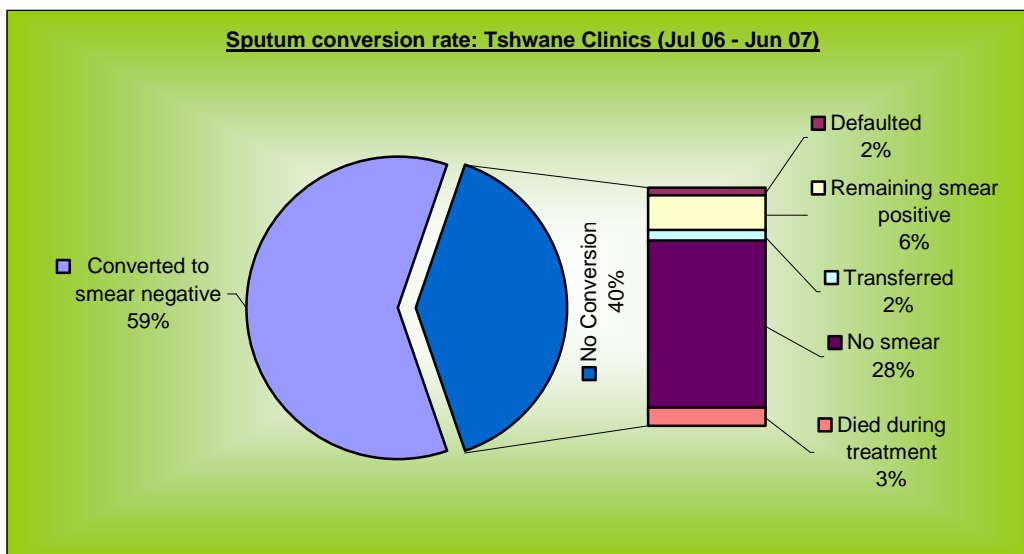


Figure 17: Sputum conversion rate: New smear-positive patients in Tshwane (July 2006 – June 2007)

3.5.5.5 Multi-drug resistance centre

The MDR centre at the Folang Clinic serves as an outpatient service point for the Tshwane area. The treatments are packed per patient at the Sizwe Tropical Hospital. This centre serves the Gauteng area of Tshwane and is part of the DOTS-PLUS national TB research study of the Medical Research Council. The clinic that refers the patient handles the DOT and sputum follow-ups of the patient. 101 MDR TB cases excluding 19 MDR TB patients admitted in Pretoria West hospital and 11 XDR TB cases were diagnosed and treated at the Sizwe Tropical Hospital during the period under review.

3.5.5.6 Coordination of TB services

Communication and coordination take place through quarterly provincial and regional TB meetings with all managers and TB service point staff.

Weekly consultations are undertaken by the Municipality's doctors and nurses at provincial hospitals and at private hospitals if needed. The TB and infection control staff remain in regular contact with the infection control staff of hospitals in Tshwane, both directly and through the region's infection control forum.

TB focal points have been identified so that a system for referring patients to TB clinics is in place and so that there is continuity in the treatment of TB patients. The following hospitals have such points: George Mukhari Hospital, Pretoria West Hospital, Kalafong Hospital, Tshwane District Hospital and Mamelodi Hospital.

3.5.6 Notifiable medical conditions

Cases of notifiable medical conditions in Tshwane are handled by the communicable disease coordinators.

3.5.6.1 Prevention of the spread of notifiable medical conditions

Follow-up are done and investigations are carried out by community health nurses who also administer prophylactic medication where indicated.

Environmental health practitioners are also involved in the investigation of all environmental-related notifiable medical conditions cases such as malaria.

3.5.6.2 Reporting of notifiable medical conditions

Weekly reports on notifiable medical conditions and investigations are forwarded to the provincial and regional offices. Reported cases of notifiable medical conditions outside the Tshwane area are reported to the appropriate authority for further investigation and a follow-up.

3.5.6.3 Notifiable medical conditions reported

Table 9: Notifiable medical conditions reported

NOTIFIABLE MEDICAL CONDITIONS				
July 2006 to June 2007				
Conditions	Central	Southern	Northern	Total
AFP – Acute flaccid paralysis	8	2	6	16
A48 – Legionellosis	2	0	1	3
B54 – Malaria	114	5	17	166
B05 – Measles	0	0	0	0
A39 – Meningococcal infection	14	0	2	16
T57 and T60 – Poisoning (agricultural stock remedies)	30	0	7	37
A80 – Poliomyelitis	0	0	0	0
A82 – Rabies	0	0	0	0
I00 – Rheumatic fever	1	0	0	1
A35 – Tetanus	1	0	0	1
A71 – Trachoma	0	0	0	0
A16.7 – Tuberculosis (primary)	308	27	105	440
A16.2 – Tuberculosis (pulmonary)	2967	319	674	3960
A16.9 – Tuberculosis (other respiratory organs)	371	39	71	481
A17.0 – Tuberculosis (meningitis)	101	5	20	126
A18.3 – Tuberculosis of intestines and peritoneum	8	0	6	14
A18.0 – Tuberculosis of bones and joints	17	1	4	22
A18.1 – Tuberculosis of genito-urinary system	5	0	1	6
A18.8 – Tuberculosis of other organs	200	15	65	280
A18.9 – Tuberculosis (miliary)	214	17	31	262
A16.3 – Tuberculosis (lymph nodes)	0	0	0	0

NOTIFIABLE MEDICAL CONDITIONS				
July 2006 to June 2007				
Conditions	Central	Southern	Northern	Total
A01 – Typhoid fever	2	0	1	3
B15.9 – Viral hepatitis A	107	0	9	126
B16.9 – Viral hepatitis B	28	2	3	33
B17.8 – Viral hepatitis C	5	2	0	7
A37 – Whooping cough	2	0	0	2

Table 9 shows all reported Notifiable Medical Conditions for Tshwane District, excluding Odi subdistrict for the period under review, July '06 to June '07

3.5.7 Responding successfully to HIV and Aids

3.5.7.1 HIV and Aids programmes

The four major HIV-related services available in the public health sector are the voluntary counselling and testing (VCT) programme, the prevention of mother-to-child transmission (PMTCT) programme, the antiretroviral treatment (ART) referral programme and the post-exposure prophylaxis (PEP) follow-up service.

Voluntary counselling and testing

Any member of the public can receive free voluntary HIV testing and counselling at any of the clinics in Tshwane. The HIV-positive rate for clients over the age of five (excluding TB and antenatal clients) decreased from 31% to 30% during the year under review.

In all, 46 783 clients in this category were tested compared with the 35 217 tests of the previous year, indicating a 33% increase. The HIV-positive rate for children under five decreased to 10.5%, the previous year was 34.6% indicating 24% decrease, decrease may be attributed to special programmes such as PMTCT etc.

Antiretroviral treatment

ART is part of the government's operational plan for the comprehensive care and treatment of people living with HIV and Aids. The ART programme was started in April 2004 and was rolled out at hospitals only, since the management of ART is not easy and demands strict adherence by and the proper management of the patient.

The ART referral programme has been introduced at all the clinics of the Municipality. The municipal PHC clinics do the initial assessment of both adults and children and refer them to a hospital site. Patients who are older than six and who have a CD4 count of less than 200 cells/mm³ are considered to be severely immune-compromised and qualify for ART. The qualifying criterion for children under 18 months is a CD4 count of less than 20%, and for those over 18 months it is a count of less than 15%.

Since the start of the programme, 17 045 patients have been assessed by the clinics of the Municipality, and 14 093 CD4 counts of HIV-positive patients have been done. The percentage of patients with CD4 counts of less than 200 has decreased from 28% to 25%, which indicates the success of the programme.

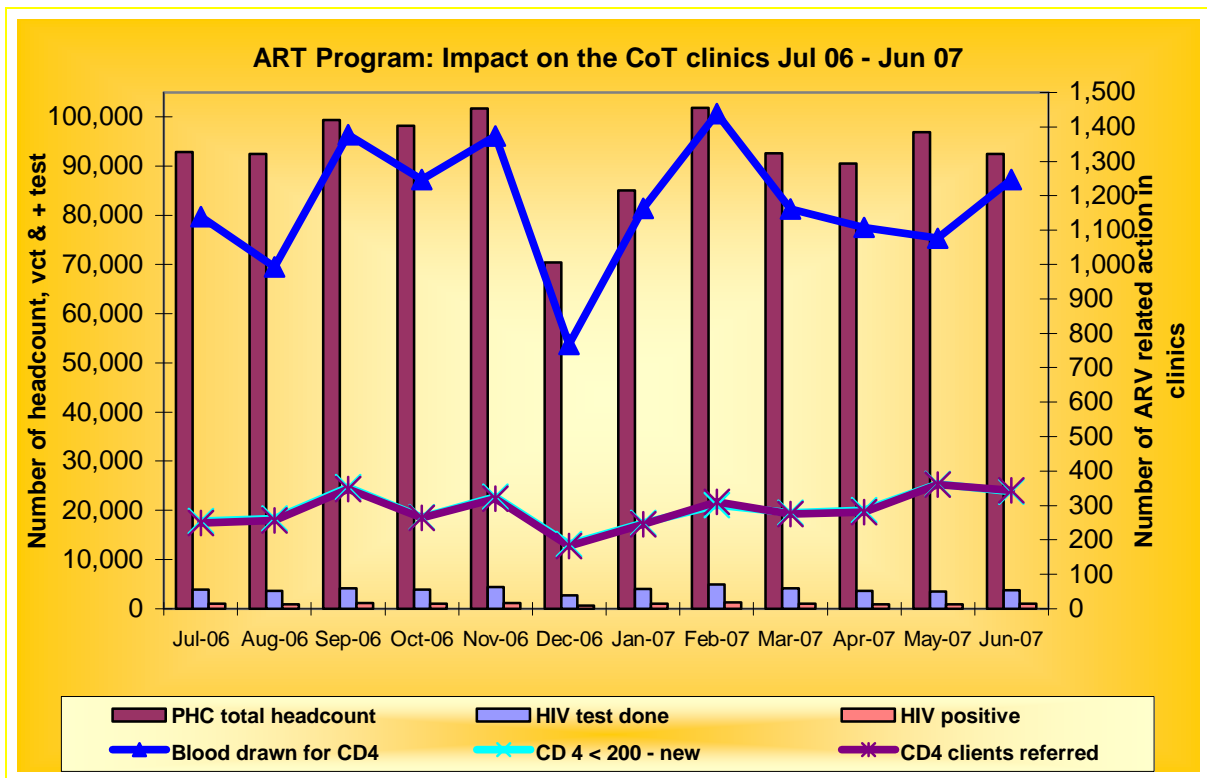


Figure 18: ARV programme: CoT clinics (July 2006 – June 2007)

Prevention of mother-to-child transmission

The prevention of mother-to-child transmission (PMTCT) service was rolled out in November 2003, and voluntary counselling and testing are available to all pregnant women visiting antenatal clinics in the public health facilities in Tshwane. The number of PMTCT sites is being increased incrementally; 90% of all facilities in the Gauteng part of Tshwane now offer the service (97% of the Municipality's clinics provide a PMTCT service). The facilities that do not provide the PMTCT service refer their pregnant HIV-positive clients to the nearest PMTCT site for further management.

The percentages in respect of facilities in the Tshwane district that render the PMTCT service are as follows: Central: 85%; South: 100%; North: 64% and Odi: 100%. Special attention should be given to improving access to this important service in the northern subdistrict.

A total of 26,398 antenatal clients were tested for HIV during the year under review, and 24% of them tested positive. HIV-positive women receive counselling on the advantages of nevirapine treatment, which reduces the chances of the transmission of HIV from mother to child. Mothers are also counselled on safer feeding options after delivery, and Pelargon is supplied if the mother prefers bottle-feeding.

Post-exposure prophylaxis follow-up service

All rape victims (men and women aged 14 years or older) should be counselled and examined at a specialised crisis centre. There are four dedicated provincial crisis centres in Tshwane: the Laudium Community Health Centre, the Mamelodi Hospital, the Tshwane District Hospital and the Soshanguve Community Health Centre. Services at these centres include ARV therapy and counselling. If a patient consents to taking prophylactic ARV therapy, treatment is initiated at the crisis centre, and the patient is referred to the nearest local clinic for further treatment and follow-ups.

3.5.7.2 Tshwane Aids Unit

Vision: An empowered community coping with the challenges of HIV and Aids.

Mission: To be a Unit of excellence that will ensure a multisectoral, coordinated and integrated response by empowering the community of Tshwane to:

- Reduce new HIV Infections
- Increase the length of productive life for those infected with HIV
- Support children and families affected by Aids to live normal lives in order to reduce the socio-economic impact of Aids on the community of Tshwane

Background:

The Aids Unit is responsible for the management of the Aids Programme on a facilitating level and focuses mainly on the multisectoral response of all role players, in an integrated and coordinated way.

Table 10: Tshwane Aids Unit priorities

Priorities: (External)	Priorities: (Internal)
Youth	HIV/Aids Workplace Programme
Women	Mainstreaming of HIV and Aids in service delivery
Transport industry	
Migrant workers	
Business sector	
Immigrants	
Men as partners	
Traditional healers	
Religious sector	
Youth	

3.5.7.3 Tshwane Aids Strategy

An updated HIV/Aids Strategy will be completed by 30 August 2007. The Tshwane Aids Strategy comprises 4 Pillars of management, namely:

Pillar 1: Effective management and financing structures, systems and processes

Pillar 2: Effective HIV/Aids services to the local communities

Pillar 3: Multi-sectoral solutions and the coordination and integration of the external parties' response to the pandemic

Pillar 4: Managing the impact of the pandemic on the Municipality itself through employee programmes in order to minimise the impact of the pandemic on the Municipality's ability to render services

Integration Strategy

- Every year the Department of Education and the Aids Unit take part in a partnership event. In August 2006 the Aids Unit jointly hosted a Women's Day conference and focused on the youth. Secondary school learners (girls) took part in poetry and prose competitions. The theme was "The celebration of women". Different aspects of identity, roles, responsibilities, challenges and dreams of young women were addressed. 297 Learners and educators attended the conference.

3.5.7.4 HIV/Aids Workplace Programme

- OCSA (Occupational Care South Africa) has been appointed in February 2007 to render an HIV/Aids Employee Support Programme until June 2009 and it includes:
 - Industrial theatre
 - Information sessions
 - Comic book, posters
 - Aids Advice electronic programme
 - Personal health line
 - Training of peer educators
 - Training of CoT managers
 - Confidential voluntary counselling and testing (VCT)
 - Psycho-social support
 - Disease management
- Three Peer educator seminars were hosted by the Aids Unit to render support to the Departmental Representatives and Peer Educators
- An amended HIV/Aids Workplace Policy has been approved

As from the beginning of March'07, a Personal Health Line is available to all employees. Any health related information can be obtained on a 24/7 basis. **The number is 0860 454 454.** Twenty new peer educators have been trained in May. A refresher course was presented to all CoT peer educators during the last peer educator seminar in June'07.

Voluntary Counselling and Testing for HIV (VCT) sessions have been arranged by several departments at different workplaces. The VCT is done on an appointment basis. There is also the option that employees can get an authorization number from OCSA to go for VCT at a private pharmacy of their choice, should they prefer to test off site. **(OCSA VCT line: 0861 105 877)**

For clients that test positive, counselling sessions are being arranged by professional social workers to ensure the necessary psychosocial support. Employees are being supported to manage their disease by guiding them and arranging further professional care, either through their medical aid or public health services.

3.5.7.5 Prevention and Care

- Capacity Building programs planned regarding HIV/AIDS for different categories for women, youth, disabled, commercial sex workers, men, immigrants were all achieved and in some cases more than what was planned.
- Support groups have been established in the vicinity of 18 of our clinics were HIV positive clients could be referred for continuity. Programs planned for enriching the support groups have been achieved by 100%.
- Two main events on our calendar have been done that is World AIDS Day in Hammanskraal and Candle Lighting Memorial in Atteridgeville with success. The World Aids Day event was preceded by a door-to-door campaign that commenced on 27 November 2006 and ended on 1 December. A total of 2166 volunteers including 25 migrants and 8 commercial sex workers, reached 307, 669 people.
- Children's Tile Projects: joint intervention by the Aids Unit and Arts and Culture at the Pretoria Art Museum for orphans was held during the period 14 November to 1 December 2006 as a build-up activity to World Aids Day
- Family Fun Run on 26 November 2006 at Pilditch Stadium to render support to the infected and affected.
- Five sessions of training programs offered to professionals on VCT, HIV counselling and basic facts were reached for this financial year. Support for the 16 Days of Activism event.



Dr Flavia (without a hat) intern M.Med student from the University of Pretoria with volunteers during HIV/AIDS awareness door to door campaign 2006.

Information Sessions: A total of 2303 people attended the 22 sessions held.

Training: A total of 485 people were trained during 25 training sessions.

Funded project for service providers: In addition to other capacity building interventions, a specific programme was rendered to assist the establishment of support groups.

Exhibitions: Exhibitions were staged at many events held in different parts of Tshwane, for example the candle-lighting memorial services; events commemorating Condom Week, and Youth Month. Exhibitions were also held at Schools, Taxi Association and at the malls.

Counselling: Clients still come to the Aids Unit seeking specialised counselling, despite there being a decentralised VCT programme. During the year under review, 220 clients were assisted.

The World Aids Day event was held at Temba, Hammanskraal, where the City of Tshwane Executive Mayor, Dr Gwen Ramokgopa and Ms Sonto Thipe, MMC for Health and Social Development delivered the keynote address. The programme was in three phases namely:

- Recreational games for children
- Formal programme
- Informal programme

3.5.7.6 Candle-lighting memorial services

The candle-lighting memorial service was decentralised, with the main event being held at St Pauls Anglican Church in Atteridgeville. The keynote address was delivered by MMC Sonto Thipe (Health and Social Development). Other candle-lighting memorial services were also held in Laudium, Olievenhoutbosch, Winterveldt Multipurpose Centre, Sediba Hope in Inner City and Soshanguve Block L.



(L to R) Ms Sonto Thipe, MMC for Health and Social Development Department and Ms Mottalepula Mofokeng, Deputy Manager: Aids Unit, delivered speech during the annual Candle-lighting ceremony held at Atteridgeville

3.5.7.7 Sport Heroes Walk Against Aids

- Objectives of the Event was to reach people through sport to change HIV/Aids risk behaviour and promote healthy living.
- South African sport personalities and SABC sport presenter, Cynthia Tshaka use sport as a tool to create awareness on HIV and Aids and raise funds to alleviate the suffering of children affected by or infected with HIV.
- The 2006 walk was undertaken from Gauteng to Mafikeng in North West. On Friday, 24 November 2006 the programme was launched at 10:00 at Daimler-Chrysler in Centurion. On Saturday, 25 November 2006 the athletes gathered at Church Square in Tshwane where they met with the Aids Unit and other role players. Morning Live covered the gathering.
- The Tshwane HIV/Aids Door-to-Door Campaign which started on Monday, 27 November 2006 across Tshwane was also promoted during that morning. At 8:00 the athletes started the walk from Church Square, along Church Street.
- A short sport/activity programme was hosted for children at Moroe Park, Moroe Street in Atteridgeville (by the Gauteng North Sport Council, assisted by the Sport and Recreation Section of Educational Service). The athletes arrived in Mafikeng on Friday 1 December 2006. This event strengthened the Aids Programme in Tshwane and was meaningful in the build-up to World Aids Day.



Executive Mayor, Dr Gwen Ramokgopa (with yellow cap) during the Sport Heroes walk against HIV/AIDS, from Church Square to Atteridgeville

3.5.7.8 Multisectoral Seminars

During the first meeting of the HIV/Aids Multisectoral Task Team on 15 February 2006 it was decided to have a six-monthly meeting / seminar to:

- To share information on programmes and plans
- To strengthen collaboration between sectors
- To share best practice models
- Share information from the sector (e.g. research findings on the health status in Tshwane)
- To debate issues

It was also agreed during the meeting that all departments/sectors functioning in Tshwane should take part in this opportunity to ensure a coordinated and integrated response to HIV and Aids.

The seminar which took place on Thursday, 21 September 2006, at 9:00 in the Sammy Marks Conference Centre, Vermeulen Street, Pretoria, was attended by 21 people from 9 organisations/departments.

The following sectors were invited to present their programmes:

- Department of Agriculture
- Department of Housing
- Department of Education
- City of Tshwane Metropolitan Municipality
- NGO (one organisation)
- Religious sector (one programme)

Due to the absence of some, only the following presentations were made:

- Department of Agriculture, Conservation and Environment
- Tshwane Aids Unit (focussing on World Aids Day 2006)
- Provincial Hospice Palliative Care Association

Fruitful discussions followed after the presentations and great interest was shown in the programmes. The next multisectoral seminar was held on 11 May 2007 and aimed at trauma with consequent risk of HIV infection and therefore focused more on the sectors rendering services in this field. It is still multisectoral, since the management of victims of such trauma requires disciplines across the spectrum of sectors.

Needs:

Many delegates from the first conference indicated that they wanted to take part in the next conferences. Other indicated that they have a sense of belonging to the Tshwane AIDS Program because of the conference; others expressed their disappointment that they could not attend, and requested to be involved in the following events.

Service providers in the field of trauma experience the lack of coordination, cooperation, communication, skills and resources. The effect thereof ranges from poor service delivery, frustration between service providers, confusion on the scope of services, deteriorating relationships between service providers, competition for resources and ultimately added trauma for the victim (often referred to as "secondary trauma"). A seminar to bring the stakeholders together could bridge some of these obstacles.

Invitations were sent to many service providers and programme managers and the response was overwhelming. A total of 80 delegates were expected, but 130 turned up, which can be an indication of the need for such an event.

Aim of the seminar:

- To strengthen the linkages and responses between the multisectoral partners in the fight against HIV and Aids focusing on trauma with consequent risk of HIV infection

Objectives:

- Sharing information on services, challenges and best practices
- Exploring opportunities to mitigate the impact of trauma
- Networking and partnerships between service providers in Tshwane

Presentations:

The following sectors and service providers rendered presentations on the work they are being doing, the challenges, needs and experiences:

- The Tshwane Aids Programme
- A medical doctor in practice
- South African Police Service
- Laudium Community Health Centre
- Human potential development network
- Inter Trauma Nexus

3.5.7.9 Funding of NGOs working in the field of HIV and Aids

Seven (7) NGOs have been selected to render HIV/Aids and related services in Tshwane. Funding has been provided by DLG for this purpose and these projects will be running from 1 July 2007 to 30 June 2008.

Guidelines were developed to support the processes involved in selecting the seven NGOs and a monitoring and evaluation tool will ensure the effective execution of the projects.

MMC SS Thipe, MMC for Health and Social Development, handed the cheques that amounted to R1 655 600.00 to the NGOs at a ceremony in the Sammy Marks conference Centre.

3.6 EMPOWERING THE COMMUNITY

3.6.1 Community participation

Getting communities to take ownership and control of their own health and destiny remains a huge challenge. Social, economic and political factors influence their choices and their commitment to planning ways of achieving better health and improving wellness. Progress with the formation of ward health sub-committees in all wards remain a challenge. Communities are however being educated constantly on health matters in various ways. Due to severe personnel and other resource shortages it is imperative that we combine our efforts in improving the health of all in Tshwane. Therefore communities, NGOs, CBOs, churches, schools, national and provincial government departments are invited to participate in the Municipality's health promotion area programmes. Pharmaceutical companies and private health institutions are also willing to participate in community programmes that will benefit the communities.

3.6.2 Community empowerment

Through community empowerment programmes, members of the community learn how to prevent diseases, improve quality of life despite chronic illnesses, and live healthy lifestyles. The Tshwane Municipality and Gauteng Provincial Health Department community empowerment efforts during the year under review include the following:

- Communities were regularly informed of services that are available to them through the printed media, community radio stations, and imbizos in various areas. Health expos were held in the Olievenhoutbosch and Atteridgeville areas.
- Various learning opportunities were created in different parts of Tshwane throughout the year to empower and enable the communities to make healthy choices and choose healthy lifestyles. Information about tuberculosis, hypertension, diabetes mellitus, child care, family planning, nutrition, etc, was conveyed. This was done through talks, exhibitions, training sessions and awareness events at places such as clinics, schools and libraries, targeting all of the community and sometimes specific community groups, e.g. women, children, youth or elderly people. All requests for health information were granted.
- To adhere to Black Economic Empowerment (BEE) procurement policy, new vendors were assisted to register for catering, drama groups and printing services. Up coming vendors are assisted in quality improvement of their product or services they render.
- Vegetable gardens at certain clinics, schools and in the communities provided for an income and improved the nutritional status of certain patients. Unfortunately there are not always enough space, personnel and other resources available to drive the projects.
- A total of 593 community volunteers, community health workers, DOTS supporters, and childminders were trained on TB, STI/HIV/Aids, VCT and Polio and measles in order to assist in the door-to-door campaigns and various other programmes. 25 childminders received training on IMCI and some crèches were visited and evaluated. Community health workers who are associated with NGOs in the communities are trained by Gauteng Provincial Government and also assist with some of the projects. They are trained to be multi-skilled and receive a stipend from the provincial government that enables them to address health education needs in the clinics and in the community. However irregular payment of stipends pose to be a real challenge as the programmes and quality of services suffer when CHW do not turn up of duty
- Due to the fact that there are only three (3) health promotion co-ordinators and no health promoters in the municipal health services, the unit has to rely heavily on other human resources e.g. provincial health promoters, volunteers, community health workers and private providers to assist in addressing the health needs of the communities. The unit therefore has to be content to concentrate mainly on awareness and provide information without being able to properly assist people in making appropriate life style changes that will benefit their health.

3.6.3 Health promoting programmes launched

Real health needs of the people of Tshwane were addressed in a more comprehensive way.

Table 11: Health Promoting Programmes

Programme	Target Group	Area	Number of people reached
Women's Health	Women	Nellmapius Pretoria west Centurion	33,351
Child health <ul style="list-style-type: none"> • Paraffin safety talks • Baby competitions • Child protection awareness • IMCI training 	The community	Day care centres and Crèches: Mamelodi Atteridgeville Nellmapius Doornpoort Laudium	73, 061
Youth <ul style="list-style-type: none"> • Youth dialogue • Talks and awareness on: <ul style="list-style-type: none"> ○ STI and HIV/AIDS ○ Drug and substance abuse ○ Teenage pregnancy 	Youth and parents	Schools and communities: Marabastad, Mamelodi, Sammy Marks square and Atteridgeville Libraries: <ul style="list-style-type: none"> • Ladium, • Danville • Moot 	2, 897
STI and HIV <ul style="list-style-type: none"> • Door to door • Talks • Exhibitions 	The community	Clinics: Phomolong Lotus Gardens Olievenhoutbosch Pyramid Saulsville Laudium Lotus Gardens Danville, Wes Park Rosslyn East Lynne	30,795
Tuberculosis <ul style="list-style-type: none"> • Door to door • Talks • Exhibitions 	The community	Shopping mall and Taxi rank: Wierdepark Clinics: Mamelodi Nellmapius Eesterust East Lynne Inner city Danville Hercules Rosslyn Laudium Lotus Gardens Centurion	38, 982

Programme (continued)	Target Group	Area	Number of people reached
Hypertension awareness <ul style="list-style-type: none"> • Talks • Exhibitions • Screening 	The community	Mayville mall Clinics: Karen Park East-Lynne Pretorius Park Danville Atteridgeville Olievenhoutbosch Laudium Lotus Gardens	2,605
Healthy Lifestyle <ul style="list-style-type: none"> • Fun walk • Talks on: <ul style="list-style-type: none"> ○ Nutrition ○ Stress ○ Exercises ○ Smoking ○ Cancer ○ scabies ○ worm infestations ○ dental care 	The community	Clinics: Hercules Nellmapius Mamelodi Danville FF Rebeiro Pretorius park Rosslyn Karen Park, East-Lynne Centurion Laudium Lotus Gardens Atteridgeville	4,372

3.7 IMPROVING ENVIRONMENTAL HEALTH CONDITIONS IN TSHWANE

According to the World Health Organization, "In its broadest sense, environmental health comprises those aspects of human health, disease, and injury that are determined or influenced by factors in the environment." This includes the study of both the direct pathological effects of various chemical, physical, and biological agents, as well as the effects on health of the broad physical and social environment, which includes housing, urban development, land-use and transportation, industry, and agriculture

The environment has adverse impact of the environment on human health, therefore protecting the environment has long been a cornerstone of public health practices. National, provincial, and local efforts to ensure clean air and safe supplies of food and water, to manage sewage and municipal wastes, and to control or eliminate vector-borne diseases have contributed a great deal to improvements in public health in developed countries.

Environmental factors: physical, chemical and biological play a central role in human development, health, and disease. Broadly defined, the environment, including infectious agents, is one of three primary factors that affect human health. The other two are genetic factors and personal behaviour.

Human exposures to hazardous agents in the air, water, soil, and food and to physical hazards in the environment are major contributors to illness, disability, and death globally. Furthermore, deterioration of environmental conditions in many parts of the world slows sustainable development. Poor environmental quality is estimated to be directly responsible for approximately 25 percent of all preventable ill health in the world, with diarrhoeal diseases and respiratory infections heading the list.

3.7.1 Infrastructure and surveillance.

Preventing health problems caused by environmental hazards requires:

- Having enough personnel and resources to investigate and respond to diseases and injuries that can potentially cause environmental hazards.
- Monitoring the population and its environment to detect hazards, exposure of the public and individuals to hazards, and diseases potentially caused by these hazards;
- Monitoring the population and its environment to assess the effectiveness of prevention programs.
- Educating the public and select populations on the relationship between health and the environment.
- ensuring that laws, regulations, and practices protect the public and the environment from hazardous agents;

- o Providing public access to understandable and useful information on hazards and their sources, distribution, and health effects.
- o Coordinating the efforts of government agencies and nongovernmental groups responsible for environmental health; and
- o Providing adequate resources to accomplish these tasks. Development of additional methods to measure environmental hazards in people will permit more careful assessments of exposures and health effects

Table 12: MHS scope of work

Number	Scope of work	Workload	Workload accomplished
1.	Monitoring of premises	49 074	7600
2.	Sampling	781	781
3.	Handling of complaints	3395	3395
4.	Advisory service	2821	2821
5.	Source of communicable diseases investigated	10	10
6.	Seizure & food condemnation	22 733 495kg	22 733 495kg
7.	Handling of license applications	517	517
	Health education & community development	435	435
	Grand total	2 789 692	2 743 263

3.7.2 Investing in agriculture for food security

The project involved the celebration of world food day held at Bachana-Mokoena Primary School on the 20th October 2006 and all the tools that made it a success.

3.7.3 Training

Table 13: Training: Environmental Health Practitioners (EHP's)

Course Name	Date	Institution	Nominated	Attended	Completed	% Courses completed successfully
Occupational Health & Safety Training	12/07/06 & 14/07/06	AFRICON	64	52	52	100%
Game Meat Examiners training, practical examination	10/08/06	Tshwane University of Technology	4	4	3	75%
SAVIC Epidemiology Refresher Course	11/09/06-15/09/06	MEDUNSA	2	2	2	100%
New Way of waste disposal	14/11/06	OMB Waste Logistics (PTY) LTD	All	64	35	54%
EPI training	19/02/07-20/02/07	Gauteng Provincial Health Office	1	1	1	100%
SA Environmental Legal Requirements applicable to ISO 14001	16/04/07-20/04/07	SABS	1	1	1	100%
Understanding SABS ISO 14001	07/05/07-11/05/07	SABS	1	1	1	100%

Table 14: Training: Students

Institution	Field of study	Period for training	Number of student	Year of study
University of Johannesburg	Environmental Health	11/08/06 – 15/08/06	2	3
Tshwane University of Technology	Environmental Health	11/08/06 – 15/08/06	3	3
MEDUNSA	Medical Practitioners	25/08/06	45	2
MEDUNSA	Medical Practitioners	06/10/06	45	2
University of Pretoria	Medical Practitioner	02/10/06 – 07/10/06	1	6
University of Pretoria	Community Nursing	25/01/07 – 26/01/07	2	2
University of Pretoria	Medical Practitioner	07/05/07	1	6
SAMHS nursing college	Community Nursing	05/02/07 - 12/02/07	45	3
CUT, Free State	Environmental Health	11/06/07	1	2
Mangosothu Technikon	Environmental Health	25/06/07	1	1
University of Johannesburg	Environmental Health	25/06/07	2	3
City of Johannesburg	Community Nursing	25/06/07	1	1

3.7.4 Events management

Arbor day

Arbor day 2006 was celebrated by the Environmental health section of health services in the City of Tshwane Metropolitan Municipality, under the theme “**Plant a tree- Grow our future**”.

National Water Week

The Department of Water Affairs and Forestry as water sector leader and custodian of our country’s water sources, is responsible for co-ordinating the National Water Week celebrations annually. National Water Week is a significant awareness week whereby the messages of using water wisely, the need for sustainable management of our water resources and the role of water in hygiene matters are communicated to the people of South Africa.

The theme for 2007 celebration is “**Water is life – Protect our scarce resources**”. As we all know, water is necessary for all aspects of society that is, it has a direct link to health and hygiene. One of the objectives is to promote health awareness in the community on land, air, soil and water pollution including sanitation issues.

Tobacco Day

World No Tobacco Day is celebrated on an annual basis on 31 May internationally. The Environmental health section celebrated this day by means of an awareness campaign for all the Departments in CoT. The event took place on 30 May 2007 and the activities comprised of presenters and exhibitions in the Library Hall, Sammy Marks Conference centre. The theme for this year’s event was: “**SMOKE- FREE ENVIRONMENTS**”

World Environment Day

Although World Environment Day is commemorated, internationally, each year on 5 June, the Environmental health section of CoT commemorated the event on 7 June 2007. Although the International Theme for 2007 was: “**Melting Ice-a Hot Topic?**” the Environmental health section in CoT focused on “**Climate change and Global warming**”. The prize giving event took place on 7 June 2007, at the Pretoria Art Museum. The winners from all 5 schools were awarded with certificates and prizes consisting of a portable radio CD player and a stationery pack filled with art equipment. All the schools received fully equipped first aid kits, as well as a laminator. The overall first, second and first prize winning schools received a computer and printer.

3.7.5 Sampling management

One of the Aims with the sampling program of the Environmental health section in the City of Tshwane is to ensure safe and healthy food supply and the production thereof, as well as the monitoring of water for potable use and the monitoring of rivers and streams for vibrio cholera. Food sampling therefore, forms an integral part of law enforcement in CoT and can provide useful information to help effective enforcement of the Foodstuffs, Cosmetics and Disinfectants Act, Act 54 of 1972.

The same principal applies to water sampling, where early detection and investigation of water contamination forms an integral part of effective disease surveillance and the implementation of control measures.

3.7.5.1 Food samples analysed (Agriculture Research Council Laboratory (ARC))

Table 15: Food samples analysed at ARC

SURFACE SWABS			
Period	Total Samples taken	Total complying with the standard	% of samples complying to the standard
July 06 - Sept 06	78	46	59%
Oct 06 - Dec 06	215	110	51%
Jan 07 - Mar 07	243	148	60%
Apr 07 - Jun 07	223	162	73%
Jul 06 – Jun 07	759	466	61%
ANALYSED AT ARC			
Period	Total Samples taken	Total complying with the standard	% of samples complying to the standard
July 06 - Sept 06	27	18	66%
Oct 06 - Dec 06	15	3	20%
Jan 07 - Mar 07	12	7	58%
Apr 07 - Jun 07	17	6	35%
Jul 06 – Jun 07	71	34	48%

3.7.5.2 Water Quality Monitoring

Table 16: Water samples analysed at ARC

Period	Total Samples taken	Total complying with the standard	% of samples complying to the standard
July 06 - Sept 06	7	3	43%
Oct 06 - Dec 06	84	35	41%
Jan 07 - Mar 07	105	39	37%
Apr 07 - Jun 07	101	38	38%
Jul 06 – Jun 07	297	115	39%

3.7.5.3 Food safety strategy

The challenge regarding the developing of a food safety plan for the Soccer 2010 tournament still continuous and various new drafts has been developed. The food safety strategy is currently being combined with the "Accommodation strategy" of Environmental health in order to streamline the process. A total of 8 SANS documents of the SABS regarding food safety were scrutinized and comments delivered to the relevant SABS technical committee. Two reports with recommendations regarding food samples were submitted in the financial year and audit reports from the Research and Development section of CoT were scrutinized.

Four introduction permits for milk and milk products have been handled off. A computer course (Excel) was attended in the financial year and the knowledge is being utilized in statistical analyses of food samples. Training regarding food poisoning were given to newly appointed Environmental Health Practitioners. Several queries were handled to prospective food manufacturers and members of the public."

3.7.6 Noise control

Background

A noise management policy was developed and approved by Council in 2004. As part of the mentioned policy objectives, a noise management system was developed for the CoT's in order to manage and control noise and to set acceptable noise impact criteria for the CoT. This system is the only of its kind in SA and is the front runner for all other Metros in SA with regards to noise management and noise control.

Noise management strategy

The Environmental health section has developed and finalized a Noise management strategy during the 2006-2007 financial year. The aim of the strategy is to ensure the implementation of a holistic approach to control all aspects of noise which have the potential to adversely affect the well-being of the general public, groups and individuals who live, work and undertake recreational activities in the City of Tshwane.

The main objectives of the noise management strategy are:

- To legalize the designated zone sound levels standards for specific homogeneous land uses and for specific times.
- To train Environmental Health Practitioners with regards to the evaluation of noise scoping reports, building plan evaluation with regards to noise, noise measurement and the handling of noise complaints. To identify a procedural framework by means of which to rectify existing noise problems identified in the CoT.
- To identify the necessary internal procedures within all of the departments of the Council which need to be tasked with aspects of noise management and control and to identify inter-departmental procedures necessary for the effective liaison between all affected departments.
- To develop a joint Standard Operating Procedure in collaboration with the Metro Police department with regards to the handling of noise complaints.
- To upgrade appropriate noise level standards for all relevant land use/activities situations in the CoT as one of the essential control mechanisms for ensuring a suitable noise climate in its area of jurisdiction.

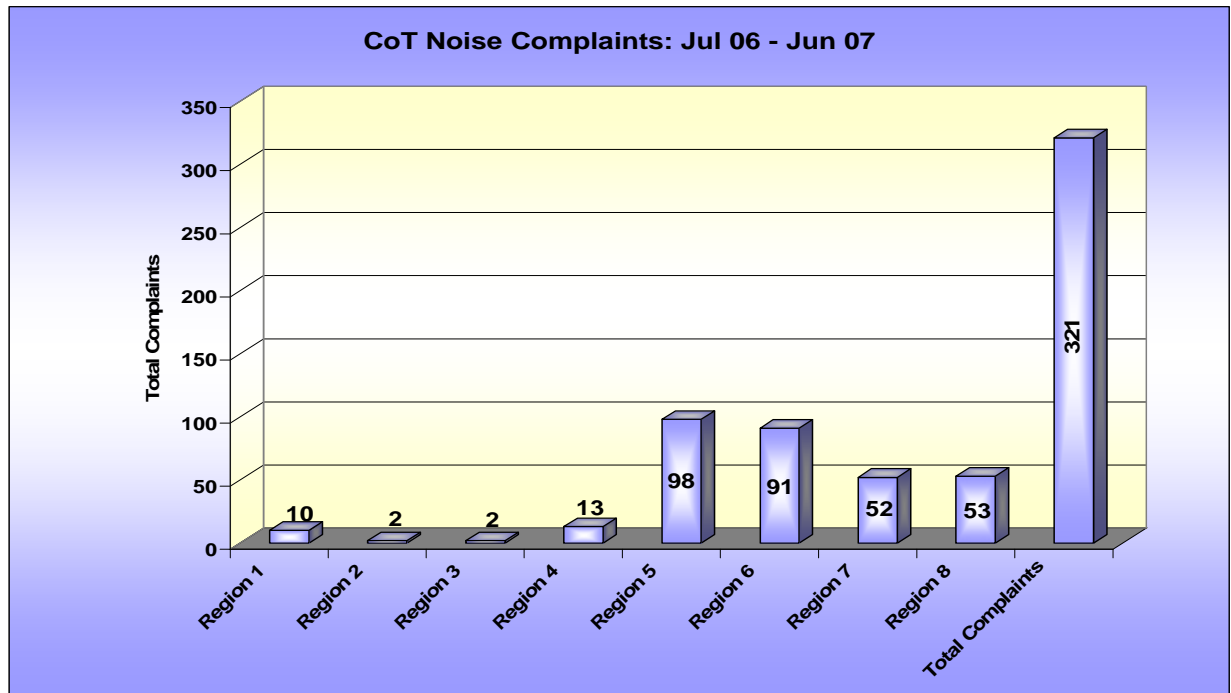


Figure 19: CoT Noise complaints

3.7.7 Information Services

Zero Carbon City Initiative

The City of Tshwane Environmental health in partnership with the British Council of South Africa and Tshwane University of Technology held the most successful exhibition of the Zero Carbon City programme in the City of Tshwane as from 2-14 October 2006.

Zero Carbon City is a global British council campaign to raise awareness and stimulate debate regarding climate change and energy challenges facing the great cities of the world. The aim thereof is to raise awareness and increase participation from communities, stakeholders and other organisations.

The exhibition was open on a daily basis and hosted visitations by schools, educators, youth and members of the community from within the City of Tshwane. Visitors to the exhibition were engaged in seminar discussions, conversations and pledges whilst using the exhibition to further enhance their knowledge regarding the impact of climate change. Other organizations such as non-governmental organizations, environmental activists, local government officials and other interested parties also participated in the event.

3.7.8 Environmental Health Outreach Programme

Exhibitions

The establishment of the Environmental health outreach programme late in October 2005 has yielded positive results in securing sustainable relationships. The City of Tshwane Environmental health Unit played a massive role in the marketing and promotion of environmental health through participation in the following initiatives:

Municipal collaborations

In addition to the abovementioned premiere events, the unit has assisted officials from two local municipalities namely; Kungwini and Emfuleni with the development of their Environmental health marketing and communication strategies.

Our active involvement in the municipal collaboration between City of Tshwane and Maasmechelen municipality has created opportunity for sharing of best practices through exchange study visits to Belgium.

Publications

In addition to numerous environmental health related articles that were published in several newspapers, the unit managed to be subscribe to two very important publications:

Milk and Juice (M & J) newsletter

This publication is targeted at the food industry, in particular the milk and juice producers. A detailed article on the Role of EHP in the food industry by Mrs Lizelle Van Niekerk was published in the magazine.

Enviro Health Vision

This Environmental Health newsletter is compiled by the Gauteng Environmental Health Directorate and aims to empower EHP's throughout the province. A total of six articles from the City of Tshwane Environmental Health Practitioners were submitted and published.

3.7.9 Management Information system statistics

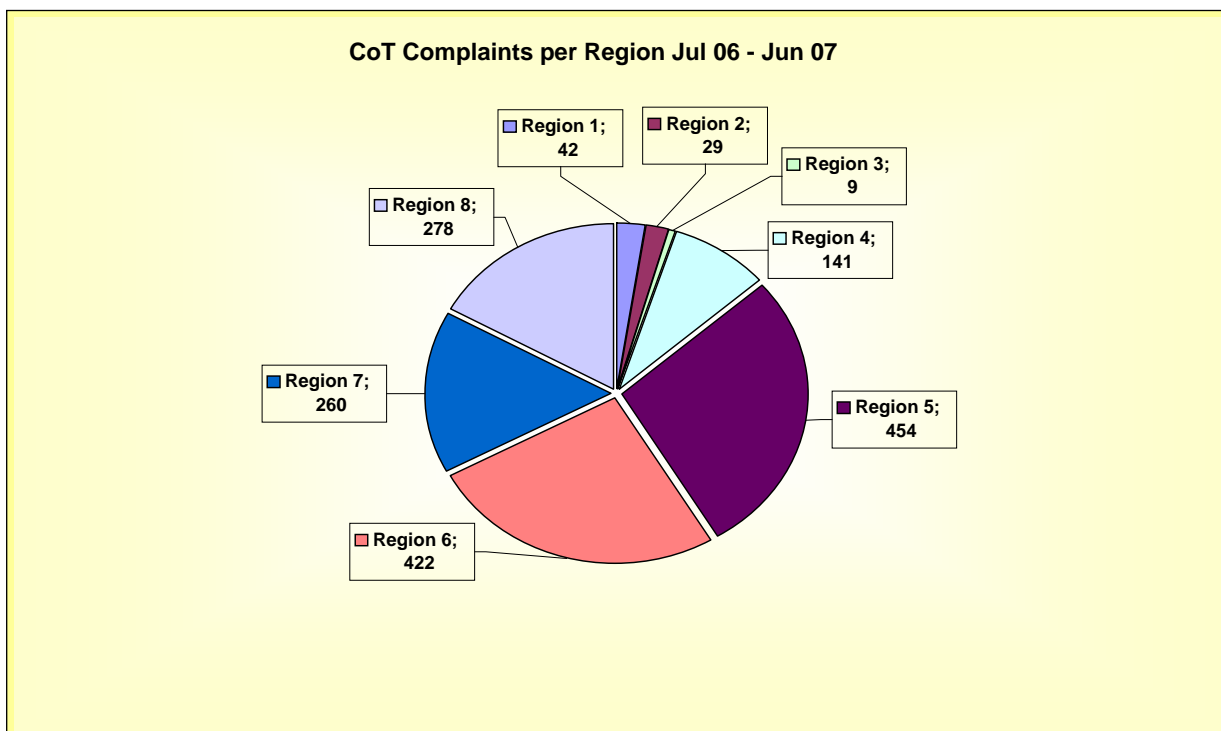


Figure 20: Complaint per region

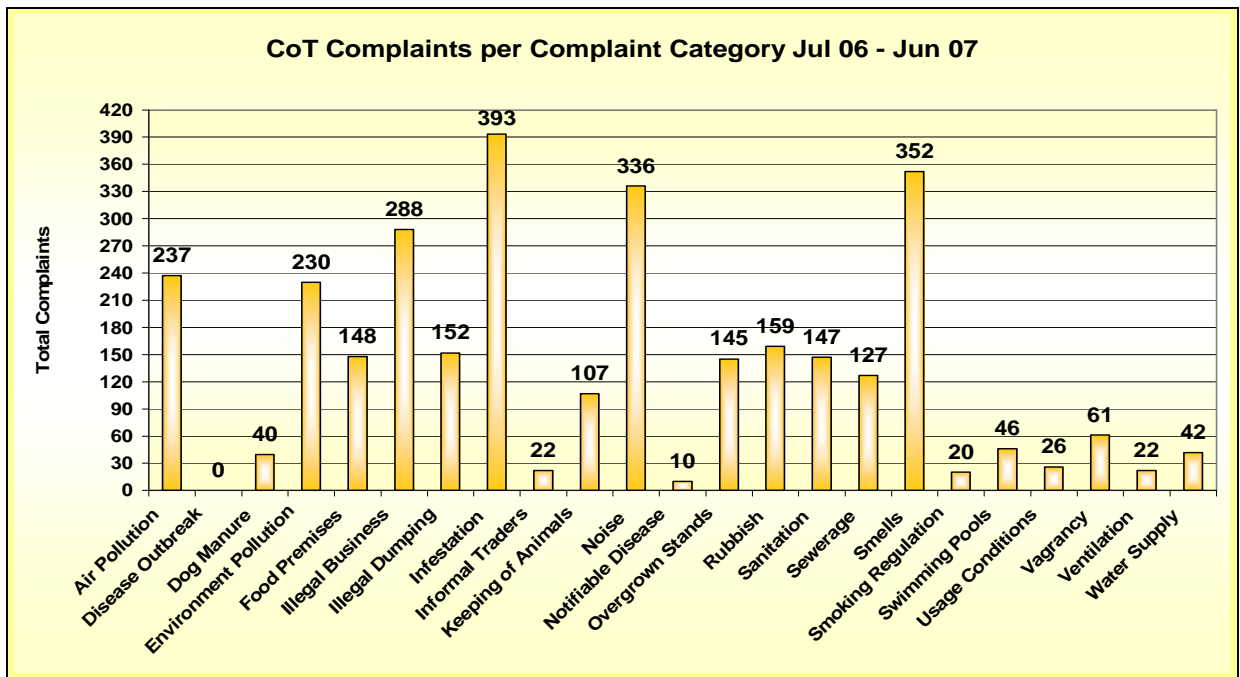


Figure 21: Complaint per complaint category

3.7.10 Law Enforcement

Fines

A fines structure for provincial and national legislation applicable to environmental health enforcement was developed and the fines were to be submitted for approval in the first quarter of the new financial year. Environmental health practitioners were registered on the Tshwane Metropolitan Police Trafman System and were issued with section 56 notice books for issuing spot fines.

Legal Training

After the section 56 notice training was completed, additional workshops were held to refresh the environmental health practitioners' knowledge.

By-Laws

The review of the four Health bylaws is underway and the draft by-laws will served before Council in the first quarter of the new financial year. The Municipal Health By-Law has been completed and will also serve before Council in the first quarter of the new financial year.

Vector Control

The Vector Control Strategy for the City of Tshwane was approved by Council. A rodent control project was held from 9 October 2006 to 1 December 2006 in Atteridgeville Ward 71 and Olievenhoutbosch Ward 48. The project was successful 20 workers and 2 supervisors from the community assisted in the project. In the project the methods used to eradicate rodents in the 2 areas are snap traps and rodenticides placed in bait boxes:

- o 230 Kilograms of rodenticides have been used.
- o 1650 Bait boxes have been used.
- o 1010 Snap traps have been used.
- o 2441 Rodents have been killed.
- o 2300 Houses have been monitored.

3.7.11 Environmental Health Programmes

Air Quality, Sustainable Energy and Climate Change Management

The City of Tshwane's Air Quality Management Plan (AQMP) was approved on 15 September 2006 by the Mayoral Committee and was to be used as a performance-monitoring tool for air quality control and as a basis for assessing air quality issues in Tshwane. Careful consideration was given to the monitoring objectives, the parameters to be monitored and the locations of the stations. The plan addresses various categories of air pollutants, including toxic and odoriferous substances, greenhouse gases and ozone-depleting substances.

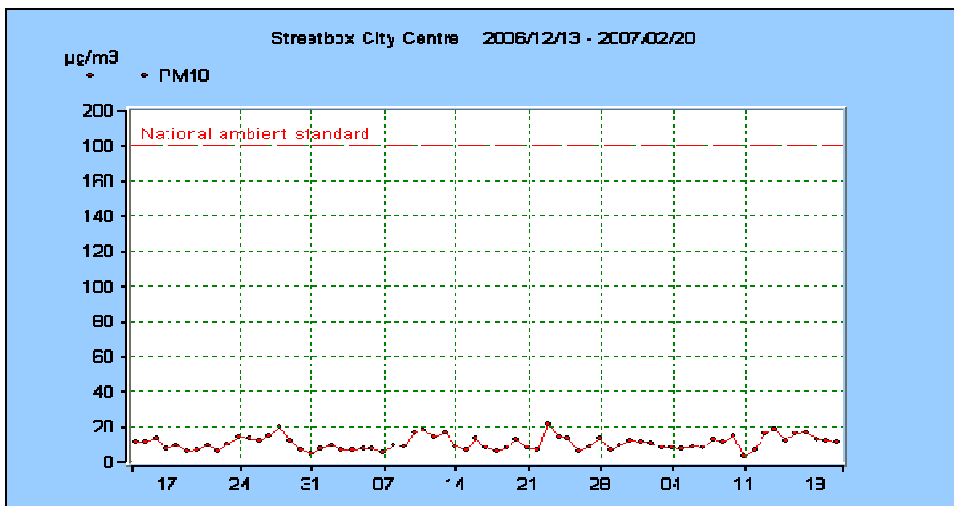
The fixed stations are in Rosslyn (northern section), Pretoria West, Mamelodi (eastern section), Booyens (western section) and Olievenhoutbosch (southern section). Apart from air quality, the mobile stations (street boxes) also

monitor transport and residential pollutants. The street boxes in Temba, East Lynne and Bosman Street in the city centre will measure sulphur dioxide and nitrogen dioxide. The street boxes in Ga-Rankuwa, Atteridgeville, Mabopane and Pretoria North will measure nitrogen oxide, carbon monoxide and sulphur dioxide. It should be noted that the boxes can be moved to other areas whenever required.



Air quality monitoring Street box in Ga-Rankuwa

For the data from the monitoring network, it is important to establish data quality objectives, data processing and reporting protocols, and monitoring methods. It is imperative that the software to be used is open-ended to allow for the interaction with any database. The data is currently submitted to the Gauteng Provincial Department of Agriculture, Conservation and Environment (GDACE) for connectivity. Integration of all the stations with the electronic software platform, Enviman should be completed in June 2007. Once completed representative, validated data will be made available for reporting and remedial actions.



Example of data received from the Street box – City Centre: The particulate matter is below the National Standard hence complies with the standards.

3.7.12 Renewable Energy and Energy Efficiency (REEEP) Project

The purpose of the REEEP programme is to "make a case" for renewable energy and energy efficiency implementation in respect of social and economic development and the reduction of emissions, meeting local and national energy and emissions targets and ensuring awareness, knowledge and capacity-building at local and national government levels.

The output of the project is a document/tool - "How to implement renewable energy and energy efficiency options – support for the South African local government". The document was launched by Sustainable Energy Africa (SEA) on 29 March 2007 during an international seminar on solar water heating in Pretoria. The document clarifies:

- The potential of cities to lead renewable energy and energy efficiency implementation.
- The potential contribution to national targets.
- Synthesise information and presentations on the economic, social and environmental case for renewable energy and energy efficiency implementation at city level.
- Capacity building of staff members in the participating cities of Cape Town, Ekurhuleni, Tshwane, Potchefstroom and Sol Plaatje.

3.7.13 Municipal Health Services Projects (MHS)

Tshwane/Basel Project

Tshwane has signed a memorandum of agreement with the City of Basel, Switzerland, and one of the areas of cooperation is on sustainable energy. With the help of South South North (SSN), a non governmental organisation specialising in these kinds of projects and appointed by Basel, Tshwane is developing a programmatic Clean Development Mechanism (CDM) project. The CDM project will entail the design and orientation of the houses and the installation of solar water heating systems, low-energy lighting and ceiling insulation in a low-cost housing project.

The resulting carbon emissions will then be sold as certified emission reductions (CERs) to the City of Basel as a demonstration of good practices.

Enerkey Project

The Energy Governance Board (EGB) was established in June 2007, and is a public-private partnership board constituted by the University of Johannesburg (UJ), through the Directorate of Research and Innovation and the Faculty of Science, and has been established to assist in developing, reviewing and approving policies for the operation of the joint activities of the University of Johannesburg and its public and private partners in the Enerkey Sustainable Megacities of Tshwane, Ekurhuleni and Johannesburg.

The EGB shall exercise its delegated authority as an advisory body to the University and to the stakeholders, in terms of this charter as agreed to or as amended from time to time with agreement between the University and the Board. The EGB shall have no standing as an independent legal persona, nor shall the Board be entitled to enter independently into binding contracts or financial commitments on behalf of the University or its Enerkey partners.

3.7.14 Summary of achievements

- Finalization and approval of the Air Quality Management Plan.
- Finalization and approval of energy and climate change strategy.
- Finalization and approval of Vector Control Strategy.
- Finalization and approval of integrated waste minimization strategy.
- Installation of three fixed and eight mobile Air Quality monitoring stations.

Health Care Annual report compiled by: Tshwane Health Care Division, R & D, Health Information Sub-section
Available on Intranet & CoT Website: www.Tshwane.gov.za
Contact enquiry line: 012 358 8831/ 8605
e-mail: Zachariah2@tshwane.gov.za