



CITY OF TSHWANE METROPOLITAN MUNICIPALITY

HEALTH CARE

**FIFTH ANNUAL REPORT
1 JULY 2005 TO 30 JUNE 2006**



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 MMC for Health and Social Development

We are confident that the programmes that we have introduced will take us forward in realising our strategic objective of eradicating poverty and improving the living conditions of our people. I am delighted to have this opportunity to share information about these programmes with you, our stakeholders, non-government organisations, the business sector, community-based organisations and the community at large.

HIV and Aids remain a daunting challenge and, in our endeavours to continue the fight against the pandemic, we are going to establish an HIV/Aids forum, bringing together community-based organisations, experts and other stakeholders. The members of this forum will, together with us, form a strong partnership to find practical ways of communicating with and conscientising our people, the aim being to curb the spread of the virus and support both the infected and affected.

Together with the provincial departments of health, we will be building health facilities where there are none, improving the services that we render and ensuring that the Batho Pele principles are put into practice.

In conclusion, I invite you to take the time to read through this report. Your involvement and commitment will strengthen us as an organisation and contribute to the realisation of our vision.



Ms Sonto Thipe
MMC for Health and Social Development

Foreword by the SEO for Social Development

The Health Care Division of the Social Development Department presents to you its Annual Report for the financial year 1 July 2005 to 30 June 2006.

This report reflects the contribution made by the Division to ensuring that the health status of the city is improved through the provision of quality environmental and primary health care services to the residents of the city.

Health care services are services to which every citizen should have access. To this end, a holistic approach to providing these services has been adopted in Tshwane: we have formed partnerships with a number of institutions, other spheres of government, community-based organisations and the community at large, and we have entered into social contracts with them.

I wish to express my sincere appreciation to all those who have contributed to making the 2005/06 financial year yet another year of success in terms of service delivery. My special thanks go to the political leadership of the city, my colleagues, the management of the Health Care Division and all staff for their support, dedication and hard work.



Ms Elizabeth Mhlongo
SEO for Social Development

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LIST OF ABBREVIATIONS AND ACRONYMS

Aids	Acquired immune deficiency syndrome
AFP	Acute flaccid paralysis
ANC	Antenatal care
ART	Antiretroviral treatment
ARV	Antiretroviral
BCG	Bacillus Calmette-Guérin (tuberculosis vaccine)
CANSA	Cancer Association of South Africa
CBO	Community-based organisation
CCP	Cities for Climate Protection
CD4	Cluster of differentiation 4 (A CD4 count is a test to determine the immune status of HIV-positive patients.)
CHC	Community health centre
CSW	Commercial sex worker
CTMM	City of Tshwane Metropolitan Municipality
DHES	District Health Expenditure Review
DHIS	District Health Information System
DOT	Directly observed therapy
DOTS	Directly observed therapy – short course
DPLG	Department of Provincial and Local Government
EAP	Employee Assistance Programme
EPI	Expanded Program on Immunization
FBO	Faith-based organisation
HBV	Hepatitis B vaccine
HCW	Health care worker
EHP	Environmental Health practitioner
HIV	Human immunodeficiency virus
ICD	International Classification of Diseases
ICLEI	International Council for Local Environmental Initiatives
IDP	Integrated Development Plan
IMCI	Integrated Management of Childhood Illnesses
MDR	Multi-drug resistance
MDS	Minimum data set
MEC	Member of the Executive Council
MMC	Member of the Mayoral Committee
NGO	Non-government organisation
NQF	National Qualifications Framework
PEP	Post-exposure prophylaxis
PHC	Primary health care
PLWHA	People living with HIV and Aids
PMDS	Performance Management Development System
PMTCT	Prevention of mother-to-child transmission
PREMOS	Pretoria Municipal Training Centre (the CTMM's training centre)
PTB	Pulmonary tuberculosis
SA	South Africa
SALGA	South African Local Government Association
Seed	Sustainable Energy for Environment and Development
SEO	Strategic executive officer
Stats SA	Statistics South Africa
STH	Sungardens, Tateni and HospiVision (the consortium that conducted the initial Aids audit)
STI	Sexually transmitted infection
TB	Tuberculosis
TMAC	Tshwane Metropolitan Aids Council
VCT	Voluntary counselling and testing

The Director-General
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0001

2005/06 Annual Report

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

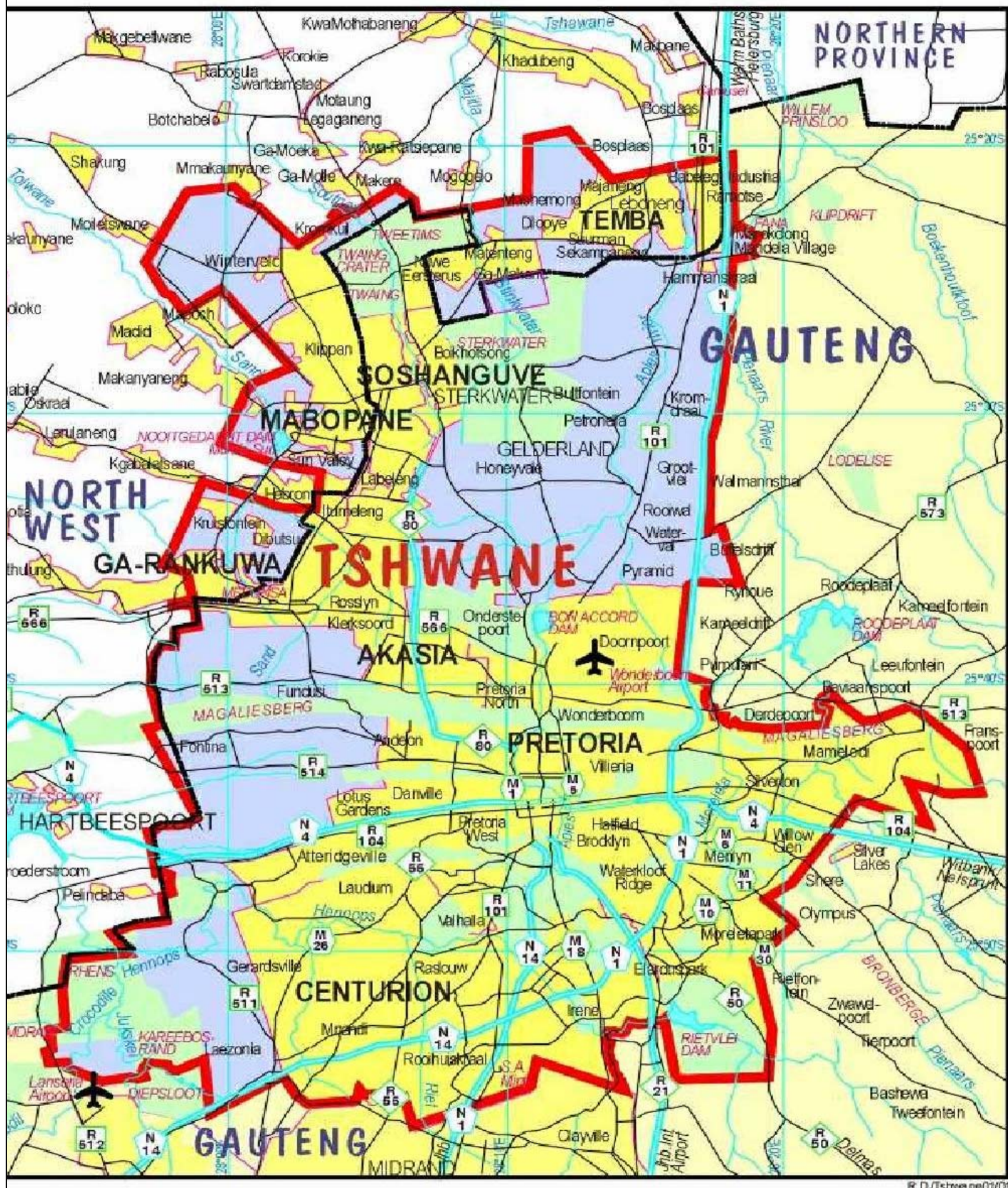
This report covers the period 1 July 2005 to 30 June 2006, which coincides with the financial year of the Municipality. The report includes combined information about the Tshwane/Metsweding Gauteng region and the North West districts (Odi and Moretele).

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.

Yours sincerely



Ms Francis Roodt
Acting General Manager: Health Care
Social Development Department
City of Tshwane Metropolitan Municipality



R. D. Tshwane 01/01

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

The City of Tshwane Metropolitan Municipality (CTMM) is classified as a category A municipality and has cross-boundary areas (ie areas in more than one province). The CTMM 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 2005 – Census 2001). The age groups between 20 and 29 represent 22% of the total population.

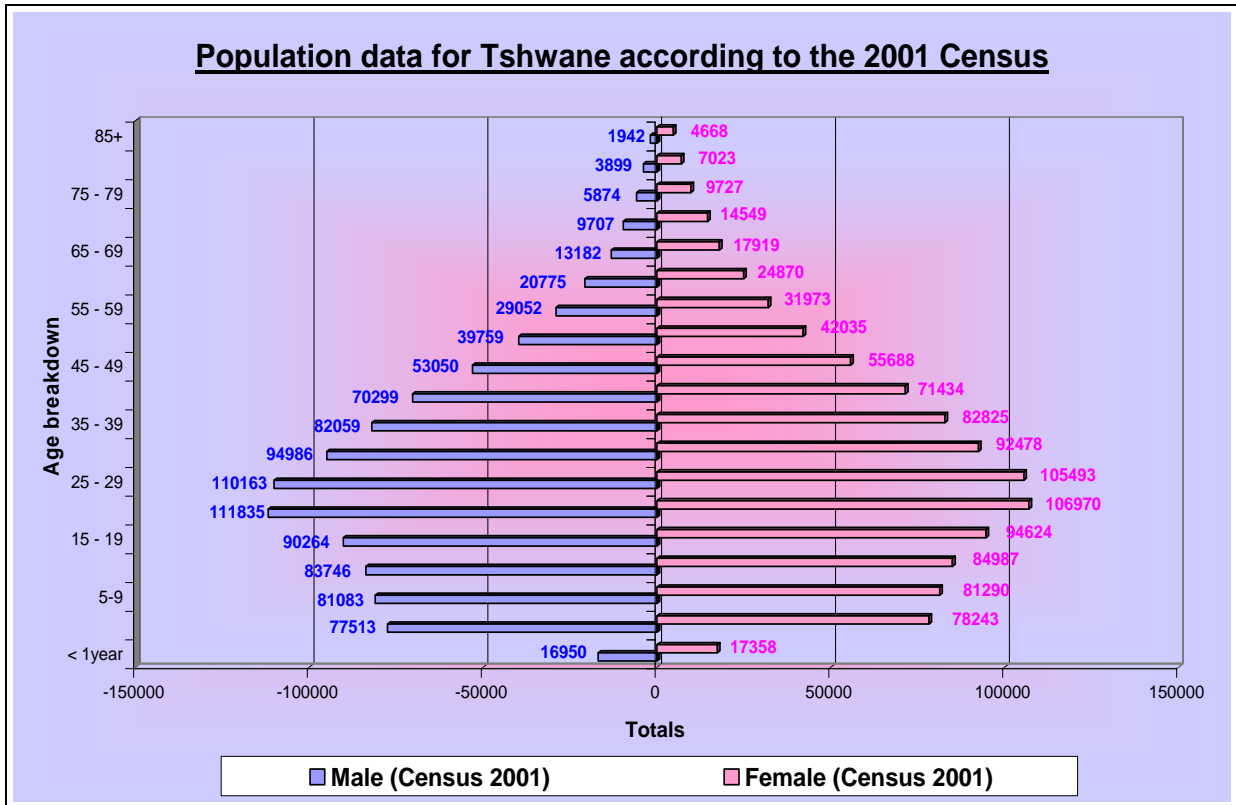


Figure 1: Tshwane's population

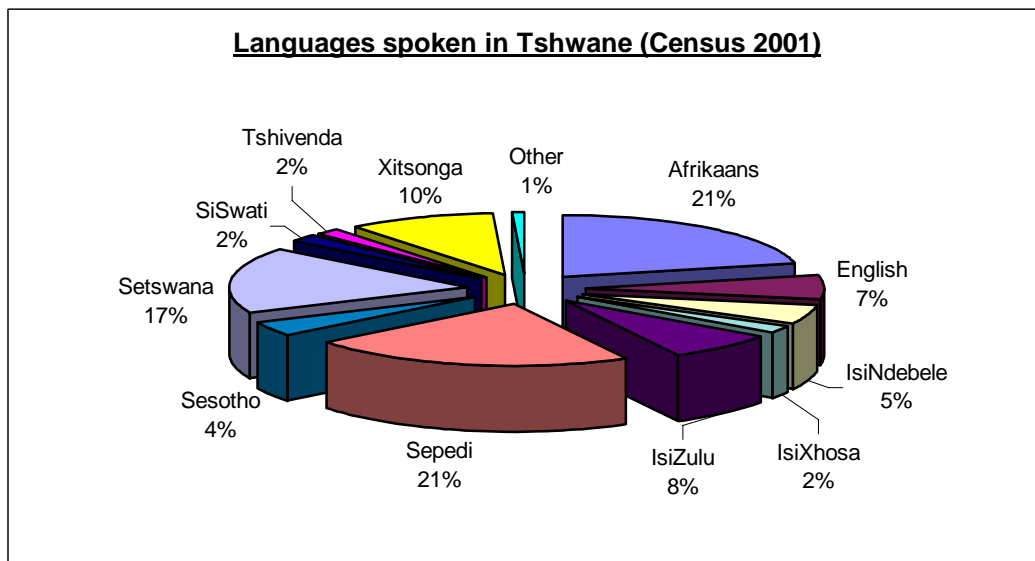


Figure 2: Languages spoken in Tshwane

Births and deaths

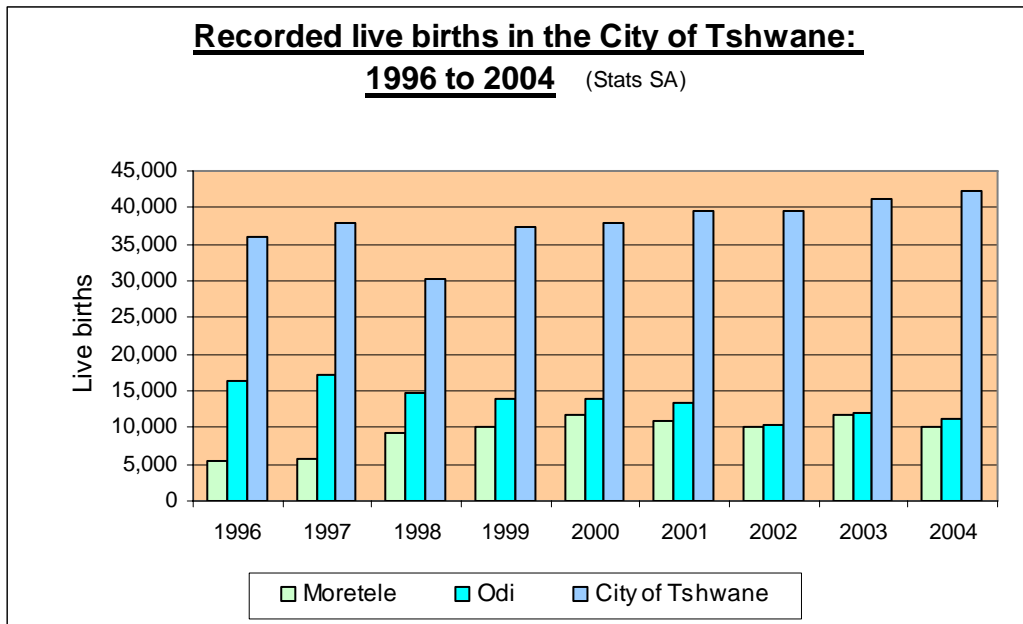


Figure 3: Registered live births for Tshwane, 1996–2004

The crude death rate has increased from 4,2 to 6,8 in the last ten years. The "additional" deaths increased from 200 in 1993 to 4 013 in 2000. The projected number of deaths in Tshwane within the next six to eight years is estimated to be 150 000.

More detailed death rate figures are available from Stats SA for the Gauteng province only and not for Tshwane separately. The leading cause of death in Gauteng in 2001 in all age groups was tuberculosis, followed by influenza/pneumonia and heart disease (see Figure 4).

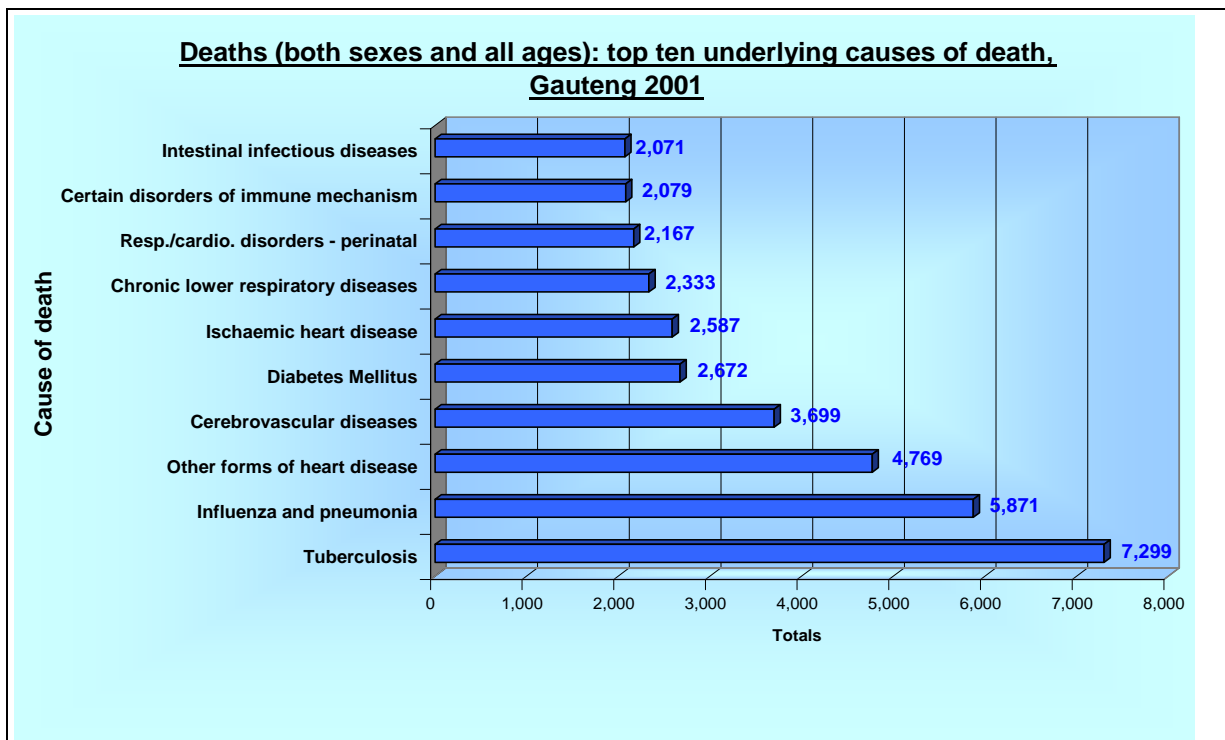


Figure 4: Top ten underlying natural causes of death in Gauteng, 2001 (Stats SA)

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 (ie 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 the CTMM, 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 OF THE CTMM

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.

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 R591 213 372 for the period under review.

The financial contributions of each were as follows:

- North West Department of Health: 38%
- Gauteng Department of Health: 48%
- City of Tshwane Metropolitan Municipality: 14% (excluding environmental health services)

The Municipality's contribution of 14% for clinic services came to R129 008 758. Environmental health services were also funded by the Municipality; they amounted to an additional R28 641 867.

In all, 66% of the budget was spent on PHC clinic services and 34% on district hospitals.

District health expenditure (excluding expenditure on environmental health and emergency medical services) amounted to R275 per capita for the total population. This represents total district expenditure, including district hospital (inpatient and outpatient), administration and management expenditure.

3 STRATEGIC GOALS OF THE CTMM'S HEALTH CARE DIVISION

The Health Care Division's goals and objectives support the priorities of the CTMM. Among these priorities are –

- managing and developing the city's infrastructure;
- developing the city's economy;
- ensuring community safety;
- building and sustaining the city's communities;
- developing and enhancing the city's natural resources;
- building the municipal institution and governing well; and
- enhancing the city's image as the capital.

All municipal activities are informed by the City Development Strategy, which focuses on –

- developing the north of the city;
- strengthening economic clusters;
- celebrating the city as the country's capital;
- building social cohesion;
- ensuring sound management and facilitating the ongoing development of the existing urban areas;
- ensuring sound financial fundamentals; and
- creating a strong developmental municipal institution.

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.)

Until agreement is reached on the final reconfiguration model for PHC services, transitional arrangements are made through service level agreements, as provided for in section 32 of the Act. A memorandum of understanding has already been signed by Tshwane's Executive Mayor and the Gauteng MEC for Health to facilitate the process, which was concretised through an interim service level agreement signed on 12 June 2006. This agreement is effective until 30 April 2007.

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 3 205 618 patients visited public PHC and reporting private PHC facilities throughout Tshwane (excluding district hospitals) during the period under review. This represents a 1,2% increase in the overall headcount compared with the previous year.

In all, 1 033 861 patients visited the local authority clinics during the 2005/06 year. This represents an increase of 8% in clinic attendance compared with the previous year, as indicated in Figure 5. The local authority clinics saw 32,2% of all patients seen at clinics in Tshwane.

The utilisation rate for the year under review remains unchanged from the previous year. The 1,8 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.

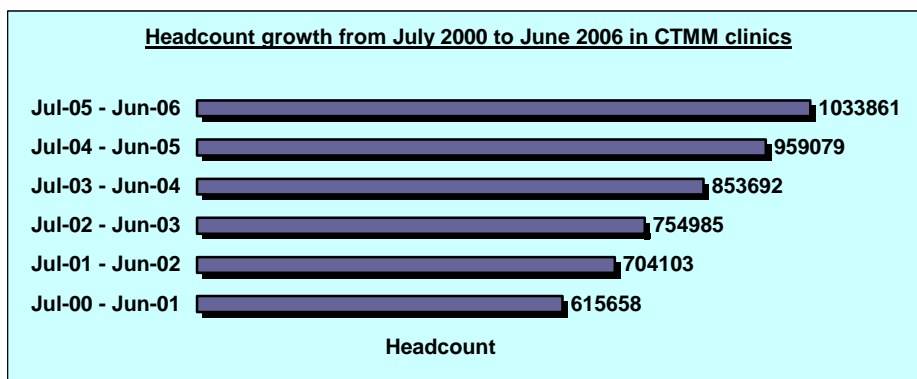


Figure 5: Increase in visits to local authority clinics

The national Department of Health has outlined a comprehensive service package for the provision 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 package of services at all service points. Sixty-one per cent of the local authority clinics already provide a comprehensive service. 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, except for the central subdistrict, where 24-hour health services are 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. There are, however, a significant number of facilities owned by the provinces that need urgent upgrading. During the 2005/06 financial year, the Municipality completed the following capital projects in order to provide better health facilities for the public:

- Replacement of the rented clinic facility in Karenpark with a new building
- Upgrading and extension of the Phomolong Clinic
- Building of a new community health centre in Klip-Kruisfontein

Table 1 lists the health-related projects approved for implementation during the next financial year. The projects are derived from the Municipality's Integrated Development Plan and are funded by the Municipality.

Table 1: Approved capital projects for health care

Capital project	Output	Year commenced	Year to be 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

3.2.3 Improving the quality of care

All clinics display both the Patients' 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 how to lodge a complaint is visible in all clinics.

3.2.3.1 Percentage of complaints successfully resolved

During the period under review, 91% 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.

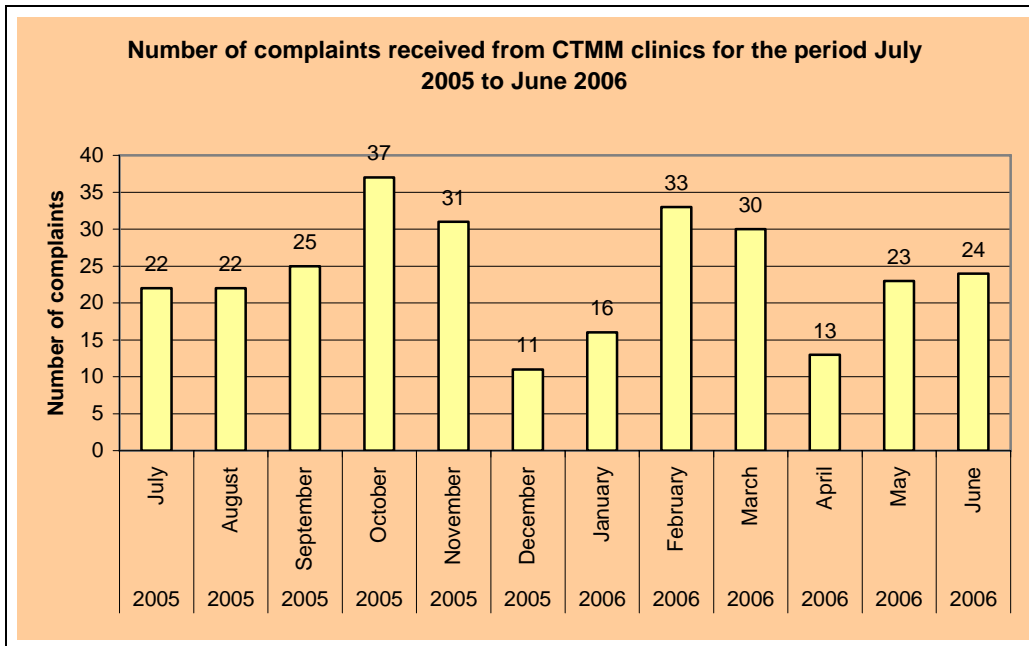


Figure 6: Complaints received by CTMM clinics

3.2.3.2 Clinic supervision

The Regular Review and Red Flag tools are used in the clinics each month to monitor and evaluate clinic administration and to facilitate clinic supervision. Quarterly supervisor 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

In-depth programme reviews were done during the year, and the findings were reported at supervisory meetings on the following dates:

- 9 August 2005 – Health promotion programme review
- 23 November 2005 – Review of youth-friendly services
- 22 February 2006 – Oral health programme review
- 24 May 2006 – HIV and Aids programme review

The in-depth reviews are done jointly by the municipal and provincial area and programme managers.

3.2.3.4 Annual rating survey

A rating survey was conducted from 18 April to 5 May 2006 to assess patient satisfaction. Table 2 shows survey results for the past four financial years.

Table 2: Comparison of results of client satisfaction surveys

Comparison of the results of the September 2002, April 2003, March 2004, February 2005 and April 2006 rating surveys in local authority clinics					
	Sept '02	Apr '03	Mar '04	Feb '05	Apr '06
Percentage of clients satisfied with the clinic environment	78%	87%	87%	89%	91%
Percentage of clients satisfied with the quality of care by staff	73%	80%	81%	94%	86%
Percentage of clients satisfied with the waiting times and clinic hours	72%	74%	74%	84%	76%

3.2.3.5 Annual survey of waiting times

A survey of waiting times was conducted in November 2005 at all local authority clinics. Figure 7 shows the results of surveys conducted in the past four financial years.

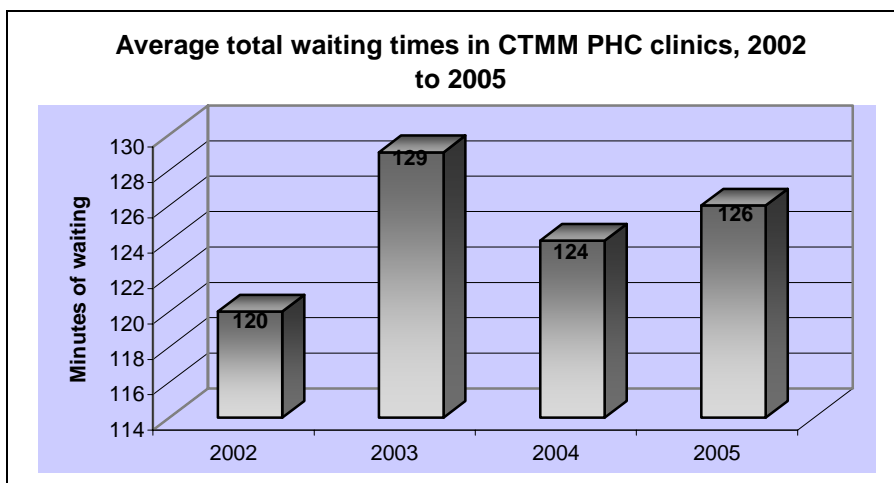


Figure 7: Average total waiting times at clinics

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 3 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 2 949 members of the uninsured population; this is an average nurse to population ratio of 34 per 100 000, as against the provincial average ratio of 136 per 100 000. This ratio improved slightly compared with the previous year.
- One doctor served 44 100 members of the uninsured population; the average doctor to population ratio was therefore 2,3 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 CTMM staffing).

Table 3: Population, PHC facilities and staff audit

Sub-district	Total population per subdistrict	Type of facility (clinic) and number	Number of professional nurses	Number of doctors
Southern	150 018	CHC (1), clinic (4), satellite (2), mobile (1)	48	3
Northern	399 666	CHC (1), clinic (7), satellite (2), mobile (2)	118	5
Central	1 190 466	CHC (2), clinic (22), satellite (1), mobile (2)	206	24
Odi	253 051	CHC (1), clinic (8), satellite (1), mobile (1)	107	6
Moretele	218 337	CHC (1), clinic (7), satellite (0), mobile (3)	118	2
Total	2 211 537	CHC (6), clinic (48), satellite (6), mobile (9)	597	40

Source of population figures: DHIS

The Tshwane district has four district hospitals and one regional hospital.

Table 4 gives a detailed breakdown of the health staff of the CTMM as at 30 June 2006.

Table 4: CTMM health staff (category and number)

Category	Number of permanent employees	Number of contract employees
Administrative	42	
Aids unit	12	
Environmental health	70	
General workers	40	
Health programmes	10	
Managers	6	
Medical officers	15 (7 full time, 7 part time, 1 senior)	2 (session doctors)
Pharmacy	31	
Primary health care	190	1
Radiography	5	
Research and development	14	
Support services	22	
Total	457	3

3.2.4.2 Personnel development

The Health Training Subsection is responsible for educating and training all health care staff to develop their skills in accordance with the workplace skills plan and the national and provincial protocols. Of importance to the subsection is the need to offer a learning environment that respects and accommodates the values and cultures of all members of staff.

During the year under review, the subsection achieved the following:

- It maintained partnerships and sound working relations with tertiary institutions.
- Ninety-three candidates, among them clinical nurses and doctors, completed the dispensing course.
- Thirteen community health nurses successfully completed their Diploma in Clinical Nursing Science.
- The management of the TB epidemic was standardised through quarterly TB courses and monthly TB clinical discussions.
- A marked improvement in the application and management of the strategy for the integrated management of childhood illnesses (IMCI) was observed in all clinics.

The challenges for the subsection are:

- The development of learning programmes and their alignment with the unit standards
- Staff shortages, which seriously impact on skills development, as staff cannot be released for training
- Financial constraints
- The provision of site support for the full implementation of the Best Practice Programme, as initiated by the national Department of Health
- Coordination and cooperation when planning training interventions with provincial counterparts

Training in the Health Care Division focused on the indicators listed in Table 5.1. The table reflects the Division's achievements in respect of training. Tables 5.2(a) and 5.2(b) give information on staff development activities in the Odi and Moretele subdistricts.

Table 5.1: Personnel development – CTMM health staff

Key performance areas of the Health Training Subsection	Service delivery indicator	Target	Performance: July 2003 to June 2004	Performance: July 2004 to June 2005	Performance: July 2005 to June 2006
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	97%	99%	96%
Career plan development	Percentage of top and senior management with a senior management qualification (NQF 6)	90% of top and senior management with a senior management qualification by June 2006	89%	89%	100%
	Percentage of professionally qualified and experienced specialists and middle management staff with a middle management qualification (NQF 5)	100% of professionally qualified and experienced specialists and middle management staff with a middle management qualification by June 2008	75%	89%	100%
	Percentage of skilled technical and academically qualified workers, junior management staff and supervisors with a junior management qualification (NQF 4)	100% of staff at supervisory level and 20% of staff in non-supervisory positions with a junior management qualification in five years	45%	60%	74%
Professional development	Percentage of professional nurses with a Diploma in Clinical Nursing Science, Health Assessment, Treatment and Care	65% by the end of June 2008	38%	51%	54%
	Percentage of facilities with more than one IMCI-trained staff member	100% by June 2006	69%	95%	100%
	Percentage of facilities with more than one VCT-trained staff member	100% by June 2006	Not measured	74%	100%
	Percentage of computer-literate staff (formal courses)	75% of designated staff computer-literate by June 2008	49%	50%	52%
	Percentage of managers with financial management training	90% by June 2006	81%	92%	93%
	Percentage of managers and deputy managers with health information management training	60% by June 2006	40%	50%	61%
	Percentage of professional nurses exposed to health information management training	38% of all health staff concerned (nurses and doctors) exposed to health information management training by the end of June 2007	24%	33%	38%
	Percentage of all professional nurses and doctors with the national dispensing certificate	80% by June 2008	Not measured	38%	61%
	Percentage of compliance with the targets set in Health Care's divisional skills development plan	80% annually	Not measured	85%	91%
External training	Number of tertiary students trained in Tshwane clinics	400 a year	100%	150%	200%
	Number of primary health care private providers trained	40 a year	100%	130%	210%

Table 5.2(A): Personnel development – Odi subdistrict

ODI SUBDISTRICT			
Programme, workshop or training	Number of staff trained	Programme, workshop or training	Number of staff trained
Project and finance management workshop	1	Training in transformation issues, Batho Pele and the rights of patients	9
Training in value clarification	3	Workshop on leave and disciplinary procedures	31
Training in adherence counselling regarding ARVs	1	District Health Information System training	5
Training in the new Mental Health Act	3	Workshop on adherence counselling regarding ART	5
Workshop for female managers	2	Refresher course for dental assistants	9
Workshop on paediatric problem identification	1	PEP and sexual assault policy and management workshop	2
Financial management training	1	Bid and tender adjudication workshop	3
DHER Training	3	Mental Health Act workshop	2
National Health Laboratory Service workshop	1	Training in the admission of patients, and completion and compilation of data	3
Workshop on the updated Vaccinator's Manual	3	Training in the auditing of patient files	2
Millennium waste management workshop	3	Integrated disease surveillance workshop	2
Computer training (introduction to computers)	1	PMDS training	35
Minimum data set workshop	3	Conference workshop on the HIV and Aids policy implementation and VCT/ARVs	20
Diabetes mellitus workshop	5	Workshop on maternity records	3
Labour relations training	2	Computer training (Excel, MS Word, PowerPoint, Orientation)	27
Workshop on youth-friendly services	1	Workshop on the paediatric problem identification programme	2
Quality assurance workshop	1	VCT and family planning workshop	42
District health planning workshop	33	TB workshop (patient files and calculation of medication)	20
Batho Pele implementation workshop (service delivery for operational managers)	1	Skills development training	7
Mentorship in-service training	4	Skills programme on report writing	2
Nutrition training workshop	2	Asset management and loss control compliance workshop	3
Mentoring programme on VCT	4	Physical activity initiative workshop	1
Baby-friendly hospital initiative programme	21	Vital registration workshop	2
IMCI training	3	Training in psychological conditions causing physical illness	14
TB management and EPI training	7		
STI master trainer course on revised guidelines	1		
Follow-up training and PMTCT training	11		
Communication strategy workshop	1		
ICD-10 training	1		
Vitamin A training	10		

Table 5.2(B): Personnel development – Moretele subdistrict

MORETELE SUBDISTRICT			
Programme, workshop or training	Number of staff trained	Programme, workshop or training	Number of staff trained
PMTCT training	63	Training in the District Health Information System	9
Baby-friendly health initiative training	77	Training in Aids care and treatment	2
Value clarification workshop	88	Training in safe motherhood and infancy	1
Mental health training	22	Training with regard to people with disabilities	1
EAP	24	Training in communicable diseases	1
Occupational health and safety training	14	Training in diabetes mellitus	3
Leave management training	28	Frontline staff training	1
Choice-of-termination-of-pregnancy training	18	Training regarding fraud and corruption	1
Training in the examination of the central nervous system	7	PEP training	3
ART training	27	Training in infection prevention and control	3
Glucometer training	3	Training in midwifery	4
PMDS training	40	Psychiatry Service Summit	1
HIV management training	5	TB management training	37
Office management training	1	Leave management training	28
Public finance management course	2	Computer training	15
VCT training	31	Nutrition Congress	1
Mentorship training	7		

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. For Tshwane, the provincial governments introduced the concept of a district information system – the District Health Information System (DHIS). Although the minimum data set (MDS) for health services within the boundaries of the Gauteng and North West provinces differs, important health status indicators could be derived even from the separate databases.

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

- 100% of the MDS data from PHC facilities and private providers of immunisation and family planning services are captured in the DHIS.
- 100% of PHC facilities report on time each month.
- 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 CTMM clinics have functional email facilities.
- A standardised PHC software program for the administration of patient records has been rolled out to all the CTMM 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.
- 100% of the clinics use an integrated electronic financial system to manage their cost centre budgets.

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

- Increasing the number of functioning email terminals in health facilities to 100%
- Improving relations and cooperation between the different DHIS units in the district to ensure streamlined and comprehensive reporting on the health status and service data of the district
- Developing integrated computerised systems to manage data related to diseases and health services
- Replacing the current (hard copy) patient records with electronic patient records

3.4 PROVISIONING OF ESSENTIAL DRUGS

Pharmaceutical services are provided by three authorities in the Tshwane municipal area. However, coordinating these pharmaceutical services to ensure that they are provided equitably throughout the municipal area poses a serious challenge, as the North West Provincial Government provides health services in the northern and northwestern parts of the municipal area, while the Gauteng Provincial Government provides them in facilities located in areas near the north and in other areas spread across the region.

3.4.1 Provisioning of medicines

The municipal clinics obtain their medicines directly from the Gauteng Regional Pharmacy, and the municipal medicine store is responsible for monitoring and coordinating the provisioning process. The medicines are funded from the annual allocation made by the provincial government.

The Gauteng Regional Pharmacy also supplies medicines to 17 Gauteng provincial clinics and mobile clinics and 4 community health centres, while the North West Provincial Government supplies medicines to the 21 North West clinics through its contracted private provider.

The total value of medicines supplied from the Gauteng Regional Pharmacy during the 2005/06 financial year was R49 million.

Delays in the national tender renewal process affected the availability of some medicines in the Tshwane region, but no serious shortages were reported.

3.4.2 Types of services

Pharmaceutical services are generally regarded as being made up of two separate yet mutually indispensable sets of services. The first set of services relates to drug supply management and provisioning, and the second to medicine utilisation and advice.

The pharmaceutical service that is rendered by the Gauteng and North West provinces concentrates mainly on drug supply and provisioning, while the Municipality also provides a medicine utilisation and advice service to municipal clinics and the public. The dispensing function in the municipal clinics is performed largely from the clinic dispensaries, while the other two authorities make use of professional nurses to dispense from their consulting rooms.

Post-basic pharmacist's assistants are being empowered to take up more of the prescriptions and perform most of the stock control functions in the dispensary. This frees the pharmacist to concentrate on monitoring drug utilisation to ensure rational drug use, cost-effectiveness, safety and general drug availability.

The Municipality offers two training sessions on drug supply management every year to staff of all three authorities, including nursing staff and learner and qualified pharmacist's assistants. The regional pharmacy is involved in training most of the pharmacist's assistants. The Municipality has three trainees only.

To ensure that the dispensaries comply with the new statutory regulations, the pharmacists were involved with the planning of the dispensaries.

3.4.3 Human resources

During the year under review, eight pharmacists held functional positions and four held management positions. Four of the functional pharmacists are employed by the Municipality and hold the positions of Regional Pharmacist. They are responsible for a number of clinic dispensaries and supervise the pharmacist's assistants. The other four functional pharmacists perform their functions in the regional pharmacy and in one of the Gauteng provincial clinics.

The district had 23 qualified post-basic pharmacist's assistants during the year, as well as 24 learner post-basic pharmacist's assistants and 9 learner basic pharmacist's assistants. The 24 learner post-basic pharmacist's assistants were scheduled to qualify at the end of 2006 and be deployed to the clinics, thereby ensuring closer compliance with the requirements of the Medicines and Related Substances Act, 1965 (Act 101 of 1965).

In order to comply with the requirements of statutory regulations, planning is under way to train the auxiliary staff in the regional pharmacy and municipal medicine store as basic pharmacist's assistants.

3.4.4 Challenges

The following posed challenges during the year under review:

- The amendments to the Medicines and Related Substances Act, 1965, and the Pharmacy Act, 1974 (Act 53 of 1974), which became effective on 1 July 2005, and their binding nature on the state – Compliance with these Acts posed huge challenges to pharmaceutical services. The majority of the clinic dispensaries did not comply with good pharmacy practice, and so funds had to be spent on improving storage conditions and security in all the clinic dispensaries and stores. Compliance in respect of size, water supply, shelving and private consulting areas in the dispensaries is expected to give rise to major expenditure, and therefore compliance can only be addressed by adopting a phased approach.
- The training of pharmacist's assistants – The training took up a great deal of the pharmacists' time. Also, limited functions in the municipal medicine store hampered the training of assistants. However, cooperation between the Municipality's pharmaceutical services, the tertiary hospital in the region and the Gauteng provincial pharmaceutical services made it possible for assistants to receive training in the manufacturing, store and distribution modules.
- Control over expenditure on medicines – Expenditure needs to be balanced against the realistic needs of the communities served. However, despite the budgetary constraints, medicine availability has always been assured throughout the region.

3.5 PROVISION OF COMPREHENSIVE PRIMARY HEALTH CARE SERVICES

The health status of the city has been improved through the provision of primary health care (PHC) services.

3.5.1 Sexually transmitted infections

People with sexually transmitted infections (STIs) are six to eight times 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 11 350 new cases were reported for the year under review compared with the 14 815 cases of the previous year. The average incidence decreased from 18 per 1 000 to 14 per 1 000 of the sexually active male population treated at public health facilities within the boundaries of the CTMM. (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, responding well to the syndromic treatment.)

The incidence of male urethral discharge and STIs is still a lot higher in Odi 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 decreased from 41 per 1 000 to 31 per 1 000. In all, 49 819 new cases were reported at the public health facilities within the boundaries of the CTMM. (These infections are "mixed" infections comprising discharges, ulcers and herpes.)

Condom distribution is an important strategy in the prevention of STIs. Over 12 million condoms were distributed by the public health sector during the year under review. Other strategies used in the prevention and treatment of STIs included adopting a syndromic treatment approach and monitoring it, and tracing contacts. Health education programmes also focused on the prevention of sexually transmitted diseases.

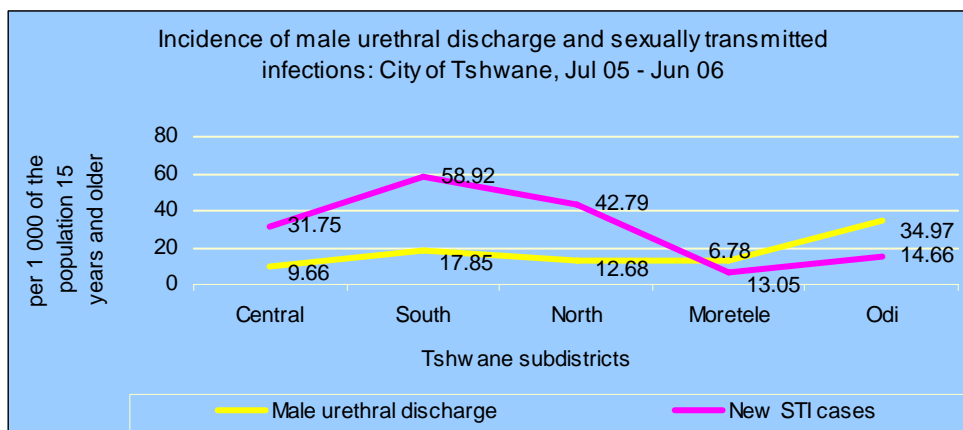


Figure 8: Incidence of STIs and male urethral discharge

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 also 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, 2,3 per 1 000 were found to be severely malnourished, and 1,7 per 1 000 who visited the PHC clinics presented with diarrhoea with dehydration. Figure 9 shows the rates per subdistrict; the two important child health indicators point to a drastic deterioration in the northern 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 (including those in the Odi and Moretele subdistricts) give 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 implemented and an extensive health promotion programme on rehydration and the prevention of dehydration was run.

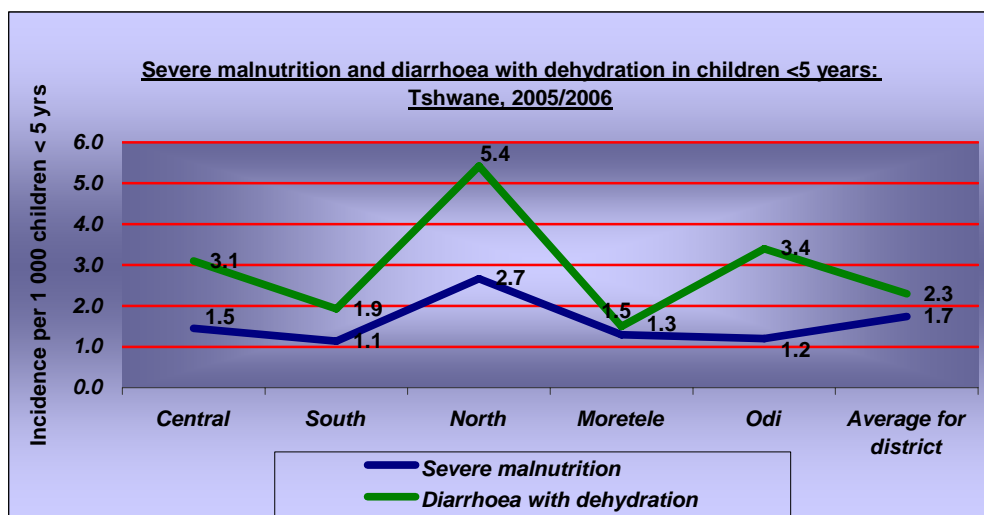


Figure 9: Incidence of severe malnutrition and diarrhoea in children under five years of age seen in public PHC facilities in Tshwane

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 94% of all children under the age of one in Tshwane are fully immunised.

3.5.2.3 Interventions targeting the youth

Although the teenage pregnancy rate dropped to 10% during the year under review, it is still cause for concern. Figure 10 shows the trend from 2000 to 2006.

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.

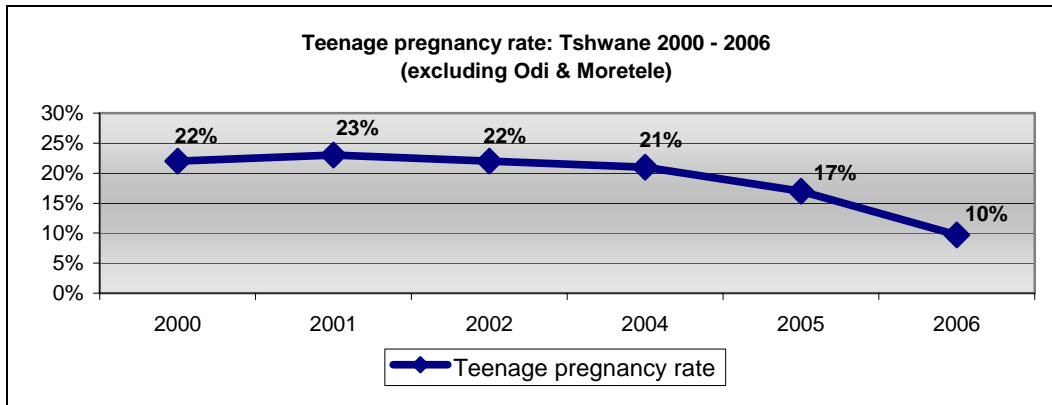


Figure 10: Teenage pregnancy rate – Public PHC clinics in the City of Tshwane

3.5.3 Women's health

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 Pap smear previously should have one done. Thereafter, a smear should be done every 10 years until the age of 60.

In all, 15 479 Pap smears were done in the Tshwane district from July 2005 to June 2006. Of these, 926 showed abnormalities, bringing the rate of abnormalities to 5,9%. As indicated by Figure 11, cervical screening coverage remains a challenge, as only 34% of the target population underwent a Pap smear. The results of the Pap tests done by the local authority clinics were further analysed. They indicate an abnormality rate of 7%. The abnormality rate includes the 20- to 29-year-old age group (see Figure 12).

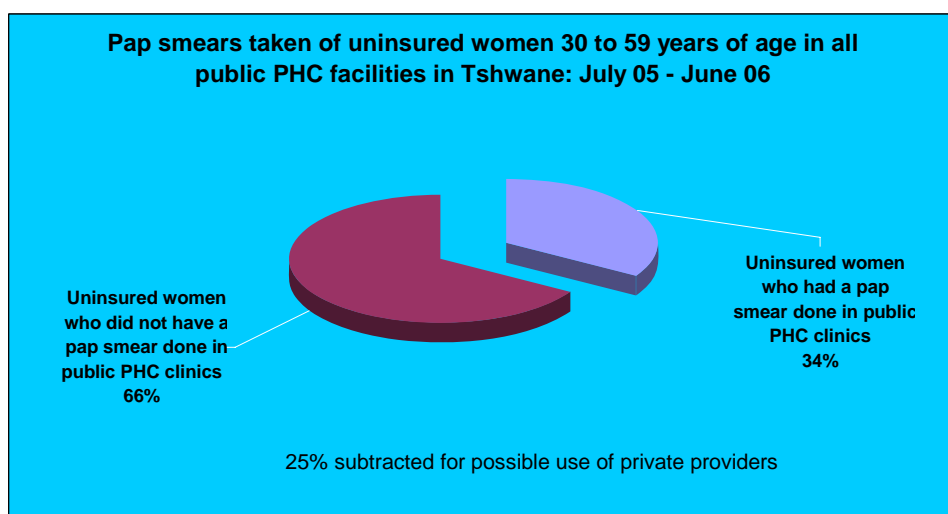


Figure 11: Cervical smears of uninsured women of 30 to 59 years of age in all public PHC facilities in Tshwane (2005/06)

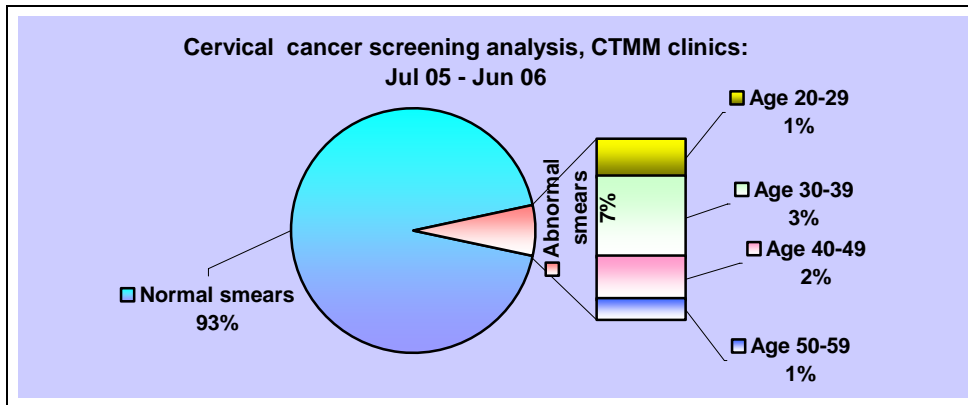


Figure 12: Cervical cancer screening analysis – CTMM clinics (July 2005 – June 2006)

3.5.3.1 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 4,4 during the year under review, which represent a 0,9% increase 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.

The number of first ANC visits to clinics during the 2005/06 year was 56 215 compared with the 45 431 of the previous year.

3.5.3.2 Family planning

Fertile female members of the community (females aged 14 to 45 years) should be protected from unwanted pregnancies. There are about 623 000 uninsured fertile females in the population of Tshwane. During the year under review, only 14,2% of them were using a reliable contraceptive method provided by the national family planning programme (compared with 14,8% for 2003/04). These figures exclude coverage through sterilisation and condom use. The national target for coverage in respect of fertile females is 65%.

Cultures in which the female members have a low status, low level of empowerment, low level of education and inadequate access to family planning services contribute to the low coverage. A large variety of contraceptive methods, not provided by the national family planning programme, is 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. In the Gauteng part of Tshwane these private providers contributed 35,6% to the 14,2% coverage for the district.

3.5.4 Curative, chronic and preventive services

Curative and chronic health services are available at 50 health facilities throughout the Tshwane area, which means that the availability of these services at the facilities stands at 91%. Twenty-three fixed facilities of the local authority (ie 100%) are now providing a general 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 increased the roll-out of chronic services from 52% to 62% during the year under review. Preventive services are provided at all the facilities.

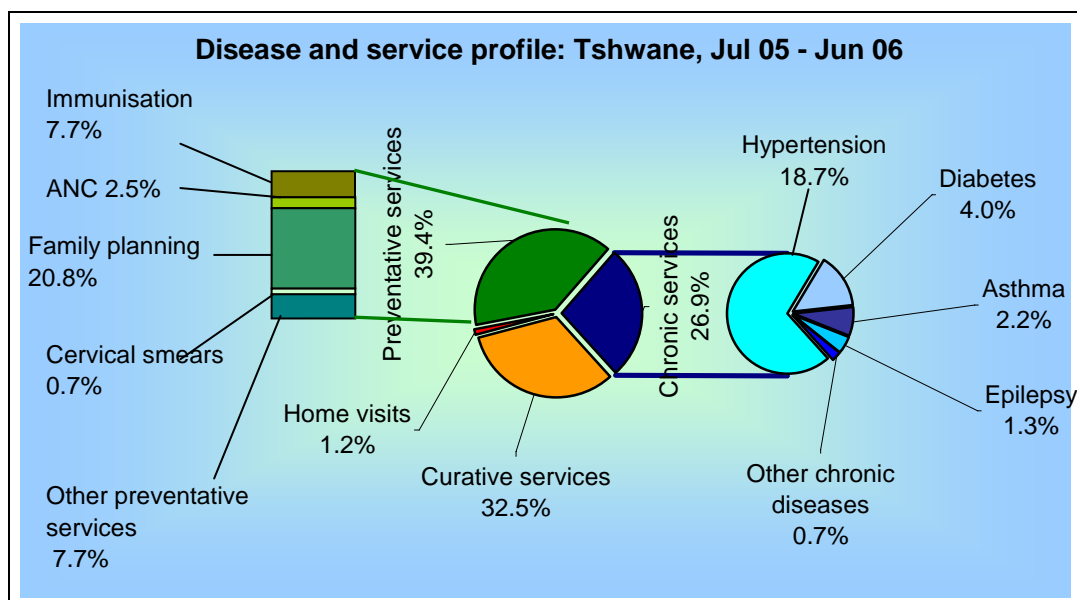


Figure 13: Disease and service profile (July 2005 – June 2006)

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 50,3% during the year under review, which is 9,7% below the rate for the previous year.

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 six 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.

Health education is provided at firms, hospitals and old-age homes, and X-rays are taken of people suspected of having TB.

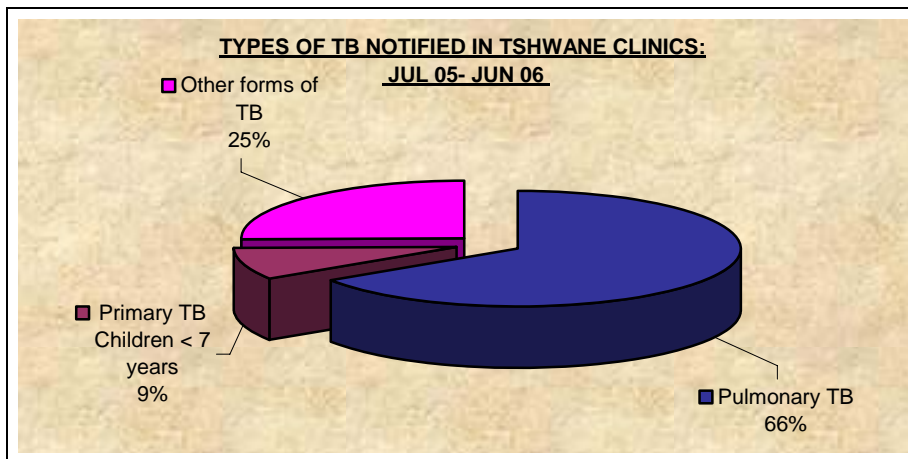


Figure 14: Types of TB notified in Tshwane (July 2005 – June 2006)

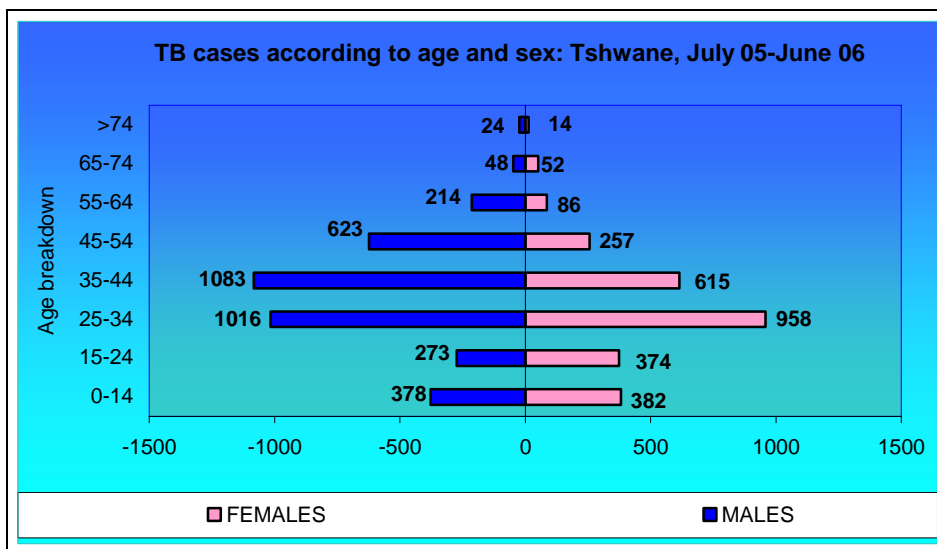


Figure 15: Age breakdown of TB patients

Note that economically active males are the most affected.

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 6: Bacteriological coverage: Tshwane (2005/06)

Area	Central	Northern	Southern	Moretele	Odi	Total
Bacteriological coverage	87,3%	84,7%	97,2%	83,4%	88,7%	87,0%
Number of PTB cases with positive sputum	2 322	471	352	968	430	4 543
Number of PTB cases with negative sputum	558	20	26	5	34	643
Number of adult PTB patients with no smear	420	89	11	193	59	772
Number of new PTB cases, 0–7 years (primary TB) with no smear	279	213	49	184	61	786
Total number of PTB cases > 7 years (able to produce a sputum sample)	3 300	580	389	1166	523	5 958
Number of extra-PTB cases	697	724	146	314	416	2 297
Total number of TB cases diagnosed	4 276	1 517	584	1 664	1 000	9 041

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). The outcome reports of PTB patients indicate the success of the patients' treatment and cure.

The health district's cure rate is 67%, and its average rate of successful treatment is 71%. The treatment outcome is evaluated a year after a patient starts his or her treatment.

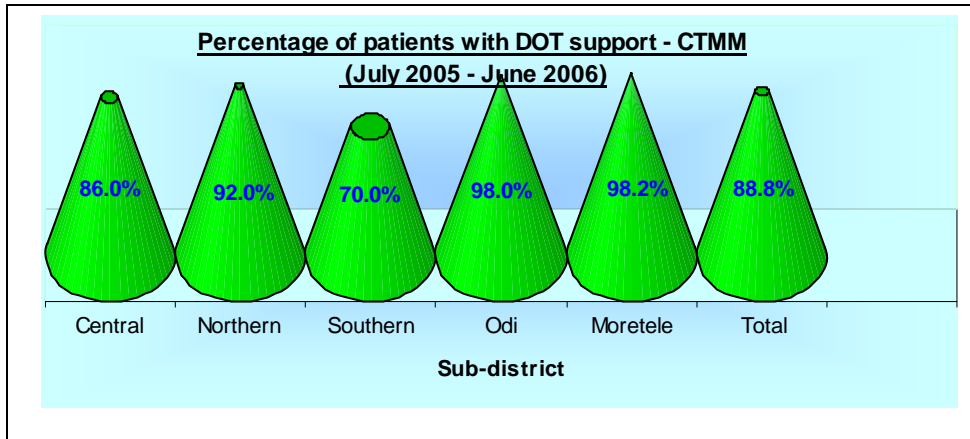


Figure 16: Percentage of patients with DOT support – Tshwane (July 2005 – June 2006)

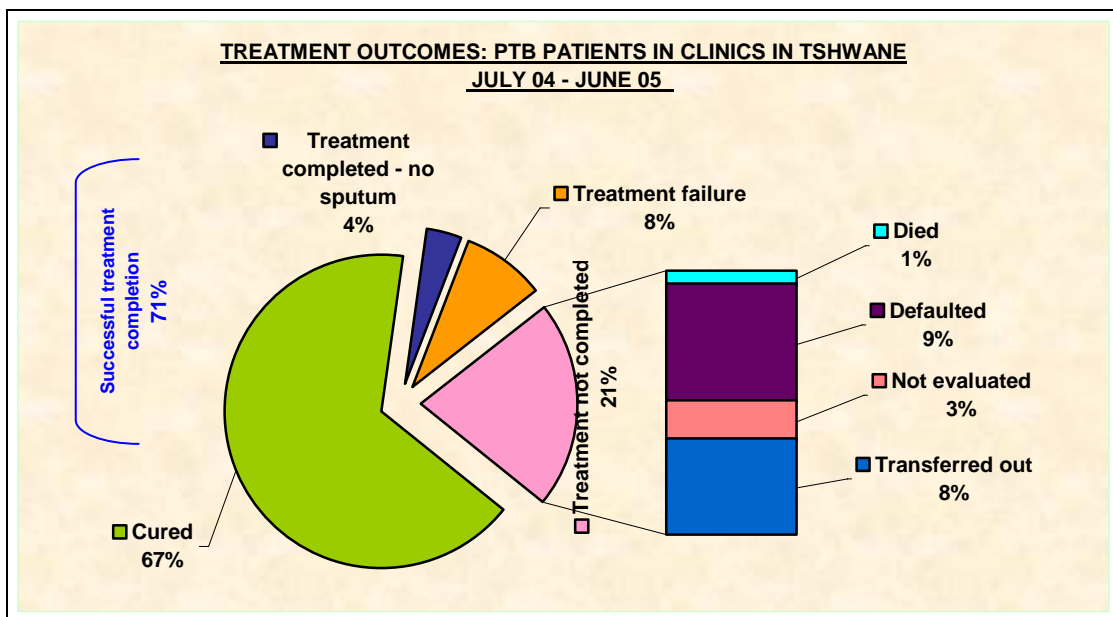


Figure 17: Treatment outcomes – PTB patients in Tshwane clinics, including Odi and Moretele (July 2004 – June 2005)

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 R300,00 per patient, but from R27 000,00 to R30 000,00 per MDR patient. Turnaround times for sputum specimens during the year under review were, relatively speaking, satisfactory, with only 3,5% taking longer than five days.

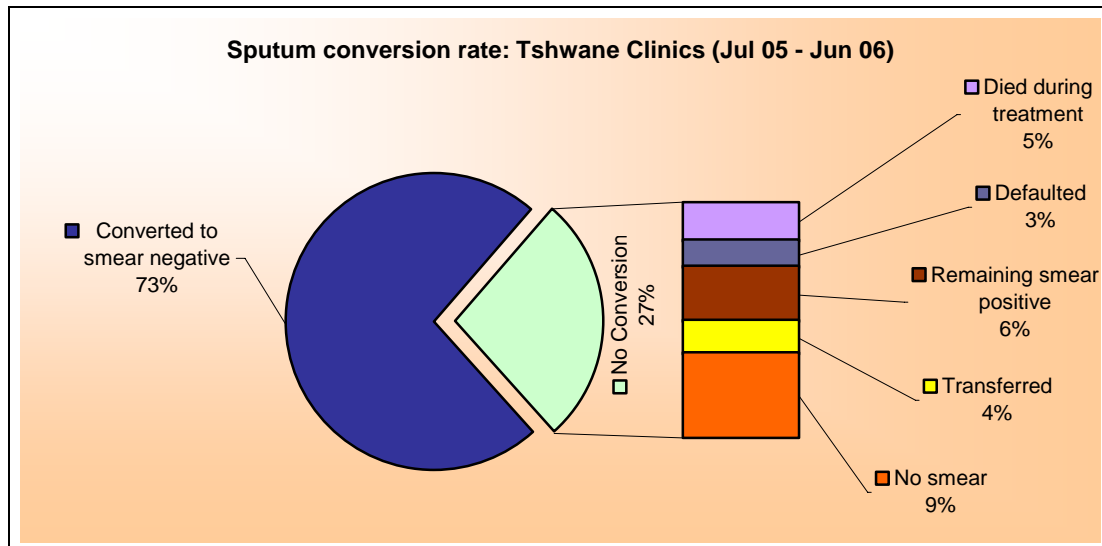


Figure 18: Sputum conversion rate: New smear-positive patients in Tshwane (July 2005 – June 2006)

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. Six new MDR 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 (Tshwane) TB meetings with all managers and TB service points.

Weekly consultations are undertaken by the Municipality's doctors and nurses at provincial hospitals and, when the need arises, at private hospitals. 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-ups and investigations are carried out by community health nurses who also administer prophylactic medication where indicated.

Environmental health practitioners are involved in the environment-related cases such as malaria. The appropriate measures indicated by the notifiable medical condition are taken.

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 7: Notifiable medical conditions reported (2005/06)

NOTIFIABLE MEDICAL CONDITION July 2005 to June 2006	TSHWANE SUBDISTRICT				
	Central	Southern	Northern	Odi	Total
AFP – Acute flaccid paralysis	2	0	0	0	2
A48 – Legionellosis	3	0	0	0	3
B54 – Malaria	234	5	3	0	242 (external sources of infection)
B05 – Measles	0	0	0	0	0
A39 – Meningococcal infection	35	2	2	0	39
T57 and T60 – Poisoning (agricultural stock remedies)	24	3	1	0	28
A80 – Poliomyelitis	0	0	0	0	0
A82 – Rabies	0	0	0	0	0
I00 – Rheumatic fever	1	0	0	0	1
A35 – Tetanus	0	0	0	0	0
A71 – Trachoma	0	0	0	0	0
A16.7 – Tuberculosis (primary)	292	122	44	28	486
A16.2 – Tuberculosis (pulmonary)	2 331	686	276	600	3 893
A16.9 – Tuberculosis (other respiratory organs)	357	197	63	97	714
A17.0 – Tuberculosis (meningitis)	68	35	3	16	122
A18.3 – Tuberculosis of intestines and peritoneum	0	0	1	0	1
A18.0 – Tuberculosis of bones and joints	3	2	1	0	6
A18.1 – Tuberculosis of genito-urinary system	0	0	0	0	0
A18.8 – Tuberculosis of other organs	97	43	10	15	165
A18.9 – Tuberculosis (miliary)	147	34	12	30	223
A16.3 – Tuberculosis (lymph nodes)	56	19	9	20	104
A01 – Typhoid fever	4	0	1	0	5
B15.9 – Viral hepatitis A	44	2	2	0	48
B16.9 – Viral hepatitis B	16	11	5	0	32
B17.8 – Viral hepatitis C	5	2	0	0	7
A37 – Whooping cough	1	0	1	0	2

Note: No data were received from the Moretele subdistrict.

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 33% to 31% during the year under review. In all, 35 217 clients in this category were tested compared with the 33 206 tests of the previous year, indicating a 6% increase. The VCT uptake rate was 35,4% compared with the 33% of the previous year. The HIV-positive rate for children under five remained 34,6%.

The National HIV Antenatal Survey for 2005 reports a prevalence rate of 32,4% in Gauteng.

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, 18 460 patients have been assessed by the clinics of the Municipality, and 18 460 CD4 counts of HIV-positive patients have been done. The percentage of patients with CD4 counts of less than 200 has decreased from 39% to 28%, which indicates the success of the programme.

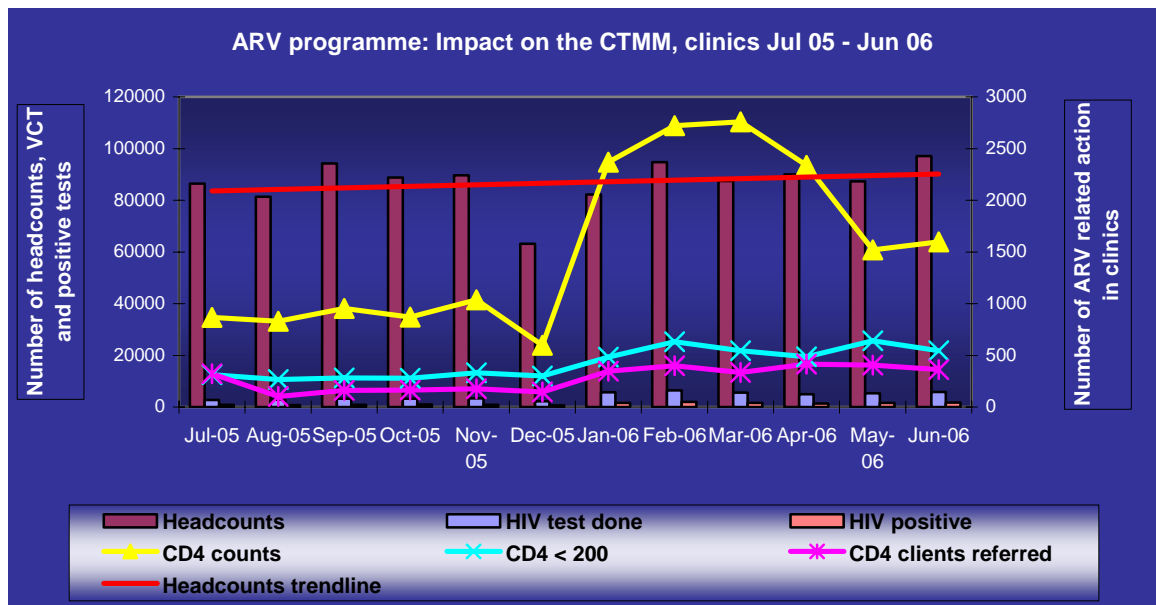


Figure 19: ARV programme: CTMM clinics (July 2005 – June 2006)

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; 74% of all facilities in the Gauteng part of Tshwane now offer the service (87% 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: 79%; South: 80%; North: 43%; Moretele: 88%; and Odi: 70%. Special attention should be given to improving access to this important service in the northern subdistrict.

A total of 24 248 antenatal clients were tested for HIV during the year under review, and 25% 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

The Aids Unit is guided by its vision of the community of Tshwane as a community empowered to cope with the challenges of HIV and Aids. Its mission is to be a unit of excellence that empowers the community through a multi-sectoral, coordinated and integrated response in order to –

- reduce the number of new HIV infections;
- lengthen the productive life of those infected with HIV; and
- support children and families affected by Aids so that they can live normal lives, and in the process reduce the socio-economic impact of Aids on the community.

The Tshwane Aids Unit was only established in 2003 following the amalgamation of the region's 13 municipalities, but the Tshwane Aids Programme has existed since 1990. This programme was originally managed by the Aids Training, Information and Counselling Centre (ATICC).

Unlike ATICC, the new Aids unit has a strategic role to play (its function is not primarily raising awareness, providing training, and doing testing and counselling). Being a strategic unit, it is able to manage the Aids programme on a higher level, focusing mainly on the multi-sectoral response of all players to ensure that action is integrated and coordinated.

The Tshwane Aids Unit pursues excellence in all it does, and in December 2005 the then Executive Mayor, Fr Smangaliso Mkhathswa, awarded Service Excellence Awards to three members of the unit (Marlene Fourie for mentoring, Thabihta Mosito for innovation, and Patricia Mbatsha for valour).

The Aids Unit does not rely solely on the budget allocated by the CTMM; it also lobbies for external funding. Since 2003 the Department of Provincial and Local Government has allocated a grant to supplement the budget. This grant has become indispensable and is needed to help manage the Tshwane Aids Programme. It currently exceeds the CTMM budget allocation. The amount received from the Department for 2005/06 was R4 558 000.

Programmes are developed strategically according to priorities, and a multi-sectoral response is pursued by involving Government departments, the Tshwane Metropolitan Aids Council, Aids councils in the area, NGO forums and ward committees. NGO and external funding is sought, as is collaboration regarding the Gauteng database.

Table 8: Priority areas of the Aids programmes

Priority area	Target groups
The youth	Children at school Students at tertiary institutions Children who have left school Orphans Child-headed households Young people in informal settlements Street children Young people at sports clubs
Women	Young women Domestic workers Women living in informal settlements Grandmothers Caregivers Commercial sex workers Men
Specific industries and groups	Transport industry: truck, taxi and bus drivers Construction industry: migrant workers Businesses and workers (via workplace programmes such as the CTMM's Employee Wellness Programme) Places of entertainment: people who visit shebeens, taverns and night clubs Occupants of single-sex hostels Immigrants Traditional healers Indigent people

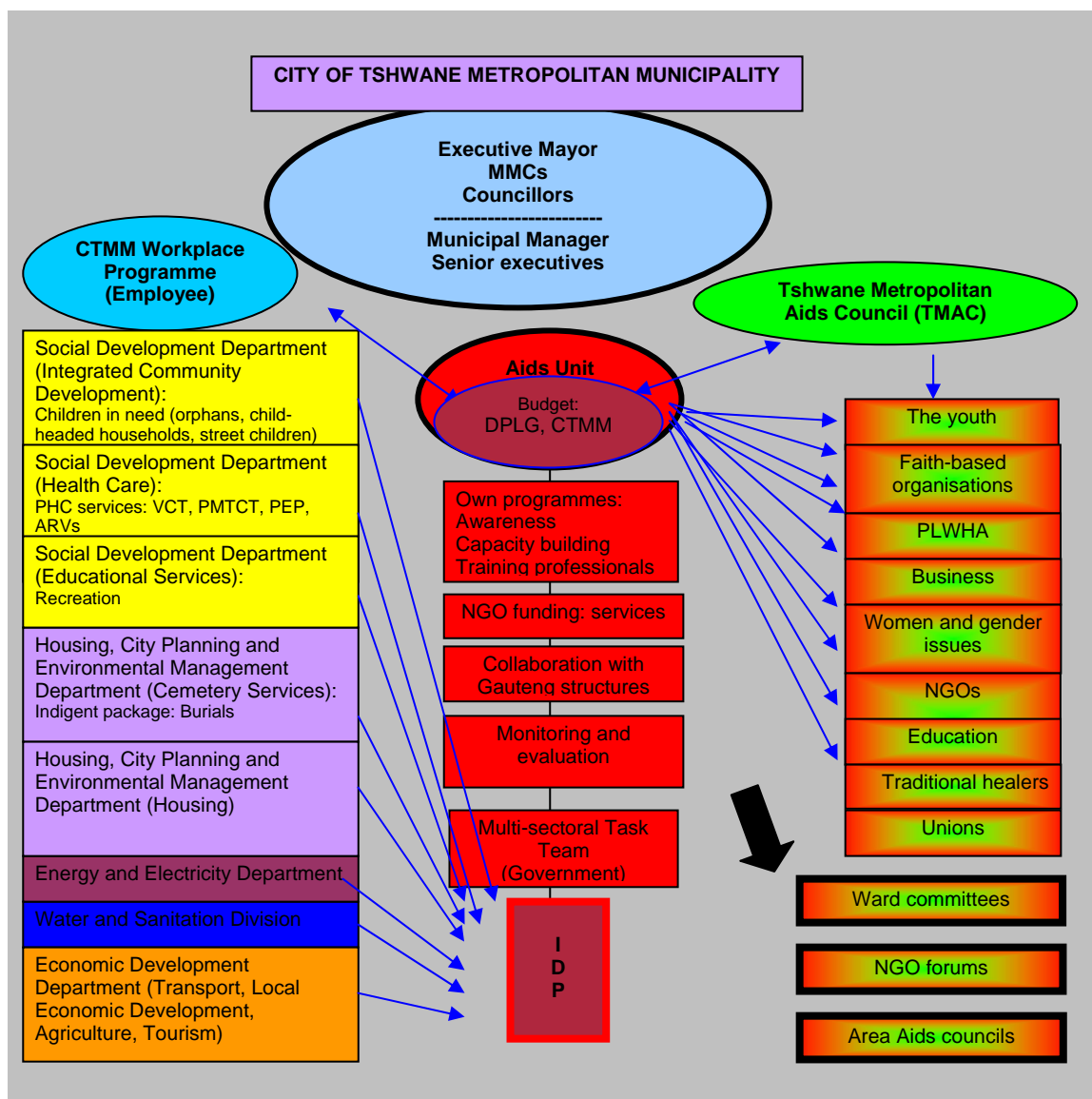


Figure 20: The context of the Tshwane Aids Programme within the CTMM

3.5.7.3 Tshwane Aids Strategy

In 2002 the STH Consortium was appointed to develop an Aids strategy for Tshwane. The Tshwane Aids Strategy that was subsequently developed comprises four pillars of management.

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

- Promotion of the Aids strategy
- Effective data collection, processing and reporting to monitor the pandemic and the response to it
- Community involvement through the Tshwane Metropolitan Aids Council
- Liaison with national and provincial health departments and the Department of Provincial and Local Government, as well as other stakeholders

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

- Social mobilisation of and communication with the community
- Prevention services rendered by the appropriate departments and divisions
- Care and support services for people living with HIV or Aids, including economic development programmes, social welfare and health services, and the Living Positively with HIV and Aids programmes

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

- Optimal resource utilisation through the coordination and integration of the resources of the different spheres of government, public and private roleplayers, NGOs, CBOs and development agencies, as well as through area development plans
- External funding
- Involvement of business in prevention, workplace and community care programmes
- Partnerships and referral networks

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

- Aids management programmes in all appropriate departments of the Municipality
- An HIV and Aids workplace programme

Funds have already been allocated for the appointment of a service provider to update the Aids strategy.

Apart from the overarching Aids strategy, strategies were also developed in respect of the following:

- Women
- The youth
- The 2010 FIFA World Cup
- The mainstreaming of the HIV and Aids response in the CTMM

To ensure that service of a high standard is maintained, the Tshwane Aids Unit formulated guidelines for the development of educational material, training protocols and procedures for dealing with enquiries.

3.5.7.4 Projects of the Tshwane Aids Unit in 2005/06

Voluntary counselling and testing

Although the Tshwane Aids Unit no longer provides VCT services, it still plays an important role in that it trains PHC staff to ensure that a high level of service is maintained in clinics. The unit continues to refer clients, as members of the community still consider the unit to be a resource for information and for the coordination of care and support.

HIV and Aids information sessions

HIV/Aids coordinators are often requested to present information sessions in the community. During the year, 23 sessions were held, with 1 024 people attending.

Training

In the years since the establishment of the early Aids programmes in the 1990s, ATICC and later the Tshwane Aids Unit gained recognition for the quality training they offered. During the year under review, 99 training sessions were held, with 2 715 people attending.

Capacity-building projects

During the period under review, service providers were appointed to present two capacity-building programmes.

The one was a programme for vulnerable women. The service provider developed manuals and trained master trainers. The programme targeted domestic workers, commercial sex workers, disabled women, women in shelters, and women who look after people infected with HIV or people affected by HIV and Aids.

The second programme was one for young people between the ages of 14 and 35 who are not at school. A peer educator programme was developed and 40 peer educators were trained.

Exhibitions

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

Counselling

Clients continue to approach the Aids Unit seeking specialised counselling, even though all PHC clinics do voluntary counselling and testing. During the 2005/06 year, 319 clients were assisted.

Sports heroes' walk against Aids

South African sports personalities and SABC sports presenter, Cynthia Tshaka, took part in the Walk Against Aids, walking from Gauteng to Nelspruit in Mpumalanga to raise funds and to heighten awareness of HIV and Aids among the communities. The objective of the walk was to use sport as a tool to change people's lives. Sports heroes play an important role in society and their high profile can be used to reach people.

The programme began on 23 November 2005 in Majaneng, Hammanskraal, with sports clinics and HIV and Aids awareness programmes. The Tshwane Metropolitan Aids Council and the Aids Unit staged exhibitions there, and Ms MPO Nyatlo, the then MMC for Health and Social Development, delivered the keynote address. On 24 November the team began their walk to Moloto and into Mpumalanga. This event strengthened the Aids programme in Tshwane and assisted with the build-up to World Aids Day.

World Aids Day

The World Aids Day event was preceded by a door-to-door campaign involving members of the Tshwane Metropolitan Aids Council. A total of 2 200 volunteers were deployed, reaching 374 718 members of the community. The main event on 1 December 2005, a mayoral event at Olievenhoutbosch, gave the multi-sectoral teams representing both the CTMM and community stakeholders the opportunity to join forces in taking action against the HIV and Aids pandemic. Trained volunteers used the event to approach and educate communities at different levels about prevention, available resources and the local referral system for HIV and Aids.



The former mayor of Tshwane (*pictured in the centre*) delivering the keynote address on World Aids Day

The keynote address at the World Aids Day event was delivered by the then mayor, Fr Smangaliso Mkhathshwa. His message was that the community should work with government to fight the scourge of HIV and Aids, stressing that education on sexuality and behaviour should start at home. This, he said, would stop children from learning the wrong behaviour from others. He emphasised the value of the ABC (abstinence, being faithful or condomise) prevention strategy, which had to start at home, and which was inexpensive. He affirmed that where abstinence was not possible, a condom should be used.

Candle-lighting memorial services

Tshwane's main candle-lighting memorial service, held on 8 May 2006 at the Bethesda Community Church in the inner city, saw the hand-over of the Torch of Hope (a SALGA Gauteng initiative). Tshwane's mayor was represented at the event by Cr Christine Mamabolo, who delivered the evening's keynote address and received the Torch of Hope from the mayor of Metsweding, Cr Agnes Molondobozi. The municipal manager of Metsweding, Mr Chikane Chikane, was also present.

This event was hosted jointly by the Tshwane Aids Unit and the Tshwane Metropolitan Aids Council. About 200 people attended the event, including athletes from Gauteng North and the SuperSport Football Club.

Other candle-lighting memorial services, coordinated by the Aids Unit and hosted by churches in different parts of Tshwane, were held:

- A service at the St Barnabas Catholic Church in Block A, Mabopane, on 18 May 2006 – About 500 people from different denominations attended. The areas represented were Ga-Rankuwa, Winterveld and Temba.
- A service held at the Church of Christ at the Sammy Marks Conference Centre on 21 May 2006 – About 400 people attended.
- A service at the Roman Catholic Church at Nellmapius – There were about 300 people present.
- A service held at the Miracle Rock of Ages Baptist Church in Lotus Gardens – About 400 people attended.
- A service in Olievenhoutbosch – About 40 people were present.



Ms Seemola Koka, a coordinator in the Tshwane Aids Unit, lights a candle at one of the candle-lighting memorial services

3.5.7.5 CTMM HIV/Aids Workplace Programme

The responsibility for coordinating the HIV/Aids Workplace Programme for CTMM employees was assigned to Dr Philip Venter, the Deputy Manager for Business Strategy, in August 2005.

The following can be reported for the year under review:

- The Workplace HIV/Aids Task Team, which is made up of representatives of all the departments, managed all HIV- and Aids-related activities in the departments and held four meetings during the year.
- A steering committee comprising representatives of Human Resources, Finance, Local Economic Development, Health Care and the unions was formed in October 2005. It reviewed the Municipality's workplace policy and held five meetings and one workshop.
- Occupational Care South Africa (OCSA) was appointed as a service provider to render a voluntary counselling and testing service for employees of the Municipality. During the year under review, 888 employees sought counselling and tests. OCSA also proposed a number of amendments to the Municipality's workplace policy.
- The National Institute for Community Development and Management (NICDAM) trained 20 additional peer educators. The Municipality now has 259 trained peer educators. Two seminars for peer educators were held during the year and two newsletters were distributed.
- A substantial amount of training material was obtained to assist peer educators with their awareness campaigns. The training material included videos, DVDs, booklets, posters and pamphlets. Thirty condom dispensers were also obtained to be installed at worksites in the various departments.

3.5.7.6 Integration strategy

The Tshwane Aids Unit operates as a facilitator and coordinator for the Tshwane Aids Programme. Given the extent of the pandemic and its complexity, it is imperative that partnerships are created, the response to the pandemic is coordinated, and HIV and Aids management is integrated into strategies and programmes.

The Minister of Health, Dr Manto Tshabalala-Msimang, recently appealed for more partnerships between the government and NGOs to address the challenges posed by HIV and Aids. She affirmed the government's commitment to giving financial and technical support to NGOs that provide services.

A number of different strategies are in place to ensure that the response is multi-sectoral. A multi-sectoral task team comprising 18 government departments and the religious sector was established on 15 February 2006. Its aim is to share information; strengthen collaboration; promote services, activities and programmes; and render and receive support from fellow sector representatives.

This task team will meet every six months for a morning seminar to present programmes and plans. After the seminar a newsletter will be distributed to members and other stakeholders.

Table 9: Overview of the sectors represented in the multi-sectoral response

SECTOR	GROUP															
Agriculture																
Arts, culture, science and technology																
Correctional services																
Defence																
Education																
Environmental affairs and tourism																
Health																
Housing																
Labour																
Public enterprises																
Science and technology																
Safety and security																
Social services																
South African Police Service																
Sport and recreation																
Statistics SA																
Trade and industry																
Transport, water affairs and forestry																
Religious																
	Women	Disabled people	PLWHA	Orphans	Elderly people	The youth	HCWs	CSWs	Migrants	Prisoners	Employers	Employees	Educators	Politicians	Traditional healers	Men

3.5.7.7 NGO funding

A portion of the grant from the Department of Provincial and Local Government has to be allocated as donations to NGOs working in the field of HIV and Aids. Guidelines on the funding of NGOs and a monitoring and evaluation tool were developed to ensure that the funds are managed responsibly.

The following seven projects were identified, and six NGOs have been recommended to render the services:

- Social mobilisation regarding HIV and Aids programmes in Tshwane (The aim is to promote a collective response in order to bring about behavioural change, a reduction in the number of HIV infections and the creation of an enabling environment that is conducive to the care of those infected with HIV or affected by HIV or Aids.)
- Capacity-building among ward committee and NGO Forum members regarding HIV and Aids (They have to be empowered to improve communication with the community and to enhance their project development competencies with regard to HIV and Aids and other related issues.)
- Capacity-building among CBOs and NGOs in Tshwane with regard to HIV and Aids (The aim is to equip their members with the competencies to implement and manage sustainable programmes that will bring about a change in the HIV and Aids pandemic.)

- Strengthening of the response of the business sector to the HIV and Aids pandemic (Small and medium-sized businesses in Tshwane will be assisted in establishing realistic and appropriate HIV and Aids workplace programmes or in strengthening their existing programmes.)
- Conveying of HIV- and Aids-related messages to the youth of Tshwane through edutainment (The idea is to empower young people to make responsible decisions.)
- Strengthening of the response of faith-based Christian, Hindu and Muslim organisations in Tshwane (The aim is to have these organisations respond optimally to the impact of the HIV and Aids pandemic through the establishment of realistic HIV and Aids programmes or the strengthening of existing ones.)
- Strengthening of the response of traditional healers to the HIV and Aids pandemic (Initiation schools and traditional mentors will be assisted in establishing HIV and Aids programmes in Tshwane or in strengthening existing ones.)

3.5.7.8 Tshwane Metropolitan Aids Council

The Tshwane Metropolitan Aids Council (TMAC) plays an advisory, advocacy and monitoring role with regard to both the community at large and the local authority. Among its functions are:

- Advocating and building a well-coordinated partnership between civil society, the CTMM and other spheres of government
- Mobilising civil society for an effective response
- Advising the CTMM on Aids
- Monitoring and evaluating the implementation of the Tshwane HIV/Aids Strategic Plan
- Promoting the allocation and equitable distribution of resources to organisations

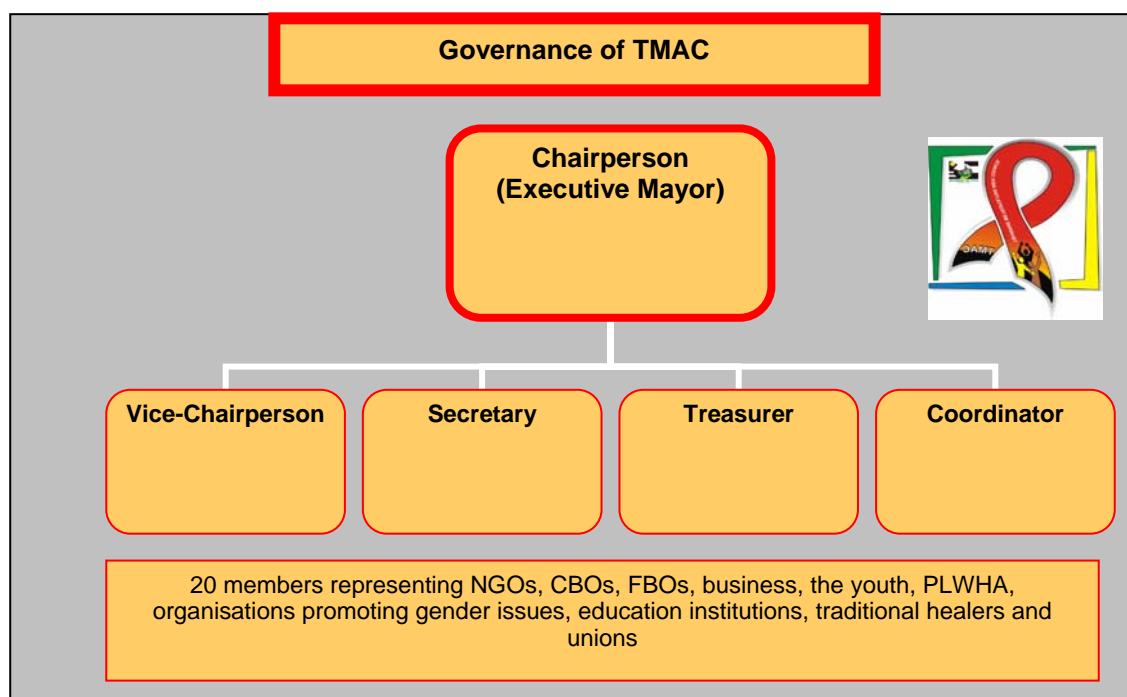


Figure 21: Governance structure of the Tshwane Metropolitan Aids Council

Four executive committee meetings and one integration conference were held during the year under review. According to the TMAC constitution, the Executive Mayor is the chairperson. The former MMC for Health and Social Development, Ms MPO Nyatlo, was delegated to serve as the chair until 28 February 2006.

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 subcommittees in all wards has remained a challenge. Communities are, however, being educated constantly on health matters in various ways.

Owing to severe personnel and other resource shortages, it is imperative that we combine our efforts to improve the health of all in Tshwane. We therefore welcome the participation of NGOs, CBOs, churches, schools, and national and provincial government departments in the Municipality's health promotion programmes. Pharmaceutical companies and private health institutions have also shown themselves 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 the quality of their lives despite chronic illnesses, and enjoy healthy lifestyles.

The empowerment efforts of the Municipality and the community of the Moretele subdistrict during the year under review included the following:

- Communities were regularly informed of services that are available to them (through the printed media and community radio stations).
- 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 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 specific community groups, eg women or elderly people. All requests for health information were granted.
- Vulnerable groups in the community were assisted through the Municipality's economic empowerment efforts: they were given help in registering as vendors for catering, drama groups, the printing of health-related material, etc.
- Vegetable gardens were established at certain clinics and schools and in some communities to provide an income and improve the nutritional status of certain patients. (Unfortunately, there were not always enough space, staff and other resources available to drive the projects.)
- Community volunteers received training in TB, STIs, family planning and the prevention of teenage pregnancies. This enabled them to assist with the various campaigns. (Community health workers who are associated with NGOs in the communities are trained by the 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.)

Since there are only three health promotion coordinators and no health promoters in the municipal health service, it has to rely heavily on resources from elsewhere, such as provincial health promoters, volunteers, community health workers and private providers, to assist it in meeting the health needs of the communities. The municipal service therefore has to concentrate mainly on raising awareness and providing information, as it does not have at its disposal comprehensive resources to assist people in making the appropriate lifestyle changes that will benefit their health. Topics that were addressed in Tshwane during the year under review are detailed in Table 10.

Table 10: Health promotion activities (2005/06)

Topic/programme	Target group
STIs, HIV and Aids, VCT, ART, PMTCT	Women, men and medical staff
Condom use	Women and men
Nutrition	Childminders and the community
Oral and dental care	The community
Eye care	The community
Child development	Childminders and mothers
Breastfeeding	Mothers and pregnant women
Health services	The community
Assessment of babies	Mothers
Drug and substance abuse	The youth and the community
Skin cancer ("Sun Safe") and albinism	Men and women
Head lice	Parents (parents' meetings)
Child protection and paraffin poisoning	The community and childminders
Immunisation	Mothers, grandmothers and childminders

Topic/programme	Target group
Oral rehydration	Mothers
Family planning	Women and the youth
Teenage pregnancy	The youth
Tuberculosis	The community
Hypertension and strokes	Men, women and aged people
Diabetes and asthma	The community
Cancer (breast, cervical and prostate)	Women and men
Epilepsy awareness	The community
Back care	The community
Awareness of services for the youth	The youth and parents
Worm infestation	The community
Health and hygiene	Schoolchildren, domestic workers and NGOs
Scabies	The community
Foetal alcohol syndrome and antenatal care	The community
Mental health and well-being	The community
Healthy lifestyles and wellness	The community
Cholera	The community
Malaria	The community
Communicable diseases	The community
Stress	The community

Printed information plays an important role in educating the community on health and lifestyle issues. Health messages were captured in various forms in pamphlets and on posters, magnets, rulers, key holders, T-shirts, pens and pull-up banners. All of this proved to be popular with the community; our purpose was to remind them of the health message long after the event.

3.6.3 Special projects or programmes launched

Every effort was made during the year under review to address the real health needs of the people of Tshwane in a more comprehensive way.

3.6.3.1 Cancer awareness and the promotion of a healthy lifestyle

To support the cervical cancer screening efforts at the clinics, emphasis was placed on the importance of regular Pap smears. Articles were published in local newspapers and invitations made on community radio stations to reach the targeted groups of women. In conjunction with CANSA, talks were presented and information was given to various community groups.

Women were also taught about the importance of regular breast self-examinations and the services available to them. Men were informed about the signs and symptoms of prostate cancer, prevention, self-examination, and the services available to them.

The importance of maintaining a healthy lifestyle in the fight against and prevention of cancer was emphasised at all times.

3.6.3.2 Women's health and the promotion of a healthy lifestyle

Measures were taken to help address the following problems that had been identified at the clinics and in the community:

- A sharp increase in the pregnancy rate, especially among teenagers
- Low family planning statistics and the under-utilisation of services
- The high number of STI cases and problems with contact tracing
- Ignorance among women about the need for regular Pap smears, or a lack of knowledge about what services are available to women
- A lack of knowledge among women about menopause

Community volunteers were trained to address these issues in a number of areas. Door-to-door campaigns took place in Orchards, Chantelle and Plastic View in Soshanguve. In all, 3 387 women received information regarding the above problems, and 972 were referred for assistance.

The Nellmapius and Phahameng Clinics presented awareness sessions where family planning methods, unwanted pregnancies, STIs, voluntary counselling and testing, and the abuse of women were discussed. They were well attended by both young people and adults. Community groups and young people also participated in drama performances, musical items, drum majorettes, and gumboot dancing.

The Folang Clinic emphasised women's health during May 2006. The Gauteng Department of Health, Fresenius Kabi and Tshwane Health Promotion participated in the clinic's activities. In all, 286 women attended the information sessions, with 27 of them being referred for family planning and 3 for STI treatment.

Women were given information about women's health issues at the Wonder Park Shopping Mall on 24 and 25 May. Tshwane Health Promotion and the private providers Fresenius Kabi, Aspen, CANSA and Wyeth supplied information to 182 women. Forty-three of the women were referred for STI treatment, family planning, Pap smears and antenatal care.

The impact of these campaigns, although small, will be visible at the clinics in the months to come.

3.6.3.3 Diabetes awareness and the promotion of a healthy lifestyle

Members of the community were made aware of the signs and symptoms of diabetes and were encouraged to test for diabetes. The exhibitions, talks, pamphlets and screening sessions that were presented drew attention to the need for a healthy lifestyle to improve general well-being and prevent diabetes and other diseases.

Awareness campaigns were run during September, November and April at Centurion Makro, Lyttelton Shoprite Checkers, Pick 'n Pay Mall Doringkloof, and at clinics in Atteridgeville, East Lynne and Mamelodi. The private companies involved were Pharmacare, Bayers Health Care and the Society for the Blind. People with high blood glucose levels were referred to clinics or their private doctors for a follow-up. Many questions were answered during the different sessions.

3.6.3.4 Hypertension awareness and the promotion of a healthy lifestyle

The communities of Tshwane received information about the signs and symptoms of hypertension and cholesterol, the risk factors, complications, and the importance of complying with treatment. They learned that they could take better care of themselves by improving their knowledge of the disease, following a healthy diet, exercising, and monitoring their blood pressure. The formal talks were attended by 337 people. The blood pressure of 386 patients was tested, and the blood glucose and cholesterol levels of 150 patients were measured during exhibitions. Thirteen patients were referred to clinics for a follow-up.

3.6.3.5 TB awareness and the promotion of a healthy lifestyle

TB remains one of the biggest health challenges in Tshwane. TB cases are on the increase, and active steps were taken to address the problem. Poor living conditions and poor diets contribute to the problem, and so a holistic approach was adopted.

To increase case findings, raise awareness and trace defaulters, a number of educational sessions were held. Sessions for both the clients and their employers were presented at places of work, exhibitions were staged, door-to-door campaigns were run, and articles were published in newspapers. People were also sensitised through community radio programmes.

Employers have become increasingly aware of their role in fighting TB, especially in light of the issue of the combination of TB and HIV. Many companies and NGOs are willing to work together, and NGOs provided volunteers and community health workers for the door-to-door campaigns in the most affected areas.

The following successful TB activities were carried out during the year under review:

- TB awareness exhibitions and talks were presented at five different venues. A total of 1 243 people attended, and 52 of them were referred to clinics.
- TB information sessions were held for the management of organisations. Eighty-four people attended the sessions at Target Panel Beaters, the Tshwane University of Technology, restaurants, the CSIR, Fatima House and several national government departments.
- Door-to-door campaigns were run. For the campaigns, 121 volunteers received TB training. In all, 5 244 houses were visited, 9 580 people received information, 75 sputum samples were collected, and 175 people were referred to clinics. The places visited were the Schubart Park flats; Soshanguve Extensions 8A, 8B and 10; Nantes, Eersterust; Nellmapius Extension D; Section F, Mamelodi West; Stanza Bopape Extension 11; Lotus Gardens; and Olievenhoutbosch.

3.6.3.6 STIs, HIV and Aids, and the promotion of a healthy lifestyle

The Health Care Division embarked on a number of activities during the year under review to address the two main problems identified in STI management, namely low case findings and low contact treatment. The contacts treated have remained at 15% to 18%, while the national target is 40%.

The following activities were carried out in specifically targeted areas:

- STI awareness sessions and exhibitions – These were held in the Centurion area, Danville, West Park, Mamelodi and at the clinics. In all, 1 769 people attended.
- STI information sessions for company workers – A total of 472 people attended.
- STI door-to-door campaigns – Training was given to 121 volunteers. The Phomolong and Olievenhoutbosch informal settlements and Lotus Gardens and Mamelodi were targeted for the home visits. In all, 5 198 homes were visited and 51 people were referred to the clinics for a follow-up.
- Contact letters for all STI client contacts – The clinics continued with these letters throughout the year, but very few of the contacts attended the clinics.
- An STI workshop on 16 February 2006 – The purpose of the workshop was to inform general practitioners, private pharmacists and occupational health nurses about the standardised syndromic management of STIs and also to strengthen the public-private partnership. Presentations were given on the current STI situation in Tshwane, the STI syndromic approach, surveillance and HIV research. The topics covered every aspect of the management of STIs. The Health Promotion Subsection staged exhibitions on STIs and the health services rendered by the CTMM. The pharmaceutical companies (Pharmacare and Fresenius Kabi) also had exhibitions promoting their STI products. Eighty-five health professionals and twenty-six doctors attended the workshop.

3.6.3.7 Healthy lifestyle

All activities focused on promoting a healthy lifestyle. The following were carried out in the Moretele subdistrict:

- 84 educational sessions on life skills
- 31 sessions of physical exercise for chronically ill clients
- 20 recreation and support programmes for disabled clients
- 20 self-help projects at schools and crèches (gardening, first-aid and hand-washing facilities)
- 20 counselling sessions for traditional practitioners and social security clients



Speakers at the STI workshop (*l to r*): Dr C Holm, Dr L Doussy, Dr S Odugwu and Dr M Vermaak, the General Manager of Health Care

3.7 IMPROVING ENVIRONMENTAL HEALTH CONDITIONS IN TSHWANE

The field of environmental health is devoted to the identification, monitoring and management of environmental hazards or stresses (ie physical, biological and chemical factors) that may cause health risks either in the workplace or in the community as a whole.

Human health and disease are determined by factors in the environment. The field of environmental health concerns itself therefore with community safety from an environmental perspective (safe water, food, air and shelter, etc) and with matters that affect community health. It deals with environmental factors that have an impact on the health and well-being of people, whereas the field of health care deals with the examination and treatment of medical conditions.

According to the Constitution of the Republic of South Africa, 1996, every person has the right to a clean and safe environment, ie an environment that is not dangerous or harmful to health or well-being. To this end the environment has to be protected for the benefit of present and future generations through legislative and other interventions that prevent pollution and ecological degradation.

In order to provide a safe and healthy environment for the residents of Tshwane, the Health Care Division has to comply with the provisions of section 20 of the Health Act, 1977. In terms of Part B of Schedule 5 to the Constitution, a local authority is obliged to render the municipal health services defined in section 1 of the National Health Act, 2003. These services include –

- water quality monitoring;
- food control;
- waste management;
- health surveillance of premises;
- surveillance and prevention of communicable diseases;
- vector control;
- environmental pollution control;
- disposal of the dead; and
- chemical safety.

The Environmental Health Section has developed and approved by-laws, policies and procedures relating to –

- the processing of game meat in butcheries;
- the slaughtering of animals outside of an approved abattoir;
- special events;
- food poisoning;
- the handling of noise complaints; and
- fines.

The Section has an electronic workflow and management information system. These will be developed further during the next financial year.

Table 11 provides an indication of the scope and volume of the work done by the Environmental Health Section.

Table 11: Scope and volume of work: Environmental Health Section

Scope of work	Workload	Workload accomplished
Monitoring of premises	49 074 premises	21 412 premises
Sampling	1 196 samples	1 196 samples
Handling of complaints	2 538 complaints	2 538 complaints
Advisory service	2 863 enquiries	2 863 enquiries
Communicable diseases	15 cases	15 cases
Seizure and food condemnation	4 883 674 kg	4 883 674 kg
Handling of licence applications	522 applications	522 applications
Health education and community development	174 projects/sessions	174 projects/sessions
Building plans	943 plans	943 plans

The workload of the Environmental Health Section is currently heavier than what the current staff establishment can handle, for example only 44% of premises can be monitored.

3.7.1 Sustainable Energy for Environment and Development (Seed) Programme

The Sustainable Energy and Climate Change Strategy was developed for the Municipality with the assistance of the consulting firm Africon. A baseline study was done and it gives an indication of how energy is consumed in the city and in turn how the city is contributing to the global emissions of greenhouse gases.

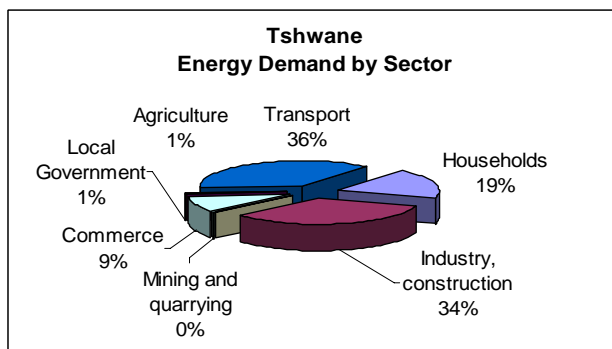


Figure 22: Energy demand by sector

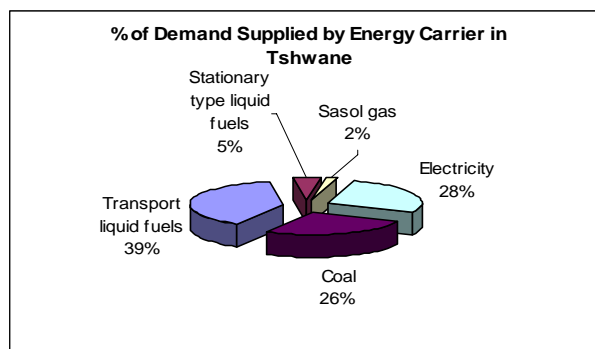


Figure 23: Energy demand by carrier

The figures above show that the transport sector and liquid fuels represent the greatest demand and supply, respectively. Transport clearly plays a major role in the consumption of energy. Overall greenhouse gas emissions have been calculated to be in the region of 12,7 million tons of carbon dioxide equivalent (this compares favourably with that of other South African cities).

By having its effective sustainable energy and climate change strategy in place, the Municipality has shown that it supports improvements in air quality and energy efficiency, particularly in transport and industry.

3.7.1.1 Programmes for sustainable energy

Enerkey projects

The Municipality, through its Environmental Health Section, was involved in Enerkey projects. Enerkey is a South Africa–Germany collaboration, which aims to develop pathways and implement projects to improve sustainability in the field of energy in the urban region of Gauteng, in particular in the three metropolitan areas. The Enerkey programme is run in collaboration with the University of Stuttgart, the University of Johannesburg, the University of Cape Town (through its Energy Research Centre) and the International Council for Local Environmental Initiatives (ICLEI).

Renewable Energy and Energy Efficiency Partnership (REEEP) Project

The REEEP programme makes the case for renewable energy and energy efficiency. It pursues social and economic development, the reduction of emissions, and the meeting of local and national energy and emission targets by raising awareness, improving knowledge and building capacity at local and national government levels.

The expected output of the project is a document clarifying the potential of cities to lead renewable energy and energy efficiency implementation, and potential contribution to national targets. The participating municipalities include Cape Town, Ekurhuleni, Tshwane, Potchefstroom and Sol Plaatje.

Sustainable Energy Demonstration Projects

A number of projects were developed in Tshwane. One of them was a project that entailed the distribution of 500 liquefied petroleum gas (LPG) bottles and stoves to households that are not connected to the electricity grid. Another involved the retrofitting of lights in buildings and the use of energy-saving technologies.

The envisaged projects include a project for the retrofitting of nine municipal buildings to improve their thermal performance, a project for the retrofitting of the greenfield housing project with solar water heating systems and a project to generate electricity from landfill gas. The latter two projects have the potential for clean development mechanism qualification.

3.7.1.2 Cities for Climate Protection campaign

The following projects were executed as part of the Cities for Climate Protection (CCP) campaign:

Balebogeng School CCP Project

The object of the project, an initiative of the national Department of Environmental Affairs and Tourism and ICLEI, is climate change mitigation and the promotion of sustainable development. This objective can be broken down further into the following: climate protection, conservation and rehabilitation, environmental education, capacity-building and community development.

The physical aspect of the Balebogeng project included retrofitting, solar panels and waste recycling on the school premises. The ceilings were insulated and the roofs painted with reflective paint, as this can play a significant role in the reduction of energy use.

This project aimed to reduce greenhouse gas emissions and thereby bring about an annual saving on carbon dioxide (CO₂) emissions, calculated at 0,8 kg/kWh of ±19,698 tons. This is a total energy saving of 24 622,9 kWh per annum and a financial saving of R7 879,33 per annum.

The project was handed over to the Balebogeng School during a ceremony on 7 October 2005.



An installed solar water-heating system

Lefatshe Mini-Munitoria CCP Project

Mini-Munitoria is a municipal facility in Atteridgeville. It consists of offices, a community hall, workshops, amenities and storerooms. The ICLEI grant received went towards the installation of efficient lighting, solar water-heating systems and the replacement of geysers to minimise electricity consumption and greenhouse gas emissions.

The Municipality's Property maintenance Subsection was responsible for the project management and operational activities.



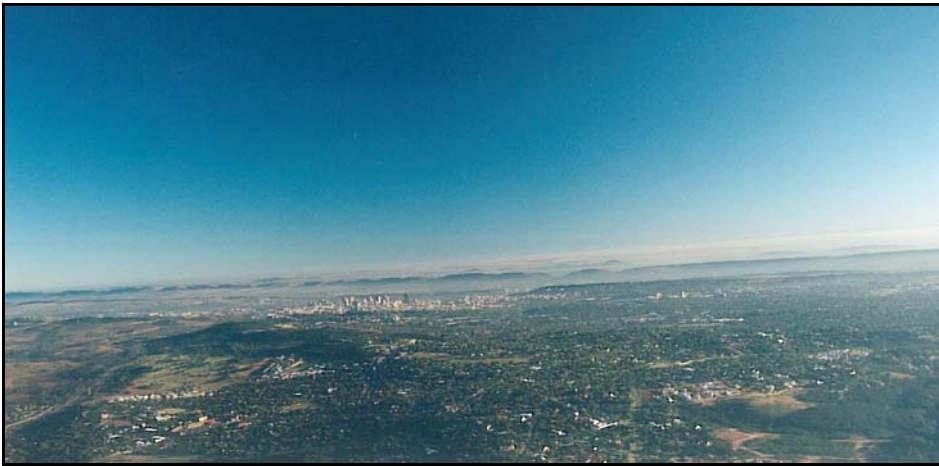
Efficient lighting, using a solar system

3.7.2 Air Quality Management Plan

Air quality management is part of the system of pollution minimisation, management and prevention. The purpose of air quality management is to improve air quality in areas with poor air quality, and maintain air quality in areas with good air quality. It is within this context that the Environmental Health Section initiated the development of an air quality management plan for the CTMM.

The main reason that the Municipality developed its Air Quality Management Plan was to enable it to meet its obligations under the National Environmental Management: Air Quality Act, 2004 (Act 39 of 2004). The plan will initiate best practices in air quality management and bring about a reduction in emissions in a cost-effective and equitable way. This will give rise to an improvement in air quality in the municipal area and a subsequent

reduction in environmental and health risks, in keeping with the requirements of the Tshwane Integrated Environmental Policy.



Aerial view of the Tshwane municipal area, from the south



Aerial view of the Tshwane municipal area, from the east

Air quality monitoring network

The two permanent ambient monitoring stations in Rosslyn and Pretoria West were supplemented in accordance with the Integrated Development Plan. The Municipality now has an additional three permanent monitoring stations and eight mobile street box stations. These stations will, for the most part, monitor pollutants such as sulphur dioxide (SO₂), particulate matter < 10 (PM₁₀), nitric oxide (NO), nitrogen dioxide (NO₂) and carbon monoxide (CO).



One of the new stations in the air quality monitoring network

3.7.3 Food safety

The 2005/06 year ushered in a challenging time in respect of food safety in that planning for the 2010 FIFA World Cup was incorporated into the third draft strategy on food safety being developed for the Health Care Division. (This task has, however, been handed over to a higher level for further execution due to the nature of the task.)

The approved strategy for food safety for Tshwane was updated in December 2005 to make it more executable. Compliance with the objectives is currently at 80%.

Various policies on food safety were developed and approved by the Division's management. The Municipality's policy on game meat was adopted as a national policy, and this should be regarded as a major achievement.

Two reports with recommendations regarding food samples were submitted during the year under review and audit reports from the Research and Development Section were scrutinised.

Five introduction permits for milk and milk products were finalised.

3.7.4 Rodent control project

A rodent control project was carried out in Ward 71 in Atteridgeville. It ran for 50 days from 19 April to 30 June 2006. The project, for which R100 000 had been made available, involved 20 unemployed workers and 2 supervisors from within the community. The snap traps and rodenticides used were placed and monitored daily.

A total of 280 kg of rodenticides, 1 800 bait boxes and 450 snap traps were used in the project. In all, 2 241 houses were visited, and 6 576 rodents were eradicated.

3.7.5 Noise management

A total of 322 complaints about noise were received during the period under review. Of these, 90% were related to noise originating from residential premises, and only 10% were about noise from business premises. Forty per cent of the complaints had to do with music, compressors and extractor fans.

When complaints are received, noise measurements are taken. This is the only way to determine if the noise level in question exceeds the noise rating level according to the SANS (South African National Standards) code criteria for the measurement and rating of environmental noise in respect of land use, health, annoyance and speech communication. This is the information base that is used to determine if a noise is a disturbing noise under the Gauteng Noise Control Regulations and the Noise Management Policy of the CTMM.

Two new sound level meters were purchased during the period under review. These meters have the capacity to download information gathered during measurement, which is vitally important for the purposes of general information, technical data and analysis.

The Environmental Health Section has developed and implemented an electronic noise management system based on the Noise Management Policy of the CTMM. This system forms the basis of control, enabling the Municipality to limit noise impact and ensure that environmental noise does not adversely affect the health and well-being of the general public. The system will also set acceptable noise level standards and noise impact criteria for all new township developments in the different designated noise control zones identified for the eight city planning regions of the municipal area.

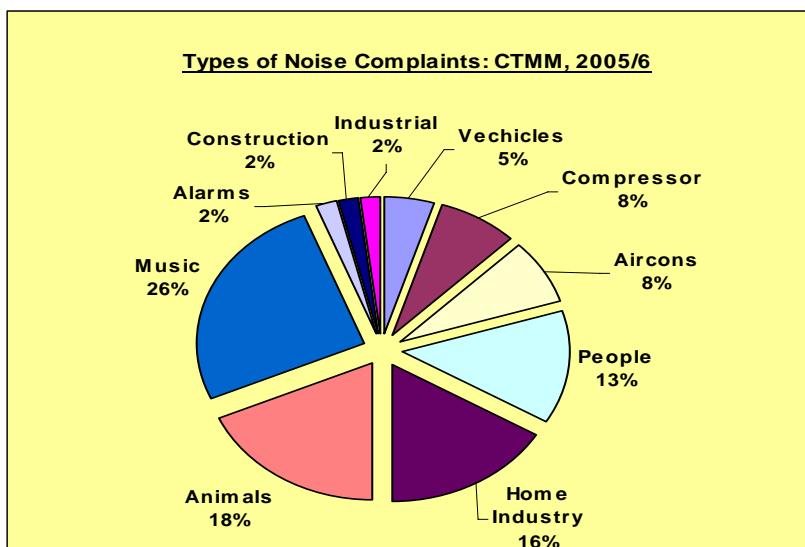


Figure 24: Types of noise complaints reported to the CTMM in 2005/06

3.7.6 Staff development and student training

Staff in the Environmental Health Section underwent the training courses set out in Table 12.

Table 12: Training of staff in the Environmental Health Section (2005/06)

Course	Institution presenting the course	Number of environmental health practitioners who successfully completed the course
Law enforcement courses	PREMOS (Metro Police)	35
MS Word XP courses	PREMOS	3
MS Excel XP course	PREMOS	1
Junior Management Course	PREMOS	1
Food Fortification Course	Tshwane University of Technology	7
Game Meat Course	Tshwane University of Technology	Ongoing
Epidemic Preparedness and Response Training	Gauteng Provincial Government	2
Air Quality Management Course	Tshwane University of Technology	12
Pest Control Operator's Course	Tshwane University of Technology	2

The Environmental Health Section also arranges experiential training opportunities for environmental health and nursing students from the Tshwane University of Technology, and medical students from Medunsa and students from the University of Johannesburg.

3.7.7 Community awareness of and training in environmental health and related issues

Arbor Day

The Environmental Health Section's theme for Arbor Day in September was *Plant a tree – Grow our future*. Learners from 16 schools took part in the festivities at their schools. Eighty trees were bought from the Booyens Nursery and supplied to these schools during Arbor Week. This project was aimed at promoting environmental awareness.

World Environment Day

World Environment Day was commemorated on 2 June 2006. The international theme was *Deserts and desertification: Don't desert dry lands!* World Environment Day is one of the principal vehicles through which environmental health services stimulate awareness of the environment and focus political attention and action on it. The main purpose of World Environment Day was to encourage people to become more active supporters of sustainable and equitable living, to promote an understanding that communities play a central role in changing attitudes towards environmental issues, and to develop the community so that they can enjoy a better quality of life.

Tshwane's World Environment Day project was a multidisciplinary project involving a number of stakeholders. Schools with special needs (schools that have learners with disabilities) were invited to take part in an art competition with the international theme. The learners of these schools had to construct an artwork out of natural materials such as soil, the bark of trees, etc. The winners from all 12 participating schools were awarded certificates and prizes. Special prizes for outstanding work were awarded to six learners, and special certificates were handed to some schools for their outstanding work.

World No Tobacco Day 2006

World No Tobacco Day was celebrated internationally on 31 May 2006. The Environmental Health Section took part in the celebrations by running an awareness campaign throughout Tshwane. The theme for the year's event was *Tobacco: Deadly in any form or disguise*. The World No Tobacco Day task team members reprinted the poster and pamphlet entitled *Smoke or be healthy* and the no smoking flyer used in the previous year's campaign in order to make the most of the limited funds available for this project. The material was distributed to the clinics and the community.

Outreach and Networking Programme

The Environmental Health Section launched its Outreach and Networking Programme at the Sammy Marks Conference Centre on 30 August 2005. The objective was to form partnerships or formalise relations with key stakeholders in the field of environmental health in an effort to bring about a clean, safe and healthy environment for all residents of and visitors to the city. Both internal and external stakeholders took the opportunity to become involved. The Section's exhibition stand encouraged participation and gave rise to roadshows.

International relations were fostered through the cooperation agreement between Tshwane and Maasmechelen in Belgium.

Educational material

During the year under review, the Environmental Health Section developed the following educational material in-house:

- *City of Tshwane Municipal Health Services, Let's Talk...*
- *Food Safety for the Formal Sector (R918)*
- *Food Safety for the Informal Food Trader*
- Information on recycling