



TSHWANE

2002 - 2003

HEALTH CARE



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LIST OF ABBREVIATIONS

ABET	Adult Basic Education and Training
AFP	Acute flaccid paralysis
AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
ATICC	Aids Training, Information and Counselling Centre
CCP	Cities of climate protection
CERF	Centre for Energy Research
CBO	Community based organisation
COAD	Chronic obstructive airway disease
CHC	Community health centres
CPR	Cardio-pulmonary resuscitation
CTMM	City of Tshwane Metropolitan Municipality
DCS	Department of Correctional Services
Dep Man QA	Deputy Manager: Quality Assurance
Dep Man	Deputy Manager
DMHER	District health expenditure review
DHIS	District health information system
DHS	District health system
DOT	Directly observed therapy
DOTS	Directly observed therapy - short course
EDL	Essential drugs list
EDS	Essential dataset
EE	Employment equity
EH	Environmental health
EHO/P	Environmental Health Officer/Practitioner
EMS	Emergency Medical Services
EPI	Expanded programme immunisation
FBO	Faith-based organisation
FP	Family planning

GB	Green buildings
GHD	Gauteng Health Department
GIS	Geographic information system
GM	General Manager
GPA	Gauteng Provincial Authority
HIV	Human Immunodeficiency Virus
HR	Human Resources
ICLEI	International Council for Local Environmental Initiatives
IDP	Integrated Development Plan
IIEC	International Initiative for Energy Conservation
IMCI	Integrated management of childhood illnesses
IT	Information Technology
LA	Local authority
LAN	Local area network
MAN R&D	Manager: Research and Development
MAN	Manager
MDR	Multidrug resistance
MDS	Minimum data set
MPI	Municipal priority issue
MTCT	Mother-to-child transmission
NA	Nursing Assistant
NDP	National Drug Policy
NGO	Non-government organisation
NMS-POP	Non-medical scheme population
NW (M)	North West – Moretele
NW (O)	North West – Odi
NWHD	North West Health Department
PEP	Prenatal education programme
PEP	Post exposure prophylaxis
PHC	Primary Health Care
PMTCT	Prevention of mother to child transmission
PN	Professional nurse
PWA	People with Aids
SANDF	South African Defence Force
SAPS	South African Police Service
SFA	Strategic focus area
SS	Support services
STI	Sexually transmitted infections
TB	Tuberculosis
UP	University of Pretoria
VCT	Voluntary counselling and testing
WAN	Wide area network

THE DIRECTOR GENERAL

Department of Health
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PRETORIA
0001

His Worship, the Executive Mayor, Members of the Mayoral Committee and councillors of the City of Tshwane Metropolitan Municipality.

Ladies and Gentlemen

2002/2003 Annual Report

It is a privilege for me to present you with the second annual report, in terms of section 23(B) of the Health Act, 1977 (Act 63 of 1977), on the activities of the Health Care Division and on the health conditions in the City of Tshwane.

The report covers the period 1 July 2002 to 30 June 2003 and coincides with the financial year of the Municipality. The report includes combined information of the Tshwane/Metsweding, Gauteng Region and North West (Odi and Moretele) Districts.

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

Yours sincerely

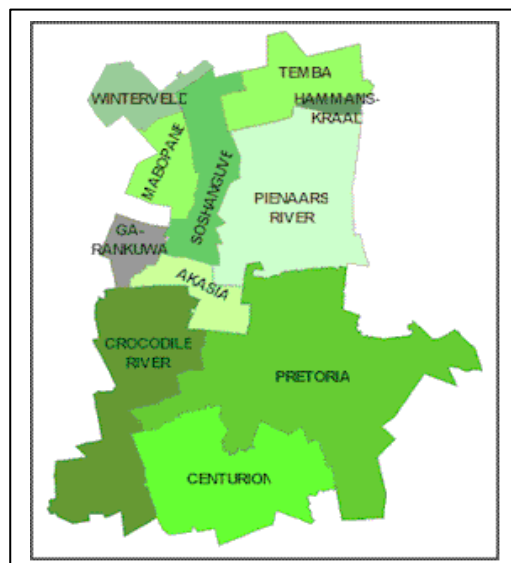
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CITY OF TSHWANE METROPOLITAN MUNICIPALITY

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 contains cross-border areas. The CTMM covers an extensive area of 3 200 km².

The CTMM comprises the following amalgamated municipalities and councils:

- * The Greater Pretoria Metropolitan Council
- * The City Council of Pretoria
- * The Town Council of Centurion
- * Northern Pretoria Metropolitan Substructure (Akasia)
- * Hammanskraal Local Area Committee
- * Eastern Gauteng Services Council
- * Pienaarsrivier Transitional Representative Council
- * Crocodile River Transitional Council
- * Western Gauteng Services Council
- * Winterveld Transitional Representative Council
- * Themba Transitional Representative Council
- * Mabopane Transitional Representative Council
- * Ga-Rankuwa Transitional Representative Council
- * Eastern District Council



1.1 DEMOGRAPHY

The CTMM has an estimated population of 2 million.

Soshanguve and Winterveld have higher percentages of children, and Pretoria has remarkably less children and a higher percentage of people older than 65 years. This will increase the need for child health services in the first two areas, and chronic disease care will be more in demand in the Pretoria area.

Mamelodi, Atteridgeville and Centurion have the highest percentages of the 30 to 49 age group which is usually the economically active group.

The gender distribution is fairly equal, except in Mamelodi, Atteridgeville and Hammanskraal, where males are predominant. Migrant labourers often increase the need for services to treat and prevent sexually transmitted infections (STIs).

TABLE 1. POPULATION GROUP, GENDER AND NUMBER OF HOUSEHOLDS

	Male	Female	TOTAL
Black African	716 850	725 728	1 442 579
Coloured	18 400	20 321	38 721
Indian or Asian	15 084	15 047	30 130
White	228 850	245 703	474 553
TOTAL	979 184	1 006 799	1 985 983
Total number of households	-	-	598637

(Source: Census 2001)

TABLE 2. NUMBER OF INDIVIDUALS ACCORDING TO AGE

	Male	Female	TOTAL
Youth (0-18)	312 078	317 528	629 606
19-65	635 863	639 625	1 275 488
Aged (66+)	31 244	49 645	80 889
TOTAL	979 184	1 006 899	1 985 983

(Source: Census 2001)

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

Service levels impact directly on the health and well-being of the community. Poor living conditions and lack of income commonly increase malnutrition and lower immunity against common infections.

Tshwane has 306 034 unemployed and 457 713 economically inactive residents. A total of 98 704 Households have no income.

16 427 households have no toilet facilities. The risk in these areas is high for Cholera and other diarrhoeal diseases.

2 HEALTH CARE DIVISION

2.1 VISION

The vision of the Health Care Division is to create a healthy city with an empowered community. It aims to do this by enhancing the quality of life of all people of Tshwane by promoting and protecting the health and well-being of its people through leadership and best practices, by providing accessible, affordable, sustainable, equitable, quality, efficient and effective services in a manner that builds partnerships.

The key objectives of the Health Care Division are to-

- improve the health status of the city;
- ensure that primary health care services are accessible to the communities of Tshwane;
- respond successfully to the HIV/Aids pandemic;
- empower the community of Tshwane through health promotion campaigns and community participation;
- improve the environmental health conditions in the city and
- ensure the establishment of partnerships and networks in the implementation of health care programmes.

Local government is currently providing primary health care services in the Pretoria, Akasia and Centurion areas. The Gauteng Provincial Administration provides primary health care services in the Soshanguve and Hammanskraal areas and the North West Provincial Administration in the Ga-Rankuwa, Mabopane, Winterveld (Odi District), Temba and Stinkwater (Moretele District) areas.

2.2 LEGAL FRAMEWORK

The Health Act, 1977 Act 63 of 1977 determined the responsibility of local government as the provision of preventive, promotive and non-personal (environmental health) services. Section 20 of the Health and Welfare Matters Amendment Act, (Act 118 of 1993) reflects the providing of primary health care services and the addition of treatment of diseases and injuries that are normally treated by a general practitioner and the provision of essential medicines.

Schedules 4 and 5 of the constitution allocate the responsibility for health services to the province and that of municipal health services to local government. However municipal health services (MHS) are not defined in any current legislation. The National Health Bill determines MHS as environmental health services.

In terms of the National Health Bill, the district health system is the vehicle for the provision of comprehensive primary health care services. Integration of services will be effected through the delegation of services from provincial to local government, according to relevant legislation, eg Sections 126 and 156(4) of the constitution.

The Gauteng District Health Services Act of December 2000 provided enabling legislation for district health system development. Regulations will be drafted for the delegation of primary health care services.

2.3 FINANCIAL MANAGEMENT OF THE TSHWANE HEALTH DISTRICT

The main budget holders are-

- the City of Tshwane Metropolitan Municipality
- Gauteng Health Department: Tshwane/Metsweding Region
- North West Health Department
 - ❖ Moretele
 - ❖ ODI

The total health district operating expenditure was R180 million, and the capital expenditure was almost R7 million for the financial reporting period 2002/2003. The expenditure of the CTMM Health Care Division is depicted in Table 3.

TABLE 3: FINANCIAL EXPENDITURE OF CTMM 2002/2003

CTMM Health expenditure 2002/2003	PHC health facilities	Pharmaceutical services	Management and support	Health Programmes: Aids and Health promotion	Environmental health services	Total expenditure
Operational	R 38,045,960	R 4,158,385	R 18,813,385	R 4,601,259	R 20,992,580	R 86,611,569
Capital	R 5,541,627					R 5,541,627

3 STRATEGIC GOALS OF THE HEALTH CARE DIVISION

The goals and objectives of the Health Care Division are in support of the strategic focus areas of the City of Tshwane. The strategic focus areas include among other things, new local government structures to ensure responsible governance, ensuring community well-being, managing physical development, encouraging of economic growth and strengthening Tshwane's status

3.1 DEVELOPING THE DISTRICT HEALTH SYSTEM IN THE CITY OF TSHWANE METROPOLITAN MUNICIPALITY

The National Health Plan determined the district health system as the vehicle for the delivery of primary health care (PHC) services. This system provides for a single authority to be responsible for all PHC in a district. A health district is equated to the Metropolitan and District Councils. Gauteng opted for the local government option for the governance of health districts. This was confirmed by a joint declaration, which was signed by all municipalities and the MEC for Health in Gauteng in November 1998. The Gauteng Health Summit of November 2002 reaffirmed this position.

Municipal health services are being defined as environmental health services in terms of the National Health Bill. The province will then delegate the rest of PHC to the municipalities. The delegation will include the secondment of provincial staff to the municipality, and provincial facilities will also be made available for providing of PHC services by the municipality. It will be a functional integration until the envisaged National process to establish a single bargaining council for all health workers in the three spheres of government, has been completed and the transfer of staff would be possible.

A memorandum of understanding has been drafted to facilitate the process and it will be concretised through a memorandum of agreement and annual service level agreements. Local government will thus be responsible for all PHC within the municipal area. It is envisaged that the memorandum of understanding will be signed before the end of June 2003.

An interim District Health Advisory Committee and joint subdistrict teams were established to facilitate joint planning and coordination.

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

3.2.1 ACCESSIBLE SERVICES

Primary health care is provided by clinics, community health centres (CHCs) and district hospitals in the Tshwane area. A total of 2 403 345 patients visited primary health care facilities throughout the City of Tshwane (excluding district hospitals). Primary Health Care (PHC) aims to promote health, prevent illness and cure diseases without admitting a patient to a hospital.

During 2001/2002 the head count at clinics increased by only 1%. The local authority (LA) facilities experienced a 7,7% increase in clinic attendances during the 2002/2003 reporting period. 32% of all patients were seen at the local authority clinics.

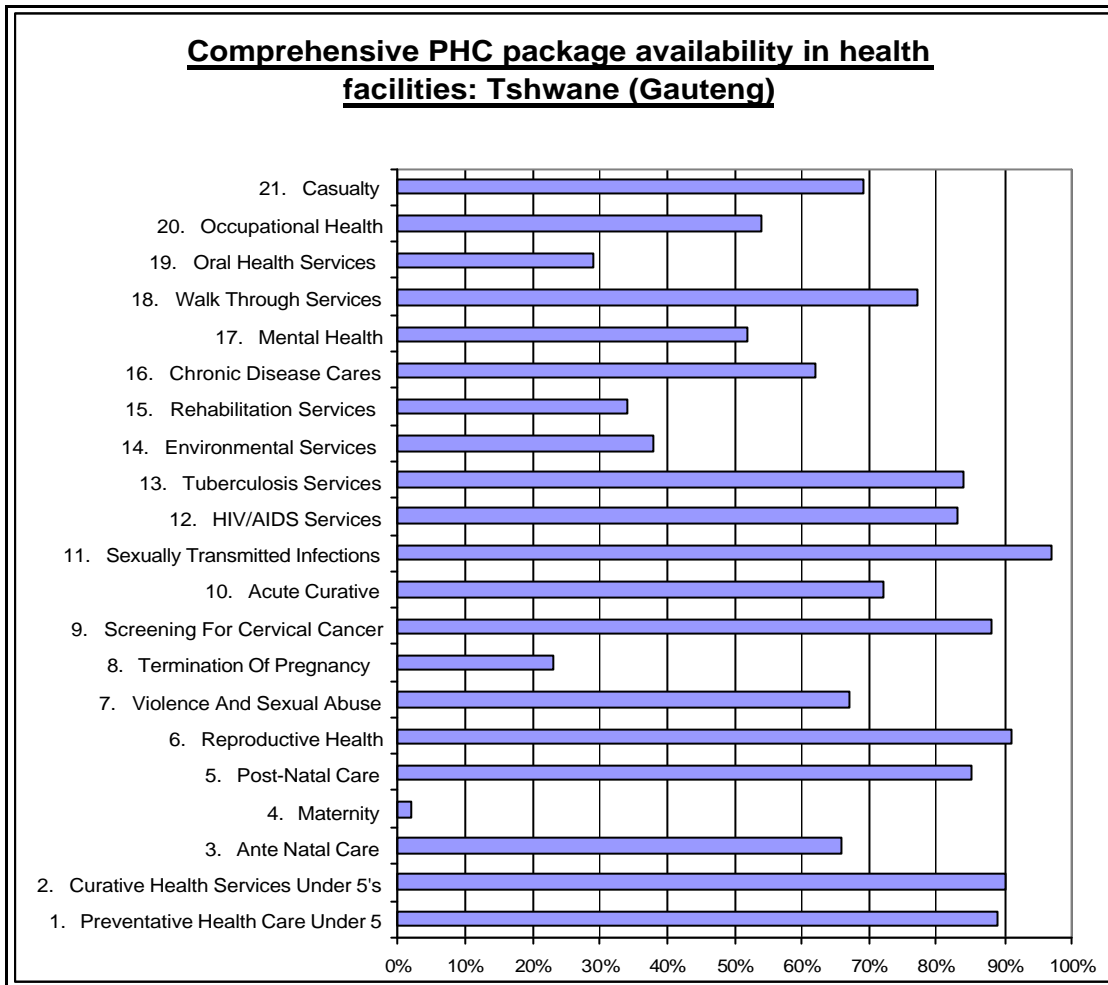
TABLE 4: DISTRIBUTION OF SERVICE POINTS BY BUDGET HOLDER

TYPE	GHD	CTMM	NWHD	TOTAL
District hospitals	3	0	2	5
Community health centres	3	0	2	5
Clinic	9	27	17	56
TOTAL	15	27	21	63

A comprehensive service package for providing of primary health care services was defined by the national Department of Health. The services defined are 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 comprehensive package of services in all service points. Graph 1 reflects the results of a recent audit done on the status of PHC package implementation in the Gauteng part of Tshwane. All public PHC facilities should

offer the full package of PHC services by March 2004. 65% of facilities provide the full package of services, compared to 43% in 2001/2002.

GRAPH 1: COMPREHENSIVE PHC PACKAGE AVAILABILITY IN HEALTH FACILITIES: TSHWANE GAUTENG



3.2.2 SUITABILITY OF THE HEALTH FACILITIES IN TSHWANE

GRAPH 2: PHYSICAL CONDITION OF THE HEALTH FACILITIES IN TSHWANE

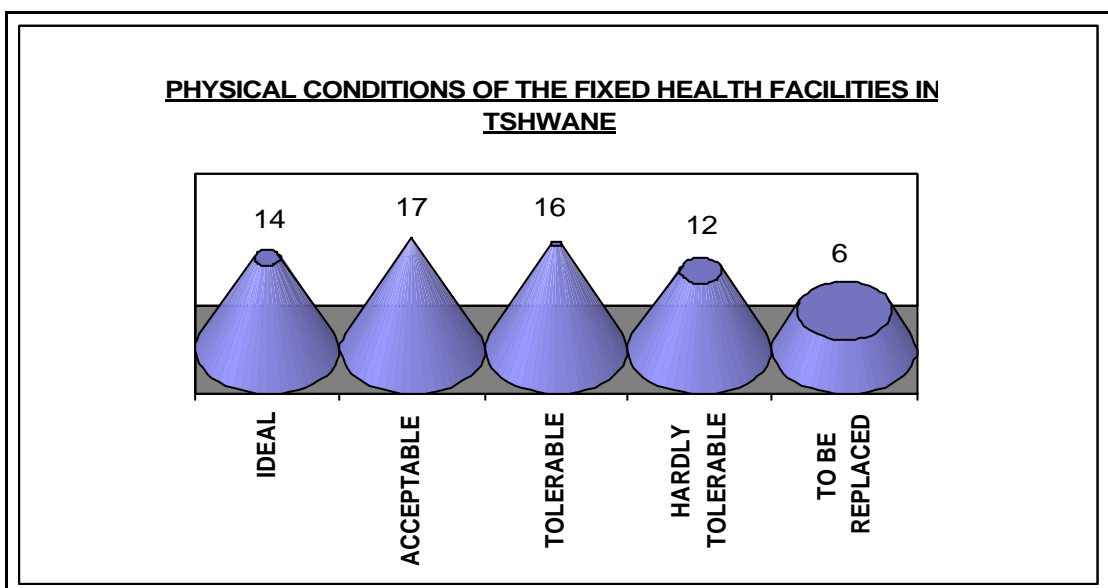


TABLE 5: HEALTH FACILITIES

Table 5 reflects the facilities and their different health services that are currently provided, as well as the physical condition of the buildings.

	Ward	Facility	Owner	Physical condition	Services provided
1	1	Hercules Clinic	LA	Acceptable	Comprehensive PHC
2	1	Daspoort Polio Clinic	UP	Acceptable	Comprehensive PHC
3	2	Jack Hindon Clinic	GPA	Tolerable	Comprehensive PHC
4	3	Folang Clinic	LA	Acceptable	Preventative/Promotative PHC services
5	3	Lerato Satellite Clinics	LA	To be replaced by a fixed clinic	Preventative/Promotative PHC services
6	4	Rosslyn Clinic	LA	Tolerable	Preventative/Promotative and acute curative PHC services
7	4	Karen Park Clinic	LA	Tolerable (hired building; should be replaced)	Preventative/Promotative and acute curative PHC services and chronic services
8	4	Malan & Seuns Mobile	GPA	Mobile	Comprehensive PHC
9	5	Doornpoort Satellites	LA	To be replaced by a fixed clinic	Preventative/Promotative PHC services
10	7	Lotus Gardens Clinic	LA	Acceptable	Preventative/Promotative PHC services
11	7	Danville Clinic	LA	Acceptable	Preventative/Promotative and Chronic PHC services
12	8	Diloye Clinic	NW (M)	Tolerable	Comprehensive PHC
13	8	Jubilee Gateway Clinic	NW (M)	Acceptable	Comprehensive PHC
14	11	Soshanguve Block JJ Satellite Clinic	GPA	Tolerable	Comprehensive PHC
15	12	Kgabo CHC	NW (O)	Acceptable	CHC
16	14	New Eersterus Clinic	NW(M)	Tolerable	Comprehensive PHC
17	14	Refentse CHC	NW(M)	Acceptable	CHC
18	16	Stanza Bopape CHC	GPA	Ideal	Comprehensive PHC
19	17	Stanza Bopape II Clinic	LA	Ideal	Preventative/Promotative PHC services
20	18	Phahameng Clinic	LA	Ideal	Preventative/Promotative PHC services
21	20	Sedilega Clinic	NW(O)	Tolerable	Comprehensive PHC
22	20	Tlamelong Clinic	NW(O)	Hardly tolerable	Comprehensive PHC
23	20	Boekenhout Clinic	NW(O)	Hardly tolerable	Comprehensive PHC
24	23	Mamelodi East Clinic	LA	Intolerable/To be replaced	TB
25	24	Winterveld Clinic	NW(O)	Acceptable	Comprehensive PHC
26	24	Mpho Ya Batho Clinic	NW (O)	Tolerable	Comprehensive PHC
27	25	Boikhutsong Clinic	GPA	Hardly tolerable	Comprehensive PHC
28	27	Soshanguve Block X Satellite Clinic	GPA	Tolerable	Comprehensive PHC
29	27	Soshanguve Block P Satellite Clinic	GPA	Hardly tolerable	Comprehensive PHC
30	28	Mamelodi West Clinic	LA	Ideal	Comprehensive PHC
31	29	Soshanguve CHC	GPA	Tolerable	CHC
32	31	Phedisong 4 Clinic	NW(O)	Intolerable/ To be replaced	Comprehensive PHC
33	31	Phedisong 1 Clinic	NW(O)	Acceptable	Comprehensive PHC
34	32	Phedisong 6 Clinic	NW(O)	Hardly tolerable	Comprehensive PHC
35	32	Itireleng Clinic	NW(O)	Tolerable	Comprehensive PHC
36	32	Pabalelo Place of Safety Clinic	NW(O)	Hardly tolerable	Health station; refer to Phedisong 1
37	33	Soshanguve 2 Clinic	GPA	Acceptable	CHC
38	39	Soshanguve Block TT Satellite Clinic	GPA	Tolerable	Comprehensive PHC

	Ward	Facility	Owner	Physical condition	Services provided
39	40	Nellmapius Clinic	LA	Ideal	Preventative/Promotative PHC services
40	41	Silverton Clinic	LA	Acceptable	Preventative/Promotative PHC services and acute curative
41	43	Eersterust Clinic	LA/GPA	Acceptable	Comprehensive PHC
42	43	Eastlynne Clinic	LA	Acceptable	Comprehensive PHC
43	45	Pretorius Park Clinic	LA	Tolerable	Preventative/Promotative PHC services
44	48	Olievenhoutbosch Huis Satellite Clinic	LA	Tolerable	Preventative/Promotative and acute curative PHC services
45	48	Olievenhoutbosch Clinic	LA	Ideal	Preventative/Promotative and acute curative PHC services
46	49	Adelaide Tambo Clinic	GPA	Ideal	Comprehensive PHC
47	49	Mandisa Shiceka Clinic	GPA	Ideal	Comprehensive PHC
48	60	Skinner Street Clinic	GPA	Hardly tolerable	Comprehensive PHC
49	60	Sammy Marks Clinic	LA	Ideal	Preventative/Promotative PHC services
50	61	Laudium CHC	GPA	Acceptable	CHC
51	61	Laudium Clinic	LA	Ideal	Preventative/Promotative and acute curative PHC services
52	62	Atteridgeville Clinic	LA	Ideal	Preventative/Promotative PHC services and chronic services
53	62	Sedibeng Clinic	GPA	Hardly tolerable	Curative services
54	63	Bophelong Clinic	GPA	Hardly tolerable	Curative Services
55	64	Rooihuiskraal Satellite Clinic	LA	Ideal	Preventative/Promotative PHC services and acute curative services
56	65	Pierre van Ryneveld Satellite Clinic	LA	Acceptable	Preventative/Promotative and acute curative PHC services
57	66	Lytelton Clinic	LA	Ideal	Preventative/Promotative, acute curative PHC services and chronic services
60	71	Phomolong Clinic	LA	Tolerable	Preventative/Promotative PHC services, curative and chronic care services
61	72	Gazankulu Clinic	LA	Hardly tolerable	Preventative/Promotative PHC services
63	73	Ramotse Clinic	NW(M)	Tolerable	Comprehensive PHC
64	74	Temba CHC	NW(M)	Hardly tolerable	CHC
65	75	Kekanastad Clinic	NW(M)	Hardly tolerable	CHC
66	76	Suurman Clinic	NW(M)	Intolerable (building of new clinic in progress)	Preventative/Promotative PHC services

Capital projects executed during the 2002/2003 financial year:

- ❖ Suurman Clinic:Construction of a new clinic almost completed
- ❖ Refentse Clinic:Upgrading of ablution and sanitation facilities at clinic
- ❖ East Lynne Clinic:.....Extension of clinic
- ❖ Phomolong Clinic:Upgrading of clinic waiting areas

3.2.3 IMPROVING THE QUALITY OF CARE

The following quality assurance programmes were implemented:

- ❖ All clinics display the patient rights charts in the appropriate language of the community.
- ❖ A service pledge for all health care workers in Tshwane was developed and is displayed in all clinics.
- ❖ A queue management policy was developed and implemented in all clinics.
- ❖ A policy and procedure on health help desks was developed and implemented in all clinics.
- ❖ A complaint system was implemented in all clinics.
- ❖ Each clinic has a visible complaint flowchart.
- ❖ The supervisor's manual was implemented in all clinics

- The regular review and red flag tools are used monthly in all clinics.
- Each clinic manager completes the clinic manager's tick list every 3 months.
- Each subdistrict manager (area manager) completes the quarterly report on supervision.
- The following in-depth reviews were done in this period of reporting:
 - Drug management
 - Expanded programme on immunisation (EPI)
 - Sexually transmitted infections (STI)
 - Tuberculosis (TB)
- 6 monthly rating surveys were done in all clinics.
- A waiting time survey was done in all clinics.

Summary of the results of the rating surveys in September 2002 and April 2003:

TABLE 6: RATING SURVEY

Comparison between the Sept 02 and April 03 rating survey in LA clinics		
	Sept 02	April 03
% of clients satisfied with client environment	77,5%	86%
% of clients satisfied with quality care by staff	73,5%	81%
% of clients satisfied with waiting time and clinic hours	72%	74%

3.2.4 ENSURING APPROPRIATELY SKILLED STAFF FOR THE HEALTH DISTRICT

3.2.4.1 Staff establishment

The total approximate staff establishment of the providers of health care within the City of Tshwane is 2 052. Table 7 reflects the staff numbers serving the population per subdistrict. One professional nurse serves 2 723 members of the population (uninsured population of 1 644 614).

Tshwane currently has an acute staff shortage. According to a study of resource requirements, to provide a comprehensive PHC package (Rispel et al, 1996), 662 professional nurses are needed per 10 000 population. The Tshwane health district currently only has 3,67 professional nurses per 10 000 of the uninsured population. In addition, 4,17 nurse auxiliaries are needed, versus the current ratio of 1,63 per 10 000 of the uninsured population. Table 8 provides a detailed breakdown of the CTMM personnel as on 31 June 2003.

TABLE 7: POPULATION, PHC FACILITIES AND NURSING STAFF AUDIT

Sub District	Population per sub-district *	Facilities (Clinics)	Professional nurses	Enrolled nurses	Auxiliary nurses	Total Nurses
Southern	122 799	CHC 1/clinics 6 mobiles 1	46	4	7	57
Northern	441 863	CHC 1/clinics 9 mobiles 1	126	32	12	170
Central	1 290 896	CHC 1/clinics 24 mobiles 2	145	28	36	209
Odi	253 051	CHC 1/clinics 10 mobiles 0	237	**	99	336
Moretele	84 209	CHC 1/clinics 7 mobiles 0	50	22	29	101
TOTAL	2 192 818	CHC 5/clinics 56 mobiles 4	604	86	183	873

* Population Source DHIS

** Counted with Auxiliary Nurses

TABLE 8: DETAILED TOTAL CTMM STAFF, DESIGNATION AND NUMBER

DESIGNATION	TOTAL	DESIGNATION	TOTAL
Acting Chief Environmental Health Officer	1	Manager: Environmental Health	1
Administrative Officer	40	Manager: Health Programmes	1
Assistant: Air Pollution Control	1	Manager: Primary Health Care North	1
Assistant Chief: Health Services	1	Manager: Primary Health Care South	1
Basic Pharmacist Assistant	5	Manager: Research and Development	1

DESIGNATION	TOTAL	DESIGNATION	TOTAL
Chief: Environmental Health Officer	1	Medical Officer	5
Chief Community Health Nurse	4	Medical Officer, part-time	3
Chief Environmental Health Officer	5	Medical Officer, session basis	4
Chief Personal Health Services	1	Messenger	2
Chief Pharmaceutical Services	1	Motorcar Driver	1
Chief: Health Services	1	Nursing Assistant	30
Community Health Nurse/(Snr)	137	Part-time Medical Health Officer	1
Computer Officer	2	Part-time Medical Officer	1
Deputy Manager: Support Services	1	Pest Control Officer	1
Director: PHC I	1	Pharmacist	4
Director: PHC III	1	Post-basic Pharmacist Assistant	10
District: Environmental Health Officer	1	Secretary	7
Divisional Community Health Nurse	9	Senior Administrative Officer	2
Driver	1	Senior Medical Officer	2
Environmental Health Practitioner/(Snr)	48	Senior Secretary	1
General Manager	1	Storekeeper	2
General Worker	30	Supplementary Radiographer	3
Health Education and Training Officer	11	Support Services Officer	3
Lorry Driver	1	Transport Coordinator	2
Manager: Aids Unit	1	X-Ray Assistant	2
Grand Total	397		

3.2.4.2 Staff development

Staff development programmes are offered in-house by the training section, internally through Premos, Management Training and externally through Gauteng Health Department, tertiary institutions, pharmaceutical companies and private training providers.

TABLE 9: TRAINING PROGRAMMES OFFERED

COURSE	No trained	TARGET GROUP
Tuberculosis	8	Community health nurses
Tuberculosis – clinic meetings	19	Doctors
Perinatal Education Programme	12	Community health nurses
Perinatal Education Programme – updates	20	Community health nurses
Abortion Value Clarification Workshop	31	Community health nurses
Abortion Value Clarification Workshop	55	Lay counsellors
Integrated Management of Childhood Illness (IMCI)	24	Community health nurses
Sexually Transmitted Infections/HIV Aids	19	Community health nurses/Enrolled nurses/Pharmacists
Family Planning	4	Community health nurses
Family Planning – update	100	Community health nurses
Expanded Programme on Immunisation (EPI)	65	Nurses/Pharmacists
District Health Information System (DHIS)	32	Community health nurses
Fire fighting	8	Nurses/admin officers/labourers
Buddy Aid	19	Nurses/admin officers/labourers

COURSE	No trained	TARGET GROUP
Cardio-pulmonary Resuscitation (CPR)	17	Nurses/admin officers/labourers
Financial Management	43	Managers/deputy managers and facility managers
Personal Mastery Programme	6	Managers/deputy managers
Updating Course – Nursing Assistants	4	Nursing assistants
Diploma Clinical Nursing Science	9	Community health nurses
Computer Courses	85	Managers/deputy managers and facility managers and administrative personnel

General information sessions are arranged for all health care staff to address identified needs. The sessions are also used to address changes in policies and procedures and inform staff on transformational issues.

TABLE 10: GENERAL INFORMATION SESSIONS

TOPICS ADDRESSED	NUMBER OF ATTENDEES
Crisis pregnancy counselling	37
Diflucan partnership programme	35
Hypertension	36
Skin infections	43
Grievance procedure	50
Information session – transformation	78
EPI and TB	71
Abortion and the law	51
Employment Equity Act	52
DISCA tool	23
Alarm systems	29

Students from tertiary training institutions are placed in the primary health care services for practical training.

The following categories of students were trained – nursing, medical, radiography, pharmacists, environmental and public health. A total of 373 basic students and 49 post-basic students were trained.

3.3 IMPLEMENTING A DISTRICT INFORMATION SYSTEM (DHIS) FOR THE HEALTH DISTRICT

Managers at all levels need appropriate and accurate information to analyse the health situation and set relevant health objectives. These health objectives need to be monitored, using predefined indicators.

Throughout the City of Tshwane, provinces implemented the District Health Information System (DHIS) concept. Although the Minimum Data Set (MDS) for the health services falling within the boundaries of the Gauteng and North West provinces differ, important health indicators could be derived even from these separate databases. A crucial need exists to integrate these essential datasets into one standardised and electronic database.

The following achievements can be reported:

- 100% of the MDS data from PHC facilities are captured in the DHIS (data from CTMM captured at provincial regional office)
- 100% of PHC health facilities report timeously on a monthly basis
- Use of information to improve quality and coverage of services
- Two formal DHIS courses were conducted

The following challenges exist for the health information units in the Tshwane health district

- Increased frequency of feedback reports to health facilities
- Integration of the data from private providers into the DHIS and data management system
- Increase the number of functioning e-mail terminals in health facilities

- Improved relationships and cooperation between the different HIS units in the district to enable streamlined and comprehensive reporting on health status and service data in the district
- Development of computerised systems to manage disease and health service related data.
- Appointment of staff in the CTMM HIS section to relieve the nursing staff in PHC health facilities of data capturing (electronic TB register)

3.4 PROVIDING ESSENTIAL DRUGS

The City of Tshwane Metropolitan Municipality pharmacy supplies essential medicines that are procured from the Gauteng provincial medicines supply depot to all municipal clinics. The adoption of the Essential Drugs List (EDL) in 1996 enabled the Municipality to standardise and rationalise the utilisation of drugs within all the facilities.

The Primary Level EDL, was published together with the Standard Treatment Guidelines. This combination ensures standardisation of treatment protocols, equity in service provision and cost-effective drug use.

During the financial year, the municipal pharmacy supplied medicines only to the former City Council of Pretoria clinics. The clinics that fell under the former Northern Metropolitan Substructure and the Centurion Town Council continued to be supplied directly by the provincial regional pharmacy. Twenty-three primary health care clinics, five PHC satellite clinics and seven occupational health clinics were supplied with medicines during this period. Four of the primary health care clinics had full-time services of qualified pharmacist's assistants. Others received only a limited dispensing and stock control service from the assistants. Area pharmacists took charge of and responsibility for the medicines used in the clinics.

3.4.1 PHARMACEUTICAL STATISTICS (CTMM RELATED)

Financial

- ❖ The total expenditure on medicines was more than R9,3 million for all the clinics.
- ❖ Average stock levels in the medicine store: R2 500 000.00
- ❖ Stock turnover rate: 3,88 (based on stock kept and supplied to former City Council of Pretoria clinics)

Clinic dispensary activities

- ❖ Average number of items per prescription:
 - Acute prescriptions: 1,9 to 2,4
 - Acute and chronic prescriptions: 2,84 to 3,25
- ❖ Out of stock rate: Increased from 5,6% during the first part of the year to 13% in the last six months as a result of inadequate storage facilities during the renovations to the medicine store.

Staffing:

- ❖ Area/Regional pharmacists: 3
- ❖ Store pharmacist: 1
- ❖ Pharmacist's assistants: 10

3.4.2 ACHIEVEMENTS

The municipal pharmacy has managed to control the expenditure on medicines to below R10 million, as a result of deduction of, and strict control of stock levels in the clinic dispensaries and the pharmacy.

Updates on the Pharmacology Course for nurses and factory visits were arranged during the earlier part of the year. A course on Drug Supply Management and Cold Chain Management was offered to nurses and pharmacist's assistants.

The project for the modification of the medicine store was successfully completed at the end of June 2002. The store now has separate and secure receiving and dispatch stores and occupies twice its original size and now meets the requirements of the SA Pharmacy Council.

3.5 PROVIDING OF COMPREHENSIVE PRIMARY HEALTH CARE SERVICES

The Health status of the city is improved through the providing of primary health care services.

The following achievements in the local authority clinics are highlighted:

- Increase of 7,7% in clinic attendance
- Chronic and curative care was introduced from 1 April in Karen Park, Hercules and Mamelodi West clinics. Progress was also made in terms of the paradigm shift to provide comprehensive services. Chronic care has also been introduced in Atteridgeville and Saulsville clinics.
- VCT (voluntary counselling and testing for HIV/Aids) rolled out at Sammy Marks, Eersterust, Mamelodi West, Saulsville, Phomolong, Lyttelton and Atteridgeville clinics, and training was done for further roll-out.
- The new clinic in Olievenhoutbosch X13 was put into operation in March 2003.
- Tuberculosis combating services were extended by introducing full TB services at three PHC delivery points, namely Danville, Nellmapius and Olievenhoutbosch clinics.
- Treatment of TB patients was done under direct observed therapy in 87% of cases during the year.
- The MDR Centre that was started at the Folang Clinic in May 2002 to treat patients with multidrug resistant TB locally instead of sending them for outpatient treatment at the Sizwe hospital in Edenvale, has taken over during the year and is treating 75% of all MDR cases of Tshwane.
- The Communicable Diseases Team, as part of the Disease Outbreak Control Team, took part in the handling of 3 suspects and 1 case of severe acute respiratory syndrome (SARS) in Tshwane.

3.5.1 SEXUALLY TRANSMITTED INFECTIONS

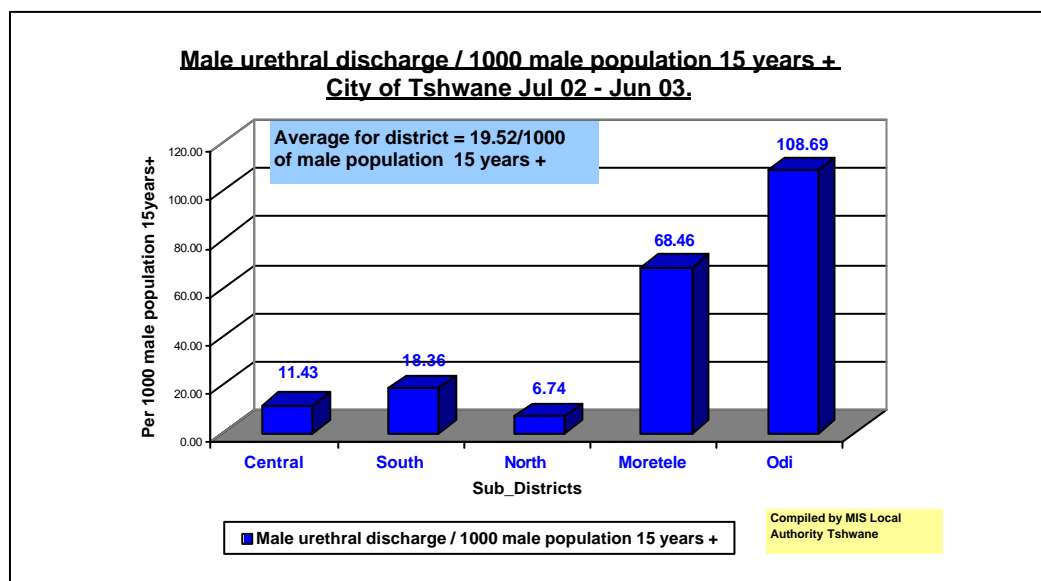
Persons with sexually transmitted infections (STIs) are six to eight times more likely to be infected with HIV than persons without a STI. It is therefore extremely important to identify and treat persons with STI.

A total of 14 473 new cases of male urethral discharge were reported for the year (growth of 5% from last year), averaging the incidence as 19 per 1000 of the sexually active male population treated at public health facilities within the borders 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, easily diagnosed, usually comes for treatment and responds well to syndromic treatment.)

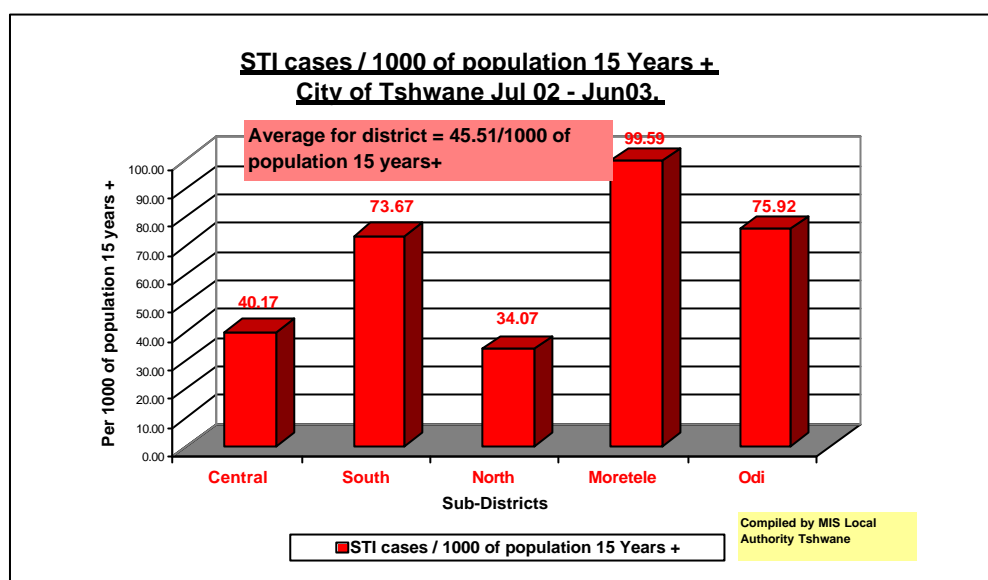
A total of 69 120 cases were treated as new sexually transmitted infections (growth of 11,9% from last year), averaging the STI incidence rate as 46 per 1000 of the sexually active male and female population seen at public health facilities within the borders of the CTMM. (These infections are "mixed infections" comprising discharges, ulcers and herpes.)

Condom distribution is an important strategy to prevent STI. The Tshwane local authority has distributed almost 10 million condoms for the year. Other strategies used in the prevention and treatment of STI are the implementation and monitoring of the syndromic treatment approach, as well as contact tracing efforts.

GRAPH 3: MALE URETHRAL DISCHARGE



GRAPH 4. STI CASES



3.5.2 EXPANDED PROGRAMME FOR IMMUNISATION (EPI)

EPI is a global programme for the control of vaccine-preventable diseases. Children are immunised with-

- ❖ BCG (Tuberculosis vaccine)
- ❖ TOPV (Trivalent Polio Vaccine)
- ❖ DTP HIB (combination of Diphtheria, Tetanus, Pertussis and Heamophilus Influenza type B)
- ❖ 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: BCG, 3 Polio, 3 DTP-HIB-HBV and measles vaccines.

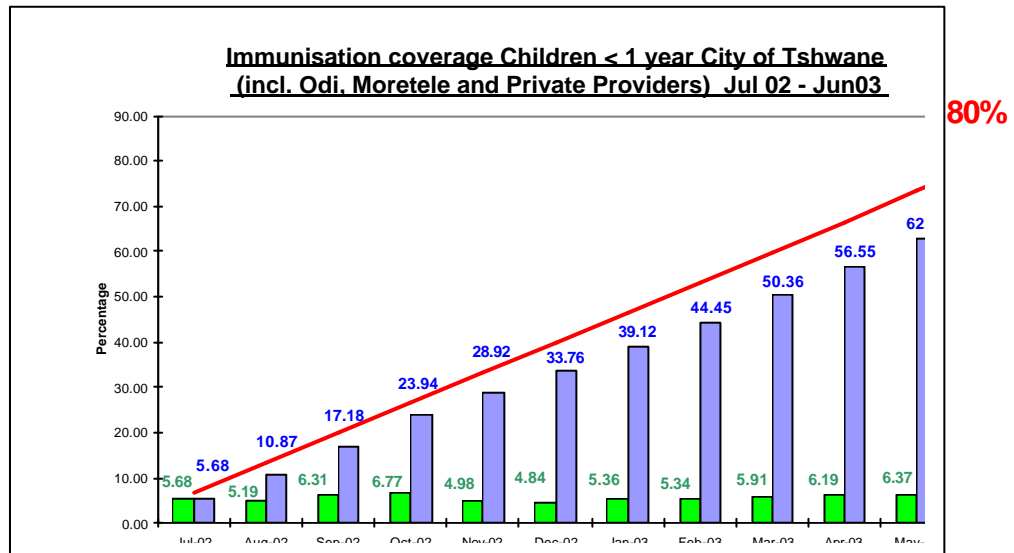
The immunisation coverage for children under one year of age is 68,86%. Private providers of immunisation are responsible for 10% of the total coverage.

(In the 2001/2002 year report the catchment population for children < 1 year was taken from the Demarcation Board's population data (children < 1 year = 26 650). The provincial DHIS requested that the DHIS population data must be used to calculate district coverage, in order to promote uniformity in reports. Note that the catchment population, according to DHIS, is much higher (children < 1 year = 35 129) which has influenced the coverage considerably. In order to compare the coverage in 2002/2003 with the coverage in 2001/2002, the coverage for 2001/2002 was calculated according to DHIS as well; children < 1 year = 34 174= 65.7% coverage. Odi and Moretele subdistricts are included in the calculation.)

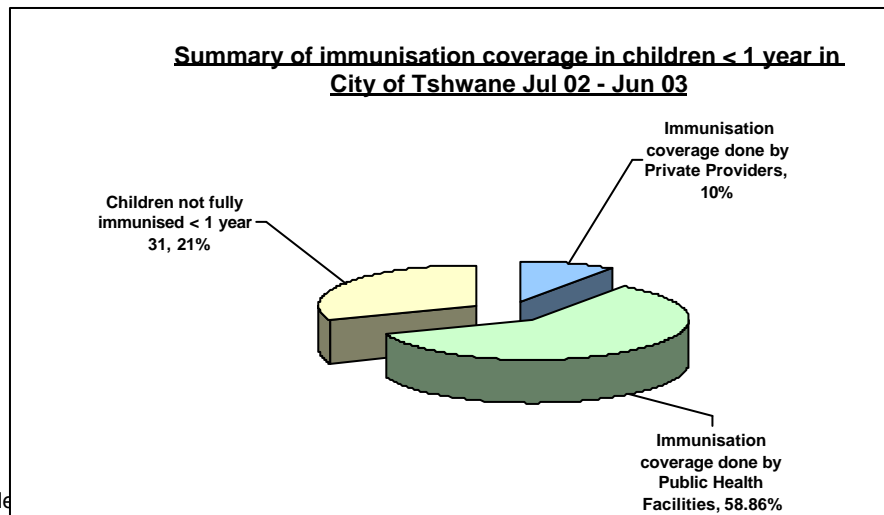
PHOTO 1. IMMUNISATION PROCEDURE



GRAPH 5. IMMUNISATION COVERAGE CHILDREN <1 YEAR, CITY OF TSHWANE, July 02 TO June 03

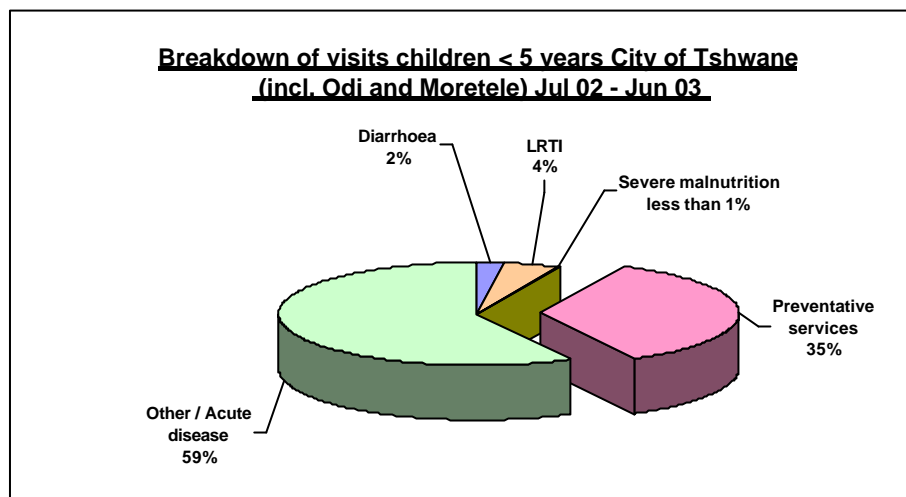


GRAPH 6. SUMMARY OF IMMUNISATION COVERAGE IN CHILDREN < 1 YEAR, CITY OF TSHWANE, JULY 02 TO JUNE 03



3.5.3 CHILD AND YOUTH SERVICES

GRAPH 7. DISEASE PROFILE: CHILDREN UNDER 5 YEARS OF AGE SEEN AT PUBLIC HEALTH FACILITIES



3.5.3.1 Integrated management of childhood illnesses (IMCI)

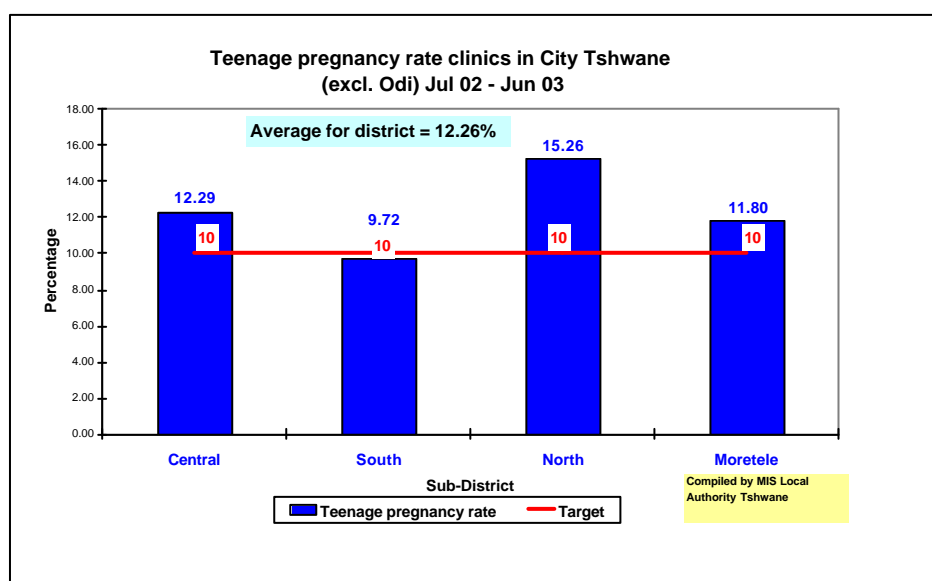
IMCI is a strategy that was adopted by South Africa in 1996 and the PHC facilities in Tshwane to reduce infant- and under-five mortality rates, wasting and stunting among children. These actions are critical to reduce the unacceptably high infant mortality rates, currently at 45 per 1000 live births and below-5 mortality rates, which is 59 per 1000 births in South Africa, and 35 per 1000 live births in Gauteng (1998).

(Currently it is impossible to isolate mortality rates for the Tshwane health district, as the database of the Department of Home Affairs gives a breakdown of provinces only.)

3.5.3.2 Youth

The teenage pregnancy rate for the period July 2002 to June 2003 is 12,26%. The teenage pregnancy rate dropped by 2,1% since the previous reporting period.

GRAPH 8. TEENAGE PREGNANCY RATE, PUBLIC PHC CLINICS IN CITY OF TSHWANE



Interventions targeting adolescents, included implementation of clinical guidelines for youth and adolescent health, and actions to reduce teenage pregnancy and substance abuse. Fast lane options for family planning services were implemented in most clinics.

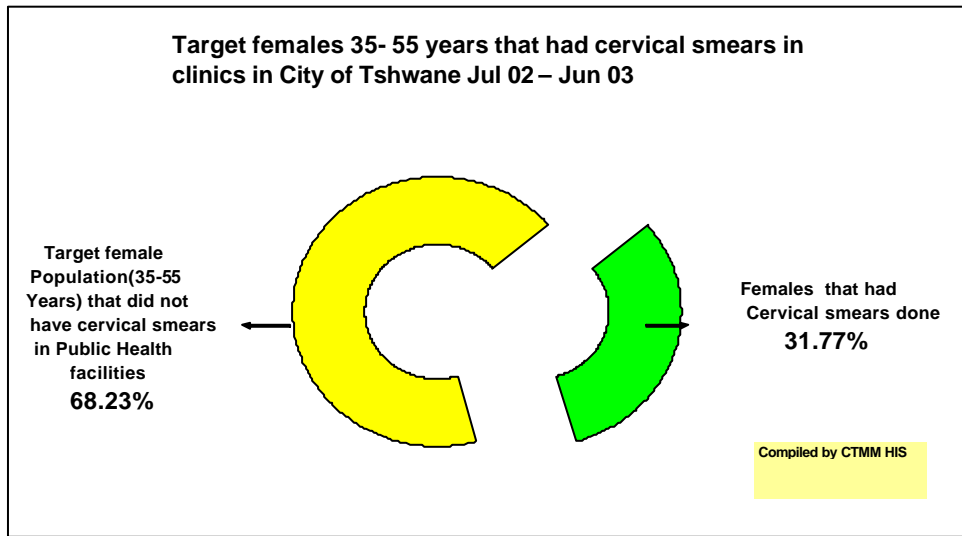
3.5.4 WOMEN'S HEALTH

Cancer of the cervix is the most common form of gynaecological cancer in South African women. The cervical screening programme can reduce the incidence and mortality of cervical cancer.

It is recommended in the National Cervical Screening Policy of South Africa, that any woman over 30 years of age, who has not had a smear previously, should have a smear taken. Thereafter, a smear should be done every 10 years until the age of 60.

To comply with the National Guidelines, the clinics situated in the City of Tshwane should do 37 745 cervical smears per annum. However, only 10 787 (last year 15 236) smears were done. The coverage for the target group for cervical screening is only 31,7%. (Provision was made for 25% of population to acquire services at a private facility.)

GRAPH 9. TARGET FEMALES 35 TO 55 YEARS THAT HAD CERVICAL SMEARS IN CLINICS IN CITY OF TSHWANE

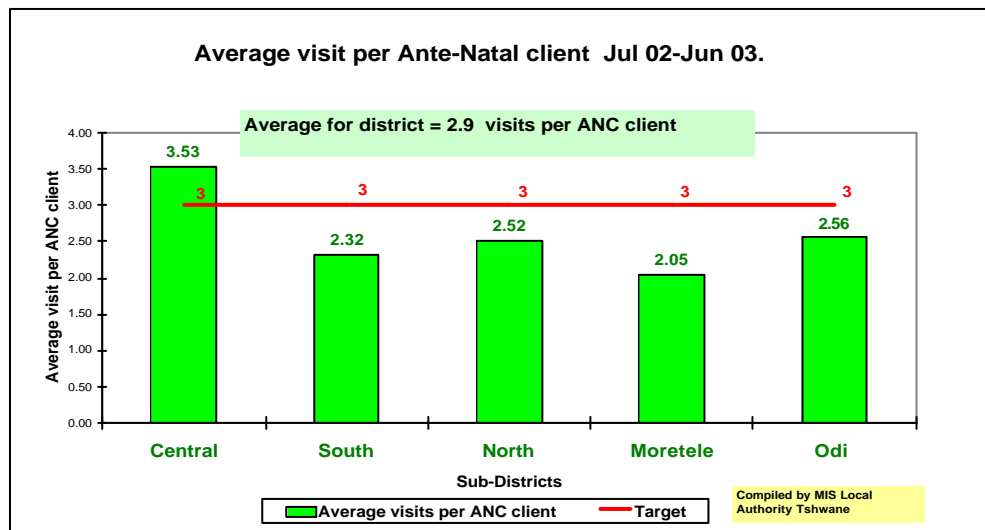


3.5.4.1 Antenatal care (ANC)

Risk and continuity indicators are important in ANC. According to the set national target, all pregnant women should pay at least three visits to a health care facility during each pregnancy. These should start before 20 weeks gestation. Low repeat visits can be the result of late booking in pregnancy where the woman delivers before she can go for three visits to the clinic. There might also be problems with the acceptability of the service and the attitude of staff that discourages follow-up visits.

The total first ANC visits (new cases) is 37 765 and the total ANC visits is 110 857 with an average of 2,9 visits/ ANC client.

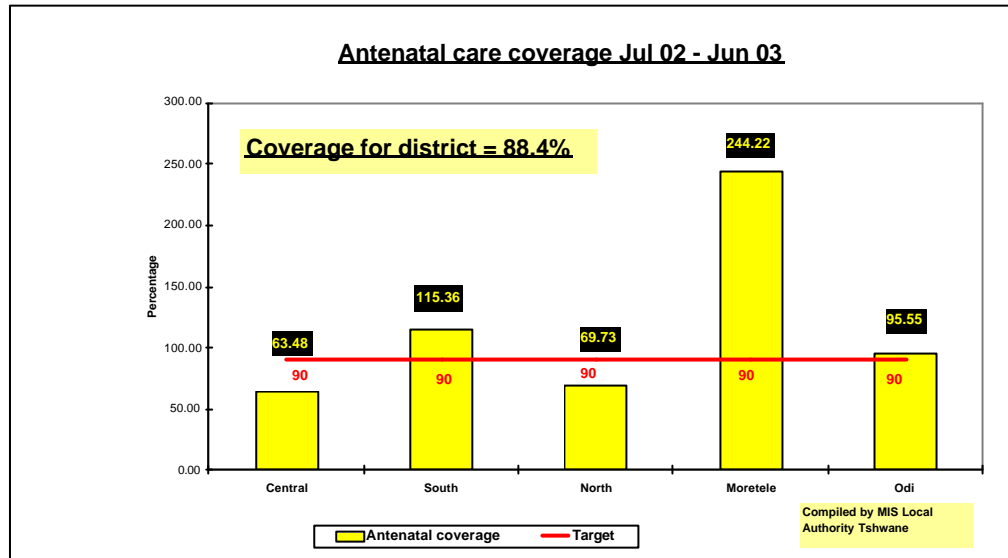
GRAPH 10. AVERAGE NUMBER OF VISITS PER ANTENATAL CLIENT



Antenatal coverage care measures the percentage of pregnant females in a community that attend ANC services at least once in the pregnancy. Low coverage can indicate accessibility problems or low awareness of the importance of antenatal care in the community. The proportion of the insured population utilising private ANC in a subdistrict will also play a role. High coverage can indicate an influx of females from other areas with no or poor ANC facilities.

The expected deliveries (2,2% of total population) are 42 641 and the total first ANC visits are 37 765, resulting in a coverage of 88,4%.

GRAPH 11. ANTENATAL CARE COVERAGE SUBDISTRICTS IN CITY OF TSHWANE



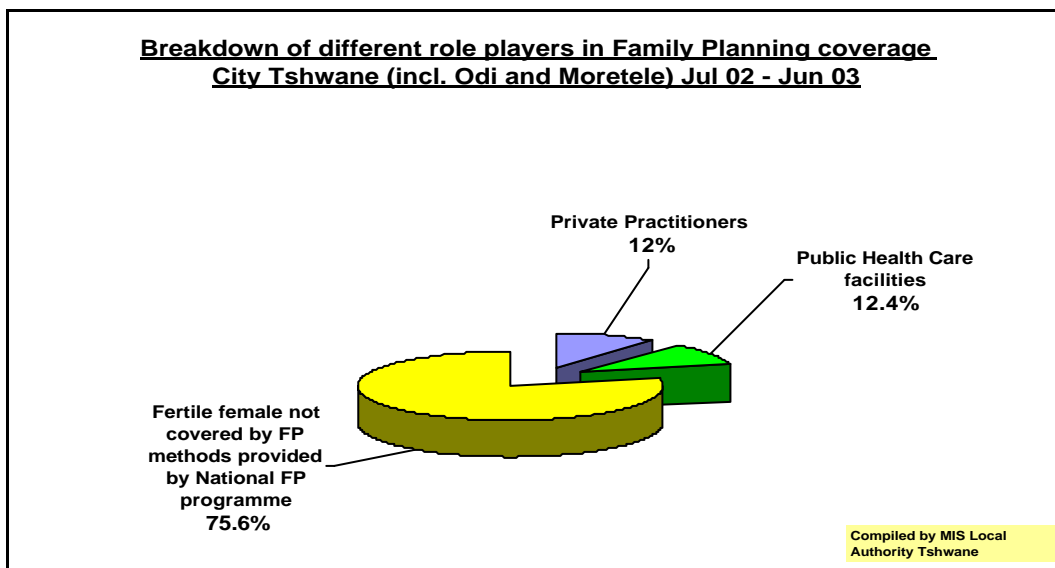
3.5.4.2 Family planning

Fertile females (14 to 45 years) in the community must be protected from unwanted pregnancies. There are approximately 589 305 fertile females in the population of Tshwane. Only 24,4% of these females are using a reliable contraceptive method. These figures exclude coverage by sterilisation and condoms. The national target for coverage of fertile females is 65%.

Cultures with low female status and empowerment, low educational status and poor accessibility to family planning services, play a role in the low coverage. A large number of contraceptive methods, not provided by the national FP programme, are available from pharmacies and doctors.

Note that private practitioners contribute approximately 50% of the total coverage of 24,4 %.

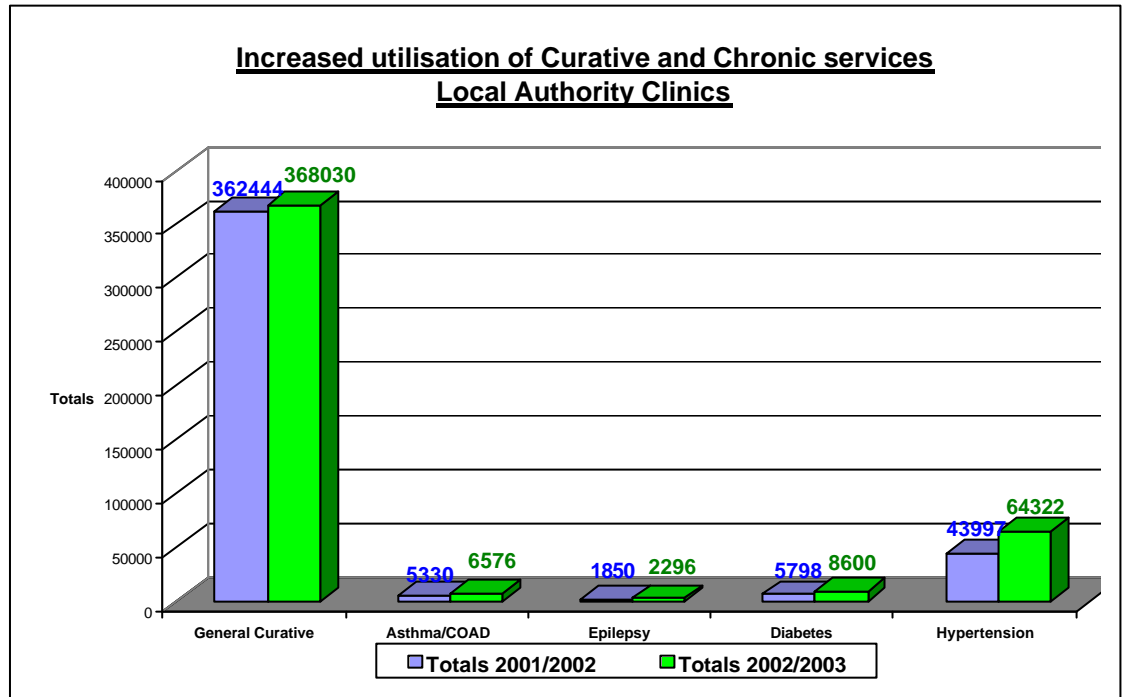
GRAPH 12. BREAKDOWN OF DIFFERENT ROLEPLAYERS IN FAMILY PLANNING COVERAGE, CITY OF TSHWANE



3.5.5 CURATIVE SERVICES

Curative and chronic health services are available at 52 health facilities throughout the Tshwane area (79%). These services are mainly provided by the provincial health facilities. 58% of the local authority clinics provide a general curative service. Since implementation, local authority clinics have experienced a marked increase in the utilisation of curative and chronic services. It is envisaged that general curative and chronic services will be implemented as part of the package of health services available at all primary health care facilities. These services will be implemented incrementally by entering into formal service level agreements with the provincial health departments.

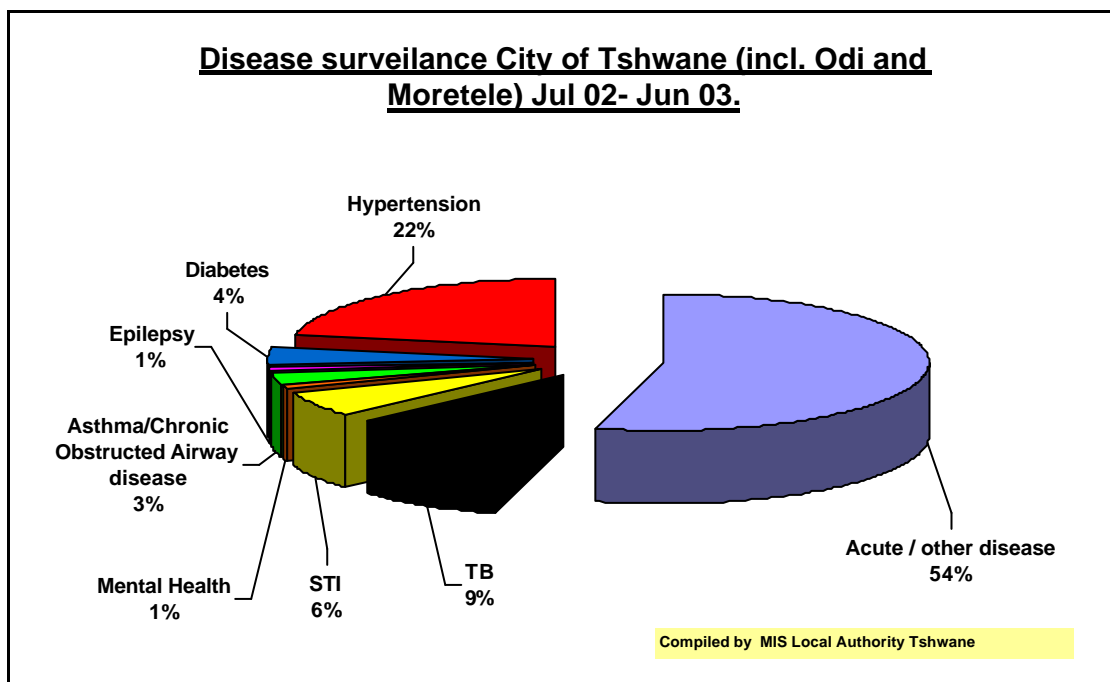
GRAPH 13: INCREASED UTILISATION OF CURATIVE AND CHRONIC SERVICES



Service for chronic care is offered at 80% of the PHC health facilities in Tshwane. Only 32% of the Local Authority clinics provide a service for chronic care.

The disease profile of adult patients visiting the PHC health facilities, is presented in the graph below.

GRAPH 14: DISEASE SURVEILLANCE: ALL GENERAL/CURATIVE VISITS: CITY OF TSHWANE JULY 02 TO JUNE 03



3.5.6 TUBERCULOSIS COMBATING SERVICES

TB combating services are delivered in Tshwane according to the National TB Control Programme. There are two subdistrict TB coordinators in the North West area and three TB subdistrict coordinators in the Gauteng area, who control and report on the services. However, notification of cases, drug procurement and TB quarterly reporting is still done separately according to the province under which the area falls.

TB services are available at 55 clinics throughout Tshwane. All clinics offer DOTS services and help to diagnose TB and trace contacts.

Facilities for admission of TB patients are available at SANTA Tshepong, Jubilee hospital, Correctional Services and 1 Military Hospital.

Staff from Tshwane joined in the Fun Run organised by Life Net for World TB day on 24 March 2003. Additional DOTS supporters were trained to be of assistance in TB combating service. As part of the World TB Day, door-to-door visits were done in Soshanguve South and the Olievenhoutbosch area to increase the knowledge of TB treatment, and cure and where services are provided. An information session was also held to improve the diagnosis and treatment of TB in children and to improve the use of the score card in children.

Evaluation of the TB services was done in October 2002, through an in depth TB review. The results showed that dedicated staff for TB services is a necessity, that sputum specimens were often not handled correctly so that they leaked and that the conversion and cure rates were still not up to standard.

Staff at 13 service points (where there was no trained staff) were sent on TB training programmes during the year. Additional staff was trained where there was only one nurse trained in TB. A total of 13 staff was trained during the year, of which 5 were provincial staff and 8 from the CTMM.

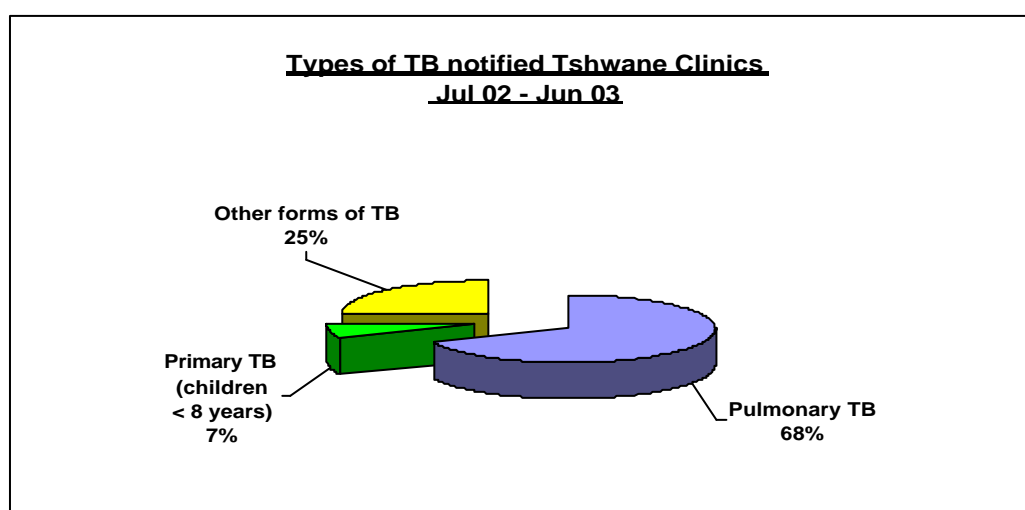
The types of TB notified in this financial year were as follows:

TABLE 11: TYPES OF TB NOTIFIED

	Central	Northern	Southern	Odi	Moretele	Total
Pulmonary TB	2 422	631	237	369	684	4 343
Primary TB	231	106	12	1	97	447
Other forms of TB	565	306	12	491	186	1 560
Total	3 218	1 043	261	861	967	6 350

(Information supplied by Carina Idema from the National TB programme)

GRAPH 15: TYPES OF TB NOTIFIED, TSHWANE CLINICS



3.5.6.1 Case finding

Tuberculosis in children < 6 years of age are diagnosed through skin testing and chest X-rays. Suspects of active TB or contacts of adult TB cases are diagnosed through sputum examination and chest x-rays.

A drive was executed at the beginning of the year to improve case finding through taking sputum from persons with signs and symptoms of TB.

Three X-ray units were active during the year. X-rays of children > 3 years of age suspected of having TB and adults with signs and symptoms of TB without positive sputum were taken at clinics. Health education drives together with X-rays of persons suspect of TB was done at firms, including hospitals and homes for the aged.

Case-finding indicators for the year per quarter for the Tshwane region of Gauteng were as follows:

TABLE 12: CASE-FINDING INDICATORS FOR THE YEAR PER QUARTER FOR THE TSHWANE REGION OF GAUTENG (excluding Odi and Moretele)

	Q3 2002	Q4 2002	Q1 2003	Q2 2003	TOTAL this year	Previous year
Bacterial coverage rate	85,6%	86,4%	86,2%	83,6%	85,5%	96%
Positive Sputum rate	68%	70,4%	75,2%	73,5%	71,8%	85,5%

(Information supplied by Carina Idema from the National TB programme)

The sputum positive rate (active TB cases) of 71,8%, slightly exceeds the acceptable range of 50% to 70%, but indicates a huge improvement since the previous reporting period.

Since the rates exceeds this range, the quality of case detection, access to TB services and reasons for late presentation of the TB patients will be investigated.

3.5.6.2 Treatment outcome report

Patients are treated according to national policy, where DOTS (Directly Observed Therapy-Short course) plays an important role. DOTS means that someone supports the patient by actually observing that the pills are taken on a daily basis. This is a cost-effective way of ensuring treatment compliance and helps to prevent MDR. The outcome report of PTB patients indicates the successful treatment and cure rate of patients.

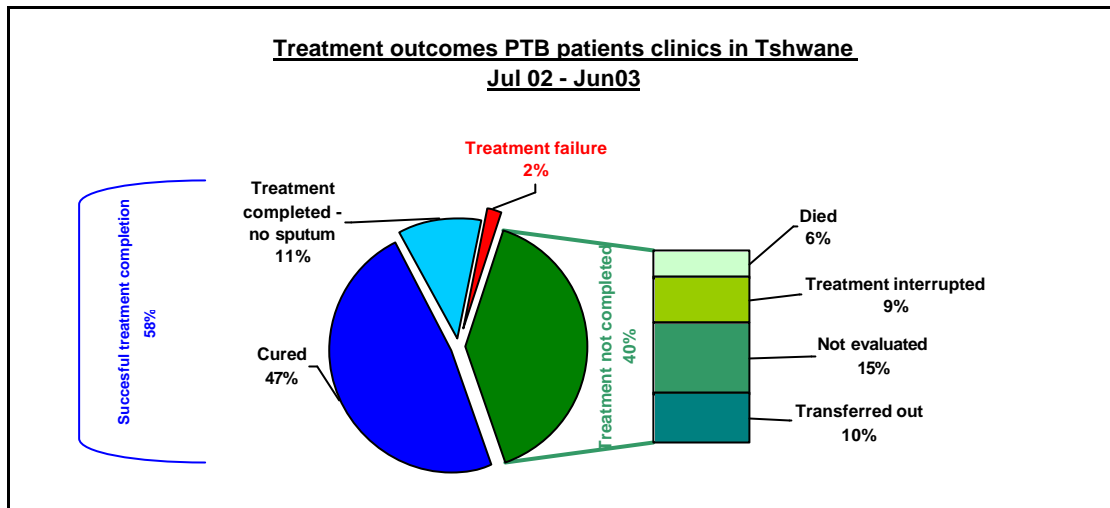
87% of the patients of Tshwane are on DOTS and 58% of patients in Tshwane were treated successfully. The national cure rate is 49,7%, and the average successful treatment rate is 60,5%.

TABLE 13: OUTCOME REPORT OF PTB PATIENTS FOR THE YEAR PER QUARTER FOR THE TSHWANE REGION OF GAUTENG

	Q3 2001	Q4 2001	Q1 2002	Q2 2002	Total
Cured	38,7%	45,8%	43,4%	47,9%	47,4%
Treatment completed - no sputum	12,9%	10,8%	10,8%	9,3%	10,8%
Died	6,4%	4,5%	5,4%	6,7%	5,7%
Treatment failure	0%	1,3%	2,4%	2,9%	2,2%
Treatment interrupted	12,9%	12%	13,4%	12,7%	9,3%
Not evaluated	19,3%	10,8%	13,9%	9,5%	14,6%
Transferred out	9,6%	8,1%	10,4%	10,6%	10%

(Information supplied by Carina Idema from the national TB programme)

GRAPH 16: TREATMENT OUTCOMES, PTB PATIENTS CLINICS IN TSHWANE



3.5.6.3 Sputum conversion

A pulmonary TB patient, with smear-positive sputum, should convert to smear-negative within 3 months of treatment. Sputum conversion confirms that the patient is susceptible to the TB antibiotics and no longer contagious.

If the patient does not convert, sputum is tested for sensitivity to the TB antibiotic to exclude multidrug resistance (MDR). Compliance with standard treatments is very important to avoid MDR. Treatment for susceptible TB patient costs about R300,00 per client and from R 25 000,00 to R 30 000,00 per client for MDR patients.

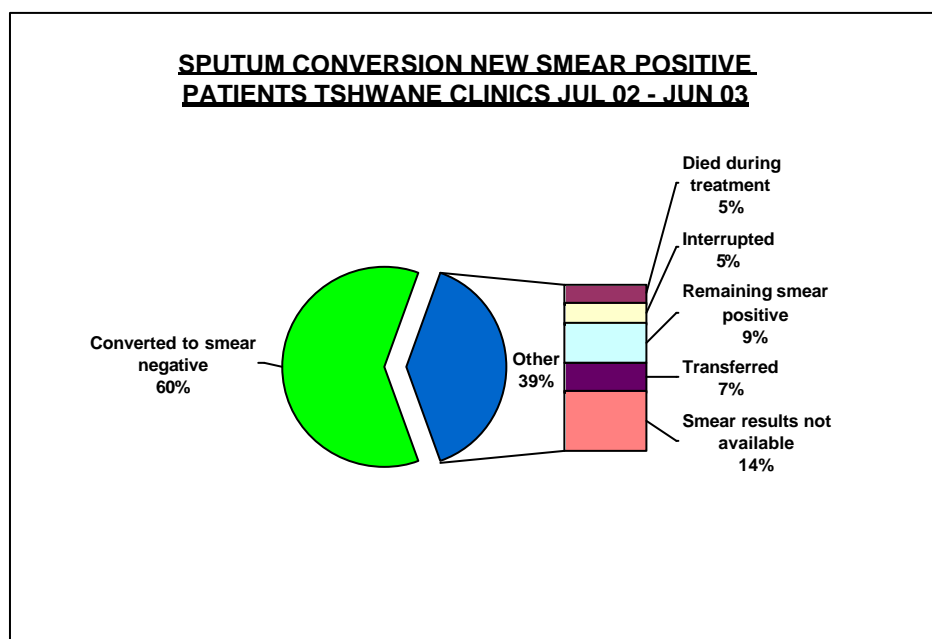
The turn-around times for sputum specimens were relatively satisfactory, with only between 2% to 11% taking longer than 5 days.

Table 14: SPUTUM CONVERSION: FOR THE TSHWANE REGION OF GAUTENG

	Q3 2002	Q4 2002	Q1 2003	Q2 2003	Total
Sputum conversion new smear-positive patients	61%	63,40%	58,20%	60,90%	60,97%

(Information supplied by Carina Idema from the national TB programme)

GRAPH 17: SPUTUM CONVERSION, NEW SMEAR-POSITIVE PATIENTS, TSHWANE CLINICS



3.5.6.4 Multidrug resistant (MDR) TB Centre

The MDR Centre at Folang acts as an arm of Sizwe Hospital. The Centre serves the Gauteng area of Tshwane and takes place in the DOTS PLUS National Study of TB Research of the Medical Research Council.

The drugs for treatment are obtained per patient directly from the Sizwe Hospital. The clinic where the patient is diagnosed with MDR TB handles the DOT of the patient.

The patient's progress followed up at the Folang Centre for the duration of the treatment, and decisions made on continuation of treatment.

From July 2002 to June 2003, twenty patients were treated at the Folang Clinic. Three of these patients died.

3.5.6.5 Coordination and communication of TB services

Communication and coordination is done through combined quarterly Tshwane TB meetings with all managers and TB service points.

A weekly consultation service is delivered at provincial hospitals and, as necessary, at private hospitals. TB and Infectious Diseases coordinators keep regular contact with infection control staff of all hospitals in Tshwane, directly and also through the Infection Control Forum of the region.

3.5.7 NOTIFIABLE DISEASES CONTROL

The amended list of notifiable diseases for local authorities is done according to the publication of *Government Gazette*, Volume 346, No 15639, 22 April 1994.

Notification of notifiable diseases are handled in Tshwane by the two Infectious Diseases coordinators of the area of Tshwane falling within North West and the three Infectious Diseases coordinators in the area of Tshwane falling within Gauteng.

3.5.7.1 Prevention of spread of notifiable diseases

A team of nursing professionals investigates all notifications. Environmental Health Officers are involved in the investigation in certain cases of notification. Preventative medication or vaccination and environmental health measures are taken as necessary to prevent the spread of disease in the community.

3.5.7.2 Disease reporting

Notifications and the handling and outcome of the investigations are reported weekly to the relevant provincial authority. Notifications of cases residing outside Tshwane are reported to the relevant local authority to follow up.

3.5.7.3 Diseases notified

Table 15 indicates the notifiable diseases that occurred within the boundaries of Tshwane and were notified during the year.

TABLE 15: NUMBER OF DISEASES NOTIFIED

NOTIFIABLE MEDICAL CONDITION: July 2002 to June 2003	TSHWANE SUBDISTRICT					
	CENTRAL	SOUTHERN	NORTHERN	ODI	MORETELE	TOTAL
AFP (Acute flaccid paralysis)	2	0	0	0	1	3
HEPATITIS A	39	3	4	0	0	46
HEPATITIS B	20	0	1	0	0	21
HEPATITIS C	1	0	1	0	0	2
MALARIA (external source of infection)	217	4	11	2	2	236
MENINGOCOCCAL INFECTION	12	1	0	0	0	13
MEASLES	0	1	0	0	4	5
LEGIONELLOSIS	0	0	1	0	0	1

PERTUSSIS (whooping cough)	1	0	0	0	0	1
ORGANOPHOSPHATE / AGRICULTURAL POISONING	25	1	5	1	107	139
TETANUS	2	0	0	0	0	2
TETANUS NEONATORUM	1	0	0	0	0	1
TUBERCULOSIS	652	214	631	748	578	2 823
TYPHOID FEVER	4	0	0	0	1	5

236 Cases of malaria notified during the year were in persons who travelled to malaria risk areas without taking the necessary precautions against contracting the disease. One malaria case claimed to have visited the Natal South Coast (not an endemic area).

3.5.7.4 Eradication of polio

As part of the national drive to eradicate polio in South Africa by the year 2005, all cases of acute flaccid paralysis in persons under 15 years of age are investigated and the relevant specimens examined at the National Institute for Communicable Diseases (NICD) to determine whether it is polio. There were three cases of acute flaccid paralysis were notified and investigated during the year in Tshwane. None of these patients had polio.

3.5.7.5 Elimination of measles

South Africa is participating in the worldwide drive to eliminate measles through high routine coverage with measles vaccine, mass immunisation campaigns, case-based surveillance with laboratory support and mopping-up activities in low coverage of high-risk areas.

A total of 30 cases of children suspected of having measles were investigated in Tshwane during the year. Only 5 of these children were found to have measles.

3.5.7.6 Elimination of neonatal tetanus

Neonatal tetanus is eliminated through immunisation of pregnant women, infection control during delivery and health education of pregnant mothers. The national goal is less than 1 case per 1000 live births in all magisterial districts.

One case of neonatal tetanus was reported, but the mother was visiting from Mpumalanga.

3.5.7.7 Influenza A

Although not a notifiable disease, it has the potential to cause an outbreak with major implications. The disease outbreak team in collaboration with the private sector, contained an outbreak at the Police College in Pretoria and successfully prevented the spread to the community.

3.5.7.8 Severe acute reparatory syndrome (SARS)

SARS posed a real threat to the community. Only one probable case was admitted to a private hospital in Tshwane. Teamwork involving the disease outbreak team and the private sector, limited the outbreak.

3.5.8 RESPONDING SUCCESSFULLY TO Aids

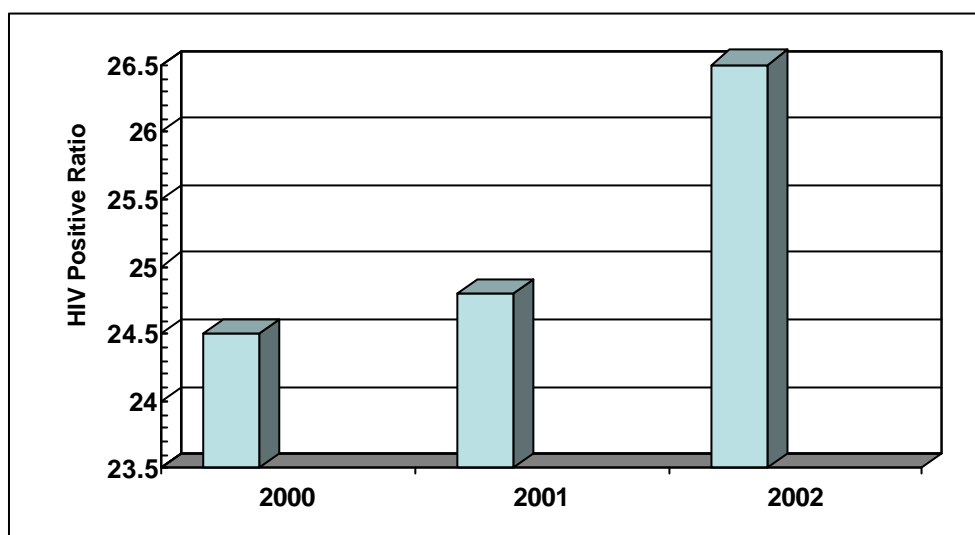
3.5.8.1 Demographic, geographic, socio-economic situation and major challenges

STH Consortium conducted an HIV/Aids study in Tshwane. For the purposes of the study, the population figures of the Municipal Demarcation Board were accepted, indicating that Tshwane has a population of approximately 1,7 million. Sixty-eight percent of the inhabitants being black, 28 percent white and the rest coloured (1,7%), Asian (1,5%) and others (0,7%). Twenty-seven percent of the inhabitants are 15 years of age or younger; 39,7% are between 16 and 35; 28,5% are between 36 and 64 years old, and 4,7% are older than 65 years. Ninety-one percent of inhabitants are literate.

3.5.8.2 Epidemiological background

The national HIV prevalence is reflected in Graph 18

GRAPH 18. HIV PREVALENCE: TRENDS IN SA 2000 TO 2002



3.5.8.3 The challenges for Tshwane

The report shows that HIV/Aids is an unprecedented catastrophe, which is destroying community life in Tshwane. The effect of the HIV/Aids epidemic in South Africa and in Tshwane is comparable to that of a war against this territory. The following are but a few of the facts supporting the statement:

- More than 10% of the population of the city is already infected with HIV and new infections occur daily.
- The death rate in Tshwane has already risen dramatically over the past 10 years; the number of “additional deaths” (deaths that are not accounted for under conditions that formerly existed) have risen from less than 200 in 1993 to 4 013 in 2000
- These 4 013 “additional deaths” in 2000 represent approximately 0,3% of the population of Tshwane. Referring to the cold figures on their own, this does not seem significant – until one realises that the period from HIV infection until death is from approximately 8 to 10 years; and until one recalls that infection rate in 1990 was just slightly more than 0,3%. Ten years after 1990, 0,3% of the population died due to situations that were not present before. With approximately 10% of the total community having been HIV+ in 2000, the implications for 2010 are horrifying. And if the tide is not stemmed, the future may even become worse.
- The number of annual deaths is expected to peak within 6 to 8 years. Based on the historic mortality figures linked to the historic infection rates eight years before, it can be estimated that approximately 150 000 Tshwane inhabitants are due to die within the next 6 to 8 years.
- Other indicators of a serious health threat in the community are as follows:
 - Infant mortalities have already risen by just more than 100% between 1990 and 1999 (ie from 17,5 deaths per 1000 live births in 1990 to 35,7 in 1999).
 - Tuberculosis notifications rose by 124%.
 - Antenatal HIV prevalence rates at Tshwane antenatal clinics increased from 1,24% in 1992 to 21,9% in 2000.
 - The HIV prevalence rate for women between 20 and 24 years of age in antenatal studies is a staggering 29,1% and the rate for women between 25 and 29 years of age is even higher at 30,6%.
 - The Institute for Pathology at the University of Pretoria found that 37% of blood specimens tested for HIV during 2001 were positive.
 - In a survey of 50 households, 19% of respondents were aware of orphaned children in their immediate area; 17% of respondents were aware of persons who were ill in the sense of showing clear symptoms; and 75% were aware of persons living with HIV or Aids.
 - A survey by the Pretoria Child and Family Association identified 110 street children in Sunnyside and 450 in the inner city of Pretoria. The profile of Sunnyside can also be applied to Arcadia and Berea.
 - The same study identified approximately 300 sex workers in Sunnyside alone, which is indicative of a significant presence of this high risk group in the city.
 - In a survey of 60 businesses, 16% of the respondents indicated that they experienced an increase of absenteeism; 17% experienced an increase in staff turnover; and 9% were aware of staff members living with HIV or Aids.
 - 55% of NGOs and CBOs indicated that an increase in demand for HIV or Aids related services was experienced.

3.5.8.4 Summary of the result of the growth of the HIV/Aids epidemic

- The city is experiencing the impact of the HIV/Aids epidemic to the full. Large numbers of its inhabitants are already set to die early, while more and more persons continue to become infected daily.
- The children of the city are threatened in an unprecedented way.
- Many have already been orphaned, and large numbers stand to be orphaned in the near future as the death toll rises.
- Many newborn babies and teenagers have already become infected.
- Large numbers of children are suffering from malnutrition and experience a lack of a safe home, parental care, proper education, etc. A new "lost generation" is being created.
- The economy of our city is under siege with the production potential being reduced due to increased absenteeism, increased staff turnover, reduced productivity, etc, and with the buying power of the population coming under pressure.
- The Municipality's own ability to continue providing its services will come under pressure.
- The environment within which the Municipality is working, the demographic constitution and the needs profile of the community are changing due to the epidemic, and will impact on the needs profile of its clients.
- A dark shadow of pain, suffering, bereavement and destitution is being drawn over every component of our society.
- Resources in the community of Tshwane are adversely affected?

Different parts of the socio-economic community respond differently to the epidemic. Some develop efficient responses, others do not respond at all.

The following is brief overview of some of the important components of the Tshwane socio-cultural and economic activity structure, with an indication of their involvement in aspects of HIV/Aids management:

- Departments of state and province have well-developed HIV/Aids strategies and workplace programmes.
 - Hospital and clinic services provided by the Gauteng Department of Health: 5 hospitals, 18 clinics
 - North West Province Department of Health: 2 hospitals, 20 clinics
 - Many other HIV/Aids management related services are provide by the Department of Health
- Division of the CTMM
 - Social Development (Health Care): 3 ATICCs, 41 clinics
 - Corporate Services (Occupational Health): Wellness Centre, CTMM HIV/Aids Workplace Programme
 - Community Safety (Disaster Management): Education and research programmes
 - Economic Development (Local Economic Development): Strategic support, Cities Network
- Seven labour unions: HIV/Aids awareness, information, ensure a safe and healthy workplace, collect and distribute food and clothing for persons living with Aids.
- 204 NGOs and 42 CBOs: 13 NGOs provide exclusively HIV and Aids services, 69 NGOs and 42 CBOs provide HIV/Aids-related services. These services are not equally distributed across Tshwane (inner city has a large number of service provide organisations, while areas such as Temba has only one organisation which provide HIV-related services.
- Tshwane has an estimate 28 400 businesses, of which 32% present HIV/Aids prevention programmes to employees, 84% employees benefit from these services, while 15% of businesses provide care services to their employees, and 61% of the staff have access to these services.
- Religious sector: 73% of Tshwane inhabitants belong to the Christian faith; 0,8% are Islam; 0,5% are Hindu; 0,2% are Jewish and 25,5% are unspecified. 33% of church leaders report that they are aware of at least one person with HIV or Aids 61% of churches are involved in activities related to HIV and Aids, but mostly, the level of activity is low. A few very active exceptions do exist.
- 44 donor organisations (including development agencies and embassies with funding programmes) exist.

3.5.8.5 Other challenges for Tshwane

- Although leaders often mention the seriousness of the situation, the extent and devastating nature of the epidemic is apparently not well internalised by municipal management, and therefore not properly addressed in the municipal priorities and programmes. The extent of the municipal responses does not balance the extent of the epidemic and a massive response, which correlates with the size of the threat to the city and its inhabitants, is urgently required.
- Management information on the epidemic, on outcomes achieved and on outputs produced is not available. Without proper management information, the epidemic cannot be managed.

- Amounts budgeted to counter the epidemic are not proportionate to the extent of the threat.
- The effectiveness of existing municipal programmes/projects against the epidemic is limited due to a lack of resources. Some of the municipal departments have planned and are implementing well-designed HIV/Aids management programmes. However, the critical volume of HIV/Aids management resources (staff and otherwise) are not available and the epidemic is not under control.
- The HIV responses that do exist in the Municipality lack coordination. The HIV/Aids related activities undertaken by different departments, divisions and subdivisions of the Municipality are not well coordinated. Roleplayers are often not aware of the involvement of colleagues in the same kind of activity. The existing coordination processes are not well supported by all and are therefore not effective. The existing coordination forum of the Municipality, ie the Aids Task Team established by the Health Care Division is not functioning well due to a lack of support by other departments and divisions.
- Liaison between municipal departments/divisions and outside parties is taking place, yet virtually everything is done in isolation, with little or no coordination of municipal contact with the external parties.
- A significant prevention and care capacity to counter the epidemic is available in the external community, yet large parts of this capacity are left unused for, example:
 - Research has shown that only a few of the large number of churches and other religious institutions are involved in HIV/Aids management programmes. The same applies to businesses and certain other organisations.
 - Although NGOs and CBOs are well placed to provide an effective and very necessary service, they are often under-resourced due to lack of funding. On the other hand, indications are that large amounts of funds are available at donor organisations and development agencies, but cannot be utilised properly due to administrative, logistic and management or control problems.

3.5.8.6 Staff component

Manager: Aids Unit:	(1)
Health education and training officers:	(3)
Nursing assistant:	(1)
Administrative officer:	(1)
General worker:	(1)

3.5.8.7 Relationship to other programmes

The CTMM HIV/Aids Programme has an effect on other programmes in the CTMM, the community of Tshwane and, other service providers, as well as government departments.

The HIV/Aids programme is intersectoral and supports the following initiatives:

- Health programmes (such as tuberculosis control, sexually transmitted infections, voluntary counselling and testing for HIV, mother and infant health, health promotion as well as hospice- and home-based care).
- Gender programmes
- Educational programmes
- Economic development programmes
- Safety and security. (Crime can play a role in the spread of HIV. Crime prevention and security programmes are affected by the HIV/Aids epidemic and the response by other sectors to combat its effects.)
- Disaster management. (Contingency plans are influenced by the HIV/Aids trends and response to it.)
- Housing, City Planning, Land and Environmental Planning (The traditional approaches to town planning and land development are challenged by the impact of HIV/Aids. The needs of society might change according to several social and cultural factors caused by the HIV/Aids epidemic.)
- Integrated Community Development
- Service delivery (Electricity supply, roads and storm water and water and sanitation, etc, are all influenced by the HIV/Aids epidemic, and projections are constantly made to align itself to the future needs of society.)

3.5.8.8 Initiatives

The Tshwane HIV/Aids Strategy is aligned with the provincial and national HIV/Aids strategies and based on four pillars of HIV/Aids management as recommended by the Aids audit and study that was done in 2002:

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

- Aids management programmes in all relevant departments in the Municipality
- Effective data collection, processing and reporting to monitor the epidemic and the response
- Community involvement through the Tshwane Metropolitan Aids Council
- Liaison with national and provincial departments of health and DPLG as well as other relevant stakeholders
- Improvement of the Aids Strategy

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

- Social mobilisation and communication with the community
- Prevention services provided by all relevant departments and divisions
- Care and support services to people living with HIV/Aids, including economic development, social welfare and health services, as well as "Living Positively with HIV/Aids" programmes
- Partnerships and referral networks

Pillar 3: Multisectoral solutions and coordinating and integrating the responses to the epidemic of external parties

- Optimal resource utilisation through co-ordination in integration among 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 terms of prevention programmes, workplace programmes and community care programmes

Pillar 4: Managing the impact of the epidemic on the Municipality itself in terms of employee programmes in order to minimise the impact of the epidemic on its ability to provide services

3.5.8.9 Current initiatives

- Council approved the establishment of an HIV/Aids Unit within the Health Care Division in November 2002, and the implementation has been initiated.
- The Tshwane Metropolitan Aids Council (TMAC) was launched on 20 March 2003 and is being operationalised.
- Partnerships are being established through the Intersectoral Task Team.
- Capacity building and training is ongoing, including workshops with ward committees and the taxi industry.
- Awareness campaigns are implemented on commemorative days and on an ongoing basis.
- Prevention services include condom distribution, treatment of STIs and TB, and roll-out of VCT and PMTCT.
- Care services include health services and services provided by other government departments and NGOs through networks and partnerships.

3.5.8.10 Partnerships

Internal partnerships

- Some CTMM departments are included in the Intersectoral Aids Task Team

External partnerships

- TMAC includes representatives from various sectors, eg the religious sector, youth, private, academic, government and the community.
- The CTMM is represented on the Gauteng Intersectoral Aids Committee.
- Relationships were established with businesses such as Ford and BMW
- Provincial Departments of health, social services and education, as well as NGOs, the private sector and tertiary institutions are members of the Tshwane Intersectoral Aids Task Team.
- The CTMM is part of the South African Civil Military Alliance.
- NGOs and FBOs (eg hospice, Tateni, child welfare, trauma centres)
- Private agencies (eg pharmacies, private clinics, private practitioners)
- Tertiary Institutions (eg universities and technikons)

3.5.8.11 Instruments

- The Tshwane HIV/Aids strategy determines the programme objectives and monitoring will be done accordingly.
- TMAC has a monitoring as well as an advocacy role.

3.5.8.12 Dependencies

The programme is dependent on the availability of the required funds in the medium term. Risks that may impact on programme successes are as follows:

- Financial constraints
- Escalation of the pandemic and increased rates especially impacting on the CTMM as a community service delivery agent (increase in demand for services may exceed capacity to provide programme)
- Staff turnover, absenteeism and low morale
- Dependence on volunteers to augment staff shortage. (Volunteers leave the Department after being skilled for other paying programmes.)

3.5.8.13 Resources

Current available resources include-

- health care budget and DPLG HIV/Aids grant funding
- skilled and motivated staff
- developed training programmes
- training facilities in three areas of Tshwane
- access to other training facilities in Tshwane
- academic support: universities and technikons, research institutions and individuals

3.5.8.14 Projects executed

- **Training of 76 Ward Committees**
The first phase of training ward committees was undertaken. This phase comprised the buy-in and orientation of ward committees in future training and partnerships.
- **Training of members of the taxi industry**
The first phase of this training programme was also initiated and further training will commence in the new financial year.
- **Tshwane HIV/Aids Edutainment programme**
Tilly's Tavern video series was introduced to employees of Tshwane through the KnowNet service. The aim of the intervention was to inform employees about HIV and Aids and to change behaviour with consequent risk of HIV infection, as well as behaviour towards people infected with or affected by HIV.
- **Voluntary Counselling and Testing (VCT)**
VCT sites were launched. ATICC provided training for VCT support workers in collaboration with Gauteng Department of Health.
- **General HIV and Aids information sessions**
During 137 sessions, 11 722 people were reached.
- **Life skills session**
Sessions at schools, churches, youth groups and tertiary institutions were well attended: during 25 sessions, 4 245 young people were present.
- **Training**
Due to the relevance and standard, training offered by ATICC remains in demand. Lay persons, as well as professionals, are trained in the following areas: HIV/Aids education, HIV/Aids befriender, HIV/Aids programme management, HIV/Aids counselling, VCT and MTCT. During 53 training sessions, 3 764 people were trained.
- **Exhibitions**
Exhibitions on HIV, Aids and related issues were held. Approximately 14 000 people attended.
- **Counselling**
552 pre- and post-HIV test counselling sessions were offered, while 240 specialised counsellings were conducted.
- **Condoms distribution**
718 910 condoms were distributed from ATTIC
- **HIV/Aids prison programme**
Since 1996 HIV and Aids programmes have been introduced in the different prisons in the Pretoria Command Area of the Department of Correctional Services. During 2002/2003, Central Prison in Pretoria was targeted and a number of projects were initiated:
 - Training of inmates on:
 - HIV/Aids peer education
 - HIV/Aids counselling

- HIV/Aids Project Management
- HIV/Aids Business Plan Development
- Establishment of an HIV/Aids committee which undertakes projects in the prison
- Establishment of an HIV/Aids information centre from where information and condoms are distributed
- Establishment of an HIV/Aids support group
- Development of educational and training materials for education and counselling sessions
- Integrated HIV/Aids education programme (trained educators are utilised in the formal training programme of the prison)

○ **Gauteng Civil Military Alliance**

A project to improve the management of trauma with consequent risk of HIV infection was launched in Tshwane as a pilot phase of the Gauteng project. The first objective was to undertake an audit of the trauma management situation and develop a database of services in Tshwane. CompreCare was appointed as the consultant and conducted the study successfully. A report was submitted and reveals valuable information for all service providers. Before entering the next phase of the project the national body, namely the South African Civil Military Alliance, announced a national project based on the work done by the Gauteng Civil Military Alliance. A business plan for a nationwide project has been developed and forwarded to the US Military for possible funding.

○ **World Aids Day**

World Aids Day 2002 was a community-driven event.

Volunteers were recruited to support the objectives of the event. The following number of volunteers per area were recruited:

• Mamelodi:.....	600
• Atteridgeville:.....	500
• Soshanguve:.....	500
• Inner city:	250
• Olievenhoutbosch:	400
• Southern region:	500
• Metsweding:	800
• Eersterust:	250

○ **Special event - Partnership with the religious sector**

This event comprised the following:

- Signing of a pledge by government and the religious leaders
- Establishment of an interfaith forum between Christians, Muslims and Hindus
- Integration of planning and coordination of resources

○ **PWA mobilisation**

A motivational speaker, Mercy Makgalemele, facilitated the response from people living with HIV and Aids to be prayed for and to sign the above memorandum.

○ **Political leadership**

Ward Councillors, the MEC and Members of the Mayoral Committee supported the proceedings.

○ **Management**

Top management from the CTMM, as well as members from the Gauteng Department of Health (Central and Regional Offices), attended.

3.6 EMPOWERING THE COMMUNITY

3.6.1 COMMUNITY PARTICIPATION

Organised workshops for community members were held in order for them to identify problems in their specific community, eg drug abuse, environmental needs, health matters, economic factors, social matters or whatever had an impact on their health and well-being.

3.6.2 PARTNERS INVOLVED IN HEALTH PROMOTIONAL ACTIVITIES

The following partners were involved:

- ❖ Schools
- ❖ Youth groups
- ❖ Churches
- ❖ Government departments, eg Office of the State Presidency, Department of Education Department of Justice, Correctional Services
- ❖ Provincial government – various departments, eg Health and Social Development
- ❖ Local authority departments, eg Tshwane libraries, Integrated Community Development, Safety and security

- ❖ NGOs - Sacotso, Ebenezer, Thusong, Topitopi, Bona Art Assembly, etc, helped in planning and participated also in drama and music groups
- ❖ Community home-based care groups, HIV/Aids volunteers
- ❖ University of Pretoria youth skills development programme
- ❖ Ward councillors/committees
- ❖ Pretoria Zoological Gardens
- ❖ Private sector/business eg Nestlé, Fresenius Kabi, SA Forum, Ethemba, Astra Zeneca, Aventis Pasteur

The above were involved in-

- awareness campaigns, eg condom week, year of the volunteer, drug programmes
- Research/Survey
- Workshops
- Exhibitions
- Health education

3.6.3 COMMUNITY EMPOWERMENT

Ward committees are still ineffective in most areas. Some counsellors are involved in programmes and eager to participate in effectively addressing the needs of their communities.

One way of empowering the community was through imbizos, the Tshwane *e a re direla* campaign and rallies which were held in some areas, eg Mamelodi, Soshanguve, and Akasia, to inform communities of available services in their areas, as well as listening to complaints and suggestions about services. These were combined efforts of the City of Tshwane Metropolitan Municipality.

Other examples are:

- ❖ Co-ordinated workshop for the Ga-Rankuwa community to participate, and make decisions, solve problems in their community on drug abuse
- ❖ Informing people on how to register as tenderers for catering, drama groups, etc, in order for them to get an income and be independent
- ❖ Educating the community about the importance of community participation in health matters
- ❖ Encouraging and co-ordinating training of volunteers as TB DOTS supporters
- ❖ Education sessions through talks, awareness days, exhibitions and lectures

3.6.4 HEALTH EDUCATION PROGRAMMES:

TABLE 16: HEALTH EDUCATION PROGRAMMES

TOPICS/PROGRAMMES	GROUPS INVOLVED			Number of people educated
	Schools	Community groups	Others	
Drug and substance abuse and teenagers	v	v	NGOs	5 401
Tuberculosis (TB)	v	v	Clinics	3 000 About 1 000
STIs and teenagers	v	v	Department of Justice Office of the State Presidency University of Pretoria	About 1 000
HIV/Aids	v	v	NGOs Prison Churches	About 4 000

TOPICS/PROGRAMMES	GROUPS INVOLVED			
Reproductive health		v		About 2 300
Child protection Women/children abuse (impact on health)		v	NGOs	About 1 000
Abuse of the aged and disabled people (impact on health)		v	NGOs	±400
Hypertension		v		300
Diabetes mellitus		v		360
Cancer awareness		v	NGOs Clinics	200 1 200
Accidents in and around the house		v		12
Head lice	v	v		30
Cholera	v	v		450
Total number of people educated				20 653

3.6.5 HEALTH PROMOTION ACTIVITIES

3.6.5.1 Material developed

Several materials needed to be developed for projects 55 posters on healthy life style, cancer, TB, nutrition, rubella, volunteer of the year, clinic services, etc. Three pamphlets on child health issues, nomination forms, evaluation forms, rulers, key holders, and T-shirts were developed. For training purposes we developed transparencies on various topics eg drug abuse, women abuse and TB DOTS.

3.6.5.2 Amount of material distributed

A total of 2 535 posters, 57 119 pamphlets, 5 450 key holders, 120 T-shirts, 100 caps and 7 050 rulers were distributed among the community. All items have health messages and information to improve health and well-being or maintain a healthy life style.

3.6.5.3 Community training

Training only took place in cooperation with other sections, eg ATICCs. Certain of the topics in the HIV/Aids curricula and home-based training were done by our staff, namely drug abuse and HIV, nutrition and HIV. Training of community members and volunteers for NGOs took place at SACOTSO and Ebenezer. 200 people were trained in TB, sexually transmitted infections, drug abuse, hypertension, diabetes and cancer.

3.6.5.4 Evaluation of health promotional programmes and projects

- Evaluation was done with people involved in planning and organising projects.
- Evaluation of programmes was mainly positive, where people enjoyed the sessions and desired more structured and frequent teaching in schools, youth groups and various community groups.
- Some also expressed their concern about the ignorance among the literate members of our society and how they choose to ignore certain facts and do not set an example for the rest of society.
- A shortcoming that needs to be addressed soon is that the evaluation forms are available only in English and need to be translated into other languages as well.

3.6.6 SPECIAL PROJECTS DONE IN TSHWANE

3.6.6.1 TB awareness

TB awareness is done throughout the year at TB clinics and workplaces of TB sufferers. Special emphasis was put on TB awareness at all clinics in Tshwane, the media and in the community during March, April and September.
Activities included-

- Education sessions on TB and nutrition, general TB information
- Door-to-door visits in problem communities
- Training of TB DOTS supporters in some areas

Exhibition were held, pamphlets and posters distributed and drama groups conveyed the message as well as talks on TB.

3.6.6.2 Polio eradication

Posters and information pamphlets were distributed at all clinics to identify AFP cases and to make people aware of the importance of polio immunisation.

Information sessions to 36 child minders and community members were given on the importance of immunisation in Olievenhoutbosch and Sacotso NGO during April.

3.6.6.3 Health Day: 16 April 2003

Theme: Healthy Environments for Children. Gauteng Province: Health Promotion coordinated this day. Various schools attended the event at Pilditch Stadium where children were made aware of all the environmental dangers which could affect their health and safety. There were exhibitions on prevention of child abuse, on HIV/Aids awareness and sexual safety.

3.6.6.4 Child protection awareness in Atteridgeville: May 2003

A day for the community's pre-school children and child-minders in partnership with Gauteng Province: Health was held to make children aware of possible dangers and to provide them with skills needed to address the dangers. Danny Cat, Moompie show, Child Protection Unit, Captain Crime Stop and an item by the Rainbow Kids formed part of the programme. About 2 500 people attended the day. Relevant information was available in the form of pamphlets.

3.6.6.5 Drug and substance abuse

Drug and substance abuse are becoming an increasing problem among the youth. One of the community surveys that was done in Ga-Rankuwa showed that alcohol, dagga, "shaba" and certain tablets were among the most common ones used. In the light of this information and requests from the community we held several awareness campaigns. An NGO named NAYASA (National Youth Association in South Africa) is now actively involved with the community.

June - An inner city drug abuse and child protection awareness programme in partnership with Bona Art Assembly (NGO) was held.

June - At Ga-Rankuwa: awareness talks, exhibitions, health talks and information were given to youth regarding substance abuse, in partnership with Safety and Security and the SAPS. The Metro Police are ready to fight crime especially related to drugs. Youths, churches, schools and councillors were involved, and 600 people attended.

June - At Atteridgeville prison, 200 people attended an awareness programme on HIV/Aids and substance abuse for prisoners.

23 to 27 June - All clinics and libraries had drug awareness programmes and exhibitions.

26 June - East Lynne and Eersterust Clinics had a special drug awareness programme in partnership with PharmaValue, Act Up and a rehabilitated heroin addict, Tshwane Health Care, churches, NGOs and United Nations. 250 people attended the sessions.

3.6.6.6 Volunteer of the Year

During 2002, emphasis was put on voluntary work that was done in the community of Tshwane. Hundreds of volunteers gave of their time daily to serve others in need in the community and in doing so, contributed towards improved services, improving the quality of life in the community, and encouraged community participation, responsibility and knowledge. The dedicated work that was done and is still continuing has not passed unnoticed. In fact, the Social Development Department of the CTMM has acknowledged the work of volunteers on various occasions during the year. On 5 December 2002 we celebrated the Volunteer of the Year Award Ceremony.

A total of 120 people were nominated for Volunteer of the Year. After evaluation, 43 volunteers received certificates of acknowledgement and 5 area winners received certificates, as well as a trophy, and various gifts from sponsors and Social Development Department of the CTMM.

The Volunteer of the Year, Mrs Precious Makhabele Mthembu, who is a dedicated TB DOTS supporter, received a certificate, a trophy, and also various gifts from sponsors and the CTMM.

This will now become an annual event, as voluntary workers are one of the means to assist us in addressing the problem of insufficient resources - human, financial, etc, and still provide quality services. It was a humbling and heart-warming experience to see how dedicated people are in serving their fellow men without any remuneration and often in difficult circumstances. The Volunteer of the Year event was definitely worthwhile and a success.

3.6.6.7 Challenges in health promotion for the future

We still see an increase of numbers in most diseases due to life style choices that are made. With limited resources it will take a long time before people start realising that they are ultimately responsible for their own health and need to get the right information, knowledge and skills to make the right and best choice for themselves, their families and communities. Community training courses are to be registered with SAQA and have to form part of the NQF. Health projects are to be developed and sustained in the community.

3.7 IMPROVING ENVIRONMENTAL HEALTH CONDITIONS IN TSHWANE

Environmental health forms the basis for ensuring the right of every individual to live in an environment that is not harmful to his or her health and well-being. The right to a healthy environment is reflected in the Constitution of the Republic of South Africa 1996, (Act 108 of 1996) and the Reconstruction and Development Programme. Environmental Health also forms the foundation for sustainable development.

Environmental Health Services creates the foundation for good personal hygiene and health, which, in turn, contributes to a healthy community and workforce for economic development of the country and forms the basis of sustainable development as reflected in Agenda 21 on Health and the Environment of the Earth Summit of 1992.

Agenda 21 focuses on protecting and promoting human programmes such as reducing health risks from environmental pollution and hazards, control of communicable diseases, promoting sustainable human settlements and development, as well as safe and environmentally sound management of environmental stresses.

The City of Tshwane area as a partially industrialised and developing area, is faced with various environmental health issues. As an industrialised area it is faced with, among other things, internal and external pollutants, pesticide residues, lead in food, antibiotics in milk and milk products and others.

As a developing area, the City of Tshwane's environmental health problems are usually poverty related due to factors such as unemployment which a rise as a result of rapid and uncontrolled urbanisation, including land invasion practices. Environmental health implications of such rapid and uncontrolled urbanisation of the already poor and disadvantaged communities will have profound implications for all aspects of development, health and the environment.

The Vision of this section is to strive for the promotion of a safe and sound environment in order to achieve the highest possible standard of hygiene and sustainability within the area of jurisdiction of the CTMM.

The Mission is to ensure an optimum and universally acceptable standard of hygiene in an efficient manner, by addressing community needs and problems within the area.

In terms of the Health Act, 1977 (Act 63 of 1977) and other relevant acts and local by-laws, local authorities have a statutory obligation to submit quarterly and annual reports pertaining to environmental health services provided. Environmental health practitioners accordingly took action to monitor food, water, the environment, air quality control and noise pollution control to eliminate unhygienic conditions and to give health education.

In terms of the Division's policy, all complaints and other matters where investigations were required, were given immediate attention. Matters concerning other departments were referred to those relevant departments for their attention.

Table 18 refers to the statistical report of projects completed during the reporting period and can be described as follows:

- Monitoring of premises entails routine visits and inspection of premises with a view to detecting compliance with the relevant legislation, guidelines and standards so that corrective measures can be implemented to avoid possible nuisances or health hazards.
- Sampling includes all samples taken for laboratory analysis in respect of chemical, biological and histological nature. This refers to water, food pesticides, meat and milk samples.
- Complaints related to all types of premises including food premises, disposal sites, animals, offensive smells, rodent infestation, overcrowding, mosquitoes, overgrown conditions, refuse removal and litter related matters, noise and air pollution problems, and water and other environmental related problems, were taken into account and reflected under this section.
- Advisory service relates to matters concerning scrutinising building plans, rezoning and consent use, health education, township development, court cases and so on.
- Seizure of perishable food includes confiscation, condemnation and destruction of unsound foodstuffs from supermarkets, fresh-produce markets and other food related premises.

- Handling of license applications entails licences in respect of food premises, accommodation establishment, places of entertainment, hawkers and other business premises.
- Health education and community development include both formal and informal courses, student training, workshops and community development projects.

TABLE 17: ENVIRONMENTAL HEALTH MONITORING AND INSPECTION STATISTICS

		WORKLOAD	WORKLOAD	ACTIONS
			ACCOMPLISHED	INVESTIGATED
1.	Monitoring of premises	1 746 869	14 513	13 848
2.	Sampling	1 953	1 782	1 841
3.	Handling of complaints	4 032	4 168	5 612
4.	Advisory service	1 626	1 626	1 804
5.	Communicable diseases	0	0	0
6.	Seizure and food condemnation	99 448	150	150
7.	Handling of licence applications	604	604	608
8.	Health education and community development.	221	221	221
	Grand total	1 854 753	23 064	22 280

3.7.1 AIR QUALITY MANAGEMENT AND CLIMATE PROTECTION

3.7.1.1 Climate protection measures

The International Council for Local Environmental Initiatives (ICLEI) made grant funding (\$59 000,00) available for the implementation of climate protection measures in the city. The following progress can be reported:

- An agreement was signed between the ICLEI and the CTMM and a baseline inventory was completed.
- 1 000 trees were planted in Babelegi to help with the sequestration of carbon dioxide, also having the following direct benefits:
 - Carbon sequestration
 - Upgrading of the visual character of the area
 - Provision of shade for workers, pedestrians and vehicles
 - Developing opportunities for redevelopment of the area
 - Air pollution reduction
 - Climate amelioration
 - Erosion control

This project also benefits economic and social development.

The ICLEI launched the national a cities for climate protection campaign in South Africa during world environment day: 5 June 2001. The City of Tshwane, like seven other South African cities was identified to participate in the Cities for Climate Protection CCP programme. Johannesburg, Potchefstroom, Saldanha Bay, EThekweni (Durban) Sol Plaatje (Kimberley), Cape Town and Buffalo City (East London), has embarked on a process to reduce green house gas emissions and are incorporating their CCP involvement into existing programmes such as Local Agenda 21, integrated development plans, and state of the environment reporting and planning activities. The City of Tshwane has reached most of the milestones of the campaign and therefore, for these achievements, a special award was presented to the CTMM.

PHOTO 2. AWARD CEREMONY: CLIMATE PROTECTION CAMPAIGN



Present: Joseph Nkosana, Acting Manager: Environmental Aspect Mitigation; Nancy Skinner, CCP International Director; Elizabeth Mhlongo, Strategic Executive: Health and Social Development, CTMM; MMC M.P.O. Nyatlo: Member of the Mayoral Committee for Health and Social Development; Juan Mostert, CCP Co-coordinator and Leluma Matoane, ICLEI

3.7.1.2. Air Quality Management Project

The primary goal of the project was to study the pollution levels which prevailed during the winter months. This approach was motivated by the fact that climatic conditions in winter months result in very stable air layers, thus reducing the dispersion of pollutants in the air. Secondly, more fossil fuels, eg coal, wood, etc, were consumed during the winter months, resulting in an increase in the production of air pollutants.

A total of nine smoke and SO₂ monitoring stations are being operated by the CTMM. Of these, three are located in Centurion and six are located in and around Pretoria.

Data collection at the nine stations is very limited. The soiling index data recovery rate and the SO₂ data recovery rate were very low, consequently no useful soiling index data was collected during the period July 2002 and June 2003. The stations were closed for a long period due to non-compliance with occupational health and safety standards.

3.7.1.3. Sustainable energy: reduction of greenhouse gas emissions

The CTMM has accepted the challenge to reduce greenhouse gas emissions in its region and is involved in the CCP campaign. As a result, CTMM has been approached by Sustainable Energy for Africa (SEA) to partake in SEAs Sustainable Energy for Environment and Development Programme. There are a few programmes which are starting to address some of the issues on energy, such as Sustainable Energy for Environment and Development (SEED) programme (a national capacity building and partnership programme focusing on low income energy issues) and the International Council for Local Environmental Initiatives' CCP campaign.

3.7.1.4. Green buildings

The Green Buildings for Africa Programme (GBAP) is aimed at supporting and promoting environmentally responsible use of facilities by property owners, managers and tenants.

The purpose and objectives of the programme from the CTMM's perspective include-

- promotion of green building principles in the management and use of city facilities in order to promote awareness of, and active participation of developers, owners and managers in green building initiatives;
- creating awareness of resource shortages, such as water and fossil fuels in the national context, while demonstrating responsible use of these resources within city facilities;
- providing opportunities for, and promoting capacity building within the city's facility management, planning and development teams and related industries within the private sector in Tshwane and South Africa, in order to enable sustainable green building initiatives throughout the local and national industry; and

- Reducing the cost of electricity, water and waste within the city property portfolio.

It is envisaged that the IIEC and the CTMM will sign an agreement of understanding. The proposal has been sent to the IIEC's headquarters in Washington DC, and correspondence in this regard is still being awaited.

3.7.2. FOOD SAFETY MANAGEMENT

The following actions were undertaken:

- ❖ Physical monitoring of all food handling premises and venues of the SA GAMES, International Pretoria Show and the World Cricket Cup.
- ❖ Coordination of inputs and comments with regard to food safety according to the South African Bureau of Standards codes and specifications.
- ❖ Successfully handling and facilitating the drafting of regulations with regard to child care centres.
- ❖ Developed a strategic plan (first draft) with regard to the Food Safety Strategy for the CTMM. This document sets out the current food safety status in the CTMM, as well as a strategic view on the providing of a quality and comprehensive food safety strategy.
- ❖ A report was submitted to the Council to obtain permission from the Minister of Health to enable the City of Tshwane to enforce the provision of the Act on Foodstuff, Cosmetics and Disinfectants This Department is awaiting approval from National Health.

3.7.3. NOISE CONTROL

An Environmental Noise Management Committee (ENMC) has been established with inter-departmental representation, including the Metro Police.

A standard operating procedure (SOP) has been drafted, which clearly defines the roles of environmental health practitioners and Metro Police officials.

A framework for a Noise Management Policy for the CTMM has been completed and documented.

3.7.4. ENVIRONMENTAL AWARD SYSTEMS FOR YOUTH PROJECT

EASY Project, an environmental award systems for youth programme, was developed to encourage sustainable environmental activities in schools and communities. It is an educational response to the environmental problems that we are faced with and makes learners aware of their cultural and natural heritage.

Museum Park Enviro Centre drives the project and the CTMM provides the certificates of commitment to participating schools. The CTMM also provides monitoring of the project on a voluntary basis. In the year 2002, 20 schools participated. The monitors went to their respective schools and allocated points to the projects on a standard form. The ceremony was held on 17 October 2002 at the Enviro Centre, and Springvale Primary School from Wierda Park was voted the overall winner. Their project involved recycling of paper and bottles.

3.7.5. WORLD ENVIRONMENT DAY CELEBRATIONS

The World Environment Day was celebrated on 5 June 2003 at Gadime Matsepe High School in Soshanguve. The main objective was to rehabilitate a site, which had been cleared of litter by making a community garden and in the process, educating the community about environmental health issues.

The project stakeholders were the Zivuseni project members, the CTMM's Environmental Health Task Team, environmental health officers, ward councillors, DACEL, forums and members of the community. The Healthcare Division allocated R 20 000,00 for this project.

3.7.6. RODENT CONTROL

The Agricultural Research Council, Bayer SA and the Environmental Health Division were engaged in a rodent control campaign which started in Temba. Cage traps and rodenticides were used to control the high rodent infestation in the area.

Educational campaigns eg as the Mayoral Imbizo in Soshanguve and actions in Ga-Rankuwa and the Tshwane Market also took place

3.7.7. WATER CATCHMENT MANAGEMENT AND ALTERNATIVE ENERGY SOURCES

Audits, site visits and participation in projects such as the EASY projects, removal of waste in rivers, cholera sampling, etc, continued throughout the year.