

***CLINIC DELIVERY TRENDS: PUBLIC HEALTH
CLINICS IN CAPE TOWN CENTRAL DISTRICT***

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Submitted in fulfillment of the requirements for the

Magister Technologiae in Environmental Health

Faculty of Applied Sciences at the Cape Technikon

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Cape Town
2003

DECLARATION

I, Xiaoyan Li, hereby declare that the contents of this thesis represent my own work, and that the thesis has not previously been submitted for academic examination towards any qualification. Furthermore, it represents my own opinions and not necessarily those of the Cape Technikon.



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ABSTRACT

This is a retrospective (descriptive) study of clinic delivery trends rendered in Cape Town Central District between July 1995 and June 2002.

The study describes the history of clinic service delivery in Cape Town Central District, which includes the Primary Health Care model, as well as the District Health system. Clinic delivery trends for the following three periods are determined:

- Before the implementation of the New Health Plan: July 1995 - July 1996;
- During the implementation of the New Health Plan: July 1997 - June 1998;
- After the implementation of the New Health Plan: July 1998 - June 2002.

The study also determines and compares the nature of public health clinic services delivered during the study period.

No official annual health reports were compiled by Cape Town Administration since July 1997. This study therefore serves to determine disease and clinic trends for the periods where no such annual reports are available. It is important to determine health delivery trends for future strategic planning purposes.

Changes to the nature and extent of services rendered by public health clinics were brought about by the following factors:

- One approach of Primary Health Care is to refer more patients to public health clinics in order to release pressure from the major tertiary hospitals. If this Primary Health Care (PHC) model is provided appropriately, about 80% of health problems should be solved without referral to another level of care;
- A number of free public health clinic services have been introduced since the democratization of South Africa in 1994, such as free services to expectant mothers as well as free clinic services to children younger than six years;
- New clinic services have been added, such as provision of medication to stabilized mental health patients;
- HIV/AIDS has become an international pandemic over the past decade and has shown a 660.8% increase in Cape Town Central District;
- A limited (19.8%) increase in the population for that area during the study period;
- Clinic services have been legislated as a nurse driven service since 1997, with an additional emphasis on the curative roles of nurses (traditional roles of nurses at public health clinics were largely preventive and promotive).

The overall number of patients visiting public health clinics in Cape Town Central District increased from 73 718 in 1995 to 314 362 in 2002. There were therefore in 2002 more than four times the number of patients visiting public health clinics than in 1995.

The largest proportion (185.6%) increase of patients visiting public health clinics, took place between July 1995 and June 1998. Free health services to expectant mothers and children younger than six years were the predominant factor for the 185.6% increase.

A 140.4% increase in the number of patients visiting public health clinics was recorded between July 1998 and June 2002. This increase could be ascribed to a number of different factors such as the Primary Health Care approach, new public health clinic services such as the provision of medication to stabilized mental health patients, an increase in HIV/AIDS, a 19.8% increase in the population for the area, as well as a newly legislated curative role of nurses at these clinics.

The number of staff at these clinics has only increased marginally in relation to the increase in the number of patients. The number of doctor workdays has increased from 1 069 in 2001 to 1 247 in 2002. Nurse workdays have increased from 6 251 in 2001 to 8 356 in 2002.

The study therefore recommends that further research be conducted in order to determine whether public health clinics are able to manage the increased patient load experienced since 1995.

Chapter one provides an exposition of the nature and extent of the study. Chapter two focuses on the history of clinic services in South Africa. The third chapter provides the methodology employed. The fourth chapter is an empirical study in which data are tabled, analyzed and presented in order to determine clinic service trends. The last chapter consists of conclusions and recommendations.

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ACKNOWLEDGMENTS

I would hereby wish to thank lecturers at the Cape Technikon, especially Mr. Lawrence Kalis, Ms. Marina Clarke, Mr. Ashraf Mohammed and Ms. Angela Dunn for their assistance and support, as well as the following people for their contributions:

Mrs. Elza Kalis

Mrs. Caretha Fourie

Mr. Rolf Proske

Ms. Liz van Aswegen

Mr. Alex Golden

Ms. Kulsum Cornelius

Mr. Hassan Mahomed

Mr. David Blease

Ms. Christa Hugo

GLOSSARY

District Health Authority

Governance structure which is responsible for ensuring the delivery of all primary health care in a health district (Dept of Health, 1997b:135).

District Hospital

First level non-specialist hospital to which patients from clinics or health centers may be referred (Dept of Health, 1997b:135).

Health District

Geographic area that is small enough to allow maximal involvement of the community so that local health needs are met, but also large enough to effect economies of scale (Dept of Health, 1997b:136).

National Health System

The organization of a country's health service (including services provided by central government, provincial government, local government, NGOs/CBOs and the private sector (Dept of Health, 1997b:136).

Primary Health Care approach

The underlying philosophy for the provision of health care services that is based on the Alma Ata Declaration, i.e. comprehensive care that includes curative, preventive, promotive and rehabilitative care within the context of, amongst others, community participation and intersectoral collaboration (Dept of Health, 1997b:136).

Regional Hospital

Usually a secondary hospital to which patients are referred from the district hospital (i.e. a hospital which serves many districts and at which more specialized services are available (Dept of Health, 1997b:137).

Hospital Level 1

Patients requiring treatment which may be adequately and appropriately provided at the first level of referral (e.g. a community hospital) by a generalist with access to basic diagnostic and therapeutic facilities (Dept of Health, 1997b:137).

Hospital Level 2

Hospitals providing specialist services at the provincial level. Such hospital would be equipped with an intensive care unit (Dept of Health, 1997b:137).

Hospital Level 3

Patients requiring the expertise and care associated with the specialties, sub-specialties and less common specialties (such as cardiology, endocrinology, oncology, plastic and trauma surgery, neonatology, sophisticated pediatrics and specialized imaging), or requiring access to scarce, expensive and specialized therapeutic and diagnostic equipment found only at a central or tertiary hospital (the third level of referral (Dept of Health, 1997b:137).

Hospital Level 4

(Or national) facilities providing quaternary health care (such as liver transplantation and heart transplants) (Dept of Health, 1997b:137).

LIST OF ACRONYMS

AIDS	Acquired Immunosuppressive Disease Syndrome
ANC	African National Congress
CBOs	Community-based Organizations
DHS	District Health System
GDP	Gross National Product
HIV	Human Immunosuppressive Virus
MCWH	Maternal, Child and Women's Health
NGO	Non-Governmental Organization
NHS	National Health System
PHC	Primary Health Care
RDP	Reconstruction and Development Programme
STDs	Sexual Transmitted Diseases
UNICEF	United Nations Fund for Population Activities
WHO	World Health Organization

CHAPTER 1

1 NATURE AND EXTENT OF THE STUDY: CLINIC DELIVERY TRENDS AT PUBLIC HEALTH CLINICS IN CAPE TOWN CENTRAL DISTRICT

1.1 INTRODUCTION

Public health clinic services in South Africa have undergone numerous changes over the past decade. This study therefore focuses on the nature and extent of these changes. Aspects such as a greater emphasis on the Primary Health Care approach brought about these changes.

There has also been a remarkable increase in certain diseases over the past decade, which has changed the nature and extent of public health clinic services. HIV for instance, has become an international pandemic. Tuberculosis cases recorded in Cape Town have been of the highest in the world.

Policies and legislation regarding clinic service delivery have further undergone major changes since the democratisation of South Africa after 1994. A range of additional services have been allocated to public health clinics, such as free services to expectant mothers and children younger than five years, and provision of medication to stabilized mental health patients.

Public health clinic services have become a nurse driven service since it has been legislated as such in 1997. This legislation further emphasises the curative role rendered by nurses employed at these clinics.

Chapter one is an introduction to the study, which includes aspects such as the research problem, aim and objectives. Chapter two provides a historical background and set standards for clinic service delivery at public health clinics in South Africa. Chapter three describes the methodology employed. Chapter four is a discussion of the findings. The last chapter provides conclusions and recommendations.

1.2 STATEMENT OF THE RESEARCH PROBLEM

Clinic delivery trends of public health clinics in Cape Town Central District, which are routinely recorded, have since 1996 not been communicated publicly. Since the change to the new health system in 1997, the extent of clinic attendance and clinic service delivery trends are unknown.

1.3 RESEARCH QUESTION

What is the nature and extent of change encountered at public health clinic services in the Cape Town Central District since 1995?

1.4 AIM

To determine clinic delivery trends at public health clinics in Cape Town Central District during 1 July 1995 to 30 June 2002.

1.5 RATIONALE

Greater emphasis has been placed on clinic services since 1994. In the primary health care approach, more patients are referred to clinics in order to release pressure from the major tertiary teaching hospitals. It is therefore important to determine health services delivery needs for future strategic planning purposes.

1.6 OBJECTIVES

The following objectives are set:

- To describe clinic services provided by public health clinics in the Cape Town Central District over a period of seven years (July 1995 - June 2002);
- To determine clinic delivery trends at public health clinics in the Cape Town Central District over a period of seven years (July 1995 - June 2002);

- To determine the extent of the increases/decrease (expressed as percentages) of clinic service delivery at public health clinics in the Cape Town Central District.

1.7 *METHODOLOGY OF STUDY*

This is a retrospective study, of available clinic data and records. The data will be obtained from the Epidemiological Section of the Health Department of the City of Cape Town.

The history of public health clinic services in Cape Town Central District will be determined by means of a literature study, and will focus mainly on the three periods mentioned in Section 1.6.

The study will describe clinic delivery trends (increases/decreases) of public health clinics in Cape Town Central District for the following three periods:

- Before implementation of the New Health Plan: July 1995 - June 1996 and July 1996 - June 1997;
- During implementation of the New Health Plan: July 1997 - June 1998;
- After implementation of the New Health Plan: July 1998 - June 2002.

The study will also determine the nature of clinic delivery trends rendered at public health clinics by identifying the types of services rendered and indicating which services have been added/withdrawn each year in the Cape Town Central District.

The study will also compare clinic delivery trends for the three periods mentioned above. Approval for use of the data has been obtained from the Medical Officer of Health of Cape Town Administration.

1.8 UNITS OF MEASUREMENT

The following occurrences will be considered as a service rendered by a Public Health Clinic: A visit to a clinic by one patient, as well as the provision of an item/treatment to a patient.

1.9 DELINEATION OF THE STUDY

The study will be conducted at all public health clinics in Cape Town Central District, which covers Chapel Street Clinic, Claremont Clinic, Facterton Clinic, Langa Clinic, Maitland Clinic, Pinelands Clinic, Schotscheskloof Clinic, Sea Point /Green Point, and Spencer Road Clinic.

1.10 CONCEPTUALIZATION

Environmental Health is a Medical Science.

1.11 SUMMARY

This chapter provided a basic introduction to the dissertation. The next chapter will focus on a literature study. The methodology employed will be provided in Chapter three. Data will be presented and discussed in Chapter four. The last chapter consists of conclusions and recommendations.

CHAPTER 2

2 LITERATURE REVIEW - HISTORY OF CLINIC SERVICES IN SOUTH AFRICA

2.1 INTRODUCTION

The first chapter served as an overall introduction, briefly covering all aspects of the study. This chapter will provide a literature review of the history of nursing and clinic services.

In the earliest times women of a household did whatever nursing was necessary. Sometimes a few women in a community were singled out for this duty because of their traditional skills. They would be called on to diagnose, to tend to the sick, to advise, to prescribe, prepare and administer herbs and to help women in labour. Their roles thus included both 'medical' and 'nursing' functions (Unwin et al., 1997:124).

In the early Christian period (AD 1-500), nursing of the sick became one of the acts of charity of Christian women. They did it to show their love for God and their fellow man. These women were called deaconesses and cared for people in their homes. In the late Middle Ages infectious diseases such as plague, leprosy and syphilis assumed pandemic proportions and nursing orders, as well as hospitals, proliferated.

During this time the St Bartholomew's and St Thomas' Hospitals in London, as well as the first psychiatric hospital in England, Bethlehem Hospital (better known as Bedlam), were established (Uys, 1999:18).

As society became more complex, more specialisation took place. There were physicians, who were gentlemen with a university education who served the elite, while apothecaries, who had served apprenticeships, were mostly at the service of the middle classes. Nursing in hospitals was usually done by members of religious orders (Unwin et al., 1997:124).

In 1517, reforms began with the "Sisters of Charity" of the order of St Vincent de Paul, which was established as a secular nursing order in Paris in 1633. After the Reformation, conditions in hospitals deteriorated, because there were no alternative workers. Nursing was done by women of the lowest social standing, they had to do all the housework, including laundry and cooking. They received no training and were often on duty for 12 to 40 hours at a time (Uys, 1999:18).

In 1850 there were some herbal medicines, of which many were also used by the village wise women. These provided relief if not cure. Medical knowledge was growing all the time, but even while of direct relevance to practice was often slow to be applied (Unwin et al., 1997:125).

In 1851, Florence Nightingale received her training under Pastor and Mrs Fliedner. She later played a major role in reforming nursing into a respectable and learned occupation. She identified the basic principles of nursing and set up the first planned educational programme for nurses at St Thomas' Hospital, London, in 1860 (Uys, 1999:18).

At this time Florence Nightingale's ideas were conveyed to South Africa (where scores of hospitals were already in existence) by Sister Henrietta Stockdale. As the settlement extended into the hinterland and the population increased, health-care needs also increased (Mellish, 1990:11).

2.2 *THE HISTORY OF HEALTH SERVICES IN DEVELOPING COUNTRIES*

Good health depends on a good environment. It is estimated that an average of 50% of the urban population in the developing countries live in conditions of extreme deprivation and squalor, which results in malnutrition, vector borne diseases, gastrointestinal diseases, and respiratory diseases, the principal causes of morbidity in the developing world (World Urbanisation Prospects, 1987).

These conditions are linked with social problems such as overwork among women, unemployment among the young, population growth and urbanisation (World Urbanisation Prospects, 1987).

Rapid urbanisation has become a global phenomenon, especially in the cities of developing countries, where annual population growth rates of 3% or more are common. In the early stages of urbanisation, population growth is largely caused by migration from the rural areas; later on, it is the excess of births over deaths that mainly accounts for the increase (World Urbanisation Prospects, 1987). Because of this, the total number of premature deaths in developing countries will continue to increase unless the problems of the urban poor are addressed. One difficulty in taking effective action to deal with the situation is the lack of data to enable community diagnoses, environmental profiles, and evaluations of health and social services to be made (WHO, 1992:6). Furthermore, growth rates of the magnitude mentioned above exceed the capacity of local governments to provide basic infrastructure and services (World Urbanisation Prospects, 1990; 1991).

Despite great efforts by developing country governments and international organisations, basic health needs of vast numbers of the world's people remain unsatisfied. In many countries less than 15% of the rural population and other underprivileged groups have access to health services. More serious, these people are both particularly exposed and prone to disease. A combination of hostile environments, poverty, ignorance of the causes of disease and of protective measures, lack of health services or inability to seek and use them, and adverse climates, all contributed to this sad situation (Djukanovic & Mach, 1975:7-11). The

situation is often compounded by natural and man-made disasters (Dennill et al., 1999:24).

As early as 1953, the WHO Executive Board stated that “assistance in the health field financed by the United Nations Expanded Programme of Technical Assistance should be designed primarily to strengthen the basic health services of the developing countries and to meet the most urgent problems affecting large sections of the population, with due regard to the stage of social or economic development of the countries concerned”.

By the 1960s, the policy of promoting basic health services, by then more clearly defined began to influence some developing countries. In 1971, the Twenty-fourth Health Assembly asked the Executive Board to conduct an organisational study on “Methods of promoting the development of basic health services”. The Executive Board concluded that the present position is unsatisfactory in some developing countries. They stated that these countries will need to make drastic or revolutionary changes in their approach to health services, and others required radical reforms. Two years later, on the basis of this study, the Health Assembly reiterated its “strong conviction that each Member State should develop a health service that is both accessible and acceptable to the total population, suited to its needs and to the socio-economic conditions of the country, and at the level of health technology

considered necessary to meet the problems of that country at a given time” (Djukanovic & Mach, 1975:110).

2.3 *THE HISTORY OF HEALTH SERVICES IN SOUTH AFRICA*

The Republic of South Africa comprises of four distinct climatic regions, which are profoundly affected by variations in altitude and topography. From the coastal belt the areas range from semi-desert regions to a subtropical area with the highveld on an average elevation of 1 700 metres. The population of 45 million is heterogeneous and multinational. Each of the large groups has its own heritage and culture. Eleven official languages are spoken. Those with a Western medical culture, and who could afford it, visited highly specialised private doctors and hospitals. Most of the people from an African culture sought the help of Sangomas and made use of traditional medicine. The poor made use of a system of overloaded, but limited public clinic and hospital services.

The knowledge and experience of the countries from which the White South African nation sprung, mainly the Netherlands and Britain, served to establish basic health services. From modest beginnings South Africa’s health services have attained a pre-eminent position in Africa and are also respected in the rest of the world (Anon, 1977:5).

South Africa's health services are the most comprehensive on the African continent (Anon, 1977:9).

2.3.1 The first phase (prior to 1919)

The first phase, prior to 1919, was characterised by increasing organisation, institutionalisation and professionalisation of health care, due to widespread British influence. This influence manifested particularly in the construction of numerous military and civilian hospitals, and in a series of health-related legislative acts and ordinances aimed at regulating the practice of health care and containing the spread of epidemics. Despite these developments, neither uniformity nor synchronisation was achieved. The political unification of the four colonies in 1910 did little in the way of consolidation, and public health was not mentioned/addressed in the legislation regarding the Union of South Africa (Burrows, 1958; Searle, 1965; Baidler & Gelfand, 1971; Van Rensburg et al, 1992). Much later Gear (Gear, 1937) reflected, "Confusion, inefficiency, inertia and extravagance are all to be laid at the door of this illogical division of public health duties."

In 1918, South Africa, like many other countries, was swept by a devastating influenza epidemic, which caused over one hundred and fifty thousand deaths. This tragedy emphasised the gross inadequacy of legislative machinery for safeguarding public health. The Government convened a Public Health Conference in

Bloemfontein in 1918 to consider and make recommendations to remedy the defects in the existing legislation and to place the administration and control of public health on a sound footing. The Public Health Bill was drafted at this historic conference and passed by Parliament the following year (Anon, 1977:14).

2.3.2 The second phase (1919-1940)

This period began with the proclamation of the Public Health Act of 1919, which established the first Department of Public Health in an attempt to co-ordinate health care more effectively at national level (Van Rensburg & Harrison, 1995).

The Public Health Act of 1919 (No. 36 of 1919) brought about important changes in the laws relating to health administration and control by repealing the old colonial and subsequent legislation. It also established a central health authority - the Department of Public Health (now the Department of Health) that was charged with advisory and executive duties in promoting general health of the population (Anon, 1977:15).

2.3.3 The third phase (1940-1950)

The years, from 1940 to 1950, heralded an exciting period in health care in South Africa. The concept of primary care originated in South Africa during this era. Attempts were made to redirect health policy entirely, to rid the prevailing system of

its numerous structural deficiencies and thus to restructure and reform it. During this period, a community-orientated primary care programme was developed by Drs. Sidney and Emily Kark at the Pholela Health Centre (Tollman, 1994).

The vision of a unified, comprehensive and state-funded National Health Service, based on primary care in the form of a network of comprehensive health centres was cultivated and even began to be established (Van Rensburg & Harrison, 1995:62).

The Institute for Family and Community Health was established in the late 1940s at Natal University as the key institution to provide training and research necessary to support the rapid growth in health centres (Tollman, 1991). The Institute and its affiliated health centres reflected the effectiveness of a community-orientated primary health care approach (Tollman & Pick, 2002).

Central to this phase of health policy development in South Africa, was the work of the National Health Services Commission (Gluckman Commission, 1944) and the initiatives which inspired and flowed from its recommendations.

The Gluckman Commission of 1944 called for a single, national health department that would serve “all sections of the population, according to their need, and without regard to race, colour, means, or status in life” (Van Rensburg et al., 1992:61).

In the end the Gluckman Commission recommended the establishment of about 400 comprehensive health centres (i.e. one per 25 000 people at that time), while general guidelines were laid down for the running of these centres. It was proposed that the model should be flexible enough to respond to differing rural and urban needs. The appointment of Gluckman as Minister of Health ensured tremendous enthusiasm and government support for the project, and by June 1946 six additional centres were operational (Gale, 1946).

3.4 The fourth phase (1950-1990): Apartheid years

The fourth phase commenced with the victory of the National Party in the elections of 1948, which brought about major political changes (Dept of Health, 1995; McIntyre *et al.*, 1995). It was characterised by legislated racial discrimination and segregation, which would affect not only the way in which health services were organised, but also the very health of the people. Services remained strictly segregated according to presumed racial origin (Apartheid), and no effective national health system was in place (Tollman & Pick, 2002).

By 1960 most of the peripheral health centres had been forced to close and were handed over to the provincial administrations for conversion into detached outpatient departments. The demise of the health centre programme brought to an end attempts to shift the emphasis away from hospital-based care and to develop an

extensive primary health care infrastructure (Tollman, 1991). Health policy development closely mirrored the ideology and social engineering of the white minority government (Savage, 1979; De Beer, 1984; Price, 1986; Van Rensburg & Benatar, 1993). The systematic racial fragmentation of South African society and its health care system during the era of Apartheid gave perverse substance to the intention of creating a “Native Health and Medical Service” (Gear, 1943). Unfortunately it was just to adopt more sophisticated strategies to maintain white privilege and supremacy (Price, 1986; Price & De Beer, 1988).

3.4.1 *The Health Act, 63 of 1977*

The Health Act, 63 of 1977 has been enforced in South Africa up till the present moment. Various attempts have been made to promulgate a new Health Act, but it has been unsuccessful.

The Health Act, No 63 of 1997 states that:

“A comprehensive health service is one, which will provide the greatest number of people with health care. It consists of promotive, preventive, curative and rehabilitative health”.

This Health Act of 1977 was an attempt to shift the emphasis in South African health care back to comprehensive and preventive care, with reasonable access for the entire population and emphasis on the role of local clinics, community health centres, health teams, and the training of paraprofessional health workers (De Beer, 1976; Dept of Health, 1977; Gilliland, 1977; South Africa, 1977). However, these noble intentions did not materialise. The emphasis still remained on curative services. Strong emphasis has been placed on a Primary Health Care approach in the Health Act of 1977.

3.4.2 *Primary health care (PHC) approach*

Given the features of the apartheid health system described above, the need for a fundamental and profound change to the entire health system was clear.

Primary health care is described as the first point of contact for people seeking advice, support and treatment (NHSME, 1993). The approach involves a health system led by PHC services, which are at the base of an integrated district health system (Dept of Health, 1997b:16).

A historic International Conference on Primary Health Care was held in Alma-Ata in the former USSR in 1978. They defined the concept of "health" and more specifically, Primary Health Care.

The Ottawa Conference was important because it shifted the focus from health education towards empowerment of individuals and communities (Ross & Mackenzie, 1996:14). The Conference strongly reaffirmed that health is a fundamental human right and that it is an important worldwide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector (WHO, 1978:2).

The PHC approach is a philosophy and a conceptual model for an ideal health system. It formed the basis of the 1978 Declaration of Alma-Ata, which promotes essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible and equitable at a cost that is affordable, with community participation (WHO, 1978:3).

The PHC approach is more than the provision of 'primary level services' that are typically provided in clinics and mobile services. It envisages a seamless referral system from the community all the way to the most sophisticated health care available (Hall et al., 2002:1).

PHC provides an integrated and holistic framework for addressing the health needs of populations according to five principles. These principles are:

- Ensuring that health care provision is equitable and distributed in ways that favor the most needy groups;
- Promoting 'community involvement in health' and a health service that is socially and culturally acceptable;
- Ensuring that health care is comprehensive and focuses more on preventive, promotive and rehabilitative health care (in addition to curative health care);
- Ensuring a health service and health system that is affordable and sustainable, and which employs appropriate technology; and
- promoting multisectoral collaboration in recognition of the fact that people's health is largely determined by their socio-economic and environmental circumstances (McCoy & Harrison, 1998).

In South Africa, the emphasis on primary health care was taken a step further in 1989 when the National Health Policy Council accepted the following resolution: "The only way to provide an affordable health service to all the inhabitants of the Republic of South Africa, is by means of a partnership between the state and the private sector based on a National Health Services Plan, with the emphasis on primary health care." (Dept of National Health and Population Development, 1992:1)

At this stage, PHC was still fragmented and merely consisted out of immunisations and family planning. Primary Health Care was to address the main health problems in

the community, providing promotive, preventive, curative and rehabilitative services accordingly. These services should include at least:

- Promotion of proper nutrition and an adequate supply of safe water;
- Basic sanitation;
- Maternal and child care, including family planning;
- Immunisation against the major infectious diseases;
- Prevention and control of locally endemic diseases;
- Education concerning prevailing health problems and the methods of preventing and controlling them; and
- appropriate treatment for common diseases and injuries (WHO, 1978:34).

Box 2-1 below provides a range of services that could be classified as Primary Health Care services.

Box: 2- 1 An exposition of the PHC package (Dept of Health, 1997b:17)

SERVICES
<p>Personal promotive and preventive service:</p> <ul style="list-style-type: none"> ▪ Health education ▪ Nutrition/dietetic services ▪ Family planning ▪ Immunisation ▪ Screening for common diseases
<p>Personal curative services for acute minor ailments, trauma, endemic, other communicable and some chronic diseases</p>
<p>Maternal and child health services:</p> <ul style="list-style-type: none"> ▪ Antenatal care ▪ Deliveries ▪ Post-natal and neonatal care
<p>Provision of essential drugs</p>
<p>PHC level investigative services:</p> <ul style="list-style-type: none"> ▪ Radiology ▪ Pathology
<p>Basic rehabilitative and physical therapy services</p>
<p>Basic oral health services</p>
<p>Basic optometry services</p>
<p>Mental health services</p>
<p>Medical social work services</p>
<p>Services organized and provided at district level</p>
<p>Health education</p>
<p>Health-related nutritional support</p>
<p>Communicable, non-communicable and endemic disease prevention and control</p>

School and institutional services for children: <ul style="list-style-type: none"> ▪ Oral health ▪ Audiology ▪ Optometry
Health-related water and sanitation services and other environmental health services
Community mental health and substance abuse services
Occupational health & safety services (*)
Community nursing and home care services, including care of the terminally ill
Essential accident and emergency services
Community geriatric services and care of the elderly
Health services support: <ul style="list-style-type: none"> Epidemiology and health information system Health monitoring Planning and administration
Basic medical-legal services (These services are likely to be provided at the district level, but may be in part or completely funded from sources other than health). (Dept of Health, 1997b:17)

In South Africa, if Primary Health Care is provided appropriately, about 80% of health problems should be solved without referral to another level of care (Uys, 1999:41). Since this level of care uses a lower level of technology and a general health practitioner instead of specialists, it costs less per client contact than any of the other levels. Effective and efficient implementation of a PHC approach therefore not only deals with health problems quickly and efficiently, thus satisfying the clients, but is also a cost-efficient way of using the health care budget.

2.3.5 The fifth phase (1990-1994)

The late 1980s and early 1990s witnessed the rediscovery of what was arguably a golden age in South Africa's blighted public health history (Yach & Tollman, 1993). It declared government policy, which revealed increasing openness and receptiveness towards preventive and primary health care (Slabber, 1988,1989; Venter, 1990, 1991; Hansard, 1990).

Eventually the National Health Service Delivery Plan of 1991 incorporated the principles of accessibility, effectiveness, affordability, equity and acceptability in health care. In addition, it sought to develop co-ordinated and streamlined referral systems and systematic regional plans for health service development (Dept of National Health and Population Development, 1991).

The period 1990 to 1994 may be distinguished because it heralded the first serious attempts to affect a significant break with the past. These were initiated under increasing pressure from a progressive health sector demanding fundamental reform of the health sector and beyond. This phase was marked by:

- Efforts to bring about defragmentation and deracialisation of government structures and health care facilities;

- Attempts to swing the emphasis in health care increasingly in the direction of primary health care; and
- objective approach to privatization (Venter, 1990; Slabber, 1991; Van Rensburg, 1991; Venter, 1991; Van Rensburg, 1992).

The fact is, however, that the steps towards reform originated and were taken within the framework of a still racially segmented and overtly undemocratic societal context, which meant that reforms were cosmetic rather than fundamental (Van Rensburg & Harrison, 1995:54). Although classified as a middle-income country and spending 8.5% of GDP on health care, South Africa in the early nineties exhibited major disparities and inequalities. There were great income inequalities in South Africa. Fifty one per cent of annual income went to the richest 10% of households while less than 4% went to the poorest 40% (World Bank, 1994). Fallon and da Silva (1994) estimated that, in 1987 Whites earned 9.5 times more per person than Africans. The racially defined government used to spend much more per person on services for Whites living in cities. Most African urban localities had poor services and the majority of the population of South Africa had inadequate access to basic services including health, clean water and basic sanitation (Dept of Health, 1997a:7).

2.3.6 Post Apartheid years (reform after 1994)

Prior to 1994, South Africa's political and administrative system was structured along racial lines. It has since been organised into a single, multiracial country with an elected National Parliament and an executive headed by a President (McIntyre et al., 1995:4). A democratic government came into power, on 27 April 1994, the date of the country's first democratic elections. An ANC-led Government of National Unity was instituted. The first African Minister of Health, Dr Nkosasana Dlamini Zuma, was appointed. She was tasked with bringing about a unitary and equitable health service for South Africans (Van Rensburg & Harrison, 1995:54). Various given issues also had to be addressed such as a rise in the number of old people, major killers such as cancer, heart disease, new risks such as HIV and AIDS, as well as the re-emergence of TB. This was complicated by high rates of unemployment and homelessness.

Butler (1994) outlines three of the central tenets of the Thatcher government, which strongly influenced the development of the reforms. These were the primacy of a sound economy. The belief that nothing should be done in the public sector that could equally well be done in the private sector. Lastly, an underlying assumption that large organisations were inefficient.

Government developed a framework for socio-economic development in its Reconstruction and Development Programme (RDP), in which it has set out broad

principles and strategies for development in all key areas and sectors, including health, in order to effectively address the various problems facing the majority of the people of South Africa. One of its key programmes is to meet basic needs of people, which includes jobs, land, housing, water, electricity, telecommunications, transport, a clean and healthy environment, nutrition, health care and social welfare (Dept of Health, 1997b:7).

The RDP gave priority to prevention and provision of essential curative care to all. There was widespread international agreement that this was the most cost-effective approach for decreasing the levels of excess sickness and premature deaths found in South Africa (World Bank, 1993; 1994).

Restructuring the health sector had the following aims:

- It unified the fragmented health services at all levels into a comprehensive and integrated NHS;
- It reduced disparities and inequities in health service delivery and increased access to improved and integrated services, based on primary health care principles;
- It provides priority to maternal, child and women's health (MCWH); and
- it mobilizes all partners, including the private sector, NGOs and communities in support of an integrated NHS (Dept of Health, 1997b:5).

The private sector was also tasked with improving the health of South Africa's population (Dept of Health, 1997b:4). Restructuring of public health services was undertaken during the period of 1994 to 1997.

Box 2-2 below presents the structure of Public Health Services in South Africa between 1994 and 1997.

Box: 2- 2 Presents the structure of public health services in South Africa between 1994 and 1997

Level of Government	Department(s)	Responsibilities/Activities
Central	Department of Health	<ul style="list-style-type: none"> - Health policy formulation - Determination of provincial budgets including component for local authority subsidies - Co-ordination of services - Line functions such as dental, forensic, national laboratory and so forth - Other support functions

Provincial	Provincial Health Department	<ul style="list-style-type: none"> - Determination of local authority budgets - Hospital-based services and mental health - Primary level curative and rehabilitation services - Comprehensive primary care services in former homelands - Ambulance services in conjunction with local authorities
Local (including Municipalities) and Regional Services Council	Local Authority Health Department	<ul style="list-style-type: none"> - Preventive, promotive and rehabilitative primary care services with particular emphasis on communicable disease control and environmental health - Ambulance services
Other (non-Health) Departments	Departments of Defense, Police and Correctional Services	<ul style="list-style-type: none"> - Provision of health services for staff, their dependants and prisoners

(Source: McIntyre *et al.*, 1995:31)

A major equity challenge faced the public health sector (McIntyre, 1995; South Africa, 1995; Makan *et al.*, 1996; Dept of Health, 1997b; McIntyre, 1997). The challenges

relating to public health care financing and expenditure are summarised in Box 2-3 below.

Box: 2-3 *Major equity challenges regarding finance and expenditure in the public health sector.*

- Improving the geographic distribution of public sector health care resources between and within provinces;
- Increasing levels of primary care utilization, particularly for currently disadvantaged groups, including;
- The redistribution of resources to improve the resourcing of primary care services while still maintaining adequate referral services;
- Reducing barriers to primary care access;
- Seeking alternative sources of finance for public health services in order to reduce reliance on general tax revenue.

(Source: McIntyre et al., 1995:29)

The Growth, Employment and Redistribution Macro Economic Strategy (GEAR) are the government's macro-economic policy. The component which has been the most vigorously implemented to date is the fiscal policy which aims to:

- Cut the budget deficit;
- Avoid permanent increases in the overall tax burden;
- Reduce consumption expenditure by general government relative to Gross Domestic Product (GDP).

Primary Health Care principles were introduced to South Africa from April 1994 with the implementation of two policies, namely “Free health for pregnant mothers and children under the age of six years”, as well as the “Universal access to primary health care for all South Africans” (Dept of Health, 2000:3). Other Primary Health Care policies that have been implemented between 1994 and 1997 are as follows (Dept of Health, 2000:6):

- Free Health Care for pregnant women and children under the age of six;
- Free Primary Health Care to all;
- Confidential Enquiry into Maternal Deaths;
- Mental Health;
- Human Resources;
- Choice of Termination of Pregnancy (Termination of Pregnancy Act, No 92 of 1996);
- Building of Clinics in Rural Areas;
- Clinic Upgrading and Building Programme;
- HIV/AIDS; and
- primary School Nutrition Programme (Dept of Health, 2000:3).

Throughout the history of health care and health policy in South Africa, primary health care occupied a rather neglected position due to the strong emphasis on curative and hospital-based care (Van Rensburg & Harrison, 1995:61). In 1995, the national Department of Health made Primary Health Care (PHC) one of its major foci for health care delivery (Daviaud et al., 1998). This gives special emphasis to the development of clinics and basic health care programmes such as safe motherhood, child health and nutrition, expanded immunisation, management of communicable disease and the treatment of chronic ailments.

In 1994, the South Africa president, in his inaugural address to the country, identified a number of health priorities. These continue to be priority projects of health and include the following.

2.3.7. New health plan (since 1997)

On 25 October 1995 the Provincial Cabinet approved a "New Provincial Health Plan" and resolved that "the Department of Health be allowed to implement the New Provincial Health Plan on a phased basis, subject to all the criteria for implementation having been satisfactorily addressed in each case" (Minute No 771/1995).

The White Paper for the Transformation of the Health System in South Africa has been published by the Minister of Health on 16 April 1997 (Dept of Health, 1997a).

The object of the White Paper is to present to the people of South Africa a set of policy objectives and principles upon which the Unified National Health System of South Africa is based. In addition to these objectives, this document presents various implementation strategies designed to meet the basic needs of all South Africans. The White Paper was based on the health objectives spelt out in the Reconstruction and Development Programme, the vehicle for socio-economic transformation in our country.

Health services have been decentralised with emphasis on the district health system, increase access to services by making primary health care available to all our citizens, ensure the availability of safe, good quality essential drugs in health facilities, and rationalise health financing through budget reprioritisation. Furthermore, the development of a National Health Information System facilitates health planning and management, and strengthens disease prevention and health promotion in areas such as HIV/AIDS, STDs and maternal, child and women's health. The integrated Nutrition Programme focuses on sustainable food security for the needy (Dept of Health, 1997a:5).

A number of phases (aspects) of this plan have already been implemented such as the District Health System, and others are well under way (Dept of Health and Social Services, 2000:3).

The proposed health sector strategies are set out below:

- The health sector must play its part in promoting equity by developing a single, unified health system;
- The health system will focus on districts as the major focus of implementation, and emphasis the primary health care (PHC) approach;
- The three spheres of government, NGOs and the private sector will unite in the promotion of common goals;
- The national, provincial and district levels will play distinct and complementary roles; and
- an integrated package of essential PHC services will be available to the entire population at the first point of contact.

The New Health Plan's mission, goals, objectives and implementation strategies are articulated in its mission statement as provided in Box 2-4 below:

Box: 2- 4 Mission statement of the New Health Plan of 1997

TO PROVIDE LEADERSHIP AND GUIDANCE
TO THE
NATIONAL HEALTH SYSTEM IN ITS EFFORTS
TO PROMOTE AND MONITOR
THE HEALTH OF ALL PEOPLE IN SOUTH AFRICA
AND TO
PROVIDE CARING AND EFFECTIVE SERVICES
THROUGH
A PRIMARY HEALTH CARE APPROACH

(Source: Dept of Health, 1997a:10)

One of the goals of the National Health System is to decentralise by establishing a district health system in which all communities are covered by a basic health unit, which offers an essential package of care.

2.3.7.1 Reorganizing the health service; Priority for primary health care

Changes dictated by the South African Constitution include the devolution of certain responsibilities for health services to the provincial and municipal levels. To give effect to this mandate, it is essential that, inter alia, a district health system (DHS), in which responsibility for service delivery is entrusted to the district level, be established as soon as possible (Dept of Health, 1997a:13).

2.3.7.2 *District health system (DHS)*

The New Health Plan of 1997 is based on the District Health System (DHS). A national committee established to develop a DHS, comprising representatives of the national and provincial health departments, agreed on twelve principles in the development of the DHS. These are:

- i. Overcoming fragmentation;
- ii. Equity;
- iii. Comprehensive services;
- iv. Effectiveness;
- v. Efficiency;
- vi. Access to services;
- vii. Local accountability;
- viii. Community participation;
- ix. Decentralization;
- x. Developmental and intersectoral approach; and
- xi. sustainability (Dept of Health, 1997a:20).

Additional public health clinic services were provided since the introduction of the District Health System. Although PHC provides a set of aims and principles for the health system, a clear policy on the structure and organisation of the health system

was also required. The Department of Health in South Africa has chosen to adopt the DHS model to achieve this (ANC, 1994a; ANC, 1994b). This is not surprising given that the DHS is perceived internationally as the most appropriate system and vehicle for delivering PHC.

The World Health Organisation defines the DHS as follows:

“A more or less self-contained segment of a National Health System that comprises of a well-defined population, living within a clearly delineated administrative and geographical area. It includes all institutions and individuals of inter-related elements that contribute to health, through the health sector and other health-related sectors. It includes all health care workers and facilities, up to and including the district hospital, as well as appropriate laboratory and logistic support services” (McCoy & Harrison, 1998).

In South Africa, the Provincial Health Departments (in terms of their own legislation) all over the country have divided their provinces into health districts (as the centre for providing services to its population). The boundary of the health district takes into account political, economic, transport and cultural dynamics of the area and is congruent with the boundaries of local government and of other health-related sectors.

The size of each health district varies according to local conditions. It is 'neither too small nor too large'; in other words, its size ensures optimal delivery of PHC. It is large enough to have the financial and management capacity to provide essential comprehensive PHC services, but small enough for efficient management and local accountability.

The characteristics of the DHS are:

- i. A number of discrete geographical sub-divisions, usually called "health districts", each with a clearly defined catchment's population;
- ii. Clear guidelines being used for demarcation of the "health districts", such as:
 - Each includes a level one hospital;
 - Population not to exceed 500 000;
- iii. The geographical size to be such that the furthest clinic can be reached in approximately 3 hours from the district office;
- iv. Being of a reasonable size so as to ensure effective management;
- v. Each "health district" has a decentralized health management team responsible for:
 - Delivery of a comprehensive and integrated package of health care to the population;

- Planning, managing, implementing and monitoring health care delivery that is appropriate for the population;
- Ensuring equitable and cost effective use of resources; and
- establishing an appropriate referral system between parts of the district health system and with relevant services outside the “health district” (Hall *et al.*, 2002:1).

The health district is responsible for the overall management and control of its health budget, and the provision and/or purchase of a full range of comprehensive primary health care services within its area of jurisdiction. The health care functions of the DHS are as follows:

- i. Ensuring health promotion services;
- ii. Providing for collaboration with other sectors of Government and NGOs in promoting health and ensuring the rendering of health services in the health district;
- iii. Providing for community participation in health promotion and health service provision;
- iv. Ensuring the availability of a full range of PHC and other relevant health services in communities, clinics, community health centers, district hospital and other facilities;

- v. Ensuring primary environmental health services, the promotion and maintenance of environmental hygiene; the prevention of water pollution; enforcement of environmental health legislation, i.e. regarding sanitation, housing, smoke, noise, litter, food hygiene, occupational hygiene, and the identification and control of local health hazards;
- vi. Rendering essential medical-legal services;
- vii. Ensuring services to those arrested and charged, in collaboration with the relevant authorities (Dept of Health, 1997a:21).

The District Health System (DHS) will ensure that each health district plans its own services, administers it with support from the provincial authorities, and either provides the health care, or contracts with another bodies to provide it. At the DHS level, local communities can have direct input into their own health care and problems can be solved where they occur (Uys, 1999:41).

Progress towards a District Health System is at different stages of development in the provinces. The process of demarcating district boundaries in all the provinces started in 1995. At present, a total of 42 health regions and 174 health districts have been defined (Dept of Health, 2000:13). The reorganisation of health services in South Africa, which commenced after the 1994 elections, still provides room for creative inputs from health professionals and communities.

2.3.8 Services to be provided by the Cape Town Central District on behalf of the Provincial Health Department

The mission of a Provincial Health Department, as mandated by the Constitution of South Africa, 1996, within the framework of national policies, strategies and guidelines, is to promote and monitor the health of the people in the province, and develop and support a caring and effective provincial health system, through the establishment of a province-wide district health system based on the principles of primary health care (Dept of Health, 1997a: 11). The Western Cape forms almost 10% of the total South African population. The majority of the population resides in urban areas (89%) compared to the national average of 54% (www.westerncape.gov.za).

According to Mahomed (2003) the number of people living in Cape Town Central District between 1995 and 2002 were as follows.

Box: 2- 5 *Increase in population for the Cape Town Central District between 1995 and 2002*

POPULATION IN CAPE TOWN CENTRAL DISTRICT: 1995 - 2002							
1995	1996	1997	1998	1999	2000	2001	2002
266 386	271 823	279 862	287 951	295 996	303 944	311 673	319 144

The Western Cape has been demarcated into five district municipalities (with 24 local Municipalities) and one metropolitan municipality, the City of Cape Town. The whole province was previously part of the Cape Province (Hall et al, 2002).

The current distribution of facilities is as follows:

- ❖ Local authorities administrate the vast majority of clinics (435), providing promotive, preventive and a limited amount of curative health services. These include 226 fixed clinics, 54 satellite clinics and 135 mobile clinics;
- ❖ Sixty-four community health centers, providing curative care to adults and children, are run by Provincial Administration. The community health centers at Retreat, Heideveld, Hanover Park, Mitchells Plain, Guguletu, Khayelitsha, Elsies River and Delft provide 24-hour Trauma and emergency services;
- ❖ Curative primary health care (ambulatory) outside the metropolis is provided by the Provincial Health Department through a part-time district surgeon service and through district hospital outpatient departments, with increasing amounts of curative work (especially for children) being done at the larger municipality and district council health facilities; and
- ❖ a large number of NGO's provide a diverse range of PHC services throughout the province. These are mainly donor funded, but also receive grants from Local Authorities and the Province (Dept of Health and Social Services, 2000:5).

Most Municipalities provide clinics for TB, sexually transmitted diseases (STDs), health education, nutrition education/supplementation, family planning, and baby clinics doing immunisation and growth monitoring (Dept of Health and Social Services, 2000:4).

2.3.9 Health legislation and policy in the Western Cape

There is no national health legislation relevant to the establishment of a District Health System, or a District Health Authority. A draft health bill is under consideration but will only be finalised once the National Health Act has been promulgated.

The current process of decentralising health services is being guided by the existing National Health Act, the Constitution, the Municipal Structures and Systems Acts, as well as financial legislation.

The Bi-ministerial Task Team (BTT) was established in 1997 to investigate the "future governance of all primary health care services in the Western Cape". The BTT report is the key over-riding policy document that has been guiding the process of devolution to date. On the basis of this report the provincial council made an in-principle decision in October 2001, to amalgamate provincial primary health services with those of local government within the City of Cape Town and to implement a

municipality-based PHC service under the metropolis municipality. It was envisaged that the district municipalities would follow (Harrison & Qose, 1998).

Some of these clinic services are still operated on a sessional basis, so that not all services are available every day of the week. Some facilities are entirely dedicated to the treatment of a particular disease, e.g. STDs and family planning (Dept of Health and Social Services, 2000:4).

The majority of curative clinical work at the primary level is done at the 64 Provincial community health centres (CHCs) throughout the Province. These community health centres treat more than three million outpatients a year. The majority of these community health centres are located in the metropolitan area (54) while 10 others are located outside the metropolis. Green Point Clinic is an example of a Provincial Community health centre in the Cape Town Central District.

The services are provided by the local authorities in terms of the Health Act of 1977, or in terms of contractual agreements with the Provincial Administration: Western Cape (PAWC). There are also a number of shared facilities where both provincial and local authority services are provided (Dept of Health and Social Services, 2000:4).

There are a small number of full-time district surgeons in the province (mainly in the Metropolis and Paarl) who provide a dedicated clinical forensic service dealing largely with victims of rape and other sexual and physical assaults, as well as drunken drivers (Dept of Health and Social Services, 2000:4). Part-time district surgeons (PDS) play a significant role in the provision of curative PHC services outside the Metropolis. These are private practitioners, commissioned by the state on a fee-for-service basis to render curative care to people in rural towns. This rural PDS service sees more than 800 000 patients a year. The PDS service has been poorly managed in the past and is currently undergoing reform. The financial management of the service has already been changed and about 25% of practices have been transformed and reintegrated into the public health system. The service is likely to continue in smaller towns, which cannot attract full-time doctors to the public service (Dept of Health and Social Services, 2000:4).

WHO has identified five major pandemics, which need to be targeted, and their trends reversed in order to reduce the burden of disease. These are tuberculosis, HIV/AIDS, malaria, poverty related diseases, chronic diseases of lifestyle and trauma (Bradshaw & Buthelezi, 1996). There is mounting evidence that South Africa is experiencing the fastest growing HIV/AIDS epidemic, with KwaZulu-Natal experiencing a prevalence of 27% in 1997 amongst pregnant women attending public sector clinics (Williams & Campbell, 1998). Efforts to control TB are not yet succeeding, and several provinces have exceedingly high rates (WHO, 1998).

Malaria remains a problem in Mpumalanga and KwaZulu-Naal (Bradshaw, 1998:11). In all provinces, STD services, child curative services, TB services and family planning services are provided by over 75% of all clinics, while antenatal and postnatal care services are only provided daily by under 65% of all clinics. Higher proportions of rural clinics provide daily health education, STD, child curative, antenatal and postnatal care services (Edwards-miller, 1998).

Tuberculosis (TB) is the predominant communicable disease in the Western Cape. This province has the highest TB rates nationally and amongst the highest in the world. There is an increase in the incidence of new smear positive TB in all regions (this may be due to improved diagnostic services). It is important to note that the new smear positive patients form the infectious pool of TB patients. An increase of infectious TB persons would place a huge demand on the already burdened state health services. For every untreated infectious person, ten persons are likely to be infected per annum. The rising prevalence of HIV is likely to increase death rates due to tuberculosis, as well as augment in the occurrence of Multiple Drug Resistance (MDR) tuberculosis. The prevalence of MDR Tuberculosis in this province is estimated to range between 2% - 4%. This clearly has implications for the allocation of resources and planning of health services in the Western Cape (www.westerncape.gov.za). It is estimated that between a third and half of all cases went unreported (Radloff & Webb, 1994). The notification rate is 35 times higher for Coloureds than for Whites. The prevalence of tuberculosis is expected to increase

because many people live in over-crowded urban areas and because the HIV virus is destroying people's immunity (McIntyre et al., 1995:15).

In recognition of this problem, in 1996, South Africa adopted the revised directly observed therapy short course (DOT's) strategy. The success of the DOT's strategy depends on 85% curing of TB sputum positive clients. DOT's has now been introduced into 63 Demonstration and Training Districts nation-wide. Monitoring of TB according to the DOT's program only began in November 1996 (Dept of Health, 2000).

2.3.10 Services rendered by Public Health Clinics

The following are services rendered by Public Health Clinics:

2.3.10.1 *Availability of services for children and women*

In restructuring South Africa's health services from a largely curative and fragmented system to a more community-orientated service, the emphasis is on improving preventive, promotive and curative services for children and women. The Department of Health is committed to achieving universal access for children including infants, children under five, adolescents and women, while improving the quality of the services provided.

Maternal, child and women's health (MCWH) services should be accessible to mothers, children, adolescents and women of all ages, the focus being on the rural and urban poor and farm workers. The planning and implementation of MCWH programmes (child and reproductive health) is district-focused and community-based. District health teams are trained to enhance their capacity for planning, implementing, supervising, monitoring and evaluating MCWH services (Dept of Health, 1997a:65).

All health facilities, as far as possible, render MCWH services on a one-stop, "supermarket" basis (Dept of Health, 1997a:63). MCWH services should include the following:

- i. Common conditions affecting children, including acute respiratory infections, diarrhoea, measles, malaria and severe malnutrition;
- ii. Antenatal, intranatal and neonatal care, as outlined in the Perinatal Education Programme (PEP);
- iii. Advanced midwifery training in accordance with the Decentralized Education Programme for Advance Midwives (DEPAM);
- iv. All aspects of adolescent health; and
- v. all other aspects of reproductive health.

Programmes have been developed to improve maternal and child health through access to quality antenatal, delivery and postnatal services for all women. This includes better transport facilities and in-service training programmes for midwives and for traditional birth attendants. These services are offered free of charge at government facilities (Dept of Health, 1997a:46).

Preventive and promotive health programmes for children are improved. Breast-feeding is encouraged and promoted, and the code of ethics on breast-milk substitutes is enforced. A more effective and expanded programme of immunisation has been achieved (Dept of Health, 1997a:46).

Every woman have the right to choose whether or not to have an early termination of pregnancy according to her own individual beliefs. One important aspect of people being able to take control of their lives is their capacity to control their own fertility. The government since ensured that appropriate information and services are available to enable all people to do this (Dept of Health, 1997a:46).

2.3.10.2 *Availability of services for nutrition health*

Nutrition is a basic human right, and a prerequisite for the attainment of a person's physical and intellectual potential. Malnutrition in South Africa has two major components. The first is under-nutrition, which manifests itself in infants and young

children, and pregnant and lactating women. South Africa has a high incidence of low birth weight babies - about 16% (Dept of Health, 1997a:53). The 1994 survey conducted by the South African Vitamin A Consultative Group found that one in three children in South Africa had a marginal Vitamin A deficiency status; one in five had iron-deficiency anaemia; one in four were stunted and one in ten were underweight for age (Dept of Health, 1997a:53).

The second component comprises chronic diseases of lifestyle, which manifest typically in adulthood as obesity-related diseases, ischemic heart disease, hypertension, diabetes and certain cancers. The RDP highlights the Government's commitment to addressing problems of under-nutrition and hunger. An Integrated Nutrition Strategy has been developed, leading to sustained improvement in the nutritional status of children, especially those under five years of age (Dept of Health, 1997a:54).

Some programmes have been developed to solve those problems. Such as a Nutrition supplementation Programme of the Health Facility Based Nutrition Programme (HFBNP), which has been established as an integral part of the PHC, package (Provincial Administration of Western Cape Department of Health, 2003). Its target groups, for the nutritionally at-risk, treated on the Nutrition Supplementation Programme of the Health Based Facility Programme are the following in order of priority:

- ◆ Children: older than six months; younger and equal to 36 months; between 37 months, but younger and equal to 60 months; between birth and younger and equal to six months;
- ◆ Lactating women/breast fed infant;
- ◆ Pregnant women;
- ◆ HIV/AIDS and TB and other debilitating conditions.

Details for each of the above target groups are provided in a circular from the Western Cape Provincial Department of Health (Provincial Administration of Western Cape Department of Health, 2003).

2.3.10.3 *Availability of immunisation*

Immunisation is one of the essential elements of primary health care services. Services are available to all children and mothers on daily basis at all clinics, and community health centres (Department of Health: 2003:1). Many serious childhood diseases are preventable by using vaccines routinely recommended for children. Since the introduction of these vaccines, rates of diseases such as polio, measles, hepatitis B, rubella, diphtheria, pertussis (whooping cough), and meningitis caused by haemophilus influenza type B (Hib) have declined by 90% (Department of Health: 2003:1).

The number of vaccines recommended for the Expanded Programme on Immunisation has increased. As a result, children are now protected from more infectious diseases than before including Hepatitis B since March 1995 and Haemophilus influenza type B since 1 July 1999 (Provincial Administration of Western Cape, 1999).

According to the World Health Organisation (WHO), immunisation currently saves an estimated three million lives per year worldwide. Pertussis vaccines save over 600 000 lives. Diphtheria has almost disappeared in some major regions of the world. Hepatitis B immunisation has caused a significant drop in the incidence of hepatocellular carcinoma.

Vaccination not only protects the individual but curb the spread of disease within the community. Immunisation is safe and getting safer and more effective all the time as a result of medical research and ongoing review by medical scientists. Immunisation is the most important and effective means through which parents can protect their children against serious diseases. Children who have not been immunized are at high risk of becoming infected with serious diseases. A recent study showed that children who had not received the measles vaccine were 35 times more likely to get the disease (Department of Health: 2003:2). Without immunisation, the diseases we are now protected from will return to cause diseases and kill many children. There

are no effective alternatives to immunisation for protection against some serious and sometimes deadly infectious diseases.

2.3.10.4 *Availability of mental and psychological health*

The mental, physical and social health of South Africans has been severely damaged by apartheid policies and their consequences. Millions of South Africans abuse alcohol, tobacco, cannabis (dagga), and other harder drugs (Dept of Health, 1997a:84).

Common manifestations are interpersonal violence, gender and age-specific forms of violence, trauma, neurosis of living under continual stress, post-traumatic stress reactions and disorders, substance abuse, adjustment-related reactions and disturbances in children and the elderly (Dept of Health, 1997a:84). Mental health services, like all other services, have been fragmented and are ill equipped to intervene effectively. Available services are neither appropriate nor accessible to the majority of the population, especially those in rural areas. In the past, mental health care was largely in favour of the urban, wealthier population in terms of access, quality and personnel. Mental health services should also follow the vertical programmes of primary health care.

The following mental health services should be undertaken at the district level:

- i. Providing mental health and substance abuse prevention, promotion and rehabilitative services, giving special attention to the planning, implementation and co-ordination of community-based rehabilitation;
- ii. Planning and implementing inpatient and day-patient care for the mentally ill and substance abusers, establishing a 24-hour consultation service for mentally ill patients and victims of substance abuse;
- iii. Providing training for health facility staff;
- iv. Undertaking mental health education programmes in communities;
- v. Establishing and maintain mental health committees and collaboration with other sectors, private practitioners, traditional healers and NGSs;
- vi. Providing emergency and crisis interventions and counseling;
- vii. Collecting data, and initiating and contracting out research in accordance with local needs, with the support of relevant institutions; and
- viii. developing appropriate indicators for monitoring and evaluation (Dept of Health, 1997a:86).

2.3.10.5 *Availability of curative service*

Registered nurses were, according to section 38 of the Nursing Act, 1978 allowed to acquire, possess, use and supply/prescribe unscheduled medicine, as well as schedule 1 - 4 medication, to some or other extent since 1981. The latest amendment to section 38 states that any registered nurse who is in the service of the

Department of Health, welfare and Pensions, a provincial administration, a local authority or an organization performing any health service and designated by the Director-General: Health, Welfare and Pensions, and who has been authorized by the said Director-General, the Director of Hospital Services of such provincial administration, the medical officer of health of such local authority or the medical practitioner in charge of such organization, as the case may be, may in the course of such service perform with reference to:

- The physical examination of any person;
- The diagnosing of any physical defect, illness or deficiency in any person;
- The keep of prescribed medicines and the supply, administering or prescribing thereof on the prescribed conditions; or
- the promotion of family planning.

Any act which the said Director - General, Director of Hospital Services, medical officer of health or medical practitioner, as the case may be after consultation with the council determine in general or in a particular case or in cases of a particular nature: Provided that such nurse may perform such act only whenever the services of a medical practitioner or pharmacist, as the circumstances may require are not available.

Between 1981 and 1997, private health clinics became progressively more of a nurse driven service. PHC nurses were not only doing preventive and promotive health services anymore, they were also engaged in curative services.

Primary health care has been legislated as a nurse driven health service since 1997 (Government Gazette, Vol. 382, No. 17910 of 16 April 1997:37). The Government Gazette stipulates that a Primary Health Care Nurse is responsible for personal curative services, for acute minor ailments, trauma, endemic, other communicable and some chronic diseases. Other services which are also allocated to PHC nurses are: Provision of essential drugs, as well as personal promotive and preventive service such as health education, Nutrition/Dietetic services, Family planning, Immunisation and screening for common diseases. Mental health services are allocated to Psychiatric nurses.

Curative services include aspects such as diarrhoea, lower respiratory infections, urethral discharge, sexually transmitted disease, TB, etc. According to Botha (2003), the newly acquired curative roles of PHC nurses have brought about a huge additional workload, to such an extent that chronic, preventive and promotive services are neglected to some extent.

2.3.10.6 *Availability of TB sputum testing*

Infectious and Communicable Diseases include Tuberculosis (TB), hepatitis, measles, polio, diphtheria pertitis, malaria, and other disease such as cholera and leprosy. The Department of Health plans to control TB by a number of strategies including improving access to Primary Health Care, improving preventive strategies; accelerating vaccination programmes and improved clinical management (Dept of Health, 1997a:74).

South Africa is facing one of the worst TB epidemics in the world and TB is one of South Africa's most important public health problems. In 1995 there were over 90 000 new cases of TB and an estimated 3 000 deaths. The incidence of TB in 1997 was estimated at over 224/100 000. The interaction between HIV and TB has enabled the HIV epidemic to contribute to a further increase in TB incidence. Other factors contributing to the increased incidence of TB is the development of multidrug resistant TB, which is difficult and expensive to treat (Dept of Health, 1997a:75).

TB is the most common opportunistic infection in people infected with HIV and kills more people than any other infectious disease. Given the high incidence of TB in South Africa, it is important that TB should be managed in a primary care setting.

Directly Observed Treatment (DOT) support TB patients by observing them swallow their TB drugs to ensure that they complete treatment and are cured, The DOT's strategy has proven to be a cost-effective way to control the spread of TB, even in poor socio-economic conditions and high levels of HIV infection (Dept of Health, 1997a:78).

According to Edwards-Miller (1998), control of TB is a national priority, yet almost a quarter of the clinics surveyed did not offer TB sputum testing, and the availability of drugs to control TB is poor with over 40% of clinics having inadequate supplies.

2.3.10.7 Availability of sexually transmitted infection services

The HIV/AIDS epidemic in South Africa is growing rapidly. Currently, more than 4 million people are infected with HIV (Dept of Health, 2003). This puts a great deal of pressure on public health services (McIntyre et al., 1995:15). Many patients repeatedly visit clinics due to opportunistic infections such as skin diseases, and secondary infections.

Overall, the Programme aims to reduce the transmission of STI's and HIV infection, and provide appropriate care, treatment and support for those infected. One of the focuses of the National AIDS Control Programme is to prevent the spread of the epidemic through the promotion of safer sexual behaviour, adequate provision of

condoms and education (Dept of Health, 1997a:68). In recent years, the value of HIV testing has become apparent, as treatments have become available (Edwards-miller, 1998). Public Health Clinics in the Western Cape provide free voluntary HIV/AIDS counselling and testing, as well as anti-retroviral medication at the fourth stage of the development of the disease.

Syphilis, and the normal vaginal infections such as Candida and Clamidia are problematic in South Africa, yet is can be effectively treated once diagnosed. All antenatal women should be routinely tested for syphilis, and it is therefore a service that should be offered at all clinics. However, 20% of clinics still do not provide syphilis testing (Edwards-miller, 1998).

2.3.10.8 *Availability of Pap smears*

More Pap smears are sampled at urban clinics (72%) than at rural clinics (29%) and differences are also apparent between provinces where for example, only 13% of Northern Province clinics offer Pap smears, compared to 97% in the Western Cape (Edwards-miller, 1998).

2.3.10.9 *Availability of chronic care*

Several guidelines in managing chronic conditions have been developed, e.g. diabetes, hypertension, foot care, asthma, etc. These policies are available from the

Department of Health (www.doh.gov.za/docs/policy/synopsis.html). Chronic disease management covers a wide range including clinical care, therapeutic education, non-drug, and drug treatment. Box 2-6 below provides an overview of chronic diseases:

Box: 2- 6 Overview of chronic diseases

Condition	Features
Chronic Diseases	<ul style="list-style-type: none"> ◆ 24.5% of all deaths are due to chronic diseases; ◆ 25% of adults 15-64 years and 70% adults over 65 years reported they had chronic diseases (Hypertension, Arthritis, respiratory, Epilepsy, cancer); ◆ Obesity, a risk factor for some chronic diseases, ranging from 3% for Indian men to 34% for African women; ◆ Mortality due to chronic obstructive respiratory disease is increasing while acute respiratory deaths are declining; ◆ Cancer of the cervix, breast and basal cell skin cancer are the most common cancers for women; ◆ Basal cell skin cancer, prostate, esophagus and lung cancer are most common for men; ◆ Smoking, a risk factor for some chronic diseases has a prevalence of 52% in men and 17% in women; ◆ Smoking rates are rising in lower socio-economic groups and women.

(Source: HST South African Review 1996)

2.3.10.10 *Health education*

Many authorities render health promotion services. At Local Authority clinics, one-on-one health education is done with patients attending clinics. The time patients wait to be seen is used to do health promotion and education. Health promotion is also done through posters and pamphlets (Dept of Health and Social Services, 2000:5). Health education is provided on aspects such as balanced diets, responsible parenthood, immunisation, and prevention of sexually transmitted disease.

2.4 *SUMMARY*

This chapter provided a historical background of public health clinic services, as the nature of the services rendered. It has been established that health services during Apartheid years were disproportionately divided amongst racial classes. The Primary Health Care approach has since been introduced in order for the national health system to become accessible to all South Africans. Public Health Clinics were therefore given a more prominent role in a system whereby patients first report to these clinics, before they are referred to secondary and tertiary hospitals. In the next chapter the research methodology employed during this study will be provided.

CHAPTER 3

3 METHODOLOGY

3.1 INTRODUCTION

In the previous chapter the historic development of public health clinic services has been discussed. This chapter will present an exposition of the research methodology employed. Data were obtained from Annual Reports, as well as directly from the Epidemiology department of Cape Town Administration.

3.2 DELINEATION

This study is conducted at public primary health clinics in the Cape Town Central District. Data for the following nine clinics were available throughout the period of study (July 1995 - June 2002) and are therefore included in the study:

- 1) Chapel Street Clinic;
- 2) Claremont Clinic;
- 3) Facterton Clinic;
- 4) Langa Clinic;
- 5) Maitland Clinic;
- 6) Pinelands Clinic;

- 7) Schotscheskloof Clinic;
- 8) Sea Point Sat/Green Point CHC;
- 9) Spencer Road Clinic.

According to a Cape Town Central District Information Officer on statistics, Sea Point Clinic was closed on September 2001, and Green Point CHC has been integrated with the Metropolis and opened on May 2001. Data for Sea Point and Green Point have therefore been combined (making use of Sea Point data before 2001 and Green Point data after 2001). There have even been a few months during which services were rendered at both clinics at the same time. In this case the data have been combined.

3.3 *METHODS*

The data included in this study range from 1 July 1995 until 30 June 2002, therefore covering a period of seven years.

The data for July 1995 to June 1996, as well as July 1996 to June 1997 were obtained from Annual Reports of the Medical Officer of Health of the City of Cape Town. These periods of twelve months runs from the middle of one year to the middle of the next year (July of the first year - June of the next year).

No Annual Health Reports were compiled by the City of Cape Town after June 1997. The data for the periods from July 1997 to June 2002 were obtained directly from the Statistics Department of Cape Town Health Department.

The following will be determined by means of this scientific study.

- 3.3.1 To describe clinic service provided by public health clinics in Cape Town Central District over a period of seven years (July 1995 - June 2002)

Changes in public health clinic services have occurred over the seven years of study. The nature of these changes (mostly additions) will be determined and indicated by means of a table. The table will indicate which services have been added/withdrawn during the years. These data will be obtained from the annual reports and statistics obtained from the Statistics Department of Cape Town Administration.

- 3.3.2 To determine clinic delivery trends at public health clinics in Cape Town Central District over a period of seven years (July 1995 - June 2002)

Data regarding the type of public health clinic service (such as reproductive and women health, mental health or curative services) rendered during the seven years will be presented by means of a separate table for each service in Chapter four.

Each of the above tables will also be illustrated by means of a graph, indicating increasing or decreasing trends of public health clinic services over the seven years. The graphs will appear on the same pages as the tables.

The graphs were mostly based on the data as available from the annual reports (July 1995 - June 1996 and July 1996 - June 1997), as well as from the statistics obtained from the Statistics Department of Cape Town Administration for the period July 1997 - June 2002 (City of Cape Town, 1996 & City of Cape Town, 1997). Reliability, in reconstructing the graphs, could therefore be verified by making use of the said annual reports and the data available from Cape Town Administration (Appendix).

There were however cases where information on a specific service (e.g. Immunisation, Reproductive and Women Health) were not classified under the same category/field throughout the seven years. The categories/fields in use before the transitional period in many cases differed from the categories/fields employed after the transitional year (July 1997 to June 1998). One such example was in calculating the total clinic attendance.

Calculation of total attendance to public health clinics was categorized as such for the last five years of the study, but not for the first two years. For the first two years the researcher had to add together, a number of sub-categories on attendance in order to arrive at a total attendance figure.

The calculation for the total attendance to public health clinics in the Cape Town Central District was done as follows for the first two years.

3.3.2.1 *Calculation of total attendance to public health clinics in the Cape Town*

Central District: July 1995 - June 1996

The following data were added together in order to obtain a total attendance figure for the first year of the study: Only the data for the nine clinics involved in the study have been included (Facterton, Chapel Street, Schotschekloof, Sea Point, Spencer Road, Maitland, Langa and Claremont). The total attendance was calculated by adding the data for:

- The number of individuals attending at various different family planning clinics;
- The number of sessions, first and total attendances at Infant welfare, Antenatal clinics (total attendance), and developmental screening done (Neo natal: 6 weeks, 9 months, 19 months, 18 months, 5 - 6 years);
- Expanded clinic service (total number for under 6 years old);
- Immunisations against Poliomyelitis (total);
- Immunisations against Diphtheria (D), Whooping Cough (Pertussis) (W or P) and Tetanus (T) (total);
- Vaccination against BCG, Hepatitis B, Haemophilic Influenza type B, Measles, Mumps and Rubella (total);

- Immunisation against Measles (total);
- Sessions held, new cases seen and total attendances at clinics (STD attendance);
- Attendances at city health department centers for the control of Tuberculosis (total attendances).

3.3.2.2 *Calculation of total attendance to public health clinics in the Cape Town*

Central District: July 1996 - June 1997

The total attendance for this period of twelve months was calculated by adding the data (for the nine clinics) for the following services:

- Total attendances at family planning clinics;
- Total attendances at child welfare, and Developmental screening done (Neo Natal, 9 months, 18 months, 5 - 6 years);
- Expanded clinic service total attendances (total number for under 6 years and 6 - 18 years old) for each clinic except for Pinelands clinic, where only data for persons younger than fifteen were included;
- Total number of children immunized;
- Total attendances at STD clinics.

3.3.3 Overall increase in services rendered by public health clinics in the Cape Town Central District

Clinic service attendance data have been divided into three periods, namely the two years before the transitional year (July 1995 - June 1997), and the four years after the transitional year (July 1998 - June 2002). The period July 1997 to June 1998 is the transitional year, during which public health clinic services were restructured (New Health Plan). The data for the transitional year differ in many aspects from the type of services rendered before and after it.

The percentage increase in the number of public health clinic services has been calculated as follows: Firstly, data for the first year of the study period (for a given service such as immunisation in July 1995 - June 1996) has been compared to data of the last year of the period for that service (data on immunisation for July 2001 - June 2002). These increases/decreases therefore does not take into consideration the fluctuations in data between these years such as for 1996, 1997, 1998, 1999, 2000 or 2001.

Percentage differences as mentioned in the previous paragraph have been calculated by means of the following method: Deduct the value for 1995 from the value for 2002. Express this difference as a percentage of the first value, by dividing the difference by the first value, and multiplying the answer by 100 (example: Value

for 'Total Attendance' between July 1995 and June 1996 equal 73 718. Subtract the previous value from the value for 'Total Attendance' between July 2001 and June 2002 equal 314 362 (314 362 – 73 718 equal 240 644). Now express the calculated difference as a percentage of the attendance value for the first year and multiplying it by a hundred ($240\ 644 / 73\ 718 \times 100$ equal 326.4%).

The second comparison of public health clinic services refers to increases and decreases in such services after the introduction of the New Health plan. It therefore indicates the extent of increases/decreases between data of the following years: July 1998 and June 2002. Data for the transitional year itself (July 1997 to June 1998) have been excluded since this data were not consistent with data for the rest of the years (categories for the transitional year for instance differed from categories for the rest of the study period).

The overall increase in public clinic health services for the entire study period (between July 1995 and June 2002) will be based on the data for total attendance to public health clinics between July 1995 and June 2002.

The overall percentage increase in public health clinic services after the introduction of the New Health Plan (July 1998 – June 2002) will be based on the average increase/decrease of all the services during this period. A table will be presented in

order to indicate individual percentage increases/decreases of services such as growth monitoring, immunisation, mental health, curative services, etc.

3.4 *SUMMARY*

This chapter provided the methodology employed in collecting, analysing and presenting the data. A detailed explanation has been provided on how the data from the Annual Reports have been compiled. Totals and averages have merely been calculated for the electronic data obtained from the Epidemiological Department of Cape Town Administration for the year after July 1997.

Since clinic attendance data were available for all the years, the increase (as a percentage of the first year) in the number of patients visiting these clinics were calculated over the period of seven years (July 1995 - June 2002). The increase in Public Health Clinic Services was calculated by comparing the number of services rendered in 1998 (July 1998 - June 1999) with 2002 (July 2001 - June 2002). The transitional year (July 1997 - June 1998) has been excluded in this calculation, since the data were classified differently during this period.

The next chapter will provide the data, as well as a discussion of the findings.

CHAPTER 4

4 FINDINGS AND DISCUSSION OF FINDINGS

4.1 INTRODUCTION

The previous chapter explained the methodology employed in obtaining and analysing the data. This chapter presents the findings and a discussion of the findings. The data will be presented along with tables and graphs. Trends will further be substantiated by means of calculations, such as averages and percentages.

4.2 *FINDINGS AND DISCUSSION OF FINDINGS REGARDING CLINIC SERVICES PROVIDED BY PUBLIC HEALTH CLINICS IN THE CAPE TOWN CENTRAL DISTRICT OVER A PERIOD OF SEVEN YEARS (JULY 1995 - JUNE 2002)*

The findings, based on the three aims set in Chapter 1, will now be presented and discussed.

4.2.1 Public health clinic services rendered during the study period (July 1995 - June 2002)

The nature of public health clinic services (first aim) has been determined by means of statistical data provided by Cape Town Administration, and is presented by way of the following table:

Table: 4-1 Public health clinic services rendered during the study period

ITEM	CATEGORY	FIELD	1995-1996	1996-1997	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
1	Attendance	PHC ¹ Headcount <5 Years	✓	✓	✓	✓	✓	✓	✓
2	Attendance	PHC Headcount >=5 Years			✓	✓	✓	✓	✓
2.1	Total Attendance		✓	✓	✓	✓	✓	✓	✓
3	Growth Monitoring	Underweight For Age <5 Years				✓	✓	✓	✓
4	Growth Monitoring	Severe Malnutrition <5 Years				✓	✓	✓	✓
5	Growth Monitoring	Growth Faltering/Failure <5 Years				✓	✓	✓	✓
6	Growth Monitoring	Child <5 Years Weighed						✓	✓
7	Growth Monitoring	Baby Examined 1 st Time <6 Weeks	✓	✓		✓	✓	✓	✓
8	Development Assessment	Development Assessment <2 Years					✓	✓	✓
9	Development Assessment	Development Assessment <5 Years				✓		✓	
10	Development Assessment	Development Delay <5 Years				✓		✓	
11	Immunisation	BCG ² at Birth			✓	✓	✓	✓	✓

¹PHC = Primary Health Care

²BCG = vaccine against tuberculosis

ITEM	CATEGORY	FIELD	1995- 1996	1996- 1997	1997- 1998	1998- 1999	1999- 2000	2000- 2001	2001- 2002
12	Immunisation	OPV ³ at Birth			✓	✓	✓	✓	✓
13	Immunisation	DTP ⁴ -Hib/ OPV/ HepB 1 st			✓	✓	✓	✓	✓
14	Immunisation	DTP-Hib ⁵ / OPV/ HepB 2 nd				✓	✓	✓	✓
15	Immunisation	DTP-Hib/ OPV/ HepB 3 rd			✓	✓	✓	✓	✓
16	Immunisation	Measles 1 st Dose at 9 Months			✓	✓	✓	✓	✓
17	Immunisation	Immunized Fully <1 Year			✓	✓	✓	✓	✓
18	Immunisation	Measles/ OPV/ DTP 18 Months				✓	✓	✓	✓
18.1	Total Number of Children Immunized		✓	✓	✓	✓	✓	✓	✓
19	Mental Health	Mental Health Client - old					✓	✓	✓
20	Mental Health	Mental Health Client - new			✓	✓	✓	✓	✓
21	Mental Health	Mental Health Client Referred to 2 nd Level				✓	✓	✓	
22	Mental Health	Mental Health Client Referred to 3 rd Level				✓	✓	✓	✓
23	Mental Health	Psych Discharge Patient						✓	✓

³ OPV = oral polio vaccine

⁴ DTP = vaccine against diphtheria whooping cough and tetanus (lock-jaw)

⁵ Hib = vaccine against Haemophilus influenza type b

ITEM	CATEGORY	FIELD	1995-1996	1996-1997	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
24	Curative Services	Prevention ONLY < 5 Years						✓	✓
25	Curative Services	Seen by Doctor			✓	✓	✓	✓	✓
26	Curative Services	Seen by Professional Nurse			✓	✓	✓	✓	✓
27	Curative Services	Referred to Doctor				✓	✓	✓	✓
28	Curative Services	Diarrhoea <5 Years - new			✓	✓	✓	✓	✓
29	Curative Services	LRI ⁶ <5 Years - new			✓	✓	✓	✓	✓
30	Curative Services	Case Treated as STI ⁷			✓	✓	✓	✓	✓
30.1	Curative Services	Total Attendance STD ⁸		✓					✓
31	Curative Services	Urethral Discharge				✓	✓	✓	✓
32	Curative Services	Curative Case <5 Years			✓	✓	✓	✓	✓
33	Curative Services	DOT's ⁹ Facility			✓			✓	✓
34	Reproductive And Women Health	Oral Pill Cycle				✓	✓	✓	✓
35	Reproductive And Women Health	Depo-Provera/Petogen Injection				✓	✓	✓	✓
36	Reproductive And Women Health	Nuristerate				✓	✓	✓	✓

⁶ LRI = lower respiratory infection

⁷ STI = sexually transmitted infection

⁸ STD = sexually transmitted diseases

⁹ DOT's = directly observed therapy short course

ITEM	CATEGORY	FIELD	1995- 1996	1996- 1997	1997- 1998	1998- 1999	1999- 2000	2000- 2001	2001- 2002
37	Reproductive And Women Health	IUCD ¹⁰ Inserted				✓	✓	✓	✓
38	Reproductive And Women Health	Condoms Distributed				✓	✓	✓	✓
39	Reproductive And Women Health	Emergency Contraception				✓	✓	✓	✓
40	Reproductive And Women Health	Referred for Termination of Pregnancy				✓	✓	✓	✓
41	Laboratory	Cervical Smear 30-59 Years				✓	✓	✓	✓
42	Medication	Prescription Issued			✓			✓	✓
43	Medication	Item Dispensed			✓			✓	✓
44	Personnel	Nurse Work Days PHC						✓	✓
45	Personnel	Doctor Work Days PHC						✓	✓
46	Chronic Care	Chronic Visit						✓	✓
47	Chronic Care	Diabetes Visit						✓	✓
48	Chronic Care	Hypertension Visit						✓	✓
49	Chronic Care	Epilepsy Visit						✓	✓

¹⁰ IUCD = intra urethral cervical devices

Table 4-1 demonstrates which public health clinic services were rendered in the Cape Town Central District between July 1995 and June 2002 (for the nine clinics concerned).

The number of patients younger than five years visiting a clinic, has always been recorded during the period of study, as found under items 1 - 2 in table 4-1. The number of patients five years and older have only been recorded since July 1998. This has been a great improvement, since it is now possible to calculate the total attendance of patients to these clinics by adding the data for those younger than five years to those of five years and older (item 2.1 of table 4-1).

Secondly, babies have always been examined for weight, growth, and development during this period (items 3 - 10 of table 4-1). Thirdly, children have always during the given period of study been immunized (items 11 - 18 of table 4-1). Only the total immunisations were recorded in the annual reports for the first two years (item 18.1 of table 4-1). The total immunisations therefore were not subdivided into various categories for those years.

Fourthly, stabilized mental health patients have only been receiving their medication from public health clinics since 1997 according to the data available

(items 19 - 23 of table 4-1). Stabilized mental health patients previously received medication from Day Hospitals.

Curative services have been legislated as a nurse driven services at PHC clinics for the first time since 1997 (items 24 - 33 of table 4-1 as well as item 2.3.8.6). According to item 30.1 of table 4-1, curative PHC services at Public Health Clinics were restricted to sexually transmitted disease before July 1997.

The second last service, namely reproductive and women health has been offered over the entire study period (items 34 - 40 of table 4-1). Dispensing of prescription medication has lastly only been recorded by primary health clinics since July 1997 (item 42 - 43 of table 4-1), although such prescriptions became common practice since 1981 (see item 2.3.8.6).

4.2.2 Clinic delivery trends

The following is a discussion of the findings of clinic delivery trends at public health clinics (second aim). Increasing or decreasing trends for each of the above services, rendered at public health clinics in the Cape Town Central District between July 1995 and June 2000, will now be discussed in more detail (third aim).

4.2.2.1 *Total attendance*

Figure 4-1 below presents the total attendance of patients at the nine clinics included in the study over the period of seven years. A constant increase in the attendance figures is apparent during those years (from 73 718 attendances in 1995 to 1996 to 314 362 in 2001 to 2002). There has therefore been a 326% increase in people attending public health clinics in the Cape Town Central District.

This dramatic increase could be ascribed to the addition of various services during and after the transitional period (1997), such as free health for pregnant women and children under the age of six (item 2.3.6). A second reason for the 326% increase of clinic services is the Primary Health Policy of first attending clinics, and then referring patients to secondary and tertiary hospitals if necessary. Detail on the nature of additional services will be provided during the discussion of the rest of the graphs, which will be trends on each of the specific clinic services.

A further reason for the 326% increase in total attendance to Public Health Clinics is the fact that it has been legislated since 1997 that PHC nurses are responsible for rendering certain curative services (see Chapter two, item 2.3.8.6).

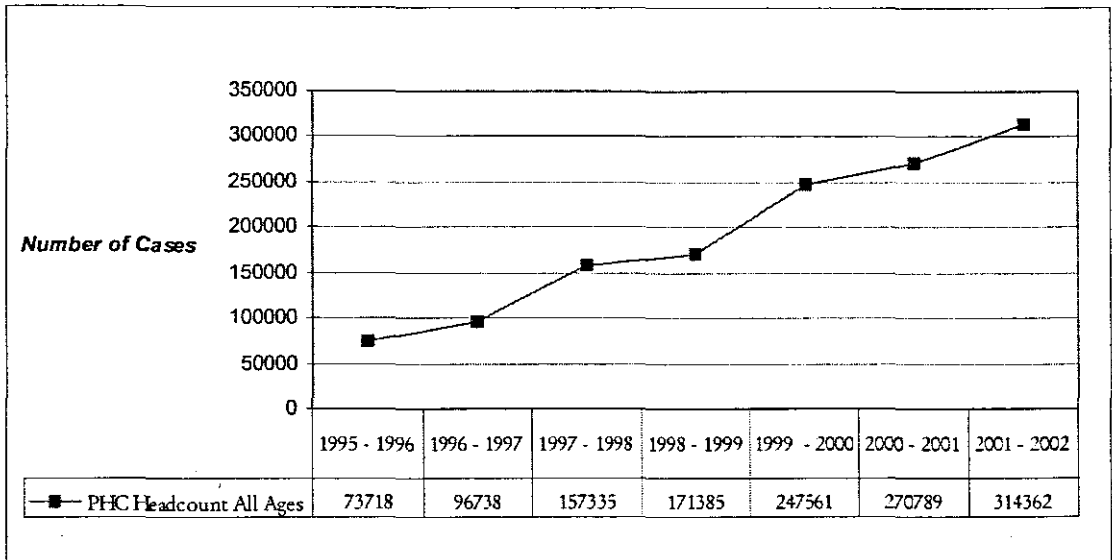


Figure: 4-1 Total attendance

4.2.2.2 Attendance trends of patients to Public Health Clinics <5 years in comparison to patients >=5 years

Figure 4-2 below is a breakdown of total clinic attendance trends (previous graph), concentrating on the number of patients younger than five years. Item 2.3.6 pointed out that health care for all children under six years of age, and for all homeless children has been provided free of charge at government clinics and health centres according the ANC Reconstruction and Development Programme since 1994. This change in policy has therefore been introduced one year prior to the period of research. The 158% increase in the services to children under five years could be ascribed to people becoming aware of these free services, as well as a possible influx of residents making use of such

services. This ANC policy became government policy with the introduction of the Government's New Health Plan, which has been introduced since 1997 (see Chapter two, item 2.3.7).

The same graph shows another statistical category, called 'Total Attendance >=5 years of age' which has been introduced since July 2000. The 97.3% increase in attendance of the age group five years and older has been recorded since July 1998.

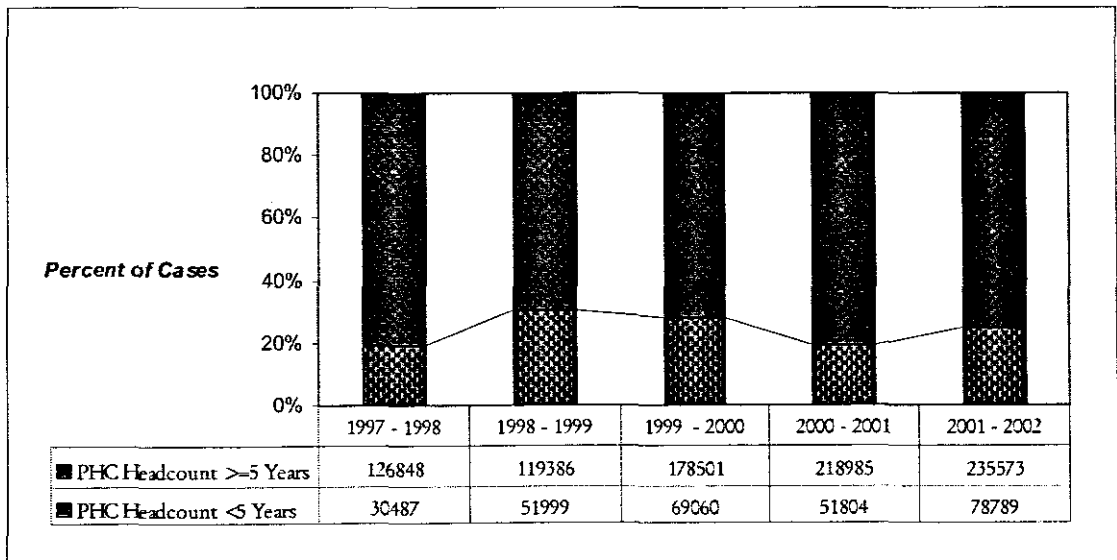


Figure: 4-2 Primary health care headcount

4.2.2.3 *Growth monitoring*

Figure 4-3 below shows a 53.5% decrease in the number of underweight cases younger than five years of age. The decrease could firstly be ascribed to two supplement food schemes: Firstly, free milk supplements for babies younger than six months, under the third weight percentile. Protein-enriched melie-meal, and Nutri-A drinks are made available to children (between 6 months and 6 years) under the third weight percentile since the introduction of the New Health Plan (1997). The decrease in the number of underweight children younger than five years is remarkable since the number of children weighed, has increased substantially (35.7 %).

The graph for severe malnutrition for children under the age of five years shows a 77.9% decrease. Reasons for the decrease are the same as for the previous graph (protein supplements). A 24.2% decrease in growth failure for children under the age of five years could also be ascribed to protein supplements being provided free of charge at the clinics.

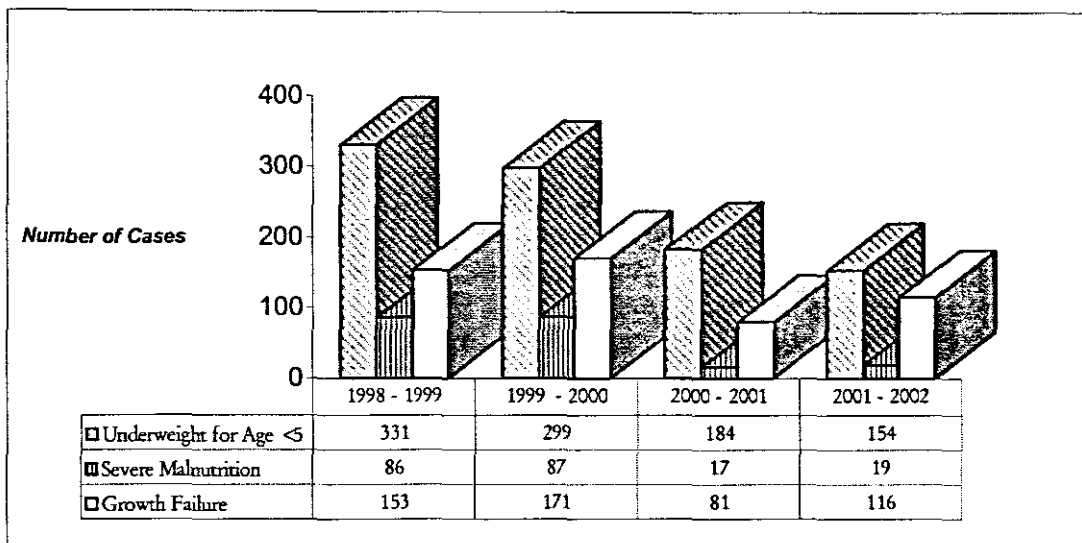


Figure: 4- 3 Growth monitoring: Babies <5 years being underweighted & Severe malnutrition & Growth failure

Figure 4-4 below shows a 35.7 % increase in the number of children younger than five years being weighed.

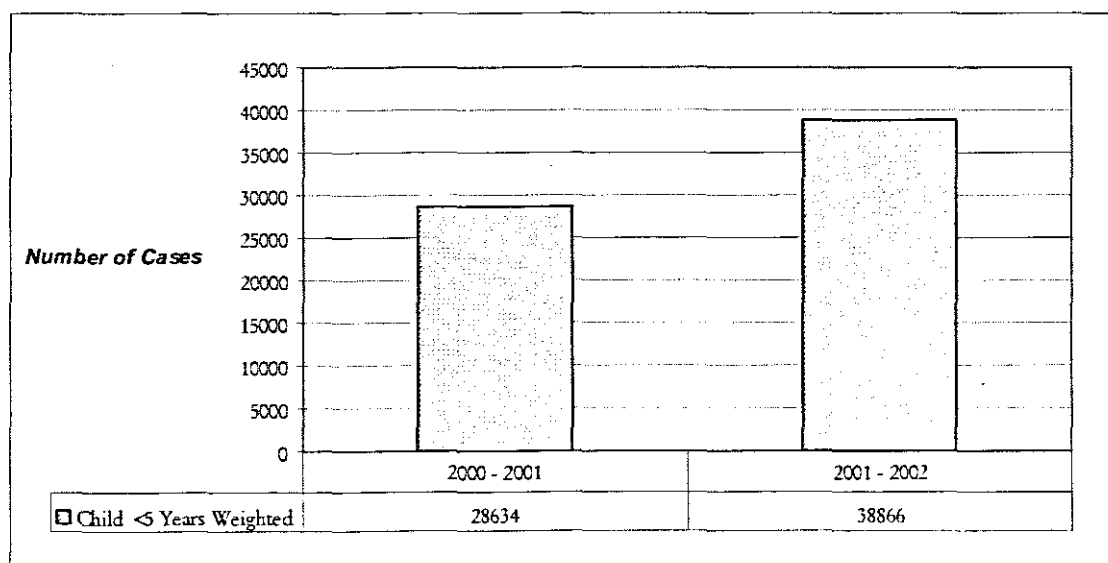


Figure: 4- 4 Growth Monitoring: Number of children <5 years being weighed

4.2.2.4 *Development assessment: baby <6 weeks being examined*

Figure 4-5 below indicates a 29.4% increase in the number of babies (younger than six weeks of age) examined for development assessment between July 1995 and June 2002. No data is available for July 1997 - June 1998. Another category was created for this one year, namely 'babies examined for development assessment younger than four weeks'. The number of babies younger than four weeks examined for development assessment for the transitional year July 1997 - June 1998 totalled 2 470 cases. This correlates well with the trend shown in the graph below.

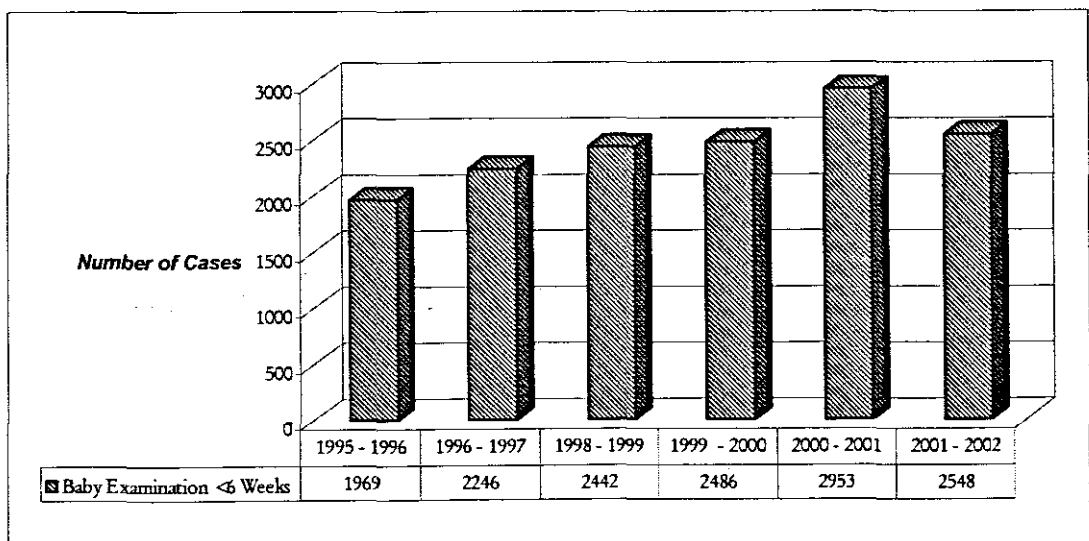


Figure: 4- 5 Development assessment: Baby < 6 weeks being examined

4.2.2.5 *Development assessment*

Table 4-2 below represents development assessments for different categories, of some services that have been discontinued or for others where it is difficult to determine a specific trend.

Table: 4-2 Development assessment

DEVELOPMENT ASSESSMENTS	1998-1999	1999-2000	2000-2001	2001-2002
Development Assessment <2 Years		12	5011	5777
Development Assessment <5 Years	4229		1565	
Development Delay <5 Years	87		26	

4.2.2.6 *Total number of children immunized*

Figure 4-6 below provides the total number of children being immunized between July 1995 and June 2002. About double the numbers of immunisations were administered during the first two years, than after the

introduction of the New Health Plan (since July 1997). A decrease of 53.8% is therefore recorded between 1995 and 2002.

Botha (2003) indicated that curative services took precedence over preventive and promotive clinic services since 1997, as brought about by the extra workload caused by curative services (see item 2. 3.8.6 of Chapter two).

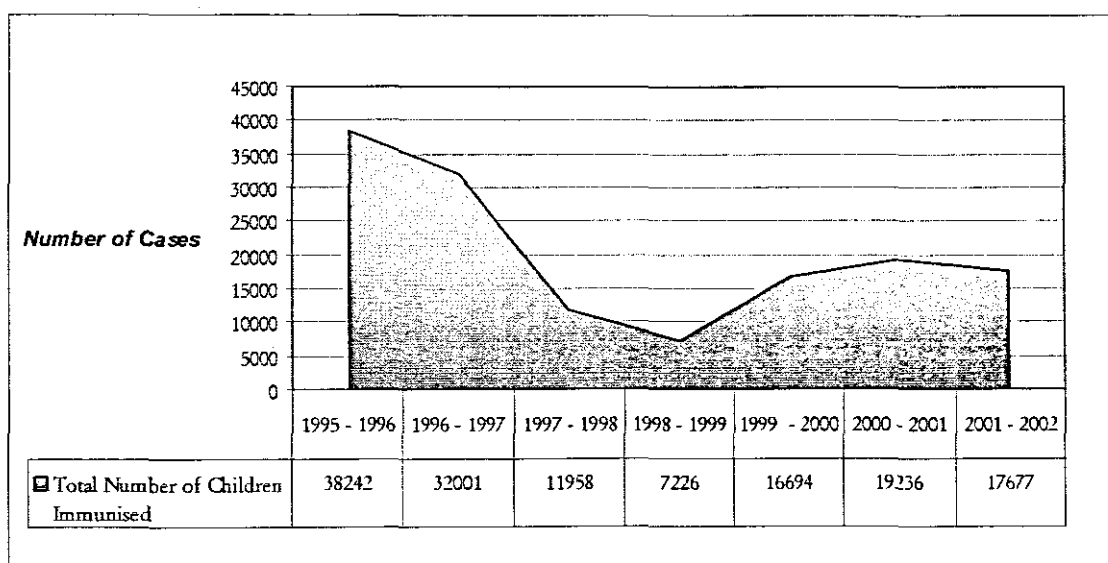


Figure: 4- 6 Total number of children immunized

4.2.2.7 Immunisation: OPV & BCG

Figure 4-7 below provides a percentage increase of 181% between July 1998 and June 2002 for Polio vaccines administered to newborn babies between July 1998 and June 2002 (1997-1998 excluded as transitional year). This is a low trend, at around 200 vaccines per year. These are women who labour at home,

then having their newborn babies vaccinated at the clinic. The trend is low, since most babies are born at hospitals. No data were recorded for the first two years (July 1995 - June 1997).

This figure also indicates that the number of immunisations against Tuberculosis (BCG) has increased by 389.7% between July 1998 and June 2002. The noticeable decrease in the number of patients receiving the BCG vaccine during July 2001 to June 2002 could be ascribed to a non-availability of BCG vaccines for a limited period during this year (Schruder, 2003).

Please note that a decrease in patients being immunized has been recorded between 1995 and 2002 (thus a comparison is drawn between the period before and after the new health plan (1997)). An increase in immunisation on the other hand, is noted for the years after July 1997.

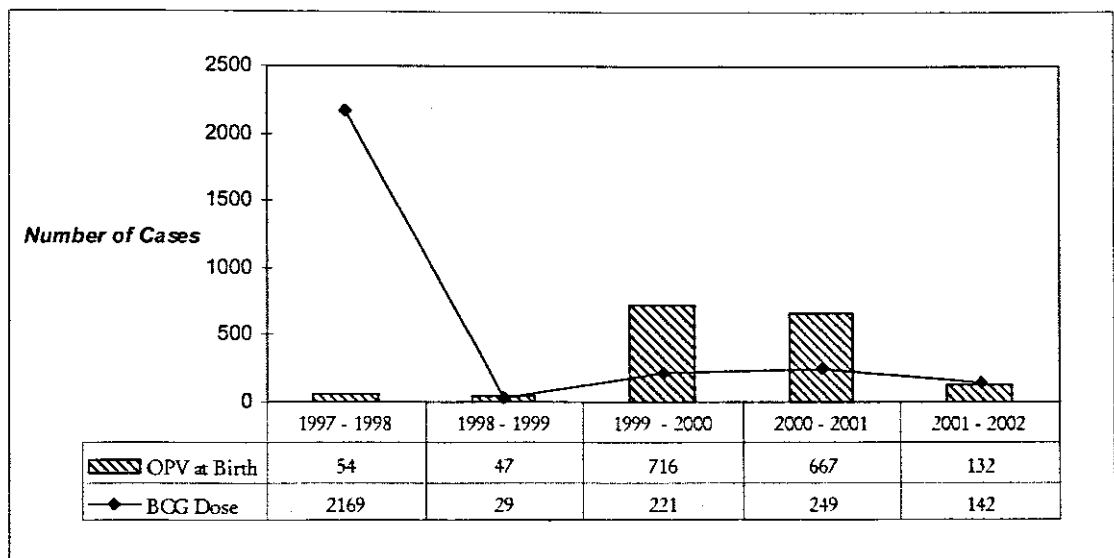


Figure: 4- 7 Immunisation: OPV/BCG

4.2.2.8 Immunisation: DTP-Hib/OPV/HepB

Figure 4-8 shows a 280.8% increase in the number of patients receiving the 1st and 2nd immunisations against Diphtheria, Tetanus, Whooping Cough (DTP), Himophilus Influenza, Polio, and Hepatitis between July 1998 and June 2002. The increase, which is noticeable after July 1999, resulted from an expansion in the facilities at Langa Clinic (Sengana, 2003). No data were recorded for the first two years (July 1995 - June 1997).

This figure further indicates a 296.8% increase for the third dose of DTP-Hib/OPV/HepB. The increase in July 1998 - June 1999 is again due to the extension of facilities at Langa Clinic. No data were recorded for the first two years (July 1995 - June 1997). The figure shows similar trends for the Tetanus,

Whooping Cough (DTP), Himophilus Influenza, Polio, and Hepatitis immunisations.

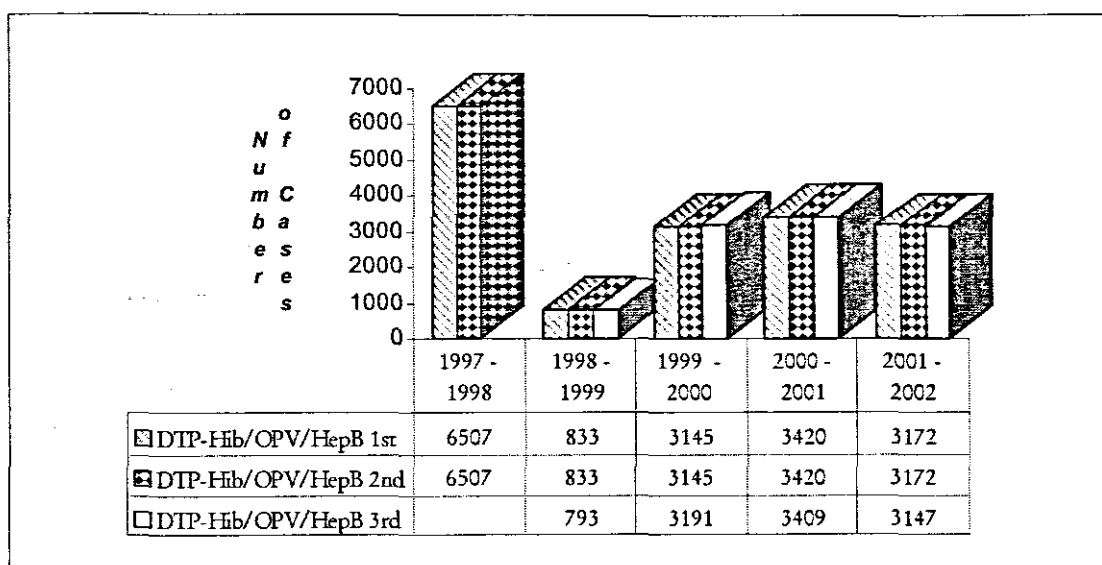


Figure: 4- 8 Immunisation: DTP-Hib/OPV/HepB dose

4.2.2.9 Immunisation: measles 1st dose at 9 month & fully immunized <1 year & measles/OPV/DPT at 18 months

Figure 4-9 below reflects the number of children who have received their first Measles dose at nine months. This item shows an 83.2% increase between July 1998 and June 2002. Langa once more was responsible for an increase in the data during 1998 to 1999 due to an extension of facilities at Langa Clinic.

The graph also refers to fully immunized children younger than 1 year. This graph shows a 40.3% increase between July 1998 and June 2002, with

immunisations increasing after July 1999 due to an extension to Langa Clinic at that time.

The same graph further points out a 321.9% increase in immunisations of children at the age of eighteen months against Measles, Polio, Diphtheria, Pertussis, and Tetanus.

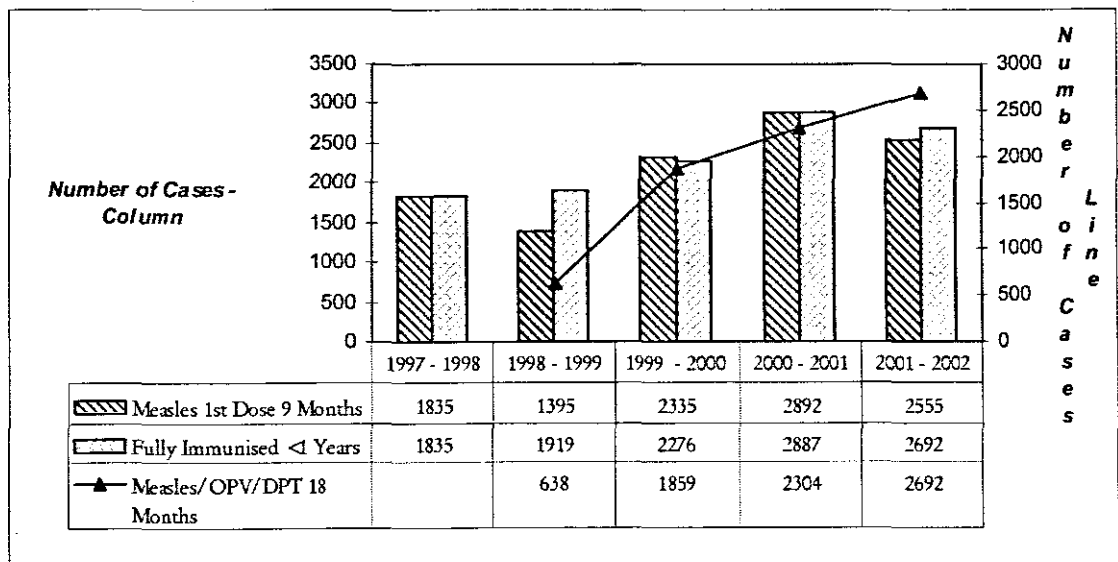


Figure: 4- 9 Immunisation: Measles 1st dose at 9 months & Fully immunized <1 year & Measles/OPV/DPT at 18 months

4.2.2.10 Mental health

Figure 4-10 below shows a 120.5% increase in the number of visits by old mental health patients (1999 - 2002), and a 943.8% increase in the number of new mental health cases since July 1999 to June 2002 (ignoring the transitional

year as explained in the methodology). These increases could be ascribed to the fact that stabilized patients were expected to receive their medication from clinics since 1997 and not only from day hospitals (see Chapter two, item 2.3.8.5 of Chapter two).

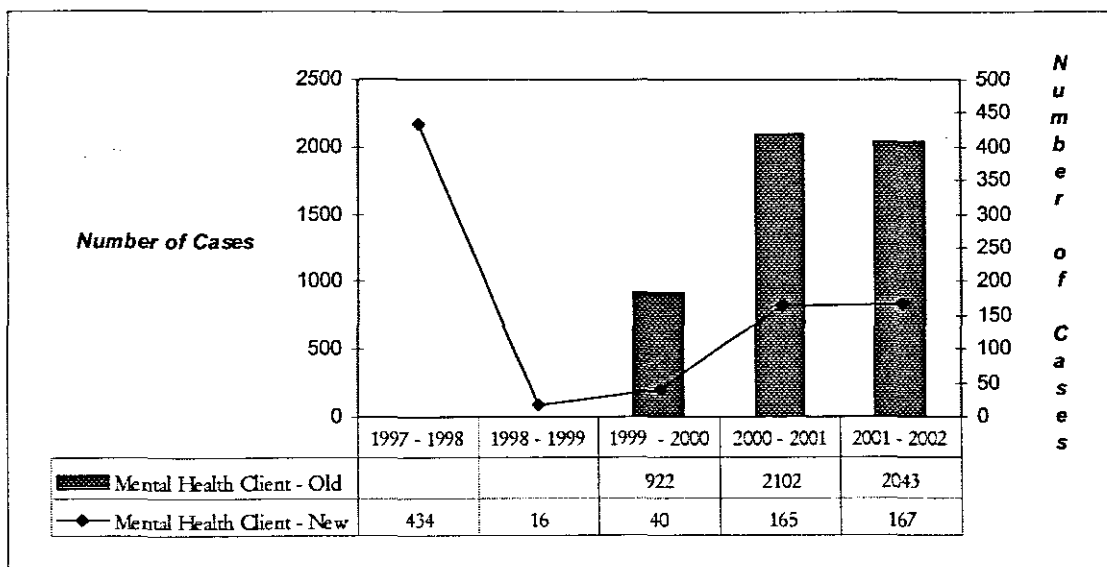


Figure: 4- 10 Mental health: Old & New health clients

4.2.2.11 Mental health: mental health client referred to 2nd & 3rd level

Figure 4-11 below indicates that less than ten mental health cases have been referred to Secondary and Tertiary Hospitals, which represents a 200% decrease and a 400% increase respectively.

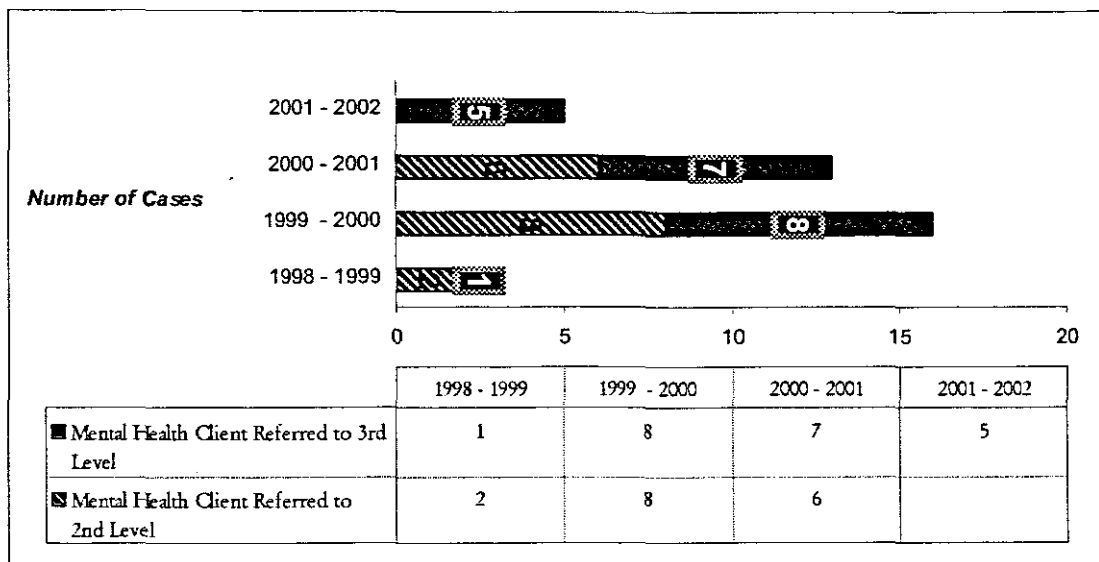


Figure: 4- 11 Mental health: Mental health cliens referred to 3rd & 2nd level

4.2.2.12 Curative services: referred to doctor & seen by professional nurse & seen by doctor & HIV/TB cases per clinic

Figure 4-12 below shows that the number of patients, who have been referred to doctors, declined by 20.5%. These are the patients who have been referred to secondary and tertiary hospitals.

This figure also shows that the number of curative cases seen by professional nurses has increased by 39% between July 1998 and June 2002. This increase in curative nursing services would have been a huge 229.4% if the data were calculated between July 1997 and June 2002. This increase in curative nursing services at public health clinics could be ascribed to the fact that public health

nursing services became a legislated nurse driven service since 1997 (see Chapter two, item 2.3.8.6 of Chapter two).

The graph further shows a 47% increase in the number of patients seen by a doctor at the clinic.

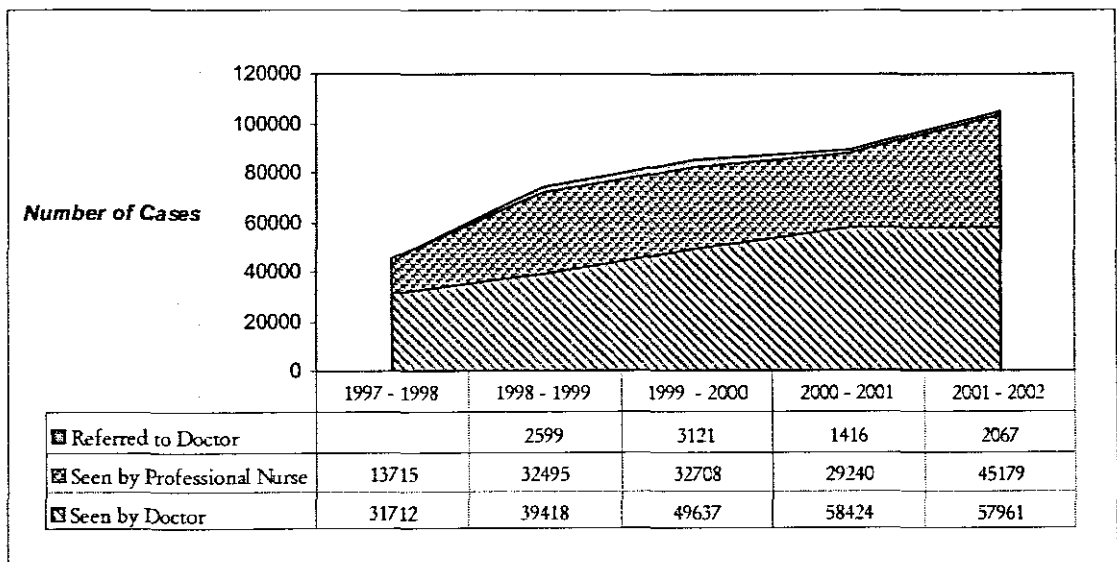


Figure: 4- 12 Curative services: Referred to Doctor & Seen by professional nurse & Seen by doctor

According to Schreuder (2003), the increases in the number of patients seen by doctors and nurses could be ascribed to the introduction of Voluntary HIV Testing and Counselling, as well as an increase in the number of HIV/AIDS cases. This theory is supported by data on HIV cases reported to clinics in the same area. The number of HIV cases for Spencer Road has for instance

increased from 29 cases in 1998 to 721 cases in 2001, which is an astronomic increase of 2386.2%. The total increase in HIV cases for the Cape Town Central District between 1998 and 2001 increased from 194 to 1 476 (660.8%).

Table: 4-3 HIV cases per clinic

HIV CASES AT CLINICS IN CENTRAL DISTRICT: CAPE TOWN				
CLINIC	1998	1999	2000	2001
Chapel Street	99	116	146	80
Claremont	6	6	14	68
Factreton	3	1	20	8
Green Point/Sea Point	1			174
Langa	56	73	208	411
Maitland				13
Pinelands				1
Schotschekloof				
Spencer Road	29	48	316	721
TOTAL	194	244	704	1476

(Source: Cape Town Administration Health Department 2003)

The number of patients receiving other curative services, besides HIV, did not show such a dramatic increase. A moderate decrease of 27.3% has even been recorded in the total TB cases, as seen in the following table on Tuberculosis.

Table: 4-4 TB cases per clinic

TB CASES IN CAPE TOWN CENTRAL DISTRICT			
CLINIC	1999	2000	2001
Chapel Street	524	513	558
Langa	752	783	697
TOTAL	1726	1296	1255

(Source: Cape Town Administration Health Department 2003)

4.2.2.13 *Curative services: Diarrhoea <5 years & lower respiratory infection & curative <5 years*

Figure 4-13 below shows an increase of 132.3% diarrhoea cases, for children less than five years. The increase (and most of the cases) occurred at Langa Clinic.

The graph also indicates an increase of 282.9% in the number of lower respiratory infection cases. Most of the cases were recorded at Langa, Claremont and Maitland clinics.

The graph also displays the total number of curative services rendered to children younger than five years. The trend has decreased by 12.3% over the last four years. Most of the cases were recorded at Langa Clinic.

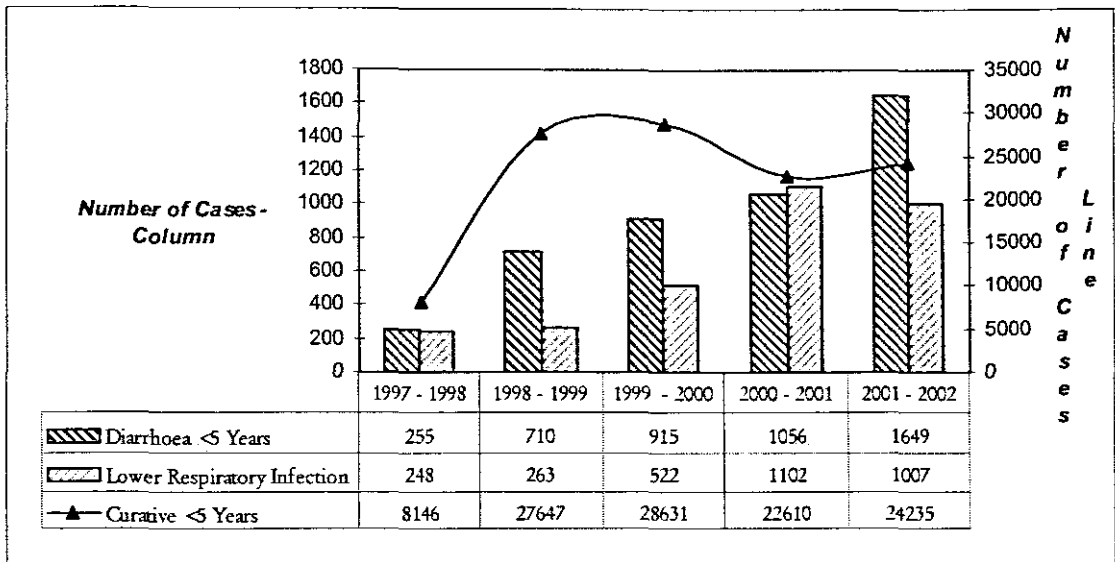


Figure: 4- 13 Curative services: Diarrhoea & Lower respiratory infection & Curative <5 years

4.2.2.14 Curative services: Urethral Discharge & STI & DOT's facility

Figure 4-14 below shows an 8.4% decrease in the number of sexually transmitted infections over the past four years. Most of the cases were reported at Spencer Road Clinic. Spencer Road Clinic used to specialize in sexually transmitted infections only, but rendered a comprehensive service since 1997. The public still regards Spencer Road Clinic as a clinic, which specializes in sexually transmitted infections (Udemans, 2003).

The graph further reveals a moderate decrease of 23.2% in the number of male urethral discharge patients. Most of the cases were again recorded at Spencer Road Clinic.

The graph also displays an increase of 44.4% in the number of directly observed treatments (DOT's) over the last two years. Most of the cases and increases were recorded at Langa Clinic. Most of the clinics are rendering this service, except for Pinelands, where no cases were recorded. Although the DOT's program has been approved in 1996, it has only been implemented during 1997 (Chapter two, item 2.3.8.6 of Chapter two).

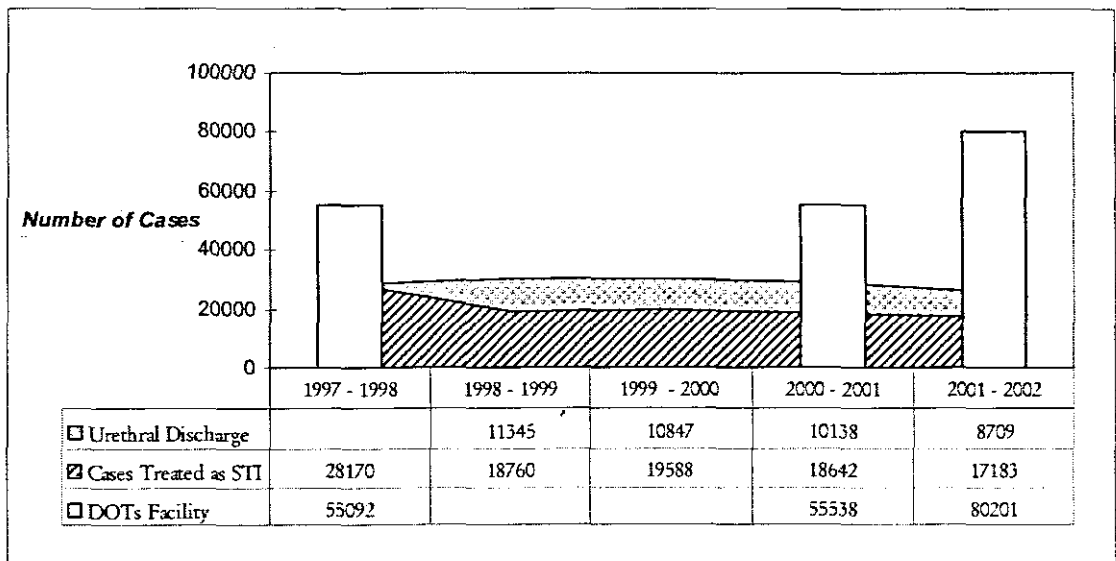


Figure: 4- 14 Curative services: Urethral discharge & STI & DOT's facility

4.2.2.15 *Reproductive and women health: Oral pill cycle & Depo-Provera & Nuristerate*

Figure 4-15 below demonstrates the number of people making use of oral contraceptive pills.

This graph also displays the number of people making use of the Depo-Provera contraceptive injection (lasting 12 weeks). There has been a 5.6% increase in the use of the injection between 1998 and 2002.

The graph further reflexes a 35% increase in the number of people making use of the Nuristerate eight-week contraceptive injection. About double the number of people make use of Nuristerate in comparison to the use of Depo-Provera (this is because women wants to return to fertility sooner after discontinuation of the injection).

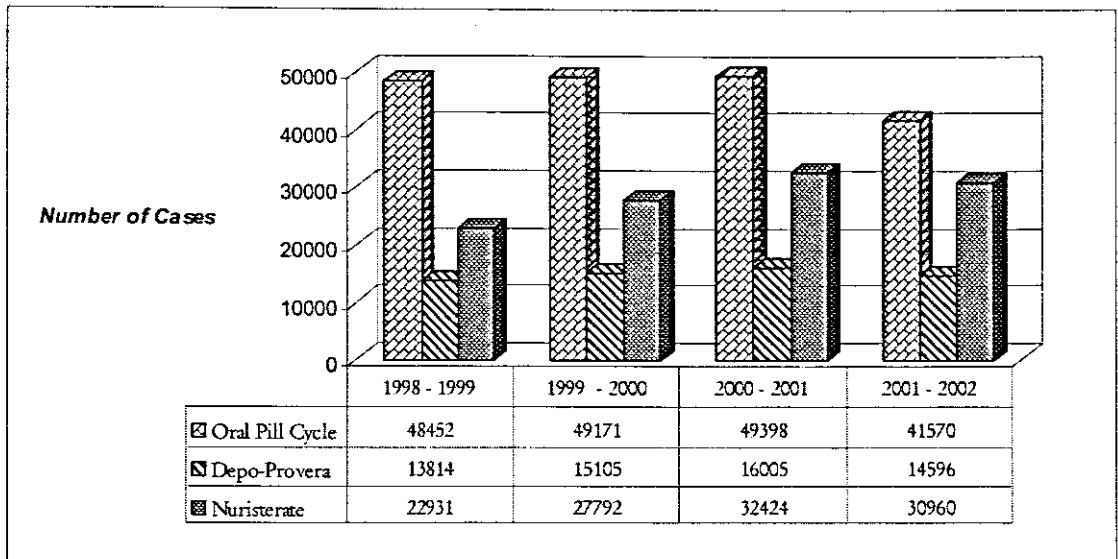


Figure: 4- 15 Reproductive and women health: Oral pill cycle & Depo-Provera & Nuristerate

4.2.2.16 Reproductive and women health: IUCD insert & emergency contraception & referred to TOP & cervical smear 30-59 years

Figure 4-16 below indicates the number of intra urethral cervical devices that have been inserted. A decreasing trend (45.6%) is noted, as well as a 2.6% decrease in the use of emergency contraception.

The graph also shows that the increase for pregnancy cases referred for termination and cervical smears for women between 30 and 59 are 163.6% and 124.6% respectively.

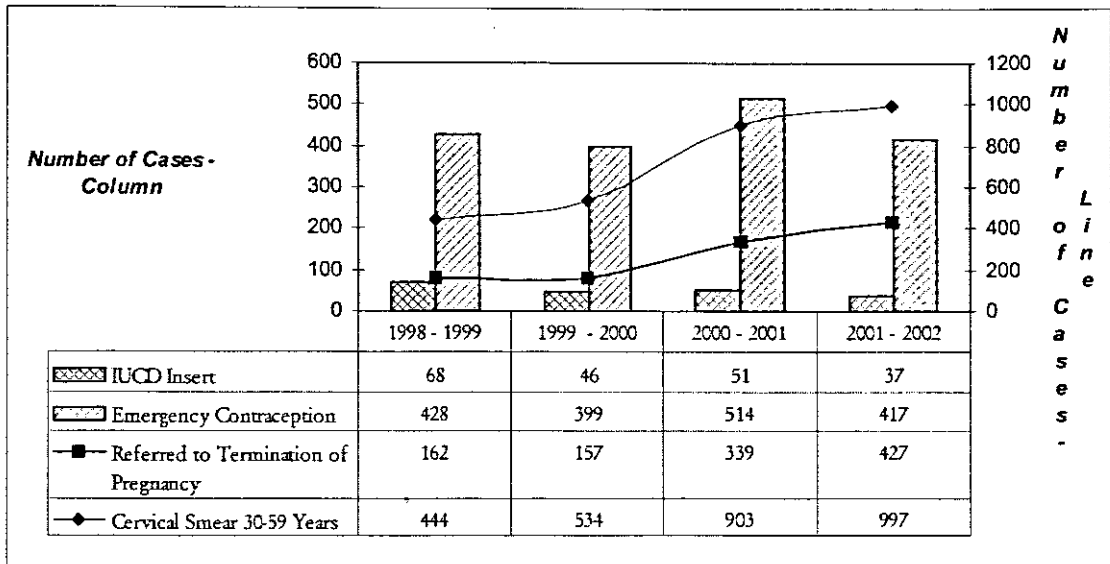


Figure: 4- 16 Reproductive and women health: IUCD insert & Emergency contraception & Referred to TOP & Cervical smear 30-59 years

4.2.2.17 Reproductive and women health: condoms distributed

Figure 4-17 below shows a remarkable increase in the number of condoms distributed. The 396.5% increase in the use of condoms could be linked to the AIDS strategy, in which people are urged to make use of condoms in order to prevent HIV/AIDS.

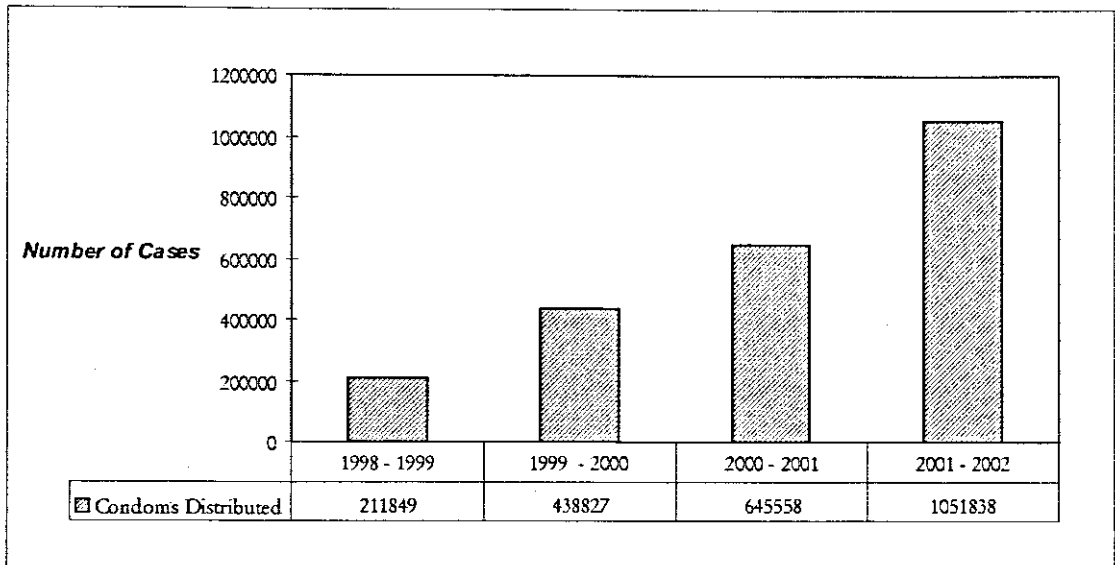


Figure: 4- 17 Reproductive and women health: Condoms distributed

4.2.2.18 Medication: prescription issued & item dispensed

Figure 4-18 below shows that the trend for prescriptions issued by clinics has increased by 57.3% over the last two years. More nurses lately obtained qualifications, which allowed them to prescribe medicine since 1981 (see Chapter two, item 2.3.8.6 of Chapter two).

The graph also represents a 49% increase in the number of items dispensed by the clinic over the last two years. This implies that most of the prescriptions prescribe at least two different types of medication. The percentage increases would have been much more if the increase were calculated since July 1997, i.e. 57.3% increase for prescriptions issued and 209.4% for item dispensed.

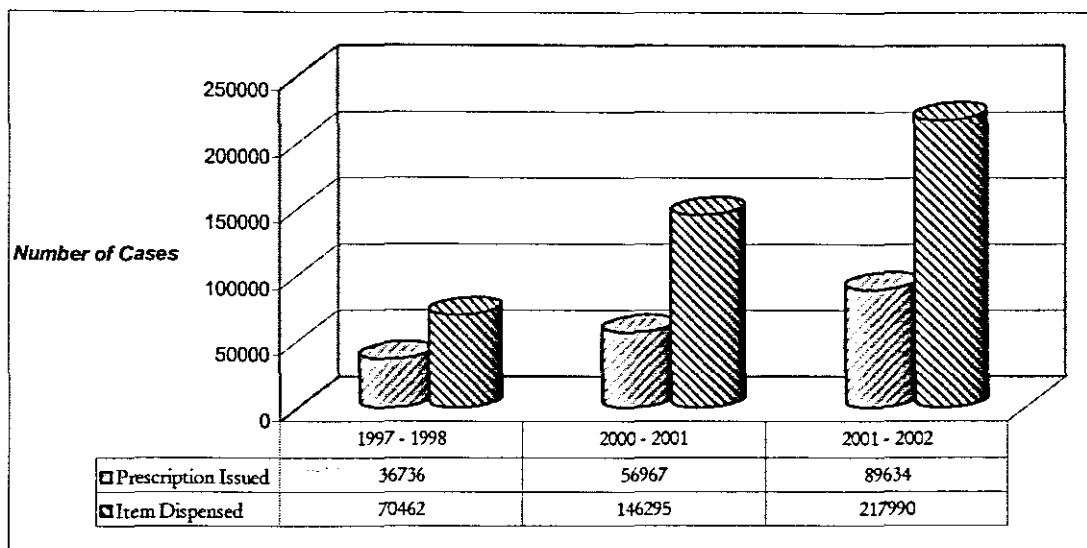


Figure: 4- 18 Medication: Prescription issued & Item dispensed

4.2.2.19 Personnel: nurse/doctor work days PHC

Figure 4-19 below shows that there has been a 33.7% increase in the number of nurses available at the nine clinics. A comparison could not be drawn between the increase in the number of patients visiting the clinics and the increase of staff, since data on additional staff is only available for the last two years.

The graph also demonstrates an increase (16.7%) in the number of doctors available at the clinics concerned over the last two years, expressed as 'Doctor workdays'.

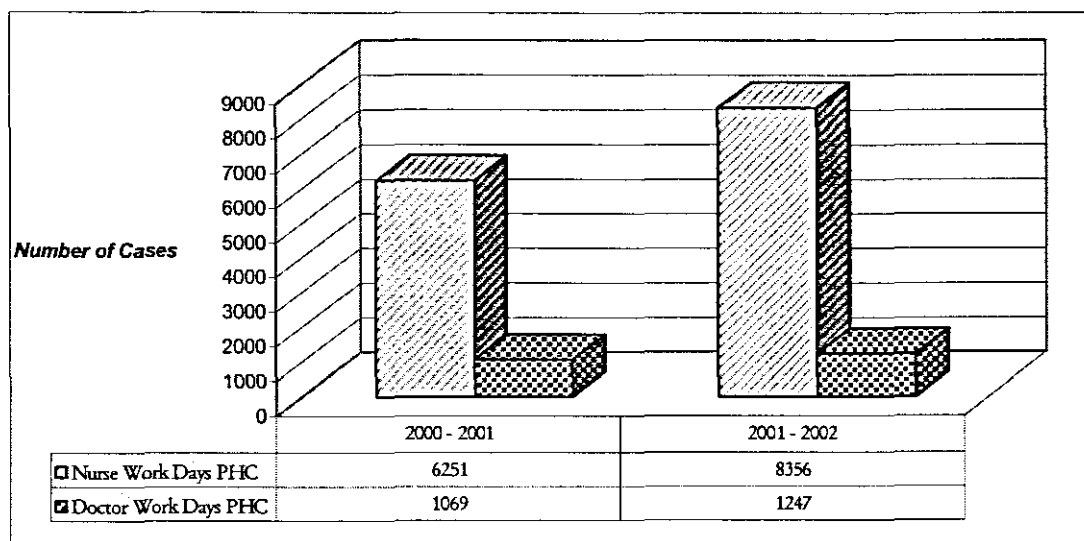


Figure: 4- 19 Personnel: Nurse/Doctor work days PHC

4.2.2.20 Chronic care: chronic & Diabetes & Hypertension & Epilepsy visit

Figure 4-20 below illustrates an increase (114.4%) in the number of chronic visits to the clinics. This chronic data refer to chronic diseases, such as Asthma, Aids, Diabetes, etc. These data are only available for the last two years.

The graph also reveals a number of other chronic conditions, namely Diabetes and Hypertension. The trends have increased by 83.3% and 91.9% over the last two years respectively.

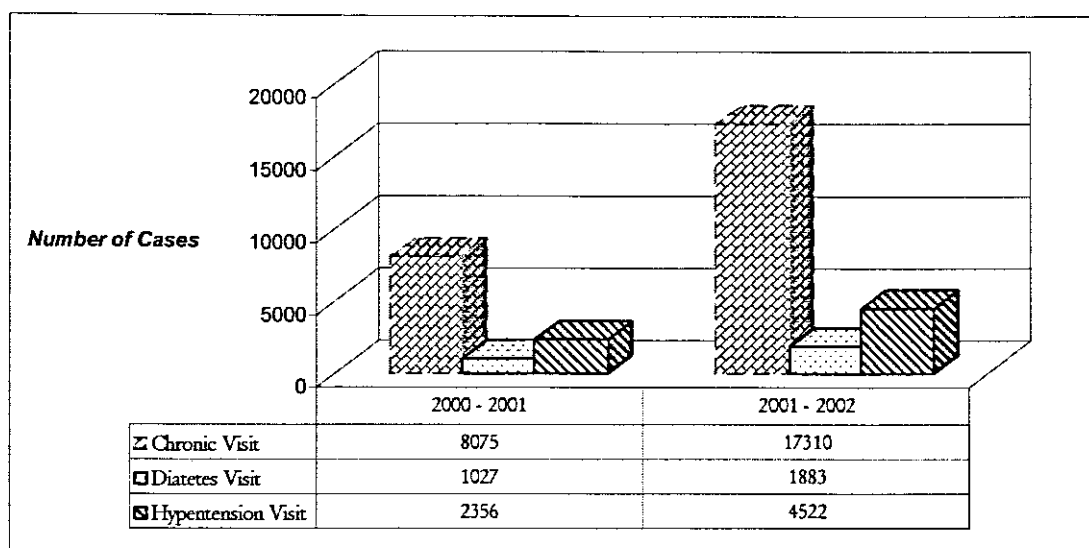


Figure: 4- 20 Chronic care: Chronic & Diabetes & Hypertension visit

Table 4-5 below shows an increase of 47.4% in Epilepsy cases over the last two years.

Table: 4- 5 Chronic care: Epilepsy visit

CHRONIC CARE	2000-2001	2001-2002
Epilepsy Visit	97	143

4.2.3 Overall increase in services rendered by public health clinics in the Cape Town Central District

Table 4-6 below shows a 326% increase in the total number of patients who have attended the nine clinics in the Cape Town Central District between July 1995 and June 2002. The 326% increase is therefore a comparison between

the numbers of clinic services rendered before the transitional period (1997) with the increase of clinic services rendered after the transitional period. It is clear from the above that there has been a significant increase in the number of patients who have been making use of public health clinic services after the introduction of the New Health Plan in 1997.

The increase in population (19.8%) residing in the Cape Town Central District between 1995 and 2002 (refer to Chapter two, box 2 – 5) was far less than the increase (326%) in the number of patients visiting public health clinics in the same area and for the same period. The 326% increase in the number of patients visiting public health clinics therefore could not only be ascribed to the relatively low increase in the study population (19.8%).

Table 4 - 6 secondly indicates a 140.4% overall increase in the number of services rendered at public health clinics in Cape Town Central District after the transitional period, therefore only between July 1998 and June 2002.

Table: 4- 6 Increase/Decrease of clinic delivery services at public health clinics in Cape Town Central District between July 1995 and June 2002

ITEM	CATEGORY	FIELD	INCREASE/DECREASE (%)	
			JULY 1995-JUNE 2002	JULY 1998-JUNE 2002
1	Attendance	PHC headcount <5 years		158
2	Attendance	PHC headcount >=5 years		97.3
2.1	Total attendance all ages		326	83.4
3	Growth Monitoring	Underweight for age <5 years		-53.5
4	Growth Monitoring	Severe malnutrition <5 years		-77.9
5	Growth Monitoring	Growth faltering/failure <5 years		-24.2
6	Growth Monitoring	Child <5 years weighed		35.7
7	Growth Monitoring	Baby examined 1 st time <6 weeks		29.4
8	Immunisation	BCG at birth		389.7
9	Immunisation	OPV at birth		181
10	Immunisation	DTP-Hib/ OPV/ HepB 1 st		280.8
11	Immunisation	DTP-Hib/ OPV/ HepB 2 nd		280.8
12	Immunisation	DTP-Hib/ OPV/ HepB 3 rd		296.8
13	Immunisation	Measles 1 st dose at 9 months		83.2
14	Immunisation	Immunized fully <1 year		40.3
15	Immunisation	Measles/ OPV/ DTP 18 months		321.9
15.1	Total number of children immunized			144.6
16	Mental Health	Mental health client - old		120.5
17	Mental Health	Mental health client - new		943.8

18	Mental Health	Mental health client referred to 2 nd level		-200
19	Mental Health	Mental health client referred to 3 rd level		400
20	Curative Services	Seen by doctor		47
21	Curative Services	Seen by professional nurse		39
22	Curative Services	Referred to doctor		-20.5
23	Curative Services	Diarrhoea <5 years – new		132.3
24	Curative Services	LRI <5 years - new		282.9
25	Curative Services	Case treated as STI		-8.4
26	Curative Services	Urethral discharge		-23.2
27	Curative Services	Curative case <5 years		-12.3
28	Curative Services	DOT's facility		44.4
29	Reproductive And Women Health	Oral pill cycle		-14.2
30	Reproductive And Women Health	Depo-Provera/Petogen injection		5.6
31	Reproductive And Women Health	Nuristerate		35
32	Reproductive And Women Health	IUCD inserted		-45.6
33	Reproductive And Women Health	Condoms distributed		396.5
34	Reproductive And Women Health	Emergency contraception		-2.6
35	Reproductive And Women Health	Referred for termination of pregnancy		163.6
36	Laboratory	Cervical smear 30-59 years		124.6
37	Medication	Prescription issued		57.3

38	Medication	Item dispensed		209.4
39	Personnel	Nurse work days PHC		33.7
40	Personnel	Doctor work days PHC		16.7
40	Chronic Care	Chronic visit		114.4
41	Chronic Care	Diabetes visit		83.3
42	Chronic Care	Hypertension visit		91.9
43	Chronic Care	Epilepsy visit		47.4
GENERAL TREND FOR ALL OF THE ABOVE SERVICES			326%	140.4%

4.3 INTERPRETATION OF THE RESULTS

Most of the services rendered at public health clinics showed a remarkable increase, especially after introduction of free public health clinic services to expectant mothers, as well as children younger than six years. A 326% increase in total attendance to public clinics in Cape Town Central District has been recorded between July 1995 and June 2002.

This overall increase of 326% in the number of patients visiting public health clinics is the most important trend that has been established. A lesser increase of 140.4% has been recorded between July 1998 and June 2002. The largest proportion of the overall increase of 326% therefore occurred during the first three years of the study (July 1995 – June 1998). There has therefore been a 185.6% ($326\% - 140.4\% = 185.6\%$) increase in public health clinic services during these first three years covered by the study. The only major change in

the nature of public health clinic services during the first three years was the introduction of free public health clinic services to expectant mothers and children younger than six years.

Free public health clinic services to expectant mothers and children younger than six years therefore have been the largest contributor to the 326% increase in patients visiting these clinics.

It reflects the change that the New Health Plan introduced in order to decrease the patient load on secondary and tertiary hospitals, and referring these patients to the first levels of PHC. HIV cases have increased by 660.8% between 1998 and 2001.

A decline has been noted in preventive public health services, but an increase was apparent in curative services. These contrasting trends were brought about by an escalation in curative services to the detriment of preventive/promotive services (see item 4.4).

The 229.4% increase in curative patients seen by a professional nurse can be ascribed to the fact that public health clinic services has since 1997 been legislated as a nursing driven services.

4.4 SUMMARY

This chapter provided findings, as well as a discussion of the findings. The data were presented by means of tables, graphs, and calculations have been conducted in order to make certain deductions. This chapter identified which public clinic services in the Cape Town Central District were rendered during each of the years between July 1995 and June 2002. Stabilized mental health patients for instance were for the first time directed to public health clinics for obtaining their medication since 1997. Immunisation programmes have been expanded to cover a wider range of immunisations. After 1997, Public Health Clinics have shifted its emphasis from preventive/promotive to curative services.

Secondly increasing/decreasing trends for each of the public health clinic services in the Cape Town Central District were established during the years that these services were rendered. Total attendance has shown a four-fold increase. Individual services rendered have in certain cases also undergone remarkable increases, such as 194 HIV cases in 1998 for the District, which has increased to 1 476 HIV cases in 2002.

CHAPTER 5

5 CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

The previous chapters determined the nature and extent of public health clinic services in Cape Town Central District. This last chapter provides conclusions and recommendations as based on the findings of this study.

5.2 CONCLUSIONS

In answer to the leading question, on the nature and extent of changes in clinic services experienced at public health clinics in Cape Town Central District between July 1995 and June 2002, it is concluded that a remarkable increase has been encountered in the number of patients visiting these clinics. The nature of these clinic services has also undergone major changes. These increases/changes will now be elaborated upon.

Public health clinics in Cape Town Central District have experienced a 326% increase in the total number of patients visiting these clinics between July 1995 and June 2002 (Chapter four, item 4.2.2.1).

The 326% increase in the number of patients visiting these clinics could be ascribed to a number of factors. Firstly, a number of free clinic services have been introduced since the democratisation of South Africa after 1994, such as free services to expectant mothers and children younger than six years (Chapter four, item 2.3.6). Secondly, the Primary Health Care approach, whereby more patients are channelled to clinics, in order to release pressure from major secondary and tertiary hospitals (Chapter two, item 2.3.4.2).

A third reason for the 326% increase is the fact that new clinic services, such as provision of medication to stabilized mental health patients, have been added to the functions of public health clinics since 1997 (see item 4.2.2.10).

A fourth reason for the 326% increase in patients visiting public health clinics has been the remarkable increase in HIV/AIDS pandemic over the past decade and has shown a 660.8% increase in Cape Town Central District between 1998 and 2001 (Chapter four, item 4.2.2.12).

A fifth reason for the 326% increase resulted from a slight (19.8%) increase in the population for that area during the study period.

The last reason for the 326% increase in the number of patients visiting public health clinics in Cape Town Central District, is the fact that these clinic services

have been legislated as a nurse driven service since 1997, with an additional emphasis on the curative roles of nurses (traditional roles of nurses at public health clinics were largely preventive and promotive in the past. Refer to Chapter two, item 2.3.8.6).

The largest proportion (185.6%) increase of patients visiting public health clinics, took place between July 1995 and June 1998. Free health services to expectant mothers and children younger than six years were the predominant factor for the 185.6% increase.

A 140.4% increase in the number of patients visiting public health clinics was recorded between July 1998 and June 2002. This increase could be ascribed to a number of different factors such as the Primary Health Care approach, new public health clinic services such as the provision of medication to stabilized mental health patients, an increase in HIV/AIDS, a 19.8% increase in the population for the area, as well as a newly legislated curative role of nurses at these clinics.

Record keeping by Cape Town Administration has improved since the introduction of the New Health Plan in 1997. Additional data were available for the period July 1998 – June 2002, which is after the introduction of the New Health Plan in 1997. An overall increase of 140.4% in public health clinic

services have been recorded for this period. More detail is available on increases/decreases for each of the services during this time (Chapter four, table 4-6). Termination of pregnancies has for instance increased by 163.6% since 1998.

Items 39 and 40 of table 4.6 further show that there has only been a 33.7% and 16.7% increase in the number of nurse and doctor workdays at these clinics respectively, which is far less than the 140.4% overall increase in the number of services rendered by these clinics.

5.3 *RECOMMENDATIONS*

Various factors have brought about an alarming 326% increase in the number of patients visiting public health clinics between July 1995 and June 2002. One of the factors for referring more patients to public health clinics was to decrease the patient load of tertiary hospitals. Further research is required/recommended in order to determine if public health clinics can accommodate the increase in patients, which these clinics have been experiencing over the past decade.

It should be established if rendering of additional services such as the emphasis on curative services, or the increase in HIV/AIDS related diseases, or the provision of medication to stabilized mental health patients, are done at the

expense of traditional public health clinic services such as preventive and promotive services.

The recommended further study should also determine if staff at public health clinics are able to cope with the increase in the number of patients, as well as the changing nature of these services. Provision of sufficiently qualified staff should be determined.

The last recommendation for the follow-up study is to determine if the facilities and equipment are sufficient in relation to the increase in patient numbers.

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APPENDIX

Table: 1 Combination: Cape Town Central District data by clinic for July 1995 to June 2002

Type of Services			Number of Cases							Grand Total
Order	Category	Field	1995 - 1996	1996 - 1997	1997 - 1998	1998 - 1999	1999 - 2000	2000 - 2001	2001 - 2002	
1	Attendance	PHC ¹¹ headcount <5 years			33 907	51 999	69 060	51 804	78 789	285 559
2	Attendance	PHC headcount >=5 years			133 854	119 386	178 501	218 985	235 573	886 299
2.1	Total Attendance		73 718	96 738	167 761	171 385	247 561	270 789	314 362	1171 858
3	Growth Monitoring	Underweight for age <5 years				331	299	184	154	968
4	Growth Monitoring	Severe malnutrition <5 years				86	87	17	19	209
5	Growth Monitoring	Growth failure <5 years				153	171	81	116	521
6	Growth Monitoring	Child <5 years weighed						28 634	38 866	67 500

¹¹ PHC = primary health care

7	Development Assessment	Baby exam <6 weeks	1 969	2 246		2 442	2 486	2 953	2 548	12 675
8	Development Assessment	Development assessment <2 years					12	5 011	5 777	10 800
9	Development Assessment	Development assessment <5 years				4 229		1 565		5 794
10	Development Assessment	Development delay <5 years				87		26		113
11	Immunisation	BCG ¹² dose			85	47	716	667	132	1 647
12	Immunisation	OPV ¹³ at birth			2 363	29	221	249	142	3 004
13	Immunisation	DTP ¹⁴ -Hib ¹⁵ /OPV/HepB 1 st			2 363	833	3 145	3 420	3 172	12 933
14	Immunisation	DTP-Hib/OPV/HepB 2nd				793	3 191	3 409	3 147	10 540
15	Immunisation	DTP-Hib/OPV/HepB 3rd			2 168	1 572	2 951	3 408	3 145	13 244
16	Immunisation	Measles 1st dose 9 months			2 032	1 395	2 335	2 892	2 555	11 209
17	Immunisation	Fully immunized <1 years			2 032	1 919	2 276	2 887	2 692	11 806
18	Immunisation	Measles/OPV/DPT 18 months				638	1 859	2 304	2 692	7 493
18.1	Total number of children immunized		38 242	32 001	13 309	7 226	16 694	19 236	17 677	71 876

¹² BCG = vaccine against tuberculosis

¹³ OPV = oral polio vaccine

¹⁴ DTP = vaccine against diphtheria whooping cough and tetanus (lock-jaw)

¹⁵ Hib = vaccine against Haemophilus influenza type b

19	Mental Health	Mental health client – old					922	2 102	2 043	5 067
20	Mental Health	Mental health client – new			434	16	40	165	167	822
21	Mental Health	Mental health client referred to 2nd level				2	8	6		16
22	Mental Health	Mental health client referred to 3 rd level				1	8	7	5	21
23	Mental Health	Psych discharge patient						9	2	11
24	Curative Services	Prevention ONLY <5						9 750	44 277	54 027
25	Curative Services	Seen by doctor			33 448	39 418	49 637	58 424	57 961	238 888
26	Curative Services	Seen by professional nurse			15 704	32 495	32 708	29 240	45 179	155 326
27	Curative Services	Referred to doctor				2 599	3 121	1 416	2 067	9 203
28	Curative Services	Diarrhoea <5 years			293	710	915	1 056	1 649	4 623
29	Curative Services	LRI ¹⁶ <5 years			354	263	522	1 102	1 007	3 248
30	Curative Services	Case treated as STI ¹⁷			28 470	18 760	19 588	18 642	17 183	102 643
31	Curative Services	Urethral discharge				11 345	10 847	10 138	8 709	41 039
32	Curative Services	Curative <5 years			9 871	27 647	28 631	22 610	24 235	112 994

¹⁶ LRI = lower respiratory infection

¹⁷ STI = sexually transmitted infection

33	Curative Services	DOT'S ¹⁸ facility			59 029			55 538	80 201	194 768
34	Reproductive and Women Health	Oral pill cycle				48 452	49 171	49 398	41 570	188 591
35	Reproductive and Women Health	Depo-Provera				13 814	15 105	16 005	14 596	59 520
36	Reproductive and Women Health	Nuristerate				22 931	27 792	32 424	30 960	114 107
37	Reproductive and Women Health	IUCD ¹⁹ inserted				68	46	51	37	202
38	Reproductive and Women Health	Condoms distributed				211 849	438 827	645 558	1 051 838	2 348 072
39	Reproductive and Women Health	Emergency contraception				428	399	514	417	1 758
40	Reproductive and Women Health	Referred for TOP ²⁰				162	157	339	427	1 085
41	Laboratory	Cervical smear 30-59 years				444	534	903	997	2 878
42	Medication	Prescription issued			38 818			56 967	89 634	185 419
43	Medication	Item dispensed			75 087			146 295	217 990	439 372
44	Personnel	Nurse work days PHC						6 251	8 356	14 607
45	Personnel	Doctor work days PHC						1 069	1 247	2 316

¹⁸ DOT'S = directly observed therapy short course

¹⁹ IUCD = intra uterine cervical devices

²⁰ TOP = termination of pregnancy

46	Chronic Care	Chronic visit									8 075	17 310	25 385
47	Chronic Care	Diabetes visit									1 027	1 883	2 910
48	Chronic Care	Hypertension visit									2 356	4 522	6 878
49	Chronic Care	Epilepsy visit									97	143	240

Table: 2 Cape Town Central District data by clinic for July 1995 to June 1996

Type of Services			Number of Cases										
Order	Category	Field	Chapel Street	Claremont	Facreton	Green Point CHC	Langa Clinic	Maitland Clinic	Pinelands	Schotscheskloof	Sea Point Sat	Spencer Road	Grand Total
1	Attendance	PHC headcount <5 years											
2	Attendance	PHC headcount >=5 years											
2.1	Total Attendance		10 444	14 306	6 603	0	29 867	3 146	0	2 400	3 879	3 073	73 718
3	Growth Monitoring	Underweight for age <5											
4	Growth Monitoring	Severe malnutrition <5 years											
5	Growth Monitoring	Growth failure <5 years											

6	Growth Monitoring	Child <5 years weighed											
7	Developmental assessment	Baby exam <6 weeks	110	315	294		931	76		67	71	105	1 969
8	Developmental assessment	Development assessment <2 years											
11	Immunisation	BCG dose	1	18	5		92	2		0	10	1	129
12	Immunisation	OPV at birth		3	4		9	1		0	2		19
13	Immunisation	DTP-Hib/OPV/HepB 1 st											
14	Immunisation	DTP-Hib/OPV/HepB 2 nd											
15	Immunisation	DTP-Hib/OPV/HepB 3 rd											
16	Immunisation	Measles 1st dose 9 months			310								310
17	Immunisation	Fully immunized <1 years											
18	Immunisation	Measles/OPV/DPT 18 months											
19	Mental Health	Mental health client – old											
20	Mental Health	Mental health client – new											
21	Mental Health	Mental health client referred to 2 nd level											

22	Mental Health	Mental health client referred to 3 rd level											
23	Mental Health	Psych discharge patient											
24	Curative Services	Prevention ONLY <5 years											
25	Curative Services	Seen by doctor											
26	Curative Services	Seen by professional nurse											
27	Curative Services	Referred to doctor											
28	Curative Services	Diarrhoea <5 years											
29	Curative Services	LRI <5 years											
30	Curative Services	Case treated as STI											
31	Curative Services	Urethral discharge											
32	Curative Services	Curative <5 years											
33	Curative Services	DOT'S facility											
34	Reproductive and Women Health	Oral pill cycle											
35	Reproductive and Women Health	Depo-Provera											

36	Reproductive and Women Health	Nuristerate											
37	Reproductive and Women Health	IUCD inserted											
38	Reproductive and Women Health	Condoms distributed											
39	Reproductive and Women Health	Emergency contraception											
40	Reproductive and Women Health	Referred for TOP											

Table: 3 Cape Town Central District data by clinic for July 1996 to June 1997

Type of Services			Number of Cases										
Order	Category	Field	Chapel Street	Claremont	Factreton	Green Point CHC	Langa Clinic	Maitland Clinic	Pinelands	Schotscheskloof	Sea Point Sat	Spencer Road	Grand Total
1	Attendance	PHC headcount <5 years											
2	Attendance	PHC headcount >=5 years											
2.1	Total Attendance												96 738

3	Growth Monitoring	Underweight for age <5 years											
4	Growth Monitoring	Severe malnutrition <5 years											
5	Growth Monitoring	Growth failure <5 years											
6	Growth Monitoring	Child <5 years weighed											
7	Developmental assessment	Baby exam <6 weeks	121	273	270	1 142	85	67	78	102	108	2 246	
8	Developmental assessment	Development assessment <2 years											
11	Immunisation	BCG dose											
12	Immunisation	OPV at birth											
13	Immunisation	DTP-Hib/OPV/HepB 1 st											
14	Immunisation	DTP-Hib/OPV/HepB 2 nd											
15	Immunisation	DTP-Hib/OPV/HepB 3 rd											

16	Immunisation	Measles 1st dose 9 months												
17	Immunisation	Fully immunized <1 years												
18	Immunisation	Measles/OPV/DPT 18 months												
18.1	Total children immunized		2 097	5 703	3 789		13 253	1 808	524		1 424	1 885	1 518	32 001
19	Mental Health	Mental health client - old												
20	Mental Health	Mental health client - new												
21	Mental Health	Mental health client referred to 2 nd level												
22	Mental Health	Mental health client referred to 3 rd level												
23	Mental Health	Psych discharge patient												

24	Curative Services	Prevention ONLY <5 years												
25	Curative Services	Seen by doctor												
26	Curative Services	Seen by professional nurse												
27	Curative Services	Referred to doctor												
28	Curative Services	Diarrhoea <5 years												
29	Curative Services	LRI <5 years												
30	Curative Services	Case treated as STI												
	Total attendance STD		556	179			993	49					1 777	
31	Curative Services	Urethral discharge												
32	Curative Services	Curative <5 years												
33	Curative Services	DOT'S facility												
42	Reproductive and Women Health	Contraceptive user <18 years	1 987	22 408	3 095		15 951	3 043	727		1 182	2 813	2 280	53 486
34	Reproductive and Women Health	Oral pill cycle												

35	Reproductive and Women Health	Depo-Provera											
36	Reproductive and Women Health	Nuristerate											
37	Reproductive and Women Health	IUCD inserted											
38	Reproductive and Women Health	Condoms distributed											
39	Reproductive and Women Health	Emergency contraception											
40	Reproductive and Women Health	Referred for TOP											

Table: 4 Cape Town Central District data by clinic for July 1997 to June 1998

Type of Services			Number of Cases								
Order	Category	Field	Chapel Street	Factreton	Langa Clinic	Maitland Clinic	Pinlands	Schotscheskloof	Sea Point Sat	Spencer Road	Grand Total
1	Attendance	PHC headcount <5 years	2 786	5 517	12 082	2 136	648	2 163	2 659	2 496	33 907

2	Attendance	PHC headcount >=5 years	18 407	6 850	54 321	6 037	868	2 632	4 822	32 911	133 854
3	Growth Monitoring	Children <2 years weighed	1 368	1 191	4 297	1 512	387	1 275	1 514	1 523	13 615
9.1	Developmental assessment	Development assessment at 9 months	108	250	1 185	140	37	113	128	82	2 241
9.2	Developmental assessment	Development assessment at 18 months	10	102	914	8		7	4	3	1 205
9.3	Developmental assessment	Development assessment at 5 years/preschool	4	22	266	10		5		1	381
9.1	Immunisation	Children immunized	745	1 429	6 347	895	336	780	759	667	13 309
11	Immunisation	BCG at birth	21	3	17		2	3	6	2	85
14	Immunisation	DTP-Hib/OPV/HepB 1 st	405	810	3 765	324	99	396	441	267	7 089
14.1	Immunisation	OPV 1 st dose	135	270	1 255	108	33	132	147	89	2 363
14.2	Immunisation	DTP-Hib 1 st	135	270	1 255	108	33	132	147	89	2 363
14.3	Immunisations	HepB 1 st dose	135	270	1 255	108	33	132	147	89	2 363
16	Immunisations	DTP-Hib/OPV/HepB 3 rd	236	538	2 242	240	60	260	274	136	4 336
16.1	Immunisations	OPV 3 rd dose	118	269	1 121	120	30	130	137	68	2 168

16.2	Immunisations	HepB 3 rd dose	118	269	1 121	120	30	130	137	68	2 168
17	Immunisations	Measles 1 st dose at 9 months	134	262	935	125	41	123	133	82	2 032
18	Immunisations	Immunized fully <1 year – new	134	262	935	125	41	123	133	82	2 032
20	Mental Health	Mental health client – new	434								434
25	Curative Services	Seen by doctor	2 739		3 510	978		7	133	24 345	33 448
26	Curative Services	Seen by professional nurse	3 730	3 031	2 751	701	298	712	538	1 954	15 704
28	Curative Services	Diarrhoea <5 years – new	38	40	93	19	2	9	5	49	293
29	Curative Services	LRI <5 years – new	18	102	2	41	7	15	21	42	354
30	Curative Services	Case treated as STI – new	1 149		1 361	157	5		4	25 494	28 470
32	Curative Services	Curative case <5 years	753	2 218	2 072	803	266	591	639	804	9 871
33	Curative Services	DOT'S facility	13 346	3 060	31 678	2 430		1 039	1 865	1 674	55 092
	Curative Services	Patients X-Rayed	3 343		2 989						7 155
	Rehabilitation Services	Seen by social worker	213		1 981					16	2 353
34	Reproductive Health	Reproductive health clients	1 933	3 077	16 233	3 371	725	1 163	2 335	2 145	33 363

	Reproductive Health	Reproductive health clients <20 years	58	155	1 200	359	17	14	34	51	2 058
40	Maternal Health	Referred for TOP	23	19	33	18		5	10	7	136
	Maternal Health	Maternal health visits	129	182	86	196	28	71	142	186	1 295
	Maternal Health	First antenatal visit	30	112	5	53	9	5	17	54	412
	Counselling	Counselled (inc HIV)	1 515	222	886	569	222	204	607	7 354	11 673
	Community Activities	Outside visits	313	640	4 616	287	227	503	975	546	8 754
41	Laboratory	Cervical smear	49	6	204	89		20	38	37	460
	Laboratory	Other specimens taken	4 416	7	6 125	8			11	20 040	32 224
42	Medication	Prescription issued	1 789	2 842	5 290	1 365	140	555	657	24 098	38 818
43	Medication	Item dispensed	2 898	6 725	6 882	1 860	149	884	1 005	50 059	75 087

Table: 5 Cape Town Central District data by clinic for July 1998 to June 1999

Type of Services			Number of Cases									
Order	Category	Field	Chapel Street	Claremont	Factreton	Langa Clinic	Maitland Clinic	Pinelands	Schotscheskloof	Sea Point Sat	Spencer Road	Grand Total
1	Attendance	PHC headcount <5 years	2 966	5 582	7 106	27 260	2 161	643	1 922	2 156	2 203	51 999
2	Attendance	PHC headcount >=5	16 132	26 209	5 534	27 026	6 460	769	2 809	3 375	31 072	119 386
3	Growth Monitoring	Underweight for age <5 years – new	8	57	37	96	7	6	25	13	6	255
4	Growth Monitoring	Severe malnutrition <5 years - new	4	5	0	62	1	2	8	4		86
5	Growth Monitoring	Growth faltering / failure <5 years – new	7	25	43	40			10	10	18	153
7	Developmental assessment	Baby examined 1st time <6 weeks	88	243	253	1 490	72	13	115	108	60	2 442
9	Developmental assessment	Development assessment <5 years	153	548	589	2 147	181	49	246	187	129	4 229
10	Developmental assessment	Development delay <5 years	10	27	3	16	4	4	5	15	3	87
11	Immunisation	BCG at birth	1	12	3	19	1	1	1	7	2	47

12	Immunisation	OPV at birth		1	3	7	1		8	3	1	24
13	Immunisation	DTP-Hib OPV and HepB 1 st dose	51	99	81	422	38	12	48	49	33	833
14	Immunisation	DTP-Hib OPV and HepB 2 nd dose	48	99	94	382	31	16	39	44	40	793
15	Immunisation	DTP-Hib OPV and HepB 3 rd dose	75	234	178	686	107	33	86	91	82	1 572
16	Immunisation	Measles 1st dose at 9 months	73	257	193	540	73	21	92	72	74	1 395
17	Immunisation	Immunized fully under 1 year – new	86	362	266	779	99	33	127	94	73	1 919
18	Immunisation	Measles OPV and DTP at 18 months	43	104	88	228	39	15	61	20	40	638
19	Mental Health	Mental health client – new	1	9	2				3	1		16
21	Mental Health	Mental health client referred to 2 nd level		2								2
22	Mental Health	Mental health client referred to 3 rd level		1								1
25	Curative Services	Seen by doctor	4 753	699	462	9 737	1 065			120	22 582	39 418
26	Curative Services	Seen by professional nurse	2 262	3 330	4 004	18 596	910	298	771	601	1 723	32 495
27	Curative Services	Referred to doctor	459	692	69	1 017	210	7	43	16	86	2 599

28	Curative Services	Diarrhoea <5 years	23	63	94	452	4		32	20	22	710
29	Curative Services	LRI <5 years	26	43	45	27	13		24	22	63	263
30	Curative Services	Case treated as STI	199	290	15	619	207	3	2	15	17 410	18 760
31	Curative Services	Urethral discharge	36	36		233					11 040	11 345
32	Curative Services	Curative case <5 years	770	2 318	3 716	17 542	750	269	744	666	872	27 647
34	Reproductive and Women Health	Oral pill cycle	1 417	30 661	2 676	3 888	2 341	1 023	2 137	2 742	1 567	48 452
35	Reproductive and Women Health	Depo-provera/Petogen injection	390	3 613	945	5 767	1 225	200	289	706	679	13 814
36	Reproductive and Women Health	Nuristerate	469	9 623	950	8 465	1 482	147	345	645	805	22 931
37	Reproductive and Women Health	IUCD inserted	2	34	8	1	9				14	68
38	Reproductive and Women Health	Condoms distributed	12 485	52 070	4 161	10 236	12 928	760	3 060	6 015	110 134	211 849
39	Reproductive and Women Health	Emergency contraception	9	351	19	10	12	5	3	3	16	428
40	Reproductive and Women Health	Referred for TOP	15	85	9	13	14	2	2	16	6	162

41	Laboratory	Cervical smear 30 - 59 years	32	183	32	43	78			29	27	20	444
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Table: 6 Cape Town Central District data by clinic for July 1999 to June 2000

Type of Services			Number of Cases										
Order	Category	Field	Chapel Street	Claremont	Factreton	Green Point CHC	Langa Clinic	Maitland Clinic	Pinelands	Schotscheskloof	Sea Point Sat	Spencer Road	Grand Total
1	Attendance	PHC headcount <5 years	5 452	6 238	12 167	577	32 852	4 107	765	2 124	1 465	3 313	69 060
2	Attendance	PHC headcount >=5 years	21 641	27 747	11 570	7 804	62 702	8 379	861	1 580	3 073	33 144	178 501
3	Growth Monitoring	Underweight for age <5 years	17	18	77	2	113	39	10	8	5	10	299
4	Growth Monitoring	Severe malnutrition <5 years	2	2	7	4	63	8			1		87
5	Growth Monitoring	Growth failure <5 years	19	18	25		41	22		27	11	8	171

7	Developmental assessment	Baby exam <6 weeks	212	320	318	19	1 198	117	14	75	70	143	2 486
8	Developmental assessment	Development assessment <2 years				12							12
11	Immunisation	BCG dose	80	123	91	5	292	69	6	9	6	35	716
12	Immunisation	OPV at birth	15	41	34		80	7	3	11	10	20	221
13	Immunisation	DTP-Hib/OPV/HepB 1 st	235	475	389		1 439	184	54	107	86	176	3 145
14	Immunisation	DTP-Hib/OPV/HepB 2 nd	237	421	406		1 438	224	53	132	93	187	3 191
15	Immunisation	DTP-Hib/OPV/HepB 3 rd	219	416	365		1 362	193	57	110	80	149	2 951
16	Immunisation	Measles 1 st dose at 9 m	201	363	308	26	932	155	40	117	67	126	2 335
17	Immunisation	Fully immunized <1 years	199	362	291	17	932	153	39	111	66	106	2 276

18	Immunisation	Measles/OPV/DPT 18 months	129	305	359		629	155	30		85	54	113	1 859
19	Mental Health	Mental health client – old		4	3	37		878						922
20	Mental Health	Mental health client – new	11	6	5			12			6			40
21	Mental Health	Mental health client referred to 2 nd level	1	3							2		2	8
22	Mental Health	Mental health client to referred 3 rd level		1				4					3	8
25	Curative Services	Seen by doctor	5 555	746	911	5 154	10 384	1 026				47	25 814	49 637
26	Curative Services	Seen by professional nurse	2 516	3 363	7 340	356	12 607	2 044	326		855	528	2 773	32 708
27	Curative Services	Referred to doctor	165	352	320	50	1 748	280	7		76	59	64	3 121
28	Curative Services	Diarrhoea <5 years	38	119	178	25	419	17			35	6	78	915

29	Curative Services	LRI <5 years	50	163	155	26	10	32	1	24	10	51	522
30	Curative Services	Case treated as STI	221	482	127	45	995	196	6	22	13	17 481	19 588
31	Curative Services	Urethral discharge	28	27	5	18	418					10 351	10 847
32	Curative Services	Curative <5 years	1 645	2 298	6 631	242	13 444	1 441	270	776	437	1 447	28 631
34	Reproductive and Women Health	Oral pill cycle	2 473	26 785	4 679	591	4 384	3 175	1 332	1 978	1 351	2 423	49 171
35	Reproductive and Women Health	Depo-Provera	671	3 804	1 518	103	5 863	1 370	177	231	381	987	15 105
36	Reproductive and Women Health	Nuristerate	854	9 465	1 480	88	12 150	1 582	212	315	377	1 269	27 792
37	Reproductive and Women Health	IUCD inserted		21	6			10				9	46
38	Reproductive and Women Health	Condoms distributed	98 420	75 790	22 125	1 570	111 810	21 312	1 648	5 082	5 480	95 590	438 827

39	Reproductive and Women Health	Emergency contraception	16	292	12	3	26	17	2	7	7	17	399
40	Reproductive and Women Health	Referred for TOP	15	69	10	4	23	9		3	4	20	157
41	Laboratory	Cervical smear 30-59 years	51	245	49	3	31	98		17	21	19	534

Table: 7 Cape Town Central District data by clinic for July 2000 to June 2001

Type of Services			Number of Cases										
Order	Category	Field	Chapel Street	Claremont	Factretton	Green Point CHC	Langa Clinic	Maitland Clinic	Pinelands	Schotscheskloof	Sea Point Sat	Spencer Road	Grand Total
1	Attendance	PHC headcount <5 years	4 317	5 473	10 075	1 869	18 730	4 361	691	1 556	989	3 743	51 804
2	Attendance	PHC headcount >=5 years	22 245	24 410	13 625	36 202	76 817	10 250	922	1 645	2 782	30 087	218 985
3	Growth Monitoring	Underweight for age <5 years	25	1	65	9	46	19	6	2		11	184
4	Growth Monitoring	Severe malnutrition <5 years	1		1	3	6	3				3	17
5	Growth Monitoring	Growth failure <5 years	14	4	13	3	2	10		4		31	81

6	Growth Monitoring	Child <5 years weighed	2 535	3 775	4 597	1 434	11 336	1 880	399	923	1 755	28 634
7	Developmental assessment	Baby exam <6 weeks	263	295	405	111	1 429	157	40	88	165	2 953
8	Developmental assessment	Development assessment <2 years	419	733	594	178	2 281	242	80	167	317	5 011
9	Developmental assessment	Development assessment <5 years	157	224	226	17	654	84	12	45	0	1 565
10	Developmental assessment	Development delay <5 years	4	0	7	1	4	3	2	3	0	26
11	Immunisation	BCG dose	46	63	99	9	374	36	5		16	667
12	Immunisation	OPV at birth	8	18	47	6	146	9	3	3	6	249
13	Immunisation	DTP-Hib/OPV/HepB 1 st	239	482	450	86	1 664	175	54	93	177	3 420
14	Immunisation	DTP-Hib/OPV/HepB 2 nd	230	484	447	107	1 614	179	62	108	178	3 409
15	Immunisation	DTP-Hib/OPV/HepB 3 rd	227	479	431	88	1 645	209	54	97	178	3 408
16	Immunisation	Measles 1st dose 9 months	197	394	393	77	1 238	165	55	117	68	2 892
17	Immunisation	Fully immunized <1 years	197	394	393	76	1 238	161	55	117	68	2 887
18	Immunisation	Measles/OPV/DP T 18 months	193	286	391	58	897	176	38	96	169	2 304
19	Mental Health	Mental health client – old				1 122		980				2 102

20	Mental Health	Mental health client – new	13	1	1	121	1	28					165
21	Mental Health	Mental health client referred to 2 nd level				2	1	3					6
22	Mental Health	Mental health client referred to 3 level	1			3		3					7
23	Mental Health	Psych discharge patient				2		7					9
24	Curative Services	Prevention ONLY <5 years	1 196	1 765	1 577	233	3 035	709	237	573		425	9 750
25	Curative Services	Seen by doctor	5 601	847	1 151	16 765	11 518	977				21 565	58 424
26	Curative Services	Seen by professional nurse	2 219	3 154	7 028	1 108	9 263	2 253	248	421		3 546	29 240
27	Curative Services	Referred to doctor	157	91	320	223	161	313	2	51		98	1 416
28	Curative Services	Diarrhoea <5 years	72	134	99	50	528	61	3	12		97	1 056
29	Curative Services	LRI <5 years	55	223	125	16	504	117	3	10		49	1 102
30	Curative Services	Case treated as STI	264	460	186	150	1 871	435	6	9		15 261	18 642
31	Curative Services	Urethral discharge	89	76	32	65	468	46		1		9 361	10 138
32	Curative Services	Curative <5 years	1 486	1 939	5 603	908	8 710	1 883	182	373		1 526	22 610
33	Curative Services	DOT'S facility	5 932	2 664	3 526	2 359	34 408	2 229		1 018		3 402	55 538

34	Reproductive and Women Health	Oral pill cycle	2 019	22 271	6 572	5 473	4 017	3 559	1 546	1 023	2 918	49 398
35	Reproductive and Women Health	Depo-Provera	750	3 704	1 927	731	6 084	1 550	164	194	901	16 005
36	Reproductive and Women Health	Nuristerate	795	8 937	1 838	991	16 342	1 789	196	235	1 301	32 424
37	Reproductive and Women Health	IUCD inserted		23	6	2		9			11	51
38	Reproductive and Women Health	Condoms distributed	142 223	68 150	38 000	26 770	95 200	43 940	1 475	2 600	227 200	645 558
39	Reproductive and Women Health	Emergency contraception	21	233	32	105	53	36	5	3	26	514
40	Reproductive and Women Health	Referred for TOP	26	91	17	107	49	27	1	3	18	339
41	Laboratory	Cervical smear 30-59 years	132	165	60	185	125	133		13	90	903
42	Medication	Prescription issued	3 266	2 175	4 055	18 912	9 893	2 203	128	218	16 117	56 967
43	Medication	Item dispensed	6 526	3 577	8 080	74 064	21 456	3 938	192	320	28 142	146 295
44	Personnel	Nurse work days PHC	758	553	621	1 723	1 370	453	59	56	658	6 251
45	Personnel	Doctor work days PHC	195	33	32	327	214	33			237	1 069
46	Chronic Care	Chronic visit	1 443			4 976	1 654	1	1			8 075

47	Chronic Care	Diabetes visit				1 027							1 027
48	Chronic Care	Hypertension visit				2 356							2 356
49	Chronic Care	Epilepsy visit				97							97

Table: 8 Cape Town Central District data by clinic for July 2001 to June 2002

Type of Services			Number of Cases									
Order	Category	Field	Chapel Street	Claremont	Factreton	Green Point CHC	Langa Clinic	Maitland Clinic	Pinelands	Schotscheskloof	Spencer Road	Grand Total
1	Attendance	PHC headcount <5 years	6 214	11 613	10 872	3 208	33 380	5 447	1 088	1 337	5 630	78 789
2	Attendance	PHC headcount >=5 years	24 758	23 058	13 700	45 916	87 001	11 081	883	695	28 481	235 573
3	Growth Monitoring	Underweight for age <5	15	3	26	16	49	24	4	1	16	154
4	Growth Monitoring	Severe malnutrition <5	3		8	1	1	3	0		3	19
5	Growth Monitoring	Growth failure <5 years	5	5	39	6	9	20	1		31	116
6	Growth Monitoring	Child <5 years weighed	3 073	5 209	6 511	1 855	15 368	3 113	646	1 011	2 080	38 866
7	Developmental assessment	Baby exam <6 weeks	323	340	316	134	1 020	145	51	75	144	2 548
8	Developmental assessment	Development assessment <2	535	1 084	620	241	2 453	280	99	132	333	5 777

11	Immunisation	BCG dose	2	2	19		107	2			0	132
12	Immunisation	OPV at birth	5	5	23	2	103	2	1		1	142
13	Immunisation	DTP- Hib/OPV/HepB 1 st	367	490	374	155	1 343	144	52	99	148	3 172
14	Immunisation	DTP- Hib/OPV/HepB 2 nd	331	479	361	137	1 383	165	63	93	135	3 147
15	Immunisation	DTP- Hib/OPV/HepB 3 rd	385	441	380	146	1 360	148	51	90	144	3 145
16	Immunisation	Measles 1 st dose 9 months	248	425	359	137	1 115	150	45	67	146	2 692
17	Immunisation	Fully immunized <1 years	248	425	359	137	1 115	150	45	67	146	2 692
18	Immunisation	Measles/OPV/DPT 18 months	209	362	401	81	957	221	58	91	148	2 528
19	Mental Health	Mental health client – old				1 567		476				2 043
20	Mental Health	Mental health client – new				149		18				167
22	Mental Health	Mental health client referred to 3 rd level				2		3				5
23	Mental Health	Psych discharge patient						2				2
24	Curative Services	Prevention ONLY <5 years	4 021	8 364	4 570	1 746	17 172	2 345	829	935	4 295	44 277
25	Curative Services	Seen by doctor	5 797	267	1 456	20 844	11 663	211			17 723	57 961

26	Curative Services	Seen by professional nurse	6 138	5 073	7 602	5 459	12 592	4 151	237	368	3 559	45 179
27	Curative Services	Referred to doctor	107	176	369	801	188	334	6	21	65	2 067
28	Curative Services	Diarrhoea <5 years	48	180	173	38	1 021	115	3	4	67	1 649
29	Curative Services	LRI <5 years	12	154	201	7	428	185	2	2	16	1 007
30	Curative Services	Case treated as STI	312	561	166	282	1 183	462	12	1	14 204	17 183
31	Curative Services	Urethral discharge	150	105	27	112	189	76			8 050	8 709
32	Curative Services	Curative <5 years	1 759	3 023	5 388	1 099	8 927	2 440	174	343	1 082	24 235
33	Curative Services	DOT'S facility	8 758	2 214	4 194	2 351	55 256	3 134		245	4 049	80 201
34	Reproductive and Women Health	Oral pill cycle	1 933	19 306	5 530	3 514	3 053	3 515	1 348	784	2 587	41 570
35	Reproductive and Women Health	Depo-Provera	810	3 396	1 960	772	4 940	1 632	169	118	799	14 596
36	Reproductive and Women Health	Nuristerate	809	8 379	2 071	1 120	14 797	2 228	232	163	1 161	30 960
37	Reproductive and Women Health	IUCD inserted		6	8	6		3			14	37
38	Reproductive and Women Health	Condoms distributed	388 100	101 600	51 986	37 500	110 200	41 406	3 160	2 262	315 624	1 051 838

39	Reproductive and Women Health	Emergency contraception	16	196	26	111	26	27	3	1	11	417
40	Reproductive and Women Health	Referred for TOP	27	87	21	156	51	59	2		24	427
41	Laboratory	Cervical smear 30-59 years	105	177	78	307	77	106			147	997
42	Medication	Prescription issued	6 530	3 672	7 151	34 946	14 849	3 859	217	320	18 090	89 634
43	Medication	Item dispensed	12 377	6 734	16 303	107 674	30 470	7 913	424	447	35 648	217 990
44	Personnel	Nurse work days PHC	1 022	787	698	2 269	2 192	433	59	62	836	8 356
45	Personnel	Doctor work days PHC	178	11	47	528	195	11			277	1 247
46	Chronic Care	Chronic visit	3 060		64	9 984	4 202					17 310
47	Chronic Care	Diabetes visit				1 883						1 883
48	Chronic Care	Hypertension visit				4 522						4 522

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