Health services in South Africa:
A basic introduction

Kerry Cullinan
Health-e News Service
January 2006

Table of contents

Context

Primary Health Care
- **Background**
- **Norms and standards**

Hospital services
- **Background**
- **Levels of hospitals**
- **District hospitals (level1)**
- **Regional hospitals (level 2)**
- **Tertiary hospitals (Level 3)**

Alarm bells

Conclusion

References

Appendix 1: Patients' Charter

Appendix 2: List of the content of district hospital package prepared by the national PHC task team

Introduction

There is a widespread perception that services in hospitals have seriously deteriorated over the past few years, due in large part to staff shortages and the growing HIV/AIDS epidemic.

Only 10% of people polled in a recent Research Surveys survey said that they trusted state hospitals, while half said hospitals gave poor customer service and a third said they “do not get things right”. The media is also filled with stories and letters about people being poorly treated when visiting hospitals.

In what amounted to an acknowledgment that all is not well in the country’s hospitals President Thabo Mbeki said his State of the Nation address to Parliament on 3 February this year: “To improve service delivery in our hospitals, by September this year we will ensure that hospital managers are delegated authority and held accountable for the functioning of hospitals, with policy issues regarding training, job grading and accountability managed by provincial Health Departments which themselves will need restructuring properly to play their role.”

Last year, the Democratic Alliance listed “the five worst hospitals” in the country. However, it did not establish baseline norms and standards against which to make this judgement, nor did it assess all of the 388 public hospitals to select the worst.

During December 2005 and in the run-up to the March 2006 local elections, the Health Minister has been paying “surprise visits” to various hospitals and pronouncing many to be working well – sometimes simply on the basis that the floors are clean!

However, it is hard to get an accurate picture of health services nationally. Has there has been a general deterioration of hospital services countrywide or are hospital services getting worse only in certain provinces and/ or certain types of areas (eg urban townships, rural areas)?

The aim of this briefing document is to try to establish what each level of the health system is supposed to do according to available official documents. While some of the information contained in this briefing document is somewhat technical, without this basic technical knowledge, it is impossible to assess any part of the system.

One of the difficulties of coming up with an accurate analysis is the lack of definition of all levels of the health service as well as a lack of official norms and standards for each level. The Department of Health has published norms and standards for the Primary Healthcare level, but it is still in the process of adopting norms and standards for the different levels of hospital services. Thus, the definitions, norms and standards for hospitals are based on draft recommendations that have been made to the Department.

The health system is complex, and the process of transforming it is massive. It is thus important to acknowledge this and to give credit to those hospitals that are trying against all odds to improve the services that they offer to patients. Even the very best run hospitals are struggling to deal with the HIV/AIDS epidemic and the massive shortages of healthcare staff – the two biggest challenges facing the overburdened health system.

But there is also evidence of widespread mismanagement, patient neglect and abuse, appalling standards of care, lack of hygiene, lack of infection control and a lack of accountability to patients of many hospitals and health facilities. It is these issues that we need to uncover.

Context

In 1994, the new democratic government inherited a highly fragmented, inequitable health system with health departments for four different racial groups as well as each of the 10 homelands had its own department of health.

Health services were essentially doctor-dependent medical services biased towards curing existing diseases (ie providing medical care) rather than preventing disease (through provision of services such as clean water and sanitation and education).

There was a strong private health sector which included health professionals in private practice, private hospitals, pharmaceutical manufacturers and distributors and medical aid schemes. Some 80% of the funds spent on health in the country are spent in the private sector, which accounts for almost half the country's approximately 400 hospitals. Yet only about 17% of the population, the majority white and Indian, have medical aid schemes and use private health facilities. The rest depend on the public health system, which is struggling to meet demand.

In 1994, the ANC adopted a Primary Health Care (PHC) philosophy. This is premised on community development and community participation in the planning, provision, control and monitoring of services.

In 1996, the new Constitution was adopted for the country. According to Clause 27.1 of the Constitution, "everyone has the right to have access to:
a.) health care services, including reproductive health;
b.) sufficient food and water; and
c.) social security, including, if they are unable to support themselves and their dependants, appropriate social support".

The Constitution compels the state to take "reasonable legislative and other measures within its available resources, to achieve the progressive realisation of each of these rights". If health care services are getting progressively worse rather than better, this is presumably unconstitutional.

In addition, according Clause 27.3 "no one may be refused emergency medical treatment". However, there are a number of reports of health workers refusing to treat people who are too dirty or too drunk, while one of the biggest problems at hospitals is the inability of "gatekeepers" at admissions to be able to judge who is in urgent need of emergency treatment.

Constitutionally, health is a "concurrent" function of both national and provincial spheres of government, with national largely responsible for setting policies and provinces largely responsible for implementing these policies. National government is supposed to monitor provincial implementation but lacks the systems and staff to do so adequately. The failure of the national tuberculosis programme to hold provinces accountable to targets and to contain in any real way the TB epidemic is one such example.

Many provinces are still administratively weak and lack the capacity to do what they are supposed to do. In 2004, six out of the nine provinces under-spent their health budgets because of a lack of capacity.

The ANC's PHC blueprint was adopted by government in the White Paper on Health Services Transformation (1997), which envisages a decentralised, nurse-driven system, based on the district health system where people can get health services near to where they live.

Transformation in the health sector has been hindered by the lack of a legislative framework to guide the process. The National Health Act, giving effect to the White Paper, was only signed into law in 2004, providing guidance on how a national health system should be managed and run.

According to the PHC philosophy, provinces have to devolve responsibility for health to district level and this is a very complex task that requires high levels of management competence to co-ordinate.

Many health districts were established before municipal boundaries were finalised and had to be re-established once the boundaries were set. This demoralised health staff who had already been involved in a very time-consuming previous process of setting up districts.

The country is finally divided in 53 health districts as part of government's drive to decentralise health services and ensure that citizens in every part of the country have access to a comprehensive package of PHC and district hospital services.

In order to understand how hospital services fit into the health system, it is important to understand the entire health system from primary level.

Primary healthcare

The doctor- and hospital-based model of care meant that people with minor ailments were often treated by doctors at the outpatients departments (OPD) of hospitals. In addition, for many people services such as family planning, immunisation for babies and the management of stable chronic diseases such as diabetes were only available at hospitals. However, this is not an efficient use of resources as there are not enough doctors to see to patients with minor problems.

To use scarce resources more efficiently, government has introduced a hierarchy of health services. Patients using the public health system are now only able to access higher levels of care once they have been assessed and referred upwards by healthworkers at a lower level. The exception to this is medical emergencies.

The first point of entry for South Africans to health services is now at primary level through local clinics and community health centres. These facilities treat what health professionals call "ambulatory patients", or people who are able to walk and do not need to be confined to bed. From April 1996, services at this level were free of charge.

A **Clinic** is defined as a facility at and from which a range of PHC services are provided, but that is normally open only 8 hours a day. Certain staff may, how ever, be required to sleep at or near the clinic so that they are available on call in case of emergency.

A **Community Health Centre** is defined as a facility that, in addition to a range of other PHC services, normally provides 24 hour maternity and accident and emergency services, and up to 30 beds w here patients can be observed for a maximum of 48 hours. There will be a procedure room but not an operating theatre, patients w ill not be given general anaesthetics, and they w ill not be admitted as inpatients in the community health centre. However, there is some confusion of roles in certain places where community health centres are very similar to district hospitals.

Primary level services are supposed to cover a comprehensive range of "preventive, promotional, curative and rehabilitation services". Both clinics and health centres are to offer services such as mother and child care, immunisation, family planning, treatment for sexually transmitted infections (STIs), minor trauma and care for those with chronic illnesses (eg diabetes, hypertension).

PHC services are run by nurses, although doctors visit many clinics regularly. If a more specialised level of care is needed, patients have to be referred to secondary level (hospitals) by clinic staff.

Government has developed an Essential Drug List which lays down what medicines each clinic needed to have. Systems for ordering and controlling stock, which had been a huge problem in the past, were improved.

To bolster the decentralisation of healthcare, over the past 11 years, over 1 300 new clinics have been built and over 250 existing clinics have been upgraded. Per capita expenditure on Primary

Health Care has improved from to R58 in 1992/93 to R183 by 2005/06, according to the Department of Health.

The Health Department's Quality Assurance Directorate developed a list of "core norms and standards for clinics" in 2000 and these are published on the DoH website (http://www.doh.gov.za/docs/policy-f.html).

These include that:

- The clinic renders comprehensive, integrated PHC services for at least 8 hours a day, five days a week;
- The clinic receives a supportive monitoring visit at least once a month to support personnel, monitor the quality of service and identify needs and priorities.
- Doctors and other specialised professionals are accessible for consultation, support and referral and provide periodic visits.
- There is an annual evaluation of the provision of the PHC services to reduce the gap between needs and service provision using a situation analysis of the community's health needs and the regular health information data collected at the clinic.
- The clinic has a mechanism for monitoring services and quality assurance and at least one annual service audit.
- Community perception of services is tested at least twice a year through patient interviews or anonymous patient questionnaires.

The "norms and standards" also stipulate that clinics need to have medicines and supplies as outlined by the essential drug list (EDL) and a mechanism for obtaining emergency supplies.

All clinics are supposed to have electricity, cold and hot water and a reliable means of communication (telephone or two-way radio), and every clinic is supposed to be able to arrange transport for an emergency within one hour.

While it is commendable that the directorate has published the norms and standards document, there are still not enough resources being allocated to PHC level to ensure that these are achieved.

A survey of PHC facilities (The Facilities Survey) published in 2004 found that almost a quarter of clinics still didn't have piped water and about about 10% did not have sanitation, electricity and telecommunications. In addition, only about 40% of facilities have trained primary health care nurses and only 30% of clinics are estimated to be visited by a doctor at least once a week. Only about half of all PHC facilities are reported to have functional clinics or community health committees, which means that communities are not being involved in their own healthcare.

One of the biggest problems of building the PHC clinics is the difficulty of attracting and retaining professional nurses (with four years' training). The burden of health service delivery has been shifted to primary level and clinics have massive patient loads, but very little has been done to make clinics attractive to qualified nurses, who are in short supply.

The Democratic Nurses Union of SA (Denosa) is particularly frustrated that government's "scarce skill allowance", which offers certain categories of nurses extra money as an incentive to retain them, did not include PHC nurses as these are the most over-burdened staff.

A survey of clinics conducted in 2003 (2003 Facilities Survey) found that almost a quarter did not provide immunisation every weekday and only half offered antenatal care. The HIV/AIDS epidemic is also taking its toll on the health system at every level. In addition, the roll-out of antiretroviral treatment for HIV positive people has increased the pressure on clinics, which have to test people for HIV and take specimens for CD4 counts and viral loads from those who test HIV positive.

In order for the new hierarchy of services to work, every level has to be functional. Given that resources are limited at PHC level and nurses are often overwhelmed, a number of patients that should have been treated effectively at primary level are transferred to hospitals.

As Sister Somana at Cecilia Makiwane Hospital in East London said in an interview: "The patient load has increased greatly since 1994. This is partly because of primary health care not taking off. The whole of the Eastern Cape is referring patients here. We often see people who should have been attended to by the clinic nurse but, because of the problems there, they end up coming here."

This precisely what government has been trying to avoid.

Some critics of the PHC system say that in practice all it has done is introduce new levels of bureaucracy, removing control of clinics from hospitals and put them in the hands of inexperienced district managers with no experience of health issues.

Hospital Services

Background

Hospitals are primarily for those who need in-patient care, although all have outpatients departments (OPD) and casualty/ emergency care. Eleven years ago, there were huge inequities in the quality of care between hospitals in formerly black areas and rural areas, and hospitals in urban areas to serve white patients. These still exist today.

In addition, much of the country's hospital stock was old and run down -- particularly in rural areas, townships and the "homelands". An audit of the hospital infrastructure in 1996 found that two thirds were not up to scratch: one third of the hospitals needed replacement and a further one third needing upgrading.

Since then, 18 new hospitals have been built and a further 190 others upgraded. There are currently 388 hospitals in the public sector in South Africa.

The hospital revitalisation programme is also focusing on improving the infrastructure, equipment, management and quality in 27 hospitals and on modernising tertiary services.

However, assessing the standard of care that hospitals provide is difficult as the DoH has never formally adopted any indicators to do so. But the National Hospital Strategy report submitted to the DoH in 1996 identified 19 priority indicators that could be used to assess and manage hospitals. These indicators include: number of inpatient admissions, length of stay of patients, bed occupancy rates, theatre use, post-operative infection rate; outpatient attendance, emergency attendance, waiting lists for outpatient attendance and staff turnover and absenteeism.

According to the White Paper on Health Services Transformation (1997, hospital management should be decentralised hospital to promote efficiency and cost-effectiveness and hospital boards will be established to increase local accountability and power.

In order to improve hospital services, most provinces have enrolled some of their hospitals in the Council for Health Services Accreditation of Southern Africa (COHSASA) process of accreditation. Cohsasa is a non-profit, independent organisation that aims to "develop and implement standards that define what is needed to provide quality service in all types of South African healthcare facilities and to accredit those that substantially comply with standards".

Public and private hospitals can apply to Cohsasa for accreditation, which means that they are assessed according to standards developed by the International Society for Quality in Health Care. These standards have been tested and modified over the past nine years in South Africa and comprise of two sections:

Health Care Organisation Management, addressing issues such as: leadership of the organisation, roles and responsibilities of staff, management of information, creation and

maintenance of a safe environment for patients, infection prevention and control, quality management and human resource management.

Patient Care (including diagnostic and pharmaceutical services), focusing on patient rights, access to care, continuum of care, patient assessment, care, planning and the delivery of care and, when appropriate, education of the patient and his or her family.

In addition, most provinces have instituted quality of care programmes, which include either internal or external reviews, and health worker awards programmes.

However, transforming the hospital services is a massive task. At the same time, the health sector is being hit hard by the impact of HIV/AIDS which some researchers estimate has meant that an extra 100 000 patients a year are now seeking treatment for AIDS-related illnesses ("A faltering pulse". FM October 21 2005.)

"Hospitals appear to have dealt with the increased pressure by raising thresholds for admission and reducing length of stay," according to Treasury's review of provincial budgets and expenditure 2001-8.

Along with the AIDS epidemic, the healthcare system is being hard hit by a shortage of skilled healthcare workers, particularly professional nurses. An estimated 42% of all health posts are vacant, with provinces such as the Eastern Cape, Mpumalanga and Limpopo bearing the brunt of the staff shortages. Without the necessary staff, it is impossible to give effect to any norms and standards.

Categories of hospitals

There are three categories of hospitals in South Africa. The most common names used to refer to these categories are District, Regional and Tertiary (provincial tertiary and national central) hospitals although government is now replacing these with the names level 1, 2 and 3 hospitals. As their names imply, they offer different levels of service.

Of the 388 public hospitals, 64% are district hospitals. Secondary and specialised hospitals making up 16% each of the total number. Together provincial and national hospitals comprise less than 4% of all hospitals in the public sector.

The Department of Health has yet to adopt a firm definition of each category or to define what services should be available at each facility or any norms and standards. Draft recommendations on these definitions and levels of care have been developed for the DoH's Quality Assurance Directorate and should be adopted in the course of 2006. The definitions outlined below are based on draft recommendations made to the DoH, and have yet to be officially endorsed by the department.

Table 1. Categories of public sector hospitals

Categories of hospital (Public Health Facilities) by province

Province	District Hospital (level 1)	Regional Hospital (level 2)	Provincial Hospital (level 3)	National Central Hospital	Specialised Hospital	Total Hospitals
EC	47	9			16	72
FS	24	5	2		3	34
GP	8	11		4	6	29
KZN	37	14	1	1	9	62
LP	37	5	2		3	47
MP	20	5	1		1	27
NC	22	1			3	26
NW	24	4			2	30
WC	28	**9**		3	21	61
SA	**247**	**63**	**6**	**8**	**64**	**388**

XXX Query: E Cape now has Nelson Mandela Hospital in Mthata, which is supposed to be a level 3 hospital.

According to a report prepared for the Department of Public Service and Administration in December 2005, "it is clear that any future strategic planning of hospitals at a national level needs to take into account the current skewed distribution. This skewing is illustrated by:

- Gauteng has more level 2 hospitals than level 1 hospitals;
- The Eastern Cape currently does not have any level 3 hospitals and has a population of 6.7 million people;
- The Northern Cape has 22 district hospitals for a population of nearly 900 000 giving a ratio of 1 hospital for every 40 000 people. The question must be posed as to whether these hospitals are properly staffed and whether they are cost-effectively run ." XXX

District Hospital (level 1)

For many South Africans, particularly those in rural areas, district hospitals are the only hospitals they will ever get admitted to. All but one (Motheo in the Free State) of the 53 health districts in the country have at least one district hospital. A district hospital is defined as a facility at which a range of outpatient and inpatient services are offered. It is open 24 hours a day, 7 days a week. The hospital would have between 30 and 200 beds, a 24-hour emergency service and an operating theatre.

This is the first level of referral and generalist staff (ordinary GPs) are be available with access to basic diagnostic and therapeutic services, such as X-rays (provided radiographers are available) and basic laboratory tests. It would have a functional operating theatre in which operations are performed regularly under general anaesthesia (although would be no specialist anaesthetist). There would be no intensive care unit.

Generalists from a range of clinical disciplines provide the services. According to the World Health Organisation's functional definition, district hospitals should provide diagnostic, treatment, care, counselling and rehabilitation services. It should cover the following clinical disciplines at generalist level: Family Medicine and Primary health care, Medicine, Obstetrics, Psychiatry, Rehabilitation, Surgery, Paediatrics and Geriatrics.

The list is not fixed, as services should be shaped by the needs of the catchment population being served. Many factors may influence the capacity of a hospital to render the full range of services. The services listed however are minimums towards which each hospital and it's staff should strive.

Norms and standards

These norms and standards were developed by the Department of Health in 2001 and are in the process of being refined. However, the original list is extensive and worth summarising.

General services

- The hospital renders comprehensive services 24 hours a day, seven days a week.
- Access to emergency care, as measured by the proportion of people transferred from clinic to hospital in less than 1 hour, is improved.
- The hospital receives visits at least once a month from senior managers to support personnel, monitor the quality of service and identify needs and priorities.
- The hospital has a mechanism for monitoring services and quality assurance and at least one annual service audit in each discipline.
- Community perception of services is tested at least once a year through patient interviews or anonymous patient questionnaires.

Emergency services

- A 24 hour emergency and resuscitation service
- Treatment of common injuries and emergencies

- Treatment and reporting of child abuse
- Referral of patients to Regional Hospital, as appropriate
- Arrangements to deal with disaster situations.

Operating Theatre

- Each district hospital has an operating theatre, with an uninterrupted power supply back-up, which is functional 100% of the time.
- All minor elective surgical procedures are performed locally.
- Waiting times for elective surgery are monitored, with 95% of such procedures performed within 3 months of the need arising.
- No anaesthetic deaths occur during elective surgery.
- Regular review of post-operative sepsis rates takes place at least quarterly.
- Regular morbidity and mortality meetings are held to discuss any untoward events, sub optimal outcomes and deaths at least bi-monthly.

Chronic care

- Doctors review all patients with chronic illnesses, who are taking long-term medication, at least six-monthly.
- A programme of follow-up is in place to ensure quality of life for patients with chronic diseases, such that the expected frequency of follow-up hospital visits is clearly set out.
- All chronically ill patients are managed according to the established national guidelines.
- Patients with uncomplicated acute illnesses do not stay longer than 7 days in hospital.
- Hospitalised patients receive their medication on time, on more than 95% of days.
- All patients with notifiable diseases are notified through the correct channels.
- Regular morbidity and mortality review meetings involving all staff caring for medical patients are held, at least 3 monthly, as part of a quality improvement process.
- Iatrogenic occurrences (e.g. bedsores, reactions to blood transfusions, swollen drip sites) are monitored and minimised.

Mental health

- There is a team approach to mental health problems, involving medical officers, dedicated psychiatric nurses, social workers, and occupational therapists.
- There is an appropriate area for temporary seclusion of patients in a calm, quiet and human environment to assist the management of uncontrollable behaviour, with adequate monitoring.
- All patients admitted to the hospital are referred back to local clinics and followed up
- There is a regular review of all patients in the district who are on psychiatric medication at least 6-monthly.

Rehabilitation

- There is a designated room or area for rehabilitation and therapy.
- Rehabilitation services are delivered in the wards, outpatient department and community.
- Hospital services are accessible to people with disabilities and beds, bathrooms and toilets are accessible to wheelchair users.

Pharmaceutical services

- All EDL drugs are available at all times
- Comply with Good Pharmacy Practice as prescribed by the Pharmacy Council
- Manage drug and medical supplies according to defined Standard Operating Procedures.

Reproductive health

- Ultrasounds are available to monitor pregnancy
- The following procedures should be available: Caesarean section; subtotal hysterectomy; repair of the uterus in case of uterine rupture; postpartum sterilisation; termination of pregnancy, D&C; pelvic abcess drainage; laparotomy.
- Induction of labour, breech delivery, vacuum extraction, forceps delivery.
- Management of obstetric emergencies such as eclampsia and multiple pregnancy.

Equipment at district level should include:

- Basic equipment for examination of patients in the OPD and wards (eg blood pressure sets, ENT/ophthalmic diagnostic sets, spatula, swab sticks, stethoscopes);
- lumbar puncture kits (spinal needles, cannulae, etc).
- X-ray view boxes and ECG,
- A sharps disposal system and sterilisation system.
- Wall and mobile oxygen supply
- Uninterrupted power supply (UPS) for life support equipment
- Adequate number of toilets for patients and staff
- Available electricity, cold and warm water and telephone.

For many district hospitals, however, these are norms and standards are simply a wish list rendered impossible by lack of staff and/ or demotivated staff that are not interested in serving their patients (GPs devoting all their energies to running their own private practices on the side is a common occurrence, as is nurses refusing to take any more outpatients after a certain time during the morning despite the fact that the OPD is supposed to run all day).

However, some rural district hospitals are run by people motivated by their religious beliefs to work in difficult areas and serve the poorest of the poor. At these, it is usually impossible for women to get abortions. However, at the same time, many of these hospitals are run well with the limited resources that they have so it is a tricky issue for health authorities. Two such examples are Church of Scotland Hospital at Tugela Ferry and Mseleni near Sodwana Bay, both in KwaZulu-Natal.

Mseleni's superintendent – a GP – has been there for many years and has pioneered offering people hip replacements under local anaesthetic. This is usually a highly specialised operation done by orthopaedic surgeons. However, there is an unusually high level of arthritis in Mseleni and the superintendent learned how to do the operation himself after becoming frustrated by the long waits his patients endured at other hospitals. He has overcome the obstacle of not having an anaesthetist by doing the operation under local anaesthetic.

Regional Hospitals (level 2)

Regional hospitals are level 2 facilities that provide care requiring the intervention of specialists and general practitioners. A hospital providing a single specialist service would be classified as a specialised level 2 hospital.

A general level 2 hospital would need to provide and be staffed permanently in **at least five** of the following eight basic specialties: surgery, medicine, orthopaedics, paediatrics, obstetrics and gynaecology, psychiatry, diagnostic radiology and anaesthetics.

There are 63 regional hospitals in the country, with KZN having the most (14) and Northern Cape, the least (1). There are a further 64 specialised hospitals in the country.

No norms or standards, even draft ones, appear to have been developed for these hospitals. However, regional hospitals are often the most overburdened of all levels of hospitals, bearing the brunt of the many inadequacies in the district hospitals. A number of district hospitals in the Eastern Cape, for example, are unable to perform basic operations such as Caesarean sections because of staff shortages. These simply get referred to regional hospitals, which are only supposed to deal with more complicated health problems.

In late 2004, Dr Dan Eghan, Mthata's principal anaesthetist with 15 years' service at the hospital, said that none of the district hospitals in the former Transkei were performing Caesareans as they lacked anaesthetists. "There has been a threefold increase in my work over the past three or four years," says Eghan. Mthata General's maternity ward deals with 400 to 500 deliveries every month, and new mothers often have to share beds.

Mthata Hospital is the referral hospital for over 20 district hospitals – many of which are severely understaffed and dysfunctional. Alongside Mthata lies the R500-million Nelson Mandela Tertiary Hospital, built to relieve Mthata and to provide specialist back-up. However, it unable to function properly as it too is severely understaffed. It cannot attract the necessary specialists to the town as it lacks decent housing and schools.

Tertiary Hospitals (Level 3)

A Level 3 facility provides specialist and sub-specialist care. Within this level, there are various different groups.

Table 1. Specialties classified as Level 3 services

Group 1 Specialties	Group 2 Specialties	Group 3 Specialties
Anaesthetics	Cardiology	Hepatology
Burns	Cardiothoracic Surgery	Liver Transplant
Clinical Pharmacology	Clinical Immunology	
Critical Care & ICU	Craniofacial Surgery	
Dermatology	Endocrinology	
Diagnostic Radiology	Geriatrics	
Ear Nose & Throat	Haematology	
Gastroenterology	Human Genetics	
Infectious Diseases	Medical & Radiation Oncology	
Mental Health	Neurology	
Neonatology	Neurosurgery	
Nephrology	Nuclear Medicine	
Obstetrics & Gynaecology	Paediatric Sub-Specialties	
Ophthalmology	Renal Transplant	
Orthopaedics	Rheumatology	
Paediatric Medicine	Spinal Injuries	
Paediatric Surgery		
Paediatric ICU		
Plastic & Reconstructive Surgery		
Rehabilitation Centre		
Respiratory Medicine		
Trauma		
Urology		
Vascular Surgery		

Provincial tertiary hospitals (tertiary 1)

These hospitals receive patients from, and provide sub-specialist support to, a number of Regional Hospitals. Most of the care should be level 3 care that requires the expertise of clinicians working as sub-specialists or in rarer specialties (eg, within surgery for example, sub-specialties such as urology, neurosurgery, plastic surgery and cardiothoracic surgery).

A **general** level 3 hospital will have sub-specialty representation in **at least** 50% of the range of the Group 1 specialties listed above. A **specialised** level 3 hospital will only have one or two specialties from groups 1, 2 or 3 represented (e.g. cardiology and anaesthetics).

In the public sector, these hospitals are defined as **Tertiary 1 hospitals** (also called **Provincial Tertiary hospitals**).

National Referral Hospitals (tertiary 2)

Some Tertiary 1 hospitals will also provide a defined range (package) of other specialised services (Group 2 specialties in Table 1 above). These are classified as **Tertiary 2 hospitals** (also called **National Referral Hospitals**). The Nelson Mandela Hospital in Umtata would fall into this category.

Central Referral Hospitals (tertiary 3)

In a very small number of hospitals, currently 2, there will be an additional package of sub-specialties (Group 3 Specialties in Table 1). These will be referred to as **Tertiary 3 hospitals** (also called **Central Referral Hospitals**). Inkosi Albert Luthuli Central Hospital in Durban is one of these.

These hospitals consist of very highly specialised national referral units that together provide an environment for multi-specialty clinical services, innovation and research. The services provided will generally be of high cost and low volume, and ones that require high technology and/or multi-disciplinary teams of people with scarce skills to provide sustained care of high quality.

Specialised Hospitals

There are wide a range of possible specialties that could be focused in a hospital, including spinal injuries, maternity, heart, infectious diseases and so on. Two common specialised hospitals catering for high incidence chronic conditions that are found nationally are: **Psychiatric hospitals** that provide long term in-patient care for patients with chronic psychiatric conditions and **TB hospital,** that provide long term in-patient care for patients with chronic TB.

Alarm bells

The descriptions above sketch, for the most part, the ideal situation of what should be offered at the different levels of care, should the full complement of skilled staff be available. The reality is generally somewhat different.

There are a number of alarm bells. Below are some of the key issues that are likely to arise out of our investigation of hospitals. Some are illustrated by way of cases. Others are drawn from personal observation and from interviews conducted with health workers.

1. Poor hygiene and poor infection control

Case 1:

In 2005, 26 babies in the intensive care unit died of klebsiella, a bacteria caused by poor hygiene, at Mahatma Gandhi Hospital in Durban. The source of the bacteria was the intravenous formula fed to the babies through drips. One batch of infected IV formula was being used to feed a number of babies in an attempt to cut costs. "Inadequate handwashing practices" introduced the bacteria to the IV formula. However, no one was held responsible for these deaths – presumably because there was a chain of negligence stretching from the ward staff to the province, which had been told by the hospital that it's neonatal intensive care unit was overcrowded and understaffed.

Case 2:

The Mandela/HSRC "South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005" found that 3,3% of new HIV infections in 2005 were of children aged 5 to 9. These infections could not be linked directly to mother-to-child transmission, and the authors suggest potential sources of their infection to be "child abuse and infection through the health system" (my underlining).

The authors based their claim on a previous study, "HIV risk exposure in children aged 2-9 years served by Public Health Facilities in the Free State, South Africa", (HSRC, MRC, University of Stellenbosch, Cadre). The study found "Poor infection control practices were found in some labour and maternity areas and in dental facilities, in particular through poor cleaning techniques and traces of visible and invisible blood found in these areas and on dental instruments."

The study found that 24.6% of dental instruments ready to be used on patient's mouths and gums and 24% of instruments destined to be used for maternity and paediatric patients were contaminated with invisible blood and 17.5% had visible blood.

The Free State is considered to have a relatively strong and well functioning health service, which means that infection control in weaker provinces is likely to be even worse.

2. Abuse and neglect of patients

In February 2005, there were press reports of psychiatric patients at Townhill Psychiatric Hospital in Pietermaritzburg being abused, including raped, by staff. An official investigation that followed made a number of shocking findings, including:

- "overwhelming evidence" of neglect of patients by staff,
- evidence of physical, sexual, verbal and emotional abuse of patients by staff,
- "ample evidence" of staff stealing patient's food and belongings.

In addition, patients were sleeping on the floor. There was little recreation. Many female patients were not wearing underwear. Staff came to work drunk and there was a high level of absenteeism, especially on payday.

The facility was seriously short-staffed, with four nurses to 30 patients, and two psychiatrists to 250 patients (in Australia there is usually six psychiatrists to 26 patients and one psychiatric nurse to two patients). There was also evidence of perceptions that unions are a stumbling block in the handling of misconduct of staff.

Although there have been many reported cases of patient abuse, the example selected is that of psychiatric patients as these patients are particularly vulnerable. They are usually confined to wards where it is hard for visitors to get access to them and, because of their mental state, their complaints are often ignored. It is relatively commonplace for male psychiatric patients to be raped by other patients in their wards when they are locked up at night.

3. Indicators of poor level of care

Various indicators provide a good picture of the quality of care at hospitals. Two particularly good ones are the number of stillbirths per 1000 births at a facility and the number of Caesareans. The District Health Barometer published in December 2005 notes that in developed world hospitals, stillbirths are about 10 per 1000 (ie 1%). South Africa's average in district hospitals is 26 per 1000, based on figures for 2004. However, the Zululand, iLembe, Namakwa, Oliver Tambo health districts and eThekwini metro all reported very high stillbirth rates of over 40 per 1000. Although Barometer compilers caution that data collection is poor in many hospitals and that HIV is known to increase the stillbirth rate, some of these rates are very high and should be investigated.

4. Crowding out of patients

Research conducted by the HSRC has found that non-AIDS patients, particularly the elderly and children, are being "crowded out" of hospitals by people with AIDS related infections, who are sicker and need more care.

Waiting times for the elderly with chronic illnesses (eg diabetes, hypertension) to see doctors and to get their medication from the pharmacy at Out Patients Departments are indicators of the levels of service they face.

5. Understaffing and poor working conditions of healthworkers

The massive staff shortages mean that those who remain in the public health sector are required to do more and more work. This leads to burn-out, demoralisation and high absenteeism. A good indicator of a healthy, disciplined working environment is the absentee rate among staff.

There is often little support for health staff. Doctors doing community service often work unsupervised, while specialists do not have administrative support so end up wasting time on menial admin tasks such as photocopying.

Categories of staff particularly in short supply include virtually all specialist doctors (the Northern Cape has one psychiatrist in the entire province), ordinary doctors, professional nurses (particularly theatre nurses, PHC-trained nurses and psychiatric nurses) and pharmacists.

6. Malfunctioning equipment

This is particularly serious for equipment used in case of emergencies. Resuscitation trollies are often not properly equipped, staff members are not trained to use these and there is sometimes a shortage of oxygen.

7. Role of trade unions

National government's Interim Management Team (IMT), sent to the Eastern Cape to help restore service delivery and assist four target departments including health, found that trade unions have "undue influence over managers" and that there was a culture of ill-discipline and a poor work ethic.

This is a common complaint levelled particularly at the National Education, Health and Allied Workers Union (Nehawu), which represents lower levels of staff such as cleaners, porters and general assistants. While it is obviously unfair to condemn the entire union’s activities, there have been a number of allegations of Nehawu officials at some hospitals protecting members who have been involved in the theft of hospital supplies and medicine. It is worth bearing this allegation in mind.

8. Theft of medicine, linen and other stock

Although many hospitals have tightened up on stock control, theft is still a serious problem.

According to a report in Business Day (1 February 2006): “Two of the Eastern Cape provincial pharmaceutical depots have failed to submit proper records for the past nine years, making it easy for drugs to be "misallocated", says the Public Service Accountability Monitor’s advocacy head, Adrienne Carlisle. "Neither the provincial health department nor depot managers can account for transactions involving purchase of medicines in the province for the (past nine years).”

Conclusion

The task of rebuilding the health system is complicated and there are many different roleplayers, including all three spheres of government, professional associations, trade unions, academic institutions, hospital boards and patients.

Some circumstances are beyond the control of the health department. Almost all countries in the world are short of healthcare staff, including developed countries where the population is living longer. However, poor management at every level of the health department and a lack of proper guidelines for the different levels of government (including norms and standards for all levels of hospitals) are exacerbating problems in health facilities.

There is a massive human resources crisis, yet the department's long-awaited document on the HR crisis released late last year, does not offer any creative solutions. Employing foreign doctors from Cuba (and now Iran and Tunisia are being considered) and other countries is a short term solution. The poor working conditions and poor pay of local health workers needs to be addressed, as does the urgent need to train more health professionals.

In addition, the lack of management capacity at every level of the health sector, including the national DoH is also hampering the development of an efficient, effective health service.

The department of health's ongoing engagement with those who do not believe HIV causes AIDS is negatively affecting efforts to address the HIV/AIDS epidemic. Stigma and bogus cures are thriving in the current environment, leading to people seeking help from health facilities when they are already extremely sick and in need of a high level of care. This makes their condition much harder to treat and strains the health system further.

At the same time, South Africa is also facing an obesity "epidemic", with older white men and middle aged black women the most prone to being seriously overweight. This is causing an upsurge in chronic "lifestyle" diseases associated with poor diets high in fat, sugar and carbohydrates and a lack of exercise – such as diabetes, hypertension (high blood pressure) and heart disease.

All these issues combined are taking their toll on the health system and are creating a situation in which services in many areas – particularly those dealing with large poor urban populations (eg. Natalspruit Hospital) and those in faraway rural areas unable to attract doctors and professional nurses.

Before we start out investigation of hospitals, we need to resolve whether to:

- concentrate on the poorest performing hospitals, or try to select a reasonable cross section (although it will be hard to select a manageable representative sample that cuts provinces, types of hospitals and gives a good urban-rural mix).
- Pay anonymous visits to hospitals, followed by officially sanctioned ones

It is an exciting but very complex project!!

References

A National Health Plan for South Africa, ANC, May 1994
http://www.anc.org.za/ancdocs/policy/health.htm

The White Paper on Health Services Transformation (1997)

Norms and standards for district hospitals (in the process of being updated)
Department of Health February 2001.

HIV risk exposure in children aged 2-9 years served by Public Health Facilities in the Free State, South Africa,(HSRC, MRC, University of Stellenbosch, Cadre). (www.hsrc.ac.za)

South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005. (www.hsrc.ac.za)

District Health Barometer Year 1 (November 2005). Health Systems Trust.
http://www.hst.org.za/uploads/files/DHB_Year1.pdf

Appendix 1

Patients' Charter

A Patients Rights Charter was launched in November 1999,
which clearly outlines the rights of patients and the complaints mechanism, should patients not be satisfied with the quality of care they received.

1. Every patient has the right to:

    - a healthy and safe environment
    - access to health care
    - confidentiality and privacy
    - informed consent
    - be referred for a second opinion
    - exercise choice in health care
    - continuity of care
    - participation in decision making that affect his/her health
    - be treated by a named health care provider
    - refuse treatment and
    - knowledge of their health insurance/medical aid scheme policies
    - complain about the health service they receive.

- Services are provided with courtesy, kindness, empathy, tolerance and dignity.
- Information about a patient is confidential and is only disclosed after informed and appropriate consent.
- Informed consent for clinical procedures is based on a patient being fully informed of the state of the illness, the diagnostic procedures, the treatment and its side effects, the possible costs and how lifestyle might be affected. If a patient is unable to give informed consent the family is consulted.
- When there is a problem the health care user is informed verbally of the health rights charter with emphasis on the right to complain and the complaints procedure is explained and handed over.
- The clinic has a formal, clear, structured complaint procedure and illiterate patients and those with disabilities are assisted in laying complaints.
- All complaints or suggestions are forwarded to the appropriate authority if they cannot be dealt with in the clinic.
- A register of complaints and how they were addressed is maintained.

The name, address, telephone number of the person in charge of the clinic is displayed.

Appendix 2

Indicative list of the content of district hospital package prepared by the national PHC task team

From: **Norms and standards for district hospitals (in the process of being updated)**

The primary function of a district hospital is to provide suitable out- and in-patient care in which medical, nursing and other professional care appropriate to the patient's condition, may effectively and efficiently be provided.

This list is not considered as fixed, as services should rather depend on the needs of the catchment area being served. The proposed services are according to disciplines or 'domains' and have been built upon those services provided at the community health centre. Furthermore, it supports those services provided at the regional hospital.

SECTION	SERVICES
OUT-PATIENTS DEPARTMENT (OPD)	*Dental Services*:- * Oral Health Education * Implement preventive programme * Basic sepsis control * Caries evacuation * Placement of simple fillings *Basic Ophthalmic Services:-* * Prevention of blindness * Promotion of eye care *Basic Curative Services including:-* * Diagnosis * Treatment * Referral *Referred Medical and Surgery Patients* *Referred Psychiatric Cases* *Referred Social Work Services* *Referred Rehabilitation Services*
CASUALTY	24 hour accident and emergency services Minor operations in casualty
THEATRE/ANAESTHETIC	60 - 80% minor operations, i.e. operations taking ± 30 minutes, and 10-30% major operations, i.e. more than 60 minutes.
RADIOGRAPHY	* Chest * Abdomen * Limbs * Skull * Barium meal (swallow) * Hysterosalpingogram
LABORATORY	Antenatal RPR, HB and RH testing Coombs test Serum pregnancy test Microscopic urine testing Biological markers for occupational related diseases *Following standard tests:-* * Biochemistry * Haematology * Lung function * Microbiology
MEDICINE	Treatment to include at least the following: * Arthritis * Asthma * Cardiac failure * Depression * Diabetes * HIV/AIDS * Hypertension * Infectious diseases * Overdose * Sexually transmitted diseases * Tuberculosis (pulmonary and extra-pulmonary) * Palliative care * Obesity

SECTION	SERVICES
	* Poisoning * Basic eye care * Foot care (podiatrics) * Services for conditions of older persons, e.g. osteoporosis, elderly abuse * Trauma
OBSTETRICS	* External cephalic version * Antenatal ultrasound * Vacuum extraction * Forceps delivery * Oxytocin augmentation * Caesarean section * Removal of retained placenta * Emergency blood transfusion facilities * Planned delivery of baby 1.5 kg - 2.5 kg * Planned breech delivery * Vaginal delivery after previous Caesarean section * Intrapartum cardiotography * Emergency hysterectomy secondary to uterine rupture
PAEDIATRICS	* HIV/AIDS * Asthma * Child Abuse * Gastroenteritis * Malnutrition * Meningitis * Neonatal jaundice * Pneumonia * Premature babies > 1200g * Rheumatic fever * Fever * Anaemia * Infectious diseases * Congenital/genetic conditions
PSYCHIATRY	* Depression * Para- or threatened suicide * Acute psychosis * Acute anxiety or panic attacks * Post-traumatic stress
SURGERY	* Cardiothoracic management of pneumo/haemothorax *ENT* * Quinsy * Tonsillectomies and Adenoidectomies * Tracheostomies *NEUROSURGERY* * Scalp suturing * Indentification of injuries, concussion & intracranial pathology *EYE* * Removal of cataracts * Enucleations * Meibomian cysts and abscesses * Eye injuries

SECTION	SERVICES
	ORTHOPAEDICS * Fractures and dislocations needing plaster-of-Paris * Traction (skin & skeletal) * Tendon repair * Amputations * Aspirations/injections of joints * Plantar wart excision/cauterisation *PLASTICS* * Practical care of extensive wounds * Debridement * Medium-sized burns and skin grafts *GENERAL* * Umbilical hernia repair * Appendicectomy * Incision and drainage of abscesses *TRAUMA* * Major/multiple trauma triage * Advanced resuscitation skills *UROLOGY* * Circumcision * Vasectomy * Hydrocelectomy * Inguinal hernia repair * Suprapubic catheterisation *VASCULAR* * Conservative management of varicose ulcers * Deep vein thrombosis * Deep venous incompetence
GYNAECOLOGY	* Postpartum/laparoscopic sterilisation * Temination of pregnancy * D&C/evacuation/manual vacuum aspiration * Pelvic abcess drainage * Laparotomy for ectopic pregnancy or ovarian torsion * Vulvar biopsy/minor surgery * Endometrial biopsy * Cervical polypectomy * Colposcopy * Breast biopsy * Hysterectomy * Repair of 3rd degree tear * Postmenopausal care
OCCUPATIONAL HEALTH	* Diagnosis and treatment of occupational-related diseases * Occupational hygiene * Information and referral services
REHABILITATION SERVICES	* Provision of basic assistive devices * Rehabilitation
PREVENTIVE SERVICES	* Health Education

SECTION	SERVICES
OUT-PATIENTS DEPARTMENT (OPD)	*Dental Services*:- * Oral Health Education * Implement preventive programme * Basic sepsis control * Caries evacuation * Placement of simple fillings *Basic Ophthalmic Services:-* * Prevention of blindness * Promotion of eye care *Basic Curative Services including:-* * Diagnosis * Treatment * Referral *Referred Medical and Surgery Patients* *Referred Psychiatric Cases* *Referred Social Work Services* *Referred Rehabilitation Services*
CASUALTY	24 hour accident and emergency services Minor operations in casualty
THEATRE/ANAESTHETIC	60 - 80% minor operations, i.e. operations taking ± 30 minutes, and 10-30% major operations, i.e. more than 60 minutes.
RADIOGRAPHY	* Chest * Abdomen * Limbs * Skull * Barium meal (swallow) * Hysterosalpingogram
LABORATORY	Antenatal RPR, HB and RH testing Coombs test Serum pregnancy test Microscopic urine testing Biological markers for occupational related diseases *Following standard tests:-* * Biochemistry * Haematology * Lung function * Microbiology
MEDICINE	Treatment to include at least the following: * Arthritis * Asthma * Cardiac failure * Depression * Diabetes * HIV/AIDS * Hypertension * Infectious diseases * Overdose * Sexually transmitted diseases * Tuberculosis (pulmonary and extra-pulmonary) * Palliative care * Obesity

SECTION	SERVICES
	* Poisoning * Basic eye care * Foot care (podiatrics) * Services for conditions of older persons, e.g. osteoporosis, elderly abuse * Trauma
OBSTETRICS	* External cephalic version * Antenatal ultrasound * Vacuum extraction * Forceps delivery * Oxytocin augmentation * Caesarean section * Removal of retained placenta * Emergency blood transfusion facilities * Planned delivery of baby 1.5 kg - 2.5 kg * Planned breech delivery * Vaginal delivery after previous Caesarean section * Intrapartum cardiotography * Emergency hysterectomy secondary to uterine rupture
PAEDIATRICS	* HIV/AIDS * Asthma * Child Abuse * Gastroenteritis * Malnutrition * Meningitis * Neonatal jaundice * Pneumonia * Premature babies > 1200g * Rheumatic fever * Fever * Anaemia * Infectious diseases * Congenital/genetic conditions
PSYCHIATRY	* Depression * Para- or threatened suicide * Acute psychosis * Acute anxiety or panic attacks * Post-traumatic stress
SURGERY	* Cardiothoracic management of pneumo/haemothorax *ENT* * Quinsy * Tonsillectomies and Adenoidectomies * Tracheostomies *NEUROSURGERY* * Scalp suturing * Indentification of injuries, concussion & intracranial pathology *EYE* * Removal of cataracts * Enucleations * Meibomian cysts and abscesses * Eye injuries

SECTION	SERVICES
	ORTHOPAEDICS * Fractures and dislocations needing plaster-of-Paris * Traction (skin & skeletal) * Tendon repair * Amputations * Aspirations/injections of joints * Plantar wart excision/cauterisation *PLASTICS* * Practical care of extensive wounds * Debridement * Medium-sized burns and skin grafts *GENERAL* * Umbilical hernia repair * Appendicectomy * Incision and drainage of abscesses *TRAUMA* * Major/multiple trauma triage * Advanced resuscitation skills *UROLOGY* * Circumcision * Vasectomy * Hydrocelectomy * Inguinal hernia repair * Suprapubic catheterisation *VASCULAR* * Conservative management of varicose ulcers * Deep vein thrombosis * Deep venous incompetence
GYNAECOLOGY	* Postpartum/laparoscopic sterilisation * Temination of pregnancy * D&C/evacuation/manual vacuum aspiration * Pelvic abcess drainage * Laparotomy for ectopic pregnancy or ovarian torsion * Vulvar biopsy/minor surgery * Endometrial biopsy * Cervical polypectomy * Colposcopy * Breast biopsy * Hysterectomy * Repair of 3rd degree tear * Postmenopausal care
OCCUPATIONAL HEALTH	* Diagnosis and treatment of occupational-related diseases * Occupational hygiene * Information and referral services
REHABILITATION SERVICES	* Provision of basic assistive devices * Rehabilitation
PREVENTIVE SERVICES	* Health Education

SECTION	SERVICES
OUT-PATIENTS DEPARTMENT (OPD)	*Dental Services*:- * Oral Health Education * Implement preventive programme * Basic sepsis control * Caries evacuation * Placement of simple fillings *Basic Ophthalmic Services:-* * Prevention of blindness * Promotion of eye care *Basic Curative Services including:-* * Diagnosis * Treatment * Referral *Referred Medical and Surgery Patients* *Referred Psychiatric Cases* *Referred Social Work Services* *Referred Rehabilitation Services*
CASUALTY	24 hour accident and emergency services Minor operations in casualty
THEATRE/ANAESTHETIC	60 - 80% minor operations, i.e. operations taking ± 30 minutes, and 10-30% major operations, i.e. more than 60 minutes.
RADIOGRAPHY	* Chest * Abdomen * Limbs * Skull * Barium meal (swallow) * Hysterosalpingogram
LABORATORY	Antenatal RPR, HB and RH testing Coombs test Serum pregnancy test Microscopic urine testing Biological markers for occupational related diseases *Following standard tests:-* * Biochemistry * Haematology * Lung function * Microbiology
MEDICINE	Treatment to include at least the following: * Arthritis * Asthma * Cardiac failure * Depression * Diabetes * HIV/AIDS

SECTION	SERVICES
	* Hypertension * Infectious diseases * Overdose * Sexually transmitted diseases * Tuberculosis (pulmonary and extra-pulmonary) * Palliative care * Obesity * Poisoning * Basic eye care * Foot care (podiatrics) * Services for conditions of older persons, e.g. osteoporosis, elderly abuse * Trauma
OBSTETRICS	* External cephalic version * Antenatal ultrasound * Vacuum extraction * Forceps delivery * Oxytocin augmentation * Caesarean section * Removal of retained placenta * Emergency blood transfusion facilities * Planned delivery of baby 1.5 kg - 2.5 kg * Planned breech delivery * Vaginal delivery after previous Caesarean section * Intrapartum cardiotography * Emergency hysterectomy secondary to uterine rupture
PAEDIATRICS	* HIV/AIDS * Asthma * Child Abuse * Gastroenteritis * Malnutrition * Meningitis * Neonatal jaundice * Pneumonia * Premature babies > 1200g * Rheumatic fever * Fever * Anaemia * Infectious diseases * Congenital/genetic conditions
PSYCHIATRY	* Depression * Para- or threatened suicide * Acute psychosis * Acute anxiety or panic attacks * Post-traumatic stress

SECTION	SERVICES
SURGERY	* Cardiothoracic management of pneumo/haemothorax *ENT* * Quinsy * Tonsillectomies and Adenoidectomies * Tracheostomies *NEUROSURGERY* * Scalp suturing * Indentification of injuries, concussion & intracranial pathology *EYE* * Removal of cataracts * Enucleations * Meibomian cysts and abscesses * Eye injuries *ORTHOPAEDICS* * Fractures and dislocations needing plaster-of-Paris * Traction (skin & skeletal) * Tendon repair * Amputations * Aspirations/injections of joints * Plantar wart excision/cauterisation *PLASTICS* * Practical care of extensive wounds * Debridement * Medium-sized burns and skin grafts *GENERAL* * Umbilical hernia repair * Appendicectomy * Incision and drainage of abscesses *TRAUMA* * Major/multiple trauma triage * Advanced resuscitation skills *UROLOGY* * Circumcision * Vasectomy * Hydrocelectomy * Inguinal hernia repair * Suprapubic catheterisation *VASCULAR* * Conservative management of varicose ulcers * Deep vein thrombosis * Deep venous incompetence
GYNAECOLOGY	* Postpartum/laparoscopic sterilisation * Temination of pregnancy * D&C/evacuation/manual vacuum aspiration

SECTION	SERVICES
	* Pelvic abcess drainage * Laparotomy for ectopic pregnancy or ovarian torsion * Vulvar biopsy/minor surgery * Endometrial biopsy * Cervical polypectomy * Colposcopy * Breast biopsy * Hysterectomy * Repair of 3rd degree tear * Postmenopausal care
OCCUPATIONAL HEALTH	* Diagnosis and treatment of occupational-related diseases * Occupational hygiene * Information and referral services
REHABILITATION SERVICES	* Provision of basic assistive devices * Rehabilitation
PREVENTIVE SERVICES	* Health Education

RANGE OF PERSONNEL REQUIRED AT THE DISTRICT HOSPITAL TO PROVIDE THESE SERVICES

This list illustrates the range of personnel that would be required at a district hospital.

DISCIPLINE	PERSONNEL
Medical and Dental	*generalists (one with occupational health training) *visiting specialists
Nursing practitioners	*general professional nurses * advanced midwifes *primary health care clinicians * psychiatric nurses *theatre nurses * paediatric nurse *enrolled nurses * nursing auxillaries *hospital infection control nurses * occupational health nurse
Pharmacy	*pharmacist (who may act as district pharmacist) *pharmacist assistant
Support personnel	*drivers *security *cleaners *gardeners *maintenance *porters *food services *messengers *translators *linen/laundry services
Therapists	*occupational therapist *physiotherapist *speech and hearing therapist *rehabilitation assistants *nutrition/dietician *oral hygienist *dental therapist *dental assistants
Laboratory	* laboratory technician/technologist
Other services	*social workers *radiographers *environmental health officer *optometrists