

Justice and Equity in the Allocation of Health Resources for Mental Health in the eThekweni Health District

By
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***Dissertation submitted in fulfillment of
the requirements for the degree:***

***LLM Degree
Master of Law (Public Health)***

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DECLARATION

The Academic Registrar
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11 December 2006

Dear Sir

I Stanford Mandlenkosi Phehlukwayo (Registration Number 2 000 009 23),
hereby declare that the study entitled:

**"Justice and Equity in the Allocation of Health Resources for Mental
Health in eThekweni Health District"**

Is the result of my own investigations and has not been submitted in part or in
full for any other degree or to any other university.



S.M. Phehlukwayo

DEDICATION

To my beloved family:

For your unconditional love and support.

ACKNOWLEDGEMENTS

I gratefully acknowledge the following people for their contributions:

My supervisor Dr Robin Joubert for her wisdom and guidance in the Research Process and for believing in me.

Mrs Dain van der Reyden for her constant support and her insightfulness into my research subject.

The Programme Manager for Chronic Diseases eThekwini District, Ms Lungi Shongwe for her resourcefulness and directive in service structures.

The Sub-District Managers, Mr Shoba (North Sub-District), Mr Mudally (South Sub-District) and Mrs Grootboom (South Sub-District) for providing me with information and for allowing me to conduct this research in their their respective Sub-Districts.

My greatest thanks go to Nursing Service Managers, Sr D. Ndaba, Sr P.T. Majozi (North Sub-District), Sr T. Beaunoir, Sr N. Luthuli (South Sub-District), Sr D. Ndlovu, and PHC Manager (Acting) Mr M. Majozi (West Sub-District) for their direct participation in this research during my data gathering.

My special thanks to Mrs. F. Clarke and Mr E. James of Persal Control, Department of Health, Province of KwaZulu-Natal and Mr T.C. Chetty, Geographic Information Systems, eThekwini Municipality, for providing critical support data for this research.

I finally thank Dr Mhlongo: Office of the Superintendent-General; Mr T.E. Msiza, District Manager: eThekwini District; Dr U. Sanker: Head, Health Unit, eThekwini Municipality and Mrs L. Coetzee: Mental Health Manager, eThekwini Municipality for granting authority to conduct this research in their respective capacity.

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ABSTRACT

Aim

The aim of the study was to establish if resources for health care were distributed in a manner which reflected justice and equity for people with mental illness at primary health care (PHC) level where mental health services were integrated into general health services.

This was done by establishing if relevant South African health policy and legislation makes relevant provisions for the transformation of health care service in line with primary health care principles. Selected health care system delivery strategies were analysed to establish if these reflect justice and equity in the distribution of health resources within a particular health district. Finally, an appropriate workload criteria was used to establish how currently employed health personnel were allocated in terms of skill mix per population size within a selected health district.

Methodology

The study was conducted in eThekweni District in the Durban Metropolitan area. A combination of descriptive and analytic study designs were adopted using the Health Systems Research(HSR)¹ as the framework for the study. The descriptive component was used to set the context for the study. The analytic component was used to establish the causal link between mental health policy provisions and the current distribution of health resources. Human resource allocation was used as the indicator for mental health resource allocation.² Simple random sampling method was used to select six sampling units of Primary Health Care (PHC) areas from the sampling frame of three Sub-Districts which constituted eThekweni District; namely North, South and West Sub-Districts. Mental Health

¹ Katzenellenbogen J.M., Joubert G. & Abdool Karim S.S., 1999, *Epidemiology: A Manual for South Africa*, 1999, Oxford University Press S.A.

² Pedersen P.D. & Lilleeng S., 2000, 'Resource Distribution in Mental Health Services: Changes in Geographic Location and Use of personnel in Norwegian Mental Health Services 1979-1994'. *The Journal for Mental Health policy and Economics*. SINTEF Unimed NIS Health Services Research, Trondheim, Norway. vol. 3, pp. 45-53.

Policy and related Legislation was analysed to establish how these made provisions for resource allocations in mental health care.

The South African Workload ratios from Rispel et.al. in WHO (2003)³ were used to determine personnel allocation per level of care and per population size served. The distribution of personnel was calculated using the fulltime equivalent scale (FTE).⁴ The geographical location of health facilities was established from the District maps to determine the location of mental health personnel.

Results

At policy level, even though relevant health legislation makes specific provisions for the development, distribution and management of human resources, the literature review indicated that there are still gaps in policies for human resource production, distribution, management and health service delivery.

At implementation level research findings indicated marked understaffing across all primary health care levels. Results also showed that the total number of currently employed health personnel in most sample PHC areas fell below the norm recommended for the population size. In addition, integrated primary health care service was mainly offered by one health discipline compared to the recommended personnel skill mix of eight health disciplines. On the other hand, there was also an underlying historical over-concentration of health facilities in urban-based areas compared to rural based areas.

³ World Health Organisation, 2003d, 'Planning and Budgeting to Deliver Services for Mental Health'

Mental Health Policy and Service Guidance Package. Mental health Policy and Service Guidance Package: Planning and budgeting to deliver services for mental health. WHO, 2003

⁴ Ibid.

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Chapter One

Introduction

1.1. Background for the study

Introduction

According to the World Health Organisation report (WHO), mental illness accounts for a substantial burden of disease in all sectors of our society. Even though mental health care interventions are available, they still remain inaccessible to the majority of mental health care users who need them. Accessibility to mental health care interventions is directly influenced by effective mental health policy and legislation, appropriate mental health care approaches, mental health finance and appropriately trained mental health personnel.¹

Worldwide mental disorders account for nearly 12% of the global burden of disease. Statistical projections indicate that by 2020, mental illness will account for about 15% of disability-adjusted life-years (DALY)² lost to illness. The most affected sector of the population is that of young adults, the most productive section of the population.³ According to the Mental Health Director for the World Health Organisation, mental health disorders and disease are already the fourth leading causes of the global disease burden.⁴

The burden of mental illness is substantial, undefined and obscured because it is embedded in the folds of social and economic burdens for families, communities and countries. As a result, mental health services generally receive less priority and face acute shortages of trained personnel and appropriate health care facilities. In addition, the burden of mental illness affects different sectors of society in different ways. People living with adverse circumstances and the least resources are the worst affected and face the highest burden of vulnerability to mental illness.⁵

¹ World Health Organisation (WHO), 2003a, 'Mental Health Context' *Mental Health Policy and Service Guidance Package*.

² This is the measure used for the burden of disease to measure the potential years of life lost due to disability or death at a given age. (Katzenellenbogen et al. 1997)

³ WHO, 2003a, op. cit.

⁴ World Health Organisation (WHO), 2004, 'WHO warns against mental illness' *MedReview Report*, accessed 2 Apr 2004.

<http://www.i-medreview.subportal.com/comtex/Health/24288584.html>.

⁵ World Health Organisation (WHO), 1998, 'Health legislation at the dawn of the XXI st century'

Historical perspectives

In order to contextualize the current burden of mental illness and related injustices facing mental health care users, this section will present a brief overview of the historical trends of mental health care up to the present moment.

According to the literature review, problems in mental health care originate from *misconceptions* about mental illness, inappropriate mental *health reform policies* and related mental health care *interventions*. For example, earlier explanations of mental illness were dominated by spiritual or religious concepts. In the early 17th century, mental illness was regarded as a physical state of violence which warranted solitary confinement. During this period, people with mental illness were locked up in public jails, workhouses, poorhouses, hospitals and private asylums. During the first part of the 18th century, the dominant view of mental illness was that of incurable sub-humans which justified keeping people with mental illness in poor living conditions and the use of physical restraints. During this (18th) century, the rise in humanitarian concerns led to the introduction of a moral treatment approach.⁶

The success of a moral treatment approach led to the increase in institutions offering treatment to people with mental illness. However, the mid 20th century saw the discrediting of mental asylums on humanitarian grounds. This led to the increase in a community care movement and the de-institutionalisation⁷ of people with chronic mental illness from state hospitals.

To date many countries around the world including South Africa, have shifted from hospital-based to community-based systems of mental health care. But there is a tendency for some countries to adopt this approach without mobilizing appropriate resources and effective policy implementation strategies which

International Digest of Health Legislation. Vol. 49, No. 1, 1998 pp. 163-167.

⁶ Moral treatment, also known as moral therapy or management, was an approach to mental disorder based on humane psychosocial care and moral discipline. It emerged in the late 18th century and came to the fore for much of the 19th century, deriving partly from psychiatry or psychology and partly from religion or moral concerns. The movement is commonly seen as influencing psychiatric practice up to the present day, including specifically therapeutic communities and occupational therapy. (From Wikipedia, the free encyclopedia)

⁷ De-institutionalisation is the process of reducing the number of chronic patients in state mental hospitals, downsizing and closing some hospitals and developing alternatives in the form of community mental health services. (From WHO, 2003c)

accompany this process. According to the World Health organization⁸ de-institutionalisation is not the mere administrative discharging of patients, it is a complex process where the de-hospitalisation of mental health care users should lead to the implementation of a network of alternatives outside psychiatric institution.

Studies by Talbott (1978) and Breakey (1996) cited in WHO (2003c)⁹ indicate that de-institutionalisation has resulted in increasing numbers of readmissions of short stay patients. In some cases it has led to an increase in homelessness among mental health care users due to limited appropriate resources and support provided in the community. De-institutionalisation has also contributed to a high rate of mental disorders in the prison population. In this regard the report prepared by Riordan (2004)¹⁰ provides some insights into the interrelationship between mental illness, homelessness and crime. In this report it was argued that both homelessness and mental illness are strong predictors for involvement with the criminal justice system. In the same report, the insufficient and under-funded mental health services were cited as the contributing factor to increased criminalization of mental health care users.

As suggested in this brief background above, uncoordinated mental health policies, inappropriate intervention strategies and inappropriate development, mobilization and allocation of human and physical resources still remain the underlying cause for the continued increase of the burden of mental illness.

Although mental health care trends in South Africa have paralleled those from the rest of the world in some respects the situation in South Africa still remains distinct and unique in some specific ways. Over and above its own burden of mental illness, South Africa is still faced with the challenge of transforming a historically abnormal health care system the repercussions of which will continue to impact on the health status of the population for years to come.

For example, prior to 1994, the ideological framework for the South African health system was characterized by racial and geographic disparities, fragmentation and duplication of health services and hospi-centricism.¹¹ In this

⁸ World Health Organisation (WHO), 2003c, 'Organisation of Services for Mental Health' *Mental Health Policy and Service Guidance Package*.

⁹ Ibid.

¹⁰ Riordan T., 2004, 'Exploring the Circle: Mental illness, Homelessness and Criminal Justice in Canada' *Political and Social Affairs Division*, PRB 04-02E, Library of Parliament, accessed 11 Dec 2007.

<http://www.parl.gc.ca/information/library/PRBpubs/prb0402-e.htm>

¹¹ Department of Health (DoH), South Africa, 1999-2004, *Health Sector Strategic Framework* DoH. Pta.

framework, mental health services were vertical and inequitable with over emphasis on curative services.¹²

In 1994 the new government commenced with the health sector transformation process. In the same year the National District Health System Committee was formed with the goal to facilitate a shift away from the curative based health system to a primary health care (PHC) based approach. The district health system (DHS) was adopted as the vehicle for delivering PHC service. PHC has remained at the centre of health care transformation policy since 1994. Currently, the DHS has been formally gazetted in the National Health Act.¹³

In the past twelve years, notable progress has been made in the transformation of health care services in some areas of health care. This is evidenced by the promulgation of some of the most progressive legislative framework and health care approaches which are designed to enhance access to health care by all citizens of the country.

Other critical achievements include the building of additional health care facilities; the introduction of free health care service to disabled people, pregnant women and children under six years and the creation of some new posts at primary health care level.¹⁴ In view of the complex context in which these transformation changes have been introduced, new challenges have emerged which now face the health care providers and health care service planners.

Health reform challenges and mental health care in South Africa

In the current dispensation health planners are faced with the task of transforming health services in a country with profound institutionalized disparities. In particular, they have to allocate specific and appropriate health care resources to specific groups with diverse, unequal and changing health needs. According to Nadasen,¹⁵ despite positive developments in the implementation of a primary health care strategy in South Africa, its objectives remain unclear. Problems include lack of co-ordination in the management of resources, inadequate attention to prioritization, poor quality assurance and inequality in health care between different social, ethnic, gender and occupational groups.

¹² South African Health Review (SAHR), 1999, *Mental Health*. Chap 25, accessed 13 Sep 2003.
<http://www.hst.org.za/sahr/99/chap25.htm>.

¹³ National Health Act No. 61 of 2003, S29(1)(2).

¹⁴ DoH, 1999-2004, op. cit.

¹⁵ Nadasen S., 2000, *Public Health Law in South Africa*. Butterworth Publishers, S.A.

Nadasen’s findings concur with health sector reform risks cited in the World Health Organization (WHO)’s¹⁶ report. According to this report, health sector reform bears risks which often compromise equitable access to mental health care services for mental health care users. *See Box 1 below.*

HEALTH SECTOR REFORM RISKS FOR MENTAL HEALTH CARE USERS
<ul style="list-style-type: none">• The marginalization of mental health services• The fragmentation and exclusion of services for people with mental disorders through decentralization• Increased out-of-pocket payment that would harm the interests of people with mental disorders who may not afford to pay for services• Pooling systems such as the public and private insurance schemes or medical aid which may exclude treatment for mental disorders <p>(WHO, 2003)¹⁷</p>

Box 1. Health sector reform risks for mental health care users.

The de-institutionalisation of mental health care users in South Africa represents a clear example of gaps in health sector reform policy implementation. The process of the de-institutionalisation of mental health care users has been initiated without the necessary infrastructure, support and resources put in place in the community. As a result, mental health care users are being discharged into the care of unprepared and desperate families. According to one major weekly newspaper report,¹⁸ chronic mentally ill patients are discharged into the care of unwilling, untrained families and often non-existent community health services. The same newspaper report also revealed that hospitals are struggling to cope with swelling numbers of relapsed patients with a record 70% re-admission rate in one hospital. In the same publication, Dr Baumann, the Consultant Psychiatrist at Valkenberg Psychiatric Hospital in Cape Town stated:

"I discharge patients when I know they are going to become sick again; when I know they are potentially violent, and that their families are at risk. when I inform families of this they say 'we are afraid', and I say 'I am sorry, I cannot keep them'. I am obliged to empty beds."

¹⁶ World Health Organisation, 2003a, 'Mental Health Context' *Mental Health Policy and Service Guidance Package*.

¹⁷ World Health Organisation, 2003c, 'Organisation of Services for Mental Health' *Mental Health Policy and Service Guidance Package*.

¹⁸ *Sunday Times* (March 14, 2004 p. 5), 'State dumps the mentally ill'

Dr Baumann's statement summarises the dilemma facing health care practitioners in their struggle to balance policy implementation with the real need for equitable access to health care.

The Province of KwaZulu-Natal and eThekweni District

The Province of KwaZulu-Natal is still comprised of the structurally, functionally and geographically fragmented health care system inherited from the previous health care system.¹⁹

In this system four different health departments offered a range of selective health care service packages to different population groups who were geographically segregated according to race. For instance, the Natal Provincial Administration was responsible for hospitals, curative care and limited preventive care in its areas. The KwaZulu Department administered and offered services in all areas under its jurisdiction. The Department of National Health and Population Department offered vertical programmes such as family planning, environmental health, tuberculosis control, mental health and school health. Local Authorities rendered a limited range of preventive services in their areas.²⁰

The geographical location, human resources, physical resources, capacity and the type of services rendered by these health facilities were based on separate development principles which are totally contrary to the current health care transformation goals. In the past few years, new health policy initiatives have been introduced in an attempt to rationalize these services in line with the current transformation initiatives but to date, very limited change has taken place. The KwaZulu-Natal Mental Health Services appear to still remain inequitable with well developed community mental health services in urban areas and poor under resourced health services in rural areas.²¹ Currently the most critical human resource reform processes have been put on hold indefinitely pending decisions on how to integrate these services.²²

¹⁹ Health Systems Trust and the Department of Health, KwaZulu-Natal, 1996, 'Implications for Planning 1996.

²⁰ Ibid.

²¹ Department of Health (DoH), South Africa, 2003, *Strategic and Implementation Plan for Delivery of*

Mental Health Services in KwaZulu-Natal. Health Ezempilo, KwaZulu-Natal.

²² Hall W., Ford-Ngomane T. and Barron P., 2005, 'The Health act and the District Health System' *Health Systems Trust (HST)*. Ch. 4, pp. 44-53.

1.2. Main issues and related theoretical concepts

Main issues

Health policy and legislation was reviewed to provide the context for this study. At a global level and conceptually, the mental health policy and service guidance package documents were consulted to establish the international trends and norms for mental health care.²³ At a national level, the health sector strategic framework documents were reviewed to establish the health service delivery framework and health sector reform goals and strategies.²⁴ The relevant South African health policy and legislation was reviewed to establish if this made appropriate provisions for just and equitable distribution of resources in line with health sector reform goals.²⁵ In addition, theories of distributive justice²⁶ were explored in relation to the health care delivery strategies within the South African Health System. These documents constituted the core resources for this study.

Theoretical concepts

Health resources refer to a wide spectrum of elements which, when combined together, deliver comprehensive health care for a given population. As shown above, South Africa is still faced with the challenge of redressing unique *historical* and *geographical* disparities in health resource allocations. These challenges are compounded by complex political, cultural and socio-economic dimensions which have resulted in *primary* and *secondary* shortcomings in resource distribution in South Africa as shown in *Box 2 below*.

²³ World Health Organisation (WHO), 2003a, 'Mental Health Context' *Mental Health Policy and Service Guidance Package*.

World Health Organisation (WHO), 2003b, 'Mental Health Policy, Plans and Programmes' *Mental Health Policy and Service Guidance Package*.

World Health Organisation (WHO), 2003d, 'Planning and Budgeting to Deliver Services for Mental Health' *Mental Health Policy and Service Guidance Package*.

²⁴ Department of Health (DoH), South Africa, 1999-2004, *Health Sector Strategic Framework*. DoH. Pta.

Department of Health (DoH), South Africa, 2005-2009, Strategic priorities for the National Health System, 2004-2009, DoH, Pta.

Department of Health (DoH), South Africa, 2003, *Strategic and Implementation Plan for Delivery of Mental Health Services in KwaZulu-Natal*. Health Ezempilo, KwaZulu-Natal.

²⁵ The Constitution of the Republic of South Africa Act No. 108 of 1996.

National Health Act No. 61 of 2003.

Mental Health Care Act No. 17 of 2002.

²⁶ J.R. Williams, 2001. Allocation of Scarce Resources in the Hospital.

<http://www.ethics.co.za/art15.htm>

J.G. Rawls, Rawls mature theory of Social Justice.

CLASSIFICATION OF HEALTH RESOURCE SHORTAGES

Health resource shortages may be **primary** or **secondary**. **Primary** resource shortages emanate from and simply exist as a result of limited financial resources, limited human resources, limited growth potential of available resources, drainage of health personnel to other sectors and countries, and the rapid increase of the population without the health care system's ability to meet the growing need. **Secondary** resource shortages result from maldistribution (poor distribution), malutilization (incorrect consumption) and even the squandering of existing personnel and material resources as a result of poor management and organization of health services and facilities.

(van Rensburg et al 1992)²⁷

Box 2: Classification of health resource shortages

Justice and *equity* are interrelated ethical principles which collectively refer to fairness. The concept of *justice* is fairly broad and has many interpretations. According to Williams (2000),²⁸ justice may be categorized into reciprocal justice (between individuals), distributive justice (within and between groups), punitive justice (paying for crime committed) and restorative justice (reversal of past or present injustices). Of these, distributive justice was found to be the most suitable category for health resource allocations. Distributive justice is further divided into five main theories namely, Liberitarian, Liberal, Socialist, Liberationist and Utilitarian theories of Distributive justice.²⁹ See Table 2 page 24. In this study the Liberal, the Liberationist and the Utilitarian Theories were chosen as the key ethical theories for informing data analysis because of their relevance to the topic.

On the other hand *equity* refers to the minimization of *avoidable disparities* in health and its determinants between groups of people who have different levels of underlying social advantages.³⁰ Historically South Africa is still one of the most inequitable societies in the world. The South African health care system is

²⁷ van Rensburg H.C.J, A. Fourie A. & E. Pretorius E., 1992, *Health Care in South Africa: Structure and Dynamics*. Academica, Arcadia St, Hatfield, Pta.

²⁸ Williams J.R., 2000, 'Justice and Health Care in South Africa,' Accessed 14 September 2000.
<http://www.ethics.co.za/art13.htm>

²⁹ Ibid.

³⁰ Gomez E., 1998, 'Integrating gender and ethnicity issues in Monitoring Health Equity' *Equity Gauge: An Approach to Monitoring Equity in Health and Health care in Developing Countries*. Pan American Health Org. HST. SA, pp. 32-35.

undergoing transformation changes which are aimed at reversing disparities of the previous health care system. The success of this process will to a certain extent depend on policy transformation strategies which are underpinned by principles of *justice* and *equity*.

1.3. Rationale for the study

Ideologically, the previous *fragmented health care system* led to duplicated and inequitable health care service delivery to different sectors of the population. On the other hand, geographically the previous curative-based health care approach resulted in the high concentration of human and physical health resources in urban-based health facilities compared to rural-based health facilities which were inadequate and of poor quality. In the broader South African context, this historical maldistribution of health resources is exacerbated by current social, economic, cultural and political diversities which eventually impact on the health status of various population sectors

As indicated in the background to this study, the *burden of mental illness* will continue unabated because it is masked by other more obvious health determinants and emerging pandemics. On the other hand the current *health sector reform initiatives* and related *strategies* seem to be causing severe bottlenecking at implementation level. For example health service improvements which include the building of new clinics, the introduction of free health service and the process of de-institutionalisation of mental health care users occurred without *complimentary* staffing and appropriate *infrastructure*.³¹

In reviewing the literature it appears that there is a very slow progress in *human resource policy interventions* in line with health sector reform demands. For instance according to Chabikuli et al. (2005),³² primary health care (PHC) is still mainly nurse driven in South Africa as they constitute the bulk of workforce in clinics and community health centres. But mental health care is multifaceted and needs *multidisciplinary skill mix* which may not be offered by a single discipline.

According to the International Journal for Equity in Health, the issue of imbalance in the distribution of human resources for health eventually leads to *inequities* in health service delivery and population health outcomes.³³ The World

³¹ DoH, 1999-2004, op. cit.

³² Chabikuli N., Blaauw D., Gilson L. and Schneider H., 2005, 'Human resource policies: Health Sector Reform and the Management of PHC Services in South Africa,' *South African Health Review*.Ch. 8, pp. 104-115.

³³ Gupta N., Zurn P., Diallo K & Dal Poz M.R., 2003, 'Uses of population census data for monitoring geographical imbalance in the health workforce: snapshots from three developing

Health Organisation (WHO) report (2003b)³⁴ maintains that *human resources* play a central part in the ongoing function of a mental health service compared to other medical and health disciplines. In the study by Pedersen and Lilleeng (2000),³⁵ personnel was cited as the *dominant* economic factor in the production of psychiatric services.

According to the above background mental *health personnel* are critical in the production of mental health services, yet *understaffing* and *inappropriate* personnel mix still dominate health care service points. Currently, there appears to be no guidelines on *appropriate staff ratios* for integrated health care service delivery.

The KwaZulu-Natal Province mission statement (*see Box 3 below*) for mental health adopted in the strategic and implementation plan for delivery of mental health services in kwaZulu-Natal is spelt out as follows:

MENTAL HEALTH MISSION STATEMENT
<p>"To develop a sustainable, co-ordinated, integrated and comprehensive mental health system at all levels of care based on the Primary Health Care approach through the District Health system"</p> <p>(DoH, 2003)³⁶</p>

Box 3. KwaZulu-Natal Mental Health Mission Statement

As indicated in the background, the KwaZulu-Natal Province is faced with he insurmountable challenge of transforming a *structurally, functionally* and *geographically fragmented* health care system.³⁷ In order to accomplish the above mission there is a need for research in the area of health resource

countries'. *International Journal for Equity in Health*, Dept. of Health Services Division, WHO, Geneva, vol. 2:11 pp.1-12

³⁴ World Health Organisation (WHO), 2003b, 'Mental Health Policy, Plans and Programmes' *Mental Health Policy and Service Guidance Package*.

³⁵ Pedersen P.D. & Lilleeng S., 2000, 'Resource Distribution in Mental Health Services: Changes in Geographic Location and Use of personnel in Norwegian Mental Health Services 1979-1994'. *The Journal for Mental Health policy and Economics*. SINTEF Unimed NIS Health Services Research, Trondheim, Norway. vol. 3, pp. 45-53.

³⁶ Department of Health (DoH), South Africa, 2003, *Strategic and Implementation Plan for Delivery of Mental Health Services in KwaZulu-Natal*. Health Ezempilo, KwaZulu-Natal.

³⁷ Health Systems Trust and the Department of Health, KwaZulu-Natal, 1996, 'Implications for Planning 1996.

allocations that will contribute towards the effective mental health care transformation in this Province.

It was envisaged that this research will contribute towards the development of a more *inclusive* health policy and strategies for effective mental health transformation and contribute towards the development of more efficient methods of *distributing* health resources in a fair and equitable manner.

In this study, policy and legislation for human resource *production*, human resource *management* and *transformation*, and *health care service delivery* was reviewed to establish its impact on health sector reform goals of equity and increased access to health care at a district level. Secondly, the key *health care service delivery strategies* were analysed using theories of *distributive justice* to establish if these strategies facilitated just and equitable access to health care within a district health system. Finally, current *staff ratios* per discipline and level of care were determined to establish how staff *numbers* compared with *recommended norms* in the context of *integrated* health care at a district level. The ratios used are based on the estimated percentage of time spent by each health care staff member on mental health care service.³⁸

Human resources were chosen as the *key indicator* for health resource allocations on the *basis* of their importance in mental *health care service production* as indicated above.

³⁸ Adapted from World Health Organisation (WHO), 2003d, 'Planning and Budgeting to Deliver Services for Mental Health' *Mental Health Policy and Service Guidance Package*.

1.4. Aims and objectives of the Study

Aim of the Study

The aim of the study was to establish if resources for health care were distributed in a manner which reflected justice and equity for people with mental illness at primary health care (PHC) level where mental health services were integrated into general health services.

Objectives of the Study

- *To establish if the relevant South African health policy and legislation makes relevant provisions for the transformation of health care service in line with primary health care principles.*
- *To determine if the current selected health care system delivery strategies reflect justice and equity in the distribution of health resources within a particular health district.*
- *To establish if current health personnel are allocated equitably in terms of discipline skill mix per population size across levels of care within the district level.*

Chapter Two

Literature Review

2.1. Introduction

This section will focus on the *legislative framework* for mental health and related *health service delivery strategies* and forms part of the *analytic data* for this research. Information from this review will therefore be utilized under the discussion of the results. See Chapter Five page 48.

The South African *health legislative framework* is regarded as an area of great achievement in health sector reform. In this regard the South African Constitution³⁹ provides a comprehensive framework for health policy and legislation particularly for issues related to justice and equity in human rights and access to health care. However, a literature review indicates gaps and limited co-ordination between policy intentions and implementation at health service points.

Findings from the South African Health Review (1997)⁴⁰ indicated that severely limited personnel particularly at Primary Health Care (PHC) and middle management levels, limited personnel training, excessive workload and insufficient trainers were amongst the hindrances for the transformation of mental health services in South Africa. Almost ten years later there is very limited evidence of progress at service delivery point.⁴¹

The Department of Health's (DoH's)⁴² human resource strategy for the period 1999- 2004 focused on the mobilization, management and retention of health personnel. In the period 2005- 2009 the DoH's⁴³ strategic plan moved the focus to the filling of vacant posts and the implementation of human resource plan to strengthen human resources for health.⁴⁴ As indicated in Section 1.3 page 9, the

³⁹ Constitution of the Republic of South Africa Act No. 108 of 1996.

⁴⁰ South African Health Review (SAHR), 1997, *Mental Health*. Ch. 17 accessed 15 Sep 2003, <http://www.hst.org.za/sahr/97/chap 17.htm>.

⁴¹ Padarath A., Ntuli A. & Berthiaume L., 2003/4, 'Human Resources', *Health Systems Trust (HST)* Ch. 22, pp. 299-316.

⁴² Department of Health (DoH), South Africa, 1999-2004, *Health Sector Strategic Framework* DoH. Pta.

⁴³ Department of Health (DoH), South Africa, 2005-2009, *Strategic priorities for the National Health System, 2004-2009*, DoH, Pta.

⁴⁴ Hall W., Ford-Ngomane T. and Barron P., 2005, 'The Health act and the District Health System' *South African Health Review*. Ch. 4, pp. 44-53.

unbalanced and unco-ordinated production of health policies in South Africa seems to be causing an overload at service delivery points.

The above problem is supported by findings in the study by Hall et al. (2005).⁴⁵ This study observed that in South Africa there is still a high emphasis on hardware issues in the form of well articulated legal frameworks, structures, organograms and technical skills with very limited attention paid to complementing software issues related to implementation of these frameworks and structures. This unbalanced emphasis between policy development and practical policy implementation is a major drawback for positive policy outcomes in health sector reform.

In this chapter, policy review was conducted using three broad policy intervention categories cited by Chabikuli et.al. (2005),⁴⁶ namely, human resource production policies, human resource management and the transformation of public service policies and health care delivery policies.

In addition the key health care delivery strategies of public-private partnership (PPP) mix and the district health system (DHS) approach used within the South African health system were reviewed to establish how these influenced equitable access to health care by all sectors of the population. Theories of distributive justice were used to analyse the PPP mix health delivery strategy in South Africa.

2.2. Policy and legislation review

Human resource production policies

According to Padarath et. al.(2003/4)⁴⁷ South Africa faces a variety of health personnel related problems which include overall staff shortages in key areas of the health sector, inequitable distribution of available personnel and a significant attrition of trained personnel from the health sector and from the country. In this regard the promulgation of the National Health Act⁴⁸ remains the most significant policy development in many areas of the national health system including issues of human resource supply.

⁴⁵ Hall W., Ford-Ngomane T. and Barron P., 2005, 'The Health act and the District Health System' *Health Systems Trust (HST)*. Ch. 4, pp. 44-53.

⁴⁶ Chabikuli N., Blaauw D., Gilson L. and Schneider H., 2005, 'Human resource policies: Health Sector Reform and the Management of PHC Services in South Africa,' *South African Health Review*.

⁴⁷ Padarath A., Ntuli A. & Berthiaume L., 2003/4, 'Human Resources', *Health Systems Trust (HST)* Ch. 22, pp. 299-316.

⁴⁸ *National Health Act* No. 61 of 2003

This Act has been developed in line with the Constitution⁴⁹ to provide specific guidelines for health care delivery initiatives and strategies in producing, developing, distributing and managing human resources within the national health system.

Section 48 of the National Health Act⁵⁰ makes provisions for the provision, distribution, development, management and utilization of human resources within the national health system. In line with this provision, the National Health Council was subsequently established.⁵¹ This state organ is charged with the responsibility of establishing guidelines to ensure adequate planning, production, management and development of human resources for health.⁵²

Section 52⁵³ of this Act further makes detailed provisions which gives the Health Minister a set of specific guidelines related to regulating, monitoring and the implementing of human resource production actions as contemplated in Section 51 of the National Health Act. To this end the literature review indicates some progress in human resource production provisions in this Act.

Section 51 of this Act⁵⁴ makes provisions for human resource production within the national health system. This section states that the Health Minister in consultation with the Minister of Education may establish academic complexes consisting of one or more health establishment at all levels of the National Health System including peripheral facilities, and one or more educational institutions working together to educate and train health care personnel. In this regard, some new teaching hospitals have been built and old hospitals have been converted to teaching hospitals. For instance, Wentworth Hospital in Durban and Umtata General Hospital are being run by Departments of Family Medicine as part of the academic training.

In line with this Act, some progressive human resource production policies have been developed. According to Chabikuli et.al⁵⁵ two medium and long term human resource policies have been developed. The first policy makes provisions for the creation of mid-level medical assistant to optimize medical services offered by doctors and nurses. Section 52 of the National Health Act⁵⁶ makes

⁴⁹ *Constitution of the Republic of South Africa Act* No. 108 of 1996.

⁵⁰ National Health Act No. 61 of 2003, S48(1)

⁵¹ Ibid. S48(1) S22(1)

⁵² Ibid. S23(1)(a)(iv)

⁵³ Ibid. S52(a)(b)(c)(d)(e)(f)

⁵⁴ Ibid. S51(a) & S52(b)

⁵⁵ Chabikuli N., Blaauw D., Gilson L. and Schneider H., 2005, 'Human resource policies: Health Sector Reform and the Management of PHC Services in South Africa,' *South African Health Review*.

⁵⁶ National Health Act No. 61 of 2003

provisions for the creation of a mid-level workers category to augment the capacity for the existing medical personnel.⁵⁷ The second policy is related to the 2003 initiative by the Department of Health in South Africa to promote and standardize the existing community based cadres of community health workers (CHW's). This particular initiative will serve to augment PHC services capacity. Even though these initiatives have the potential to alleviate staff shortages at PHC level the future of these cadres remains bleak due to lack of clarity regarding career pathways and remuneration. There is also no clarity on the scope of practice for both the medical assistants and community health workers. The outstanding lack of clarity on the scope of practice, career pathing, and discrepancies in conditions for service and remuneration constitute a threat to the long term sustainability of these initiatives.

Although not fully utilized or clearly defined, the principle of joint appointment of staff between the provincial departments of health and the academic institutions has a lot of potential for health personnel retention and career pathing.⁵⁸

Statistically the picture for human resource production for mental health in South Africa is still unacceptable. A typical case scenario is that of psychiatrists in the country. Nationally, there are about 500 registered psychiatrists but due to staff attrition factors such as emigration to private sector and developed countries and preference for working in urban areas, there are areas in the country where the psychiatrist to patient ratio stands at over 5 million.⁵⁹ In the Province of KwaZulu-Natal, there are currently 13 full time psychiatrists who are employed by the Department of Health in the province making it 1 psychiatrist for every 700 000 population members, which is 200 000 above the 1: 500 000 norm.⁶⁰

Human resource management and the transformation of public service policies

The Department of Health's (DoH)⁶¹ human resource strategy for the period 1999- 2004 focused on the mobilization, management and retention of health personnel.⁶² Literature review indicates that there are still many impediments to

⁵⁷ Ibid. S51(c)

⁵⁸ Couper I., de Viliers M. & Sondzaba N., 2005, 'Human Resources: District Hospitals, *Health Systems Trust*, Ch. 9, pp. 118-133.

⁵⁹ World Health Organisation (WHO), 2003c, 'Organisation of Services for Mental Health' *Mental Health Policy and Service Guidance Package*.

⁶⁰ Department of Health (DoH), South Africa, 2003, *Strategic and Implementation Plan for Delivery of Mental Health Services in KwaZulu-Natal*. Health Ezempilo, KwaZulu-Natal.

⁶¹ Department of Health (DoH), South Africa, 1999-2004, *Health Sector Strategic Framework* DoH. Pta.

⁶² Hall W., Ford-Ngomane T. and Barron P., 2005, 'The Health act and the District Health System' *South African Health Review*. Ch. 4, pp. 44-53.

equitable transformation of mental health service at policy and implementation levels.⁶³ The National Health Act makes key provisions for the regulation of human resources for health.⁶⁴

In line with these provisions, section 52⁶⁵ of this Act makes provisions for the recruitment of foreign health personnel to work in under resourced areas. To date several programmes have been implemented in line with section 52 of this Act but there has been very limited impact on the ground. One of the examples of such programmes is the recruitment of Cuban doctors. But this initiative has currently been substituted with the Cuba-SA agreement which was signed in 1997. This agreement has produced 57 graduates who are still being acclimatized to the South African environment. In the meantime the withdrawal of Cuban doctors has created a vacuum which has resulted in a serious shortage of doctors in district hospitals. In another development a group of Iranian doctors were due to be recruited to work in district hospitals by 2004.⁶⁶ From this account there is no clear indication of the exact short, medium and long term plan on how the government will optimize the recruitment of foreign health personnel to address staff shortages in under-served areas. Even though the country is also experiencing the shortages of other categories of health personnel, there appears to be no evidence of initiatives to recruit these health professionals internationally.

Section 52⁶⁷ of this Act makes further provisions for the Minister of Health to prescribe strategies for the retention of health personnel within the national health system. In line with this provision, two key strategies were implemented. The first one was the introduction of compulsory community service for health personnel between 1998 and 2003 with the aim of improving provision of health services to all citizens of the country. This initiative was soon followed by the introduction of the rural and scarce skills allowance in 2004 to attract and retain health personnel.⁶⁸ Although these initiatives reflect serious commitment by the Health Ministry to address the retention of staff particularly in under-resourced areas, there is still a long way to go in addressing the backlog in infrastructure development and the parity in basic conditions of service. These basic issues are at the core of the problem of health personnel attrition in under-resourced and underserved areas.

⁶³ Hall W., Ford-Ngomane T. and Barron P., 2005, 'The Health act and the District Health System' *South African Health Review*. Ch. 4, pp. 44-53.

⁶⁴ National Health Act No. 61 of 2003

⁶⁵ Ibid. S52(d)(i) & S52(h)(i)

⁶⁶ Couper I., de Villiers M. and Sondzaba N., 2005, 'Human resources:district hospitals', *Health Systems Trust (HST)*, Ch. 9, pp. 118-124.

⁶⁷ National Health Act S52(e)

⁶⁸ Padarath A., Ntuli A. & Berthiaume L., 2003/4, 'Human Resources', *Health Systems Trust (HST)* Ch. 22, pp. 299-316.

Health care service delivery

The Strategic Priorities for the National Health System: 2005-2009⁶⁹ focuses on the removal of human resource obstacles to service delivery. In this initiative the Department of Health is focusing on the filling of vacant posts and the implementation of human resource plan to strengthen human resources for health.⁷⁰ In spite of such an initiative staffing problems still exist and this continues to impact on the quality of service at service delivery point.

For instance, research findings by Chabikuli et al. (2005)⁷¹ indicate that primary health care (PHC) service is still mainly nurse driven in South Africa. Further review of literature also indicates that understaffing and inappropriate personnel mix still dominate health care service delivery. Staff shortages and failure to appoint appropriately qualified staff results in staff burn out and poor quality of care.

Findings from the South African Health Review (1999) indicate that public sector services are still limited in reaching the most vulnerable sectors of the population. Impediments to the transformation of mental health service include the lack of clear definitions and goals regarding the nature of a transformed health service. The delay in forging new provincial structures, numerous practical implementation problems, feelings of resentment and burnout of the staff, insufficient training of staff, poor fiscal management systems and inadequate funding for mental health constitute impediments to equitable transformation of mental health service.⁷² Almost eight years later, these issues are far from resolved and this is stifling key areas of health sector transformation process which include the devolution of health personnel to underserved areas.

The Constitution of the Republic of South Africa guarantees specific rights of access to health care and provides clear guidelines on measures to be taken by the state to ensure realisation of this right.⁷³ The Mental Health Act makes provisions for mental health services to be available, accessible and integrated

⁶⁹ Department of Health (DoH), South Africa, 2005-2009, Strategic priorities for the National Health System, 2004-2009, DoH, Pta.

⁷⁰ Hall W., Ford-Ngomane T. and Barron P., 2005, 'The Health act and the District Health System' *South African Health Review*. Ch. 4, pp. 44-53.

⁷¹ Chabikuli N., Blaauw D., Gilson L. and Schneider H., 2005, 'Human resource policies: Health Sector Reform and the Management of PHC Services in South Africa,' *South African Health Review*. Ch. 8, pp. 104-115.

⁷² South African Health Review (SAHR), 1999, *Mental Health*. Chap 25 accessed 13 Sep 2003. <http://www.hst.org.za/sahr/99/chap25.htm>.

⁷³ Constitution of the Republic of South Africa. Act 108 of 1996 S27(1)(a) & S27(2).

into the general health services environment as contemplated in section 27 of the Constitution.⁷⁴

Some examples of the implementation of the provisions of this Constitution include the introduction of free health care for pregnant women and children under six years as well as the introduction of free primary health care for people not on medical aid schemes.⁷⁵ On the other hand, as indicated above, this has resulted in work overload due to poor human resource production and retention strategies. Research findings by Chabikuli et al. (2005) indicate that even though the South African human resource production remains relatively higher than that of many developing countries the number of primary health care nurses who are emigrating to developed countries has risen in recent years.⁷⁶

The Patients' Rights Charter has been proclaimed by the Department of Health as a *common standard* tool to realise individual's right of access to health services in South Africa. The Charter makes specific provisions in line with the Constitution⁷⁷ for access to health care by individuals with special needs including *newborn infants, children, pregnant women, the aged, disabled persons, patients in pain, person living with HIV or AIDS patients*. But, as outlined in the literature review above, some provisions in the legislative framework seem to be still compromised by staff shortages and skill mix at primary health care level.

In addition the Charter further asserts individual's rights to continuity of care by specifying that no one shall be abandoned by a health care professional or a health facility. But on the hand, as indicated in Chapter One pages 4-5 (*Health reform challenges in health care in SA*), in the process of the de-institutionalisation of people with mental illness, mental health care users are discharged into the care of unprepared families and limited support structures at a community level. This de-institutionalisation which is mostly done in a bid to empty hospital beds is tantamount to a violation of mental health care users' right to *continuity of care* as specified in the Charter.

Some progress however has been made in the development of service delivery policies. In this regard, the National Health Act, the Strategic Priorities for the National Health System:2005-2009 and the Comprehensive HIV and AIDS

⁷⁴ Mental Health Care Act No.17 of 2002, S3(a)(i)(ii)(iii)

⁷⁵ Ntuli A. and Day C., 2003/4, 'Ten years on- Have we got what we ordered?', *Health Systems Trust*, Ch. 1, pp. 1-10.

⁷⁶ Chabikuli N., Blaauw D., Gilson L. and Schneider H., 2005, 'Human resource policies: Health Sector Reform and the Management of PHC Services in South Africa,' *South African Health Review*.Ch. 8, pp. 104-115.

⁷⁷ Constitution of the Republic of South Africa op. cit.

package constitute three key policy documents under health care delivery policies. The long overdue National Health Act makes key provisions for the development, provision and distribution of human resources.

The National Health Act⁷⁸ gives guidelines for the collaboration between public health and private health establishments. Section 45(1) gives power to the Minister of Health to prescribe mechanisms that will facilitate a co-ordinated relationship for the delivery of health services between the two establishments.

Section 45(2) gives authority to both the provincial and local government to enter into an agreement with any *private practitioner, private health establishment or non-governmental organization* in order to achieve any objective of this Act. In line with these provisions health services can be delivered through the proposed ⁷⁹ *public/ private partnership (PPP)* mixes which are utilized to deliver health services in South Africa.

In addition, Section 29(1) of the National Health Act makes provisions for the *establishment of the district health system (DHS)*.⁸⁰ Section 30(1) gives guidelines for the division of the health district into sub-districts by the relevant member of the Executive Council as contemplated in section 26(2)(a) of this Act.⁸¹ To this effect the eThekweni District has been configured into three sub-districts with a total of eighteen primary health care (PHC) areas. *See figure 4 page 42.*

2.3. Health care service delivery strategies review and theories of distributive justice.

The public/ private partnership (PPP) mix and the district health system (DHS) were selected as the core strategies for health service delivery. In this section the PPP mix and DHS strategies will be analysed with reference to theories of distributive justice.

⁷⁸ National Health Act No. 61 of 2003, S45(1)(2)

⁷⁹ Department of Health (DoH), South Africa, 1999, 'Public/ Private Partnership in the Health Sector'. *Draft Policy Framework for Distribution to the National Health Consultative Forum*. Nat. Dept. of Health, S.A.

⁸⁰ National Health Act S29(1)

⁸¹ National Health Act S30(1)(a)(b)(c)

The Public/ private partnership (PPP) mix strategy analysis

Currently the country's health services are delivered through four types of proposed ⁸² partnership mixes namely, *purchased services, outsourcing, joint venture and private finance initiatives*.⁸³ See Table 1 below. In the context of complex diversities in South Africa the public/ private partnership (PPP) initiative is potentially a cost effective strategy for resource distribution, but it is not without its challenges. According to the Draft Policy Framework Document⁸⁴ proposals, South Africa is still a long way from coming up with a real solution that will practically facilitate effective access to health care through the PPP strategy.

PARTNERSHIP CATEGORY	DESCRIPTION
Purchased services	Special services are purchased from a doctor or specialist to meet short term needs.
Outsourcing	An independent organization is contracted to assume full operating responsibility for a specific function
Joint venture	Goods and services are exchanged on a formal agreement
Private finance initiative	a private entity funds the acquisition of a major asset such as the building of equipment for public sector or shared use

Table 1: The public/ private partnership mix.

The purchased services partnership mix can serve to improve *access* to health service and *quality* of health care through services offered by specialists from the private sector. Purchased service partnership mix offer the flexibility of buying specialized services to alleviate the immediate effect of the past and current inequities in health care and the phasing out of this partnership when the longer term effects of health sector reform process set in. In this way the *continuity of care* and *access* to health care service as contemplated in the *Patients' Right Charter* can be achieved. The purchased service partnership mix still remains problematic in South Africa due to the high cost of specialist services with limited health resources in the country.

⁸² Department of Health (DoH), South Africa, 1999, 'Public/ Private Partnership in the Health Sector'. *Draft Policy Framework for Distribution to the National Health Consultative Forum*. Nat. Dept. of Health, S.A.

⁸³ Ibid.

⁸⁴ Ibid.

The outsourcing partnership mix when well monitored, can serve as a cost saver while also offering improved *efficiency*, *quality* and *access* to health care services. In this partnership mix existing public sector resources can be freed up and utilized elsewhere, thus enhancing *access* to health care service with the added benefit of often good *quality* and *efficient* service offered by the private organizations. On the other hand the risk in this partnership mix lies in the state relinquishing its constitutional responsibility and its ability to directly render health care service to its citizens. Without adequate quality control mechanism in place this partnership can be ineffective since independent contractors often tend to *cut costs* and offer inferior service because they are profit driven.

The joint venture mix can contribute towards the generation of resources for the public sector. In this mix health resources in *short supply* in the public sector such as health personnel are *augmented* at a reduced overall cost. This (joint venture) mix provides favourable conditions for health resource distribution control. For instance under this partnership mix, the *Certificate of need* process may be easily implemented to *control the oversupply* of health services and to encourage the *optimum* utilization of *existing* services. However, the poor control mechanisms in this partnership mix are resulting in the private sector dumping patients who cannot afford their fees in state hospitals. This situation is resulting to *inequitable access* to health resources.

The private finance initiative partnership mix presents a combination of challenges. When carefully applied, this mix can be utilized to upgrade health facilities and to improve the *quality* of health care with cost risks transferred to private sector. However, with poor planning the public sector may inherit unaffordable long term maintenance costs which can *compromise the quality* of health care.

The district health system (DHS) strategy analysis.

A district health system (DHS) is designed to deliver health care service through specific *key principles* which are based on the Declaration of Alma Ata and the Global Strategy for Health for All. *See Box 4 below.*

PRINCIPLES OF A DISTRICT HEALTH SYSTEM
<ul style="list-style-type: none">• Equity• Access to services• Quality• Overcoming fragmentation• Comprehensive services• Effectiveness• Efficiency• Local accountability• Community participation• Developmental and intersectoral approach• Sustainability <p>(National Health Act No. 61 of 2003)⁸⁵</p>

Box 4. Principles of a district health system

Conceptually, a district health system is a *self contained* entity with its *own complement* of health facilities and resources for serving a *specific population type* and a specific population size. *See box 5 below.* These elements of a district are critical in overcoming fragmentation and for rendering sustainable and comprehensive health services as contemplated in the DHS principles.

DEFINITION OF A DISTRICT HEALTH SYSTEM
<p>"This is a more or less self-contained segment of the National Health System, comprised of a well defined population, living within a clearly delineated administrative and geographical area. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private or traditional."</p> <p>Department of Health (1996)⁸⁶</p>

Box 5. Definition of a district health system.

⁸⁵ National Health Act op. cit. S29(1) & S30(2)(a)-(k).

⁸⁶ Department of Health (DoH), 1996. A Policy for the Development of a District Health System for South Africa

As a strategy for health service delivery the DHS is also influenced by the PPP mixes. In this regard *purchased services* and *outsourcing* partnership mixes can be utilized to achieve *equity* in health care, *access* to health services and to improve *quality* of health care at a primary health care (PHC) level. The *outsourcing* partnership mix can also enhance the *efficiency* and *effectiveness* of health care service delivery. The joint venture partnership mix on the other hand can provide suitable conditions for *comprehensive* health services as outlined in the DHS principles.

The *overlapping* Local Authority boundaries and the *high mobility* of the South African population due to historical resource disparities, pose a complex challenge for the eThekweni District in meeting all the elements of a typical district health system (DHS). However a lot of progress has been made in eThekweni District in configuring a working structure for this District. *See figure 4 page 42.*

Theories of distributive justice and the health service delivery strategies.

The combined public-private-partnership (PPP) mixes and the district health system (DHS) health service delivery strategies may be conceptualized as being underpinned by three ethical theories of distributive justice⁸⁷ namely, the *Liberal, Liberationist and Utilitarian Theories*. *See Table 2 below.* These theories provide the guiding principles which can be used in health resource distribution.

ETHICAL THEORY	DESCRIPTION
Liberal Theory	Resources should be distributed in a way that benefits the least advantaged, within limits set by equal political rights, equal opportunity and savings for future generations.
Liberationist Theory	Resources should be distributed so as to remedy current unjust distribution or to liberate from oppression.
Utilitarian Theory	The Utilitarian theory proposes that resources be distributed according to the principle of maximum benefit for the majority.

Table 2: Theories of distributive justice.

⁸⁷ Williams J.R., 2000, 'Justice and Health Care in South Africa,' Accessed 14 September 2000. <http://www.ethics.co.za/art13.htm>

The Province of KwaZulu-Natal in South Africa has one of the most difficult tasks of uniting the *structurally, functionally and geographically fragmented* health care system inherited from the previous health care system. These areas originally fell under three different departments namely, the former Natal Provincial Administration, Department of National Health and Population Development and the KwaZulu Administration.⁸⁸ Services in these areas were mostly *fragmented, inappropriate and inequitable* across the population groups.

In this Province more than 80% of the population is not on medical aid and therefore relies on the public Health service for health care. Although 53% of the population in this province resides in urban and peri-urban areas, the rest of the communities reside in deep rural and rural settlements.⁸⁹ These community settlements are *sparse* and are situated in *mountainous* topography with deep valleys which makes *accessibility* to health care facilities difficult. *Accessibility* challenges are compounded by *cross-border flows of migrants* from neighbouring countries which hampers adequate service provision in the districts.

Ethekwini District is currently comprised of three sub-districts which serve areas with a varying mixture of provincially controlled, local government controlled, state aided and private health facilities. Historically these authorities were resourced according to apartheid principles which were designed to allocate resources inequitably according to race and class

The Liberal Theory is founded on principles which are in line with the Constitution of the country. This Theory advocates for *equitable access* to health care whilst also recognizing the limitation of *individual rights* as contemplated in the Constitution. The Liberationist approach therefore remains crucial in dealing with the past and current *unjust distribution* of health resources.

The Utilitarian Theory provides the overarching principles across the PPP mix and DHS health service delivery strategies. The Utilitarian Theory principles underpin the primary health care (PHC) approach which is central to health care transformation policy since 1994 (*see historical perspectives pages 2- 4*). In the context of South Africa the principle of *maximum benefit for the majority* is critical in mobilizing health resources in a shift from a *curative* based approach to *primary health care* (PHC) based approach.

⁸⁸ Health Systems Trust and the Department of Health, KwaZulu-Natal, 1996, 'Implications for Planning 1996.

⁸⁹ Ibid.

Chapter Three

Methodology

3.1. Research design

In order to fulfill the aim of this study a combination of descriptive and analytic study designs were used. The systems theory concepts in health systems research (HSR) approach by Katzenellenbogen et. al ⁹⁰ was used as the main theoretical framework for the study. Systems theory is defined as a general science of organization and wholeness.⁹¹ According to the systems theory, no entity of any description can be fully understood unless we take into account the whole system. Since this research is based on the delivery of mental health service through a health care system, the health system approach was considered the most appropriate approach for this study.

According to Katzenellenbogen (1999) Health systems research (HSR) is that research done on the health system and all its component parts and activities. HSR is compatible with systems theory because it (HSR) is based on systems theory concepts of input, processes and outcomes. A health care system is conceptualized as a collection of people, things and events that function together towards a specific goal to provide treatment for illness, to prevent illness and to promote health. People include clinical and support personnel, communities, patients and families; things include buildings, vehicles, equipment, materials, drugs, schedules, policies and budgets; and events refer to consultations, procedures, evaluations, meetings. In this research issues related to personnel and facilities outlined above were investigated.

In the HSR, health care is conceptualized as a process with five distinct stages of health care delivery; namely, *policy development, inputs, processes, outputs* and *outcomes* (see Figure 1 below).⁹²

⁹⁰ Katzenellenbogen J.M., Joubert G. & Abdool Karim S.S., 1999, *Epidemiology: A Manual for South Africa*, 1999, Oxford Univ. Press, S.A. Ch. 15 p. 147- 151.

⁹¹ Higgs P. & Smith J. (2002). 'Systems Theory Truth as a Whole' *Rethinking Truth*. Juta Publishers, Landsdowne. Ch.3 p.33-46.

⁹² Katzenellenbogen et al. op. cit.

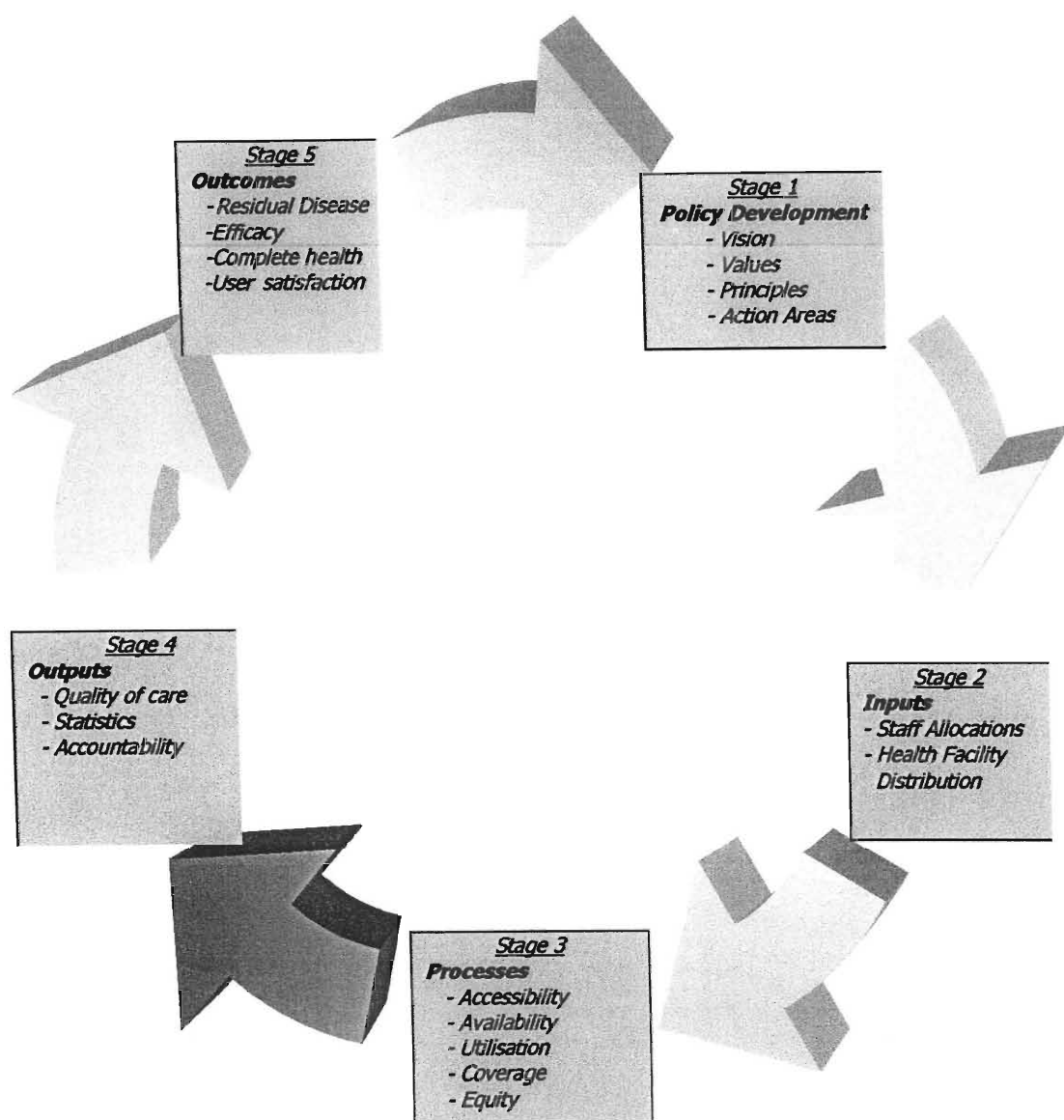


Figure 1. Stages of health care delivery
Adapted from Katzenellenbogen et al. (1999)

The first stage of health care delivery is *policy development*. A Policy is a reflection of the government's vision of health care delivery, stated as goals and plans of action to deliver health care.⁹³ In order to establish the context for this study, relevant policy documents at international, national, provincial and local levels, together with key legislation on mental health were reviewed. In addition human resource production policies, human resource management and the transformation of public service policies and health care delivery policies were reviewed to establish how these impacted on health service delivery. See *Chapter Two page 13*.

⁹³ Katzenellenbogen et al. op. cit.

The second stage of health care delivery is *inputs*. Inputs are comprised of people and things which are utilized to deliver mental health care. People include clinical and support personnel, communities, families and patients. Things include buildings, vehicles, equipment, materials, drugs, schedules, policies and budgets. In this study data was collected on the number and location of health facilities per level of care as well as the number and specific combination of various mental health care personnel allocated to these facilities. In addition, data was collected on the size of the population served by the sub-districts in the sampling units. The third stage namely, *processes* refers to complex interactions which take place in service delivery. In this study ethical principles of distributive justice were used to analyse selected health service delivery strategies within the South African health care system to establish how the strategies influenced equitable access to health care service by all. The fourth stage of *outputs* refers to units of care produced in the interactions between health care processes and inputs. The fifth stage namely, *outcomes* refers to the final states of people or groups or communities that results from the interactions with the health system. The final two stages were used to contextualize the initial research question as well as conclusions from this research.⁹⁴

3.2. Sampling procedure

3.2.1. Study site location

The study was conducted in eThekweni District which is located within the Durban Metropolitan area. EThekweni District constituted a *sample frame* of three (3) sub-districts namely North, South and West sub-districts. Each sub-district is further divided into primary health care (PHC) areas. *See Figure 4 page 42.* EThekweni District provides comprehensive primary health care service through a district health system approach as outlined in *Section 2.3 pages 23-25.*

EThekweni District was chosen for the following reasons:

- *This District covers a catchment area which has a combination of urban, semi-urban and rural population that will provide a geographically representative sample for the study.*
- *eThekweni District health services are provided by a combination of health facilities which are controlled by the Province, Local Authority and Private Sectors. Such a combination will provide insights to the Public/ Private Partnership (PPP) mix and dynamics on access to health care services*

⁹⁴ Katzenellenbogen et al. op. cit.

- *The District has a combination of previously advantaged Local Authority, State Aided and privately run health facilities as well as previously disadvantaged and Province controlled health facilities. This combination will provide a realistic scenario for establishing the extent to which transformation of health services has progressed from previous disparities.*
- *The District is easily accessible to the researcher and therefore it would be cost effective to do research in this District.*
- *The district health system has been implemented in the District*

3.2.2. Sample Selection

In order to capture the essence of the eThekweni District characteristics outlined above, the non-random purposive sampling method was used. Purposive sampling was used to select primary health care (PHC) areas that would allow comparative analysis of resource allocations under the following *dimensions*:

- *Urban, semi-urban and rural based health facilities,*
- *Province, Local Government, State-Aided or Private health care facilities, or*
- *Previously advantaged and previously disadvantaged health care facilities.*

Primary health care (PHC) areas which constitute service point *clusters* (see *Figure 4 page 42*) for each sub-district (North, South & West) were selected as the sampling units for this study. Each PHC area is comprised of a combination of *service points* which range from a *hospital, community health centre* (CHC), a *clinic* to a *mobile* unit. The sampling units were selected based on their *geographical location* and *control structures* as indicated in the above *dimensions*.

EThekweni District *maps* were used to determine the physical *location* of the sampling units. Sampling unit information on *control structures* (Province, Local Government and State-Aided or Private), was obtained from the *site information* schedules supplied by the District office.

A total of 6 PHC areas out of 18 PHC areas were selected for the study. During the sample selection process using the *above dimensions* as the selection *criteria*, PHC areas N1, N2, S3, S4, W1 and W4 were found to be having the best combination of dimensions needed to fulfill the objectives of the study. *See Table 3 below.* The sampling units constituted 30% of the sampling frame.

According to Seaberg (1988) & Grinnel and Williams (1990) in de Vos et. al (2002)⁹⁵, in most cases a 10% sample is sufficient for controlling *sampling errors*. For this reason, 30% was regarded as the sufficient sample *size* for this study.

PHC AREA	GEOGRAPHICAL LOCATION COMBINATION			MAIN CONTROL STRUCTURE COMBINATION		
	RURAL	PERI-URBAN ⁹⁶	URBAN	PROVINCE	LOCAL GOVT	PRIVATE/ STATE AIDED
N2		X		X	X	X
N4	X	X				
S3		X	X	X	X	X
S4		X	X			
W1	X		X	X	X	X
W4		X	X			

Table 3. The geographical location and control structure for sample units

3.2.3. Participants

The following participants were invited to participate in the research by virtue of their position of being in charge of the facilities and structures included in the study:

- *The Programme Manager for Chronic Diseases in the Districts*
- *All three sub-district Managers in charge of the North, South and West sub-district*
- *Six Nursing Service Managers in charge of the primary health care areas within the sub-districts*
- *Personnel Control, Department of Health, Province of KwaZulu-Natal*
- *Informatics (Personnel), eThekwini District Office*
- *Informatics (Sub-District Maps), Ethekwini Municipality*

⁹⁵ De Vos et.al, 2002, 'Research at Grass Roots', Ch. 13 p. 197-209, Van Schaik Publishers 1064 Arcadia Street, Hatfield, Pta.

⁹⁶ Areas in transition with a combination of rural and urban elements

3.3. Data gathering instruments

3.3.1. Instrument Design

A set of two questionnaires namely, the *Sub-District Questionnaire* and the *Health Facility Questionnaire*, were used to collect data for this research. These questionnaires were designed using the information obtained from the Programme Manager and relevant sources on questionnaire design. *See Section 3.4.1. below.*

The Sub-District Questionnaire covered information on the description of the sub-district, demographic data of the sub-district and the distribution and organisation of health facilities in the sub-district. *See Annexure 14 page 87.* The Health Facility Questionnaire was designed to cover information on health personnel allocation and occupational mix per level of care and population size. *See Annexure 15 page 89.*

3.4. Research procedure

3.4.1. Phase 1: Consultation

Consultation

In developing a sound conceptual framework for this study, the researcher consulted appropriately with experts in policy analysis and research methods, by utilizing available University resources and the expertise of the allocated supervisor.

In order to establish a realistic picture of what is going on in the sample frame, the researcher undertook to hold a preliminary meeting with relevant stakeholders in mental health service. Following a written request for preliminary consultation with the eThekweni District Manager (*see Annexure 3 page 69*), the Programme Manager for Chronic Disease (hereafter the Manager) was appointed by the District Manager to work with the researcher (*see Annexure 4 page 70*).

A preliminary consultation meeting with the Manager was held on the 18th of February 2005. During this meeting the researcher presented the outline of the study to the Manager. The Manager provided information and directive in specific areas related to the research topic. This meeting served to provide the researcher with an overview of how eThekweni District functioned and contributed towards the development of the sub-district questionnaire which was used to collect data on the sub-districts as outlined in section 3.3.1. above.




3.4.2. Phase 2: Implementation

i. Data gathering: Analytic Data




Analytic data gathering was conducted by reviewing appropriate documents on Policy, legislation and related health service delivery strategies. See Chapter Two page 13. This review was structured to cover mental health care issues at International, National, Provincial and Local Levels. See *Data Sets 1, 2 and 3 below.*

DATA SET	SOURCE OF DATA	PURPOSE OF DATA	METHOD OF DATA ANALYSIS
Policy			
World Health Organisation, 2003, 'Mental Health Policy, Plans and Programmes' <i>Mental Health Policy and Service Guidance Package.</i>	Library	To establish policy provisions for justice and equity in the allocation of health resources	Policy Analysis with particular reference to those aspects of policy related to norms and standards of service delivery
World Health Organisation, 2003, 'Planning and Budgeting to Deliver Services for Mental Health' <i>Mental Health Policy and Service Guidance Package.</i>	Library		
Department of Health (DoH), South Africa, 1999-2004, <i>Health Sector Strategic Framework.</i> DoH. Pta.	Library		
Department of Health, South Africa, 2003, <i>Strategic and Implementation Plan for Delivery of Mental Health Services in KwaZulu-Natal.</i> Health Ezempilo, KwaZulu-Natal	Library		
South African Health Review (SAHR), 1997, <i>Mental Health.</i> Ch. 17 accessed 15 Sep 2003. http://www.hst.org.za/sahr/97/chap17.htm .	Electronic search		
South African Health Review (SAHR), 1999, <i>Mental Health.</i> Chap 25 accessed 13 Sep 2003. http://www.hst.org.za/sahr/99/chap25.htm	Electronic search		

Data Set 1: Policy

DATA SET	SOURCE OF DATA	PURPOSE OF DATA COLLECTION	METHOD OF DATA ANALYSIS
Legislation Constitution of the Republic of South Africa. Act 108 of 1996 National Health Act No. 61 of 2003 Mental Health Care Act No 17 of 2002	Library 	To establish ethical considerations and legal provisions for mental health resource allocations 	Legislation review with reference to provisions made for equitable allocation of resources 

Data Set 2: Legislation

DATA SET	SOURCE OF DATA	PURPOSE OF DATA COLLECTION	METHOD OF DATA ANALYSIS
Williams J.R., 2000, 'Justice and Health Care in South Africa,' Accessed 14 September 2000. http://www.ethics.co.za/art13.htm van Rensburg H.C.J, A. Fourie A. & E. Pretorius E., 1992, <i>Health Care in South Africa: Structure and Dynamics</i> . Academica, Arcadia St, Hatfield, Pta.	Electronic search and Library 	To establish if the South African health system care strategies reflect considerations for justice and equity in terms of access to health care for all 	Health care system analysis with reference to principles of distributive justice 

Data Set 3: Ethics and the South African health system

ii. Data Gathering: Descriptive Data

A formal interview was used to gather information on the overall functioning of eThekweni District as outlined below. Supporting documents were obtained from the Geographic Information Systems Division of eThekweni Municipality. *See Data Set 4 below.* Questionnaires were used to gather data on the sub-districts and health facilities. *See Data Set 5 below and Annexures 14 and 15 on pages 87 and 89 respectively.*

DATA SET	SOURCE OF DATA	PURPOSE OF DATA COLLECTION	METHOD OF DATA ANALYSIS
Maps Ethekewini district Primary Health Care Areas: <ul style="list-style-type: none"> • North Sub-District • South Sub-District • West Sub-District 	EThekewini Municipality Geographic Information Systems EThekewini Municipality Geographic Information Systems	To establish how health facilities are distributed in eThekewini District ↓	Map Analysis with reference to the geographical distribution of health facilities in eThekewini District. ↓

Data Set 4: Maps

DATA SET	SOURCE OF DATA	PURPOSE OF DATA COLLECTION	METHOD OF DATA ANALYSIS
Questionnaires <ul style="list-style-type: none"> • Sub-District • Health Facility 	Sub-District Managers Nursing Service Managers ↓	To establish how services are organized To establish how health personnel are mixed To establish how personnel are allocated per population size	Structured interviews with reference to the organization of services in the sub-districts Structured interviews with reference to health personnel mix per level of care Structured interviews with reference to health personnel allocation per population size

Data Set 5: Questionnaires

a) Formal Interview: Programme Manager

The formal interview with the Programme Manager was used to collect information of the district as a whole. During this interview information was captured through written notes from verbal responses to the questions asked under the following headings:

1. Name of the District
2. Vision, Mission and Goals of the District
3. Structure and Control of the District
4. Size of the District
5. Population Size
6. Health Facilities in the District
7. Programmes and Services offered by the District
8. Challenges and Successes

b) Questionnaire Administration: Sub-District Managers

The Sub-District Questionnaire was used to collect data on all three sub-districts from the Sub-District Managers for each Sub-District. Data on the population size and the geographical distribution of health services was collected over a period of one and a half hours through structured interviews from the Sub-District Managers. The following topics were covered on all three sub-districts:

1. **Description of the Sub-District**
2. **Demographic Data of the Sub-District**
3. **Distribution of health facilities**

See annexure 14: Sub-District Questionnaire page 87

c) Questionnaire Administration: Nursing Services Managers

The Health Facility Questionnaire was used to collect data on all six sample units. Information on health personnel with reference to discipline, qualification and the number of personnel currently employed in the health facility was obtained over a period one and a half hours through structured interviews from the Nursing Services Managers. *See Annexure 1 page 67.* The following topics were covered:

1. **Health Facility Detail**
2. **Supporting documents and Maps**
3. **Personnel Allocation**

See Annexure 15: Health Facility Questionnaire page 89.

d) Supporting Documents: Geographical Information System (GIS) Data

Maps of the eThekweni District and primary health care (PHC) areas were obtained from the Geographical Information Systems Division of eThekweni Municipality. These maps constituted the supporting documentation indicating the geographical location of the health facilities in the District. *See:*

- *Annexure 16 Distribution of Health Facilities: eThekweni District, page 91*
- *Annexure 17 Primary Health Care areas: North Sub-District, page 92*
- *Annexure 18 Primary Health Care areas: South Sub-District, page 93*
- *Annexure 19 Primary Health Care areas: West Sub-District, page 94*

3.5. Data analysis

3.5.1. Analytic Data

Analytic data was used to investigate the causal link between legislative framework and implementation of mental health care service.⁹⁷ Policy outcome analysis was conducted to determine its influence on the transformation of mental health services with regard to resource mobilization and allocation with reference to key health service delivery strategies of public-private-partnership (PPP) mix and the district health system (DHS) within the South African health system.

i. Policy review

Relevant policy and legislation review was conducted using three policy intervention categories as classified in Chabikuli et. al (2005)⁹⁸ as the framework for the policy review. These policy categories are classified into:

- Human resource production policies
- Human resource management and the transformation of public service policies, and
- Health care delivery policies

ii. Ethical theories and national health system design

Theories of distributive justice were used to analyse the South African health care system in order to establish if the strategies employed within the system reflected equitable access to health care. *See Table 2 page 24.* The Ethical Theories of Distributive justice were used to analyse the selected health care service delivery strategies in Chapter Two on pages 20-25.

⁹⁷ Katzenellenbogen J.M., Joubert G. & Abdool Karim S.S., 1999, *Epidemiology: A Manual for South Africa*, 1999, Oxford Univ. Press, S.A.

⁹⁸ Chabikuli N., Blaauw D., Gilson L. and Schneider H., 2005, 'Human resource policies: Health Sector Reform and the Management of PHC Services in South Africa,' *South African Health Review*.

3.5.2. Descriptive Data

Ethekwini District health services are currently offered in an integrated health care package as outlined in the *district hospital service*⁹⁹ and the *comprehensive primary health care service*¹⁰⁰ packages for South Africa. An integrated health care service can be effectively offered by a specific discipline mix. Such a mix can be determined by calculating the full-time equivalent (FTE) of staff required to serve a given population size and type.

In an integrated health care system, the FTE of a specific staff member is based on the percentage of time spent by that staff member on a specific intervention programme such as mental health care, oral health, reproductive health and others.

Staff member numbers are therefore calculated per service requirements at a specific level of care. The full-time equivalent for staff numbers in a community health centre (CHC) can be calculated using the formula in figure 2 below.

$$\text{Full-time equivalent (FTE) staff} = \frac{\text{Daily patient visits} \times \text{actual working days per year}}{\text{Current consultations per day} \times \text{staff working days per year}}$$

Figure 2. Workload formula for staff full-time equivalent

In this study the South African Workload ratios from Rispel, Price & Cabral, in WHO (2003d)¹⁰¹ were adapted to determine personnel numbers for community health centres, clinics, mobile units and management in the sample units. See Table 4 below.

⁹⁹ Department of Health, South Africa, 2002, *A District Hospital Service Package for South Africa A set of Norms and Standards*, Dept of Health, Pta.

¹⁰⁰ Department of Health, South Africa, 2001, *A Comprehensive Primary Health Care Service Package for South Africa*. Dept of Health, Pta

¹⁰¹ World Health Organisation (WHO), 2003d, 'Planning and Budgeting to Deliver Services for Mental Health' *Mental Health Policy and Service Guidance Package*.

TYPE OF PROFESSIONAL	LEVEL OF CARE PERSONNEL RATIOS			
	CHC	CLINIC	MOBILE UNIT	MANAGEMENT
PSYCHIATRISTS	0,5	0	0,25	0,2
PROFESSIONAL NURSES	14	8	7	1
REGISTRARS	1	0	0,75	0
SOCIAL WORKERS	1	0,5	1	0
OCCUPATIONAL THERAPISTS	0	1	0,5	0
CLINICAL PSYCHOLOGISTS	0	0,5	1	0
COUNSELLOR	0	0,5	0	0
O. T. ASSISTANTS	0	2	1,5	0
ADMINISTRATION CLERKS	0	0,2	0	0

Table 4. Recommended health personnel mix ratios per 100 000 population at PHC level
(Adapted from WHO, 2003)¹⁰²

The ratios in table 4 above were used to calculate the recommended specific health personnel number per level of care to serve a specific population size in each primary health care (PHC) area. The original *Residential acute inpatient* ratios were used to represent the *Community Health Centre (CHC)* ratios on the basis of the similarity between the acute bed setting and the community health centre (CHC) setting. This similarity was supported by the information obtained from the Programme Manager and Sub-District Managers which indicated that CHC's functioned in a similar way as acute inpatient units. The original *Day service, Ambulatory care* and *Managerial* ratios were renamed *Clinic, Mobile unit* and *Management* ratios respectively since these were current terms used in eThekweni District. These ratios were based on the greater prevalence of severe psychiatric conditions namely, non-affective psychosis, bipolar affective disorder, major depression, anxiety disorder and post traumatic stress disorder in the population group aged 15 years and over.¹⁰³

Recommended health personnel full-time equivalent (FTE)¹⁰⁴ per PHC area was calculated by converting recommended ratios per 100 000 population to determine specific health personnel FTE's per current population size in the sample PHC Areas. See the formula in Figure 3 below.

¹⁰² World Health Organisation (WHO), 2003d, 'Planning and Budgeting to Deliver Services for Mental Health' *Mental Health Policy and Service Guidance Package*, p. 53.

¹⁰³ Ibid

¹⁰⁴ Ibid.

$$\text{Recommended Personnel FTE} = \frac{\text{Ratio per 100 000 Population} \times \text{Current PHC Area Population size}}{100\,000}$$

Figure 3. Workload formula developed for this research

Calculations were based on the latest population records from EThekweni Municipality Health Department.

3.6. Ethical considerations

Ethical clearance was obtained from the Biomedical Research Ethics Committee of the University of KwaZulu-Natal as a University requirement and in order for my study to be entered into the register of the Research Office (*See Annexure 6, page 73*). Prior to commencement of this research, a preliminary meeting was sought with the District Manager of eThekweni District to introduce my topic and to assert the feasibility of my study in eThekweni District (*See Annexures 3 & 4, pages 69 & 70*).

Consent letters (*see Annexures 9, 10 and 11 on pages 78, 80 and 82 respectively*) requesting permission to conduct research in the sub-districts were sent to the all three Sub-district Managers. Subsequent to the consent letters, meetings were set up with each Sub-District Manager to present my research proposal and request permission to do research in their sub-districts. Verbal consent was obtained from each sub-district manager to conduct research in their Sub-District Primary Health Care Areas. Nursing Service Managers were then delegated by the sub-district managers to work with the researcher. *See Annexure 1 page 67.*

Subsequent to this, permission was obtained from the Superintendent-General of the Department of Health in the Province of KwaZulu-Natal, as a normal procedure followed in any research in the province (*See Annexures 7 & 8 pages 74 & 77*). In addition permission was obtained from eThekweni Municipality, Health, Safety and Social Services Cluster Health Unit Head as a requirement for all research conducted in health facilities under eThekweni Municipality (*See Annexures 12 & 13, pages 84 & 86*).

All participants as indicated in *Section 3.2.3. on page 30* were assured anonymity on their responses and that information obtained during the research would be kept confidential and used only for the purpose of this research.

3.7. Dissemination of information.

A copy in an appropriate format will be made available to the Superintendent's Office, Department of Health, Province of KwaZulu-Natal as a condition specified when permission was granted for conducting this research. In addition a copy of this report will be provided to the Faculty of Law in order to ensure a follow up on my recommendations by Public Health Law students. It is envisaged that the findings from this study be presented in the local and regional forums, and conferences in order to share knowledge and insights to this topic with my colleagues in health practice. It is further intended by the researcher that this study be published in an appropriate Journal within a period of one year after completion.

Chapter Four

Results

4.1. Introduction

The stages of health care system delivery¹⁰⁵ namely; policy development, inputs and outputs were adapted as the *format* for presenting the data. Policy, legislation and health system strategy analysis constituted the *analytic data* (see Chapter Two page 13) under stages one and three of *policy development* and *processes* respectively. The distribution of health facilities and the allocation of health personnel constituted the *descriptive data* under stage two of *inputs* of health care system delivery. See Figure 1 page 27.

4.2. Distribution of health facilities

4.2.1. Introduction

This section will present the overall information of the District; specific organization and structure of health facilities in the district; specific services offered by the health facilities; specific allocation and occupational mix of personnel per health facility and the population size per primary health (PHC) area from the sampling units.

4.2.2. eThekwini District

a) Demographic Information

eThekwini District serves a population size of just over 3 million people. See Table 5 page below. The district delivers health care service through its 19 mobile units, 107 clinics, six community health care centres and 8 district hospitals. In addition the district also hosts 1 tertiary hospital. The referral structure and the geographical layout for eThekwini District is provided in Annexure 16 page 91.

¹⁰⁵ Katzenellenbogen J.M., Joubert G. & Abdool Karim S.S., 1999, *Epidemiology: A Manual for South Africa*, 1999, Oxford Univ. Press, S.A.

Ethekwini District Population Size (Whole District)	3 129 677
Number of Sub-Districts Districts (North, South & West)	3
Number of Primary Health Care Service Areas (North=6, South=8 West=4)	18

Table 5. EThekwini District health facilities

EThekwini District is basically organized into a coherent managerial and service structure which is comprised of a District Manager who is overall in charge and various Programme Managers immediately under the District Manager. Programme Managers are in charge of specific programmes such as chronic diseases etc. Under the Programme Managers are the Sub-District Managers who are in charge of PHC Area Managers. PHC Managers are in charge of Nursing Service Managers who in turn co-ordinate team leaders who render specific service programmes at service points with their respective teams.

Structurally, each sub-district has a number of primary health care (PHC) areas. Each PHC area is identified by the first letter of the sub-district it falls under, followed by the digit which represents the sequential number of that PHC area. For example, PHC area **N1** refers to the **first** Primary Health Care area under the **North** Sub-District. See *Figure 4 below*. The geographical layout of each PHC is indicated in *Annexure 17 page 92* (North Sub-District), *Annexure 18 page 93* (South Sub-District) and *Annexure 19 page 94* (West Sub-District).

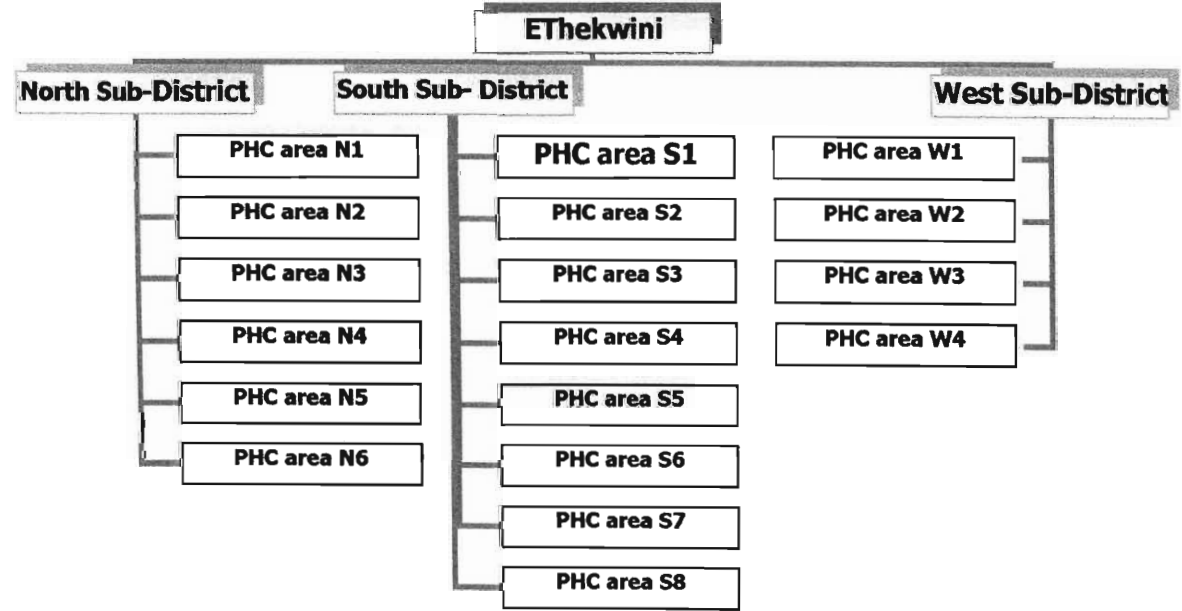
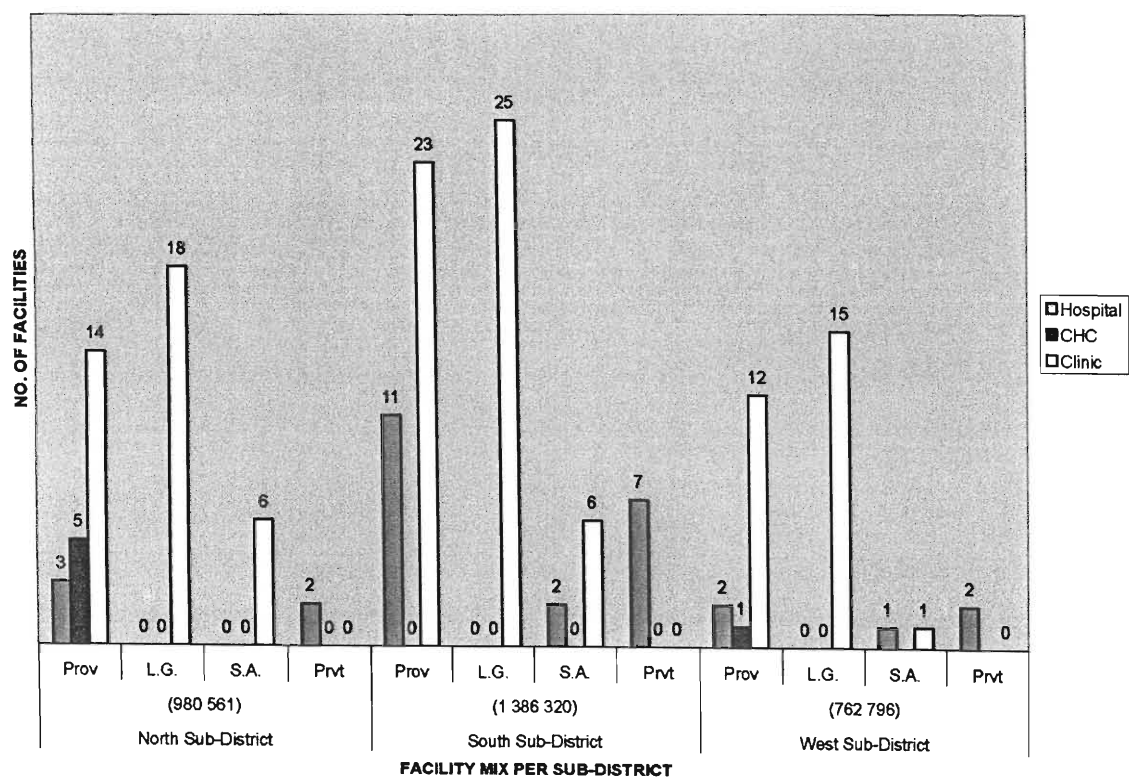


Figure 4. Service structure organogram: eThekwini district
(Compiled from information collected during data collection)

4.2.3. Primary Health Care (PHC) area information

a) Distribution of Facilities per Sub-District

Ethekwini District has inherited a structurally, functionally and geographically fragmented health care system from the previous health care system. Health services in this district were offered by three historically different departments namely, the former Natal Provincial Administration, Department of National Health and Population Development and the KwaZulu Administration. In all three sub-districts these services are currently offered by four types of authorities namely, provincial, private state aided, private and local government authorities.¹⁰⁶ See graph 1 and table 6 below.



Graph 1. Distribution of health facilities and related authority mix: Ethekwini District

¹⁰⁶ Health Systems Trust and the Department of Health, KwaZulu-Natal, 1996, 'Implications for Planning 1996.

Facility	North Sub-District (980 561)				South Sub-District (1 386 320)				West Sub-District (762 796)			
	Prov	L.G.	S.A.	Prvt	Prov	L.G.	S.A.	Prvt	Prov	L.G.	S.A.	Prvt
Hospital	3	0	0	2	11	0	2	7	2	0	1	2
CHC	5	0	0	0	0	0	0	0	1	0		
Clinic	14	18	6	0	23	25	6	0	12	15	1	0
TOTAL	22	18	6	2	34	25	8	7	15	15	2	2

KEY: P = Provincial L.G. = Local Government S.A. = State Aided Prvt = Private

Table 6. Distribution of health facilities and related authority mix: Ethekwini District

4.3. Distribution of health personnel

4.3.1. North Sub-District: Primary Health Care (PHC) areas N2/4

Although the overall staff allocation for PHC area N2 reflects an above norm allocation, but the overall allocation between the two areas indicates overall below norm allocation of 20.3 staff full-time equivalent (FTE's). In addition permanently appointed health personnel between these areas and across all levels of care in these areas are only in the disciplines of nursing, medicine and social work. Of these disciplines, the nursing discipline was in the majority. In addition the majority of the disciplines recommended in the personnel mix are not employed at the district level. The managerial component in both of PHC areas N2 and N4 was below the recommended norm.

In both Primary Health Care areas N2 and N4 there are currently no clinics. In these areas services required at clinic and community levels are offered through vertical programmes from the community health centres. *See Tables 7 and 8 below.*

LEVEL OF CARE	MANAGERIAL		COMMUNITY HEALTH CENTRE		CLINIC		MOBILE UNIT	
	NORM	CURRENT	NORM	CURRENT	NORM	CURRENT	NORM	CURRENT
STAFF STATUS:	0.3	0	0.7	0	0	0	0.4	0
PSYCHIATRISTS	0.3	0	0.7	0	0	0	0.4	0
PROF. NURSES	1.4	1	20	50	11.4	0	10	3
REGISTRARS	0	0	1.4	3	0	0	1	0
SOCIAL WORKERS	0	0	1.4	3	0.7	0	1.4	0
OCC. THERAPISTS	0	0	0	0	1.4	0	0.7	0
CL. PSYCHOLOGISTS	0	0	0	0	0.7	0	1.4	0
COUNSELLORS	0	0	0	0	0.7	0	0	0
O.T. ASSISTANTS	0	0	0	0	2.9	0	2.1	0
ADMIN CLERKS	0	0	10.3	0	0	0	0	1
TOTAL STAFF (POP. SIZE=142 779)	1.7	1	33.1	66	17.8	0	17	4

Table 7. Norm and current health personnel Full-Time Equivalent (FTE's) in PHCA N2

LEVEL OF CARE	MANAGERIAL		COMMUNITY HEALTH CENTRE		CLINIC		MOBILE UNIT	
STAFF STATUS	NORM	CURRENT	NORM	CURRENT	NORM	CURRENT	NORM	CURRENT
PSYCHIATRISTS	0.4	0	0.9	0	0	0	0.5	0
PROF. NURSES	1.8	1	25.1	46	14.4	0	12.6	9
REGISTRARS	0	0	1.8	1	0	0	1.3	0
SOCIAL WORKERS	0	0	1.8	0	0.9	0	1.8	0
OCC. THERAPISTS	0	0	0	0	1.8	0	1	0
CL. PSYCHOLOGISTS	0	0	0	0	0.9	0	1.3	0
COUNSELLOR	0	0	0	0	0	0	0	0
O.T. ASSISTANTS	0	0	0	0	3.6	0	2.7	0
ADMIN CLERKS	0	0	0	3	0	0	0	1
TOTAL STAFF (POP. SIZE=179 532)	2.2	1	29.6	50	21.6	0	21.2	10

Table 8. Norm and current staff Full Time Equivalent (FTE's) in PHCA N4

4.3.2. South Sub-District: Primary Health Care(PHC) areas S3/4

Based on the population size of about ¼ million people between PHC areas S3 and S4, permanent staff allocation for S4 indicates an above norm staff FTE of 4.1. But both areas also reflect an overall below norm allocation of 20.6 staff FTE's. Nursing still remains the most dominant health discipline for permanently employed staff in these areas. All other health personnel recommended for this level are not appointed across all levels and in both areas.

In terms of facility distribution, both PHC areas S3 and S4 do not have community health centres. Referrals from the clinics are channeled to clinics annexed to hospitals. *See Tables 9 and 10 below.*

LEVEL OF CARE	MANAGERIAL		COMMUNITY HEALTH CENTRE		CLINIC		MOBILE UNIT	
STAFF STATUS	NORM	CURRENT	NORM	CURRENT	NORM	CURRENT	NORM	CURRENT
PSYCHIATRISTS	0.3	0	0.3	0	0	0	0.3	0
PROF. NURSES	1.3	1	17.8	0	8.9	17	8.9	6
REGISTRARS	0	0	1.3	0	0	0	1	0
SOCIAL WORKERS	0	0	1.3	0	0.6	0	1.3	0
OCC. THERAPISTS	0	0	0	0	1.3	0	0.6	0
CL. PSYCHOLOGISTS	0	0	0	0	0.6	0	1.3	0
COUNSELLOR	0	0	0	0	0.6	0	0	0
O.T. ASSISTANTS	0	0	0	0	2.5	6	2	0
ADMIN CLERKS	1	0	0	0	0	3	0	0
TOTAL STAFF (POP. SIZE=126 993)	1.6	1	20.7	0	14.5	26	15.4	6

Table 9. Norm and current staff Full-Time Equivalent (FTE's) in PHCA S3

LEVEL OF CARE	MANAGERIAL		COMMUNITY HEALTH CENTRE		CLINIC		MOBILE UNIT	
STAFF STATUS	NORM	CURRENT	NORM	CURRENT	NORM	CURRENT	NORM	CURRENT
PSYCHIATRISTS	0.3	0	0.7	0	0	0	0.3	0
PROF. NURSES	1.4	1	19	0	10.9	41	9.5	0
REGISTRARS	0	0	1.4	0	0	0	1	0
SOCIAL WORKERS	0	0	1.4	0	0.7	0	1	0
OCC. THERAPISTS	0	0	0	0	1.4	0	1.4	0
CL. PSYCHOLOGISTS	0	0	0	0	0.7	0	1	0
COUNSELLOR	0	0	0	0	0.7	12	0	0
O.T. ASSISTANTS	0	0	0	0	2.7	0	2	0
ADMIN CLERKS	1	0	0	0	0	7	0	0
STAFF STATUS (POP. SIZE=136 181)	2.7	1	22.5	0	17.1	60	16.2	0

Table 10. Norm and current staff Full Time Equivalent (FTE's) in PHCA S4

4.3.3. West Sub-District: Primary Health Care areas (PHCA) W1/4

PHC areas W1 and W4 reflect abnormal extremes of 49.6 below norm staff FTE's for PHC area W4 and 61.5 above norm staff FTE's for PHC area W1. The two areas which are serving a population size of more than a ¼ of a million people share only one community health centre. Like the rest of the other sample areas, nursing is the most dominant and mainly the only discipline rendering health care in these areas.

In terms of health facility allocations, PHC areas W1 and W4 were the least resourced areas compared to other areas. *See Tables 11 and 12 below.*

LEVEL OF CARE	MANAGERIAL		COMMUNITY HEALTH CENTRE		CLINIC		MOBILE UNIT	
STAFF STATUS	NORM	CURRENT	NORM	CURRENT	NORM	CURRENT	NORM	CURRENT
PSYCHIATRISTS	0.3	0	0.8	0	0	0	0.4	0
PROF. NURSES	1.6	1	22.7	89	12.9	8	11.4	0
REGISTRARS	0	0	1.6	3	0	0	1.2	0
SOCIAL WORKERS	0	0	1.6	0	0.8	0	1.6	0
OCC. THERAPISTS	0	0	0	0	1.6	0	0.8	0
CL. PSYCHOLOGISTS	0	0	0	0	0.8	0	1.6	0
EDUCATION/ COUNSELLOR	0	0	0	0	0.8	9	0	0
OCC. THERAPY ASSISTANTS	0	0	0	0	3.2	0	2.4	0
ADMIN CLERKS	0	0	0	17	0.3	2	0	0
STAFF STATUS (POP. SIZE=162 384)	1.9	1	26.7	109	20.4	19	19.4	0

Table 11. Norm and current staff Full Time Equivalent (FTE's) in PHCA W1

LEVEL OF CARE	MANAGERIAL		COMMUNITY HEALTH CENTRE		CLINIC		MOBILE UNIT	
STAFF STATUS	NORM	CURRENT	NORM	CURRENT	NORM	CURRENT	NORM	CURRENT
PSYCHIATRISTS	0.4	0	1	0	0	0	0.5	0
PROF. NURSES	2	1	28	0	16.3	24	14.3	13
REGISTRARS	0	0	2	0	0	0	1.5	0
SOCIAL WORKERS	0	0	2	0	1	0	2	0
OCC. THERAPISTS	0	0	0	0	2	0	1	0
CL. PSYCHOLOGISTS	0	0	0	0	1	0	2	0
COUNSELLOR	0	0	0	0	1	1	0	0
O.T. ASSISTANTS	0	0	0	0	4	0	3	0
ADMIN CLERKS	0	0	0	0	0.4	7	0	0
STAFF STATUS (POP. SIZE=204 202)	2.4	1	33	0	25.3	25	24.3	8

Table 12. Norm and current staff Full Time Equivalent (FTE's) in PHCA W4

Chapter Five

Discussion

5.1. Introduction

The purpose of this study was to establish the impact of health policy and legislation on the allocation of resources in line with the health care transformation strategy of an equitable comprehensive community-based health care service in a district health system. The health care system delivery format was used to present a discussion of the results. (*See figure 1 page 27.*)

This chapter is based on the findings from the *analytic data on policy, legislation and health service delivery strategies* review in Chapter Two page 13 and from the *descriptive data on the distribution of health facilities and health personnel* presented in Chapter Four page 41.

In Section 5.2. the impact of policy and legislation on the *production, distribution and management* of human resources, as well as the *transformation* and the *delivery* of health care service will be discussed. Section 5.3. will discuss the implications for the current *distribution of health facilities and health personnel* in eThekweni District. Section 5.4. will deal with the *interactions* between policy, legislation and resource allocation and how these interactions influence *service delivery*. Section 5.5. will discuss the extent to which current policy, legislation and health resources allocated to the district in question reflect *justice and equity* for mental health care users.

5.2. Policy development (*Stage 1*)

(*Based on Section 2.2 pages 14-20*)

A health policy is a reflection of the government's vision of health care delivery, stated as goals and plans of action to deliver health care¹⁰⁷. This section will focus on the development and co-ordination of policy and legislation in an integrated health care approach used at a district level in South Africa.

¹⁰⁷ Katzenellenbogen J.M., Joubert G. & Abdool Karim S.S., 1999, *Epidemiology: A Manual for South Africa*, 1999, Oxford Univ. Press, S.A.

5.2.1. Human resource production

Even though the National Health Act¹⁰⁸ makes clear provisions for the recruitment of foreign personnel, according to the policy and literature review, there were no clear cut strategies in place with time frames, phases of implementation and related targets for alleviating staff shortages at primary health care. Instead there were records of inconsistent recruitment of foreign doctors from various countries and a cumbersome programme of training doctors outside the country and bringing them back for additional 'internship' in the country. Current literature review still indicates severe staff shortages in under resourced areas.

Provisions by the National Health Act¹⁰⁹ for health establishments and educational institutions to train health personnel at various levels of care show good potential for medium to long term human resource production. This is evidenced by the current academic complex setup between the Department of Family Medicine and Umtata and Wentworth hospitals. But the issue of mid-level workers still remains unresolved pending the outstanding clarification on the scope of practice and remuneration packages for these cadres.

According to policy review, there are still many challenges and shortcomings which face human resource production initiatives. These shortcomings are characterized by lack of a coherent recruitment plan as indicated above and lack of coordination between health service demands and supply of appropriate health personnel mix as indicated by the findings of this research. *See section 5.3. below.*

5.2.2. Human resource management and the transformation of public service

Another area of weakness in human resource policies is that of retention strategies for staff in under-resourced rural areas. Rural areas are still understaffed and overburdened with increasing patient load due to unclear recruitment and retention strategies for staff in these areas. As a result there is still a very high attrition rate of health personnel at primary health care (PHC) level. Even with the enforcement of compulsory community service and the introduction of rural and scarce skills allowance, health personnel still continue to migrate to urban areas, join private sector or migrate to developed countries.¹¹⁰ As indicated earlier in Chapter 1, the previous institution-based health care combined with poor infrastructure and poor working conditions in rural areas has

¹⁰⁸ National Health Act No. 61 of 2003

¹⁰⁹ National Health Act No. 61 of 2003 S51(a) & S52(b)

¹¹⁰ Couper I., de Villiers M. and Sondzaba N., 2005, 'Human resources :district hospitals', *Health Systems Trust (HST)*, Ch. 9, pp. 118-124.

resulted in the high concentration of health personnel in health facilities located in more adequately resourced urban areas. In KwaZulu-Natal the situation is further complicated by the current hold on the movement of staff from province to local authority pending the agreement on service conditions between Local Government and Provincial Government.¹¹¹ As a result there are still severe staff shortages at primary health care (PHC) and middle management levels. The other health sector transformation problem is the unco-ordinated move to de-institutionalise chronic mental health care users before appropriate human resources and support structures are put in place at community level. This move has already started a revolving door syndrome in some hospitals as indicated in Chapter 1 and in studies by Talbott (1978) and Breakey (1996) in WHO (2003c)¹¹²

The critical role played by personnel in mental health was emphasized in the reports by the International Journal for Equity in Health (Gupta et.al, 2003)¹¹³ and the World Health Organisation ((WHO, 2003b)¹¹⁴ in Chapter 1 of this report. But the findings in this research indicate that of the eight categories of personnel required to offer integrated community based health service, only three staff categories were permanently employed. In addition, even these appointments were characterized by understaffing and maldistribution across levels of care and between urban and rural areas.

Findings from the situational analysis of health services in KwaZulu-Natal (DoH, 2003)¹¹⁵ indicated that although mental health services had been integrated at a primary health care level, most of the facilities especially in the general hospitals, could only handle mild mental health conditions due to lack of relevant expertise and physical facilities to manage severe mental illnesses.

According to the South African Health Review (1999) public sector services are still limited in reaching the most vulnerable sectors of the population. Legislation aimed at addressing these areas of transformation are unclear. Amongst other related problems, the transformation process is beleaguered with implementation

¹¹¹ Hall W., Ford-Ngomane T. and Barron P., 2005, 'The Health act and the District Health System' *Health Systems Trust (HST)*. Ch. 4, pp. 44-53.

¹¹² World Health Organisation, 2003c, 'Organisation of Services for Mental Health' *Mental Health Policy and Service Guidance Package*.

¹¹³ Gupta N., Zurn P., Diallo K & Dal Poz M.R., 2003, 'Uses of population census data for monitoring geographical imbalance in the health workforce: snapshots from three developing countries'. *International Journal for Equity in Health*, Dept. of Health Services Division, WHO, Geneva, vol. 2:11 pp.1-12.

¹¹⁴ World Health Organisation (WHO), 2003b, 'Mental Health Policy, Plans and Programmes' *Mental Health Policy and Service Guidance Package*.

¹¹⁵ Department of Health (DoH), South Africa, 2003, *Strategic and Implementation Plan for Delivery of Mental Health Services in KwaZulu-Natal*. Health Ezempilo, KwaZulu-Natal.

problems, feelings of resentment and burnout of the staff, insufficient staff training and inadequate funding for mental health which constitute a barrier to mental health transformation.¹¹⁶

5.3. Inputs (*Stage 2*)

(Based on Chapter Four: Results pages 41-47)

In this study data was collected on the number and location of health facilities per level of care as well as the number and specific combination of various mental health care personnel allocated to these facilities. In addition, data was collected on the size of the population served by the sub-districts in the sampling units.

Findings in this research revealed the maldistribution and the shortages of both human and physical resources which are not in line with primary health care (PHC) approach as envisaged in the current health sector transformation process.

As indicated in the introduction, Etheke District health services are offered by a combination of four different authorities who historically delivered different health services within a structurally, functionally and geographically fragmented health care system. In addition, the inherent social, economic, cultural and political diversities of EThekweni District population profile also directly impacts on the health status of its population. As a result, these historical fragmentation, maldistribution and inequalities in resource allocations were also imbedded in the inherent diversities which also impacted on the health status of the population.

Inequality is generally known as maldistribution and is characterized by over and underconcentration of human resources, services and facilities.¹¹⁷ According to van Rensburg et. al (1992) problems of inequality are further expressed in uneven utilization with over-consumption, under-consumption and non-consumption of health services. Maldistribution of health facilities may lead to unequal access to health services which eventually negatively affects the health status of the population including vulnerable groups.

The research findings, generally indicated understaffing across all levels of care. However the most critical findings for this research was that the permanently

¹¹⁶ South African Health Review (SAHR), 1999, *Mental Health*. Chap 25 accessed 13 Sep 2003. <http://www.hst.org.za/sahr/99/chap25.htm>.

¹¹⁷ van Rensburg H.C.J, A. Fourie A. & E. Pretorius E., 1992, *Health Care in South Africa: Structure and Dynamics*. Academica, Arcadia St, Hatfield, Pta.

employed health personnel mostly fell below the norm recommended for the population size in each PHC area. In addition, as indicated by the policy review, the so called integrated primary health care service was still mainly offered by one health discipline viz. nursing, compared to the recommended personnel skill mix of eight health disciplines (*see Tables 7-12 pages 44-47*). On the other hand, there was also an underlying historical over-concentration of health facilities in urban-based areas compared to rural based areas. These disparities indicate that the progress made in the building of new clinics in the past twelve years was still far from making an impact at grass roots level. Findings from this research were supported by similar findings from the situational analysis of health services in KwaZulu-Natal which indicated significant maldistribution of health resources in the Province.¹¹⁸

In the course of this research the researcher was subjected to first hand experience of some structural and functional fragmentation which was characterized by different procedures, isolated and duplicated data sources and cumbersome duplicated authority structures. This same experience could also translate into similar experiences by health service consumers at various health service points.

According to these research findings, all three North, South and West sub-districts were dominated by maldistribution of facilities which were characterized by over and under concentration of both human resources and facilities in most areas. These findings indicate a significant gap for policy initiatives which can influence effective health resource development, mobilization and management.

5.4. Processes (Stage 3)

(Based on Section 2.3 pages 20- 25)

Processes refers to complex interactions which take place in service delivery. This section will discuss the influence of policy, legislation, human and physical resources on the nature of service delivery.

Section 45(1) of the National Health Act¹¹⁹ provides guidelines for the development of the relationship between public health and private health establishments. The main purpose of this provision is to ensure the optimum distribution and efficient utilization of available health resources in the country. However, according to research findings these public/private sector initiatives

¹¹⁸ Department of Health (DOH), South Africa, 2003, *Strategic and Implementation Plan for Delivery of Mental Health Services in KwaZulu-Natal*. Health Ezempilo, KwaZulu-Natal.

¹¹⁹ National Health Act No. 61 of 2003

continue to produce unintended consequences which have a negative impact on the effective health service delivery.

For example, despite measures put in place to regulate the private sector, the number of insured population declined from just under 17% in 1997 to 15.2% of the population in 2002. The number of people dependent on public sector has increased by 6.5 million people since 1995, but the real per capita spending in South Africa has not increased proportionally.¹²⁰

According to Ntuli et. al.¹²¹ there has also been a reduction in inter-provincial per capita spending, but this has masked the intra-provincial inequities at primary health care levels, where per capita spending ranges from R389 to R42 between the highest spending and the lowest spending districts. The per capita spending in the lowest spending districts is R172 lower than the basic Primary Health Care package recommended by the Department of Health. This maldistribution of resources seriously undermines the primary health care (PHC) principles of equitable access to health resources by all citizens of the country.

At a policy level, the Certificate of Need and Licensing process provisions in the National Health Act¹²² are designed to control the supply, distribution, access and quality of health service.¹²³ But, currently in the public/private sector partnership, 60% of expenditure in health care is accessed by 20% of the population.¹²⁴ This expenditure goes towards the lower risk and affluent minority sector of the population through medical aid scheme subsidies by the government. In addition, 77% of all specialists providing quality care equal to the best in the world, work in the private sector. The combination of poor working conditions and low salaries in the public sector are resulting in the mass migration of health workers into private sector and this is imposing a heavy imbalance in the partnership. (*See human production policies above*)

In the context of South Africa, the above account is an indication that the public/ private initiatives in health care are still marginalizing the vulnerable sectors of our society who need health care the most. In view of the above statistics, 80% of the higher risk majority sector of the population which includes poor, unemployed and disabled groups have to compete for 40% of the rest of the budget.

¹²⁰ Ntuli A. and Day C., 2003/4, 'Ten years on- Have we got what we ordered?'" *Health Systems Trust*, Ch. 1, pp. 1-10.

¹²¹ Ibid.

¹²² National Health Act No. 61 of 2003

¹²³ National Health Act No. 61 of 2003. S36(a)(b)(c)(d) & S39(2)(a)(d) (e)(f)(g)(h)

¹²⁴ Health Systems trust. *The South African Equity Gauge*.

According to the World Bank, South Africa is classified as a middle income country, but this classification is masking the real South African picture of two worlds in one – the one of poor communities who mostly live in under-resourced rural areas and the other of the rich middle and upper class community who live in abundantly resourced urban areas.¹²⁵ There is a need for a serious review of more equitable health care finance packages that will take into consideration the real existence of socio-economic disparities which are exacerbating the morbidity burden in South Africa.

5.5. Outputs and Outcomes (*Stages 4 &5*)

(Based on stages 1-3 of health service delivery discussed above)

Outputs refer to units of care produced in the interactions between health care processes and inputs and outcomes refer to the final health status of the target population. This section will summarise policy and legislation outcomes with reference to the impact this has on justice and equity in the allocation of resources for mental health in an integrated health care system.

According to van Rensburg et. al. (1992) the origins of inequality in the provision, quality, distribution and consumption of health resources can be traced back to the broader contexts of political, social, cultural and economic dispensation of the country as well as the prevailing health policy. These contexts are crucial in determining where health personnel are located, where certain facilities are erected, which facilities and services receive priority, which personnel and how many will be trained for which clientele.¹²⁶

Mental health care is primarily based on care, support and management of psychiatric conditions which must be offered directly by specific mental health care team members at a point and time in the treatment and rehabilitation of people with mental illness. Although mental health services have been integrated at a primary health care level in KwaZulu-Natal, findings from the situational analysis of health services in KwaZulu-Natal (2003)¹²⁷ indicate that most of the facilities especially in the general hospitals, can only handle mild mental health conditions due to lack of relevant expertise and physical facilities to manage the more severe mental illnesses.

¹²⁵ Department of Health, South Africa, 1999-2004, *Health Sector Strategic Framework*. DoH. Pta.

¹²⁶ van Rensburg H.C.J, A. Fourie A. & E. Pretorius E., 1992, *Health Care in South Africa: Structure and Dynamics*. Academica, Arcadia St, Hatfield, Pta.

¹²⁷ Department of Health (DOH), South Africa, 2003, *Strategic and Implementation Plan for Delivery of Mental Health Services in KwaZulu-Natal*. Health Ezempilo, KwaZulu-Natal.

Compromise in the form of staff shortage or limited service by recommended mental health personnel may result in often irreversible deterioration in the functioning of people with mental illness. Without the effective human resource policy interventions and the appropriate health personnel mix at primary health care level, the burden of mental health illness will continue to escalate. As indicated in the introduction, the burden of mental illness has a substantial impact on the society as a whole and its impact eventually affects the health status of the whole population.

Chapter Six

Conclusions and Recommendations

6.1. Conclusions

The need for this research was inspired by the challenge of the insidious increase of the burden of mental illness faced by various countries all over the world. Historically this increase in the burden of mental illness has been exacerbated by inappropriate health care policies, incorrect approaches to mental illness which are not always evidence based and inappropriate interventions.

In this study the literature and policy review indicate that much progress has been made in the improvement of mental health care in South Africa. However, findings in this research indicate that there are still gaps between health policy and legislation provisions for the development, supply and management of health resources in line with the current health care transformation approach for integrated, comprehensive and equitable access to health care for all. Further findings also indicate that specific health care service delivery strategies utilized within the South African health system are still compromised by the historical geographical and structural disparities.

6.1.1. Research Findings

Although there are specific provisions made by the National Health Act¹²⁸ for the development, adequate and appropriate distribution and management of human resources but research findings indicate that there are still gaps in some areas in human resource *production*, human resource *distribution*, human resource *management* and *service delivery*.

In terms of human resource *production* there is no clear *short*, *medium* and *long term* human resource strategic *plan* for the *recruitment* of foreign health personnel to alleviate current human resource shortages in line with health care transformation approach demands.¹²⁹ The potential for the academic and health establishments initiatives to fast track the training and supply of additional health

¹²⁸ *National Health Act* No. 61 of 2003.

¹²⁹ The current improvements at primary health care (PHC) infrastructure, the introduction of free health care service at PHC level and integrated health care initiatives have the resulted in the increase of patient load at PHC level.

personnel has been poorly explored with some minimal sporadic implementation. There is still no clear *programme* to practically address human resource production within the country. Research findings indicate that there is no clear match between health *service demands* and the *supply* of appropriate health *personnel mix* for *integrated* health care per level of care. See Table 4 page 38.

With regard to human resource *management* research findings indicate that strategies to retain health personnel in under-resourced areas are ineffective due to poor employment conditions experienced by health personnel. Research findings also show that *discrepant* service conditions between different *spheres of government* are *inhibiting* the devolution of personnel in line with health care transformation goals.¹³⁰

Further research findings indicate that lack of *co-ordination* in the implementation of health sector *transformation strategies* are resulting in the *bottlenecking* at service points. Findings in this research indicate that health care transformation *strategies* to improve *access* to health care are *not balanced* with strategies to effectively *retain health personnel* to cope with the *increase* in *demand* for health care.

In the case of health resource *distribution* and health care service delivery the *public/ private partnership (PPP) mix* does not seem to fulfill its intended purpose of ensuring the *optimum distribution* and efficient utilization of available health resources especially for people in *rural-based under resourced areas*. See section 5.4 page 52 above.

In terms of health care *finance* the reduction in inter-provincial per capita spending for health care is exacerbating the *intra-provincial inequities* at primary health care levels with the resultant *poor quality of health care* at service points. Service management and delivery at a district level are still structurally, functionally and geographically *fragmented*.

Conceptually, the findings in this study indicate that the South African policy and legislation makes relevant provisions for the transformation of health care service in line with primary health care principles. In addition, the health care system delivery strategies utilized within the South African health care system are appropriate for its population diversities and are in line with principles of ethics and democracy. The main problem lies with limited co-ordination and unsystematic implementation of policy, and legislation provisions at service points. This is further confounded by the historical backlog of geographical fragmentations and inequitable resource allocations.

¹³⁰ Transformation of health care service to comprehensive community-based equitable health care at primary health care level.

Research findings in eThekweni District generally indicate the maldistributions of both health facilities and health personnel between urban and rural areas. These maldistributions are characterized by the over-concentration of human and health facility resources in over-resourced urban areas and shortages of human and health facility resources in under-resourced rural areas. Findings also indicate that primary health care service is still mainly offered by one dominant health discipline compared to the recommended health personnel skill mix of up to eight categories of disciplines for comprehensive PHC care service.

As indicated in the introduction, mental health care users are at risk of being excluded and marginalized during health sector transformation. In the current health care transformation phase in eThekweni District, there is limited mental health care taking place at primary health care level because health care services are still mainly offered by a single health discipline. At present there are no existing facilities to cater for mental health care at primary health care level. Based on this background it can be concluded that the allocation of health resources for mental health at eThekweni District still remains unjust and inequitable.

6.1.2. Limitations of the study

- i. Normally a typical district should have a specifically delegated district hospital. In the case of eThekweni District at the time of the study the process of restructuring and grading of hospitals was still underway. There was therefore no information on specific district hospitals for a specific Primary Health Care (PHC) Area. For this reason, the district hospitals were excluded from the study.
- ii. Time constraints did not allow for extending the study to include views of consumers of service to establish their level of satisfaction and their perceptions of the quality of health care they receive at service points. *See stages 4 and 5 of health care system delivery.*

6.2. Recommendations

The current government initiative to transform the health sector face complex challenges of historical disparities, cultural and socio-economic diversities which have resulted in the maldistribution of health resources. According to the findings in this research current health personnel and facilities at primary health care level are not adequate and appropriate to cope with mental health care needs. In this way mental health care users will be marginalized and the burden of mental illness will continue to increase. Findings in this research indicate that health personnel are maldistributed geographically and fall far below the skill mix norm recommended for comprehensive health care at primary health care level.

It is recommended that a well co-ordinated strategic plan be drawn up to practically address the *production, distribution and management* of human resources and *infrastructure* in line with primary health care *demand for health service* based on population size of each primary health care (PHC) area as follows:

6.2.1. Health service demand

The development of specific *staff structures* by the Sub-District managers for each primary health care (PHC) area using the *workload formula* for staff full-time equivalents (FTE's). These staff structures should include all *discipline categories* recommended for *integrated* health care at primary health care level. See table 3 page 30. These staff structures will be used to:

- i. Indicate the current *human resource status* at service points in the PHC areas.
- ii. Inform the *programmes* for human resource production, distribution and management.
- iii. Assist in *monitoring* the staff coverage and the availability of health service at service points.

6.2.2. Human resource production

The rolling out of a *practical programme* by the Provincial Health Department for the *training of specific disciplines* in line with staff structures developed by the Sub-District Managers by:

- i. Identifying specific *academic* establishments and *health* establishments which can collaboratively *recruit* and *train* specific numbers of health *personnel mix* to fill in the positions as necessary.
- ii. Allocating an *appropriate budget* to cover the training expenses for those disciplines.

6.2.3. *Human resource mobilization*

For the national, provincial and local *government tiers* of government to urgently finalise an agreement on *uniform conditions* for service for all health personnel across all *government levels* in order to:

- i. Facilitate *easy deployment* of health personnel in line with health sector transformation to primary health care.
- ii. Facilitate the deployment of *available adequately experienced* management personnel to serve in *under-resourced* areas

6.2.4. *Human resource management, service delivery and access*

For the Provincial Government to *improve the infrastructure* and the *working conditions* for personnel in *under-resourced* areas by:

- i. Providing adequate *security* for staff, *appropriate equipment, materials* and *health facilities* at primary health care level.
- ii. Improving infrastructure and *basic services* in under-resourced areas to make it easier for health personnel to work in all areas and for health consumers to *access* health service points.

6.3. Areas for future research

- i. The impact of de-institutionalisation for mental health care users in an integrated health care approach: Implications for policy development.
- ii. Mental health care economics: Identification of cost drivers in mental health care.
- iii. Perceptions of integrated health care service by mental health care users attending primary health care clinics.

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ANNEXURES

ANNEXURE 1

Schedule of data collection

DATE	TIME	RESPONDENT
1. 10/02/06	14:00 -16:00	Sub-District Manager
3. 16/02/06	09:30 – 11:00	Nursing Service Manager- Area N2
3. 16/02/06	13:00 - 15:00	Sub-District Manager- South
4. 03/03/06	14:00 – 16:00	Mental Health Manager: North, South & West
5. 10/03/06	11:00 – 12:30	Nursing Service Manager- Area S3
6. 13/03/06	14:00 – 15:00	Nursing Service Manager- Area S4
7. 15/03/06	14:30 – 15:30	Sub-District Manager- West
8. 17/03/06	13:00 – 14:00	Nursing Service Manager- Area S6
9. 20/03/06	14:00 – 15:00	Nursing Service Manager- Area S3
10. 22/03/06	13:30 – 14:15	Nursing Service Manager- Area N4
11. 22/03/06	14:15 – 15:00	Nursing Service Manager- Area
12. 20/04/06	14:00 -15:00	Geographic Information Systems (GIS) Data EThekweni Municipality
13. 22/06/06	10:00 – 15:00	Persal Control Department of Health Province of KwaZulu-Natal

ANNEXURE 2

Public/Private Partnerships (PPP) mix in health care.

(Adopted from the Draft Policy Framework: Public/Private Partnership in the Health Sector)

DIMENSION	CATEGORY OF PARTNERSHIP			
	PURCHASED SERVICES	OUTSOURCING	JOINT VENTURE	PRIVATE FINANCE INITIATIVES
PRIMARY NEED	Improve access or quality of service	Reduce public sector cost or improve quality or access for same cost	Generates resources for public sector and or reduce overall cost	Upgrade public hospital facilities
STRENGTH	Can get specialist services not available in private sector	Can save funds through greater efficiency	Can leverage resources in short supply such as doctors Can acquire management skills and systems Can reduce public and public costs	Can overcome capital funding constraints Can transfer some risks to private sector
WEAKNESSES	Requires increased spending Requires some public management skills not widely available	Can lose ability to provide service Have to lay off staff Requires some public management skills not widely available	If unable to use revenue, may require increased public expenditure for staffing or to improve quality Requires some public management skills not widely available	Recurrent costs may be unaffordable Demand may mainly be in places where there is over-supply Requires some public management skills not widely available
OPPORTUNITIES			Medical Schemes Act should increase demand Certificate of need process will control oversupply and encourage maximum utilization of existing services	May be appropriate for renovation of public health facilities
THREATS			Private sector may transfer patients whose costs exceed public sector fees	

ANNEXURE 3

Request for preliminary consultation

Occupational Therapy Department
University of KwaZulu-Natal
Westville Campus
Private Bag X54001
Durban
4000

Tel **031 2607954**
Cell **082 752 4514**
Fax 031 260 7227
e-mail phehlukwayos@ukzn.ac.za

24 January 2005

The District Manager
eThekweni (Durban) District Office
Prince Wing Building

Sir

REQUEST FOR PRELIMINARY CONSULTATION

I am currently studying towards the degree in **Masters in Public Health Law** in the above university. My field of specialty is **Mental Health**. My research topic is based on **resource allocations** for mental health in a **District Health System**.

I hereby request an appointment for a short **initial consultation** meeting with you at with regard to:

- **My Research proposal**
- **Field Guidance in terms of need**

I am fully aware of your tight schedule from my previous attempts to reach you telephonically; but would greatly appreciate **at least half an hour of your time at your earliest possible**.

Thank you.

Yours truly,
S.M. Phehlukwayo (Mr)

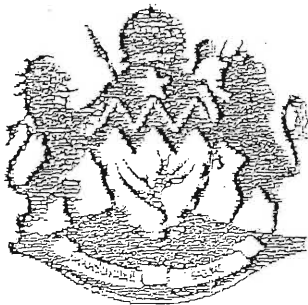


ANNEXURE 4

Permission: request for preliminary consultation

Consultation & Collaboration

**Office of the eThekwin District Manager
Department of Health Province of KwaZulu-Natal**



DEPARTMENT OF HEALTH

PROVINCE OF KWAZULU-NATAL

Office of the eThekwin District Manager
Private Bag X54318, DURBAN, 4000
Prince Wing, Cnr Prince Street and Hospital Road, South Beach

Tel No. 031-3277856 Fax No. 031-3321229
E-Mail Address: h041202@dohho.kznhl.gov.za

Ref. No. 11-02-2005 (Research)

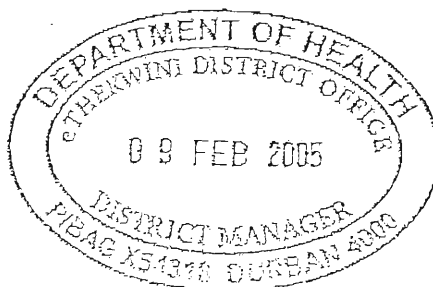
7 February 2005

Mr. S.M. Phehlukwayo
Occupational Therapy Department
University of KwaZulu-Natal

REQUEST FOR PRELIMINARY CONSULTATION ON RESEARCH

1. Your matter has been referred to the Programme Manager for Chronic Diseases who advises the District Manager on Mental Health Services.
2. You will henceforth hear from the Programme Manager (Ms. L. Shongwe).


MR. T.E. MSIZA
DISTRICT MANAGER: eTHEKWINI
TEM/vd



ANNEXURE 5

Consent letter: District Manager & Programme Manager

Occupational Therapy Department
University of KwaZulu-Natal
Westville Campus
Private Bag X54001
Durban
4000

Tel 031 2607954
Cell 082 752 4514
Fax 031 260 7227
e-mail phehlukwayos@ukzn.ac.za

Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN YOUR HEALTH DISTRICT

RESEARCH TITLE

JUSTICE AND EQUITY
IN
THE ALLOCATION OF HEALTH RESOURCES FOR MENTAL HEALTH
IN eETHEKWINI DISTRICT

I am a Public Health Law Masters student in the University of KwaZulu-Natal Westville Campus (formally, University of Durban-Westville). I am currently doing a study in the above topic as part of my requirements towards the completion of the degree in Public Health Law. I hereby request permission to conduct research on this study in your district.

Based on my literature search and own observations there is an insidious increase of severe mental illness and a tendency to marginalize mentally ill people in the allocation of health resources. Most mentally ill people do not disclose their illness for fear of stigmatization. When severely ill, mentally ill people will not seek help due to lack of insight to their illness. With limited knowledge about mental illness, which is also confounded by socio-cultural dynamics, mentally ill people end with limited, inappropriate or no access to mental health care. The situation is exacerbated by co-existence of mental symptoms in the HIV-AIDS patients. In some cases mental illness remains undetected and only gets diagnosed when the patient presents with a physical condition. On the other hand physical illness is more evident, most of its symptoms are well known, most physical conditions have limited or no stigma

attached and demand urgent attention, particularly when life is being threatened. As a consequent, competing health needs between mentally ill and physically ill seems to have led to the progressive marginalisation of mentally ill in the allocation of health resources.

While an impressive number of new policies and legislation has been passed in South Africa in the past ten years; existing public sector services are still limited in reaching the most vulnerable sectors of our patient population; the severe mentally ill.

Currently mentally ill patients are being discharged into the community with limited or no resources/ relevant infrastructure to cater for their health needs. The purpose of this study is to establish if the allocation of human resources for mental health reflect justice and equity in line with policy and strategies for the transformation of mental health services within a District health System.

Document analysis of relevant policy and legislation will be carried out to provide context to the study and data will be gathered to establish how health facilities are distributed geographically in the Health District and how mental health human resources have been allocated across all levels of care

It is envisaged that the findings from this study will provide critical insights for health planners and inform the development process for local policies and strategies that will facilitate just and equitable distribution of resources for severe mental illness in the Health District.

Although your participation in this research is voluntary, your unique contribution to this study will be of great value towards the development of services for one of the vulnerable population sectors of our society. Your favourable consideration of this request will therefore be most appreciated.

Ethical clearance to conduct this study has been obtained from the University of KwaZulu-Natal Research and Ethics Committee (see annexure 3)

Should you have any further queries, you are most welcome to contact me directly through any of my contact details above.

Kindly reply me through fax or postal address provided.

Thank you.

Yours truly,

.....

S.M. Phehlukwayo(Researcher)

ANNEXURE 6

Ethical clearance



RESEARCH OFFICE (FRANCIS STOCK BUILDING)
HOWARD COLLEGE
TELEPHONE NO.: 031 – 2603587

6 APRIL 2005

MR. SM PHEHLUKWAYO (200000923)
PUBLIC HEALTH LAW

Dear Mr. Phehlukwayo

ETHICAL CLEARANCE:

I wish to confirm that ethical clearance has been granted for the following project:

“Justice and equity in the allocation of Health Resources for Mental Health in Durban-eThekweni Health District”

Yours faithfully

MS. PHUMELELE XIMBA
RESEARCH OFFICE

PS: The following general condition is applicable to all projects that have been granted ethical clearance:

THE RELEVANT AUTHORITIES SHOULD BE CONTACTED IN ORDER TO OBTAIN THE NECESSARY APPROVAL SHOULD THE RESEARCH INVOLVE UTILIZATION OF SPACE AND/OR FACILITIES AT OTHER INSTITUTIONS/ORGANISATIONS. WHERE QUESTIONNAIRES ARE USED IN THE PROJECT, THE RESEARCHER SHOULD ENSURE THAT THE QUESTIONNAIRE INCLUDES A SECTION AT THE END WHICH SHOULD BE COMPLETED BY THE PARTICIPANT (PRIOR TO THE COMPLETION OF THE QUESTIONNAIRE) INDICATING THAT HE/SHE WAS INFORMED OF THE NATURE AND PURPOSE OF THE PROJECT AND THAT THE INFORMATION GIVEN WILL BE KEPT CONFIDENTIAL.

cc. Faculty Officer
cc. Supervisor

ANNEXURE 7

Consent letter: the Superintendent-General

KWAZULU-NATAL HEALTH SERVICES

Occupational Therapy Department
University of KwaZulu-Natal
Westville Campus
Private Bag X54001
Durban
4000
April 25, 2005

Sir

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN eTHEKWINI DISTRICT

RESEARCH TITLE

"JUSTICE AND EQUITY
IN
THE ALLOCATION OF HEALTH RESOURCES FOR MENTAL HEALTH
IN eTHEKWINI DISTRICT"

I am a Public Health Law Masters student at the University of KwaZulu-Natal, Westville Campus (formally, University of Durban-Westville). I am currently doing a study in the above topic as part of the requirements towards the completion of this degree. I hereby request permission to conduct research on this study in eThekwin District.

Despite a lot of work already done in the Province, Mental Health Services in KwaZulu-Natal still face many challenges emanating from the legacy of the past and the nature of mental illness. Based on literature search and own observations there is an insidious increase of severe mental illness and a tendency to marginalize mentally ill people due to a variety factors. Most mentally ill people tend to avoid disclosing their illness for fear of stigmatization. Due to the nature of mental illness itself, some mentally ill people fail to seek help due to lack of insight to their illness. In addition, limited knowledge about mental illness by the society and in particular, care givers, which may be further confounded by the underlying socio-cultural dynamics; mentally ill people end up with limited, inappropriate or no access to mental health care. The situation is exacerbated by co-existence of mental symptoms in the HIV-AIDS patients. In some cases mental illness remains undetected and only gets diagnosed when the patient presents with a physical condition. On the other hand physical illness is more evident, most of its symptoms are well known, most physical conditions have limited or no stigma attached and demand urgent attention, particularly when life is being threatened. As a result, competing health needs between mentally ill and physically ill seem to have led to the progressive marginalisation of mentally ill in the allocation of health resources.

While an impressive number of new policies and legislation has been passed in South Africa in the past ten years; existing public sector services are still limited in reaching people with severe mental illness.

Currently mentally ill patients are being discharged into the community with limited or no resources and relevant infrastructure to cater for their health needs. Human resource distribution plays a crucial role in the supply of mental health service. There is a need for specific mental health policy research to inform the process and strategies for mental health service transformation. The purpose of this study is to establish if the allocation of human resources for mental health reflect justice and equity in line with policy and strategies for the transformation of mental health services within a District Health System.

Analysis of relevant policy and legislation will be carried out to provide context to the study. Data will be gathered on population size and point prevalence for severe mental illness to establish the extent of demand for mental health service. Data will also be established on geographical distribution of health facilities as well as the distribution and occupational mix of mental health personnel, to determine the extent of mental health service supply across all levels of care in your District.

Data on population size, point prevalence for severe mental illness, geographical distribution of health services and mental health services will be collected over a period of two hours through structured from the District Office (as per annexure 6). Data on occupational mix and allocation of health personnel will be gathered from the sampling units which will be comprised of four sub-districts (see section 2.2 on page 6 of the protocol) over four days from the Health Facilities as per annexure 7. See section 2.5 on page 9 of the Protocol.

It is envisaged that the findings from this study will contribute towards the current initiatives of Mental Health Policy development and related strategies in facilitating just and equitable distribution of resources for severe mental health care in eThekweni District.

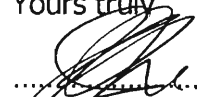
For me, this study extends beyond my academic requirement to complete this degree, to that of need to contribute towards the development of effective Mental Health Policy and Legislation that will ensure the best quality of Mental Health Service for one of the most vulnerable sectors of our society, the mentally ill. Your favourable consideration of this request will make this need possible; and this will be most appreciated.

Ethical clearance to conduct this study has been obtained from the University of KwaZulu-Natal Research and Ethics Committee.

I further attach my Research Proposal for your information. Should you have any further queries, you are most welcome to contact me directly through any of my contact details above.

Kindly reply me through fax or postal address provided.
Thank you.

Yours truly



.....
S.M. Phehlukwayo
(Researcher)

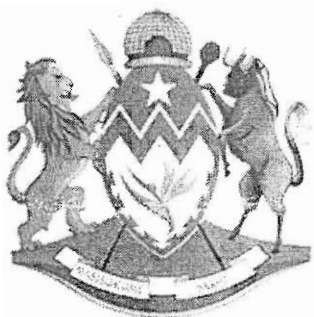
ANNEXURE 8

Letter of approval

PERMISSION TO CONDUCT RESEARCH IN eTHEKWINI DISTRICT

THE SUPERINTENDENT-GENERAL

KWAZULU-NATAL HEALTH SERVICES



DEPARTMENT OF HEALTH

PROVINCE OF KWAZULU-NATAL

SPECIAL SUPPORT SERVICES

Natalia, 330 Longmarket Street, Pietermaritzburg, 3201
Private Bag X9051, Pietermaritzburg, 3200
Tel.: 033 395 2813, Fax.: 033 345 4433

Enquiries: Miss A. Kopman
Extension: 2813
Reference: 9/2/3/R

12 OCT 2005

Mr S.M. Phehlukwayo
Occupational Therapy Department
University of KwaZulu-Natal
Westville Campus
Private Bag X54001
DURBAN
4000

Dear Sir

JUSTICE AND EQUITY IN THE ALLOCATION OF HEALTH RESOURCES FOR MENTAL HEALTH IN e-ETHEKWINI DISTRICT

Your correspondence in the above regard refers.

Please be advised that authority is granted for you to conduct research, "**Justice and equity in the allocation of health resources for mental health in e-Ethekwini district**" provided that :-

- (a) Prior approval is obtained from the Heads of the institutions;
- (b) Confidentiality is maintained;
- (c) The Department is acknowledged; and
- (d) The Department receives a copy of the report on completion.

Yours sincerely


SUPERINTENDENT GENERAL
HEAD : DEPARTMENT OF HEALTH
AJK/phehlukwayo



ANNEXURE 9

Consent letter: Sub-District Manager - North Sub-District

Occupational Therapy Department
University of KwaZulu-Natal
Westville Campus
Private Bag X54001
Durban
4000

February 1, 2006

Tel 031 2607954
Cell 082 752 4514
Fax 031 260 7227
e-mail phehlukwayos@ukzn.ac.za

Sir

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN YOUR SUB-DISTRICT

RESEARCH TITLE

JUSTICE AND EQUITY IN THE ALLOCATION OF HEALTH RESOURCES FOR MENTAL HEALTH IN eETHEKWINI DISTRICT

I am a Public Health Law Masters student at the University of KwaZulu-Natal Westville Campus (formally, University of Durban-Westville). I am currently doing a study in the above topic as part of the requirements towards the completion of this degree. I hereby request permission to conduct research on this study in your District.

Based on my literature search and own observations there is an insidious increase of severe mental illness and a tendency to marginalize mentally ill people in the allocation of health resources. Most mentally ill people tend to avoid disclosing their illness for fear of stigmatization. Due to the nature of mental illness, some mentally ill people fail to seek help due to lack of insight to their illness. In addition, limited knowledge about mental illness by the society and in particular, care givers, which may be further confounded by the underlying socio-cultural dynamics; mentally ill people end up with limited, inappropriate or no access to mental health care. The situation is exacerbated by co-existence of mental symptoms in the HIV-AIDS patients. In some cases mental illness remains undetected and only gets diagnosed when the patient presents with a physical condition. On the other hand physical illness is more evident, most of its symptoms are well known, most physical conditions have limited or no stigma attached and demand urgent attention, particularly when life is being threatened. As a consequent, competing health needs between mentally ill and physically ill seems to

have led to the progressive marginalisation of mentally ill in the allocation of health resources.

While an impressive number of new policies and legislation has been passed in South Africa in the past ten years; existing public sector services are still limited in reaching the most vulnerable sectors of our patient population which includes people with severe mental illness.

Currently mentally ill patients are being discharged into the community with limited or no resources and relevant infrastructure to cater for their health needs. Human resource distribution plays a crucial role in the supply of mental health service. The purpose of this study is to establish if the allocation of human resources for mental health reflect justice and equity in line with policy and strategies for the transformation of mental health services within a District Health System.

Analysis of relevant policy and legislation will be carried out to provide context to the study. Data will be gathered on population size and point prevalence for severe mental illness to establish the extent of demand for mental health service. Data will also be established on geographical distribution of health facilities and allocation of mental health personnel to determine the extent of mental health service supply across all levels of care in your District.

It is envisaged that the findings from this study will provide critical insights which may be used to inform the development of policies and strategies that will facilitate just and equitable distribution of resources for severe mental health care in the District (see annexure 4)

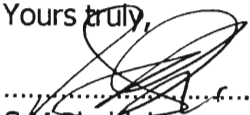
Although your participation in this research is voluntary, your unique contribution to this study will be of great value towards the development of services for one of the vulnerable population sectors of our society. Your favourable consideration of this request will therefore be most appreciated.

Ethical clearance to conduct this study has been obtained from the University of KwaZulu-Natal Research and Ethics Committee (see annexure 3)

Should you have any further queries, you are most welcome to contact me directly through any of my contact details above.

Kindly reply me through fax or postal address provided.

Thank you.

Yours truly,

.....
S.M.Phehlukwayo
(Researcher)

ANNEXURE 10

Consent letter: Sub-District Manager - South Sub-District

Occupational Therapy Department
University of KwaZulu-Natal
Westville Campus
Private Bag X54001
Durban
4000
February 1, 2006

Tel 031 2607954
Cell 082 752 4514
Fax 031 260 7227
e-mail phehlukwayos@ukzn.ac.za

Sir

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN YOUR SUB-DISTRICT

RESEARCH TITLE

JUSTICE AND EQUITY
IN
THE ALLOCATION OF HEALTH RESOURCES FOR MENTAL HEALTH
IN eETHEKWINI DISTRICT

I am a Public Health Law Masters student at the University of KwaZulu-Natal Westville Campus (formally, University of Durban-Westville). I am currently doing a study in the above topic as part of the requirements towards the completion of this degree. I hereby request permission to conduct research on this study in your District.

Based on my literature search and own observations there is an insidious increase of severe mental illness and a tendency to marginalize mentally ill people in the allocation of health resources. Most mentally ill people tend to avoid disclosing their illness for fear of stigmatization. Due to the nature of mental illness, some mentally ill people fail to seek help due to lack of insight to their illness. In addition, limited knowledge about mental illness by the society and in particular, care givers, which may be further confounded by the underlying socio-cultural dynamics; mentally ill people end up with limited, inappropriate or no access to mental health care. The situation is exacerbated by co-existence of mental symptoms in the HIV-AIDS patients. In some cases mental illness remains undetected and only gets diagnosed when the patient presents with a physical condition. On the other hand physical illness is more evident, most of its symptoms are well known, most physical conditions have limited or no stigma attached and demand urgent attention, particularly when life is being threatened. As a consequent, competing health needs between mentally ill and physically ill seems to

have led to the progressive marginalisation of mentally ill in the allocation of health resources.

While an impressive number of new policies and legislation has been passed in South Africa in the past ten years; existing public sector services are still limited in reaching the most vulnerable sectors of our patient population which includes people with severe mental illness.

Currently mentally ill patients are being discharged into the community with limited or no resources and relevant infrastructure to cater for their health needs. Human resource distribution plays a crucial role in the supply of mental health service. The purpose of this study is to establish if the allocation of human resources for mental health reflect justice and equity in line with policy and strategies for the transformation of mental health services within a District Health System.

Analysis of relevant policy and legislation will be carried out to provide context to the study. Data will be gathered on population size and point prevalence for severe mental illness to establish the extent of demand for mental health service. Data will also be established on geographical distribution of health facilities and allocation of mental health personnel to determine the extent of mental health service supply across all levels of care in your District.

It is envisaged that the findings from this study will provide critical insights which may be used to inform the development of policies and strategies that will facilitate just and equitable distribution of resources for severe mental health care in the District (see annexure 4)

Although your participation in this research is voluntary, your unique contribution to this study will be of great value towards the development of services for one of the vulnerable population sectors of our society. Your favourable consideration of this request will therefore be most appreciated.

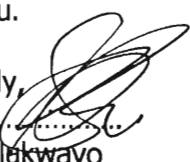
Ethical clearance to conduct this study has been obtained from the University of KwaZulu-Natal Research and Ethics Committee (see annexure 3)

Should you have any further queries, you are most welcome to contact me directly through any of my contact details above.

Kindly reply me through fax or postal address provided.

Thank you.

Yours truly,


.....
S.M.Phehlukwayo
(Researcher)

ANNEXURE 11

Consent letter: Sub-District Manager - West Sub-District

Occupational Therapy Department
University of KwaZulu-Natal
Westville Campus
Private Bag X54001
Durban
4000
March 1, 2006

Tel 031 2607954
Cell 082 752 4514
Fax 031 260 7227
e-mail phehlukwayos@ukzn.ac.za

Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN YOUR SUB-DISTRICT

RESEARCH TITLE

JUSTICE AND EQUITY
IN
THE ALLOCATION OF HEALTH RESOURCES FOR MENTAL HEALTH
IN eTHEKWINI DISTRICT

I am a Public Health Law Masters student at the University of KwaZulu-Natal Westville Campus (formally, University of Durban-Westville). I am currently doing a study in the above topic as part of the requirements towards the completion of this degree. I hereby request permission to conduct research on this study in your District.

Based on my literature search and own observations there is an insidious increase of severe mental illness and a tendency to marginalize mentally ill people in the allocation of health resources. Most mentally ill people tend to avoid disclosing their illness for fear of stigmatization. Due to the nature of mental illness, some mentally ill people fail to seek help due to lack of insight to their illness. In addition, limited knowledge about mental illness by the society and in particular, care givers, which may be further confounded by the underlying socio-cultural dynamics; mentally ill people end up with limited, inappropriate or no access to mental health care. The situation is exacerbated by co-existence of mental symptoms in the HIV-AIDS patients. In some cases mental illness remains undetected and only gets diagnosed when the patient presents with a physical condition. On the other hand physical illness is more evident, most of its symptoms are well known, most physical conditions have limited or no stigma attached and demand urgent attention, particularly when life is being threatened. As a consequent, competing health needs between mentally ill and physically ill seems to

have led to the progressive marginalisation of mentally ill in the allocation of health resources.

While an impressive number of new policies and legislation has been passed in South Africa in the past ten years; existing public sector services are still limited in reaching the most vulnerable sectors of our patient population which includes people with severe mental illness.

Currently mentally ill patients are being discharged into the community with limited or no resources and relevant infrastructure to cater for their health needs. Human resource distribution plays a crucial role in the supply of mental health service. The purpose of this study is to establish if the allocation of human resources for mental health reflect justice and equity in line with policy and strategies for the transformation of mental health services within a District Health System.

Analysis of relevant policy and legislation will be carried out to provide context to the study. Data will be gathered on population size and point prevalence for severe mental illness to establish the extent of demand for mental health service. Data will also be established on geographical distribution of health facilities and allocation of mental health personnel to determine the extent of mental health service supply across all levels of care in your District.

It is envisaged that the findings from this study will provide critical insights which may be used to inform the development of policies and strategies that will facilitate just and equitable distribution of resources for severe mental health care in the District (see annexure 4)

Although your participation in this research is voluntary, your unique contribution to this study will be of great value towards the development of services for one of the vulnerable population sectors of our society. Your favourable consideration of this request will therefore be most appreciated.

Ethical clearance to conduct this study has been obtained from the University of KwaZulu-Natal Research and Ethics Committee (see annexure 3)

Should you have any further queries, you are most welcome to contact me directly through any of my contact details above.

Kindly reply me through fax or postal address provided.

Thank you.

Yours truly,

.....
S.M.Phehlukwayo
(Researcher)

ANNEXURE 12

Consent letter: e-Thekwini Municipality

*HEALTH, SAFETY AND SOCIAL SERVICES CLUSTER
HEALTH UNIT
CLINICAL SUPPORT SERVICES*

Occupational Therapy Department
University of KwaZulu-Natal
Westville Campus
Private Bag X54001
Durban
4000
February 6, 2006

Tel 031 2607954
Cell 082 752 4514
Fax 031 260 7227
e-mail phehlukwayos@ukzn.ac.za

Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN YOUR SUB- DISTRICT

RESEARCH TITLE

JUSTICE AND EQUITY
IN
THE ALLOCATION OF HEALTH RESOURCES FOR MENTAL HEALTH
IN eTHEKWINI DISTRICT

I am a Public Health Law Masters student at the University of KwaZulu-Natal Westville Campus (formally, University of Durban-Westville). I am currently doing a study in the above topic as part of the requirements towards the completion of this degree. I hereby request permission to conduct research on this study in your District.

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Kindly reply me through fax or postal address provided.

Thank you.

Yours truly,

.....
S.M.Phehlukwayo

(Researcher)

ANNEXURE 13

Approval letter: e-Thekwini Municipality

*HEALTH, SAFETY AND SOCIAL SERVICES CLUSTER
HEALTH UNIT
CLINICAL SUPPORT SERVICES*

ETHEKWINI MUNICIPALITY
Health, Safety and Social Services Cluster
Health Unit

9 Old Fort Place
Durban 4001

P O Box 2443
Durban 4000

Tel: (031) 300 3911
Fax: (031) 300 3030

Website: <http://www.durban.org.za>



Your Ref :

Your Ref :

Enquiries :

CLINICAL SUPPORT SERVICES
(Dr R Gajee)
Telephone 311-3679

2006-02-23

Mr Mandla Phehlukwayo
Occupational Therapy Department
University of KwaZulu Natal
Westville Campus
Private Bag X54001
4000 DURBAN

Dear Mr Phehlukwayo

**RE: RESEARCH REQUEST : JUSTICE AND EQUITY IN THE ALLOCATION OF
HEALTH RESOURCES FOR MENTAL HEALTH IN THE ETHEKWINI DISTRICT**

Permission is granted for the above study to be conducted in the eThekwin Municipality – Health Unit. Please contact our Mental Health Manager : Mrs Lesley Coetzee (311-3586) to arrange an appointment.

Please ensure that you adhere to our requirements outlined in the attached list.

Yours faithfully

U. Sanker
HEAD : HEALTH

Address correspondence to the Head : Health

G:\citypit\userdata\Monica\Clinical\Letr\2006-02-23.doc/1



ANNEXURE 14

Sub-District Questionnaire

Purpose

The purpose of this questionnaire is to assess demand and existing facilities for mental health services in the sub-structure.

Confidentiality Pledge

- Your identity and the identity of your facility will be kept anonymous in the report
- All raw data gathered from this interview will be kept confidential and only used for the purpose of this study.

Name of interviewer :

Date of interview :

1. Description of Sub-structure

- Name of sub-structure :
- Name of District :

2. Demographic Data of the Sub-structure

Please provide demographic details of your district as indicated below:

Population size	
-----------------	--

3. Distribution of health facilities

Please indicate the distribution and organization of health facilities in your district as indicated below:

LEVEL	NAME/ TYPE OF FACILITY	LOCATION/ ADDRESS	REFERRAL FACILITY

ANNEXURE 15

Health Facility Questionnaire

Purpose

The purpose of this questionnaire is to assess the distribution of mental health personnel in the sub-structure.

Confidentiality Pledge

- Your identity and the identity of your facility will be kept anonymous in the report
- All raw data gathered from this interview will be kept confidential and only used for the purpose of this study.

Name of interviewer :

Date of interview :

1. Health Facility Details

- Name of Health Facility :
- Level & Type :
- Sub-structure :
- Local Authority :

2. Supporting Documents and Maps

Please provide access/ supply copies of the supporting documents and maps on your District (for reference & use as annexures in the final report

3. Personnel Allocation

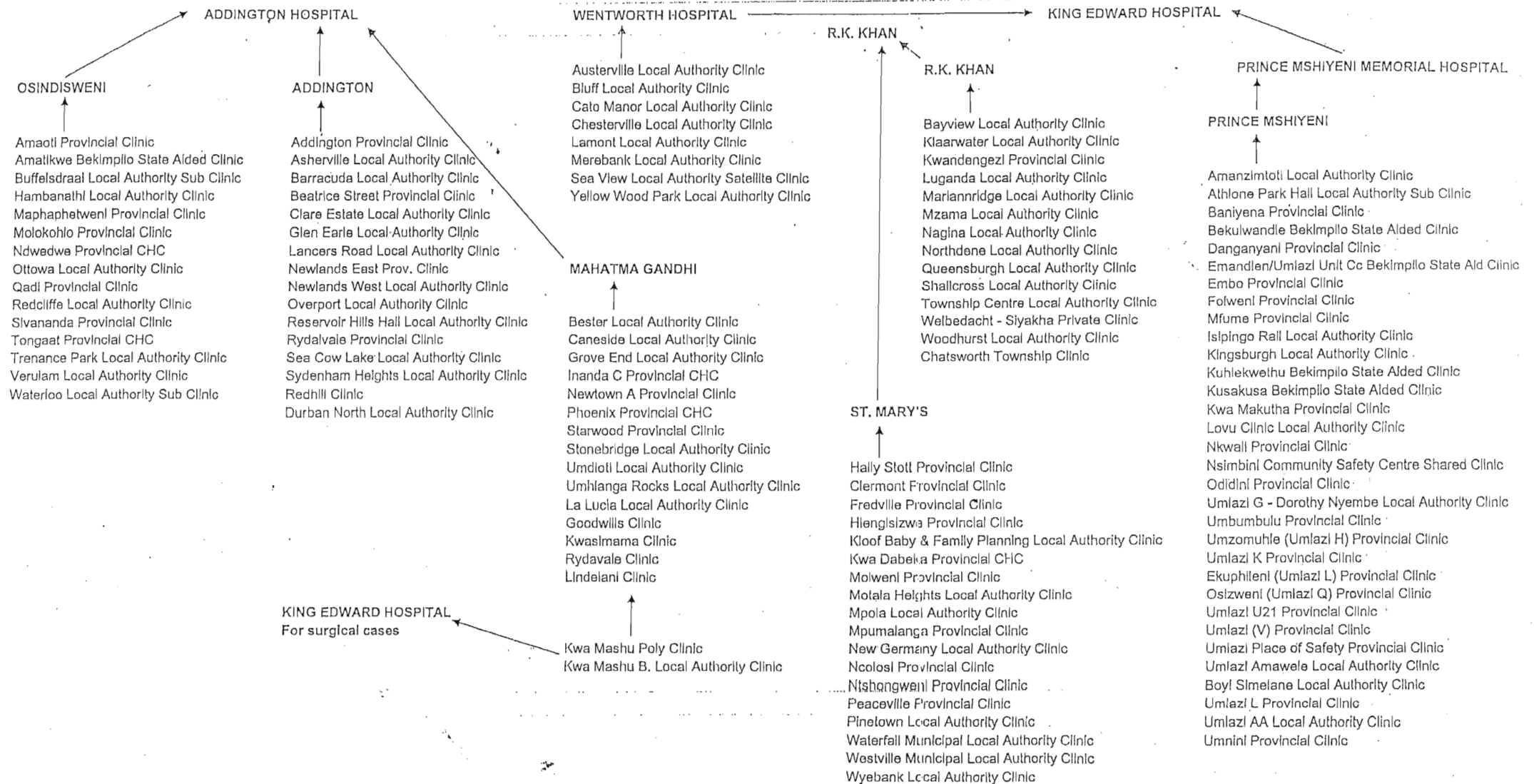
Please provide the category/ discipline and the total number of health personnel in your health facility.

STAFF CATEGORY/DISCIPLINE	NUMBER OF STAFF

ANNEXURE 16

Distribution of health facilities: e-Thekwini District

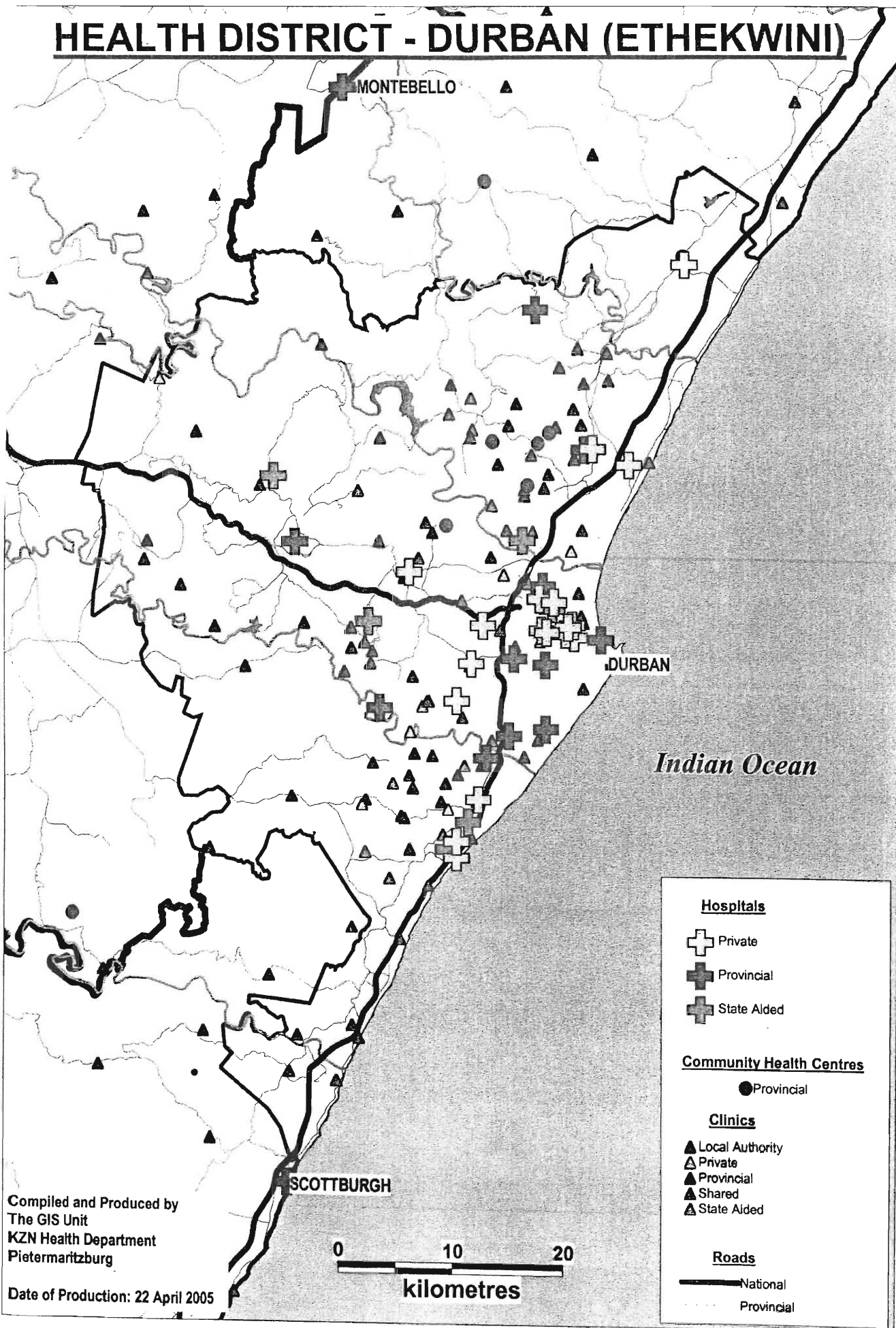
(ETHEKWINI)



NOTE: 1 ALL TERTIARY SERVICES ARE REFERRED DIRECTLY TO INKOSI ALBERT LUTHULI CENTRAL HOSPITAL BY ALL INSTITUTIONS.
2 WENTWORTH TO REFER REGIONAL PATIENTS TO KING EDWARD VIII HOSPITAL.

Revised: New referral pattern with effect 16 September 2005.

HEALTH DISTRICT - DURBAN (ETHEKWINI)

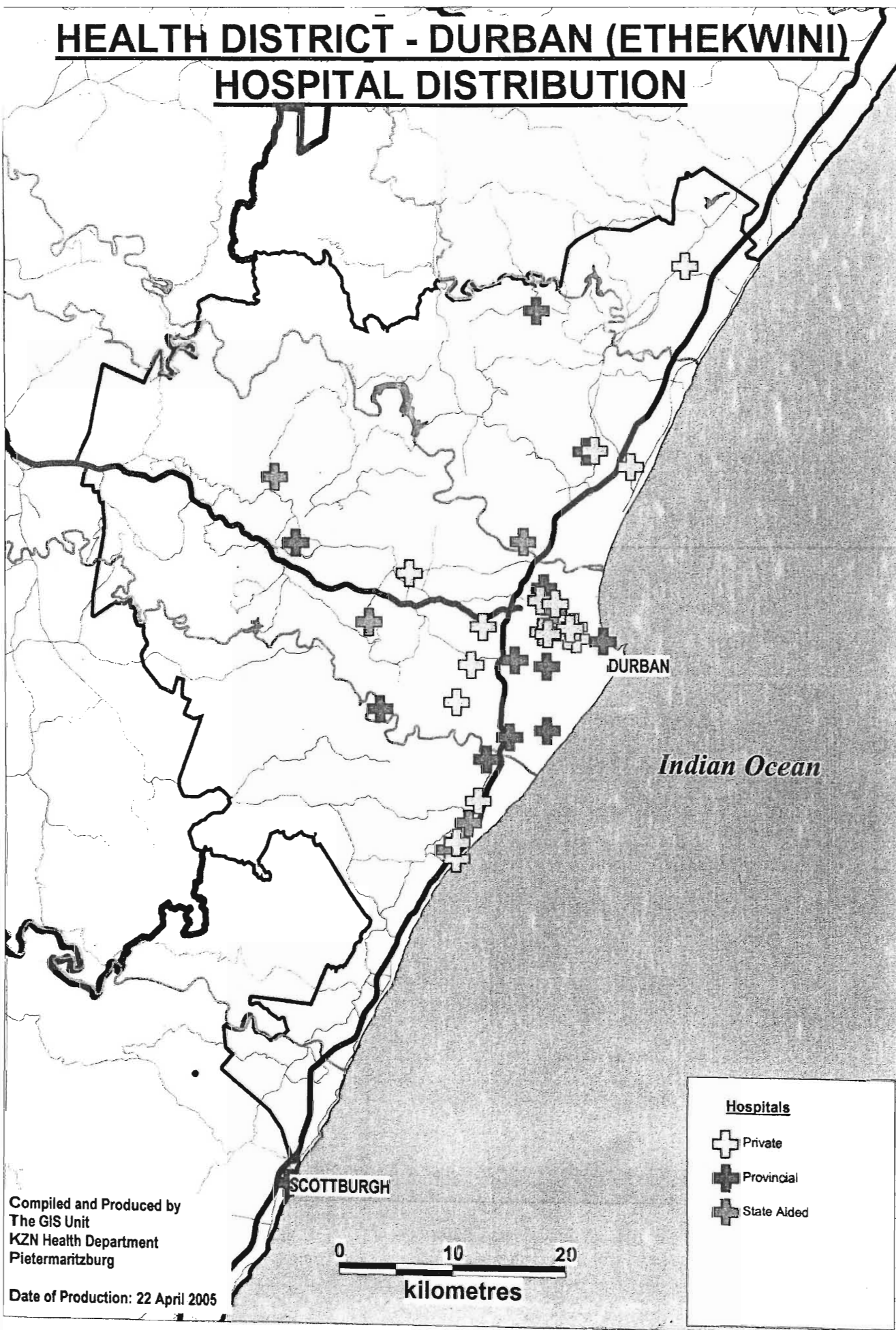


Compiled and Produced by
The GIS Unit
KZN Health Department
Pietermaritzburg

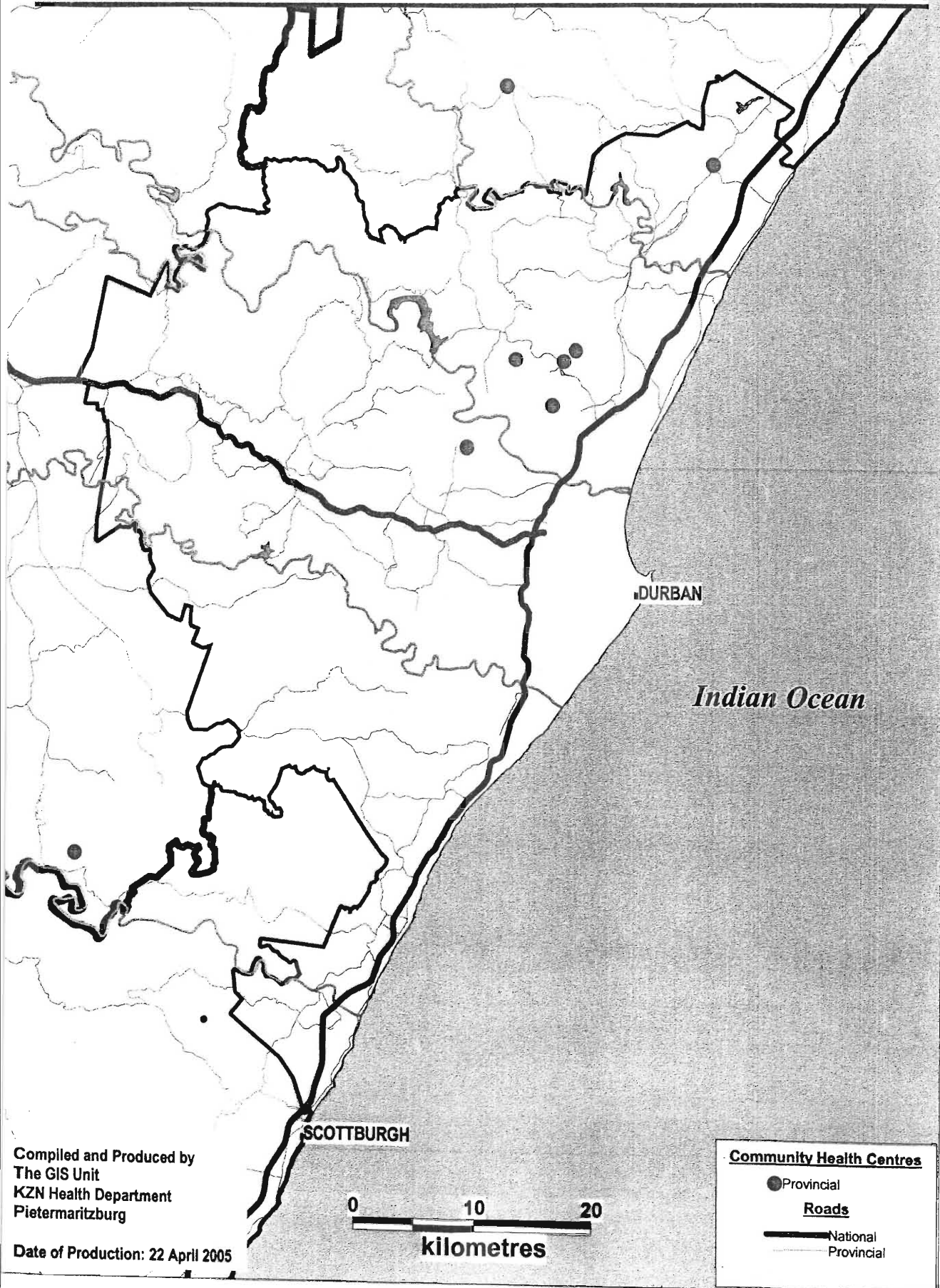
Date of Production: 22 April 2005

HEALTH DISTRICT - DURBAN (ETHEKWINI)

HOSPITAL DISTRIBUTION

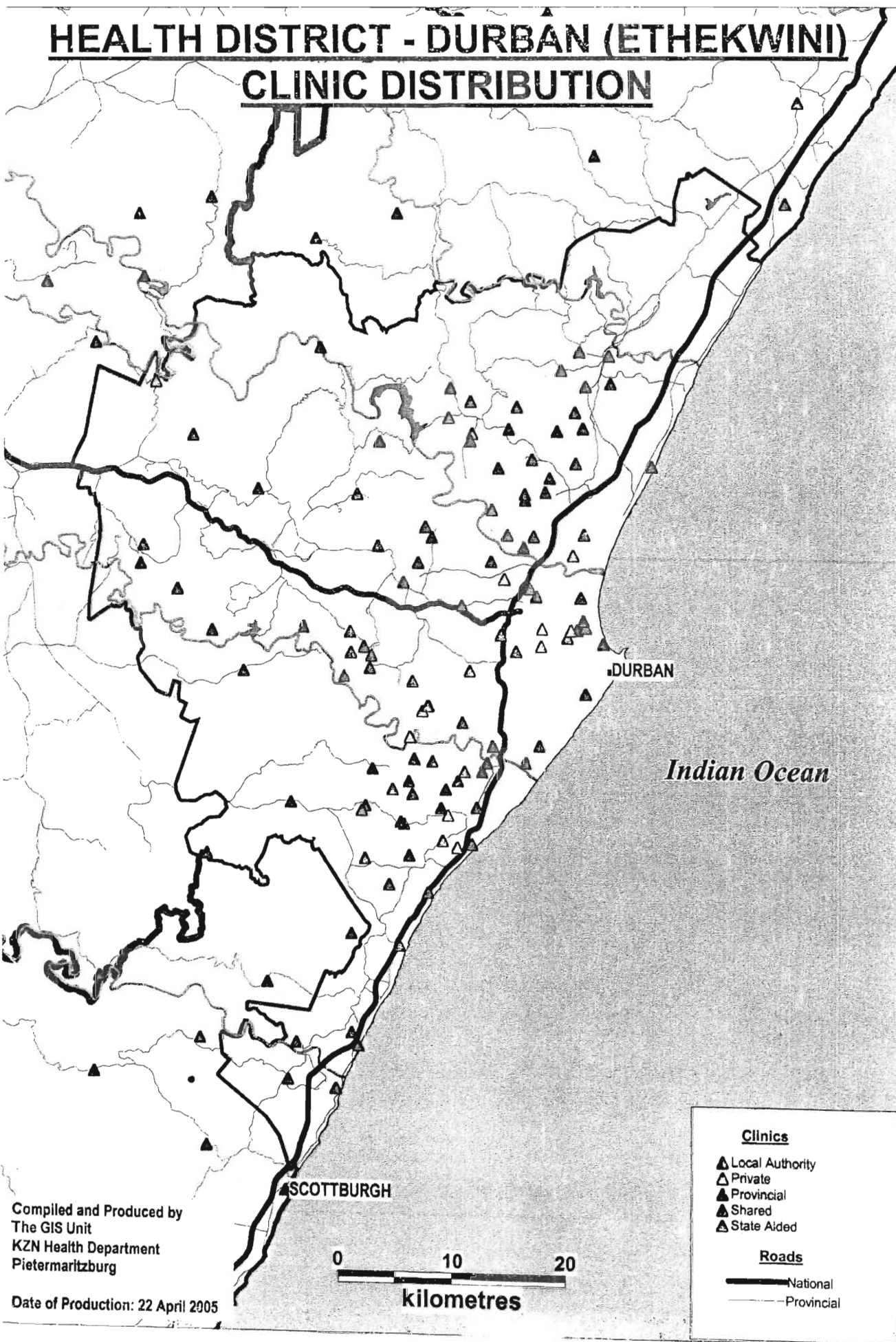


HEALTH DISTRICT - DURBAN (ETHEKWINI) COMMUNITY HEALTH CENTRE DISTRIBUTION



HEALTH DISTRICT - DURBAN (ETHEKWINI)

CLINIC DISTRIBUTION



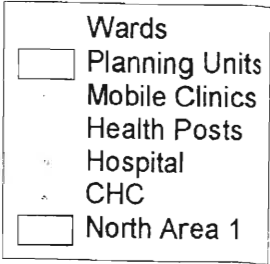
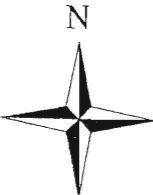
Compiled and Produced by
The GIS Unit
KZN Health Department
Pietermaritzburg

Date of Production: 22 April 2005

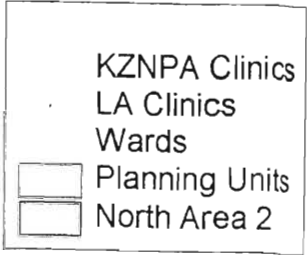
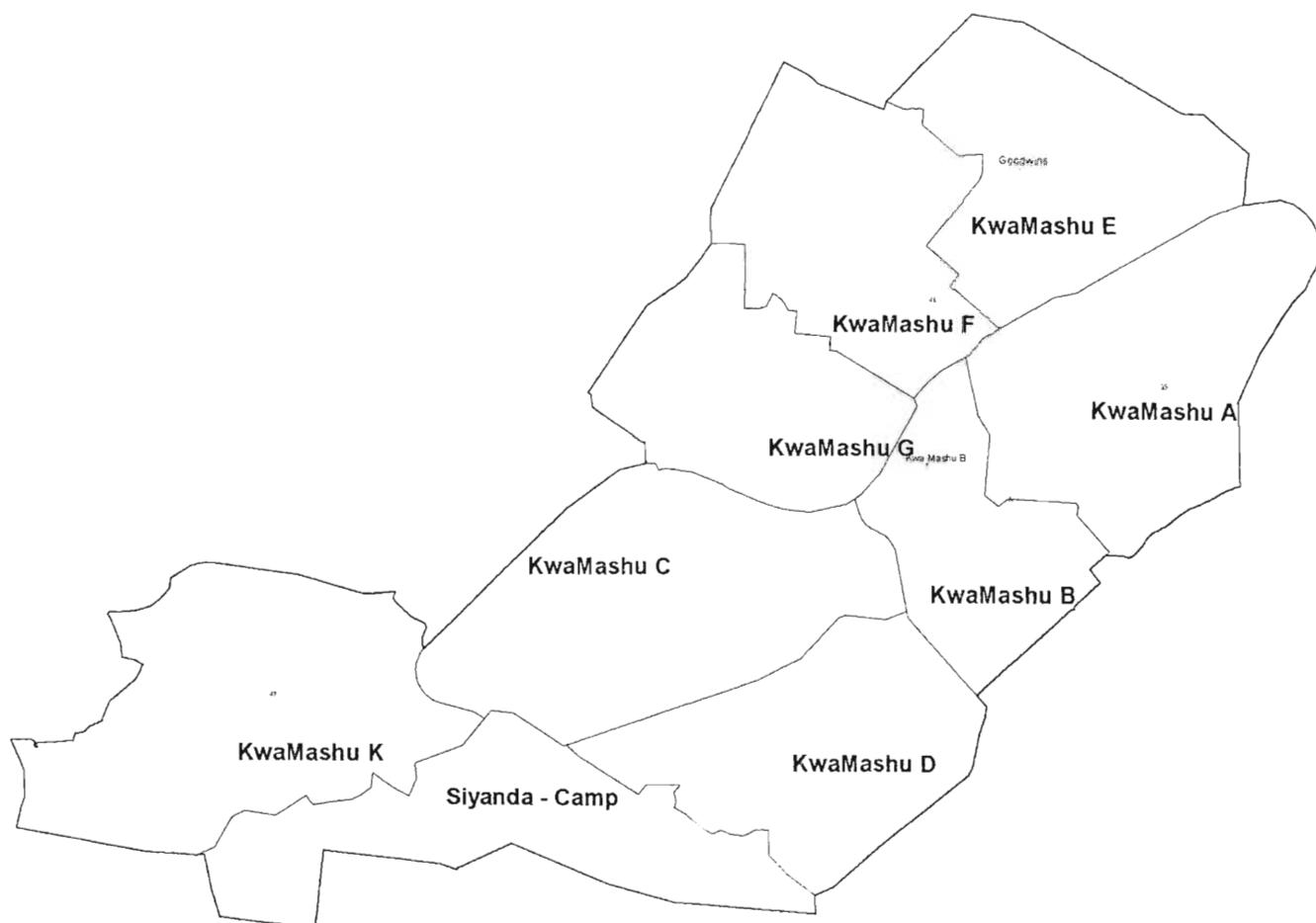
ANNEXURE 17

Primary health care (PHC) areas: North Sub-District

North Area 1



North Area 2



North Area 3



Mobile Clinics

LA Clinics

KZNPA Clinics

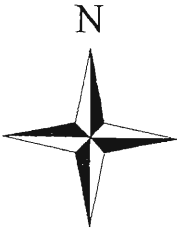
CHC

Wards

Planning Unit

North Area 3

North Area 4



Mobile Clinics

KZNPA Clinics

CHC"S

Wards

Planning Units

North Area 4

North Area 5



•	LA Clinics
•	KZNPA Clinics
•	Hospitals
•	CHC
•	Health Post
•	Mobile
•	Wards
	Planning Units
	North Area 5

North Area 6



- LA Clinics
KZNPA Clinics
Hospitals
CHC
Health Posts
Mobiles
☐ Planning Unit
Wards
☐ North Area 6

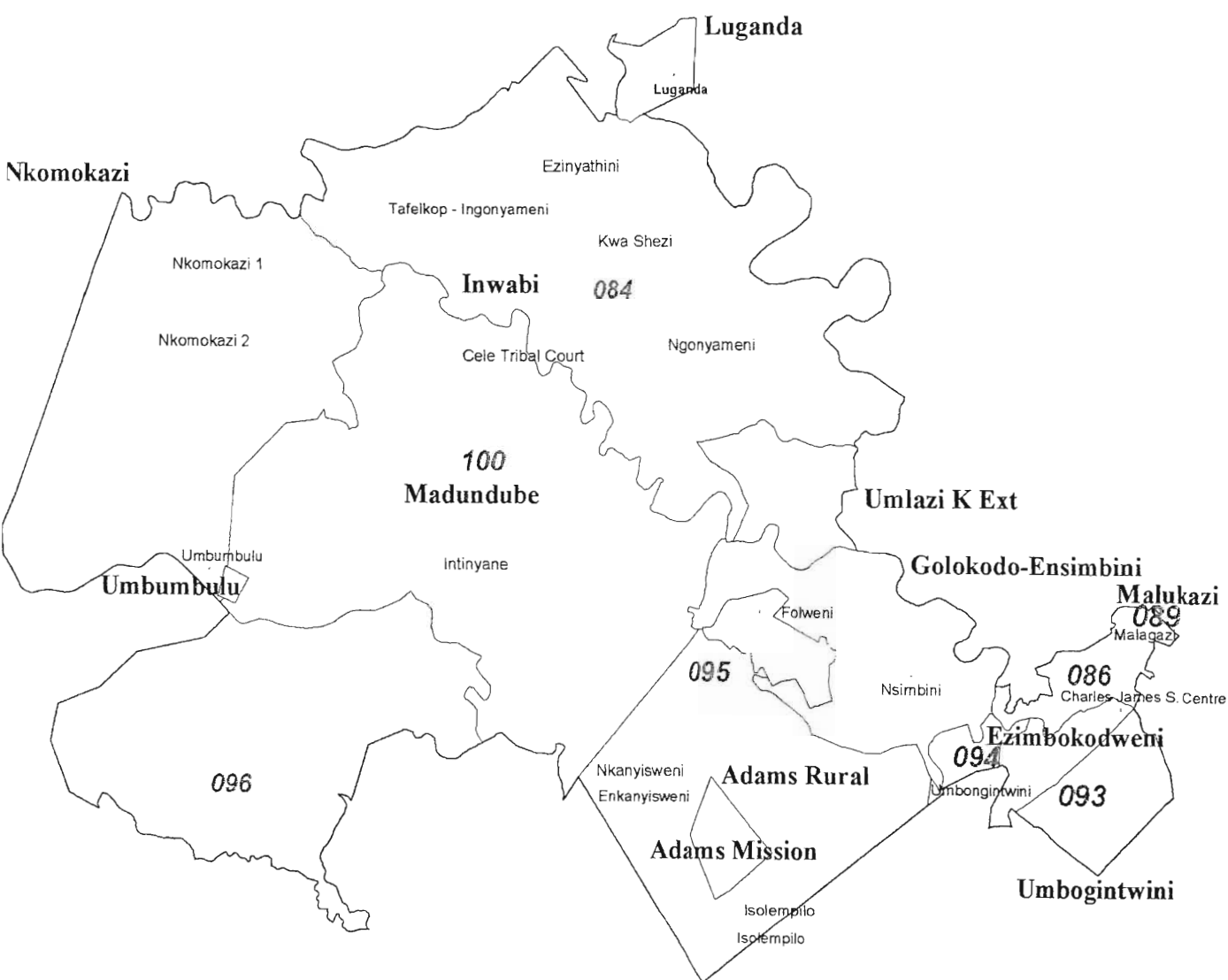
ANNEXURE 18

Primary health care (PHC) areas: South Sub-District

SOUTH AREA 1

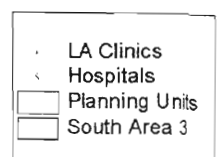


SOUTH AREA 2



- Mobile Clinics
- KZNPA Clinics
- LA Clinics
- Health Posts
- Hospitals
- Planning Units
- South Area 2

South Area 3



South Area 4



LA Clinics

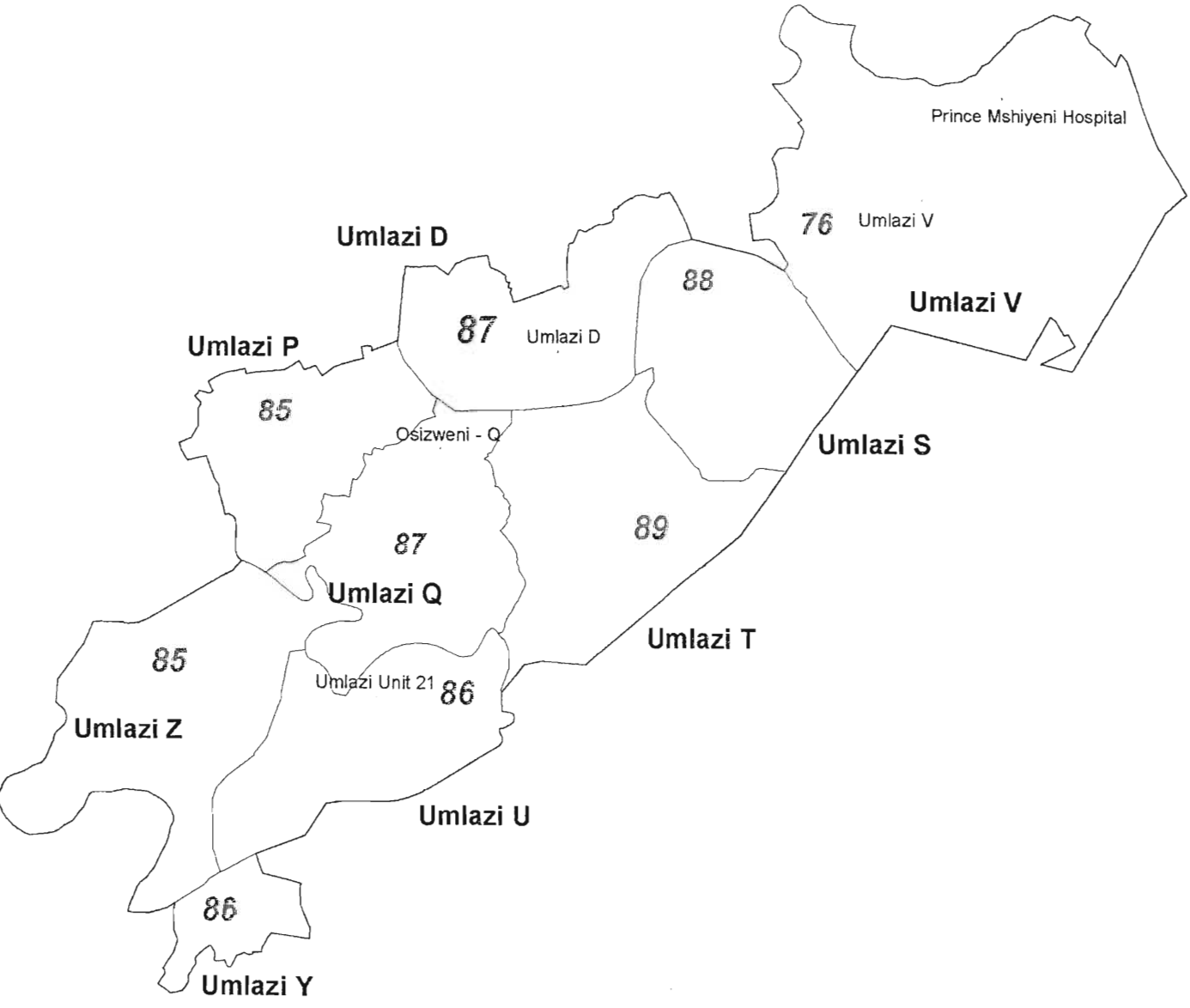
Mobile Clinics

Hospitals

Planning Units

South Area 4

South Area 5



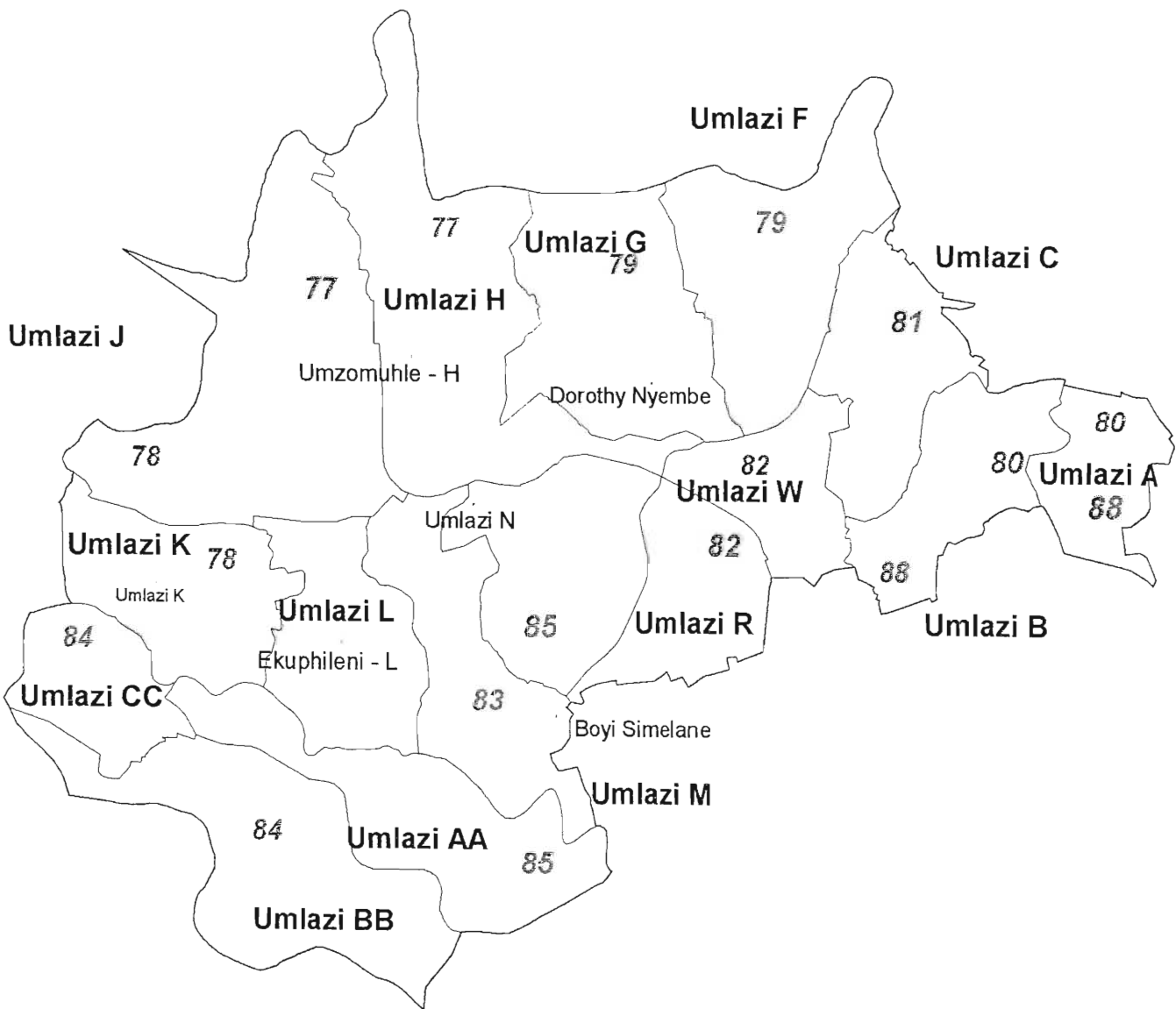
KZNPA Clinics

Hospitals

Planning Units

South Area 5

South Area 6



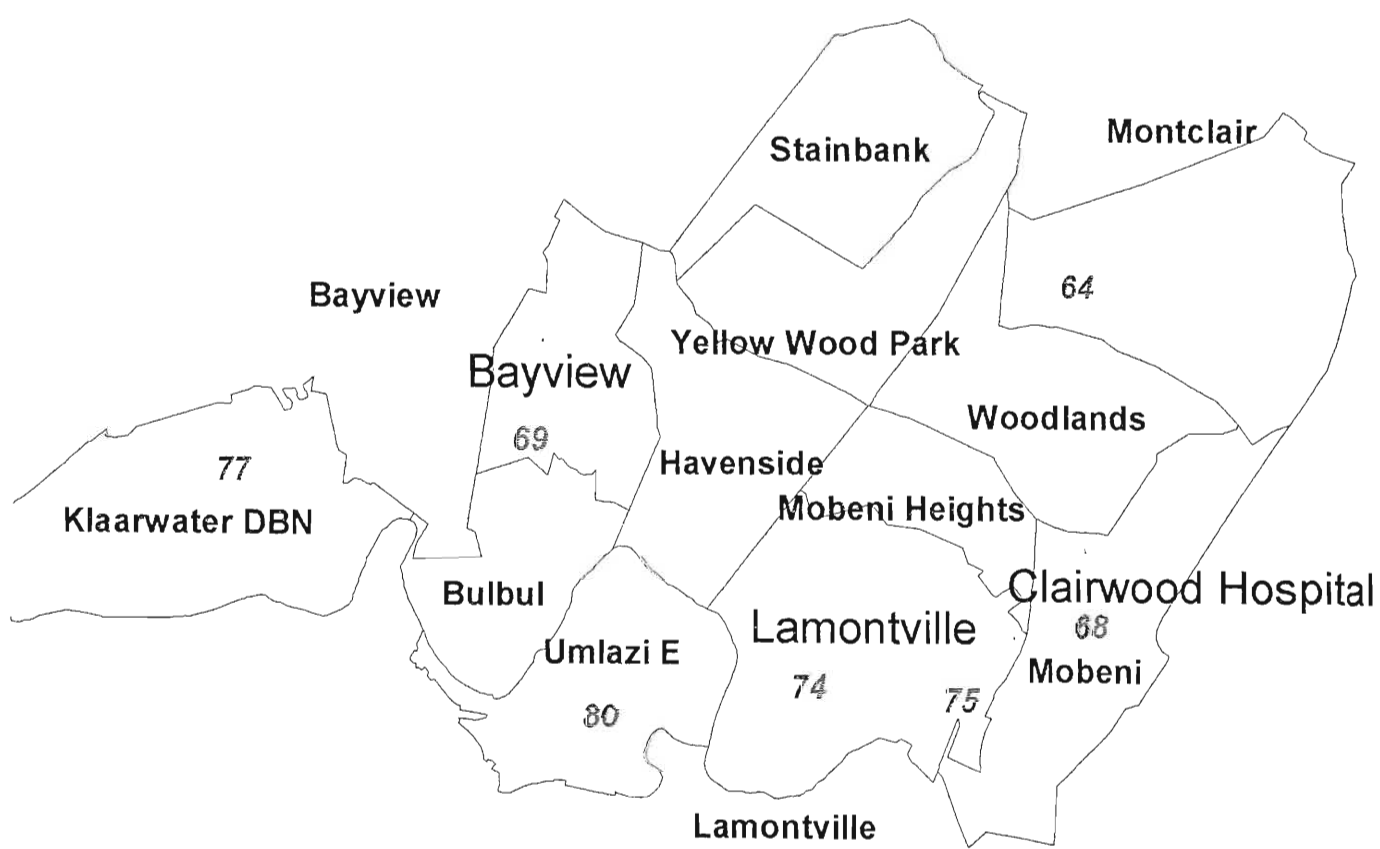
KZNPA Clinic

LA Clinics

Planning Units

South Area 6

South Area 7



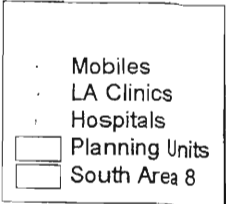
LA Clinics

Hospital

Planning Units

South Area 7

South Area 8



ANNEXURE 19

Primary health care (PHC) areas: West Sub-District

West Area1

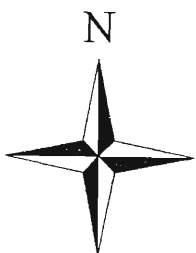


- KZNPA Clinics
- LA Clinics
- Hospitals
- Mobile Clinics
- Health Posts
- CHC
- Planning Units
- Wards
- West Area 1

West Area 2



West Area 3



- Mobile Clinics
- LA Clinics
- KZNPA Clinics
- Health Posts
- Hospital
- Wards
- Planning Units
- West Area 3

WEST AREA 4

Clermont Emngeni



- Hospitals
- LA Clinics
- KZNPA Clinics
- Health Posts
- Mobiles
- Planning Units
- West Area 4
- Wards