KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

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Honourable M Govender
Chairperson: Standing Committee on Public Accounts
KwaZulu-Natal Provincial Legislature
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Attention: Hon M Govender

STANDING COMMITTEE ON PUBLIC ACCOUNTS - REPORT OF THE STANDING COMMITTEE ON PUBLIC ACCOUNTS ON THE HEARINGS HELD IN OCTOBER 2023 ON THE 2022/2023 REPORT OF THE AUDITOR-GENERAL: DEPARTMENTS OF HEALTH

1. The Standing Committee on Public Accounts (SCOPA) convened hearings during October 2023 to consider the 2022/2023 reports of the Auditor-General on provincial government departments and public entities, has reference.

2. Appended are the responses of the Department relative to the Resolutions of the Committee.

RESOLUTION 103/2023 - UNCERTAINTY RELATING TO FUTURE OUTCOME OF LITIGATION

Noting that:

(a) The department is the defendant in various litigation matters relating to medical negligence and other claims amounting to R7.87 billion. The ultimate outcome of these matters cannot be determined and no provision for any liability that may result was made in the financial statements.
(b) The amount is based on an analysis of settlement trends, active and non-active cases and the probabilities of success in defending the matters.
(c) The amount is equivalent to 42.7% of the 2023/24 budget of the department.

***The committee resolves**: -*

That the accounting officer report to the committee by 31 January 2024 on strategies adopted and measures implemented by the department to:

(a) Identify and address the root causes of medico-legal claims; and
(b) Mitigate its liability in respect of medico-legal claims, including but not limited to improved record-keeping for evidential purposes and training of staff to avoid future claims.

RESPONSE OF THE DEPARTMENT

The Resolution of the Committee is noted. Appended are the responses of the Department relative to the above resolutions:

(a) Identify and address the root causes of medico-legal claims;

In this regard, the literature, case studies and anecdotal evidence points out various factors that contribute to the increase in medico-legal claims instituted against the Department. The most important factor for the increase in medico-legal claims relates to the inconsistent and fluctuating levels of quality of health care provided at facilities, the impact of the volumes of patients seeking healthcare, reliance on manual and poorly managed record keeping systems, understaffed medico-legal unit, management of the referral system, non-implementation of quality improvement plans, key staff shortages, inadequately trained staff in the service delivery platform and the imposed financial constraints nationally. The attorneys have been actively seeking these opportunities to make claims against the Department as they recognise this as a very lucrative legal avenue to pursue Internally.

(b) Mitigate its liability in respect of medico-legal claims, including but not limited to improved record-keeping for evidential purposes and training of staff to avoid future claims.

In this regard, a five-pronged approach has been adopted by the Department to mitigate these claims and improve the service delivery platform. The "Pillars" of this strategy to reduce the medico-legal claims are as follows:

1. Prevention
2. Redress, (includes providing rehabilitation services within the Department as required for those who have suffered adverse events during their care in the Department)
3. Mediation, includes the offering of rehabilitation services within the Department
4. Engagement from
   a. Internal, and
   b. External
5. Rehabilitation, Care and Treatment

RESOLUTION 104/2023 - PAYABLES NOT RECOGNISED: R212.05 MILLION

Noting that:

(a) Payables not recognised amounting to R212.05 million exceeded the payment term of 30 days. This amount in turn exceeded the R5.9 million of voted funds to be surrendered by R206.15 million.
(b) The inability of the department to pay creditors by due date at year end due to a lack of available cash, resulting in the accrued expenditure being payable from the subsequent year's budget, has placed a strain on funds available for service delivery in 2023/24.
(c) The department has taken measures to ensure future payments are made within 30 days and the rollout of LOGIS is underway which will assist in providing a system warning of invoices that are due.

The committee resolves:

That the accounting officer report to the committee by 31 January 2024 on:

[1] The impact the accrued expenditure has had on service delivery in 2023/24 and measures implemented to mitigate the impact.
[2] The outcome of ongoing discussions with Provincial Treasury on the impact of budget cuts on service delivery in the department.
[3] The effectiveness of the steps taken to ensure all invoices are paid within 30 days.

RESPONSE OF THE DEPARTMENT

The Resolution of the Committee is noted. Appended are the responses of the Department relative to the Resolutions.

[1] The impact the accrued expenditure has had on service delivery in 2023/24 and measures implemented to mitigate the impact.

Due to the budget cuts, the accrued expenditure from the prior year expenditure was paid from the 2023/24 financial year's budget.

In mitigating the impact of this additional expenditure in the current financial year and in ensuring that services were delivered without significant delays, the Department had engaged with service providers where necessary, to negotiate better payment terms as well as to continue receiving goods and services as per the expected dates.

Further, a savings plan was developed and implemented to achieve efficiency gains. In addition, the implementation of the LOGIS is being fast-tracked to achieve efficiencies going forward.

[2] The outcome of ongoing discussions with Provincial Treasury on the impact of budget cuts on service delivery in the department.

The two Departments are continuing to engage to find solutions in dealing with the budget cuts. It is clear from the discussions that the Provincial Treasury cannot make additional budgets available to any of the Departments as all Provincial resources have been fully allocated. In this regard, the Department has been urged to reduce spending to match the available budget. Consequently, the Department has embarked on an extensive zero-based budgeting process which it believes may positively impact on the cost savings initiatives.

These initiatives have resulted in significant improvements being realised; however, the risk has not been fully mitigated due to the prevalent cash flow challenges. Notwithstanding this, it is anticipated that the Department's savings strategy that was developed and implemented, would assist in lessening the impact of the budget cuts and the cash flow challenges.

[3] The effectiveness of the steps taken to ensure all invoices are paid within 30 days.

The Department continues to enforce various initiatives to ensure that invoices are paid within 30 days of receipt thereof. However, the accruals have had a negative effect on the budget as the Department had to pay for the prior year's expenditure in the current financial year, resulting in the current financial year's budget being reduced by R 212.05 million. This has inadvertently contributed to the cash flow challenges, where the Department could not pay all of its suppliers within 30 days. Notwithstanding this, payments are being prioritised in order to ensure that service delivery was not affected.

RESOLUTION 105/2023 - IRREGULAR EXPENDITURE IN 2022/23: R2.55 BILLION (2022: R2.53 BILLION)

Noting that:

(a) The department incurred irregular expenditure of R2.55 billion in 2022/23.
(b) Most of the irregular expenditure was due to the continued use of expired contracts. The department attempted to appoint some new service providers; however, these awards ended in arbitration.
(c) None of the irregular expenditure of R2.53 billion incurred in the 2021/22 financial year has been investigated. This has impacted negatively on consequence management.

The committee resolves:

That the accounting officer report to the committee by 31 January 2024 on:

[1] Progress made in the determination testing of the irregular expenditure, as required in terms of the PFMA Compliance and Reporting Framework issued under National Treasury Instruction Note 4 of 2022/23 and time frames for concluding the determination testing.
[2] If the determination testing has been concluded, the outcomes thereof, including:
- *the root causes of the expenditure;*
- *measures implemented to address any deficiencies in internal control to avoid a recurrence and the effectiveness of the measures;*

- *disciplinary action taken against the officials responsible for the irregular expenditure and the sanctions imposed;*
- *steps taken to recover any losses;*
- *the outcome of any criminal investigation and steps taken pursuant thereto; and*
- *the time frames for concluding the above processes.*

[3] Progress made in submitting a request for condonation to the relevant authority and the outcome of the condonation request.

RESPONSE OF THE DEPARTMENT

The Resolution of the Committee is noted. Appended are the responses of the Department relative to the Resolutions.

[1] Progress made in the determination testing of the irregular expenditure, as required in terms of the PFMA Compliance and Reporting Framework issued under National Treasury Instruction Note 4 of 2022/23 and time frames for concluding the determination testing.

The Department has been experiencing resource / capacity challenges to undertake and complete the determination testing for Irregular Expenditure. The Department has commenced with the exercise which is currently in progress. Notwithstanding this, the Department has identified additional internal resources to assist with the determination testing and this exercise is currently in progress. It is anticipated that these cases can be finalised in the 2024/25 financial year.

[2] If the determination testing has been concluded, the outcomes thereof, including:

- *disciplinary action taken against the officials responsible for the irregular expenditure and the sanctions imposed;*

The Department is currently in the process of conducting determination tests on the various irregular expenditure transactions. Thus far, the investigation reports have not implicated any officials relative to being responsible for the incurring of irregular expenditure. It is envisaged that should the outcomes of the determination test reveal any wrongdoing, disciplinary action will be taken against those officials responsible for the irregular expenditure.

[3] Progress made in submitting a request for condonation to the relevant authority and the outcome of the condonation request.

The Department has made representations to the Provincial Treasury for condonation and based on the work undertaken and the discussions between the Provincial Treasury and the Department, it is expected that a formal response will be received in the fourth quarter of the 2023/24 financial year. Further, as per the resolution taken at the Provincial CFO Forum, the Department is in the process of preparing documentation to enable the write-off of all Irregular Expenditure that was reported where documents are missing.

RESOLUTION 106/2023 - IRREGULAR EXPENDITURE: CUMULATIVE BALANCE INCURRED IN PRIOR FINANCIAL YEARS NOT YET CONDONED: R15.91 BILLION.

Noting that:

(a) The cumulative balance of irregular expenditure incurred in prior financial years amounting to R15.91 billion (including R2.53 billion incurred in 2021/22) has not yet been condoned.
(b) Provincial Treasury has called for further information and supporting documents to evaluate condonation requests totalling R1.133 billion. The department has submitted some of the information.
(c) An amount of R2.51 billion submitted for condonation relates to transactions where the department no longer has the supporting evidence. Provincial Treasury has requested guidance from National Treasury on how to address this submission.
(d) The remaining irregular expenditure has not yet been submitted for condonation.

The committee resolves:

That the accounting officer report to the committee by 31 January 2024 on:

[1] Progress made in submitting all outstanding information to Provincial Treasury relating to the condonation requests of R1.133 billion.
[2] Progress made in submitting all remaining irregular expenditure not yet submitted for condonation and time frames for making the submissions.
[3] Overall progress made in the finalisation of all condonation requests.
[4] Details of consequence management implemented, and sanctions imposed, where applicable.

RESPONSE OF THE DEPARTMENT

The Resolution of the Committee is noted.

[1] Progress made in submitting all outstanding information to Provincial Treasury relating to the condonation requests of R1.133 billion.

Cognisance should be taken of the fact that during the Provincial CFO Forum meeting convened by the Provincial Accountant General (PAG), the Provincial Treasury clarified that they cannot condone irregular expenditure based on the non-availability of source documents. Further, it was suggested that the Accounting Officers of Departments should condone this irregular expenditure.

In light of the aforementioned, the Department is, currently preparing a comprehensive submission for approval by the Accounting Officer.

In addition, it should be noted that in terms of the other condonation cases, where documents are available, these have been evaluated and submitted to the condonation committee in the Provincial Treasury for approval.

[2] Progress made in submitting all remaining irregular expenditure not yet submitted for condonation and time frames for making the submissions.
[3] Overall progress made in the finalisation of all condonation requests.

The irregular expenditure listing of the Department includes transactions incurred as far back as 2010. The process of collating information and extracting source documents is time-consuming; however, the analysis and packaging of the entire listing for condonation is at an advanced stage and a substantial amount of the listing has been completed. The Department will soon compile a submission with all supporting documents for presentation to the Provincial Treasury for condonation.

[4] Details of consequence management implemented, and sanctions imposed, where applicable.

In this regard, one (1) official has had consequence management implemented in the form of a letter of warning and was subsequently removed from the Departments Central Supply Chain Management.

Further to the above, it should be noted that the determination testing for irregular expenditure is still in progress and thus far, the investigation reports have not implicated any officials relative to being responsible for the incurring of irregular expenditure. It is envisaged that should the outcomes of the determination test reveal any wrongdoing, disciplinary action will be taken against those officials responsible for the irregular expenditure.

RESOLUTION 107/2023 - CONSEQUENCE MANAGEMENT: UNAUTHORISED EXPENDITURE IN PRIOR FINANCIAL YEARS: R93.83 MILLION

Noting that:

(a) *The Auditor-General was unable to find any evidence that the department has dealt with unauthorised expenditure of R93.83 million incurred in prior financial years, in terms of*

implementing consequence management, taking disciplinary steps against officials responsible for the unauthorised expenditure, taking steps to recover any losses from those officials responsible, opening criminal cases in matters where criminal conduct was found and in terms of measures implemented to prevent future unauthorised expenditure.

(b) *Proper and complete records were not maintained as evidence to support the investigations into the unauthorised expenditure.*

The committee resolves:

That the accounting officer report to the committee by 31 January 2024 on the implementation of consequence management against officials responsible for the unauthorised expenditure, steps taken to recover any losses, opening of criminal cases where criminal conduct was found and measures implemented to prevent a future recurrence.

RESPONSE OF THE DEPARTMENT

The unauthorised expenditure was unavoidable despite the Department implementing strict controls and was unfortunately unable to prevent the over-expenditure. The over-expenditure that was incurred was in respect of service delivery and thus no particular official can be held accountable.

RESOLUTION 108/2023 - FRUITLESS AND WASTEFUL EXPENDITURE IN 2022/23: R 870 000

Noting that:

The department incurred fruitless and wasteful expenditure of R870 000 in 2022/23. The main contributors to this expenditure were expired stock (62%) and interest charges (26%) due to late payment of debts.

The committee resolves:

That the accounting officer report to the committee by 31 January 2024 on:

[1] Progress made in the determination testing of the fruitless and wasteful expenditure, as required in terms of the PFMA Compliance and Reporting Framework issued under National Treasury Instruction Note 4 of 2022/23 and time frames for concluding the determination testing.

[2] If the determination testing has been concluded, the outcomes thereof, including:

- *the root causes of the fruitless and wasteful expenditure;*
- *disciplinary action taken against officials responsible for the fruitless and wasteful expenditure and the sanctions imposed;*
- *steps taken to recover any losses and the amount of any losses recovered or written off;*
- *measures implemented to address any deficiencies in internal control to avoid a recurrence and the effectiveness of the measures;*
- *the outcome of any criminal investigation and steps taken pursuant thereto; and*
- *the time frames for concluding the above processes.*

RESPONSE OF THE DEPARTMENT

Cognisance should be taken of the fact that this function has been decentralised to the individual institutions and these institutions are responsible for performing the determination tests as per the relevant policy as well as the Standard Operating Procedure (SOP). The Departments Finance Unit is closely monitoring facilities to ensure compliance to the Policy and SOPs. Further, the Department is reviewing the Policy and the SOP to exclude cases that in the Department's opinion, are inappropriately classified as fruitless and wasteful expenditure. These include the following cases:

- Inventory expiring due to global or local regime changes - When a regime change is implemented, all medication acquired and in stock is no longer made available for use and, therefore, would expire.

- Some stock expires due the company delivering the stock that is short dated without the requisite protection letters. The Departments Pharmaceutical Services have implemented controls to reduce the amount of expired stock.
- Safety Stock for certain medicines, e.g., anti-venom, which by law, facilities are required to maintain minimum quantities of in case of snake bites. If there are no snake bite cases presented at facilities, such medication will expire.
- Other cases, e.g., cancer medication is procured specifically for an individual patient, and if that patient passes on, that medication cannot be used by any other patient and would inadvertently expire.

It is therefore technically incorrect to classify these as fruitless and wasteful as these expenses were not incurred in vain. It is anticipated that the review of the Policy and the SOP will correct this matter.

In respect of municipal accounts, some municipalities can only afford the Departments fifteen (15) days to settle their invoices and immediately charge interest after this period. It is challenging for the Department to meet such stringent timeframes. In light of the aforementioned, discussions are currently underway with the affected parties to extend the period to 30 days, as reflected in the PFMA.

- *disciplinary action taken against officials responsible for the fruitless and wasteful expenditure and the sanctions imposed;*

There have been no investigations that has resulted in the instituting of disciplinary action being instituted against any official who may have been responsible for the incurring of fruitless and wasteful expenditure.

RESOLUTION 109/2023 - FRUITLESS AND WASTEFUL EXPENDITURE INCURRED PRIOR TO 2022/23 NOT YET RESOLVED: R2.7 MILLION

Noting that:

The department has not yet resolved fruitless and wasteful expenditure of R2.7 million incurred in prior financial years.

The committee resolves:

That the accounting officer report to the committee by 31 January 2024 on:

[1] A breakdown of the fruitless and wasteful expenditure.

[2] The reasons for the delay in resolving the balance of the fruitless and wasteful expenditure from prior financial years, progress made in the investigations and the time frames for the conclusion of the investigations.

[3] The findings and recommendations of the investigations and steps taken to implement the recommendations, including disciplinary steps taken against those officials responsible for the expenditure, the sanctions imposed, steps taken to recover any losses, measures implemented to avoid a recurrence, opening of criminal cases where criminal conduct was found, the amounts written off and the time frames for concluding the implementation of all recommendations.

RESPONSE OF THE DEPARTMENT

The Resolution of the Committee is noted. Appended are the responses of the Department to the individual points.

[1] A breakdown of the fruitless and wasteful expenditure.

The Department is currently resolving the R 2.7 million that was classified as fruitless and wasteful expenditure. Appended is a listing of the progress that has been recorded thus far:

- Recoveries in 2021/22 R 232 032,56

- Recoveries in 2022/23 R 368 971,98
- Written off R 277 543,24
- **Total** **R 878 547,78**

It should be noted that finalisation of cases relating to Fruitless and Wasteful Expenditure does take time as due to the lengthy procedures that is required to be followed prior to a case being finalised.

[2] The reasons for the delay in resolving the balance of the fruitless and wasteful expenditure from prior financial years, progress made in the investigations and the time frames for the conclusion of the investigations.

The remaining cases are currently being processed, and a detailed report will be submitted to the Committee once finalised. As mentioned in point 1 above, the processes in finalising these cases are long and challenging, and in this regard, it is anticipated that these will be finalised before the end of the 2024/25 financial year.

[3] The findings and recommendations of the investigations and steps taken to implement the recommendations, including disciplinary steps taken against those officials responsible for the expenditure, the sanctions imposed, steps taken to recover any losses, measures implemented to avoid a recurrence, opening of criminal cases where criminal conduct was found, the amounts written off and the time frames for concluding the implementation of all recommendations.

It should be noted that the determination testing for the expenditure is still in progress and thus far, the investigation reports have not implicated any officials relative to being responsible for the incurring of the expenditure. It is envisaged that should the outcomes of the determination test reveal any wrongdoing or criminality, disciplinary action as well as criminal charges will be instituted against those officials responsible for the expenditure.

RESOLUTION 110/2023 - PROCUREMENT AND CONTRACT MANAGEMENT: NON-COMPLIANCE WITH LEGISLATION

Noting:

The audit findings on procurement and contract management and the responses of the department as follows:

FINDINGS	***RESPONSE OF DEPARTMENT***
Lack of evidence that all contracts were awarded in accordance with legislative requirements due to poor records management.	*The department is in the process of digitising their records and obtaining scanners to ensure electronic records are kept.*
Some quotations were not awarded in an economical manner and the process were not reasonable.	*The department is in the process of digitising their records and obtaining scanners to ensure electronic records are kept.*
Some goods and services with a transaction value above R1 million were obtained without inviting competitive bids and deviations were approved by the accounting officer although it was practical to invite competitive bids.	*The department has observed due process.*
Some contracts were awarded to bidders based on evaluation criteria that were not stipulated.	*The department has trained bid committees on SCM procedures.*
The preference point system was not applied in some instances.	*The department has updated its SOM and bid committees have been trained.*
Lack of evidence that construction contracts were awarded to contractors who are registered with the CIDB and qualified for the contracts in accordance with the CIDB Act and Regulations.	*It is now mandatory that CIBD registration printouts are kept on file for audit.*
Bid documentation or invitation to tender for procurement of commodities designated for local	*The new regulations no longer have this requirement.*

FINDINGS	RESPONSE OF DEPARTMENT
content and production did not stipulate the minimum threshold for local production and content.	
Persons in service of the department who had a private or business interest in contracts awarded by the department failed to disclose such interest. Similar non-compliance was reported in the previous year and no disciplinary action was taken by the department.	*The amended SOP now provides that prior to all awards, the officials must confirm with the CSD report that no conflict of interest exists.*
Persons in service of the department whose close family members, partners or associates had a private or business interest in contracts awarded by the department failed to disclose such interest. Similar non-compliance was reported in the previous year and no disciplinary action was taken against the officials involved.	*The Office of the Accounting Officer will follow-up with all affected officials.*

The committee resolves:

That the accounting officer report to the committee by 31 January 2024 on:

[1] Progress made in the implementation of measures to address the findings on procurement and contract management and the adequacy and effectiveness thereof to avoid a recurrence of the findings.

[2] A list of all transactions above R1 million awarded without inviting competitive bids where deviations were approved, the value of those transactions and the reasons for the deviations.

[3] Details of disciplinary action taken against officials who had a private or business interest in contracts awarded by the department who failed to disclose such interest as well as officials whose close family members, partners or associates had a private or business interest in contracts awarded by the department and who failed to disclose such interest, the value of the contracts awarded in those instances and the sanctions imposed.

RESPONSE OF THE DEPARTMENT

The Resolution of the Committee is noted. Appended are the responses of the Department relative to the Resolutions.

[1] Progress made in the implementation of measures to address the findings on procurement and contract management and the adequacy and effectiveness thereof to avoid a recurrence of the findings.

- *Lack of evidence that all contracts were awarded in accordance with legislative requirements due to poor records management.*

The number of missing documentations have been significantly reduced and the Department is continuing in its efforts to digitise the documents across the Department.

- *Some quotations were not awarded in an economical manner and the process were not reasonable.*

The Department is in the process of digitising their records and obtaining scanners to ensure electronic records are maintained.

- *Some goods and services with a transaction value above R1 million were obtained without inviting competitive bids and deviations were approved by the accounting officer although it was practical to invite competitive bids.*

The Department continues to follow due process in instances where it is deemed impractical to follow normal SCM processes.

- *Some contracts were awarded to bidders based on evaluation criteria that were not stipulated.*

The Department has trained bid committees on SCM procedures. The heads of SCM at all facilities have also been trained during the roadshows when it was indicated that the evaluation can only be based on published evaluation criteria.

- *The preference point system was not applied in some instances.*

The Department has updated its SOM and bid committees have been trained.

- *Lack of evidence that construction contracts were awarded to contractors who are registered with the CIDB and qualified for the contracts in accordance with the CIDB Act and Regulations.*

It is now mandatory that CIBD registration reports are printed immediately and kept on file for audit. This has been emphasised particularly because the CIDB website does not allow for the printing of retrospective reports.

- *Bid documentation or invitation to tender for procurement of commodities designated for local content and production did not stipulate the minimum threshold for local production and content*

This is no longer applicable as the new regulations no longer have this requirement.

- *Persons in service of the department who had a private or business interest in contracts awarded by the department failed to disclose such interest. Similar non-compliance was reported in the previous year and no disciplinary action was taken by the department.*

The amended SOP now prescribes that prior to all awards, the officials must confirm with the CSD report that no conflict of interest exists. The CSD report is now a mandatory requirement prior to all awards.

- *Persons in service of the department whose close family members, partners or associates had a private or business interest in contracts awarded by the department failed to disclose such interest. Similar non-compliance was reported in the previous year and no disciplinary action was taken against the officials involved.*

The identified cases have being referred for investigation by the Departments Ethics Office which is part of the Office of the Accounting Officer. Once these investigations have been concluded and if any wrongdoing has been identified, the necessary disciplinary steps will be implemented.

[2] A list of all transactions above R1 million awarded without inviting competitive bids where deviations were approved, the value of those transactions and the reasons for the deviations.

A copy of the Departments Deviations Register is attached for ease of reference. ***(Annexure A)***.

[3] Details of disciplinary action taken against officials who had a private or business interest in contracts awarded by the department who failed to disclose such interest as well as officials whose close family members, partners or associates had a private or business interest in contracts awarded by the department and who failed to disclose such interest, the value of the contracts awarded in those instances and the sanctions imposed.

The identified cases have been referred for investigation by the Departments Ethics Office which is part of the Office of the Accounting Officer. Once these investigations have been concluded and if any wrongdoing has been identified, the necessary disciplinary steps will be implemented.

Further, it should be noted that a case was referred for disciplinary action to be taken against an official who was implicated in having a private or business interest in contracts awarded by the Department and this official had failed to disclose such interests. The official involved is in the process of being charged with misconduct. The estimated value of this instance is approximately R 3000.00.

RESOLUTION 111/2023 - MATERIAL FINDINGS ON PERFORMANCE INFORMATION: PROGRAMME 2: DISTRICT HEALTH SERVICES - VARIOUS INDICATORS

Noting that:

(a) Some supporting evidence was not provided for auditing and where evidence was provided, material differences between the actual and reported achievements for various indicators were noted.
(b) The department has implemented an audit improvement plan to address these findings, focussing on compliance measures and data verification and ensuring that the annual performance report is aligned to the underlying records.

The committee resolves:

That the accounting officer report to the committee by 31 January 2024 on progress made in the implementation of the audit improvement plan and the adequacy and effectiveness of these measures.

Noting that:

(a) Adequate supporting evidence was not provided for auditing to support the reported achievement of 93.4%.
(b) The department has developed Standard Operating Procedures to guide assessments and to standardise the assessment practice.

The committee resolves:

That the accounting officer report to the committee by 31 January 2024 on progress made in the implementation of the SOP and standardised assessment practices and the adequacy and effectiveness of these measures.

RESPONSE OF THE DEPARTMENT

The Resolution of the Committee is noted.

A revised Audit Improvement Plan (AIP) has been workshopped with all districts and facilities following the release of the Management Report. A different approach was utilised in the development of the AIP for this year, in that, it focused on step-by-step activities that needed to be actioned at different levels of management. The AIP includes activities relating to the verification of data, as well as the availability of source documents and files at the facility level.

Further, special records management and data quality teams have been established at a district level to monitor the progress within the facilities. Accountability tools were also developed to ensure that managers are accountable and responsible for the accurate recording of data before it leaves the facility. These new tools require and only allows for the CEO to sign off on the month's data, only if certain quality assurance activities have been completed by the facility. These include compulsory verification exercises that should occur regularly and includes indicators that are part of the Annual Performance Plan (APP). These revised sign-off tools are available for hospital, clinic, and district levels.

In addition, District Directors are also required to provide feedback to the Provincial team on a weekly basis on the progress made. This step has also enhanced accountability at a district level. Progress reports on each item is monitored on a monthly basis and are used to evaluate progress made prior to the next audit. This report outlines the endeavours made in the Department to improve the data at the facility level.

The effectiveness of these measures will be measured in Quarter 4 with one facility in each district being audited to evaluate the effectiveness of the AIP. The Department has seen huge improvements subsequent to the commencement of the compulsory weekly meetings and the implementation of the AIP.

RESOLUTION 112/2023 - MATERIAL FINDINGS ON PERFORMANCE INFORMATION: PROGRAMME 2: DISTRICT HEALTH SERVICES - IDEAL CLINIC STATUS RATE

Noting that:

(a) Adequate supporting evidence was not provided for auditing to support the reported achievement of 93.4%.
(b) The department has developed Standard Operating Procedures to guide assessments and to standardise the assessment practice.

The committee resolves:

That the accounting officer report to the committee by 31 January 2024 on progress made in the implementation of the SOP and standardised assessment practices and the adequacy and effectiveness of these measures.

RESPONSE OF THE DEPARTMENT

The Department has developed a standardised guideline with amended easy to follow instructions on how to conduct the assessment. These trainings were completed, and all districts have been notified of the practice going forward. One of the major revisions to the SOP include the use of digital images to support the validity of the assessment. Progress on the implementation of the revised SOP is also discussed at the Department's weekly meetings with all District Directors and accountable Managers. The introduction of these meetings has seen a huge improvement in the reporting of data and the quality of data itself. The Department is confident that if the SOPs are complied with, this will no longer be a recurring finding.

RESOLUTION 113/2023 - MATERIAL FINDINGS ON PERFORMANCE INFORMATION: PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES - VARIOUS INDICATORS

Noting that:

(a) Based on audit evidence, the actual achievements for two indicators did not agree with what was reported and the Auditor-General was unable to determine the actual achievements.
(b) The department will undertake regular tests, reconciliations and reviews to confirm adequate implementation and operational effectiveness of the SOP's, in line with appropriate verification processes and reviews to ensure accurate performance statistics are produced.

The committee resolves:

That the accounting officer report to the committee by 31 January 2024 on progress made in the implementation of the measures intended to address these findings and the adequacy and effectiveness of the measures.

RESPONSE OF THE DEPARTMENT

The Resolution of the Committee is noted.

There has been an extensive shift in the visibility of oversight and supervision of facilities during the last quarter of the year. Districts have been tasked with conducting four (4) facility visits, where they will ensure that the SOPs are complied with and that the data is accurately captured and reported on. These

visits are conducted to monitor progress since the last Management Report was released, as well as ensure that all controls are complied with, which ultimately will ensure good practice and audit outcomes. A virtual platform has been setup (by the District Health Systems Chief Directorate) for Districts to report on progress fortnightly. The following progress had been made thus far:

1. A revised Audit Improvement Plan has been workshopped with all districts and facilities. Progress reports on each item is monitored on a monthly basis and will be used to evaluate progress made prior to the next audit. This report outlines the endeavours made by the Department to improve the data at the facility level.
2. The Provincial office has conducted fifty (50) facility visits to date. These support visits include control checking, reconciliation of data, compliance testing, mentoring and other performance information monitoring. Following each visit, there is a close out meeting where findings are shared with management. Reports are also compiled and shared with District Management teams.
3. District offices have also conducted support visits to monitor compliance and to ensure that facilities are audit ready at any time. One facility per district will be audited by the Provincial office in Q4 to test for improvements. These visits are highlighted in the attached AIP. The Department has noted the improvement in data and the general commitment from staff since the support visits have been mandated.
4. Revised sign-off tools have been developed and workshopped with all Districts to improve accountability at the facility level. These new tools require the CEO to only sign off on the month's data if certain quality assurance activities have been completed by the facility. These include compulsory verification exercises that should occur regularly and includes indicators that are part of the APP. These revised sign-off tools are available for hospital, clinic, and district levels. District Directors are also required to provide feedback to the Provincial team on a weekly basis on progress made. This step has also enhanced the accountability at a District level.
5. Apart from the routine verification exercises that are necessary at facility level, the Provincial office also conducted a full data alignment and technical session in December 2023 which included all hospitals and CHC's. Completeness, validation, timeliness and outlier reports were run and errors were corrected at these sessions. This also doubled as a capacity building workshop so that facilities are able to run these quality assurance functions on their own going forward. 119 people participated in this verification/data review workshop.
6. The Department has also committed to providing feedback to Districts in relation to their performance and possible errors that need to be verified. This is a high level overview and does not dive into each service area. However, Districts are able to use this feedback to drill down to their own facilities and verify and correct their data. The evidence of these feedbacks are available should the Committee require it.

RESOLUTION 114/2023 - ACHIEVEMENT OF PLANNED TARGETS: KEY SERVICE DELIVERY INDICATORS NOT ACHIEVED: PROGRAMME 2: DISTRICT HEALTH SERVICES AND PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES

Noting that:

(a) The department reported 49.3% achievement of targets in programme 2: District Health Services, while 100% of the budget was spent.
(b) The department reported 36.4% achievement of targets in programme 4: Provincial Hospital Services, while 100% of the budget was spent.
(c) Key service delivery targets were not met.
(d) The department has undertaken to engage in realistic target setting in future, in line with budget allocations.

The committee resolves:

That the accounting officer report to the committee by 31 January 2024 on progress made in the implementation of the measures intended to address these findings and the adequacy and effectiveness of the measures.

RESPONSE OF THE DEPARTMENT

It should be noted that the certain targets set in the Annual Performance Plan (APP) are prescribed by the National Department of Health (NDoH). This had necessitated the Department to conform and implement these national targets at a Provincial level.

It should be noted that in the 2022/23 financial year, the budget was allocated in conjunction with the targets that were set in the Annual Performance Plan (APP), and it was anticipated that these targets would have been 100% achieved. In this regard, cognisance should be taken of the fact that the budgeting is done at the beginning of the financial year when the targets are set, and the budgeting process had considered the total number of resources that would be required to achieve 100% of the targets set. However, cognisance should be taken of the fact that there is no linear correlation between the targets set and the budget allocated.

Cognisance should be taken of the fact that targets are set at a national level which may not always be achieved within the province due to the primary constraints of a reduced budget allocation. However, it should be noted that to achieve optimal healthcare targets and to ensure service delivery and the targets that are set within the province, adequate resources both human and financial must be available. It should be noted that the budget allocated will in the majority of times be spent in full as a large percentage is expended against fixed costs i.e. Human Capital, etc.

Thus, cognisance should be taken of the fact that the budget set against targets does not necessarily imply that there was a sufficient allocation at the outset. The achievement of targets are often dependent on external factors i.e. the client visiting the facility, the statutory requirements, etc.

In addressing the finding, the Department has reviewed the performance of each indicator and had subsequently coordinated a meeting between the Departments Strategic Health Programs and the Strategic Health Planning Unit to review the set indicators. The Programme Managers have been requested to provide input for the next APP and to ensure the following:

- The setting of realistic targets; however, avoiding setting targets that are so low that they affect service delivery
- Finding a balance between a target that is achievable and one that has a positive impact on service delivery
- Reviews to be undertaken to monitor the achievements of the targets on a quarterly basis.
- Interventions to be developed and implemented to improve specific programme performance and to realise the achievements of such targets.

Further to the above, a process of quarterly reviews is being conducted with the various District Management Teams by the Departments Strategic Health Programmes. Further, the process of target setting in line with the budget allocations has commenced and the targets are being adjusted accordingly.

With due consideration to the above, it is anticipated that the extent of these interventions will only be realised in the 2024/25 financial year.

RESOLUTION 115/2023 - STRATEGIC PLANNING AND PERFORMANCE MANAGEMENT (REPEAT FINDING)

Noting that:

(a) *Information systems (both electronic and manual) were not effectively implemented to enable the monitoring of progress made towards achieving targets, core objectives and service delivery.*

(b) *Information was not always updated regularly and data verification prior to electronic capturing was not always performed. As a result, a number of performance indicators are not reliable as reported in the annual performance report.*

(c) *The department has implemented a detailed audit improvement plan at district and facility level to address this finding, focussing on compliance measures and data verification and alignment of the annual performance report with the underlying records. The department has also revived the standard patient registration system where applicable. The department has also taken steps*

to address poor connectivity and improving broadband speed at facility level through the installation of a secondary network through Telkom.

The committee resolves:

That the accounting officer report to the committee by 31 January 2024 on progress made in the implementation of the audit improvement plan and the adequacy and effectiveness thereof in addressing this audit finding and avoiding a recurrence.

RESPONSE OF THE DEPARTMENT

The Resolution of the Committee is noted.

As reported in the last quarter, this finding relates to non-compliance with the Standard Operating Procedures (SOP's) at facility level. The Department has commenced with the actions required to ensure that the controls are being adhered to at a facility level in terms of correcting recording, capturing and reporting of data.

- Facilities have intensified data verification between source documents, summary forms and the system. Supporting evidence is being kept proving that these verification procedures occurred. These verification tools have been standardised and is being submitted to the CEO prior to sign off of monthly data.
- CEO's, Facility Managers and District Directors are completing and submitting the revised data sign-off tools that were implemented in September 2023.
- Districts have been conducting visits to ensure that facilities are implementing an accepted Date of birth (D.O.B)/HPRN filing system. This is being reported on in the AIP and in the weekly Provincial meetings with District Directors.
- Districts have been conducting visits to ensure that facilities are implementing a suitable file flow that is feasible for that type of facility. This is being reported on in the AIP and in the weekly Provincial meetings with District Directors.
- Districts have been conducting visits to ensure that facilities are implementing a control register to ensure the daily reconciliation of files issued against files received back. This is being reported on in the AIP and in the weekly Provincial meetings with District Directors.
- District Offices have established teams to conduct facility data audits which will cover governance, data management and records management processes. Districts have been visiting facilities that are sometimes well over their target of 4 visits a month (min). This is being reported on in the AIP and in the weekly Provincial meetings with District Directors.
- Weekly Provincial Meetings are conducted every Wednesday to discuss progress on the action plans as mentioned above. These meetings are proving valuable.
- With the above progress, the Department is expecting to see an improvement in compliance as well as a reduction in discrepancies in data reported. These will be closely evaluated in Quarter 4 where all Districts will be audited by the Provincial office.

Further, the Department has also taken steps to address poor connectivity and the improvement of broadband speed at a facility level through the installation of a secondary network through Telkom.

The installation of the Phase 1 Secondary Network (including 42 initial hospitals) was completed in September 2023. Telkom is busy with connecting hospitals to the fibre infrastructure, and where applicable will see improved connectivity upon final commissioning.

RESOLUTION 116/2023 - MATERIAL IRREGULARITIES: INTEREST ON OVERDUE ACCOUNTS: R2.09 MILLION

Noting that:

(a) The department incurred a financial loss of R2.09 million in relation to interest paid on overdue accounts. The interest was imposed due to the department not paying within 30 days of receipt of invoices.

(b) *The department investigated the matter and it was noted that a portion of the interest amounting to R1.45 million was incorrectly charged by the service provider. This amount was refunded to the department.*

(c) *An investigation the balance of R640 000 is in progress.*

The committee resolves:

That the accounting officer report to the committee by 31 January 2024 on the outcome of the investigation relating to the balance of R640 000, the findings and recommendations and steps taken to implement the recommendations, including disciplinary steps against the officials responsible, the sanctions imposed, steps taken to recover the losses and measures put in place to avoid a recurrence, as well as time frames for concluding all processes.

RESPONSE OF THE DEPARTMENT

The Department has engaged with the contractor regarding the refund of the outstanding amount and in this regard, the contractor has since communicated with the Department via a letter in August 2023 and has confirmed that they will be refunding the remaining amount of R 635,391.59, being the default interest charges that was levied against the Department and this amount will be deducted from their final invoice. The Department is currently awaiting the final invoice and once received, the recovery will be made.

RESOLUTION 117/2023 - INTERNAL CONTROL DEFICIENCIES: PROPER DOCUMENT MANAGEMENT AND RECORD KEEPING SYSTEM NOT IMPLEMENTED: EHEALTH SYSTEM

Noting that:

(a) *The department did not implement a proper document management and record keeping system to ensure that complete, relevant and accurate information is accessible to support performance reporting.*

(b) *The department relies significantly on manual processes with extensive human intervention, which makes the department's financial and patient records management prone to errors, omissions and misplacement.*

(c) *The department embarked on a strategic project in 2019/20 to implement the eHealth System, an electronic Patient Records Management System. The eHealth System was planned to be implemented at all health institutions, with 70 hospitals being completed by the end of the 2023/23 financial year.*

(d) *Due to poor ICT project management, 8 hospitals still did not have the infrastructure rolled out to them at the time of audit, with only 18 facilities partially utilising the system and no facility fully utilising the system.*

(e) *This has resulted in extended patient waiting times, missing or damaged patient files and the department struggling to defend itself against medico-legal claims.*

(f) *The ICT staff who are managing the project do not have previous IT project management and system development skills.*

(g) *The acting CIO and Director: ICT Governance and Project Management should develop formal project management practices and standards based on established frameworks. Regular monitoring of the project status, costs, timelines and return on investment should be performed.*

The committee resolves: -

That the accounting officer report to the committee by 31 January 2024 on:

[1] *Effective interventions implemented to address the audit findings and recommendations regarding the eHealth System as a matter of priority, including:*
- *the development of a project management plan;*
- *the establishment of formal project management practices and standards, to be implemented retrospectively;*

- *the appointment of suitably skilled and experienced persons to manage the project;*
- *regular monitoring of the project status, quantification of costs, timelines and return on investment; and*
- *the time frames for full implementation of the eHealth System at all health institutions.*

[2] A quantification of the costs incurred thus far and the anticipated final costs.

RESPONSE OF THE DEPARTMENT

The Resolution of the Committee is noted. Appended are the responses of the Department

[1] Effective interventions implemented to address the audit findings and recommendations regarding the eHealth System as a matter of priority, including:

- *the development of a project management plan;*
- *the establishment of formal project management practices and standards, to be implemented retrospectively;*
- *the appointment of suitably skilled and experienced persons to manage the project;*
- *regular monitoring of the project status, quantification of costs, timelines and return on investment; and*
- *the time frames for full implementation of the eHealth System at all health institutions.*

A project management plan has been developed and will be presented in the next Departmental ICT Steering Committee. Further, it should be noted that all of the abovementioned points have been incorporated in the project management plan.

[2] A quantification of the costs incurred thus far and the anticipated final costs.

The cost that was incurred in the 2023/24 Financial Year thus far has been R 305,250,612.51. Further, the anticipated cost in the 2024/25 Financial Year is R 451,992,000.00

RESOLUTION 118/2023 - ICT CONTROL ENVIRONMENT REQUIRING INTERVENTION

Noting that:

(a) The overall information technology (IT) control environment requires intervention due to inadequate IT governance, IT security management, user access management, IT service continuity, program change management and cybersecurity.

(b) IT activities are not aligned to the overall departmental objectives due to lack of an IT Governance Framework and ICT Strategy for the department.

(c) ICT expenditure on machinery and equipment exceeded the budgeted amount by 101%.

(d) The ICT directorate is insufficiently staffed due to the revised ICT Organisational Structure not being approved. Key funded director posts are vacant.

(e) Implementation of the Digital Health Strategic Plan has been delayed.

(f) The medico-legal claims register shared drive continues to be used with an outdated SOP due to inadequate configuration of the Abacus system.

(g) Information stored on IT systems is unreliable and incomplete.

(h) The IT assets register is inadequate, resulting in the department not being able to accurately account for its software assets.

The committee resolves:

That the accounting officer report to the committee by 31 January 2024 on measures implemented to address the ICT-related audit findings, time frames for implementation and the adequacy and effectiveness of the interventions.

RESPONSE OF THE DEPARTMENT

The Resolution of the Committee is noted. Appended are the responses of the Department

(a) The overall information technology (IT) control environment requires intervention due to inadequate IT governance, IT security management, user access management, IT service continuity, program change management and cybersecurity

The recruitment of an Information and Communication Technology (ICT) Security Manager is currently underway through the Departments Human Resources Management Services (HRMS) and upon the appointment thereof, the IT Security Policy will be reviewed and updated to include the required key security management controls, guidelines and IT best practices. Once the policy has been updated, it will be approved and communicated to the relevant stakeholders for implementation and monitoring.

(b) IT Governance Framework and comprehensive ICT Strategy for KZN Health

The Department became aware of the capacity of SITA in this area and has since requested SITA to develop an ICT Strategy of behalf of the Department. A submission was approved by the Department and SITA has been tasked to commence with the necessary processes.

(c) ICT expenditure on machinery and equipment exceeded the budgeted amount by 101%.

The Department has engaged SITA to develop a comprehensive ICT Strategy. The ICT Governance and Project Manager will then implement formal project management practices based on the established ICT Strategy and Standards. The ICT Steering Committee will establish robust budget monitoring mechanisms, such as a detailed budget and forecast reviews with any variances being investigated to ensure that the return on investment will still be achieved for spend on ICT. The ICT Expenditure will also be discussed at the relevant Finance Committee meetings.

(d) The ICT directorate is insufficiently staffed due to the revised ICT Organisational Structure not being approved. Key funded posts are vacant.

The Department is currently reviewing the Organisational Structure, and in the interim the following posts are being addressed:

- The position of the Director: Information Technology Governance and Project Management was filled on 1 March 2023.
- The post of the Assistant Director: Information Technology was filled in August 2023,

Interviews for the posts of four (4) Network Engineers and four (4) Server Engineers were conducted on 14 August 2023, and in this regard, no suitable candidates were found. The process of re-advertisement is currently underway through HRMS.

Two (2) year contract internship posts for the incumbents to assist in boosting ICT capacity for the digitisation strategy, were advertised on 16 August 2023. The recruitment is currently underway through HRMS.

(e) Implementation of the Digital Health Strategic Plan has been delayed.

The Digital Health Strategic Plan and related processes will be addressed as part of the ICT Strategy being developed through SITA with processes being monitored and managed by the ICT Governance and Project Manager.

(f) The medico-legal claims register shared drive continues to be used with an outdated SOP due to inadequate configuration of the Abacus system.

The Abacus System which was developed and rolled out by the National Department of Health (NDOH) has been discontinued. The Departments Legal Services Unit is currently utilising an excel based in-house system which is being utilised for managing all medico-legal claims.

(g) Information stored on IT systems is unreliable and incomplete.

The Department has a centralised ICT helpdesk for users to report all IT related faults.

(h) The IT assets register is inadequate, resulting in the department not being able to accurately account for its software assets.

The Department will review its user active directory access which will restrict the download and installation of unauthorised software on the Department's network.

RESOLUTION 119/2023 - INVESTIGATIONS

Noting that:

(a) The special investigations unit in the department, other appointed service providers and the Forensic Unit at the Office of the Premier are conducting several investigations relating to allegations of incorrect awarding of contracts, theft, employees performing unauthorised remunerative work outside the public service and the misappropriation of inventory. The investigations cover the period 1 July 2008 to 31 March 2023.

(b) Sixty- nine investigations are still in progress, 22 have been closed as there was no case to meet, 20 have been finalised in that disciplinary hearings have been completed and 94 have been finalised and referred for implementation of disciplinary action and criminal action, where applicable.

The committee resolves:

That the accounting officer report to the committee by 31 January 2024 on:

[1] The nature of the allegations and the amounts involved, per investigation still in progress or finalised.

[2] The findings and recommendations of completed investigations.

[3] Steps taken to implement the recommendations and the outcomes of finalised investigations, including disciplinary steps and the sanctions imposed, steps taken to recover any losses, opening of criminal cases where criminal conduct was found and remedial steps taken to avoid a recurrence.

[4] The anticipated time frame for completion of all ongoing investigations and implementation of all recommendations.

RESPONSE OF THE DEPARTMENT

The Resolution of the Committee is noted. Appended are the responses of the Department relative to the Resolution of the Committee.

[1] The nature of the allegations and the amounts involved, per investigation still in progress or finalised.

Appended are the nature of the allegations per investigation, the number of cases and the amounts involved that were referred to the Departments Investigations Services:

NO	SCHEME	NO. CASES	AMOUNT
1	Assault	1	-
2	Non-Compliance	1	-
3	Maladministration	1	-
4	Misuse of vehicle	1	-
5	Extortion	1	R 20 000
6	Ghost Employee	1	-
7	Negligence	2	-
8	Gross Misconduct	3	-
9	Bribery	3	R 15 000
10	Intimidation	5	-

NO	SCHEME	NO. CASES	AMOUNT
11	HR Irregularities	12	-
12	Other Remunerative Work Outside Public Service (ORWOPS)	13	R 307 400
13	Conflict of interest	14	-
14	Fruitless and Wasteful Expenditure	09	R 8 900 000
15	Theft	15	R 405 700
16	Misconduct	15	-
17	Corruption	29	R 180 000
18	SCM Irregularities	36	-
19	Fraud	43	R 1 820 000

[2] The findings and recommendations of completed investigations.

In this regard, some cases were closed due to a lack of evidence. These cases were investigated, and it was established that there were no officials who could be implicated and could be subjected to disciplinary proceedings, but only require internal control improvements. Such cases were referred to the respective accounting officers of the institutions, for the implementation of the recommendations.

Disciplinary processes are recommended for all cases where the investigating team had proven on the balance of probabilities that the officials were involved in misconduct issues. In these instances, the Department engages its Legal unit for any recoveries, in the event where officials who are entitled to pay back the Department's money, resign before they could be charged. The recovery is still conducted as recommended from the implicated official's pension.

[3] Steps taken to implement the recommendations and the outcomes of finalised investigations, including disciplinary steps and the sanctions imposed, steps taken to recover any losses, opening of criminal cases where criminal conduct was found and remedial steps taken to avoid a recurrence.

Cases where the allegations could be proven, are referred to Departments Labour Relations for implementation of corrective actions.

There are instances where cases are withdrawn at a hearing stage and the implicated officials are found not guilty due to there being insufficient evidence. It should be noted that nineteen (19) cases are pending finalisation of the disciplinary processes. In respect of the cases that have been finalised, the outcome was as follows:

- Twenty-one (21) officials have been dismissed.
- One (1) official was issued with a one (1) month suspension without pay and a final written warning.
- Eighteen (18) officials had resigned during the disciplinary process.
- Six (6) officials were issued with three (3) months suspension without pay and a final written warning.
- One (1) official was issued with a two (2) month suspension without pay and a final written warning.
- One (1) official was given a final written warning.
- One (1) official had resigned during the disciplinary hearing and was subsequently arrested. The pension pay-out was frozen so that the R 800 000 could be recovered from her pension.

[4] The anticipated time frame for completion of all ongoing investigations and implementation of all recommendations.

It is anticipated that the ongoing investigations will be completed by the end of the last quarter (31 March 2024) of the 2023/24 financial year. Further, with regards to the implementation of the recommendations, it is anticipated that the disciplinary processes will be completed by the end of first quarter (30 June 2024) of 2024/25.

RESOLUTION 120/2023 - VARIOUS FLOOD RELIEF INITIATIVES

Noting that:

(a) A real-time audit was conducted on the response of the department to address the damage to infrastructure caused by the floods in April 2022.
(b) The department identified infrastructure damage to the value of R200 million across several health care facilities.
(c) The response of the department in addressing the damaged infrastructure was slow and delays were experienced in undertaking flood projects. The department identified twelve infrastructure projects but none were awarded due to Provincial Treasury findings of SCM non-compliance. All 12 projects were re-advertised.
(d) Poor workmanship was noted at some of the clinics.
(e) The department does not have an approved disaster management plan in place.

***The committee resolves:** -*

That the accounting officer report to the committee by 31 January 2024 on progress made in addressing the audit findings, the status of the flood relief projects and the adoption of a disaster management plan.

RESPONSE OF THE DEPARTMENT

The Resolution of the Committee is noted.

The progress on the twelve (12) Flood Damage Projects that was implemented by the Department in respect of the floods of April 2022, is outlined in the appended table:

NO	FACILITY NAME	MILESTONE REACHED	AWARD AMOUNT	PROGRESS COMMENT
1	Nkandla Hospital	Construction started	R 11 639 347.05	**Construction Stage:** Site handover achieved on the 12 September 2023. Progress is about 5% achieved
2	Prince Mshiyeni Hospital	Construction started	R 6 189 466.75	**Construction Stage:** Site handed over on 15 June 2023. Progress is 30% achieved on site.
3	Clairwood hospital	Construction started	R 15 387 759,00	**Construction Stage:** Project in progress and contractor is on track but rain is hampering progress. The project is 25 % in progress
4	RK Khan Hospital	Construction started	R 6 804 872.00	**Construction Stage:** Site handed over to the contractor on 16 November 2023. Work is on site and progress is at 10% complete
5	RK Khan Hospital	Construction started	R 3 342 916.97	**Construction Stage:** Construction commenced on 23 October 2023 and progress is at 35%.
6	Phoenix CHC	Construction started	R 11 849 243.27	**Construction Stage:** Site Handover was on 31 May 2023. Progress is at 15% achieved on site.
7	Addington Hospital Nursing Home	Construction started	R 6 952 945.70	**Construction Stage:** Site handover was achieved on 05 June 2023. Progress on site 26% complete.
8	G J Crookes	Construction started	R 11 964 255.00	**Construction Stage:** The site handover was conducted on 15 June 2023. Project is on site at 8% progress
9	Wentworth Hospital	Award finalised	R 20 701 529.50	**Construction Stage:** Site was handed over on 03 November 2023.

NO	FACILITY NAME	MILESTONE REACHED	AWARD AMOUNT	PROGRESS COMMENT
				Project is design and build and the team is busy with detail design.
10	Addington Hospital	Award finalised	R 6 952 945.70	**Construction Stage:** Site handed over to the contractor on the 20 November 2023. Project is design and build and the team is busy with detail design.
11	King Edward XIII Hospital	Award finalised	R 8 770 914.07	**Construction Stage:** Site handed over to the contractor on the 21 July 2023. Project is design and build and the team is busy with detail design.
12	Justice Gizenga Mpanza Hospital	Tender stage	R 9 558 837.00	Original appointed Contractor withdrew. Appointment of second Contractor by SCM is anticipated to be finalised by 26 January 2024
TOTAL			**R 120 115 032.01**	

(f) *The department does not have an approved disaster management plan in place.*

Cognisance should be taken of the fact that the Departments Disaster Management Plan has since been approved and submitted to the Department of Cooperative Governance and Traditional Affairs. Please refer to the attached annexures for ease of reference. ***(Annexure B)***

RESOLUTION 121/2023 - INFRASTRUCTURE PROJECTS: DR PIXLEY KA SEME MEMORIAL HOSPITAL

Noting that:

(a) *Practical completion of the project, which commenced in 2005, was achieved in March 2022 at a cost of R2.7 billion (against a budget of R2.4 billion).*
(b) *The project team did not meet the project deliverables.*
(c) *More than a year after practical completion, the neonatal unit of the hospital is not yet operational due to the lack of human capital resources and a shortage of equipment. In addition, the contractor is still on site to remedy defective work.*

The committee resolves*: -*

That the accounting officer report to the committee by 31 January 2024 on:

[1] *The appointment of human capital resources, as a matter of priority, to run the neonatal unit and ensuring all plant and equipment are available and functional to fully operationalize the hospital, as well as the timelines for implementation.*
[2] *Measures implemented to finalise the defective work and the timelines for completion.*
[3] *Steps taken to implement consequence management against the responsible members of the project team for not meeting the project deliverables.*

RESPONSE OF THE DEPARTMENT

The Resolution of the Committee is noted. Appended are the responses of the Department

[1] *The appointment of human capital resources, as a matter of priority, to run the neonatal unit and ensuring all plant and equipment are available and functional to fully operationalize the hospital, as well as the timelines for implementation.*

The institution has been officially opened by the President in November 2023. All services are operational; however, due to the lack of human resources brought on by the budgetary constraints, the mother and child services has not been commissioned. In this regard, it should be noted that an amount of R 146,000,000 is required to commission these services. Further, it should be noted that the equipment required to run mother and child service is available.

[2] Measures implemented to finalise the defective work and the timelines for completion.

All major structural and systems defects were completed leading to the works completion taking place in May 2023 except for the nurse call system which suffered latent defects after works completion. These are being attended to which will lead to the recommissioning of this system before end of February 2024.

[3] Steps taken to implement consequence management against the responsible members of the project team for not meeting the project deliverables.

To a large extent the Project duration was extended in line with an approved extension of times meaning that the delay experienced was due to the causes that were justifiable. In instances where delays were as a result of the Professional Team failing to pass-over construction information to the Contractor on time, the money paid to the Contractor was recovered from consultants.

RESOLUTION 122/2023 - INFRASTRUCTURE PROJECTS: MCCORD EYE HOSPITAL

Noting that:

(a) The due date for the completion of the refurbishment project at the hospital was extended to February 2023 (from December 2021).
(b) The project team did not sufficiently monitor the project implementation to ensure the quality of work was suitable for a hospital and allowed early occupation without ensuring key compliance issues were met, including the servicing of fire extinguishers.
(c) Due to defective work to the flooring and other outstanding repairs, the theatre where cataract operations are performed had to be closed shortly after opening and remains closed, causing significant delays in cataract operations. The hospital is also functioning without a fire detection system.

The committee resolves:

That the accounting officer report to the committee by 31 January 2024 on the plans and steps taken to remedy the defective work and to complete the installation of a fire detection system, as well as timelines for completion of all work.

RESPONSE OF THE DEPARTMENT

In this regard, all critical defects were repaired leading to practical completion taking place on 3 June 2023. Snags underway and partial final completion was taken on 25 September 2023 except for the latent defects pertaining to the roof leaks which were caused by the recent storms which are being repaired with a view to take final completion by the end of February 2024.

RESOLUTION 123/2023 - INFRASTRUCTURE PROJECTS: KING EDWARD HOSPITAL

Noting that:

(a) The due date for the completion of the project for the alterations, additions and renovations to the hospital was extended from November 2019 to March 2022, due to ten variation orders being approved during the implementation of the project. The contract value increased from R42,5 million to R95.2 million. Final completion was achieved in May 2022.
(b) The delay in the project and the related increase in costs arose from design errors in the roof structure.

(c) *Additional repairs to the maternity ward have not yet been carried out. As a result, the ward is not in use.*
(d) *The newly installed air-conditioning and biometric access systems at the neonatal unit are non-functional.*

The committee resolves:

That the accounting officer report to the committee by 31 January 2024 on the plans and steps taken to remedy the outstanding and defective work and to complete the additional repairs, as well as timelines for completion of all work.

RESPONSE OF THE DEPARTMENT

The Resolution of the Committee is noted.

In respect of the Maternity Ward 2 that was not in use, the following should be noted:

- Maternity Ward 2 was first damaged by the storm in October 2017 and was further damaged by the storms in April 2022. As a result, the Maternity Ward could not be used anymore.
- A Capital Project to fully Refurbish the Maternity Ward was initiated in 2023. The process will involve appointing a team of consultants to do the full design.
- Once the design has been finalised, a contractor will be appointed through SCM processes, to refurbish the Maternity Ward
- The appointment of the consultants is at SCM awaiting the convening of the BAC Committee for award and it is anticipated that the order will be issued on 8 March 2024.

In respect of the Air-Conditioner and Biometric System not being functional, the following should be noted:

a. Fire Panel
   - The alarm panel was serviced and is functional.
   - It was serviced in April 2023 and the next service is due in April 2024.
   - In respect of the two (2) faults that were noted, the necessary reviews and action will be implemented.

b. HVAC System

- The HVAC System received a major service and is currently functional.
- There are a few after service recommendations/repairs that need to be attend to and these are currently being attended to and will be completed at the end of February 2024.
- The HVAC units and Chiller are functional and are in operation.
- Some of the Chilled Water Fan Coil units, DX Units and the system serving the NICU were not functional. These are being addressed as part of the after service report and the entire system should fully operational before end of February 2024.

RESOLUTION 124/2023 - IDEAL CLINIC REALISATION AND MAINTENANCE PROGRAMME

Noting that:

(a) *An audit was conducted to determine the status of the implementation of the Ideal Clinic Realisation Maintenance (ICRM) programme in the province and to determine whether selected vital elements relating to pharmaceuticals, human resources and infrastructure are present and functional at selected facilities. The audit team visited the KwaMsane CHC, Madwaleni CHC and Khaylihle CHC.*
(b) *All three facilities were found lacking to a large extent in some of the vital elements.*
(c) *According to the audit opinion this is due to a lack of care by the department in not ensuring that the clinics comply with all the elements of the ideal clinic checklist and a lack of monitoring and enforcing compliance and implementation by management of the clinics.*

The committee resolves:

That the accounting officer report to the committee by 31 January 2024 on steps taken to ensure quality improvement plans are implemented by the clinics and are monitored, as well as steps taken to implement consequence management for non-compliance by officials responsible.

RESPONSE OF THE DEPARTMENT

The Department has implemented a monitoring and evaluation system to improve its compliance relative to the Ideal Clinic Realisation and Maintenance Programme. In this regard, the District Directors, Deputy Managers Clinical & Programs report on the progress made in addressing the findings at the clinics on every second Wednesday of the month.

Further, the districts and facilities Operational Managers have been requested to identify Ideal Clinic Realization & Maintenance Champions, who will be responsible for ensuring that all the essential elements that has been lacking, are adequately addressed. The facilities have developed an Ideal Clinic Realization and Maintenance Programme improvement plan, to address the gaps which are being updated on a monthly basis.

Further, the Department has developed an Audit Improvement Plan to address the gaps relating to the transversal elements in terms of Human Resources, Infrastructure and Medical Supplies. In addition, the Departments Primary Health Care Services has implemented the following actions:

- A two (2) day workshop was conducted for the District Ideal Clinic Realization and Maintenance Programme champions and teams on the Standard Operating Procedures (SOP's) for the conducting of assessments. The Departmental SOP on how to conduct the Ideal Clinic Assessments was developed and disseminated to all Districts, effective from October 2023.
- The workshop also addressed the monitoring of the Non-Negotiable vital (NNVs) and Vital (V) elements, the storage and retrieval of all reports for all quarters as well as how to extract the reports for the previous financial years.

District Management Teams have been urged to continue to monitor and support the poorly performing facilities.

RESOLUTION 125/2023 - EMERGENCY MEDICAL SERVICES (EMS)

Noting that:

(a) An audit was conducted in the eThekwini, iLembe and Zululand districts on the efficiency and effectiveness of the ambulance EMS.

(b) The actual response times in all areas exceeded the targeted times. In eThekwini 60% of the response times ranged from 90 minutes to 12 hours (against a target of 30 minutes), in iLembe 75% of the response times ranged from 2 hours to 15.5 hours (against a target of 60 minutes) and in Zululand 100% of the response times ranged from 90 minutes to 11 hours (against a target of 60 minutes). All cases included priority cases.

(c) Forty-seven percent of ambulances exceeded their useful life. eThekwini and iLembe wrote off 47 ambulances in the financial year. Ambulances spend months in workshops for repairs.

(d) Sixty-seven ambulances in eThekwini and 17 in iLembe did not have prescribed essential life support equipment on board.

(e) Linen was not replaced after each patient and ambulances were not cleaned. Pharmaceuticals were transported in worn-out lunch bags.

(f) Oxygen cylinders did not have gauges and were not secured correctly. Equipment was old and broken. Storage practice over medical supplies was unsatisfactory with stock left on the floor.

The committee resolves:

That the accounting officer report to the committee by 31 January 2024 on:

[1] Implementation of a long-term procurement strategy for ambulances and prioritising budgets for the replacement of ambulances.

[2] Corrective action to be taken for: -

- *delays in response times and repairing of ambulances;*
- *lack of due care by staff regarding proper hygiene practices, proper storage and management of medication, equipment and medical supplies;*
- *replacement of equipment;*
- *enforcement of strict control over compliance with policies, regulations and SOP's; and*
- *implementation of consequence management where officials have failed to perform their duties.*

RESPONSE OF THE DEPARTMENT

The Resolution of the Committee is noted. Appended are the responses of the Department to the resolution.

[1] Implementation of a long-term procurement strategy for ambulances and prioritising budgets for the replacement of ambulances.

A fleet growth plan was developed and approved by the Departments Management Committee (Manco) to grow the fleet in EMS.

[2] Corrective action to be taken for: - delays in response times and repairing of ambulances;

In this regard, the following was undertaken:

- The vehicle management service provider has been engaged to increase the pool of service providers and increase supervision of fleet matters.
- District Fleet Officers to engage with the service providers regularly to limit ambulance downtime.
- Weekly monitoring of vehicle downtime.
- Operational status monitoring per shift.
- EMS operational staff roster and working hours to be revised in order to reduce the compulsory overtime expenditure. If this is achieved, then EMS will have budget for voluntary overtime as well as employing of new staff to ensure the operational schedule is achieved.
- Thirty-two (32) new ambulances have been procured and the Department is awaiting delivery. The distribution of the thirty-two (32) new ambulances will be as follows:

DISTRICT	NUMBER
Amajuba	3
Ethekwini	5
Harry Gwala	3
Ilembe	3
King Cetshwayo	3
Ugu	2
Umgungundlovu	3
Umkhanyakude	3
Umzinyathi	2
Uthukela	2
Zululand	3

Further to the above, the following should be noted:

- *In respect of the lack of due care by staff regarding proper hygiene practices, proper storage and management of medication, equipment and medical supplies;*
  - EMS Forms part of the District IPC Committee to ensure proper hygiene practices are maintenance

- Schedule 2 – 5 drugs are kept are under lock and key, a register is maintained and signed off by the District Health Manager of the relevant districts.
- SCM at District Health Office is responsible for the procurement of equipment and medical sundries

▪ *Replacement of equipment;*

- Equipment is procured at the Head Office level and disseminated to the Districts. An order was placed for medical equipment for delivery in mid-December 2023;

ITEM	QUANTITY
Forceps - Magill Child	37
Forceps - Artery - Spencer Wells	37
Scissors - Nurses Blunt	37
Forceps - Magill - Infant	37
Forceps - Magill - Infant	37
Oxygen Flowmeter - Single	37
Battery - 3 Lead ECG Monitor	37

▪ *Enforcement of strict control over compliance with policies, regulations and SOP's; and implementation of consequence management where officials have failed to perform their duties.*

- SOPs are in place to ensure compliance
- Compliance is in line with the departmental policy and the HPCSA guidelines.

3. Should further clarity be sought regarding the response, you are kindly requested to contact my office.

Yours sincerely

DR SC TSHABALALA
HEAD OF DEPARTMENT: HEALTH
KWAZULU-NATAL

DATE: 30/01/2024

ANNEXURE A

REPORTING OF PROCUREMENT BY OTHER MEANS, VARIATIONS AND EXPANSIONS OF CONTRACTS **ANNEXURE B**

Full Name of National/ Provincial Institution: DEPARTMENT OF HEALTH, KZN

Name of Accounting Officer / Delegated Official: MR K.B.L. VILAKAZI

Chief Director SCM: MR K.E. MTSHALI

Telephone number and email address: (033) 815 8302 / Khondlo.mtshali@kznhealth.gov.za

Date: 30-Apr-23

REPORTING OF PROCUREMENT BY DEVIATION

No	Project Description	Name of Supplier	Contract Number	Reason for the procurement by other means	Value of contract	Award Date	Contract start date	Contract expiry
1	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL

The Accounting Officer/ Authority confirms that the infomation captured in this report is a true reflection of the approved procurement by Deviation and the approved expansions and variations of contracts.

Mr KE Mtshali
Chief Director: CSCM

Mr K.B.L. Vilakazi
Chief Financial Officer

Dr S. C. Tshabalala
Head of Department: Health, KZN

REPORTING OF PROCUREMENT BY OTHER MEANS, VARIATIONS AND EXPANSIONS OF CONTRACTS **ANNEXURE B**

Full Name of National/ Provincial Institution: DEPARTMENT OF HEALTH, KZN

Name of Accounting Officer / Delegated Official: DR S. C. TSHABALALA

Chief Director SCM: MR K.E. MTSHALI

Telephone number and email address: (033) 815 8302 / Khondlo.mtshali@kznhealth.gov.za

Date: 31 May 2023

REPORTING OF PROCUREMENT BY DEVIATION

No	Project Description	Name of Supplier	Contract Number	Reason for the procurement by other means	Value of contract	Award Date	Contract start date	Contract expiry
1	Audit readiness: Financial Managemnet	Abacwaningi Business OR-000582	ZNB5050/2022-H ZNQ/HOH/0040/24	To appoint a service providerto assist the Department with addressing the challenges as identified in the Auditor General report.	R1 200 000,00	17/02/2023	01/05/2023	Nov,2023
2	Audit readiness: Movable Assets	Lwandle OR-000580	ZNB5050/2022-H ZNQ/HOH/0042/24	To appoint a service providerto assist the Department with addressing the challenges as identified in the Auditor General report.	R3 174 000,00	17/02/2023	01/05/2023	Nov,2023
3	Audit readiness: Financial Managemnet	Lwandle OR-000579	ZNB5050/2022-H ZNQ/HOH/0044/24	To appoint a service providerto assist the Department with addressing the challenges as identified in the Auditor General report.	R2 760 000,00	17/02/2023	01/05/2023	Nov,2023
4	Audit readiness: Financial Managemnet	Yesholata Singh OR-000584	ZNB5050/2022-H ZNQ/HOH/0043/24	To appoint a service providerto assist the Department with addressing the challenges as identified in the Auditor General report.	R1 200 000,00	17/02/2023	01/05/2023	Nov,2023

The Accounting Officer/ Authority confirms that the infomation captured in this report is a true reflection of the approved procurement by Deviation and the approved expansions and variations of contracts.

Mr KE Mtshali
Chief Director: CSCM

Mr K.B.L. Vilakazi
Chief Financial Officer

Dr S. C. Tshabalala
Head of Department: Health, KZN

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Name of Accounting Officer / Delegated Official: MR K.B.L. VILAKAZI

Chief Director SCM: MR K.E. MTSHALI

Telephone number and email address: (033) 815 8302 / Khondlo.mtshali@kznhealth.gov.za

Date: 30-Jun-23

REPORTING OF PROCUREMENT BY DEVIATION

No	Project Description	Name of Supplier	Contract Number	Reason for the procurement by other means	Value of contract	Award Date	Contract start date	Contract expiry
1	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL

The Accounting Officer/ Authority confirms that the infomation captured in this report is a true reflection of the approved procurement by Deviation and the approved expansions and variations of contracts.

Mr KE Mtshali
Chief Director: CSCM

Mr K.B.L. Vilakazi
Chief Financial Officer

Dr S. C. Tshabalala
Head of Department: Health, KZN

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Name of Accounting Officer / Delegated Official: MR K.B.L. VILAKAZI

Chief Director SCM: MR K.E. MTSHALI

Telephone number and email address: (033) 815 8302 / Khondlo.mtshali@kznhealth.gov.za

Date: 31-Jul-23

REPORTING OF PROCUREMENT BY DEVIATION

No	Project Description	Name of Supplier	Contract Number	Reason for the procurement by other means	Value of contract	Award Date	Contract start date	Contract expiry
1	NIL	NIL	NIL	NIL		NIL	NIL	NIL

The Accounting Officer/ Authority confirms that the infomation captured in this report is a true reflection of the approved procurement by Deviation and the approved expansions and variations of contracts.

Mr KE Mtshali
Chief Director: CSCM

Mr K.B.L. Vilakazi
Chief Financial Officer

Dr S. C. Tshabalala
Head of Department: Health, KZN

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ANNEXURE B

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Name of Accounting Officer / Delegated Official: MR K.B.L. VILAKAZI

Chief Director SCM: MR K.E. MTSHALI

Telephone number and email address: (033) 815 8302 / Khondlo.mtshali@kznhealth.gov.za

Date: 31-Aug-23

REPORTING OF PROCUREMENT BY DEVIATION

No	Project Description	Name of Supplier	Contract Number	Reason for the procurement by other means	Value of contract	Award Date	Contract start date	Contract expiry
1	Leadership & Mentorship	Khanyanjalo Consulting	ZNQ/HOH/1000/24	Only one eligible service provider could be identified R276 600,00	R276,600,00	16/08/2023	16/08/2023	NIL
2	Assess & repair ironer no. 1	Nkosinathi Projects	ZNQ/HOH/1026/24	Backlog of linnen to be ironed. Testyl trading failed to repair	R96 195,04	15/08/2023	15/08/2023	NIL

The Accounting Officer/ Authority confirms that the infomation captured in this report is a true reflection of the approved procurement by Deviation and the approved expansions and variations of contracts.

Mr KE Mtshali
Chief Director: CSCM

Mr K.B.L. Vilakazi
Chief Financial Officer

Dr S. C. Tshabalala
Head of Department: Health, KZN

REPORTING OF PROCUREMENT BY OTHER MEANS, VARIATIONS AND EXPANSIONS OF CONTRACTS

ANNEXURE B

Full Name of National/ Provincial Institution: DEPARTMENT OF HEALTH, KZN

Name of Accounting Officer / Delegated Official: MR K.B.L. VILAKAZI

Chief Director SCM: MR K.E. MTSHALI

Telephone number and email address: (033) 815 8302 / Khondlo.mtshali@kznhealth.gov.za

Date: 30-Sep-23

REPORTING OF PROCUREMENT BY DEVIATION

No	Project Description	Name of Supplier	Contract Number	Reason for the procurement by other means	Value of contract	Award Date	Contract start date	Contract expiry
1	Catering	Fedics Order number OR-001733	ZNQ/HOH/1118/24	Catering for BRICS delegation visit at Inkosi Albert Luthuli Central Hospital R32 056.25		06/09/2023	06/09/2023	

The Accounting Officer/ Authority confirms that the infomation captured in this report is a true reflection of the approved procurement by Deviation and the approved expansions and variations of contracts.

Mr KE Mtshali
Chief Director: CSCM

Mr K.B.L. Vilakazi
Chief Financial Officer

Dr S. C. Tshabalala
Head of Department: Health, KZN

REPORTING OF PROCUREMENT BY OTHER MEANS, VARIATIONS AND EXPANSIONS OF CONTRACTS

ANNEXURE B

Full Name of National/ Provincial Institution: DEPARTMENT OF HEALTH, KZN

Name of Accounting Officer / Delegated Official: MR K.B.L. VILAKAZI

Chief Director SCM: MR K.E. MTSHALI

Telephone number and email address: (033) 815 8302 / Khondlo.mtshali@kznhealth.gov.za

Date: 31-Oct-23

REPORTING OF PROCUREMENT BY DEVIATION								
No	Project Description	Name of Supplier	Contract Number	Reason for the procurement by other means	Value of contract	Award Date	Contract start date	Contract expiry
1	Diversity Management	Busiswa Communications	ZNQ/HOH/1397/24	Second day session it was noticed that some attendees were deaf R 10 000,00		12/10/2023	28/06/2023	28/06/2023

The Accounting Officer/ Authority confirms that the infomation captured in this report is a true reflection of the approved procurement by Deviation and the approved expansions and variations of contracts

Mr KE Mtshali
Chief Director: CSCM

Mr K.B.L. Vilakazi
Chief Financial Officer

Dr S. C. Tshabalala
Head of Department: Health, KZN

REPORTING OF PROCUREMENT BY OTHER MEANS, VARIATIONS AND EXPANSIONS OF CONTRACTS **ANNEXURE B**

Full Name of National/ Provincial Institution: DEPARTMENT OF HEALTH, KZN

Name of Accounting Officer / Delegated Official: MR K.B.L. VILAKAZI

Chief Director SCM: MR K.E. MTSHALI

Telephone number and email address: (033) 815 8302 / Khondlo.Mtshali@kznhealth.gov.za

Date: 30-Nov-23

REPORTING OF PROCUREMENT BY DEVIATION								
No	**Project Description**	**Name of Supplier**	**Contract Number**	**Reason for the procurement by other means**	**Value of contract**	**Award Date**	**Contract start date**	**Contract expiry**
1	Catering	Mandate Meal Management	ZNQ/HOH/1334/24	Lebone College Team And Gauteng Director: EMS Benchmarking 18/08/2023		09/11/2023		
2	Renewal of Licence	Uniclox	ZNQ/HOH/1610/24	Sole Proprieter		23/11/2023		

The Accounting Officer/ Authority confirms that the infomation captured in this report is a true reflection of the approved procurement by Deviation and the approved expansions and variations of contracts.

Mr KE Mtshali
Chief Director: CSCM

Mr K.B.L. Vilakazi
Chief Financial Officer

Dr S. C. Tshabalala
Head of Department: Health, KZN

REPORTING OF PROCUREMENT BY OTHER MEANS, VARIATIONS AND EXPANSIONS OF CONTRACTS **ANNEXURE B**

Full Name of National/ Provincial Institution: DEPARTMENT OF HEALTH, KZN

Name of Accounting Officer / Delegated Official: MR K.B.L. VILAKAZI

Chief Director SCM: MR K.E. MTSHALI

Telephone number and email address: (033) 815 8302 / Khondlo.mtshali@kznhealth.gov.za

Date: 31-Dec-23

REPORTING OF PROCUREMENT BY DEVIATION								
No	**Project Description**	**Name of Supplier**	**Contract Number**	**Reason for the procurement by other means**	**Value of contract**	**Award Date**	**Contract start date**	**Contract expiry**
1	Investigation & Reporting of support with Irregular expenditure assessment	Morar	ZNQ/HOH/1584/24 ZNB5050/2022-H	To improve audit outcomes of the 2021/22 Annual Financial Statement		05/12/2023		
2	Provision of Infrastructure (Capital Commitment & work in progress	Isizwe	ZNQ/HOH/1586/24 ZNB5050/2022-H	Capital commitments & work in progress		05/12/2023		

The Accounting Officer/ Authority confirms that the infomation captured in this report is a true reflection of the approved procurement by Deviation and the approved expansions and variations of contracts.

Mr KE Mtshali
Chief Director: CSCM

Mr K.B.L. Vilakazi
Chief Financial Officer

Dr S. C. Tshabalala
Head of Department: Health, KZN

ANNEXURE B

KWAZULU-NATAL DEPARTMENT OF HEALTH

DISASTER MANAGEMENT PLAN

Version: 01/2022

Version	Version 1/2022
Short description	KwaZulu-Natal Department of Health - Disaster Management Plan (DMP)
Relevant to	KZN Department of Health is obligated to develop a disaster management plan ito the Disaster Management Act 57 of 2002, National Health Act 61 of 2003, World Health Assembly International Health Act 28 of 1974
Authority	This DMP has been approved by the Head of Health: KwaZulu-Natal Department of Health in terms of Section 25 (1) of the Disaster Management Act 57 of 2002 and section 3.6 of the National Disaster Management Framework, 2005 (NDMF), Section 21(2) (e) and Section 25(2) (g) of the National Health Act 61 of 2003, World Health Assembly International Health Act No 28 of 1974, National Environmental Management Act 107 of 1998
Responsible officer	Assistant Director: Disaster Management
Responsible Chief Directorate	Clinical Support Services
Date introduced	1 June 2022
Date(s) modified	First Issue
Next scheduled review date	1 June 2024
Related documents	World Health Organisation (WHO) Health – Emergency and Disaster Risk Management Framework
Related legislation	Disaster Management Act, 2002 (DMA), National Disaster Management Framework, 2005 (NDMF, 2005) National Health Act, 2003 National Environmental Management Act, 1998 World Health Assembly – International Health Act, 1974

ACKNOWLEDGMENTS

Many individuals participated in the process to prepare this Disaster Management Plan. Appreciation goes to all those who have given their time and inputs in this regard. The KwaZulu-Natal Department of Health would specifically like to acknowledge the following individuals and organisations for their contributions.

- Ms BN Zungu – Director EMS– KZN Department of Health
- Mr Rajen Naidoo – eThekwini EMS District EMS Manager – KZN Department of Health
- Mr Anwar Mahomed – KZN Department of Health
- Ms Elizabeth Leonard – Clinton Health Access Initiative
- Ms Jennifer Kolokoto – Director: Disaster Risk Reduction and Planning – National Disaster Management Centre
- Dr Wayne Smith – Head – Disaster Management Centre – Western Cape Department of Health – Emergency Medical Services

TABLE OF CONTENTS:

ACRONYMS....i

DEFINITIONS....i

COMPATIBILITY WITH OTHER POLICIES, PROCEDURES AND GUIDELINES....i

EXECUTIVE SUMMARY....i

CHAPTER 1....1

1.1. PURPOSE OF THE PLAN....6

1.2. INTEGRATED AND COMPREHENSIVE HEALTH SYSTEM....6

1.3. DEMOGRAPHIC PROFILE....7

1.4. SOCIO-ECONOMIC PROFILE:....8

1.4.1. SOCIAL DETERMINANTS OF HEALTH....9

CHAPTER 2....10

2.1. CONSTITUTIONAL, LEGISLATIVE AND POLICY MANDATES....10

2.1.1. Constitution:....10

2.1.2. Legislative:....10

2.1.3. ROLES AND RESPONSIBILITIES OF NATIONAL ORGANS OF STATE....12

2.1.4. NATIONAL DISASTER MANAGEMENT FRAMEWORK....13

2.2. INTERNATIONAL LAW:....15

2.2.1. STRATEGIC OBJECTIVES OF INTERNATIONAL HEALTH REGULATION 2005.16

2.2.2. UNITED NATIONS INTERNATIONAL STRATEGY FOR DISASTER RISK REDUCTION (UNISDR)....16

2.2.3. HYOGO FRAMEWORK OF ACTION 2005....16

2.2.4. SENDAI FRAMEWORK OF ACTION: 2015-2030....20

2.3. POLICY, PROCEDURES AND GUIDELINES AND LEGISLATIVE FRAMEWORK...24

2.3.1. Legislative framework....24

CHAPTER 3....25

3.1. Organisational Hierarchy....26

3.2. The Public Health Emergency Coordinating Committee (PHECC)....28

3.3. Strategic framework for disaster medicine/management....34

CHAPTER 4....35

4.1. Hazard and Vulnerability Assessment (HVA)....39

4.2. Healthcare Facility Disaster Plan Self-Assessment Tool 41
CHAPTER 5 42
5.1. The NDMF defines disaster risk reduction as; 42
5.2. Disaster Risk Reduction Strategies 48
CHAPTER 6 51
6.1. Decision making structures 51
6.1.1. Public Health Emergency Coordinating Committee (PHECC) 51
6.1.5. DISASTER/EMERGENCY PLANNING COMMITTEE 59
6.1.6. INCIDENT MANAGEMENT SYSTEM (IMS) 61
6.1.7. CHAIN OF COMMAND 63
6.1.8. DISASTER RESPONSE TEAM (DRT) 63
6.1.9. ORGANISATIONAL CHART: 64
6.2. Decision Making Supporting Structures 65
6.2.1. ACTION CARDS 65
6.2.2. PLANNING AND TRAINING 66
6.2.3. MONITORING/AUDIT SYSTEMS 67
6.2.4. PARTNERSHIP/COALITION DEVELOPMENT MUTUAL AID AGREEMENT 67
6.2.5. EARLY DETECTION: 68
6.2.6. STRATEGIC EMERGENCY PREPAREDNESS ACTIONS: 69
6.2.7. NATIONAL CLIMATE CHANGE AND HEALTH ADAPTATION 71
6.2.8. HEALTHCARE FACILITY PREPAREDNESS PLAN 77
6.3. BUSINESS CONTINUED PLANNING/MANAGEMENT (BCP/M) 77
6.3.1. Business Continuity Tool: 78
6.3.2. Department Status Form 80
6.3.3. Downtime Departmental Disaster Status Report Form: 81
6.3.4. Department Status Summary 82
6.4. MEDICAL EVACUATION/SHELTER IN PLACE/ALTERNATE CARE FACILITY AND TEMPORARY SHELTERS 83
6.4.1. Alternate Care Facility 83
6.4.2. Activation criterion 84
6.4.3. Temporary shelters 84
6.4.4. Primary Health Services 84
6.4.5. Environmental Health Services 85
6.5. Registration of Volunteer Health Professionals 88
6.6. Critical Infrastructure Protection 88

6.7. Resources (Critical Medical Equipment)....89
6.8. Education and Preparedness Training....89
6.9. FATALITY MANAGEMENT....90
6.9.1. VICTIM INFORMATION CENTRE TEAM – HELPING FAMILIES FIND CLOSURE IN THE WORST OF TIMES....90
6.9.2. Forensic Pathology Services -....91
6.10. PREPAREDNESS - ROLES AND RESPONSIBILITY within the Department of Health....91
CHAPTER 7....94
7.1. Immediate response: Assess the situation – Hours 0 to 2....94
7.2. Intermediate Response – Hours 2 to 6....94
7.3. Extended Response – Hours 12 to 24....94
7.4. Strategic focus....96
7.5. Coordination....96
7.6. Health Systems....96
7.7. Public Health Emergency Operations Centre - PHEOC....97
7.8. Hospital Command Centre (HCC)....99
7.10. Flow Charts for Emergency/Disaster Response....100
CHAPTER 8....101
CHAPTER 9....102
9.1. KEY PERFORMANCE INDICATORS....104
9.1.1. KPA 1 - INTEGRATED INSTITUTIONAL CAPACITY FOR DISASTER RISK MANAGEMENT....104
9.1.2. KPA 2 – DISASTER RISK ASSESSMENT....104
9.1.3. KPA 3 – DISASTER RISK REDUCTION....105
9.1.4. KPA 4: RESPONSE AND RECOVERY....107
9.2. ENABLERS....109
9.2.1. ENABLER 1: INFORMATION MANAGEMENT AND COMMUNICATION....109
9.2.2. ENABLER 2: EDUCATION, TRAINING, PUBLIC AWARENESS AND TRAINING.....111
9.3. EDUCATION, TRAINING AND RESEARCH....111
9.4. INTEGRATED REPORTING, MONITORING AND EVALUATION....112
9.5. PROCUREMENT (FUNDING ARRANGEMENTS)....112

9.6. STRATEGIC DIRECTIVES: ...113

9.7. PRIORITY ISSUES...114

CHAPTER 10...115

10.1. Type of Exercises ...115

10.2. Review of Disaster Plans...116

CHAPTER 11...117

CHAPTER 12...117

CHAPTER 14...119

14.1. Annexures...119

Annexure "A" Public Health Emergency Coordinating Committee (PHECC)...119
Annexure "B" Strategic framework for the implementation of Disaster Management...119
Annexure "C" National Action Plan – (2019-2021)...119
Annexure "D" Hazard Vulnerability Tool...119
Annexure "E" National Guidelines of Epidemic Preparedness and Response...119
Annexure "F" Government Gazette 41330 ...119
Annexure "G" Healthcare Facility Disaster Plan Self-Assessment Tool ...119
Annexure "H" National Climate Change and Health Adaptation Plan (2014-2019) ...119
Annexure "I" Healthcare Facility Preparedness Plan (DMP) ...119
Annexure "J" Business Continuity Management/Plan – (Microsoft Excel spreadsheet) ..119
Annexure "K" Forensic Pathology Services – Mass Fatality Incident Management Plan 119
Annexure "L" Flowcharts for Emergencies/Disaster Response...119

14.2. List of Tables ...120

14.3. List of Figures...121

14.4. List of Policies, Procedures and Guidelines ...122

14.5. Reference Documents ...122

ACRONYMS

A&ED – *Accident & Emergency Department*

CSSD – *Central Supply Services Department*

CSIR – *Centre for Science and Innovation Research*

DPC – *Disaster Planning Committee*

DRT – *Disaster Response Team*

DRR – *Disaster Risk Reduction*

EOC – *Emergency Operations Centre*

EMT – *Emergency Medical Team*

HCC – *Hospital Command Centre*

HMIMMS – *Hospital Major Incident Medical Management and Support*

HVA – *Hazard and Vulnerability Assessment*

IHR – *International Health Regulations - 2005*

ICT – *Information Communication and Technology*

ICS – *Incident Command System*

IMC – *Inter-Ministerial Committee*

IMS – *Incident Management System*

JEE – *Joint External Evaluation*

KPA – *Key Performance Area*

MEC – *Member of the Executive*

MNORT – *Multi-Sectoral National Outbreak Response Team*

NATHOC – *National Health Operations Centre*

NICD – *National Institute for Communicable Disease*

NGO – *Non-Governmental Organization*

NDMC – *National Disaster Management Centre*

NDMAF – *National Disaster Management Advisory Forum*

PDMC – *Provincial Disaster Management Centre*

PHECC – *Public Health Emergency Coordinating Committee*

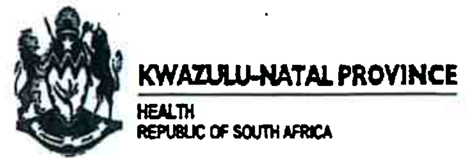
PROVJOINTS – *Provincial Joint Operations and Intelligence Structure*

PDMAF – *Provincial Disaster Management Advisory Forum*

PHOC – *Provincial Health Operations Centre*

UNISDR– *United Nations International Strategy for Disaster Reduction*

WHO – *World Health Organisation*



DEFINITIONS

"alternate care facility" An alternate care facility (ACF) is a site where "medical needs" sheltering, urgent care services and select traditional inpatient services are not usually provided but which is repurposed for provision of specific services during select disasters.

"business continuity" means the ability of an organisation to function during and after a disastrous event.

"disaster" means a progressive or sudden, widespread or localised natural or human made occurrence in an urban, peri-urban or rural area which;

a) Causes or threatens to cause;
   - death, injury or disease;
   - damage to property, infrastructure or the environment;
   - disruption to a community;
   - Is of a magnitude that exceeds the ability of a province or a municipality within the province affected by the disaster to cope with its effects using only its existing resources.

"disaster management" means a continuous and integrated multi-sectoral, multi-disciplinary process of planning and implementation of measures aimed at;

- risk assessment of the potential for the occurrence of disasters;
- preventing or reducing the risks of disasters;
- mitigating the severity or consequences of disasters;
- emergency preparedness;
- a rapid and effective response to emergencies;
- Post-disaster recovery and rehabilitation.

"disaster medicine" means the area of medical specialisation serving the dual areas of providing medical care to disaster survivors and providing medically related disaster planning, risk reduction, disaster preparation and disaster recovery leadership throughout the disaster life cycle, and which inter-links with the Disaster Management Act, Act 57 Of 2002.

"disaster risk management" disaster risk management is the application of disaster risk reduction policies and strategies, to prevent new disaster risks, reduce existing disaster risks, and manage residual risk, contributing to the strengthening of resilience and reduction of losses.

Disaster risk management actions can be categorised into; prospective disaster risk management, corrective disaster risk management and compensatory disaster risk management.

"disaster risk reduction" is aimed at preventing new and reducing existing disaster risk and managing residual risk, all of which contribute to strengthening resilience and therefore achievement of sustainable development.

"Emergency medical team" (EMT) - The term Emergency Medical Team or EMT refers to groups of health professionals providing direct clinical care to populations affected by

disasters, outbreaks and/or other emergencies as a surge capacity to support the local health system. They include governmental (both civilian and military) and nongovernmental teams and can include both national and international EMTs.

"Health Operations Centre" means a facility established to provide a controlling and coordinating role and which becomes the national and or provincial Health nodal point during and event

"international health regulation IHR 2005" defined as: to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.

"major incident" defined as "beyond the scope of business-as-usual and is likely to involve serious harm, damage, disruption or risk to human life or welfare, essential services, the environment or provincial or national security".

"NatHOC" means National Health Operations Centre
"one health" which recognizes that the health of people is closely connected to the health of animals and our shared environment.

"ProvHOC" means Provincial Heath Operations Centre

"public health emergency" is defined as an occurrence or imminent threat of an illness or health condition, caused by bio-terrorism, epidemic or pandemic disease, or (a) novel and highly fatal infectious agent or biological toxin.

"risk" means the probability of harmful consequences, or expected losses (deaths, injuries, property, livelihood, economic activity disrupted or environment damaged) resulting from interactions between natural or human-induced hazards and vulnerabilities

"risk reduction" means a formal planned process of reducing the chances or the consequences of a disaster

"Standard Operational Procedure SOP" means a method of functioning that has been established in order to execute a specific task or react to a specific set of circumstances

COMPATIBILITY WITH OTHER POLICIES, PROCEDURES AND GUIDELINES

This Disaster Management Plan interrelates with the National Disaster Management Centre (NDMC) guideline on the development and structure of the disaster management plan

Version1.1 dated 15 April 2017, Section 25 (1) of the Disaster Management Act 57 of 2002 and section 3.6 of the National Disaster Management Framework, 2005 (NDMF), Section 21(2) (e) and Section 25(2) (g) of the National Health Act 61 of 2003, World Health Assembly International Health Act No 28 of 1974, National Environmental Management Act 107 of 1998

It further interrelates with the KwaZulu-Natal Department of Health ***Public Health Emergency Coordinating Committee (PHEEC) Terms of Reference*** **(Annexure "A")**, ***Strategic Framework for the Implementation of Disaster Management within the Department of Health*** **(Annexure "B")**, World Health Organisation (WHO) ***International Health Regulations (IHR-2005) – National Action Plan 2019-2020*** **(Annexure "C")**, National Guidelines on Epidemic Preparedness and Response, WHO, Health Sector Emergency Preparedness Guide, the (WHO) Health-Emergency Disaster Risk Management Framework, (H-EDRMF).

EXECUTIVE SUMMARY

Many countries across the world are currently grappling with making health care safer for patients, through carefully designed systems and methods of care that reduce the risk to patients and health care facilities in a disaster situation. The need to redesign and strengthen existing healthcare systems and evidence-based methods, has been fanned by the sudden emergence and re-emergence of infectious diseases, especially the emergence of novel coronavirus disease COVID 19.

The Disaster Management Act 52 of 2002, in sections 21, 25, 38, 39 and 52, places explicit responsibility on organs of state and municipalities, including provincial organs of state and municipalities, and other institutional role players involved in disaster risk management for the development and implementation of disaster risk management plans.

This requirement is further expanded by the National Disaster Management Framework (NDMF) in Key Performance Area (KPA) 3, which requires that these plans and their implementation should provide for the developmentally oriented approaches, plans, programmes and projects that reduce disaster risks. KPA 3 also addresses requirements for the alignment of disaster management frameworks and planning within all spheres of government. It also gives particular attention to the planning for and integration of the core risk reduction principles of prevention and mitigation into ongoing programmes and initiatives.

It is against this background that the Public Health Emergency Coordinating Committee (PHECC) which functions as a Coordinating/Advisory Committee for the Department of Health provides a platform for members to consult one another, with the strategic focus to coordinate the Department's prevention, detection, response and management of public health emergencies in order to ensure effective delivery of health services, further ensuring multi-sectoral/multidisciplinary approaches through provincial and national partnerships for effective alert and response systems which are all-hazards approach.

The terms of reference of the PHECC ensures a cohesive and inclusive approach in the implementation of the disaster medicine strategies within the health system, comprising of both external and internal stakeholders and to provide a mechanism for future decision making and develop a common understanding and to facilitate compliance with the World Health Organisation (WHO) International Health Regulations (IHR) 2005 i.e. to prevent, protect against, control and provide a public health response to the international spread of

disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.

Our healthcare facilities are further guided by the strategic framework on disaster management/ medicine to ensure a uniform and systematic approach to ensure compliance across all health systems.

Our healthcare facilities practice the Hospital Major Incident Medical Management and Support (HMIMMS)-based Incident Management System (IMS) a legacy from the 2010 Soccer World Cup, of which we are proud of.

Each of our healthcare facility has appointed disaster planning committee to ensure compliance /medicine plan is dynamic and living document that has been developed and continues to be maintained by the healthcare facility. It is the responsibility of each healthcare facility, department and/or unit manager to ensure that their section of the Response Plan Annex is updated and that each of their staff members is familiar with its content on a regular basis.

The Response Plan Annex provides each department and unit within the hospital several unit-specific guidelines as a quick reference for the actions that staff members must take in any emergency situation.

DR SC TSHABALALA
HEAD OF HEALTH
KWAZULU-NATAL DEPARTMENT OF HEALTH
DATE: 2023 -12- 04

CHAPTER 1

INTRODUCTION

This Disaster Management Plan (DMP) is developed with the goal of establishing a guideline to all healthcare facilities in all health districts and head office, which will ultimately lead to a concretised strategy to deal with all aspects of the generic disaster management cycle within the healthcare system.

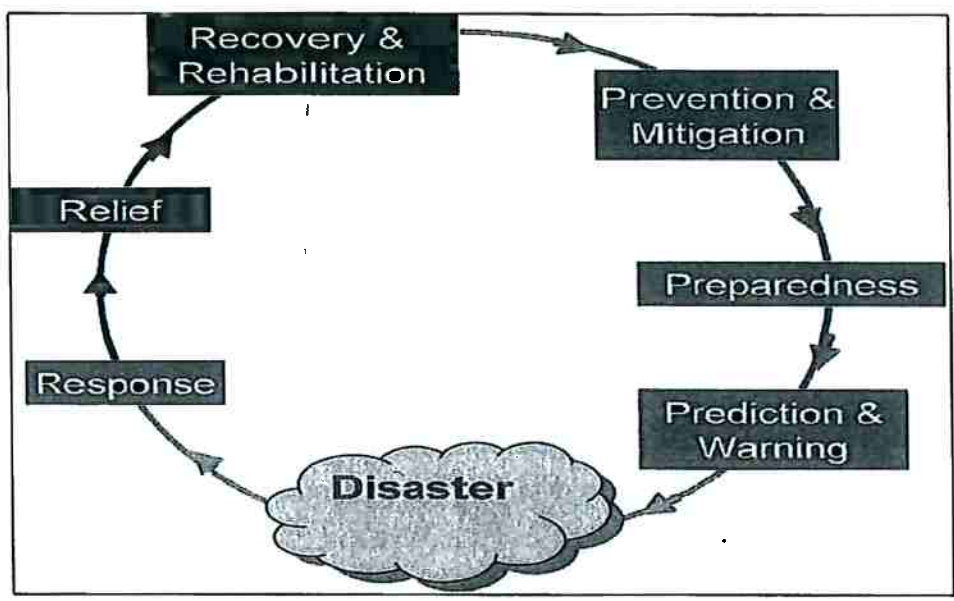


Figure 1: Disaster Management Continuum

Figure 1 applies equally to disaster medicine, which is the healthcare systems response to all aspects of disaster risk management.

The KwaZulu-Natal Department of Health has a legal obligation to ensure that it has strategies in place to deal with a disaster. These are contained in the Disaster Management Act, Act 57 of 2002, interrelated with the World Health Organisation (WHO) International Health Regulations (IHR-2005), and the (WHO) Health-Emergency Disaster Risk Management (H-EDRM) Framework.

Further to this, the National Health Act 61 of 2003, places the responsibility to coordinate health and medical services during national disasters within the duties of both the Provincial Head of Health and the Director-General – National Department of Health.

As the provincial caretaker of the KwaZulu-Natal healthcare system, the Department has a duty to ensure that it has a strategy with which to oversee and coordinate any health related

disastrous event which is of such a magnitude that it will have an extraordinary effect on communities.

This strategy cannot be undertaken without the close partnership of various stakeholders within the province and the National Department of Health, and it is essential that the provincial strategy is mirrored at a national level, in order to ensure that there is a strong focus on business continuity.

Disaster medicine strategies which are adequately and suitably embedded, supported and managed within the healthcare system, resulting in a stronger business continuity model for the province.

Disaster risk management is not only about strategies, but importantly, the coordination and evaluation of activities throughout the disaster risk management cycle. Similarly, disaster medicine also has a strong coordination focus, as it is embedded within the healthcare system and requires a strong multidisciplinary approach. Activities need to be synergistic, and silos overcome if the implementation of strategies is to be successful.

In most instances disaster medicine is just an escalation of major incident management. Therefore, applying the principles embodied within the proposed strategies will have the added benefit of better management systems in place to deal with everyday occurrences, especially over weekends, where surges are commonly experienced. The knock-on effect of this will be better patient management outcomes and improved service delivery.

Events that can have a direct bearing on the functioning of the healthcare system include natural and human induced disasters, industrial action (internally and externally), major communicable disease outbreaks and epidemics.

Wherever there is the threat of disruption of the healthcare system, strategies need to be in place to ensure that the situation is timeously mitigated and that steps are taken to contain and normalise the situation as soon as possible.

A major aspect of disaster medicine is maintaining business continuity, and a successful programme will certainly ensure that Health's responsibilities regarding the Negotiated Service Delivery Agreement will not be impeded abnormally by a disastrous event.

In meeting these obligations, it is therefore necessary to analyse the role of the healthcare system, identify risks, evaluate health related intelligence, take steps to minimise such risks and, lastly, to establish contingency plans to implement a suitable response during a

disaster. This is complimented by a clear mechanism of returning to normality as soon as possible.

To ensure that this aspect of disaster medicine is fully incorporated into the work cycle of the Department, it is essential that there is a monitoring and evaluation role that closely assesses situations, initiates and monitors response and appraises the Executive Management accordingly.

As disaster medicine consists of several facets, ranging from risk reduction to response and recovery, it is necessary that in managing all spectrums of disaster risk management, close inter-action with relevant stakeholders is maintained.

In addition to this, the Department also has a role to play in ensuring the care receivers and members of the public are able to access information during a crisis, or where there is a serious issue affecting the direct health of the population. This responsibility also incorporates a mechanism for members of the public to lodge complaints without fear of reprisal.

To achieve this goal, it is therefore of absolute importance that the appropriate structures and supportive mechanisms is created at both a provincial and district level, and that this initiative is included in the strategic and operational planning processes.

In accordance with the Disaster Management Act 57 of 2002 and with the desire to better provide for the wellbeing of its citizens of the province of KwaZulu-Natal, the Department of Health has developed the Disaster Risk Management Plan to strengthen and sustain communities' abilities to prevent, protect against, mitigate the effects of, respond to, and recover from incidents with negative health effects.

The Province of KwaZulu-Natal is highly exposed to a wide range of hazards and disasters that frequently result in loss of lives and livelihoods, destruction of assets and loss of economic investments. The hazards that affect the province include: tropical cyclones, snow, storms and rains, heavy winds, floods, droughts and veld/wild fires, pest infestation (such as army worms), human and animal-related diseases (such as cholera and foot-and-mouth diseases), etc.

Disasters hit hardest at the local community levels with the potential to cause loss of life and disruption in the social, economic and environmental aspects of communities. The poor and socially disadvantaged groups in developing countries are always the most affected (United Nations International Strategy for Disaster Reduction -UNISDR, 2015). ***"This happens***

because planning for the eventuality of disasters and implementation of Disaster Risk Reduction (DRR) programmes usually place greater emphasis on the hazard profile of a locality, instead of the vulnerability profile of the populace".

What is required is to invest in disaster risk reduction (DRR) and climate change adaptation strategies, plans and programmes that seek to enhance an understanding of disaster risks, and disaster induced mortalities. This understanding will assist in strengthening disaster risk governance, investment in DRR for reduced mortalities, economic losses and damages and enhance disaster preparedness for effective response and building back better in recovery (rehabilitation and reconstruction).

The primary role of the KwaZulu-Natal Department of Health is to strengthen and sustain communities' abilities to prevent, protect against, mitigate the effects of, respond to, and recover from incidents with negative health effects and to assist municipal health services prepare for, respond to, and recover from emergencies and disasters in a manner that will protect the healthcare system and safeguard lives.

In addition, the KwaZulu-Natal Department of Health strives to work with communities to protect residents by preparing for and responding to man-made and naturally occurring public health emergencies in the province.

Specific services include planning and implementing programs to ensure prevention, preparedness and rapid response to communicable disease outbreak, as well as appropriate surveillance strategies and other public health and environmental threats and emergencies through work with Municipal Health Departments, KZN Department of Cooperative Governance and Traditional Affairs (COGTA)), Department of Social Development (DSD), other sector departments and NGO's/CBO's.

The provision of health care in KwaZulu-Natal is wide ranging consisting of various facets of health care within the province, which entails 10 districts and 1 category "A" municipality.

For the purpose of the disaster risk management plan, tabulated in Table 1 are healthcare facilities within the Province of KwaZulu-Natal.

Table 1: healthcare facilities within KwaZulu-Natal

Specialised & Tertiary Hospitals	Regional Hospitals	District Hospitals	Community Health Centres	Primary Health Clinics
24	12	39	22	775

In concurrence with the Disaster Management Act 57/2002 and the National Disaster Management Framework (NDMF) and the World Health (WHO) International Health Regulations (IHR-2005) the KwaZulu-Natal Department of Health has rolled-out a disaster management/medicine strategic framework to all health districts to ensure district coordination and collaboration of risk reduction, preparedness activities and response planning and to enhance the ability of hospitals and supporting health care systems to prepare for and respond to major incidents and disasters and other healthcare emergencies within the Province of KwaZulu-Natal in order to sustain an optimal level of preparedness.

The overall goal of the KwaZulu-Natal Department of Health is to strengthen an integrated health and emergency disaster risk management capability province-wide in accordance with the principles of the World Health Organisation, Health-Emergency Disaster Risk Management (H-EDRM) Framework. This will be accomplished by:

- Undertaking a comprehensive disaster risk assessment and determining the results of the assessment, based on risk evaluation that will impact on healthcare system province wide.
- Supporting district planning efforts for alternate care sites, and obtaining, storing, and mobilising medical assets, pharmaceutical caches, personal protective and decontamination equipment;
- fostering an integrated response environment that is Major Incident Medical Management and Support (MIMMS) compliant;
- encouraging and supporting integrated district planning, education, and training efforts;
- addressing the activities needed to complete all capabilities related to interoperable communications, bed tracking, fatality management and hospital evacuation planning;
- improving the level of preparedness and response through continual testing, exercising, and evaluating of all aspects; and
- continually involving public health and medical preparedness/response partners at the national, provincial, and district/local levels, to include special groups such as Traditional Healers/Leaders, community-at-risk population, public and private entities in all planning efforts.

1.1. PURPOSE OF THE PLAN

This Disaster Management Plan is developed in terms of Section 25 (1) of the Disaster Management Act 57 of 2002 and section 3.6 of the National Disaster Management Framework, 2005 (NDMF), Section 21(2) (e) and Section 25(2) (g) of the National Health Act 61 of 2003, World Health Assembly International Health Act No 28 of 1974, National Environmental Management Act 107 of 1998 which provides a uniform structure and checklist to all cluster managers, district health managers and all healthcare facilities in the Province of KwaZulu-Natal to prepare a Disaster Management Plan.

1.2. INTEGRATED AND COMPREHENSIVE HEALTH SYSTEM

The vision of the KwaZulu-Natal Department of Health is *"Optimal health for all persons in KwaZulu-Natal"* and the mission is *"to develop and implement a sustainable, coordinated, integrated and comprehensive health system at all levels, based on the Primary Health Care approach through the District Health System, to ensure universal access to health care"*, along with the Department of Health motto ***"Growing KwaZulu-Natal Together"***.

The KwaZulu-Natal Department of Health is guided by the National Health Act 61 of 2003 and various other pieces of legislation to ensure compliance. Within the KwaZulu-Natal Department of Health there are 8 Programmes supported by sub-programmes, namely:

***Programme 1*- Administration,**

Conduct the strategic management and overall administration of the Department of Health,

***Programme 2* – District Health Services,**

Tor render Primary Health Care Services and District Hospital Service,

***Programme 3* – Emergency Medical Services**

To render pre-hospital emergency medical services, including inter-facility transfers and planned patient transport and disaster management.

***Programme 4* – Provincial Hospitals (Regional and Specialised)**

Deliver hospital services, which are accessible, appropriate, and effective and provide general specialist services, including specialized rehabilitation services, as well as a platform for training health professionals and research.

***Programme 5* – Central and Tertiary Hospitals**

To provide tertiary services and create a platform for training of health professionals

Programme 6 – **Health Sciences and Training**

Render training and development opportunities for actual and potential employees of the Department of Health

Programme 7 – **Health Care Support Services**

To render support services required by the Department to realise its aims

Programme 8 – **Health Facilities Management**

Provision of new health facilities and the refurbishment, upgrading and maintenance of existing health facilities

1.3. DEMOGRAPHIC PROFILE

KwaZulu-Natal is the second most populous province in South Africa with a total population of 11 384 722 (2018). According to the Stats-SA Mid-Year Population Estimates, the Kwazulu-Natal (KZN) population increased from 11 074 800 (19.6% of the total South African population) in 2017 to 11 384 722 (19.7% of the population) in 2018.

The province occupies 7.6% (92,100 sq. km) of the total land surface of South Africa. The province shares borders with Swaziland and Mozambique in the North, Mpumalanga in the North-West, Free State and Lesotho in the West and the Eastern Cape in the South. The Northern Districts of uMkhanyakude and Zululand attract patients from Mozambique and Swaziland and patients from the Eastern Cape utilise health services in the Southern Districts of Ugu and Harry Gwala. Natural features including rivers, wetlands and mountainous terrain, and the scattered distribution of homesteads in the rural areas pose unique transport and access challenges for equitable distribution of health services.

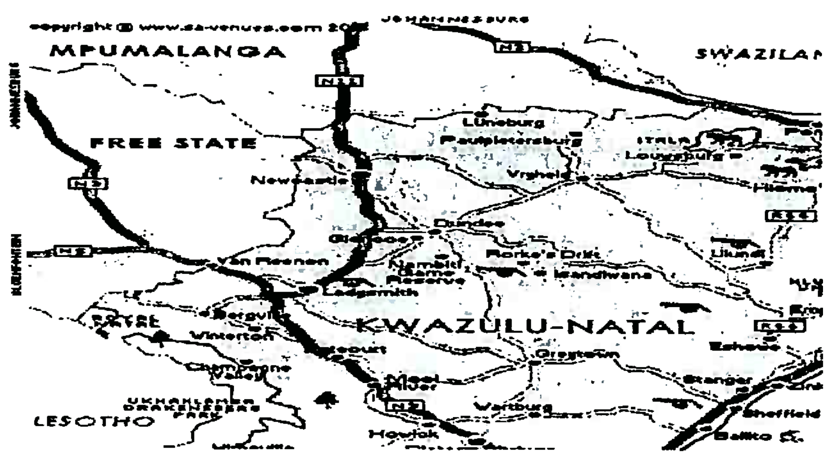


Figure 2: Map of KwaZulu-Natal

1.4. SOCIO-ECONOMIC PROFILE:

The Province of KwaZulu-Natal is highly exposed to a wide range of hazards and disasters that frequently result in loss of lives and livelihoods, destruction of assets and loss of economic investments. The hazards that affect the province include: tropical cyclones, snow, storms and rains, heavy winds, floods, droughts and veld/wild fires, pest infestation (such as army worms), human and animal-related diseases (such as cholera and foot-and-mouth diseases),

Socio economic factors are associated with health status and health outcomes. There are 2.8 million households in KZN. Fewer than fifty eight percent of children aged 0 to 4 years are cared for at home with a parent or guardian. Under 91% of children aged 5 and older are attending school. In 2017, 80.7% of learners attending public schools benefitted from the school nutrition programme compared to 63.0% in 2009. The persons aged 20 years and older with no formal schooling decreased from 12.8% in 2002 to 5.4% in 2017. The 2017 General household survey showed that 36.4% of individuals and 49.5% of households in KZN were beneficiaries of social grants.

Table 2 below includes district-specific measures of poverty and access to basic services that impact on health outcomes. Prioritisation will take into account these variables in structuring services in an effort to improve equity in service delivery as well as responding to community and population specific priorities. uMkhanyakude has the highest percentage of households with no access to piped or tap water (50%) and no access to sanitation (10.2%). ***(Source KZN – Department of Health Annual Performance Plan 2019-2020).***

1.4.1. SOCIAL DETERMINANTS OF HEALTH

Table 2: Social Determinants of Health

District	Population	Household	Intensity of poverty	2015 Grants and subsidies received as a % of Total income	Access to piped or tap water	Households (HH) No Access to piped water	% No access piped water (HH)	No access to sanitation (HH)	% No access to sanitation (HH)	No Electricity (HH)	% No access to electricity (HH)
Ugu	789 953	180 921	42.3%	66,5%	158 402	22 519	12%	7 628	4.2%	26 562	14.7%
uMgungundlovu	1 111 872	300 953	42,1%	80,0%	274 567	26 386	9%	3 948	1.3%	19 424	6.5%
uThukela	706 808	161 864	42,5%	78,8%	122 362	39 502	34%	3 708	2.3%	16 954	10.5%
uMzinyathi	551 177	126 071	43,7%	59,3%	79642	46 429	37%	2937	2.3%	26882	21.3%
Amajuba	531 107	117 181	41,4%	89,4%	111623	5 558	5%	2324	2.0%	8641	7.4%
Zululand	892 310	178 516	42,8%	93,5%	115071	63 445	36%	13901	7.8%	24494	13.7%
uMkhanyakude	689 090	151 245	44,1%	90,5%	75 672	75 573	50%	15 460	10.2%	62 887	41.6%
King Cetshwayo	971 135	225 797	43,1%	86,8%	190 303	35 494	16%	5 486	2.4%	14 064	6.2%
ILembe	657 612	191 369	43,0%	69,8%	144 923	46 446	24%	5 201	2.7%	25 731	13.4%
Harry Gwala	502 265	122 436	43,5%	89,1%	83 175	39 261	32%	2 428	2.0%	20 192	16.5%
eThekwini	3 661 911	1 119 492	40,8%	18,3%	1 101 610	17 882	2%	9 408	0.8%	40393	3.6%
KWAZULU-NATAL	11 065 240	2 875 843	42.5%		2 457 350	418 493	15%	72 428	2.5%	286 224	10.0%

***Source:* 2016 Stats SA Community Survey**

CHAPTER 2

CONSTITUTION, LEGISLATURES & MANDATES

2.1. CONSTITUTIONAL, LEGISLATIVE AND POLICY MANDATES

2.1.1. Constitution:

The primary responsibility for disaster risk management in South Africa rests with government. In terms of section 41(I) (b) of the Constitution of the Republic of South Africa, all spheres of government are required to "secure the well-being of the people of the Republic". Disaster management is listed as a functional area in Part A of Schedule 4 of the Constitution, meaning that both the national and provincial spheres of government are competent to develop and execute laws within this area and have powers and responsibilities in relation to disaster management.

2.1.2. Legislative:

Although disaster management falls within the custodianship of the Ministry: Cooperative Governance and Traditional Affairs, the Department of Health has a critical and focused role which is clearly spelt out in various pieces of legislation.

The first is contained within the **Disaster Management Act No. 57 of 2002**.

Section 38 (1) states as follows –

Preparations of disaster management plans:

38 (1) each provincial organ of state indicated in the national or provincial disaster management framework must, within the applicable provincial disaster management framework –

a). prepare a disaster management plan setting out –

i. the way in which the concept and principles of disaster management are to be applied in its functional area;

ii. its role and responsibilities in terms of the national or provincial disaster management framework;

iii. its role and responsibilities regarding emergency response and post-disaster recovery and rehabilitation;

iv. its capacity to fulfil its role and responsibilities;

v. particulars of its disaster management strategies; and contingency strategies and emergency procedures in the event of a disaster, including measures to finance these strategies:

(b) coordinate and align the implication of its plan with those of other organs of state and institutional role-players; and

(c) regularly review and update its plan.

Section 38 (2) –

The disaster management plan of a provincial organ of state referred to in subsection (1) must form an integral part of its planning.

Section 38 (3) –

(a) A provincial organ of state must submit a copy of its disaster management plan and any amendments to the plan to the National Centre and the relevant provincial disaster management centre.

(b) If a provincial organ of state fails to submit a copy of its disaster management plan or of any amendments to the plan in terms of paragraph (a), the National Centre or the provincial disaster management centre must report the failure to the MEC, who must take such steps as may be necessary to secure compliance with the paragraph, including reporting the failure to the provincial legislature.

The second piece of legislation having a direct bearing on this is the **National Health Act No. 61 of 2003;**

Section 21 (2) (e) states as follows –

The Director-General must coordinate health and medical services during national disasters

Section 25 (2) (g) –

The head of a provincial department must coordinate health and medical services during a provincial disaster

The third area of applicability lies within the **National Disaster Management Framework**. The framework was established under Notice 654 of 2005 and must be read in conjunction with the Disaster Management Act 57 of 2002.

The following are extracts from the National Disaster Management Framework –

"The Act provides for:

- *an integrated and coordinated disaster risk management policy that focuses on preventing or reducing the risk of disasters, mitigating the severity of disasters, preparedness, rapid and effective response to disasters, and post-disaster recovery.*
- *the establishment of national, provincial and municipal disaster management centres*
- *disaster risk management volunteers*
- *matters relating to these issues.*

The Act recognises the wide-ranging opportunities in South Africa to avoid and reduce disaster losses through the concerted energies and efforts of all spheres of government, civil society and the private sector. However, it also acknowledges the crucial need for uniformity in the approach taken by such a diversity of role players and partners.

The national disaster management framework is the legal instrument specified by the Act to address such needs for consistency across multiple interest groups, by providing 'a coherent, transparent and inclusive policy on disaster management appropriate for the Republic as a whole'."

2.1.3. ROLES AND RESPONSIBILITIES OF NATIONAL ORGANS OF STATE

National departments must assess any national legislation applicable to their function in terms of section 2 of the Act and advise the NDMC on the state of such legislation. Based on the principle of auxiliary (using existing structures and resources), disaster risk management responsibilities must be integrated into the routine activities of the various sectors and disciplines within the relevant organs of state and their substructures. These responsibilities must be reflected in the job descriptions of the relevant role players and appropriate key performance indicators must be provided.

In terms of the Act, each national organ of state must determine its role and responsibilities in relation to disaster risk management and assess its capacity to adhere to the requirements of the Act, particularly with reference to setting priorities for disaster risk reduction initiatives and for response and recovery. Such capacity must be supplemented, where necessary, by collateral support and the sharing of resources among organs of state, and by harnessing the capacity of the private sector and non-governmental organisations (NGOs). The parameters of such assistance must be clearly defined in memoranda of understanding.

2.1.4. NATIONAL DISASTER MANAGEMENT FRAMEWORK

The National Disaster Management Framework is the implementing process in order to meet the prescripts of the Disaster Management Act 57 of 2002. The KwaZulu-Natal Department of Health has adopted this process in order to ensure that initiatives are in concert with the National/Provincial Disaster Management Centres and other sector departments.

The Framework comprises of 4 key performance areas and 3 enablers which cut across national, provincial and local levels, as shown in Table 3.

Table 3: Key Performance Areas and Enablers

Title	Function
Key performance area 1:	Institutional capacity
Key performance area 2:	Disaster risk assessment
Key performance area 3:	Disaster risk reduction
Key performance area 4:	Response and recovery
Enabler 1:	Information management and communication
Enabler 2:	Education, training, public awareness and research
Enabler 3:	Funding arrangements for disaster risk management

The following is an extract of the Framework:

Key performance area (KPA) 1 focuses on establishing the necessary institutional arrangements for implementing disaster risk management within the national, provincial and municipal spheres of government. It specifically addresses the application of the principle of co-operative governance for the purpose of disaster risk management. It also emphasises the involvement of all stakeholders in strengthening the capabilities of national, provincial and municipal organs of state to reduce the likelihood and severity of disasters. ***KPA 1*** describes processes and mechanisms for establishing co-operative arrangements with international role players and countries within southern Africa.

Key performance area 2 addresses the need for disaster risk assessment and monitoring to set priorities, guide risk reduction action and monitor the effectiveness of our efforts. Although South Africa faces many different types of risk, disaster risk specifically refers to the likelihood of harm or loss due to the action of hazards or other external threats on vulnerable structures, services, areas, communities and households. ***KPA 2*** outlines the

requirements for implementing disaster risk assessment and monitoring by organs of state within all spheres of government.

Key performance area 3 introduces disaster risk management planning and implementation to inform developmentally-oriented approaches, plans, programmes and projects that reduce disaster risks. ***KPA 3*** addresses requirements for the alignment of disaster management frameworks and planning within all spheres of government. It also gives particular attention to the planning for and integration of the core risk reduction principles of prevention and mitigation into ongoing programmes and initiatives.

Key performance area 4 presents implementing priorities concerned with disaster response and recovery and rehabilitation. ***KPA 4*** addresses requirements in the Act for an integrated and coordinated policy that focuses on rapid and effective response to disasters and post disaster recovery. When a significant event or disaster occurs or is threatening to occur, it is imperative that there must be no confusion as to roles and responsibilities and the necessary procedures to be followed. ***KPA 4*** describes measures to ensure effective disaster response, recovery and rehabilitation planning.

Enabler 1 focuses on priorities related to the establishment of an ***integrated and comprehensive information management and communication system for disaster risk management.*** More specifically, it addresses the information and communication requirements of each ***KPA*** and ***Enablers 2 and 3*** and emphasises the need to establish integrated communication links with all disaster risk management role players in national, provincial and municipal spheres of government.

Enabler 2 addresses disaster risk management priorities in ***education, training, public awareness and research.*** This enabler describes mechanisms for the development of education and training programmes for disaster risk management and associated professions and the incorporation of relevant aspects of disaster risk management in primary and secondary school curricula. It addresses requirements to promote and support a broad-based culture of risk avoidance through strengthened public awareness and responsibility. It also discusses priorities and mechanisms for supporting and developing a coherent and collaborative disaster risk research agenda.

Enabler 3 sets out the mechanisms for the ***funding of disaster risk management*** in South Africa.

2.2. INTERNATIONAL LAW:

South Africa is signatory to the World Health Organisation (WHO) International Health Regulation (IHR-2005), a binding instrument of international law entered into force on 15 June 2007.

194 countries across the globe have agreed to implement the International Health Regulations (2005) (IHR), in response to the exponential increase in international travel and trade, and emergence and re-emergence of international disease threats and other health risks,

The purpose and scope of the IHR are "*to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.*"

IHR is not limited to specific diseases, but is applicable to health risks, irrespective of their origin or source; they follow the evolution of diseases and the factors affecting their emergence and transmission. IHR require countries to strengthen core surveillance and response capacities at the primary, intermediate and national level, as well as at designated international ports, airports and ground crossings. IHR introduce a series of health documents, including ship sanitation certificates and an international certificate of vaccination or prophylaxis for travellers.

Preparedness for public health emergencies is not optional; hence South Africa is a signatory to the International Health Regulations (2005) (IHR-2005).

In December 2017, South Africa conducted the Joint External Evaluation (JEE) of the IHR in collaboration with all relevant government departments and key stakeholders. Following the release of the report, several collaborative meetings were held with stakeholders to develop an ***all-hazard*** National Action Plan to implement the International Health Regulations in South Africa. **(Annexure "C" – National Action Plan – 2019-2021).**

2.2.1. STRATEGIC OBJECTIVES OF INTERNATIONAL HEALTH REGULATION 2005

The strategic objectives of the IHR are to:

- Strengthen capacity to ***prevent and mitigate*** consequences of all public health emergencies.
- Strengthen capacity for ***early detection and reporting*** of diseases, conditions and events using a one-health approach.
- Strengthen capacity for timely and *effective* ***multi-sectoral response*** to all public health emergencies.
- Strengthen routine and emergency IHR capacities at designated ***points of entry*** (POE) to manage all public health risks.
- Improve integrated surveillance and response capacity for ***chemical events*** through effective multi-sectoral collaboration.
- Improve integrated surveillance and response capacity ***for radio-nuclear hazards*** through effective multi-sectoral collaboration.
- Establish a ***mechanism for sustainable financing*** of IHR implementation and resilient public health systems.

2.2.2. UNITED NATIONS INTERNATIONAL STRATEGY FOR DISASTER RISK REDUCTION (UNISDR)

South Africa is a signatory of the United Nations International Strategy for Disaster Risk Reduction (UNISDR) and thus ascribes to provisions of the Hyogo Framework of Action: 2005-2015 and currently, the Sendai Framework of Action: 2015-2030. Good progress has been made in implementing the priority actions and strategic objectives of both frameworks and the following, amongst others has thus far been achieved.

> *"The starting point for reducing disaster risk.... lies in the knowledge of the hazards and the physical, social, economic and environmental vulnerabilities....and of the ways in which hazards and vulnerabilities are changing in the short and long term, followed by action taken on the basis of that knowledge"* Hyogo Framework for Action 2005-2015.

2.2.3. HYOGO FRAMEWORK OF ACTION 2005

The Hyogo Framework for Action (2005-2015) identifies 5 priorities for action towards strengthening community and country resilience to disasters. The application of these 5 priorities for the KwaZulu-Natal Department of Health is described below;

Priority 1: Emergency/disaster risk management for health as a national and provincial priority.

- The KwaZulu-Natal Department of Health has developed and implemented the Public Health Emergency Coordinating Committee (PHECC) which is a multi-sectoral multi-disciplinary coordination mechanism at local, district, provincial and national levels to facilitate joint action on risk reduction, response and recovery by the various health and non-health actors.
- It further ensures a consolidated approach in the disaster medicine strategy and assumes the leadership role in terms of health initiatives in respect of disaster medicine in the province.
- The establishment and implementation of the PHECC ensures an ***all-hazards approach*** in managing threats to the healthcare system province-wide, as stipulated in the World Health Organisation (WHO) International Health Regulations (IHR-2005).
- The Provincial Outbreak Response Team – (PORT) mirrored upon the National Department of Health - Multi-Sectoral National Outbreak Response Team (MNORT) policies and strategies (Strategic Implementation of Disaster Risk Management) to provide direction and support for disaster/ emergency risk management, especially at district/municipality levels.

Priority 2: Health risk assessment and early warning

- The KwaZulu-Natal Department of Health has implemented a broad-based Hazard & Vulnerability Assessment Tool (HVA), to guide healthcare facilities in determining the most prevalent risk in each of the districts by identification of the hazards and assessment of the magnitude and probability of their occurrence ***(Annexure "D" Hazard and Vulnerability Tool).***
- A detailed analysis of vulnerability of individuals, population, infrastructure and other community elements to the hazards.
- And its capacity to manage the health risks, by reducing hazards or vulnerability of, responding to and recovery of its health systems.
- Surveillance and monitoring of potential threats to health, particularly from biological, natural and technological (chemical, radiological) sources to enable early detection and warning to prompt action by the public health care workers and other sectors, through its Provincial and District Outbreak Response Team (PORT / DORT) and the Provincial Health Operations Centre (PHOC).

Priority 3: Education and information to build a culture of health, safety and resilience at all levels.

- Through education, training and technical guidance, the Department of Health strengthens the knowledge, skills and attitudes of professionals in health and other sectors for managing the health risks of disasters.
- Regular information, education and risk communication for households and at-risk-communities to promote healthy behaviours to reduce risks and prepare for disasters. The recent outbreak of Listeriosis and presently "Severe Acute Respiratory Syndrome Coronavirus 2 (COVID19) indicates the Department's province-wide communication strategy through the media, home visits, public venues and community-based organisations in the Province of KwaZulu-Natal.

Priority 4: Reduction of underlying risk factors to health and health systems.

Poverty reduction measures and systems aimed at improving the underlying health status of people at risk of disasters.

a) Child Health:

- Severe Acute Malnutrition (SAM) case fatality has declined over the 5 year period which indicates improved quality of clinical care within the health system. The severity of the drought in Northern and Western KZN combined with the downturn of the economic situation in South Africa expected to impact heavily on the SAM incidence rates increasing the number of children affecting by SAM – the Province saw a drop of 1860 less SAM cases in 2017/18 (3 266 new incidences) compared to the previous year.
- Thus early diagnosis at a community level and effective clinical management at Primary Health Care Clinic level impact on the number of cases referred upwards for admission to hospital.
- Implementation of preventative interventions such as breastfeeding, Vitamin "A" supplementation and growth monitoring and promotion have contributed to a decrease in SAM incidence over the past 5 years. ***(Source KZN – Department of Health Annual Performance Plan 2019-2020).***

HIV/AIDS Programme – Family Planning

- The KwaZulu-Natal Department of Health employs a centralised system to manage the treatment of HIV/AIDS, through the Centralised Chronic Medicine Dispensing and Distribution CCMDD, which further monitors Total Remaining on ART (TROA),

coupled with continuous health promotion, education and awareness campaign of the risk of HIV/AIDS.

- The prevalence of HIV in KZN indicates that many women who have untreated AIDS and a low CD4 count, fall pregnant unintentionally placing themselves and their babies at risk. Girls aged 15 – 24 years have the highest incidence of HIV infections, family planning education and family planning methods (short and long term) are freely available at clinics frequented by this age group. ***(Source KZN – Department of Health Annual Performance Plan 2019-2020).***

b) Maternal Health:

The KZN Department of Health has a series of campaigns to:

- Strengthen access to a wide range of sexual health services, especially family planning
- Promote early antenatal care attendance and booking
- Enable better access to skilled birth attendance through the provision of obstetric ambulances to every facility where deliveries are conducted
- Establish maternity waiting homes where necessary
- Strength Human Resources for maternal and child health through training
- Promote of breast-feeding
- Intensify efforts to manage HIV positive mothers and children through improved access to treatment and management of co-infections
- Eliminate of Mother to Child Transmission of HIV

c) Infrastructure:

- New hospitals are built with sufficient level of protection and existing health care infrastructure is strengthened to remain functional and deliver health services in emergency situations.
- Protection of other vital infrastructure and facilities that have the potential to generate risks to public health, such as water and sanitation systems and chemical facilities, also apply risk management measures.
- Adherence to building standards and retrofitting of vulnerable health infrastructure, protection of ecosystems, and ensuring effective insurance regimes and micro-finance initiatives to ensure business community across all health care settings.

Priority 5: Emergency preparedness for effective health response and recovery at all levels.

- The KwaZulu-Natal Department of Health is committed to providing a higher quality of life for all the citizens of the province, by preventing or reducing the risk of disasters, mitigating the severity or consequences of disasters, emergency preparedness, a rapid and effective response to disasters; and post-disaster recovery and rehabilitation.
- Emergency preparedness, including response planning, training, pre-positioning of health supplies, development of surge capacity and exercises (disaster drills) for healthcare professionals and other emergency service personnel is critical for the effective performance of the health sector in the response.
- The goal of implementing Disaster Medicine practices in our healthcare facilities is not only to adhere to legislation, but more so to ensure that our healthcare facilities are prepared and able to manage incidents both externally and internally, which may result in surge capacity that will have an adverse effect on the health care system.
- The Department continues to engage with the Districts, Municipalities, relevant stakeholders and partners to develop and operationalise disaster risk management activities for all healthcare facilities in the Province, specifically on all Disaster Management activities as promulgated in the Disaster Management Act 57 of 2002 that defines the responsibility of the Department of Health, including matters of the World Health Organisation –WHO – International Health Regulation –IHR-2005.
- The Districts and Municipalities health offices have established disaster/emergency planning committees and developed the District Health Disaster Medicine plans in conjunction with all healthcare facilities in the respective areas and in liaison with District, Municipal and Provincial Disaster Management Centres.

2.2.4. SENDAI FRAMEWORK OF ACTION: 2015-2030

The goal of the Sendai Framework is to;

Prevent new and reduce existing disaster risk through the implementation of integrated and inclusive economic, structural, legal, social, health, cultural, educational, environmental, technological, political and institutional measures that prevent and reduce hazard exposure and vulnerability to disaster, increase preparedness for response and recovery, and thus strengthen resilience.

The Sendai Framework has identified focused actions within and across all States at local, national, regional and global levels in the four priority areas. The KwaZulu-Natal Department of Health continues to make strides in keeping with international trend and adherence to the Sendai Framework of Action by implementing the following:

1) Institutional arrangements at provincial and district level is in place i.e. Advisory Forums and functional; ***Public Health Emergency Coordinating Committee (PHECC),*** Disaster Management Stakeholder Engagement with District Health Directors.
2) Development of disaster risk management plans in progress across all districts and all healthcare facilities;
3) Disaster Risk Reduction programs and strategies are in place, e.g. ***National Guidelines on Epidemic Preparedness and Response, National Action Plan on International Health Regulations (IHR-2005).***
4) Development and alignment of Climate Change Adaptation strategies within the Department of Health e.g. ***National Climate Change and Health Adaptation Plan 2014-2019,*** with long term adaptation scenarios have been developed.

Priority 1: Understanding disaster risk.

The KwaZulu-Natal Department of Health has made strides in the development of early warning systems. The leading agency responsible for the Weather Forecasting in the country is the South African Weather Services. The PDMC is the lead repository of early warning in the Province of KwaZulu-Natal.

The National Department of Health through the National Institute for Communicable Diseases (NICD) monitors communicable diseases countrywide, with provincial representatives in KwaZulu-Natal.

The purpose of the system is to ensure effective health disaster risk management planning, especially on early warnings, surveillance reporting, data management and archives as well as research through its links with all academic institutions using the one health approach.

In addition, the KwaZulu-Natal Department of Health has mirrored the Multi-Sectoral National Outbreak Response Team (MNORT) at provincial and district level, Provincial Outbreak Response Team (PORT) – District Outbreak Response Team (DORT), which meets quarterly, with daily surveillance of at-risk-communities.

Priority 2: Strengthening disaster risk governance to manage disaster risk.

The National Disaster Management Framework (2005) and Disaster Management Act No. 57 of 2002, stipulates and emphases the establishment of institutional systems such as the Interdepartmental Committee on disaster risk management which is established by the President and represented by all members from all the 3 spheres of government.

The Public Health Emergency Coordinating Committee (PHECC), is established within the KwaZulu-Natal Department of Health, which is mirrored at a national level provides a platform for members to consult one another, with the strategic focus to coordinate the Department's disaster risk reduction, prevention, detection, response and management of public health emergencies in order to ensure effective delivery of health services, further ensuring multi-sectoral/multidisciplinary approach through provincial and national partnerships.

The establishment and implementation of the PHECC, therefore, ensures an ***"all-hazards approach"*** in managing threats to the healthcare system province-wide, as stipulated in the WHO-International Health Regulations -2005.

The PHECC is mirrored at a national level in order to ensure a consolidated approach in the disaster medicine strategy and assumes the leadership role in terms of health initiatives in respect of disaster medicine in the province, which is cascaded to all health districts.

In addition the PHECC outlays a comprehensive terms of reference to ensure a cohesive and inclusive approach in the implementation of disaster management/medicine strategies within the health system.

Priority 3: Investing in disaster risk reduction for resilience.

Prevention and preparedness is the heart of public health, health-emergency disaster risk management (H-EDRM) is the bread and butter of public health.

The primary role within the KwaZulu-Natal Department of Health is to provide public health leadership, improve health and well-being of the citizens of KwaZulu-Natal by promoting health, preventing disease and injury, protecting and effectively responding to all types of health emergencies including bioterrorism, infectious disease outbreaks and natural disasters.

The two top hazards that have an adverse effect on public health are severe weather-related events and systems/technology events. The third hazard is pandemic influenza, which has a detrimental impact on at-risk-communities.

Different platforms at provincial, district and community level are established to ensure that all voices are heard and experiences are shared to ensure coherence in policies and upscale the mainstreaming of disaster risk reduction within stakeholders' programmes.

Measles prevention campaign, awareness programs and community engagement is the heart of health emergency disaster risk reduction. Hazard mapping of vulnerable communities help target at-risk-communities, to enhance vaccination programmes to reduce the risk of infection.

Priority 4: Enhancing disaster preparedness for effective response and to "Build Back Better" in recovery, rehabilitation and reconstruction.

KwaZulu-Natal Department of Health has commenced with an integrated disaster response mechanism which incorporates incident management system (IMS) at a provincial level. Integrated planning and coordination in responding to provincial incidents is implemented through relevant structures including political structures monitoring the processes and progress. This is evident through the effective response to the COVID-19 pandemic in the country.

Lessons continue to be learnt, that assist the Department of Health in ***"building back better"***

The Department of Health continues to make strides in developing Provincial Disaster Response Strategy by implementing lessons learnt from the ongoing COVID-19 pandemic, improving provincial, district and community coordination and response towards incidents/events and ***"building back better",*** by strengthening and prioritising emergency preparedness to ensure effective response at all healthcare facilities, enforcing monitoring and evaluation to enhance accountability for disaster risk reduction, and promoting information sharing and dissemination of good practices across all healthcare facilities and by all healthcare workers and at-risk-communities.

The building back better concept has assisted the KwaZulu-Natal Department of Health with lessons continue to be learnt from the COVID-19 pandemic, regarding alternate sites (field hospitals) personal protective equipment, critical infrastructure and critical medical equipment.

2.3. POLICY, PROCEDURES AND GUIDELINES AND LEGISLATIVE FRAMEWORK

The Department of Health is further aided by policies, procedures and guidelines in the implementation of disaster risk reduction risk assessment, emergency preparedness, response, recovery and rehabilitation.

The emergence and re-emergence of infectious diseases is continuously monitored by the Department of Health to avert potential outbreaks, which calls for improved preparedness, strong coordination and rapid response. Epidemics can reach disastrous proportions where there is poor preparation, weak and uncoordinated responses. Experience has shown that where epidemic preparedness plans are formulated and implemented, not only have outbreaks been detected early, but also the response is rapid and well-targeted, resulting in effective and rapid control.

The benefits of early detection assist the Department of Health to enable rapid response, which limits the number of infection and geographical spread, shortens the duration of the outbreak and reduces fatalities. These benefits do not only help reduce the associated morbidity and mortality, but also save resources that would be necessary to manage a large epidemic.

The KwaZulu-Natal Department of Health together with the National and other Provincial Health Departments, academic institutions and research institutes have developed the National Guideline on Epidemic Preparedness and Response (EPR) focused on preparedness, response actions, ways to monitor activities and evaluation of the effectiveness on control measures. **(Annexure "E" National Guidelines on Epidemic Preparedness and Response).**

2.3.1. Legislative framework

a) The National Health Act (Act 61 Of 2003)

Section 3 (1) (c) of the Act, gives the Minister of Health the responsibility to, within the limits of available resources determine the policies and measures necessary to **protect, promote and maintain the health of the population.**

In addition, the Act empowers the Director General of Health to:

- Ensure the implementation of national health policy in so far as it relates to the national department (section 21, (1) (a)).

- Issue guidelines for the implementation of national health policy (section21, (1) (b))
- Issue and promote adherence to, norms and standards on health matters (section 21 (2) (b)).
- Coordinate health and medical services during disasters (section 21 (2) (e)).
- Facilitate and promote the provision of health services for the management, prevention and control of communicable and non-communicable diseases (section 21 (2) (k)).

Section 23 (a) of the Act:

The National Health Council advises the Minister on "*epidemiological surveillance and monitoring of national and provincial trends with regards to major diseases and risk factors for diseases*". Provincial and district health councils also have similar functions on communicable disease control coordinators.

This piece of legislation requires provinces and health districts to compile Strategic and Annual Performance Plans, which should be made up of components that include Disaster Management Plans.

List of Policies, Procedures and Guidelines;

- National Epidemic Preparedness and Response
- Malaria Policy
- TB Policy
- Non-communicable Disease policy. Angels Initiative (Stroke Management)
- National Climate Change and Health Adaptation Policy
- Guidelines for the Management of Infection Prevention and Control
- Environmental Health policy
- Waste Management Policy
- Multi-sectoral National Outbreak Response Team (MNORT) Policy
- National Action Plan – International Health Regulation (IHR-2005)

CHAPTER 3

INTEGRATED INSTITUTIONAL CAPACITY

In this chapter, the Public Health Emergency Coordinating Committee (PHECC) are considered.

3.1. Organisational Hierarchy

Organogram of the Department of Health and each clusters area of function and responsibility.

- Member of the Executive Council
  - Head of Health
    - Executive Support Services
    - Branch Specialised Services and Clinical Support
      - Chief Directorate Clinical Support
      - Chief Directorate Hospital Management Services
      - Chief Directorate Forensic Pathology Services
      - Chief Directorate Health Support Programme
      - Chief Directorate Professional Standards & Compliance
    - Branch District Health Services
      - Chief Directorate Strategic Health Programmes
      - Chief Directorate District Hospitals & PHC Services
      - Chief Directorate (EThekwini and Lamba)
      - Chief Directorate Strategic Planning and Support
      - Chief Directorate Communicable Disease Control
    - Branch Financial Management Services
      - Chief Directorate Budget Planning, Management & Control
      - Chief Directorate Supply Chain Management
      - Chief Directorate Financial Accounting and Reporting
      - Chief Directorate Information Technology
    - Branch Corporate Management Services
      - Chief Directorate Human Resource Development
      - Chief Directorate Human Resource Development, Planning and OD
      - Chief Directorate Legal Services
      - Chief Directorate Corporate Communication Services
    - Chief Directorate Risk Assurance Management
    - **Chief Directorate Disaster Management**
    - Chief Directorate Infrastructure Development, Maintenance and Technical Services

3.2. The Public Health Emergency Coordinating Committee (PHECC)

The Disaster Management Act 57 and of 2002, in sections 21, 25, 38, 39 and 52, places explicit responsibility on organs of state and municipalities, including provincial organs of state and municipalities, and other institutional role players involved in disaster risk management for the development and implementation of disaster risk management plans.

The preparation and alignment of disaster management plans with the respective disaster management frameworks for all spheres of government; are the cornerstone for the successful implementation of the Act. These are strategic mechanisms through which disaster risk management action is coordinated and integrated across all spheres of government.

The NDMF recommends an approach that is uniform, coherent and transparent for all stakeholders participating in disaster risk management, as well as ensuring that disaster risk management becomes an integral part of the development planning process.

The Public Health Emergency Coordinating Committee (PHECC) which functions as a Coordinating/Advisory Committee for the Department of Health provides a platform for members to consult one another, with the strategic focus to coordinate the Department's prevention, detection, response and management of public health emergencies in order to ensure effective delivery of health services, further ensuring multi-sectoral/multidisciplinary approaches through provincial and national partnerships for effective alert and response systems which are all-hazards approach

According to World Health Organisation (WHO), a public health emergency is defined as "an occurrence or imminent threat of an illness or health condition, caused by bio-terrorism, epidemic or pandemic disease, or (a) novel and highly fatal infectious agent or biological toxin. Public health emergencies are defined as much by their health consequences as by their causes and precipitating events. A situation becomes emergent when its health consequences have the potential to overwhelm routine community capabilities to address them.

The establishment and implementation of the PHECC, therefore, will ensure an all-hazards approach in managing threats to the health care system, as stipulated in the International Health Regulations (IHR), 2005 and Joint External Evaluation (JEE) undertaken in 2017.

The PHECC is mirrored at a national level in order to ensure a consolidated approach in the disaster medicine strategy and assumes the leadership role in terms of health initiatives in respect of disaster medicine in the province.

The terms of reference of the PHECC ensures a cohesive and inclusive approach in the implementation of the disaster medicine strategies within the health system, comprising of both external and internal stakeholders and to provide a mechanism for future decision making and develop a common understanding. To facilitate compliance with the IHR 2005 i.e. to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.

- To ensure coordinated approach that is based on multi-sectoral practices.
- To implement a multidisciplinary, multi-sectoral and integrated coordination approach in managing disasters in accordance with the Disaster Management Act, by preventing or reducing the risk of disasters, mitigating the severity of disasters, emergency preparedness, rapid and effective response to disasters and post-disaster recovery
- To serve as the technical arm to the Inter-Ministerial Committee (IMC) on public health events.
- To establish integrated technical task teams also known as Priority Committees for specific public health events.
- Manage public health event matters expediently and to ensure that the appropriate technical staff and priority committees are assigned to deal with events that have a direct impact on the health care system.
- To coordinate and collaborate with sector departments, regional counterparts and global stakeholders on public health events.
- To represent the KwaZulu-Natal Department of Health at the Provincial Joint Operations and Intelligence Structure (ProvJOINTS), Provincial Disaster Management Advisory Forum (PDMAF) and any other key stakeholder as and when required.

- To advise the MEC of Health and Head of Health on policy and guideline formulation on matters related to public health events;
- Advise the District Health, non-governmental organisations, communities or the private sector on any matter relating to public health.
- Undertake a comprehensive health disaster risk assessment.
- Develop and implement disaster medicine policies, plans, programmes and projects that focus on disaster risk reduction.
- Establish an early warning system and promote public awareness on the importance of heeding early warnings.
- Develop and maintain public health information management and communication systems.
- To ensure that the Provincial Health Operations Centre (ProvHOC) is utilised as a centralised communication platform, linking both internal and external role-players in the Province.
- To establish, activate, manage and coordinate the World Health Organisation (WHO) - Emergency Medical Teams Initiative (EMT Initiative) in relation to the population affected by disasters or outbreaks and emergencies and to manage surge capacity to support the local health system and the African continent.

Figure 3 illustrates the linkage of the Priority Committee on communicable disease outbreak response team with the Public Health Emergency Committee and various stakeholders and the coordination thereof

Figure 4 provides for the linkages between the Provincial Department of Health and the Provincial Joint Operations and Intelligence Structure (ProvJOINTS)

Figure 3: PHECC / PRIORITY COMMITTEE COORDINATION WITH INTERNAL / EXTERNALSTAKEHOLDER

Figure 4: DISASTER RISK MANAGEMENT – MULTI-DISCIPLINARY TECHNICAL TASK TEAM (TTT) PLATFORM - KZN - PDMC

3.3. Strategic framework for disaster medicine/management

Figure 5 below provides for a comprehensive approach to the implementation of disaster medicine strategy within the Department of Health.

The strategic framework for disaster management cycle consists of four phases; Prevention/Mitigation, Preparedness, in the pre-event stage, Response and Rehabilitation/Reconstruction in the post-event stage.

- ***The "prevention/mitigation phase;*** efforts are made to prevent or mitigate damage
- **Preparedness phase;** are activities and measures for ensuring an effective response to the impact of hazards
- ***Response phase;*** includes activities as rescue efforts, health and medical care, evacuation etc.
- ***Rehabilitation/Reconstruction phase;*** measures taken to normalise services and doing things better.

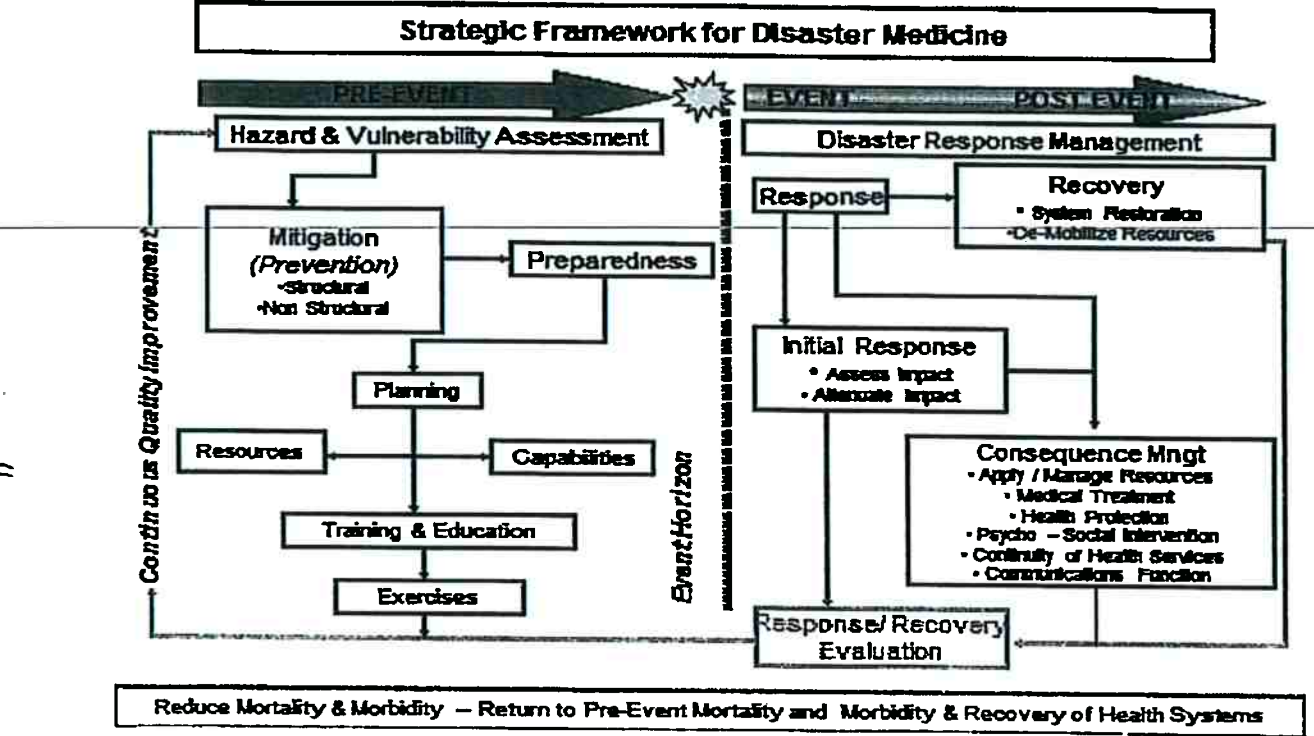


Figure 5: Strategic Framework for Disaster Medicine – Integrated Institutional Capacity

CHAPTER 4

DISASTER RISK ASSESSMENT

The KwaZulu-Natal Department of Health has implemented capacity building within all of its healthcare facilities and improved relationship with other Sector Departments across the spectrum of Disaster Management, to manage risk of hazards to community at local, district and provincial level, including enhancing national partnership, through the process of the Public Health Emergency Coordinating Committee (PHECC).

Mitigation strategies include decreasing exposure and the susceptibility to the hazard and building resilience of individual and communities to protect health, respond and recover effectively from the impact of the hazard. The Provincial Outbreak Response Team (PORT) leads the process of risk reassessment of communicable disease through the global One-Health Approach, which recognizes that the health of people is closely connected to the health of animals and our shared environment.

Through the development of risk management systems with emphasis on primary prevention, vulnerability reduction and strengthening community, health facility and health system resilience by re-enforcing a community-centred primary health care approach.

Through sustainability of Disaster Risk Assessment the loss of life and cost impact of disasters is reduced. The goal of the KwaZulu-Natal Department of Health disaster risk assessment process is to provide objective and transparent information for making decisions on countermeasures to reduce disaster risk.

The two top hazards that have an adverse effect on public health are severe weather-related events and systems/technology events. The third hazard is pandemic influenza, which has a detrimental impact on at-risk-communities.

The National Guideline on Epidemic Preparedness and Response provides for an all-encompassing guideline to the Department of Health on assessing risk, prevention and control of epidemic prone communicable disease in the Province of KwaZulu-Natal.

Epidemic prone diseases such as meningococcal disease, cholera, typhoid fever, yellow fever and viral haemorrhagic fevers (VHF) have resulted in high morbidity and mortality globally.
The emergence and re-emergence of infectious diseases of epidemic potential calls for improved risk assessment based upon at-risk-communities, with special emphasis on cross-border management of population movement, cross-border transportation and shipment.
In addition, regulations relating to the surveillance and control of notifiable condition **(Government Gazette No 41330)** 17 December 2017 to ensure that structures, processes and systems are in place for the surveillance and control of notifiable medical conditions as stipulated in the **National Guideline on Epidemic Preparedness and Response and International Health Regulations - 2005** . **(Annexure "F" – Government Gazette 41330)**

The last decade has seen the global emergence of infectious disease epidemics. Notable examples include: the outbreak of Severe Acute Respiratory Syndrome (SARS) in 2003; Lujo Virus outbreak in 2008, , the Cholera outbreak in 2000/2008/2009, the outbreak of (H1N1) of 2009; the Rift Valley Fever outbreak in 2010/2011, the Measles outbreak in 2011 the recent outbreak of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) that started in 2012; the outbreak of Avian Influenza (H7N9) that started in 2013 and the Ebola Virus Disease (EVD) outbreak that started in December 2013, and presently the COVID-19(2019) pandemic.

The technical advisory committee of the Provincial Outbreak Response Team and District Outbreak Response Team (PORT & DORT) has been active since the late 1990's and deals with risk assessment, surveillance, and collation of data. The PORT & DORT is multi-disciplinary, multi-sectoral committee that oversees the management of disease through the global One-Health Approach, which recognizes that the health of people is closely connected to the health of animals and our shared environment, with various stakeholders including academia.

The technical committee is guided by a strict set of terms of reference mirrored upon the National Department of Health technical committee (MNORT) Multi-Sectoral National Outbreak Response Team.

To promote robust and reliable public health security capabilities at the provincial, district and local levels and advocates for:

- **Enhancing disease situational awareness** provincially, locally and across neighbouring provinces and countries, including detection, identification, and investigation.
- **Strengthening disease containment**, including capabilities for isolation, quarantine, social distancing, and decontamination.
- **Improving risk communication** and public preparedness.
- **Ensuring rapid medical countermeasures** distribution and dispensing in an emergency.
- **Growing the next generation of leaders** to marshal the best minds in science and health, through the National Institute of Communicable Disease (NICD) and various academia's.
- **Modernizing response and recovery capabilities** to address the provinces immediate and future health security threats.

The KwaZulu-Natal Department of Health follows the stages of a disaster risk assessment, as suggested in part by the United Nations International Strategy on Disaster Reduction (UNISDR) publication: **(Living with Risk – A Global Review of Disaster Reduction)** a global review of disaster reduction initiatives, shown in the order in which they are normally conducted.

a) **Hazard identification & mapping**
- Comprehensive identification and mapping is undertaken per district to determine prevalent risk in that particular district.
- Collated data is shared with neighbouring provinces and countries via MNORT to identify the nature, location, intensity and likelihood (probability or frequency) of a threat.

b) **Vulnerability analysis**
- to determine the existence and degree of vulnerabilities and exposure to a threat(s)

c) **Capacity analysis**
- to identify the capacities and resources available to reduce the level of risk, or the effects of a disaster

d) **Risk analysis**
- to determine levels of risk

e) **Risk evaluation**
- to make decisions about which risks need countermeasures and priorities

f) **Risk communication**
- the imparting and exchanging of information about the existence, nature, form, likelihood, severity, acceptability, treatment or other aspects of risk. Ensuring that risk communication is important at each stage of the risk assessment process.

Disaster Risk Management Cycle

The disaster risk management cycle consists of four phases as shown in **Figure 6**; Prevention/Mitigation, Preparedness, in the pre-disaster stage, Response and Rehabilitation/Reconstruction in the post-disaster stage.

Figure 6: Disaster Risk Management Cycle

- The "prevention/mitigation phase, efforts are made to prevent or mitigate damage
- Preparedness phase, are activities and measures for ensuring and effective response to the impact of hazards
- Response phase includes activities as rescue efforts, medical treatment, firefighting and evacuation
- Rehabilitation/Reconstruction phase, Measures taken to normalise services and doing things better

4.1. Hazard and Vulnerability Assessment (HVA)

The hazard and vulnerability assessment (HVA) tool utilised by the KwaZulu-Natal Department of Health is a comprehensive guide to evaluate the potential for an event incident and the resulting response among the following categories using the hazard specific scale.

Listed below are specific criteria to determine accuracy of issues for;

- ***Probability***
  - Known risk, historical data, (10 year time frame)

- ***Human impact***
  - Potential for staff death or injury
  - Potential for death or injury to patients and visitors

- (Acuity and Volume), the severity and number of the injured and the level of attention or service that will be required from the medical team.

- *Property Damage*
  - Cost to replace
  - Cost to set up temporary replacement - field hospital, office space
  - Cost to repair
  - Time to recover
  - Cost to repair/replace based on past incidents
- *Business Impact*
  - Business interruption/services
  - Employees unable to report to work - Curfew, road closure security alert
  - Clients/patients unable to reach facility
  - Company in violation of contractual agreements
  - Imposition of fines and penalties or legal costs
  - Interruption of critical supplies/services
  - Interruption of product distribution
  - Reputation and public image
  - Financial impact/burden
  - Loss of business
  - Revenue lost during past incidents
- *Preparedness*
  - Status of current plans - preparedness and rehearsed
  - Frequency of drills and exercises
  - Training status
  - Insurance
  - Availability of alternate sources for critical supplies/services after hours contact details etc.
- *Internal Resources*
  - Types of supplies on hand/ will they meet the need
  - Volume of supplies on hand/ will they meet the need
  - Staff availability
  - Coordination with Directorates/ Clusters and District Health Offices
  - Coordination of MOU's
  - Availability of back-up systems
  - Internal resources ability to withstand disasters/survivability

- ***External Resources***
    - Types of agreements with the community, local authorities/drills?
    - Coordination with local, provincial and national entities
    - Coordination with proximal health care facilities
    - Coordination with treatment specific facilities
    - Community/local authority resources – decontamination unit
    - Time to marshal on-scene response
    - Scope (extent) of response capability
    - Local emergency response availability (historical evaluation of response success - past data on response capabilities)

4.2. Healthcare Facility Disaster Plan Self-Assessment Tool

The healthcare facility self-assessment tool is implemented across all healthcare facilities in the Province in revising and updating existing disaster/emergency plans and to assist in the development of new disaster plans, the tool provides an excellent check list to assure every aspect of disaster planning is addressed. **(Annexure "G" Healthcare Facility Disaster Plan Self-Assessment Tool).**

CHAPTER 5

DISASTER RISK REDUCTION

The disaster risk reduction identified by the Department of Health is based upon risk analysis undertaken by utilising the Hazard and Vulnerability Assessment tool, which determines appropriate risk reduction strategies.

5.1. The NDMF defines disaster risk reduction as;

The conceptual; framework of elements considered with the possibilities to minimise vulnerabilities and disaster risk throughout a society, to avoid (prevention) or to limit (mitigation and preparedness) the adverse impacts of hazards, within the broad context of sustainable development.

The NDMF also indicates that: There is a need to regain a level of inclusive intergovernmental participation, before a disaster occurs. Community responsibility will require a collective discipline that can be sustained through the education and practice of many trades and professions. Since disaster reduction is based on a continuous strategy of vulnerability and risk assessment, many role players need to be involved, drawn from government, technical and educational institutions, professions and local communities. Disaster prevention/mitigation activities pertaining to specific potential disastrous incidents/events are summarised in the table below.

Table 4:.Disaster prevention/mitigation activities

HAZARD	VULNERABILITY	RISK	CAPACITY	RISK REDUCTION OPTIONS
Health related: contagious diseases	Fans/tourists, livestock, Health facilities and institutions, at-risk-communities	High rate of Injury/loss of life	• Disaster Management • Metro Police • Traffic • Emergency Services • Housing • Health • Water • Municipal Infrastructure – trucks, etc • Dept of Agriculture • SANDF • SAPS • NGOs	• Awareness • Training • Inoculations • Warnings • Disinfection Control • Security controls • Quarantine procedures • Inspections • Medication • Monitoring (ablution facilities, etc)
Mass casualties	Emergency agencies, Airports, Harbours, Trains, Stations, Hospitals and high density facilities	Inability to cope with high volume of casualties	• Disaster Management • Metro Police • Traffic • Emergency Services • Housing • Health • Municipal Infrastructure – buses, etc • Public Works • SANDF • SAPS • NGOs	• Training • Awareness • Pre-event planning to cater for high volumes of casualties – (event site) • Sufficient trained personnel and equipment • Exercises • Field treatment facilities • Hospital disaster planning • Communication protocols
Food poisoning	All beings (Human and Animals)	Illness and or death	• Disaster • Emergency Services • Health • Dept of Agriculture • SAPS • NGOs • Public and Private Laboratories	• Food testing • Registration of all • Inspections • Monitoring – vendors • Monitoring – Health facilities • Law enforcement • Awareness (signage) • Training • Mobile clinics (refer to Mass Casualties)

DISASTER RISK REDUCTION - RISK PROFILE

Hazard, risk and vulnerability profile of the Province of KwaZulu-Natal is given in the following table, Table 5

Table 5: Hazard & Vulnerability Assessment Tool - Example

Potential Hazard	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	*Possibility of death or injury*	*Physical losses and damages*	*Interruption of services*	*Preplanning*	*Time, effectiveness, resources*	*Community/ Mutual Aid staff and supplies*	*Medium Risk*
	0 = N/A 1 = Low 2 = Moderate 3 = High	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	
Natural								
Flooding (Ext)	*High*	*High*	*High*	*High*	*High*	*High*	*High*	
Damaging Winds	*High*	*High*	*High*	*High*	*High*	*High*	*High*	
Hail Storm	*High*	*High*	*High*	*High*	*High*	*High*	*High*	
Ecological (Infectious Disease)	*Medium*	*High*	*Low*	*Medium*	*High*	*High*	*High*	
Severe Thunderstorm	*High*	*High*	*High*	*High*	*High*	*High*	*High*	
Tornado	*High*	*High*	*High*	*High*	*High*	*High*	*High*	
Temperature Extreme	*High*	*High*	*Low*	*High*	*High*	*High*	*High*	
Technological								

Potential Hazard	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	Possibility of death or injury	Physical losses and damages	Interruption of services	Preplanning	Time, effectiveness, resources	Community/ Mutual Aid staff and supplies	Medium Risk
	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	
Communication system failure	Medium	Low	Low	Medium	Medium	Medium	Medium	Medium
							High	
Flood (Internal	High	High	High	High	High	High	High	
HVAC Failure	Medium	Low	Low	Low	Moderate	Moderate	Moderate	medium
Human								
Mass Casualty	High	High	Medium	High	High	High	High	
Road Accident	High	High	High	High	High	High	High	
Air Crash	Low	Low	Low	Low	Moderate	Moderate	Moderate	
Emergency sheltering	Moderate	Low	High	High	High	High	High	Medium
Surge or influx of patients	Moderate	Low	Low	High	High	High	High	Medium

Vulnerability of various elements is shown in the following table that may have an adverse effect:

Table 6: Example - Elements to severe weather

Potential Hazards	Population	Road Accidents	Hospitals	Clinics	Infrastructure
Flooding (Ext)	High				
Damaging winds	High				
Hail Storm	High	High	Medium	Medium	High
Ecological	High	Low	Medium	Medium	Low
Severe Thunderstorm	High	High	Medium	Medium	High
Mass Casualty	High	[illegible]	High	High	Medium
Emergency sheltering	High	Low	Medium	Medium	
Temperate Extreme	High	Medium	Low	Low	low

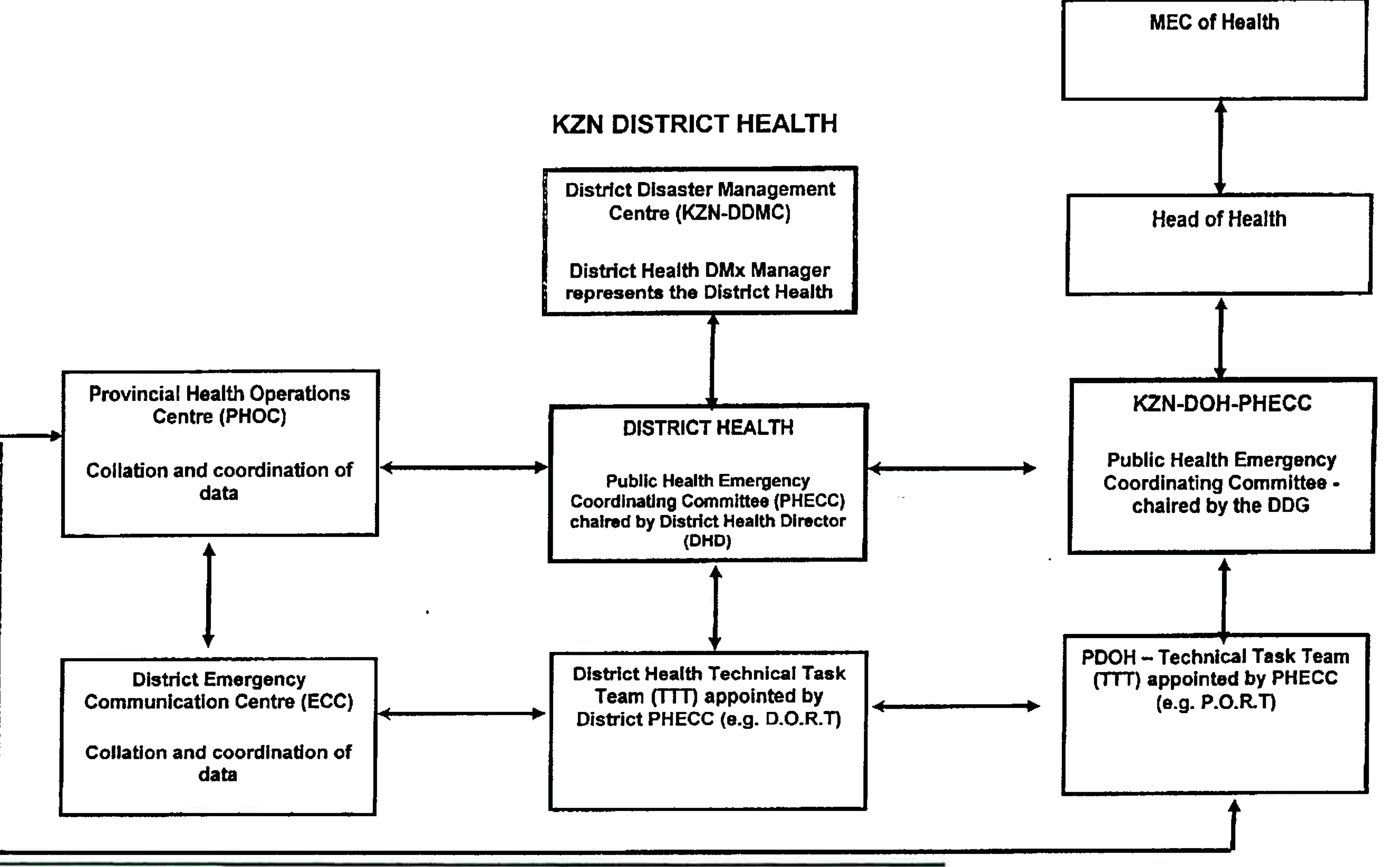
5.2. Disaster Risk Reduction Strategies

The KwaZulu-Natal Department of Health risk reduction strategies are planned for and executed in an integrated and optimal manner to reduce the impact on health and health systems.

Table 7: Disaster Risk Reduction Strategies

Hazard	Potential consequence	Risk reduction strategies
• *Flooding (External)* • *Flooding (Internal)* • *Damaging winds* • *Hail Storm* • *Ecological(infectious disease)* • *Severe Thunderstorm* • *Mass Casualty* • *Emergency sheltering* • Temperature Extreme • Work-force disruption	• Loss of life; • Severe injury/illness • Damage to infrastructure • Increased risk of diseases • Heat strokes • Reduced health and medical services	• Develop early warning system • Develop and implement response annex for specific risks for internal and external stakeholders • Public awareness campaign – communicable disease • Upgrade and maintenance of infrastructure • Establish hazard specific Technical Task Team (TTT) • Healthcare facility staff training in disaster management/medicine • MOU with SA Military Health Service on human resource support

Figure 7: Integrated and Linkage of District Health and District Disaster Management Centre



CHAPTER 6

PREPAREDNESS PLANNING

The two top hazards that have an adverse effect on public health are severe weather-related events and systems/technology events. The third hazard is pandemic influenza (ecological events), which has a detrimental impact on at-risk-communities.

Large scale-emergencies of epidemic potential, calls for improved preparedness, strong coordination and rapid response. These emergencies, can reach disastrous proportions where there is poor preparation, weak and uncoordinated responses. Experience in the Province of KwaZulu-Natal has shown that where preparedness plans have been formulated and implemented, not only have potential large-scale emergencies been detected timely, but also the response has been rapid and well-targeted, resulting in effective and rapid control.

The last decade has seen the global emergence of infectious disease epidemics. Notable examples include: the outbreak of Severe Acute Respiratory Syndrome (SARS) in 2003; Lujo Virus outbreak in 2008, , the Cholera outbreak in 2000/2008/2009, the outbreak of (H1N1) of 2009; the Rift Valley Fever outbreak in 2010/2011, the Measles outbreak in 2011 the recent outbreak of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) that started in 2012; the outbreak of Avian Influenza (H7N9) that started in 2013 and the Ebola Virus Disease (EVD) outbreak that started in December 2013, and presently the COVID-19(2019) pandemic. The preparedness program within the Department of Health is in line with international best practices, i.e. planning, training, education, resource management and exercise, as prevention and preparedness is the heart of public health.

6.1. Decision making structures

6.1.1. Public Health Emergency Coordinating Committee (PHECC)

The Public Health Emergency Coordinating Committee (PHECC) which functions as a Coordinating/Advisory Committee for the Department of Health provides a platform for members to consult one another, with the strategic focus to coordinate the Department's prevention, detection, response and management of public health emergencies in order to ensure effective delivery of health services, further ensuring multi-sectoral/multidisciplinary approaches through provincial and national partnerships for effective alert and response systems which are all-hazards approach

According to World Health Organisation (WHO), a public health emergency is defined as "an occurrence or imminent threat of an illness or health condition, caused by bio-terrorism, epidemic or pandemic disease, or (a) novel and highly fatal infectious agent or biological toxin. Public health emergencies are defined as much by their health consequences as by their causes and precipitating events. A situation becomes emergent when its health consequences have the potential to overwhelm routine community capabilities to address them.

The establishment and implementation of the PHECC, ensures an all-hazards approach in managing threats to the health care system, as stipulated in the International Health Regulations (IHR), 2005 and Joint External Evaluation (JEE) undertaken in 2017.

The PHECC is mirrored at a national level in order to ensure a consolidated approach in the disaster medicine strategy and assumes the leadership role in terms of health initiatives in respect of disaster medicine in the province.

The terms of reference of the PHECC ensures a cohesive and inclusive approach in the implementation of the disaster medicine strategies within the health system, comprising of both external and internal stakeholders and to provide a mechanism for future decision making and develop a common understanding, and to;
Facilitate compliance with the IHR 2005 i.e. to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.

- To ensure coordinated approach that is based on multi-sectoral practices.
- To implement a multidisciplinary, multi-sectoral and integrated coordination approach in managing disasters in accordance with the Disaster Management Act, by preventing or reducing the risk of disasters, mitigating the severity of disasters, emergency preparedness, rapid and effective response to disasters and post-disaster recovery
- To serve as the technical arm to the Inter-Ministerial/MEC Committee (IMC) on public health events.
- To establish integrated technical task teams also known as Priority Committees for specific public health events.

- To manage public health event matters expediently and to ensure that the appropriate technical staff and priority committees are assigned to deal with events that have a direct impact on the health care system.
- To coordinate and collaborate with sector departments, regional counterparts and global stakeholders on public health events.
- To represent the KwaZulu-Natal Department of Health at the Provincial Joint Operations and Intelligence Structure (ProvJOINTS), Provincial Disaster Management Advisory Forum (PDMAF) and any other key stakeholder as and when required.
- To advise the MEC of Health and Head of Health on policy and guideline formulation on matters related to public health events;
- To advise the District Health, non-governmental organisations, communities or the private sector on any matter relating to public health.
- To undertake a comprehensive health disaster risk assessment.
- To develop and implement disaster medicine policies, plans, programmes and projects that focus on disaster risk reduction.
- To establish an early warning system and promote public awareness on the importance of heeding early warnings.
- To develop and maintain public health information management and communication systems.
- To ensure that the Provincial Health Operations Centre (PHOC) is utilised as a centralised communication platform, linking both internal and external role-players in the Province.
- To establish, activate, manage and coordinate the World Health Organisation (WHO) - Emergency Medical Teams Initiative (EMT Initiative) in relation to the population affected by disasters or outbreaks and emergencies and to manage surge capacity to support the local health system and the African continent.
- The coordination, communication and collation of data and support management extends to all healthcare facilities, which is further described below.

Figure 8 illustrates the linkage of the Priority Committee on communicable disease outbreak response team with the Public Health Emergency Committee and various stakeholders and the coordination thereof

Figure 9 illustrates the linkages between the Provincial Department of Health and the Provincial Joint Operations and Intelligence Structure (ProvJOINTS).

Figure 10 illustrates the linkages between the KZN Department of Health and the KZN Provincial Disaster Management Centre (PDMC).

Figure 8: FLOWCHART - PHECC / PRIORITY COMMITTEE COORDINATION WITH INTERNAL / EXTERNALSTAKEHOLDER

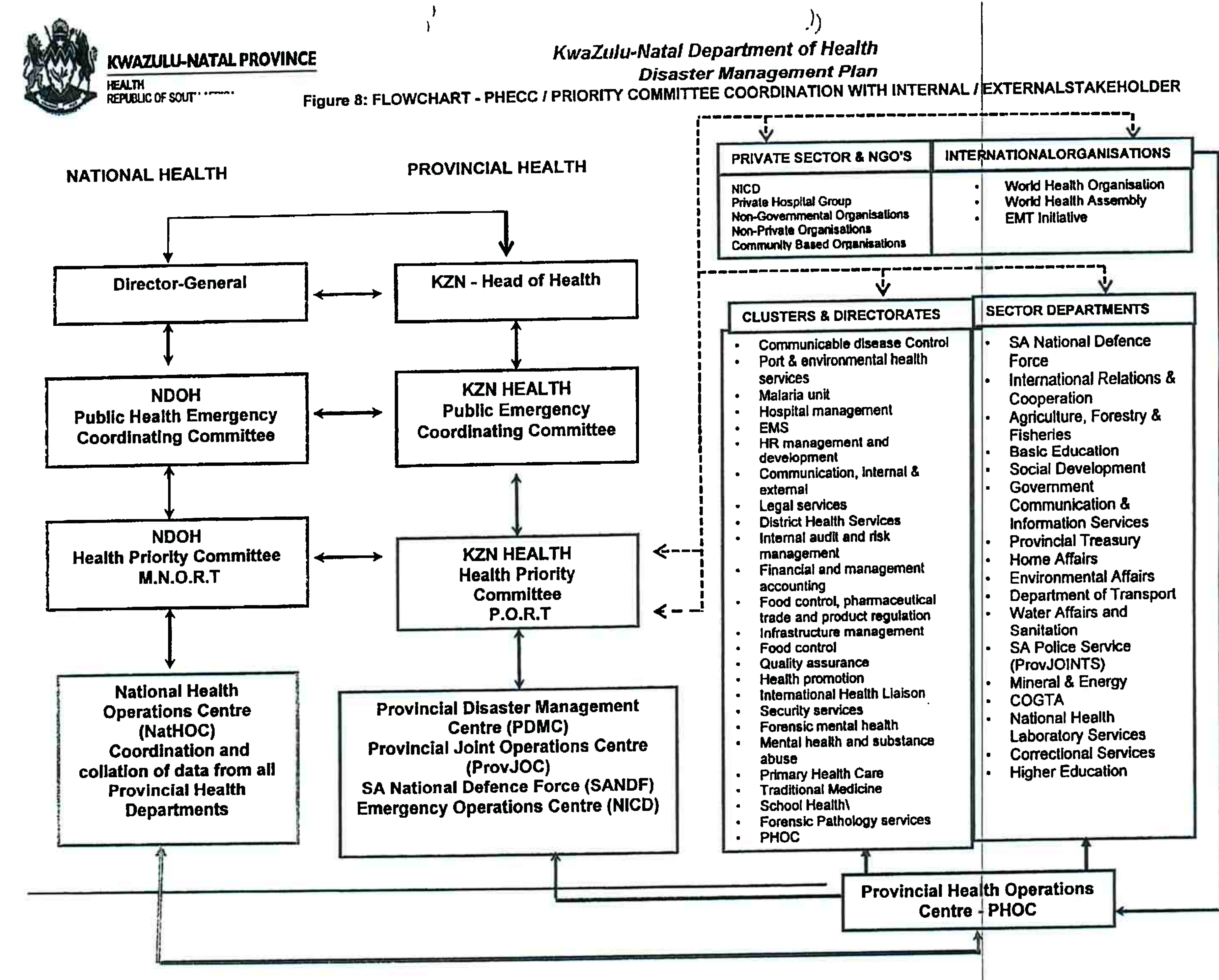


Figure 9: FLOWCHART - INTEGRATED AND COORDINATED APPROACH TO SAFETY AND SECURITY - PROVINCE OF KWAZULU-NATAL

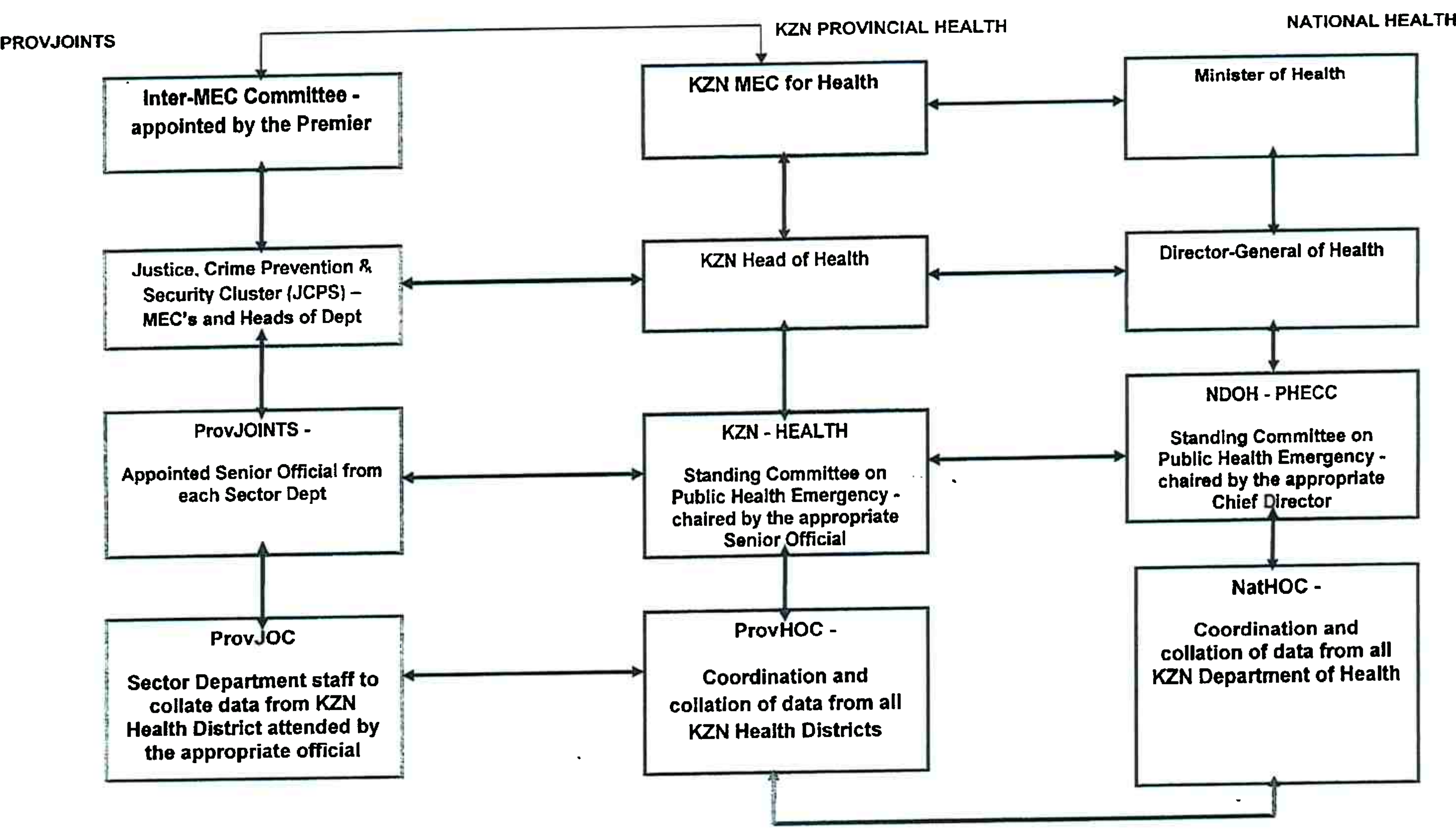
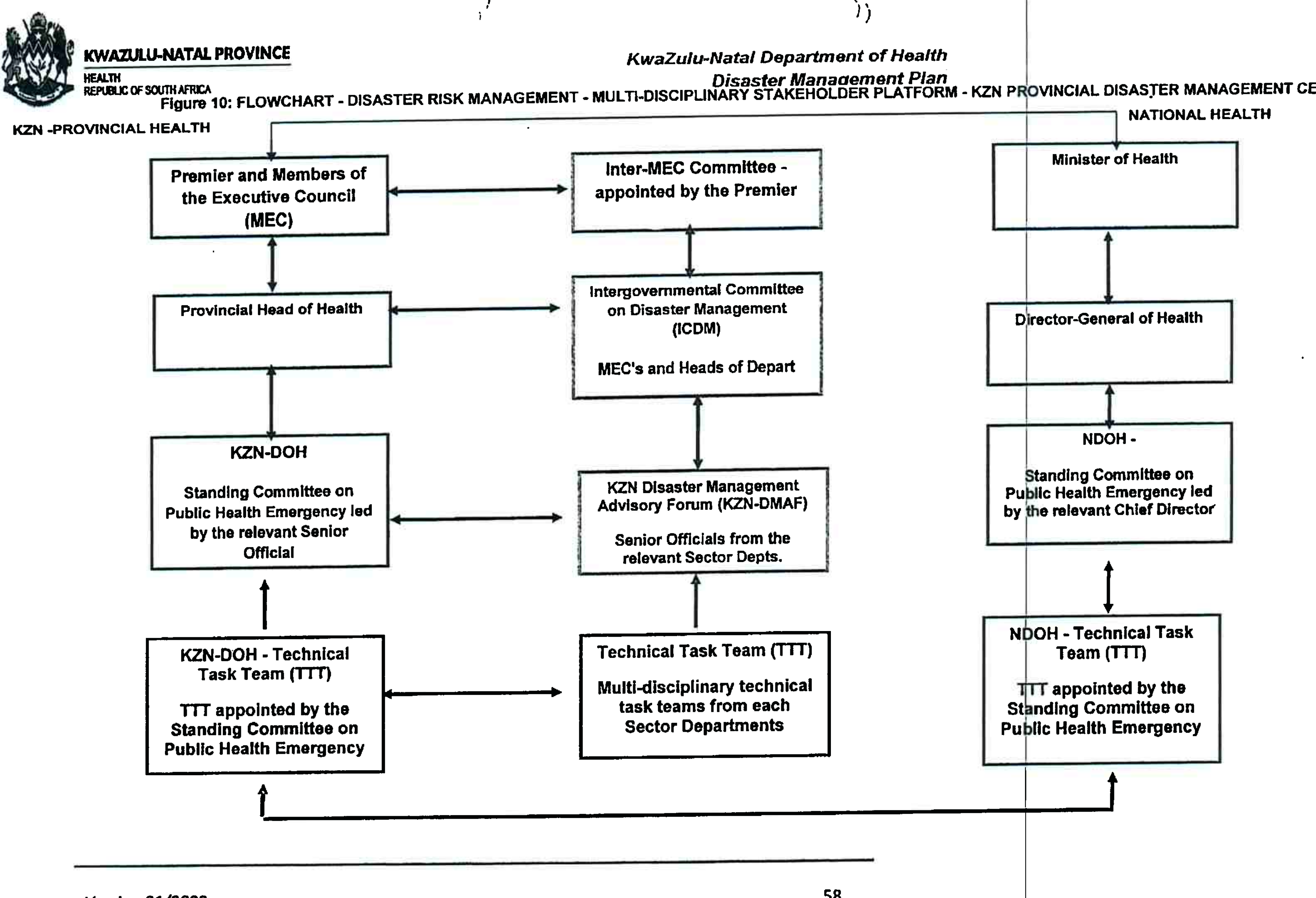


Figure 10: FLOWCHART - DISASTER RISK MANAGEMENT - MULTI-DISCIPLINARY STAKEHOLDER PLATFORM - KZN PROVINCIAL DISASTER MANAGEMENT CENTR



6.1.5. DISASTER/EMERGENCY PLANNING COMMITTEE

As part of the development of the emergency preparedness and response program, an emergency/disaster committee is established and are responsible for coordinating the disaster risk management programme activities within each healthcare facility.

All healthcare facilities have appointed Disaster Planning Committee (DPC) to implement Disaster Medicine practices in our healthcare facilities to ensure that our healthcare facilities are prepared and able to manage incidents both externally and internally, which may result in surge capacity that may have an adverse effect on our health care system.

Through commitment and rigorous execution of roles and responsibilities by our health care workers and managers at all levels, by preventing or reducing the risk of disasters, mitigating the severity or consequences of disasters, emergency preparedness, a rapid and effective response to disasters; and post-disaster recovery and rehabilitation.

The disaster planning committee (DPC) is multidisciplinary and consists of personnel from different areas of the healthcare facility

The functions and responsibilities of the disaster planning committee are to;

- Participate in the committee responsible for drafting mitigation and emergency plans
- Coordinate the drafting, approval, execution and evaluation of the plans
- Establish and maintain communication and coordinate activities with entities at provincial district and local level responsible for emergency/disaster response.
- Maintain contact with vendors or providers of equipment, producers of chemicals and professional associations that contribute to emergency/disaster response.
- Carry out periodic review and updating of emergency/disaster plans.
- Develop necessary budgets for implementing the disaster plan and present to healthcare facility management.
- Provide and supervise ongoing training of personnel in emergency/disaster procedures.

The terms of reference of the Disaster Planning Committee (DPC) includes, but not limited to;

- To undertake risk assessment
- To coordinate hazard and vulnerability analysis.
- To develop, review and revise the healthcare facility arrangements for managing both internal and external emergencies and disasters.
- ~~To arrange for the conduct of the healthcare facility exercise bi-annually.~~
- To advise the hospital management on the state of preparedness of the healthcare facility to manage an internal emergency/external disaster and the resource implication thereof.
- To provide advice on the training of staff to enable them to respond to such events.
- To provide to the hospital management as to the capability and arrangements of the healthcare facility with regard to participating in a response to a disaster and
- To liaise with external healthcare providers with regard to overall coordination of care and resources.
- To update details of healthcare facilities within the geographical area and forwarded to the PHOC.
- To maintain an up-to-date directory of Disaster Management role players, including contact details. (As per section 17 of the Disaster Management Act).
- To ensure correct implementation of reporting protocols (status, incident and disaster reports) on daily basis and during disasters.
- To maintain checklist of two-way radio testing for functionality and upgrading.
- To ensure maintenance and replacement programmes for 2 way radios and medical equipment.
- To evaluate and update Medical Equipment Pools.
- To review drills and their feedback into equipment usage, disaster plans and training by:
  - Assessing the performance of paper and mock exercises.
  - Identifying gaps and ensuring corrective action.
  - Review and updating of the drills calendar.
  - Ensure that drills are being implemented.
  - Evaluate the implementation of Disaster Plans.
  - Reworking the lessons learned on national and international disasters into the disaster management methodology and ongoing training.

- Training on equipment techniques and procedures.
- Administrative training in terms of Disaster Management.
- Review and updating of Disaster Plans, contact details, procedures, changes to structures.

- To ensure amended Disaster Plans are forwarded to Provincial and District Disaster Management Centres (as per the Disaster Management Act).

6.1.6. INCIDENT MANAGEMENT SYSTEM (IMS)

The Hospital Major Incident Medical Management and Support (HMIMMS)-based Incident Command/Management System (ICS/IMS) is an emergency management system which employs a logical management structure, defined responsibilities, clear reporting channels and a common nomenclature to help unify the healthcare facility with all other departments.

For the purpose of uniformity, the IMS terminology is used throughout this document, as with national trend.

The HMIMMS was first introduced to the Department of Health during the preparation for the 2010 Soccer World Cup.

The system is flexible and allows the healthcare facility to activate and organize a command structure based upon the response needs of the actual event. In most cases, Healthcare Facility Management and other key staff will assume disaster response responsibilities consistent with their primary responsibilities and establishes a (pre-designated) command centre, if warranted by the specific situation.

The success of emergency/disaster response activities is due to an integrated effort by all functional areas of the facility and certain external departments. In order to ensure coordination of healthcare facility and community resources allocated to the disaster response effort.

The primary purpose of the IMS is provide administrative coordination and support for all healthcare facility resources allocated to the response effort and to establish effective communication and coordination with external departments that may assist in the response effort. The IMS facilitates a flexible, "all hazards" approach to disaster/emergency management that can be adapted to respond to a variety of emergencies.

Confusion and chaos is commonly experienced by the healthcare facility at the onset of a disaster. However, these negative effects are minimized when the healthcare facility staff responds quickly with a structured and focused direction of activities.

IMS is the gold standard for health care disaster response internationally and offers the following features.

- **Flexible organizational chart**

  Allows flexible response to specific emergencies with a structured chain of command i.e. Major Incident versus a disaster.

- **Action Cards**

  Duty sheet for key positions, detailing tasks

- **Accountability & Identification**

  Ensures accountability of position function, i.e. Triage Nurse, Physician Room Captain, preventing duplication and department freelancing

- **Documentation**

  Documentation of tracking personnel e.g. Manpower Pool Log and Patient Tracking

- **Common language**

  Use of common language for the identification of persons or positions, e.g. Critical Care Coordinator, Medical Care Director to help promote communication and facilitate assistance.

- **Cost effective activation**

  Occurs as a result of more efficient use of personnel and resources, financial resources are saved by activating only those positions which are necessary.

Incident Management System **(IMS)** is an emergency management system made up of positions on an organizational chart. Each position has a specific mission to address an emergency situation. Each position represented has an individual checklist – ***Action Card*** – designed to direct the assigned individual in disaster tasks.

The IMS plan is flexible. Only those position, or function, which are needed are activated. The IMS plan allows for the addition of needed positions as well as the deactivating of positions at any time (modular in approach). This equates to promoting efficiency and cost effectiveness. The organizational chart can be fully activated for a large, extended disaster such as mass casualty incident.

More than one position may be assigned to an individual – ***Multi-tasking.*** Situations of a critical nature may require an individual to perform multiple tasks until additional support can be obtained. This is made possible with the use of the individual position checklists – ***Action Cards.***

6.1.7. CHAIN OF COMMAND

The Disaster Response Team (DRT) is headed by the highest ranking administrative officer (Incident Manager) of the healthcare facility, who will be in command and control of all aspects of the emergency which includes front-line management of the incident, strategic planning and execution, determining the type of assistance needed, whether internal or external resources.

The Incident Manager can be any employee, but a member of management with the authority to make decisions is usually the best choice.

The Incident Manager must have the capability and authority to:

- Assume command
- Assess the situation
- Implement the emergency management plan
- Determine response strategies
- Activate resources
- Order an evacuation
- Oversee all incident response activities
- Declare that the incident is "over"

6.1.8. DISASTER RESPONSE TEAM (DRT)

The Disaster Response Team (DRT) is the team responsible for the big picture. It controls all incident-related activities.

The DRT supports the Incident Manager (IM) by allocating resources and by interfacing with all departments internally, and externally the media, outside response agencies (SA Red Cross, EMS) regulatory authorities (MEC of Health) and other hospitals etc.

DRT members are senior managers who have the authority to:

- Determine the short- and long- term effects of the emergency
- Coordinate and manage patient care & allocation
- Order the evacuation or shutdown of the facility
- Interface with departments
- Interface with outside organizations and the media
- Issue press releases via the Incident Manager and the Provincial Health spokesperson
- Resource management
- Record keeping – patient tracking
- Information processing – i.e. Staff communication,

6.1.9. ORGANISATIONAL CHART:

The Organizational Chart shows a chain of command which incorporates four sections of the Incident Management System, i.e.

- Logistics
- Planning,
- Communications
- Operations

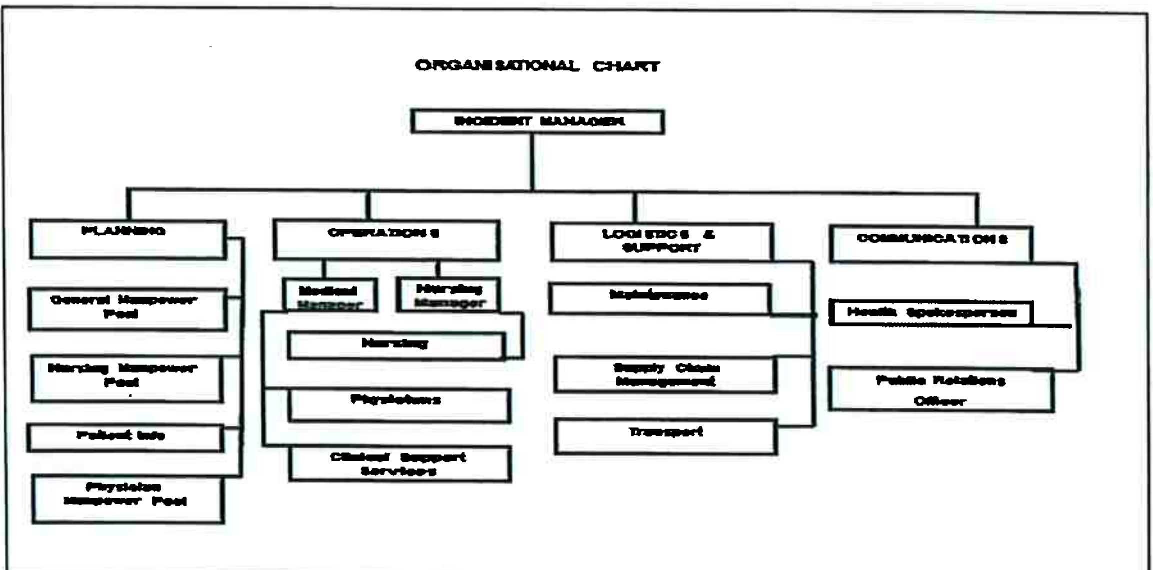


Figure 11: Example – Organisational Chart

These positions are under the leadership of the Incident Manager, Each of these positions has a Senior Official appointed by the Incident Manager responsible for their section / department. The Official in turn designates managers or unit leaders to sub functions, with

supervisors and officers filling other crucial roles. This structure limits the span of control of each manager in the attempt to distribute the work. It also provides for a system of documenting and reporting all emergency response activities including accountability.

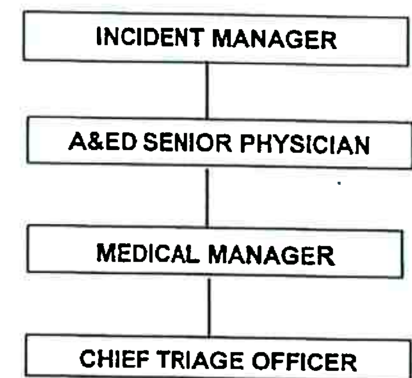


Figure 12: Example: Chain of Command A&E

6.2. Decision Making Supporting Structures

6.2.1. ACTION CARDS

Each one of the positions on the organizational chart has an Action Card describing the important duties of each particular role. Every Action Card begins with the:

- Job title or position title
- Supervising person
- Location of the section / departments command centre
- Mission statement

The duties listed on the Action Card are categorized as:

- Immediate
- Intermediate, and
- Extended

A line to the left of the action is allocated for the recording of the time when the duty was accomplished or last completed.

The Action Card's mission statement is most important, as it defines the responsibility and directs the individual in accomplishing the task, and prevents department freelancing, which is likely to happen in an emergency. The Action Card also serves as a reminder of the lines

of communication or chain of command and helps promote the documentation of the incident.

health
Department: Health
PROVINCE OF KWAZULU-NATAL

INCIDENT MANAGEMENT SYSTEM ACTION CARD

ACCIDENT & EMERGENCY DEPARTMENT SENIOR PHYSICIAN

Positioned Assigned To: ______________________

You Report To: ______________________ **Medical Manager**

A&E Command Center: ______________________ **Telephone:** ____________

Mission: Initiate and supervise the patient triage process. Assure treatment of casualties according to triage categories and manage the treatment area(s). Provide for a controlled patient discharge. Supervise morgue service.

Immediate:

_______ Receive appointment from Medical Manager
_______ Read this entire Action Card
_______ Put on position identification vest.
_______ Receive briefing from the Medical Manager and develop action plan with Treatment Area Coordinators and Chief Triage Officer
_______ Establish the A&E Command Center within the A&E dept
_______ Appoint coordinators for the following treatment areas:

- Triage Area
- Immediate Treatment - Red – P1
- Delayed Treatment - Yellow – P2
- Minor Treatment - Green – P3
- Morgue - Blue – P4

_______ Distribute corresponding Action Cards, request a documentation aide/assistant for each coordinator from General Manpower Pool.
_______ Brief Treatment Area coordinators - Designate time for follow-up meeting
_______ Assist establishment of Triage, Immediate, Delayed, Treatment and Morgue Areas in pre-established locations
_______ Assess problem, treatment needs and customize the staffing and supplies in each area.
_______ Liaise / meet with the Medical Manager to discuss medical care plan of action and staffing in all triage/treatment/morgue areas.
_______ Receive, coordinate and forward requests for personnel and supplies to the Medical Manager and Supply Chain Manager copy all communication to the Medical Manager.

Intermediate:

_______ Contact the Security Command Center for any security needs, especially those in the Triage and Morgue areas. Advise the Medical Manager of any actions/requests.
_______ Report equipment needs to Supply Chain Manager.
_______ Establish communication (telephone or runner) with Medical Manager
_______ Assess environmental services (housekeeping) needs for all Treatment Areas; contact Housekeeping Manager for assistance.
_______ Observe and assist any staff who exhibit signs of stress and fatigue. Report any concerns to Medical Manager. Provide for staff rest periods and relief.
_______ Assist Patient Tracking Officer in obtaining information.

Extended:

_______ Report frequently and routinely to Medical Manager to keep appraised of situation
_______ Document all action/decisions with a copy sent to the Medical Manager.
_______ Other concerns:

Figure 13: Example - Action Card A&ED Senior Physician

6.2.2. PLANNING AND TRAINING

The Healthcare Facility Disaster Planning Committee (DPC) assumes responsibility for coordinating the development, evaluation, and revision of the Disaster Management Plan. To ensure that the plan is integrated with the Municipal/District and Provincial Disaster Risk Management Plan.

The chairperson of the healthcare facility DPC must serve as a member of the Disaster Management Advisory Forum at the Municipal/District Disaster Management Centre.

The Disaster Planning Committee will evaluate the Disaster Management Plan and its objective, scope, and effectiveness annually using established criteria and as changes to the healthcare facilities and programs necessitate. The DPC will ensure that disaster preparedness drills, are conducted at least twice annually and serve as a basis for continuing evaluation and modification of the overall plan and individual contingency plans, and after each period of activation of the Disaster Management Plan.

6.2.3. MONITORING/AUDIT SYSTEMS

Monitoring/audit systems is a function of the Public Health Emergency Coordinating Committee (PHECC). The monitoring/audit is performed by the PHECC on a regular basis.

The process is to perform the monitoring and audit of the following:

- Monitoring of healthcare facility Disaster Planning Committee to evaluate capacity and capabilities.
- Finance – availability, correct allocation and discrepancies.
- Problems in implementing Disaster Management Act, solutions and recommendations.

6.2.4. PARTNERSHIP/COALITION DEVELOPMENT MUTUAL AID AGREEMENT

The changing nature, magnitude and impact of disasters, forces organisations from different sectors and jurisdictions to work together to overcome capacity problems, recent events in Kwazulu-Natal confirmed that no single Department could meet the urgent demands of large-scale incidents.

Inter-departmental and multi-sectoral cooperation requires mutual aid agreement that extends beyond the daily routine of the department.

Mutual aid agreements are entered into between different spheres of government that provide a mechanism to quickly obtain emergency assistance.

The primary objective is to facilitate rapid, short-term deployment of support prior, during and after an incident and to limit the impact and duration of the event.

National and Provincial MOU/MOA is in place especially key stakeholders that provide immediate support, resource management, such as medical personnel and equipment from

the SA Military Health Service, National Institute of Communicable Disease for epidemiology support, private hospital group for additional patient in-take/admissions.

Memorandums of understanding and memorandums of agreement are agreed upon with the private sector and NGOs, community-based, faith-based and national organisations such as SA Red Cross and Gift of the Givers.

- It expedites emergency response by establishing protocols and procedures for requesting and providing assistance;
- Determine policies for reimbursement and compensation in advance;
- Eliminate or lessen the extent to which these issues must be negotiated with each new event;

6.2.5. EARLY DETECTION:

The benefits of early detection are numerous. Early detection enables rapid response, which limits the number of cases and geographical spread, shortens the duration of the emergency and reduces fatalities. These benefits do not only help reduce the associated morbidity and mortality but also save resources that would be necessary to tackle a large-scale emergency.

The strategic emergency preparedness of the KwaZulu-Natal Department of Health listed in the table below provides a comprehensive description of the various directorates/ clusters and districts preparedness planning in managing incidents that may have an adverse impact on healthcare systems province-wide.

6.2.6. STRATEGIC EMERGENCY PREPAREDNESS ACTIONS:

Table 8: emergency preparedness clusters and activities

Clusters	Activities	Priority	Where/What	Responsibility and Potential Partners/Stakeholders
Health Promotion	Increased health promotion campaigns Public education, through PHC/ district health/ municipalities/ NGO's • Hand hygiene • Contaminated water usage • Safety of drinking water • Air pollution	Immediate	At-risk-communities	Provincial and District Health/ Municipality and private partners/stakeholders/ NGO's/CBO's
Risk Communication	• Inform the affected communities of the risks and what they should do	Immediate	At-risk-communities	Provincial and District Health/ Municipality and private partners/stakeholders/ NGO's/CBO's
Surveillance	• Increased disease surveillance	Immediate	At-risk-communities	Communicable Disease Surveillance/ National Institute of Communicable Disease NICD
Communicable Disease Control	• Alert outbreak response teams • Maintain capacity to respond to communicable disease outbreaks	Immediate	At-risk-communities	CDC/Surveillance/ NICD/MNORT/PORT/DOR T
Malaria	• Vector/Mosquito control • Support surveillance activities	Immediate	At-risk-communities	Malaria/Surveillance/ NICD/MNORT/PORT/DOR T
Food Control	• Preventive programmes • Food hygiene and inspection • Monitor nutrition of affected communities	Immediate	At-risk-communities	Nutrition/ Provincial and District Health/ NDOH/Municipality and private partners/stakeholders/ NGO's/CBO's/ PORT/NICD
Environmental Health Services	• Strengthening climate change adaptation programmes developed by the department of health. • Waste management • Vendors - enforcement • Sanitation services • Inspections	Immediate	At-risk-communities	Provincial and District Health/ Municipality and private partners/stakeholders/ NGO's/CBO's

Clusters	Activities	Priority	Where/What	Responsibility and Potential Partners/Stakeholders
	• Food hygiene • Support surveillance activities • Identify risk areas			
Port Health services	• Increased surveillance • Education of travellers on emergency measures • Ensure safe transport of food across borders	Immediate	High risk countries	BMA - Border Management Agency/ Border Police/ Home Affairs/ SANDF/SAMHS
Child Health	• Monitor nutrition of vulnerable populations		At-risk-communities	Child Health/Nutrition, provincial, district, NGO's, CBO's
Hospital Management/ Services	• Intensify infection control at identified hospitals • Emergency/disaster preparedness • Preventive actions and Inspections • Waste management • Sanitation services	Immediate	Vulnerable health care facilities	Provincial and District Health/ Municipality and private partners/stakeholders/ NGO's/CBO's
Mental Health Care	• Assess the potential mental health impacts of the emergency • Communities directly impacted by the emergency/disaster i.e. the elderly, chronic conditions • Individuals who have lost employment, livelihood due to disaster	Immediate	At-risk-communities	Provincial and District Health/ Municipality and private partners/stakeholders/ NGO's/CBO's
Emergency Medical Services	• Primary function to deliver emergency medical care in all cases of emergency conditions, including disaster. • Professional standards, organisational arrangements and coordination mechanism intra and inter-districts, i.e. District health Management, Healthcare facility management	Immediate	At-risk-communities	Intra and inter-districts, i.e. District Health Management, Healthcare facility management. Supporting state and private emergency services

CLIMATE CHANGE AND HEALTH MONITORING PREPAREDNESS INDICATORS

Table 9: CLIMATE CHANGE AND HEALTH MONITORING PREPAREDNESS INDICATORS

Health focus area/s	Indicator name	Type of Indicator	Numerator	Denominator	Indicator definition	Reporting frequency	Purpose in relation to Climate Change	Unit responsibl for reportin
1. Food Insecurity, Hunger, Malnutrition	*Child under 5 years severe acute malnutrition incidence	Per 1000	Child under 5 with severe acute malnutrition-new	Population under 5	Children under 5 years newly diagnosed with severe acute malnutrition per 1,000 children under 5 years in the population	Monthly.	Monitors prevention and diagnosis of severe acute malnutrition in children under 5 years diagnosed once only. Follow-up visits for the same episode of malnutrition are not counted here. Increased incidences in relation to climate events can be identified and analysed.	Integrated Managemen of Childhooc Illnesses/ Child Health
	*Child under 5 years diarrhoea with dehydration incidence	Per 1000	Child under 5 diarrhoea with dehydration-new	Population under 5	Children under 5 years newly diagnosed with diarrhoea with dehydration per 1,000 children under 5 years in the population	Monthly	Monitors prevention of diarrhoea with dehydration (IMCI classification) in children under 5 years diagnosed once only. Follow-up visits for the same episode of diarrhoea are not counted. Increased incidences in relation to climate events can be identified and analysed.	Integrated Managemen of Childhood Illnesses/ Child Health
	*School learner underweight rate	%	School learners underweight	School learners screened – total	Proportion of learners screened by a nurse in line with the ISHP service package diagnosed as underweight (below -2SD but above -3SD)	Monthly	Monitors implementation of the Integrated School Health Program (ISHP) and increased incidences in relation to climate events can be identified and analysed	School healt
2. Food safety	EH Food sample chemical compliance	%	EH Food sample chemically compliant	EH Food sample chemical analysis	Proportion of food samples chemically tested that complies to the Foodstuffs,	Monthly	Monitors food safety, including imported foodstuffs. Increased non-compliance from aflatoxin during climate event can be	Environment al Health

Health focus area/s	Indicator name	Type of Indicator	Numerator	Denominator	Indicator definition	Reporting frequency	Purpose in relation to Climate Change	Unit responsible for reporting
	West Nile virus incidence rate	indicator			West Nile virus cases in a province	reported	Nile virus cases in a province. West Nile virus cases in a province during climate events can be identified and analysed.	al Health/ Surveillance/ CDC
	*Reported Rift Valley Fever incidence rate	Count indicator	-	-	Number of reported Valley Fever cases in a province	As per cases reported	Monitors the incidences of Rift Valley Fever cases in a province. Rift Valley Fever cases in a province during climate events can be identified and analysed.	Environmental Health/ Surveillance/ CDC
5. Mental Illness	Mental illness admission rate	%	Mental illness admissions total	Inpatient separations total	Proportion of patients admitted/separate for mental illness problems. Inpatient separations is the total of day patients, inpatient discharges, inpatient deaths and inpatient transfer outs	Monthly	Monitor trends in mental illness admissions in non-mental health institutions. Mental health hospitals excluded. Increased mental health admission during climate events can be identified and analysed	Mental Health
	*Mental illness case load	%	Mental illness patient total	PHC (Primary Health Care) headcount total	Mental illness care patients as proportion of total PHC headcount in the facility	Monthly	Monitor access to and utilization of mental health services in the public health sector. Increased mental illness cases during climate events can be identified and analysed	Mental Health
6.Health care system and emergency response readiness assessment	*Emergency Medical Services (EMS) P1 urban response under 15 minutes rate	%	EMS P1 urban response under 15 minutes	EMS P1 urban calls	Emergency P1 calls in urban locations with response times under 15 minutes as a proportion of EMS P1 urban calls. Response time is calculated from the time the call is received to the time of the first dispatched	Monthly	Monitors compliance with the norm for critically ill or injured patients to receive EMS within 15 minutes in urban areas, to ensure an effective EMS service in urban areas when casualties occur as a result of climate event.	EMS

Health focus area/s	Indicator name	Type of Indicator	Numerator	Denominator	Indicator definition	Reporting frequency	Purpose in relation to Climate Change	Unit responsible for reporting
	health centre)/CDC(Community Day Centre)				clinics plus fixed CHCs/CDCs			
	National Core Standards self-assessment rate	%	National Core Standards self-assessment	Fixed PHC clinics/fixed CHCs/CDCs plus hospital (public)	Fixed health establishments that have conducted annual National Core Standards self-assessment as a proportion of fixed health facilities.	Monthly	Monitors whether health establishments are measuring their own level of compliance with standards in order to close identified gaps, so that the quality of health care is improved.	Quality Assurance
	*Developed district health plans has situational analysis and strategies to address climate change and health adaptation areas	%	Districts with developed district health plans that address climate change and health adaptation areas	Total number of districts	Developed district health plans that address climate change and health adaptation areas	Annual	Monitor developed district health plans to ensure that that climate change health risk factors are identified and health adaptation measures are planned and implemented.	Districts and Developmen

Purpose:

The ultimate goal of Business Continuity Planning/Management (BCP/M) is to **resume business functions to a normal state after a period of time post event.**

The KZN Department of Health has a moral responsibility to ensure continuation of patient's services, protect employees, the community, the environment and facilitate compliance with legislative requirements of the National Health Act 61 of 2003.

BCP/M enhances the ability to reduce disruptions to service delivery, financial loss, and damage to equipment. The BCP/M is a dynamic tool utilised to maintain and/or resume business operations, which provides information regarding **(Annexure "J")**

- Critical Business Processes
- Critical Equipment and Resources
- Information Communication Technology (ICT) applications
- Staff positions and additional support.
- Critical records management, i.e. medical records, management records
- Departmental dependencies, supply chain management, pharmaceutical services, laboratory etc.

The BCP/M is used in emergencies and other catastrophic events where the building or a department is severely impacted due to loss of service, power outages, water supply, including significant physical, operational (disruption to services), and business challenges and risks

In addition, to support business continuity of service, within the facility, to ensure ongoing facility viability and community support.

The BCP/M is used in addition to the Hospital Command Centre (HCC) to resume/return business functions to a normal state post-disaster.

6.3.1. Business Continuity Tool:

The Business Continuity Plan Tool is segmented into multiple Microsoft Excel tabs:

The Tiers tab

- Critical Processes are prioritized into tiers based on operational periods:
    - Tier 1 (0-2 hours)
    - Tier 2 (2-12 hours)

A	B
[Hospital Name] Business Continuity Pla View by Tier	
Tier 1 (0-2 hours)	
Department	**Critical Business Function/Process**
Admin	Support
Cardio Services	Diagnostic Testing
	Registration
Cath Lab	Treatment
	Discharge
Critical Care Unit (CCU)	Admissions
	Transfer
	Treatment
Dietary	Preparing Food
	Receive Diet Orders
	Patient Food Modification
	Delivery of food
	Dishwashing
	Maintaining Sanitation
	Menu Planning
Emergency Department	Triage
	Emergency Treatment
	Diagnostic Testing
HIM	Chart archive management
	Dictation
	Release of information
Tier 2 (2-12 hours)	
Department	**Critical Business Function/Process**
Cardio Services	Reporting
Emergency Department	Fast Track Treatment Area
Laboratory	Path Services
Medical Imaging	Reporting
Rehab Services	Assessment
	Diagnostic Testing
Emergency Department	Registration
	Disposition - Discharge / Admit
HR	Documentation
Women's Health Center (WHC)	Post Partum Care
Tier 3 (12-24 hours)	

Figure 14: Business Continuity Plan

6.3.2. Department Status Form

The document provides operational status of the departments i.e. # of injuries, staff census, general patient's census, utilities, equipment needs.

The document also provides for the originator i.e. Department Manager, when to complete the document i.e. onset of the incident and prior to shift change, upon completion of the operational status form, the document is escalated to the Business Continuity Manager.

6.3.4. Department Status Summary

Figure 16: Template showing summary of department status

	#Injuries			Staff census						Patients Census					# of patients requiring assistance				Operational Status	
Department	Staff	Patient	Visitor	Registered nurses	Doctors	Clerical	Supervisors/Managers/Directors	Allied health	Others	# of Occupied Beds in Department/ Unit	# of Empty Beds in Unit	# of patients too critical for Emergency Discharge/ Transfer	How many patients can be Rapid Discharged	#of patients which waiting to be triaged?	No Assistance	Some assistance	Maximum Assistance	Utilities Issues:	Can your department remain operational for the next 8 hours?	Immediate Needs or Safety Concerns:

- To deliver urgent care for both disaster-related and unrelated medical conditions to ease-off pressure of the Emergency Departments (ED) and ambulatory care clinics.
- To screen large numbers of potentially exposed people (e.g., radiation, pathogen, toxic substance), and facilitate treatment and follow-up for recommended groups.

6.4.2. Activation criterion

The activation criterion for ACF is predetermined by the district health management and is incorporated in the respective district disaster management plan.

6.4.3. Temporary shelters

The provision of temporary shelter in a disaster situation is normally provided by the district disaster management centre, which requires the respective district health management to coordinate and provide the necessary health and medical services

However, the District health office together with the Provincial Health Management will oversee temporary shelter design to restore human dignity and protect women and children during disasters or conflicts.

These among others include attention to strategic and physical planning considerations, minimal covered living space areas, appropriateness of design, ease of construction and low environmental impact.

Overcrowding conditions within a shelter is avoided to prevent the spread of airborne communicable diseases.

The tent design must be appropriate for all seasons and be able to withstand such extreme conditions as heavy rainfalls, flooding and cold winter. The tents must also be able to accommodate people with disability and elderly people's needs.

Access to essential services is ensured, including schools, health facilities and safe play areas.

6.4.4. Primary Health Services

Disasters always have significant impacts on the public health and well-being of affected people. The primary goal of humanitarian response to humanitarian crises is to prevent mortality and morbidity/sickness at the shelters.

The KwaZulu-Natal Department of Health is responsible to ensure the wellbeing of disaster affected communities and management of resources and responsibilities for dealing with all

whether treatment is needed. The water quality testing needs is conducted before the water is used by the occupants of the shelter to prevent disease outbreaks. The following need is provided during disasters;

- 15 litres of water per person per day for drinking water and personal hygiene;
- Stand pipe connections depending on the number of the people within the temporary shelter;
- The water point should be accessible to all the people.
- Provision of laundry facilities i.e. washing basins and laundry areas for people. 1 x washing basin per family.
- Temporary showers or 1 bathing basin per family.

It is important that the affected people are made aware of and provided with all necessary means to maintain and sustain the systems provided.

ii) Sanitation

The provision of appropriate facilities for sanitation is one of a number of emergency responses essential for people's dignity, safety, health and well-being. The sanitation facilities is appropriately designed and built to ensure safe use by all the people including children, older persons, pregnant women and persons with disability.

It is important to note that only a maximum of 20 people per 1 toilet. The facility should not be more than 50 metres from the tents. The facilities must be monitored and maintained daily to prevent health nuisances. Defective toilets must be locked until repaired. The following be made available depending on the availability of services;

- Flushable toilets
- Portable toilets
- Hand washing facilities to promote hygiene

iv) Health promotion

Hygiene programmes such as WASH (Water and Sanitation Hygiene) to promote good personal and environmental hygiene in order to protect health is very vital. Sector collaboration is required in this regard to ensure collaborated efforts in preventing and mitigating any health related hazards. Capacity building through awareness building needs to be implemented within the shelters.

v) Food Security, Nutrition and Food Safety

The coordinating District Disaster Management Centre (DDMC) must ensure sufficient provision of food to all the affected people, at all times, people should have access to

ix) Emergency Medical Services:

Emergency Medical Services is provided to all in need of emergent care and transportation by either ambulance or patient transport vehicle to health facilities. This is provided through normal emergency medical services daily operations with regards to services to the community.

EMS is managed through a 24 hour control centre (112) for the receipt of emergency calls and the despatch of relevant medical services. In the event of mass casualties, the affected District health activates it mass casualty management plan in accordance with pre-determined response criterion.

x) Communicable Disease Control

The Provincial and Municipal Outbreak Response Teams will continue to provide surveillance of communities with regards to the monitoring of disease management, case definition and regular reporting of suspected cases to the Multi National Outbreak Response Teams (MNORT) as constituted by the Minister of Health. This is managed through the close cooperation of all stakeholders in the respective health district.

6.5. Registration of Volunteer Health Professionals

Disaster management plans enables the Department of Health to effectively manage a disaster by providing clear guidance to those involved in the various facets of the disaster continuum, including health volunteers and disaster relief-organisations. It is envisaged that in addition to this DMP, the PHECC provides guidance on the roles and responsibilities of healthcare volunteers in preparing for and responding to an all-hazards plan, which enables the PHECC to recognise the needs for such preparedness and response.

Volunteers are a key source for increasing the community's prevention, preparedness and response capacity. A written volunteer-management plan needs to be put in place in-conjunction with this disaster management plan, so address the needs of the community whom would offer to assist during a disaster that is managed in a safe and efficient way, providing clarity for response personnel and a means of sharing critical, time-sensitive information with healthcare volunteers

6.6. Critical Infrastructure Protection

Critical Infrastructure Protection (CIP) for our healthcare facilities is a coordinated effort to ensure that our facilities have the plans and programmes needed to prepare for threats to our infrastructure, manage risks and remain resilient during and after a disaster or emergency.

- Disaster management plan - facilitation
- Volunteer program/ selection
- Develop provincial database
- Develop district database
- Incident management systems training
- Provincial disaster management centre bilateral meeting: concept
- District disaster management centre bilateral meeting: concept for districts
- Provincial Health Operations Centre (PHOC) – facilitation

6.9. FATALITY MANAGEMENT

6.9.1. VICTIM INFORMATION CENTRE TEAM – HELPING FAMILIES FIND CLOSURE IN THE WORST OF TIMES

Following a disaster, communities and families need to find closure. The KwaZulu-Natal Department of Health establishes a victim information centre (VIC) team to manage mass fatalities.

The KwaZulu-Natal Department of Health VIC members provide technical assistance and consultation on the collection of management of ante-mortem data and related issues. The VIC team perform a wide range of functions, in-conjunction with the South African Police Service – Victim Identification Centre (Pretoria)

- Collecting dental records, medical records, DNA and other ante-mortem data
- Providing subject matter expertise in mass fatalities management and victim information procurement through various academia.
- Training partners to appropriately gather the information required for victim identification from the family interview process.
- Coordinating with national, provincial, district and local law enforcement agencies by gathering ante-mortem data to facilitate victim identification and manage the missing persons list.
- Updating the Victim Identification Programme database.
- Coordinate the release of remains
- Coordinate the environmental health permits/documentation
- Follow the agreed-upon policy for Mass Deaths in a disaster.

CLUSTERS	HAZARD	ROLE
	• *Emergency sheltering* • *Temperate Extreme*	• Liaison with stakeholders of affected areas • Geo mapping of identified areas for EMS access • Coordination with support services, i.e. SAMHS, SAPS, private EMS and relevant stakeholders. • Personnel and vehicle deployment
• Communication, internal & external		• Provide internal and external communication
• Financial Management		• Manage funding allocation to affected district/ healthcare facilities.
• Pharmaceutical Services		• Coordinate and manage pharmaceutical supplies
• Food Management		• Management food supply to staff and patients
• Health promotion		• Enforce health promotion and health hygiene • Provide health education and training, aimed at preventing environmentally or chemically induced disease occurrence in affected communities during normal times.
• Mental health		• Provide psycho-social services
• Primary Health Care Services	• *Flooding (External)* • *Flooding (Internal)* • *Damaging winds* • *Hail Storm* • *Ecological* • *Severe Thunderstorm* • *Mass Casualty* • *Emergency sheltering* • *Temperate Extreme*	• Continuous monitoring for possible flood victims • Monitor availability of standard treatment guidelines, infection prevention and control, and refresher training for Healthcare workers on management of acute diarrheal diseases including cholera and typhoid epidemics. • Strengthen surveillance: • Identify main disease threats (list of diseases to be monitored). • Weekly/daily reports on diseases of epidemic potential shared with the PHOC, and neighbouring clinics.
• Traditional medicine		• Participate in community awareness campaigns • Imparting of Indigenous knowledge
• Forensic Pathology Services		• Coordinate the storage and management of individual or mass deaths
• PHEOC		• Provide for central communication platform, link

CHAPTER 7

RESPONSE

An essential part of response strategy is ensuring that resources are in place to prevent, minimise or treat health effects to the community when they occur. The KwaZulu-Natal Department of Health is guided by World Health Organisation in its approach to disaster response, by implementing the three response timeframes, i.e. ***Immediate, Intermediate*** and ***Extended.*** The response guide is generic to the Department of Health, at healthcare facility levels; a more institutional response framework is applied to that specific facility' needs.

7.1. Immediate response: Assess the situation – Hours 0 to 2

- Healthcare facilities initiate the response by assessing the situation, either internal or external.
- Contacting personnel within the Department that have a role in disaster response.
- Activating the Public Health Emergency Coordinating Committee (PHECC)
- Notifying and activating the PHOC
- Establish key communication with stakeholders
- Initiating risk communication activities to the public by simple, timely, accurate, relevant, credible and consistent messages.
- Documenting all response activities.

7.2. Intermediate Response – Hours 2 to 6

- Operationalising health surveillance teams
- Identifying laboratories that will be utilised.
- Assessing and addressing the needs of special population i.e. children, women, disabled, elderly etc.
- Activating of health volunteers
- Updating risk communication messages
- Collecting and analysing available data through health surveillance and laboratories.
- Assessing health resource needs

7.3. Extended Response – Hours 12 to 24

- Addressing mental and behavioural health support needs

7.4. Strategic focus

Strategic deployment of health teams based upon analysis and assessment from the KwaZulu-Natal Provincial Disaster Management Centre to most affected communities and health facilities.

Consistently improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability during the disaster.

7.5. Coordination

In addition, the establishment of the PHECC is the key to the prevention and mitigation of the effects of the disaster, as this committee is directly responsible for the management of prevention, mitigation, preparedness and response to affected health facility and communities at risk and will ensure an uninterrupted conduit of vital information from the affected district so as to ensure that immediate response to affected areas is promptly addressed.

7.6. Health Systems

An essential part of response is ensuring that resources are in place to prevent, minimise or treat health effects to the community should they occur. It is therefore imperative that prevention, mitigation and response strategies are put in place to counteract the effects of the drought, by implementing the following measures;

- Undertake situational assessment of identified high risk areas to determine the immediate needs
- To intensify water quality monitoring and monitor water quality data;
- To be able to issue water advisories when needed;
- To communicate the importance of implementing additional water treatment measures where necessary;
- To communicate the importance of hand hygiene and offering alternatives to hand washing when water quantity and quality are severely limited;
- To analyse surveillance data, hospital admissions, disaster-sensitive diseases to determine which diseases are reported more frequently during a disaster;
- To raise awareness and educate people to use water sparingly, re-use grey water for other purposes, other than drinking;
- To intensify health promotion activities to empower affected communities with the knowledge and skills to protect own health and especially the health of children under 5 years that might be highly affected by the effects of the disaster and water scarcity;

The following intends to further define the purpose of the PHEOC in accordance with management of PHECC on matters pertaining to health & medical services that affects the citizens of the province, including visitors

- To facilitate compliance with the International Health Regulations (IHR) 2005 i.e. to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.
- To implement a multidisciplinary, multi-sectoral and integrated coordination approach in managing disasters in accordance with the Disaster Management Act, by preventing or reducing the risk of disasters, mitigating the severity of disasters, emergency preparedness, rapid and effective response to disasters and post-disaster recovery
- To serve as the operational arm to the Department of Health/ PHECC on public health events and threats to the healthcare system.
- To coordinate with technical task teams also known as Priority Committees for the specific public health events.
- To coordinate and collaborate with sector departments, provincial counterparts and global stakeholders World Health Organisation (WHO) on public health events.
- Liaise and coordinate with the National Department of Health Operations Centre (NatHOC), non-governmental organisations, communities or the private sector on any matter relating to public health emergency.
- Undertake a comprehensive health disaster risk assessment in-conjunction with the PHECC.
- Develop and implement disaster medicine policies, plans, programmes and projects that focus on disaster risk reduction.
- Establish an early warning system in conjunction with Directorates, Clusters and District Health management and promote public awareness on the importance of heeding early warnings.
- Develop and maintain public health information management and communication systems. *PHEOC is the central communication platform, linking all healthcare facilities and internal structures within the Department of Health in the province.*
- Liaise and coordinate with Provincial counterpart of National Institute of Communicable Disease (NICD) Emergency Operations Centre (EOC) on data flow, information sharing and reporting.

- Additional manpower
- Logistics
- Safety and Security
- Outpatients
- Laboratory
- Blood Bank
- Central Supply Services Department (CSSD)
- Pharmacy
- Radiology Services
- Accident & Emergency Department (A&ED)
- Admission, Discharge and Transfer Unit
- Food Services
- Housekeeping Services
- Information Communication and Technology (ICT)
- Public Relations

7.10. Flow Charts for Emergency/Disaster Response

(Annexure "L") provides for a detailed flow of response of the KwaZulu-Natal Department of Health to emergencies/disasters that may impact our healthcare system.

- Disasters and Health, General
- Earthquake and Disaster Response,
- Drought and Health Response,
- Floods and Health,
- Landslide and Health,
- Volcanic Eruption and Health Response,
- Epidemic Emergencies,
- Fires and Health,
- Food and Emergencies,
- Violence and Public Health,
- Displacement and Health,
- Refugee and Internally Displaced Populations,

CHAPTER 9

INFORMATION MANAGEMENT AND COMMUNICATION – ENABLER 1

The KwaZulu-Natal Department of Health adheres to an integrated information management and communication (Enabler-1) model as summarised in the National Disaster Management Framework (NDMF) as indicated below.

Figure 18: An integrated information management and communication system for disaster risk management

9.1. KEY PERFORMANCE INDICATORS

9.1.1. KPA 1 - INTEGRATED INSTITUTIONAL CAPACITY FOR DISASTER RISK MANAGEMENT

The objective of KPA1 is to outline integrated institutional arrangements within the Department of Health to enable effective implementation of disaster management activities.

The effective integration between institutions in managing disaster risk requires clearly defined communication channels that will ensure fast and accurate messaging.

For this reason the PHECC comprises of representatives from all relevant stakeholders to ensure a constant flow of messages and information through established channels.

The relevant communication mechanisms that will facilitate this flow is identified below. It is envisaged the Department of Health will utilise the PHECC as a vehicle to ensure integration and information flow between various stakeholders.

District health will be responsible to act as a focal point for accurate information and message flow, involving communities and municipal representatives. The Provincial Health office will be responsible to engage with National structures.

9.1.2. KPA 2 – DISASTER RISK ASSESSMENT

The objective of KPA 2 is to ensure that sustainable communities can be built and effective risk reduction programmes can be identified and be put into operation

Assessment of disaster risk requires the involvement of communities/households to ensure sustainability, in order to have continuous community/household involvement, communication channels between communities at risk and risk assessors needs to be established, effective and credible. This requires the development of a public participation strategy and the continuous involvement of community health care workers, health promotion, environmental health and health facilities.

Communication between internal and external stakeholders continually involved with monitoring, update and dissemination of disaster risk information needs to be well defined and executed.

The risk assessment will produce data used for important decision-making and trend analysis, which will require the PHECC to establish the needed communications channels and effective coordination.

No	Risk Reduction Requirement	Communication Mechanism	Protocol
2	• Access to accurate, clear and timely information	• Meetings • Capacity building sessions • Information sessions • E-mail • Phone • Website	• Community Health Worker • Local Healthcare facility • Local Municipality • District Health Management • District health facilities • District Outbreak Response Team (DORT)
3	• Information gathering and sharing	• Meetings • E-mail • Website • Capacity building • sessions	• Community Health Worker • Local Healthcare facility • Local Municipality • District Health Management • District health facilities • District Outbreak Response Team (DORT)
4	• Community capacity building and resourcing	• Meetings • Training/capacity building sessions • Information stations	• Community Health Worker • Local Healthcare facility • Local Municipality • District Health Management • District health facilities • District Outbreak Response Team (DORT)
5	• Awareness creation	• Meetings • Information stations • Flyers/brochures • Posters • SMS	• Community Health Worker • Local Healthcare facility • Local Municipality • District Health Management • District health facilities • District Outbreak Response Team (DORT)
6	• Empower communities to be self sufficient	• Meetings • Training/capacity building	• Community Health Worker • Local Healthcare facility • Local Municipality • District Health Management • District health facilities • District Outbreak Response Team (DORT)
7	• Continuous community/ household involvement	• Meetings • Training/capacity building sessions • Information stations	• Community Health Worker • Local Healthcare facility • Local Municipality • District Health Management • District health facilities • District Outbreak Response Team (DORT)
8	• Sustainability	Meetings Information sessions Training/capacity building sessions Information stations • SMS	• Community Health Worker • Local Healthcare facility • Local Municipality • District Health Management • District health facilities • District Outbreak Response Team (DORT)

No	Response requirement	Communication mechanism	Protocol
	• Real time data received from SA Weather Services and external sources and stakeholders	• Radio • Two-way radio	• District health facilities • District Outbreak Response Team (DORT)
3	• Accurate situational information	• SMS • Phone	• Community Health Worker • Local Healthcare facility • Local Municipality • District Health Management • District health facilities • District Outbreak Response Team (DORT)
4	• Accurate stakeholder information and database	• Website • E-mail	• Community Health Worker • Local Healthcare facility • Local Municipality • District Health Management • District health facilities • District Outbreak Response Team (DORT)
5	• Community and civil society participation	• Meetings • Information stations • Training/capacity building	• Community Health Worker • Local Healthcare facility • Local Municipality • District Health Management • District health facilities • District Outbreak Response Team (DORT)
6	• Strengthen community response ability and efforts	• Meetings • Information stations • Training/capacity building	• Community Health Worker • Local Healthcare facility • Local Municipality • District Health Management • District health facilities • District Outbreak Response Team (DORT)
7	• Structured, well planned coordination	• Meetings • Information documents	• Community Health Worker • Local Healthcare facility • Local Municipality • District Health Management • District health facilities • District Outbreak Response Team (DORT)
8	• Cross border engagement	• Meetings • E-mail • Letters	• PDMC • KZN ProvJOINTS • Port Health • PHOC • National Health - NatHOC

Table 13: Communication Mechanisms

Mechanism	Create Understanding	Speed	Ease of use	Financial cost	Accessibility	Disaster Management Phase
Website	High	High	High	High	High	B,D,A
Email						
SMS						
Letters						
Telephone/mobile phone						
Radio						
Meetings						
Information session/workshop						
Media interviews						
Flyers/ brochures						
Posters						
Information documents						
Information stations/kiosks						
Training or capacity building sessions						
Loudhailer						
Two-way radio communication						
Social media						

Aspects which are important for effective communication and information sharing to enable the various KPAs are:

- Availability of summarised communication protocols and policies parties/individuals responsible for driving communication.
- Availability of full Department of Health disaster management communications plan that would specifically contain key messages to be used, before, during and after an incident.
- Stakeholder issues register available electronically which can be updated continuously and used for analysis.
- Availability of electronic stakeholder map with defined roles and responsibility which can be updated continuously.
- Availability of electronic information and communication flow diagram to include the following;
- Stakeholders
- Roles and responsibilities
- Contact details
- Communication mechanism
- Who will be involved (associated protocols)

9.4. INTEGRATED REPORTING, MONITORING AND EVALUATION

The Disaster Management Act requires that the KwaZulu-Natal Department of Health will monitor, progress, prevention, mitigation, response and compliance with the Act and measure performance in this regard.

Taking into consideration the requirements of the NDMF, the following approach will be followed in this regard:

- Creating a formal disaster management performance management process for KZN Department of Health by developing a series of checklist ***(Healthcare Facility Disaster Management Checklist - Annexure "M")*** to assist with future monitoring and evaluation processes and a procedures guideline document to be used by the Department of Health disaster management function personnel.
- Review results of disasters and major incidents in areas where these have occurred and developing contingency arrangements in the interim from lessons learned.
- Constant progress reporting to the PDMC and National Department of Health or other entities.

9.5. PROCUREMENT *(FUNDING ARRANGEMENTS)*

Funding arrangement for disaster management is specified in the NDMF as indicated below and these guidelines will be followed by the KZN Department of Health.

- Cost expenditure on routine disaster risk management activities must be funded through the budgets of the relevant organs of state.
- Preparedness must be funded through the budgets of national, provincial and local organs of state as part of their routine disaster management activities.

Chapter 6 of the Disaster Management Act outlines two principles that should be applied to funding the cost of a disaster when such an event is declared. Firstly, section 56(2) of the Act states that in the event of a disaster, "national, provincial and local organs of state may financially contribute to response efforts and post—disaster recovery and rehabilitation.

Secondly, the Act assigns the responsibility for repairing or replacing infrastructure to the organ of state responsible for the maintenance of such infrastructure".
The procurement process will be guided by the office of the Chief Finance Officer, with regards to all standard operating procedures (SOP's) for the processing of procurement matters.

- Disaster management planning and risk reduction in the health sector is the responsibility of all healthcare facilities, district health management, stakeholders and role-players in the health sector working with the respective local, district disaster management centres and functionaries. .
- Disaster prevention, mitigation, preparedness, response, recovery and rehabilitation remain the primary responsibility of the respective district health office.

9.7. PRIORITY ISSUES

The specific priorities identified for disaster management in the health sector over the next 5 years.

Table 14: Disaster Management Priorities

Priority	Primary Responsibility
Detailed resource and capacity analysis regarding disaster management capabilities in the KZN Department of Health will be conducted	Disaster Management
Ensure institutional structures i.e. Public Health Emergency Coordinating Committee (PHECC) and capacity is in place to effectively implement the strategic directives and priority actions identified in this strategy.	Disaster Management and all District health Office. Office of the DDG – Clinical Support Services
Health and medical services related disaster management capacity building, training and guidance to the health sector	Disaster Management/ PHECC/
Development of a health sector-related disaster management communication and awareness strategy	Disaster Management – Communication
Undertake scientific health hazard related disaster risk assessment	PORT/DORT
Drafting risk reduction and contingency plans on prioritised health related risks	District Health Office/ Healthcare facilities, relevant stakeholders
Developing disaster management plans for all healthcare facilities	District Health Office

- Walkthroughs, workshops or orientation seminars
- Table-top exercises
- Functional exercises i.e. per unit, directorate, and communication centre etc.
- Full-scale exercises

Walkthroughs, workshops and orientation seminars are basic training for team members, which is designed to familiarise team members with emergency response, business continuity and crisis communication plans and their roles and responsibilities.

Table-top exercises are discussion-based sessions where team members meet in an informal classroom setting to discuss their roles during an emergency and their responses to a particular emergency situation.

The facilitator guides participants through a discussion of one or more scenarios. Many table-top exercises can be conducted in a few hours, so they are cost-effective tools to validate plans and capabilities.

Functional exercises allow personnel to validate plans and readiness by performing their duties in a simulated operational environment. Functional exercises are designed to exercise specific team members, procedures and resources (e.g. communications, warning, notification and mobilisation protocols and equipment set-up).

Full-scale exercise is close to the real incident as possible, which takes place on location using as much as possible the equipment and personnel that would be called upon in the real event. Full-scale exercises include the participation of all necessary sector departments. The testing of the disaster management plan will take place bi-annually with at least one full-scale exercise annually.

10.2. Review of Disaster Plans

Regular reviewing of this disaster management plan is essential to ensure legislative requirements, minor reviews will be done annually and major reviews to be done bi-annually or whenever there is a change in the institution that will compromise the effectiveness of this disaster management plan.

Such changes may include;

- Changes in management, funding, legislative requirements or processes.
- Identification of new hazards
- Changes to the physical work site, infrastructure or workforce population.
- The discovery of weaknesses during drills, tests or exercises that requires corrective actions.

CHAPTER 13

APPROVAL

Custodian of this plan:

The ultimate custodianship of this disaster management plan lies with the Head of Health, Dr SC Tshabalala operationally supported by the Acting Deputy-Director General: Clinical Support Services - Ms P Msimango and Deputy Director-General: Clinical Services – Dr T Moji and supported by the Department of Health nodal point on disaster management.

DIRECTOR: MS BN ZUNGU DIRECTOR: EMERGENCY MEDICAL SERVICES DATE: 27/7/2023	CHIEF DIRECTOR: MR L LANGA CLINICAL SUPPORT SERVICES DATE: 05/08/2023 Recommended/~~Not recommended~~
ACTING DEPUTY DIRECTOR-GENERAL: MS PD MSIMANGO CLINICAL SUPPORT SERVICES DATE: 01/08/2023 Recommended/~~Not recommended~~	DEPUTY DIRECTOR-GENERAL: DR T MOJI CLINICAL SERVICES DATE: 31/8/2023 Recommended/~~Not recommended~~
HEAD OF HEALTH: DR SC TSHABALALA KWAZULU-NATAL DATE: 2023-12-04 APPROVED/~~NOT APPROVED~~	