Province of the
EASTERN CAPE
HEALTH

# ANNUAL PERFORMANCE PLAN

2019/20

*Together, moving the health system forward*

2030 NDP

Province of the
EASTERN CAPE
HEALTH

# ANNUAL PERFORMANCE PLAN 2019/20

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# ABBREVIATIONS & ACRONYMS

| | |
|---|---|
| AG | Auditor General |
| APP | Annual Performance Plan |
| AIP | Audit Intervention Plan |
| ART | Antiretroviral Therapy |
| BANC | Basic Ante Natal Care |
| CCMDD | Central Chronic Medicine Dispensing and Distribution |
| CFO | Chief Financial Officer |
| CIDB | Construction Industry Development Board |
| CSSD | Central Sterile Supply Department |
| CHCs | Community Health Centres |
| CQI | Continuous Quality Improvement |
| DCSTs | District Clinical Specialist Teams |
| DDG | Deputy Director General |
| DHIS | District Health Information System |
| DHIMS | District Health Information Management System |
| DHS | District Health Services |
| DM | District Municipality |
| DMT | District Management Team |
| EC | Eastern Cape |
| ECDoH | Eastern Cape Department of Health |
| ECAC | Eastern Cape AIDS Council |
| ECSECC | Eastern Cape Socio-Economic Consultative Council |
| EDR-TB | Extreme Drug Resistance Tuberculosis |
| EMS | Emergency Medical Services |
| ESMOE | Essential Steps in the Management of Obstetric Emergencies |
| GIAMA | Government Immovable Asset Management Act |
| GP | General Practitioner |
| HST | Health Sciences and Training |
| HAST | HIV & AIDS, STI and TB control |
| HCSS | Health Care Support Services |
| HFM | Health Facilities Management |
| HIV/AIDS | Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome |
| HPRS | Health Patient Registration System |
| HPTD | Health Professionals Training and Development (Grant) |
| HRM | Human Resource Management |
| HRD | Human Resource Development |
| HRH | Human Resources for Health |
| ICRM | Ideal Clinic Realisation and Maintenance |
| ICT | Information and Communications Technology |
| IDMS | Infrastructure Delivery Management System |
| IDIP | Infrastructure Delivery Improvement Programme |
| IMCI | Integrated Management of Childhood Diseases |
| IMR | Infant Mortality Rate |
| ISHP | Integrated School Health Programme |
| LEDIS | Local Economic Development Implementation Strategy |
| MDGs | Millennium Developmental Goals |
| MDR-TB | Multi-drug resistant TB |
| MEC | Member of the Executive Council |
| METROs | Medical Emergency Transport and Rescue Organizations |
| MLSIP | Medico Legal Strategy Implementation Plan |
| MMR | Maternal Mortality Ratio |
| MTCT | Mother-To-Child-Transmission |
| MTSF | Medium Term Strategic Framework |
| MTEF | Medium Term Expenditure Framework |
| NCDs | Non-Communicable Diseases |
| NCS | National Core Standards |
| NDoH | National Department of Health |
| NDP | National Development Plan |
| NHI | National Health Insurance |
| NHLS | National Health Laboratory Services |
| NSDA | Negotiated Service Delivery Agreement |

| | |
|---|---|
| NTSG | National Tertiary Services Grant |
| O&P | Orthotic and Prosthetic |
| OHH | Outreach Households |
| OPD | Outpatient Department |
| OTP | Office of the Premier |
| PAJA | Promotion of Administration Justice Act |
| PAIA | Promotion of Access to Information Act |
| PDE | Patient Day Equivalent |
| PDMT | Provincial District Management Team |
| PDP | Provincial Development Plan |
| PERSAL | Personnel and Salaries |
| PGDP | Provincial Growth and Development Plan |
| PHC | Primary Health Care |
| PMTCT | Prevention of Mother-To-Child Transmission |
| PPPs | Public-Private Partnerships |
| PPTICRM | Perfect Permanent Team for Ideal Clinic Realization and Management |
| RPHC | Re-engineering the Primary Health Care System |
| SDGs | Sustainable Development Goals |
| SCM | Supply Chain Management |
| SOP | Standard Operating Procedure |
| Stats SA | Statistics South Africa |
| TB | Tuberculosis |
| TROA | Total clients remaining On ART |
| UTT | Universal Test and Treat |
| WBPHCOTs | Ward-Based Primary Health Care Outreach Teams |

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# FOREWORD BY THE EXECUTIVE AUTHORITY

It is my great pleasure to submit the Annual Performance Plan (APP) for the final year of the Medium Term Strategic Framework (MTSF) 2015/16 – 2019/20 which is the fifth term of government. The Eastern Cape Provincial government declared this period as a period for accelerated delivery of services to the people of the Province in recognition of an obligation to achieve the health targets outlined in the Eastern Cape Department of Health (ECDoH) five-year Strategic Plan 2015/16 – 2019/20. The ECDoH has set very ambitious goals to achieve the targets that are articulated in both the Provincial and the National Development Plans.

This plan hence provides a clear outline on how the department aims to carry through its mandate during the financial year 2019/20 to make certain our people access to quality health care and consequently a better life for all. In doing so, the department will ensure that an efficient health service is provided to all our clients, regardless of their economic classification in society to reduce the burden of disease.

As the department, we remain committed to implementing the key priorities of the health chapter of the NDP 2030, which envisage an increase in life expectancy rate to at least 70 years for men and women; HIV free youth (under 20s); radical reduction of quadruple burden of disease; an infant mortality rate of less than 20 deaths per thousand live births and an under five mortality rate of less than 30 deaths per thousand; as well as availability of universal health coverage. The Department recognises the importance of disease prevention, prioritises community engagement and involvement through PHC re-engineering, a component of the National Health Insurance (NHI) as a national strategy. During this last year of the MTEF, the DOH having achieved the target to pilot NHI in two Districts of the EC Province, will start ensuring that this programme is rolled-out to all other districts of the EC Province. These efforts get complimented with the ***Thuma-mina Health Outreach*** program which re-enforces the community engagement, increase health awareness and access to health services.

This Annual Performance Plan contains the department's detailed targets for the 2019/20 financial year to fulfil its objectives and mandate. We are proud that some of the targets in the five-year strategic plan had been achieved as articulated in the five-year progress report 2014/15 – 2018/19 of the ECDoH. During this last lag, every effort will be put towards meeting those targets not yet achieved whilst sustaining the gains achieved thus far.

This Annual Performance Plan hence carries the department's pledge for delivery of a quality healthcare service which has far reaching impact on our people and communities, highlighting health's importance as a priority of the governing organisation.

We are continuing to strengthen with great appreciation our collaboration and partnerships with the community structures, non-profit organisations, the NDoH and the sector departments in realising the social determinants of health. As we move forward with our plans, special emphasis will focus on addressing the upstream factors of these social determinants of health in an integrated manner.

And finally, I would like to express my sincere appreciation to the ECDoH employees and service providers who tirelessly soldier on even during difficult moments, doing more with less within a shrinking economic space.

**Hon S, Gomba MPL**
**MEC for Health**

# STATEMENT BY THE HEAD AND ACCOUNTING OFFICER OF THE DEPARTMENT

As we come to the end of the 5-year strategy 2015/16-2019/20 implementation, we have taken stock of progress made over the last 4 years and ensured that our plans for the 2019/20 are aligned with our promise to deliver quality health services to people of the Province. The plans, as captured in this 2019/20 Annual Performance Plan are premised on the National Development Plan's "Vision 2030", the State of the Nation Address, the State of the Province Address and the Provincial Medium Term Strategic Framework.

The department continues to be confronted with challenges of a shrinking fiscal envelope, the increasing demand for services, and the scourge of medico legal claims. The department has developed its medico legal strategy to deal with the medico legal challenges using an approach of doing much more with less resources, strengthen our clinical practices to improve quality of care especially on maternal and child health services, and intensify efforts to implement the departmental multi-pronged medico legal strategy. We are confident that the priorities we will pursue in the year under review, will yield positive results. For the 2019/20 year, we will therefore be focusing on the following key focus areas as the department:

- Expansion of the primary health care system with a focus on community health worker programme;
- Roll out of quality health improvement plan in public health facilities to ensure that they meet the quality standards required for the certification and accreditation for NHI
- Strengthening the public health system to deliver services covered by NHI; Delegating responsibility to district and frontline health service managers in hospitals and clinics that will significantly reduce patient waiting times;
- Development and implementation of a comprehensive strategy and operational plan to address human resources requirements, including filling of critical vacant posts;
- Strengthening the Mandela-Fidel Castro programme to supplement the production of much needed medical practitioners and collaboration with local universities;
- Enhance management and leadership of the entire health sector to ensure improved service delivery;
- Development and implementation of comprehensive policy and legislative framework to mitigate the risks to medico legal litigation.
- Development of a streamlined, integrated information system for decision-making in support of implementation that will remove duplication at all levels.
- Implement and drive national health wellness and healthy lifestyle campaigns to reduce the burden of disease and ill health including testing people for TB and initiating treatment for those with the disease, as part of ensuring that by 2020, 90% of all people with HIV know their status, 90% of those who know their status and are HIV positive are put on treatment and 90% of those on anti-retroviral are virally suppressed.

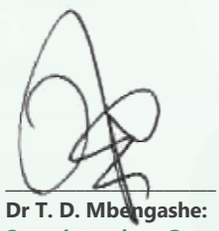
As the department, we will implement the following plans that give effect to these priorities:

- Strengthen the provision of universal access to public health services within a district which will be based on lessons learnt from the national OR Tambo pilot site as well as the Alfred Nzo pilot site districts. The lessons learnt will be incorporated into the NHI streams of Ward Based Outreach Teams, Integrated School Health Program (ISHP), Ideal Clinic Realisation and Maintenance, District Clinical Specialist Team, GP based contracting at CHC and PHC level, and the implementation of Thuma Mina outreach community services.
- The hospital services will include major revitalization of provincial and regional hospitals to meet the requirements of the Office of Health Standards Compliance. The hospitals will be accredited by the NHI to be providers of choice for personal health care and hospital based universal access services.
- The department of health will fast track the implementation of the new organogram micro structures as of April 2019. The health reform agenda will reposition the department of health as a provider of choice through a radical change in the strategy, function and structure of the health department into a lean head office, strong NHI districts, decentralized support services, priority investment in frontline services, strong outreach and down referral service delivery platform.
- The HR reform will include opportunities for task shifting by investing in speciality training for 2000 professional nurses in psychiatry, orthopaedic, theatre, neonatal, PHC and advanced midwives to complement scarce specialist services.

- The EMS will be strengthened by incorporating the services in the NHI district to ensure EMS services that respond to the needs of district. The strategy for EMS maintenance and operation will be strengthened by introducing strong ICT based logistics support and achieve quick turnaround times for emergency vehicle repairs.
- The program to strengthen 26 district hospitals as centres of excellent for maternal and neonatal health services will be strengthened as part of rigorous drive to eliminate avoidable maternity related adverse events and reduce exposure of the department to medico legal litigation.
- The infrastructure program will shift focus from building new facilities or major rehabilitation of health infrastructure portfolio to meet the Ideal clinic and Office of Health Standards accreditation requirements in readiness for the NHI accreditation. The focus will be planned maintenance and use of maintenance contracts for all health technology equipment.
- The department will focus on reducing the costs of doing business and explore opportunities within the SCM preferential regime to promote SMMEs and will enforce the 30% sub-contractors' provisions and set up a dedicated unit for SMMEs support including the payment within 30 days.

All health programs will be realigned to the priorities of the social cluster strategy to improve key social determinants of health including an integrated program to improve educational attainment, build social compact with local communities for services, promote social cohesion and contribute to economic development and elimination of poverty in particular to the five quintile one districts.

Lastly, I wish to thank MEC Gomba for her support and leadership, our health partners and stakeholders who continue to support us in achieving our objectives. A final word of appreciation goes to the departmental staff, who make it possible for us to provide health services to our people.



**Dr T. D. Mbengashe:**
**Superintendent General**

# OFFICIAL SIGN-OFF OF THE 2019/20 ANNUAL PERFORMANCE PLAN

It is hereby certified that this Annual Performance Plan:

- Was developed by the Provincial Department of Health in the Eastern Cape Province;
- Was prepared in line with the current Strategic Plan of the Eastern Cape Department of Health under the guidance of the MEC for Health, Hon S. Gomba
- Accurately reflects the performance targets which the Provincial Department of Health in the Eastern Cape will endeavor to achieve given the resources made available in the budget for 2019/20

**Dr S.T. Moko**
**Chief Director: Strategy and Organizational Performance**
**Date**: 27 /06/ 2019

**Mr S. Frachet**
**Acting Chief Financial Officer**
**Date**: 27 /06/ 2019

**Dr T. D. Mbengashe:**
**Accounting Officer**
**Date**: 27 /06/ 2019

APPROVED BY:

**Hon S. Gomba, MPL**
**Executive Authority**
**Date**: 27 /06/ 2019

# PART A
# STRATEGIC OVERVIEW

# Part A

## Strategic Overview

### 1. Vision

A quality health service to the people of the Eastern Cape Province, promoting a better life for all.

### 2. Mission

To provide and ensure accessible, comprehensive, integrated services in the Eastern Cape, emphasizing the primary health care approach, optimally utilizing all resources to enable all its present and future generations to enjoy health and quality of life.

### 3. VALUES

The department's activities will be anchored on the following values:

- Equity of both distribution and quality of services
- Service excellence, including customer and patient satisfaction
- Fair labour practices
- Performance-driven organization
- High degree of accountability
- Transparency

### 4. Strategic Goals

The Eastern Cape Department of Health, in the final year of the 2015/16 – 2019/2020 strategic plan implementation, continues to contribute to its obligations of the National Development Plan (NDP) 2030 through the identified three strategic goals. These goals are:

- Prevent and reduce the disease burden and promote health
- Improve quality of care and
- Universal health coverage

The Annual Performance Plan (APP) is aligned to the Medium Term Strategic Framework, the Five-year Strategic Plan, the Provincial Development Plan, the National Development Plan and Sustainable Development Goals (SDGs).

### 4.1 Sustainable Development Goals 2030

The National Department of Health has adopted and will contribute to the Sustainable Development Goals as well as the National Development Plan. Health is centrally positioned within the sustainable development goals, addressed through goal 3" ensuring healthy lives and promoting well-being for all at all ages". This provincial plan will attempt to address the priorities of the SDGs through implementation of the National development plan 2030 priorities and targets.

### 4.2 National Development Plan 2030

The National Development Plan (NDP) sets out nine (9) long-term health goals for South Africa. Five of these goals relate to improving the health and well-being of the population, and the other four deals with aspects of health systems strengthening.

By 2030, South Africa should have:

1. Raised the life expectancy of South Africans to at least 70 years and an AIDS-free under 20 years' generation
2. Progressively improve TB prevention and cure
3. Reduce maternal, infant and child mortality
4. Significantly reduce prevalence of non-communicable diseases
5. Reduce injury, accidents and violence by 50 percent from 2010 levels
6. Complete Health system reforms
7. Primary healthcare teams provide care to families and communities
8. Universal health care coverage
9. Fill posts with skilled, committed and competent individuals

### 4.3 Provincial Development Plan

The Provincial Development Plan (PDP) of the Eastern Cape is rooted in the NDP, and was developed collaboratively

with citizens, organizations and institutions within and outside the Province.

There are five related goals that inform the PDP. The five goals are interrelated, for example, good health (goal 3) is important for effective learning (goal 2) and productive economic activity (goal 1). Achieving the first three goals will inevitably create more vibrant communities (goal 4). The fifth goal, capable and accountable institutions, enables the implementation of first four goals.

## GOAL 3: A HEALTHY POPULATION

The PDP is premised on the constitutional aspiration of improving the quality of life for all citizens. It seeks to ensure that all citizens of the Eastern Cape live longer healthy lives. This will mainly be achieved by providing quality healthcare to people in need. The health system must value patients, care for communities, provide reliable services and value partnerships. In addition, the system should rest on a good primary healthcare platform and be integrated across primary, secondary and tertiary levels of healthcare.

To improve the health profile and achieve NDP 2030 targets which aims to increase life expectancy of 70 years and an AIDS-free under-20 generation, the objectives and strategic actions for this goal are:

- **Health system stability through primary healthcare re-engineering**. The Eastern Cape Department of Health aims to invest its priorities and place people-centred primary healthcare above Hospital-based curative care. This will require system re-engineering and public commitment and support. A strong primary healthcare system would lay the foundation for a service delivery platform that strengthens health care. The health care systems comprise of the following: Integrated School Health Programme, Ward-based Outreach Teams (WBOTs), District Clinical Specialist Teams (DCSTs), and General Practitioner Contracting (GPC), as well as the Ideal Clinic Realization Initiative; Central Chronic Medicine Dispensing and Distribution (CCMDD) system, the e-Health and m-Health initiatives, and compliance with the National Core Standards (NCS). The Province aims to improve the health system by building on what exists. Stabilizing the health service platform includes establishing robust referral systems, stabilizing leadership and ensuring appropriate health system financing through budget allocations from the Treasury, the implementation of national health insurance, and the consolidation of robust financial management practices.

- **Quality Improvements**. Health system leaders need to ensure that quality issues in health services are addressed, including workforce planning, development and management; improving the quality of management; enhancing clinical governance; improving workforce skills and knowledge; refurbishing physical infrastructure; ensuring the acquisition and proper maintenance of medical technology; modernizing and improving supply chain management and establishing reliable connectivity in health facilities.

- **Leadership and social partnering**. To improve leadership, the PDP proposes the following critical strategic actions: creating long-term stability, particularly at senior levels, establishing and achieving the requisite knowledge and technical expertise at appropriate levels, and establishing leadership development programmes for health.

- Social partnering refers to community and health-sector integration as well as provincial civic health education campaign. This is underpinned by the belief that individuals and families should take ownership of their health. To encourage social partnering, the PDP proposes the following strategic actions: developing community health education and awareness programmes, intensifying health promotion through the community health worker programme, and improving the level of community commitment to the governance of local health facilities.

- **Social determinants of health and disease**. The social determinants of health in the Province involve a complex mix of political, social and economic issues. They also relate to matters outside the direct scope and control of the Department of Health, such as water, sanitation, nutrition, education, energy, communications, unemployment, transport and infrastructure. As a result, the response to this challenge cuts across various goals in the plan, including improving education, developing the economy and the related positive effect on income and livelihoods, and improving human settlements and other social infrastructure. The plan emphasizes the importance of interventions and programmes to improve nutrition and food security, roads infrastructure, water and sanitation, the safe disposal of refuse and waste, as well as proper spatial planning for human settlements. The health sector should play a role in planning for these programmes.

## 4.4 Strategic Goals of the Eastern Cape Department of Health 2020

The Five-year (2015/16 – 2019/20) Strategic Plan of the Eastern Cape Department of Health has three strategic goals aligned to those of the National Department of Health and will continue to be implemented in the year 2019/20. The strategic objectives are linked to the Medium Term Strategic Framework (MTSF) and the National Health Council Priorities.

Table 1: ECDOH Strategic Objectives, Outcomes and Linkage with the MTSF Expected Outcomes for 2014 - 2019

| MTSF 2014-2019 (Expected Outcomes) | Strategic Objectives | ECDOH Strategic Plan Targets |
|---|---|---|
| • HIV & AIDS and Tuberculosis prevented and successfully managed;<br>• Maternal, infant and child mortality reduced. | • HIV infection rate reduced by 15% by 2019<br>• TB death rate reduced by 30% in 2019;<br>• Child Mortality Reduced to less than 34 per 1000 population by 2019;<br>• Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019;<br>• 40% of Quintile 1&2 school screened by Integrated School Health (ISH) Teams in 2019<br>• Screening coverage of chronic illnesses increased to more than a million by 2019 | • HIV test done – 1 748 488<br>• TB death rate – 5%<br>• Neonatal death in facility rate – 11/1000<br>• Maternal Mortality in facility ratio – 105/100 000<br>• School Grade 1 – learners screened - 48 178<br>• Clients 40 years and older screened for hypertension – 1 500 000<br>• Clients 40 years and older screened for diabetes – 1 542 304 |
| • Improved quality of health care | • Patient/Client satisfaction rate increased to more than 75% in health services by 2019;<br>• Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019; | • Complaint Resolution within 25 working days rate – 85%<br>• District Hospitals achieved 75% and more on National Core Standards self-assessment rate – 42 % |
| • Information System for improved decision making Efficient Health Management | • 100% of health facilities connected to web-based DHIS through broadband by 2019 | • Percentage of hospitals with broadband access – 100%<br>• Percentage of PHC facilities with broadband access – 100% |
| • Improved human resources for health | • First year Health professional students receiving bursaries by 2019 | • Number of Bursaries awarded for first year medicine students – 10<br>• Number of Bursaries awarded for first year nursing students – 350 |
| • Improved health management and leadership | • Unqualified audit opinion achieved by 2019 | • Audit opinion from Auditor – General – Unqualified Audit Opinion |

# 5. Situational Analysis

## 5.1 Demographic Profile

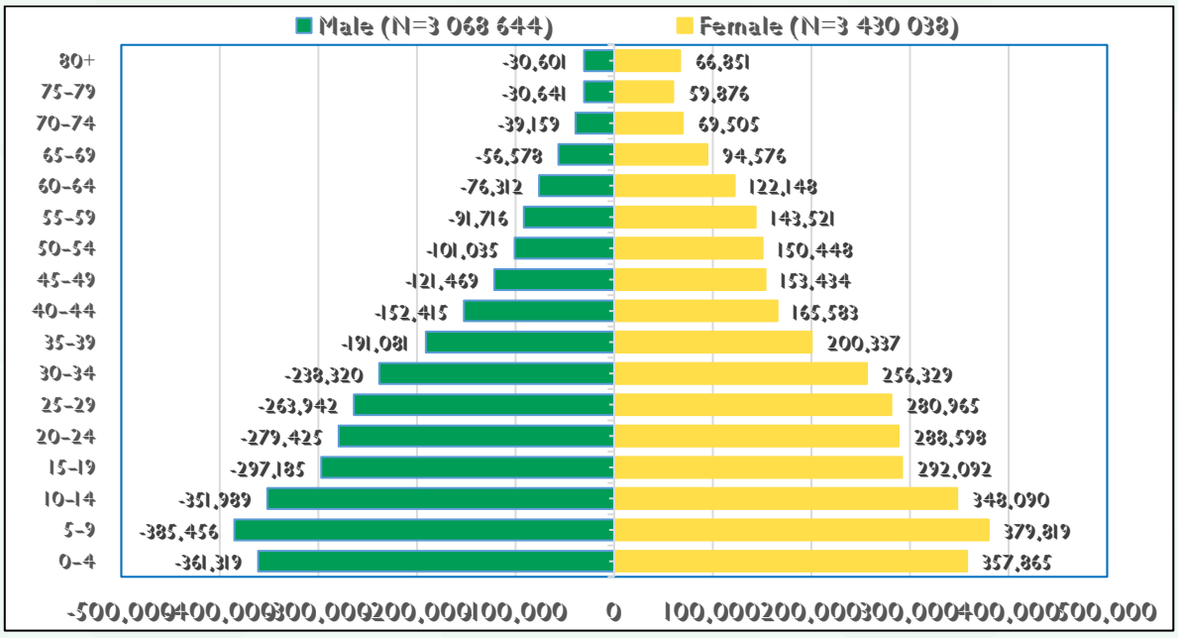
The Province is spread over an area of 168 966 km$^2$ and constitutes 13.8% of the total South African land area as depicted in Figure 1. The total population for the Eastern Cape Province is depicted in table 2 and is estimated at 6 522 734 for the year 2018 with males and females comprising 3 070 981 and 3 451 753 respectively (Statistics South Africa, 2018). The females accounted for more than half (52.9%) of the total population. The largest provincial population (20.8%) are living in OR Tambo district while Joe Gqabi district has the smallest (5.3%) of the total EC provincial population (Table 2).

The Eastern Cape Province is home to a largely younger population. Children (under age 15) comprise just above one third (34.3%) of the total population, Youth age 15-24 years constitute 17.2% and adults in reproductive age (15-49 years) 48%.(Figure 2)

Figure. 1: District municipalities of the Eastern Cape Province


*Source: Stats SA 2017*

Figure. 2: Eastern Cape Population




Source: Stats Sa 2017

Table 2 below outlines the population distribution by districts, Stats SA 2016

Table 2: Population Distribution by Health District Municipality (DM), 2016 estimates

| District Municipality/ Metro | Total population[1] | Males | Females | % population[2] | Size of Area (km²) [3] |
|---|---|---|---|---|---|
| Alfred Nzo DM | 808 819 | 380 792 | 428 027 | 12.4 | 10731.2 |
| Amathole DM | 854 478 | 402 288 | 452 190 | 13.1 | 21594.9 |
| Buffalo City Metro | 756 637 | 356 225 | 400 412 | 11.6 | 2535.9 |
| Chris Hani DM | 776 205 | 365 437 | 410 768 | 11.9 | 36143.5 |
| Joe Gqabi DM | 345 705 | 162 758 | 182 947 | 5.3 | 25662.7 |
| Nelson Mandela MM | 1 180 615 | 555 833 | 624 781 | 18.1 | 1958.9 |
| OR Tambo DM | 1 356 729 | 638 748 | 717 981 | 20.8 | 12095.5 |
| Sarah Baartman DM | 450 069 | 211 892 | 238 176 | 6.9 | 58243.3 |
| **Eastern Cape** | **6 522 734** | **3 070 981** | **3 451 753** | **100** | **168,966.0** |

**Sources: [1]Stats SA mid-year population estimates, 2018; [2]CS Stats SA 2016; [3]ECSECC 2012**

Based on the Stats SA population estimates and the health facilities headcount, the Department of Health (DOH) District Health Information System (DHIS) estimates the health facilities catchment population which is programmed in the systems to calculate population-based indicators. Due to rounding off, DHIS tend to have higher overall district and provincial population figures than those published by the Stats SA i.e. 6, 52 million versus 7.2 million in DHIS, 2018 revised estimates.

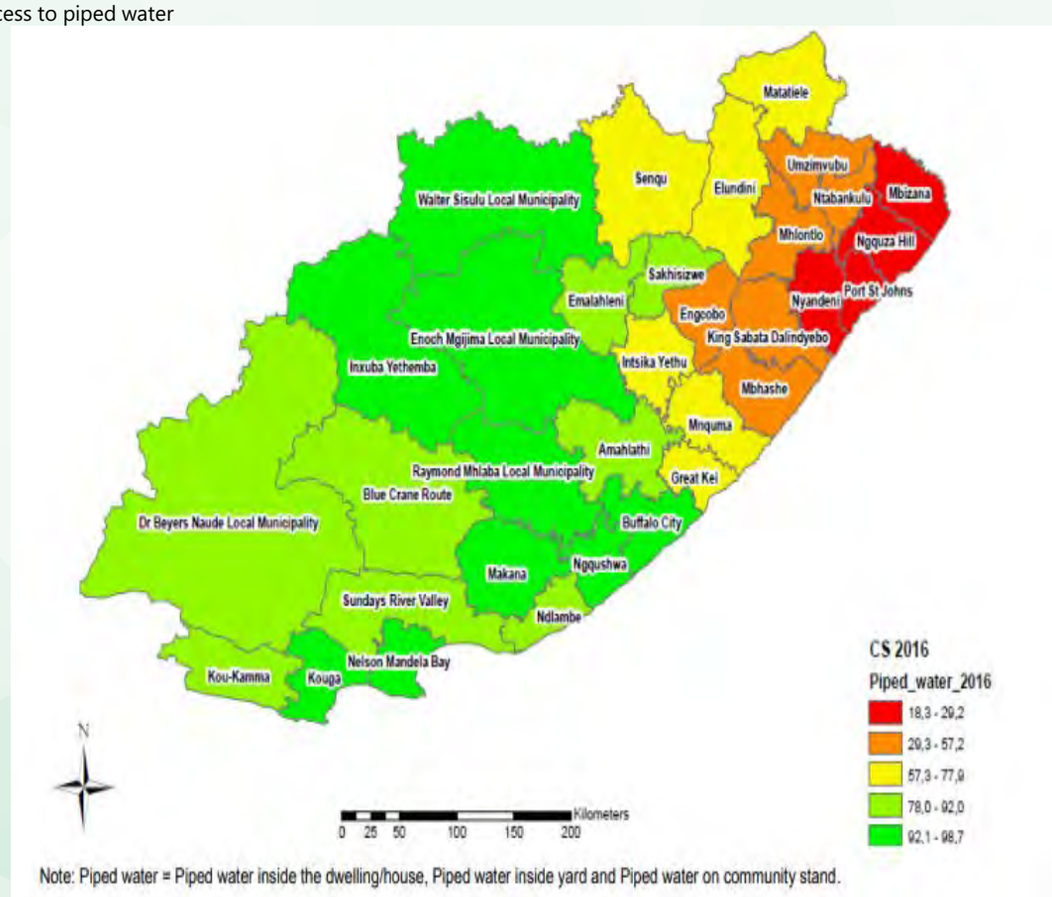
## The Socio-Economic Profile of the Province

Poverty, unemployment, education, housing, access to piped water and sanitation are the social determinants of health that characterize the Eastern Cape Province, in particular the districts of Alfred Nzo, Amathole, Chris Hani and OR Tambo. This is evident in the socio-economic indicators in table 3 below. These poor socio-economic conditions directly affect the health outcomes and the quality of life of the larger population of the Eastern Cape. Alfred Nzo has the lowest percentage of the population with medical aid coverage (at only 3.5%). The huge population has a very limited medical aid coverage, and Province-wide 89.3% of the population depend on government health services or pay for their medical bills in private health facilities.

| Table 3: Social determinants of Health (Source: HST 2017, Stats SA 2016) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **INDICATOR** | **AN** | **AM** | **BCM** | **CH** | **JG** | **NM** | **OR** | **SB** | **EC Prov** |
| Unemployed | 43.5 | 42.9 | 35.1 | 39.0 | 35.4 | 36.6 | 44.1 | 24.9 | 34.4 |
| Youth Unemployed | 52.3 | 53.4 | 45.1 | 48.5 | 43.3 | 45.1 | 54.2 | 31.4 | 34 |
| No Schooling | 9.1 | 10.2 | 4.0 | 12.2 | 8.0 | 2.6 | 13.9 | 4.8 | 6.5 |
| Matric | 16.5 | 19.0 | 31.0 | 20.0 | 19.5 | 34.9 | 18.0 | 24.5 | 64.9 |
| Higher Education | 5.5 | 5.7 | 13.7 | 6.5 | 5.8 | 11.1 | 6.4 | 6.4 | 9.5 |
| Household (HH) | 195 975 | 213 763 | 253 477 | 194 291 | 95 107 | 368 520 | 314 080 | 138 182 | 1 773 395 |
| Female Headed HH | 57.0 | 52.2 | 45.3 | 51.5 | 46.9 | 41.6 | 57.1 | 40.0 | 49.1 |
| Formal Dwell | 42.6 | 55.9 | 70.2 | 56.3 | 69.6 | 92.5 | 43.6 | 87.1 | 65.1 |
| Flush Toilet | 4.2 | 17.0 | 73.1 | 31.6 | 28.2 | 90.5 | 9.4 | 77.2 | 44.4 |
| Weekly Refuse | 5.3 | 17.4 | 57.1 | 27.0 | 34.1 | 84.8 | 9.0 | 83.0 | 41.3 |
| Electricity for Lighting | 63.1 | 82.4 | 86.6 | 89.9 | 80.0 | 95.4 | 83.6 | 91.0 | 83.4 |
| Blue Drop H2O | 62.9 | 80.4 | 72.8 | 83.4 | 75.0 | 72.4 | 48.7 | 61.2 | |
| Medical Aid coverage | 3.5 | 8.7 | 24.6 | 5.9 | 5.0 | 22.6 | 4.6 | 14.6 | 10.7 |

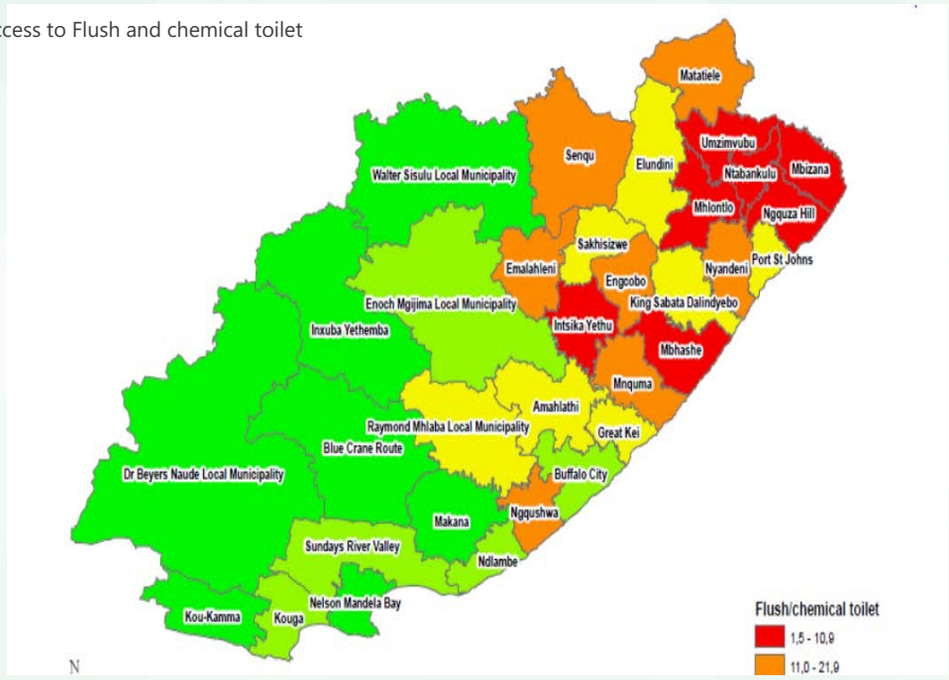
The Province remains spatially imbalanced, with deep deprivations in the rural, north and eastern parts of the Province. The figures 3 & 4 below capture the circumstances of access to piped water and flush / chemical toilets, clearly indicating the deprivations in the same spatial areas. These social determinants of health are directly linked to the health outcomes.

Figure 3: Access to piped water




Note: Piped water = Piped water inside the dwelling/house, Piped water inside yard and Piped water on community stand.

Figure 4: Access to Flush and chemical toilet



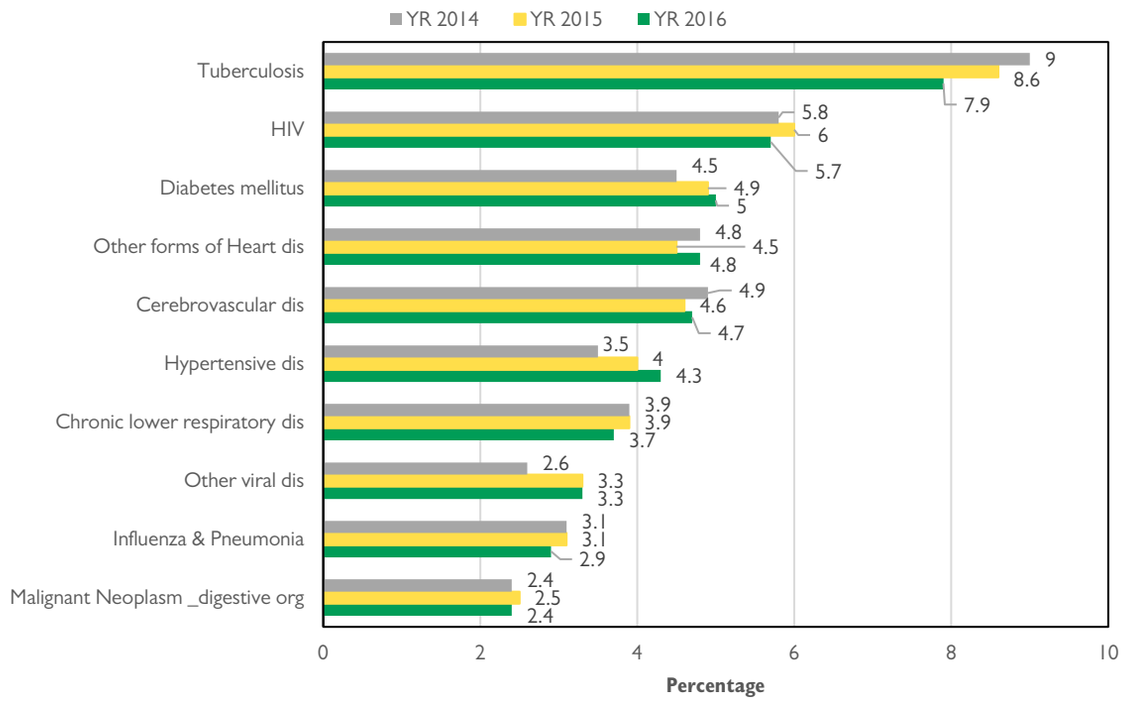

## 5.2 Burden of Disease

The Province is characterized by a quadruple burden of disease- namely communicable (including TB/ HIV/AIDS), perinatal and maternal, non-communicable and injury-related conditions. These are the result of the low socio- economic conditions that directly affect the health outcomes and the quality of life (current health status of an individual).

### The Causes of Mortality

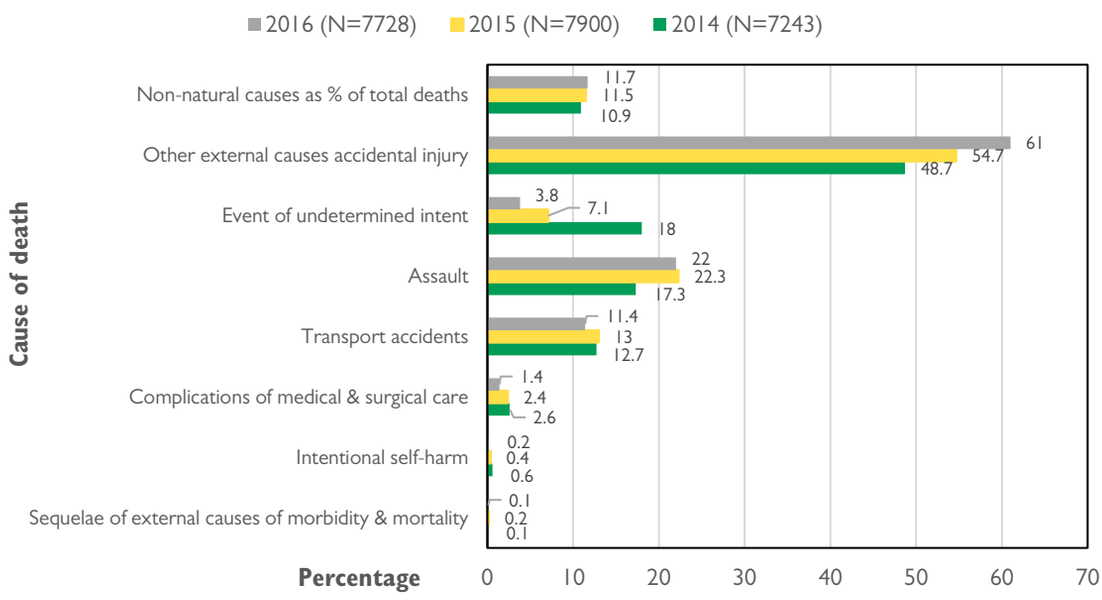
Figure 5 shows the 10 leading causes of death in the EC Province over a 3-year period 2014-2016. The socio-economic conditions play a huge contribution in the fight against morbidity and mortality in particular due to communicable diseases. TB, the leading cause of death in the Eastern Cape Province is showing a steady declining trend which is attributable to efforts to detect clients infected with TB and those co-infected with HIV early through screening and early initiation on treatment.

**Figure 5: Ten leading causes of deaths in the EC Province, 2014 - 2016 (Source: Statsssa death notifications)**




Non-natural causes of death have been increasing over the past three years from 10.9% in 2014 to 11.7 % in 2016 (There was an increase in other external causes of accidental injury whilst the complications of medical & surgical care decreased significantly. Deaths due to assault and transport accidents are significant contributing factors.

**Figure 6 : Non-natural causes of death in the EC Province, 2014-2016**




## Tuberculosis

The TB incidence has been decreasing in the Eastern Cape over the years (Figure 7). The Pulmonary TB new smear positive incidence rate was 300 per 100,000 in 2014 and, thereafter it gradually decreased to a lower rate of 154 per 100,000 in 2017. The distribution by districts has shown that the Nelson Mandela Metro remained with the highest incidence (340 per 100,000)

with the lowest incidence (73 per 100,000) reported by Alfred Nzo district in 2016 (figure 8). All the districts have shown a decline in 2017 when compared against 2016. Decrease in TB incidence can be explained by the introduction of GeneXpert that diagnose resistant TB and allow early initiation of drug resistant TB treatment. The intensification of HIV testing together with screening of these HIV positive clients, controls transmission of TB infection.

Figure 7: TB incidence (per 100 000) in the Eastern Cape Province , 2014 - 2017

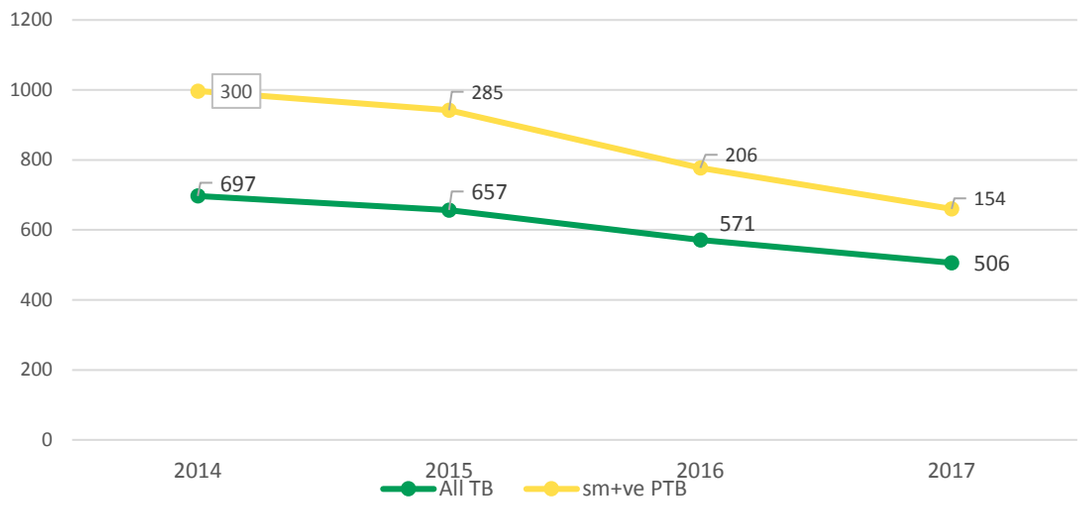
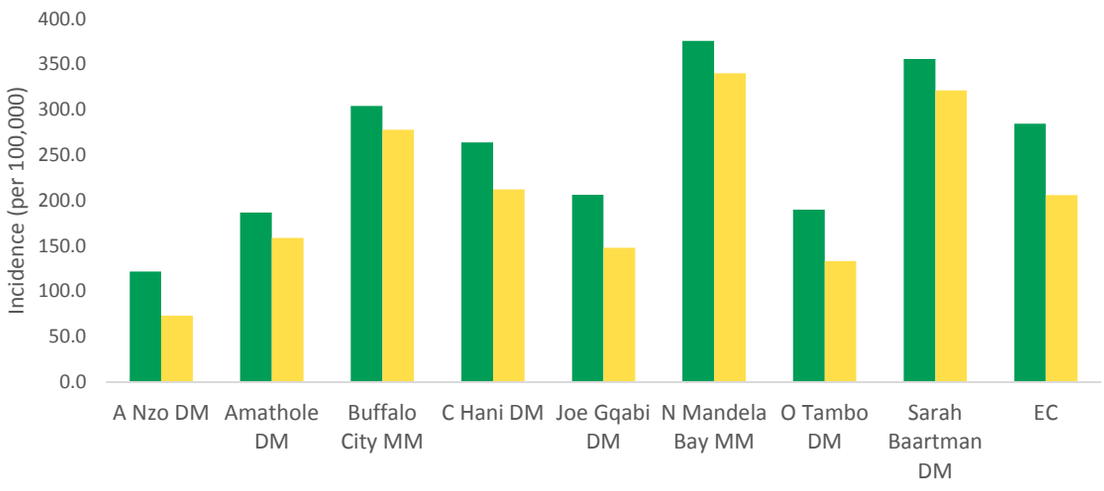



Figure. 8 : TB incidence by district in the Eastern Cape, 2015-2016
(Source: DHIS 2017)




## HIV & AIDS

Figure 9 shows the percentage of clients 15 years and older testing positive for HIV in health facilities. There has been a declining trend in all the eight districts of the Eastern Cape Province. In 2017, Statistics South Africa estimated prevalence in the EC Province to be around 10%; various strategies embedded within the 1st 90 of the 909090 strategy are implemented to maximise positivity yield including testing of key population groups, testing TB patients for HIV and provider-initiated counselling and testing. Latest data has shown high incidence of HIV among youth particularly young women. HIV testing services are targeting this population group as well in order to reduce new HIV infections, STIs and pregnancy rate. Strategies include collaboration

with other government departments e.g. Department of Education as well as non-governmental organisations.

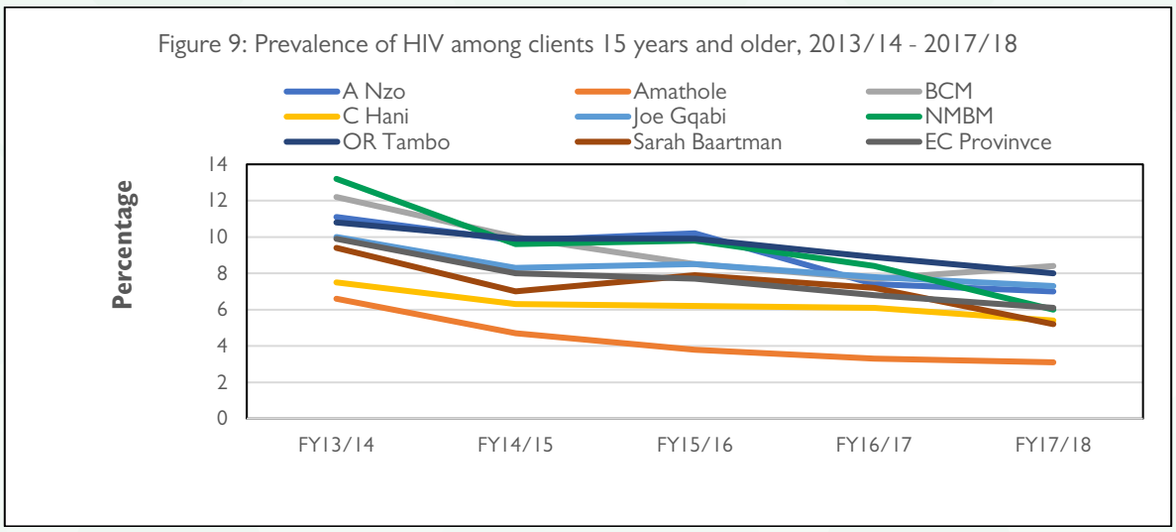
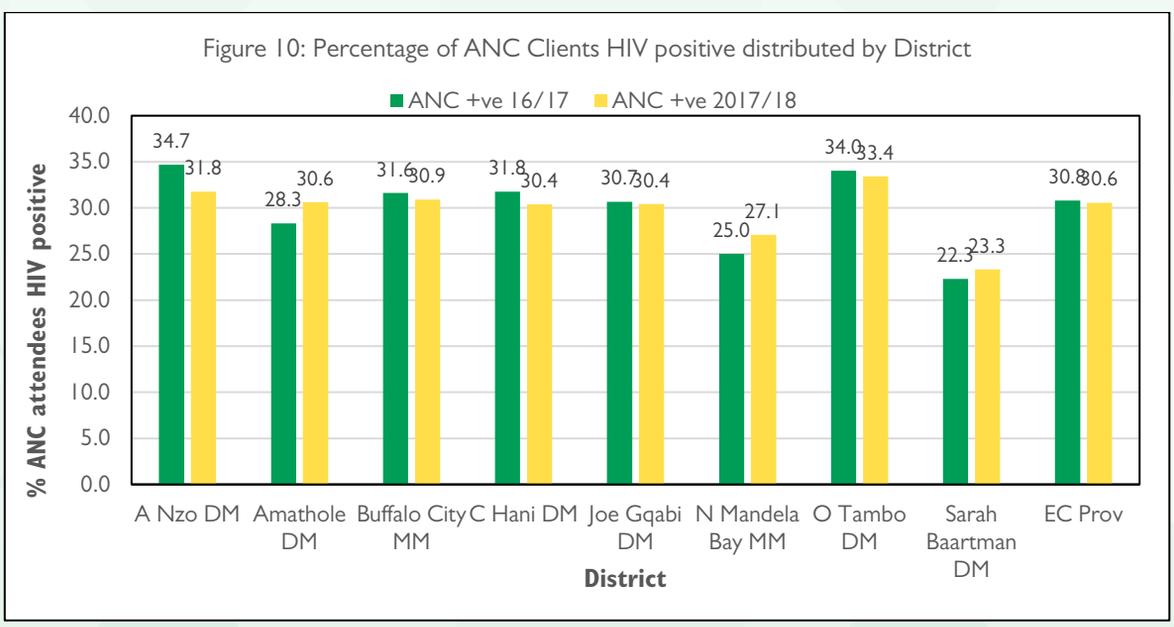


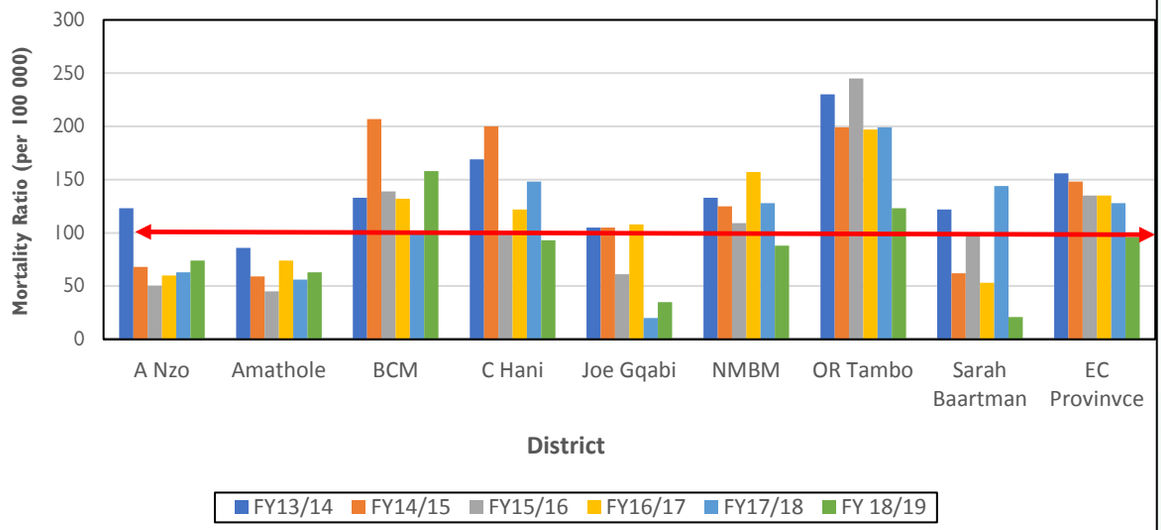

Figure 10 below outlines the percentage of HIV positive ANC clients per district. Alfred Nzo and OR Tambo still show high rates with 31.8% and 33.4% respectively




## Maternal Health

In the EC Province, maternal mortality ratio (MMR) in health facilities is showing a steady declining trend (figure 11). An 18% decrease is observed from 156/100 000 live births in 2013/14 to 128/ 100 000 in 2017/18 financial years. Three districts OR Tambo, Chris Hani and Sarah Baartman recorded MMR that is above provincial average with OR Tambo district with its referral central hospital Nelson Mandela Academic remains the most challenged district. Non-pregnancy related infections (NPRI) including HIV and TB remain the leading cause of maternal deaths. Teenage pregnancy and poor or non-attendance of ANC is another contributing factor that results in severe complications. Hypertension in pregnancy and obstetric haemorrhage rank 2nd and 3rd causes respectively.

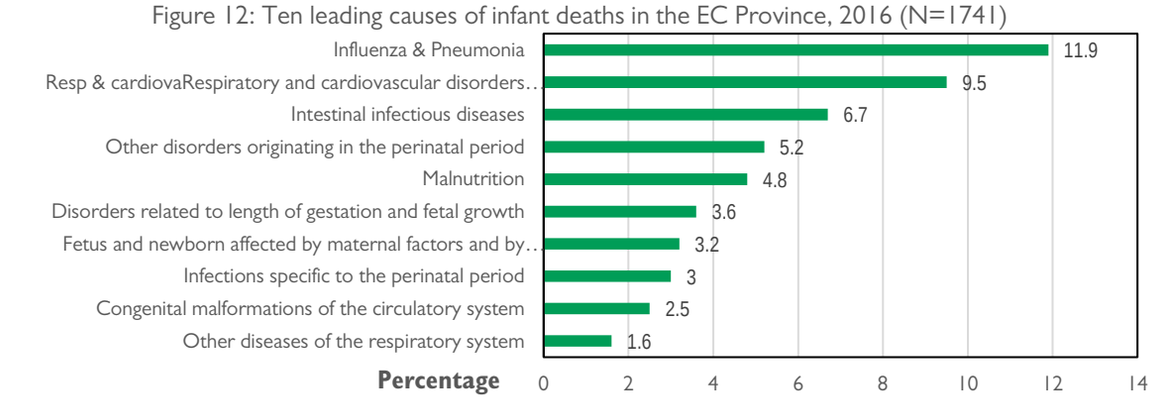
Figure 11 : Maternal mortality in facility ratio/100 000 FY 2013/14 - 2018/19

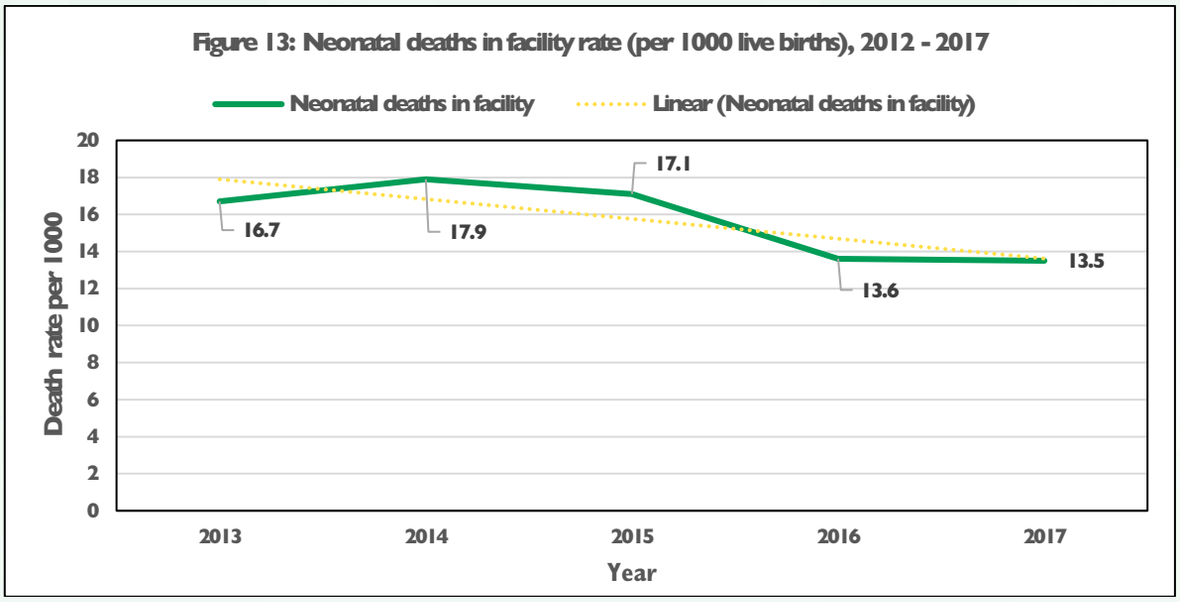


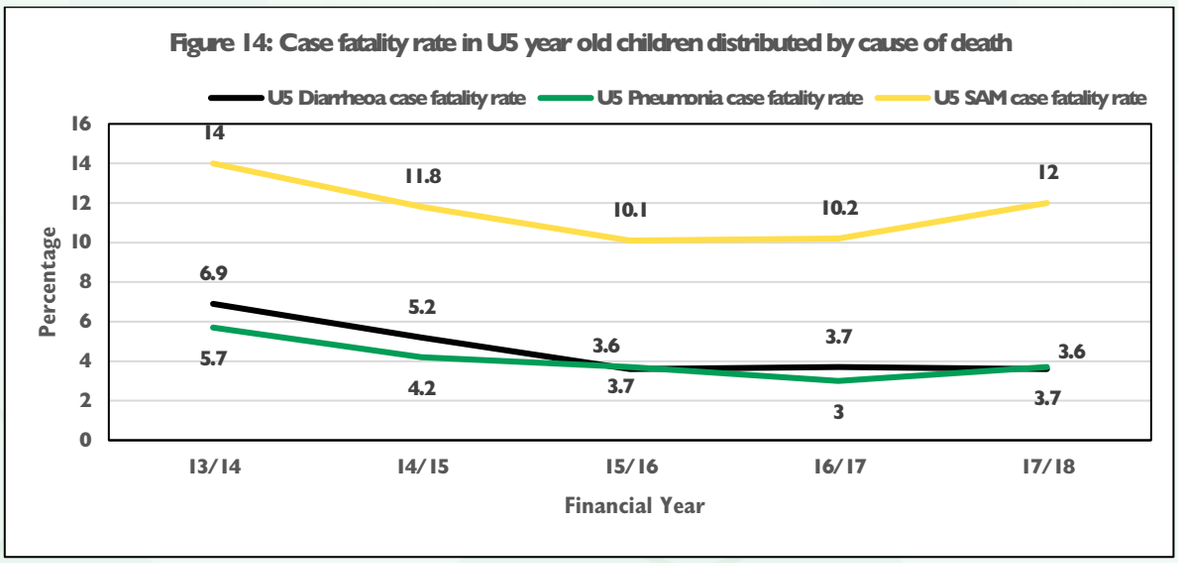

## Child Health

The 10 leading causes of infant deaths in the EC Province are shown in figure 12. Influenza & pneumonia and respiratory & cardiovascular conditions ranked 1st and 2nd causes of death respectively in this population group. Infant mortality rate (IMR) in the EC Province decreased from 20 to 17 per 1000 live births during 2015 and 2016 respectively. Immunisation coverage has been consistently around 69%. Neonatal deaths in facility rate which contributes to infant mortality, is showing a declining trend from 18 in 2014 to 13.5 per 1000 live births in 2017/18FY (figure 13). Similarly, U5 case fatality rate at facility due to diarrhoea, pneumonia and severe acute malnutrition has been showing a declining trend (figure 14).

Figure 12: Ten leading causes of infant deaths in the EC Province, 2016 (N=1741)






## Non-Communicable Diseases

Diabetes and hypertension: Morbidity and mortality due to diabetes and hypertension has been increasing over the recent years. Diabetes and hypertension rank the third and sixth leading cause of death in the EC Province respectively, figures 15 and 16 (StatsSA 2017). In the Nelson Mandela Bay Metro, diabetes is the leading cause of death.

In 2016, diabetes incidence in the EC Province was 2.6 per 1000 population, was highest at C Hani district with 5.5 per 1000 population and lowest at Alfred Nzo with one per 1000 population (Figure 18). The incidence is fluctuating in districts over the years but remains below 3 per 1000 population in most of the districts. The hypertension incidence had been increasing in the Province from 18.2 per 1000 population in 2013/14 to 21.8 per 1000 population in 2016/17 (Figure 15). The Nelson Mandela Metro had been reporting the lowest rates of hypertension incidence in all the past three years prior to 2016/17 wherein the lowest incidence (12 per 1000) was observed in Alfred Nzo district.

Stable adult patients on chronic medication are registered on central chronic medicines dispensation and distribution (CCMDD) model that has both facility based and external pickup points for treatment collection to reduce waiting times at facilities.

Malignant neoplasm of digestive organs ranks the 10$^{th}$ leading cause of death in the EC province. Cancers such as breast and cervical cancers in women, oesophageal and prostate cancers in men and colon cancers in both sexes, predominate oncology presentations at EC hospitals. Cervical screening policy prescribes three cervical smears at 10-year interval for women aged 30 and older. There is a significant improvement in cervical screening program, 81% output in quarter 3 was achieved against a target of 63% set for the period under review and against a baseline of 60% during the previous FY 2018/19. This is because of

the introduction of the liquid cytology technique which makes it easy to get adequate results. The new technique addresses the issues of smear inadequacy and high smear rejection rate by the laboratory when the conventional PAP smear method was used. All districts are performing well on cervical screening indicator due to the training that was conducted on cervical and breast cancer policy. The Department is in the process of developing comprehensive provincial cancer strategy to deal with rising incidence of cancer.

Figure 15: Diabetes incidence in the E Cape, 2013/14 - 2016/17
(DHIS 2017)

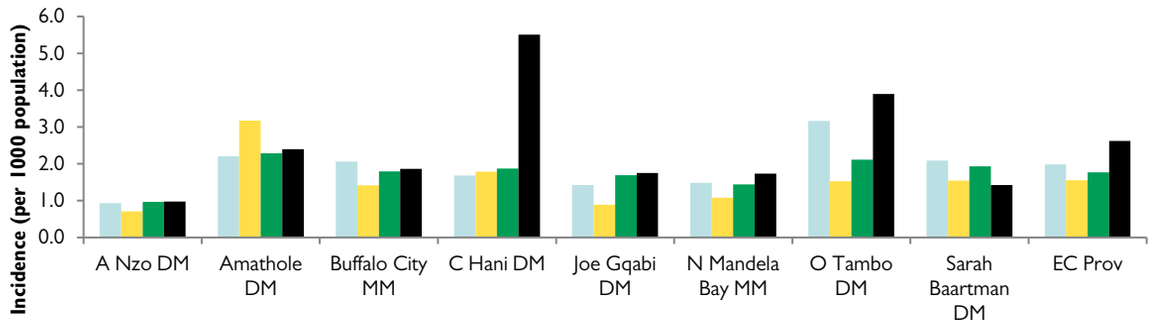
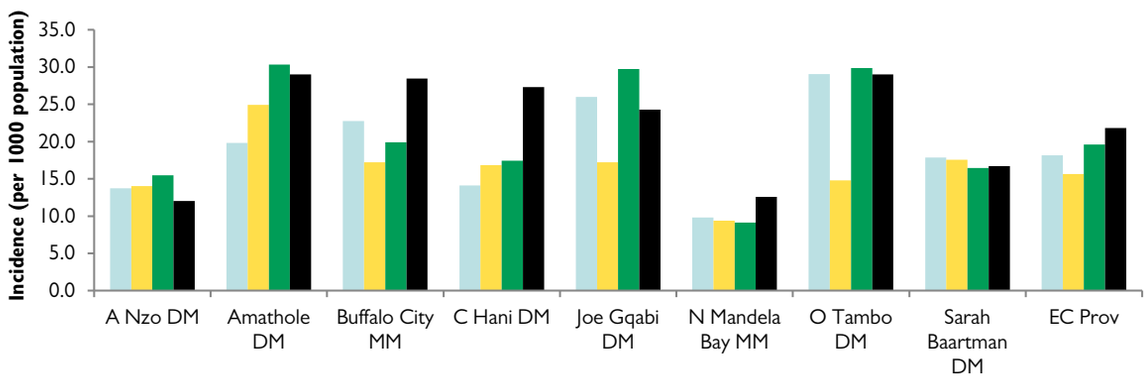



Figure.16: Hypertension incidence in E Cape, 2013/14 - 2016/17
(DHIS 2017)




## Quality of Health Care

Eastern Cape Department of Health is embarking on a revolutionary path to improving service delivery and has emerged with a coherent and concrete strategy to get all health facilities attaining compliance with National Core Standards (NCS), the Six Ministerial Priority Areas and Extreme, Vital and Essential Measures – in the form of the Continuous Quality Improvement [CQI] blue print strategy for institutionalization of the NCS and delivery of quality health services.

The strategy envisaged, entailed implementing a "quality assurance package' at all 864 health facilities in the Province; and in turn was sustained by instilling a quality improvement culture, characterized by an approach of embedding, empowering and capacitating health facilities to attaining compliance with the NCS as decidedly the ultimate goal**.**

The areas of poor outcomes related to the domains of patient rights, patient safety and security, clinical governance and care and infrastructure as well as the ministerial priority areas of waiting times, positive attitudes, availability of medicines and cleanliness.

Overall, in the last five years the Province has demonstrated an upward improvement in assessment outcome scores by the OHSC with a Provincial Average Score of 52%. Significant improvement has particularly been achieved in the Domains of Infrastructure, Patient Rights, ministerial priorities Waiting Times and Positive Attitudes where the highest scores was attained.

# 6. Organisational Environment

## Organisational Structure

The Department has concluded the process of revising its macro organizational structure to align with an improved Service Delivery Model, which has its emphasis on the Primary Health Care (PHC) approach. The departmental macro structure was approved by MEC in March 2018 based on the validation by OTP and concurrence of the Minister for Public Service and Administration and the new organogram is being rolled-out effective from 01 April 2019. Between April 2018 and April 2019 the Department was busy with pre-implementation activities. Furthermore, the department has initiated a Change Management intervention and to-date Top Management and Provincial District Management Team (PDMT) has undergone this training. During the month of February 2019 the Department trained Senior Management on Change Management in order to equip them with skills and competencies to support and lead the change process. Further to this, Train-the-trainer (inclusive of Social Partners) will also be completed during the financial year 2019. The trained trainers will be at local level and assist to drive implementation and strengthen communication.

The organisational realignment is an intentional action by the department to respond to the needs and demands of providing patient centred quality health care services to the people of the Eastern Cape. This is a strategic move to correct the weaknesses of the previous service delivery model and the previous organogram which were more centralised and emphasized curative care as opposed to primary health care.

The characteristics of the new organogram include:

- Delayering and decentralisation of services to districts with emphasis on the Re-engineering of Primary Health Care (Outreach) and implementation of National Health Insurance.
- Emphasis on managing patients as close to home as possible and entering into a social compact with the community
- Lean Head Office that focuses on strategy, policy formulation, monitoring & evaluation and that promotes integration
- Alignment of health services in line with the National Gazette on classification and management of hospitals.
- Reduction on cost of employment by ensuring cost effective structures with optimal staff compliment

The Organisational reform is based on the new organogram and has made provision for strong district and hospital management teams led by high ranking leaders who are empowered to exercise management decisions to manage resources and deliver quality services.

A Migration Plan which has been consulted extensively with key stakeholders and with Social Partners has been developed. The objective of the plan is to provide the framework for inclusivity, and ensuring that there is a single, uniform strategy. This aimed at implementing the repopulation and deployment process and ensure that the procedure is applied in an open, transparent and standardized manner across the board in the implementation of the approved organogram. Furthermore, it ensures compliance with the provisions of the applicable legislative framework.

Other than the retirement of the Deputy Director General for clinical services and the recent transfer out of the Deputy Director General: Chief Financial Officer, the Department has been fully stable at the Executive Management level with the Accounting Officer. The Department has appointed two DDGs to drive the core business of the rendering quality health services across the platform. Most of the SMS positions are permanently filled across the Department and the target has been achieved.

# ORGANISATIONAL STRUCTURE

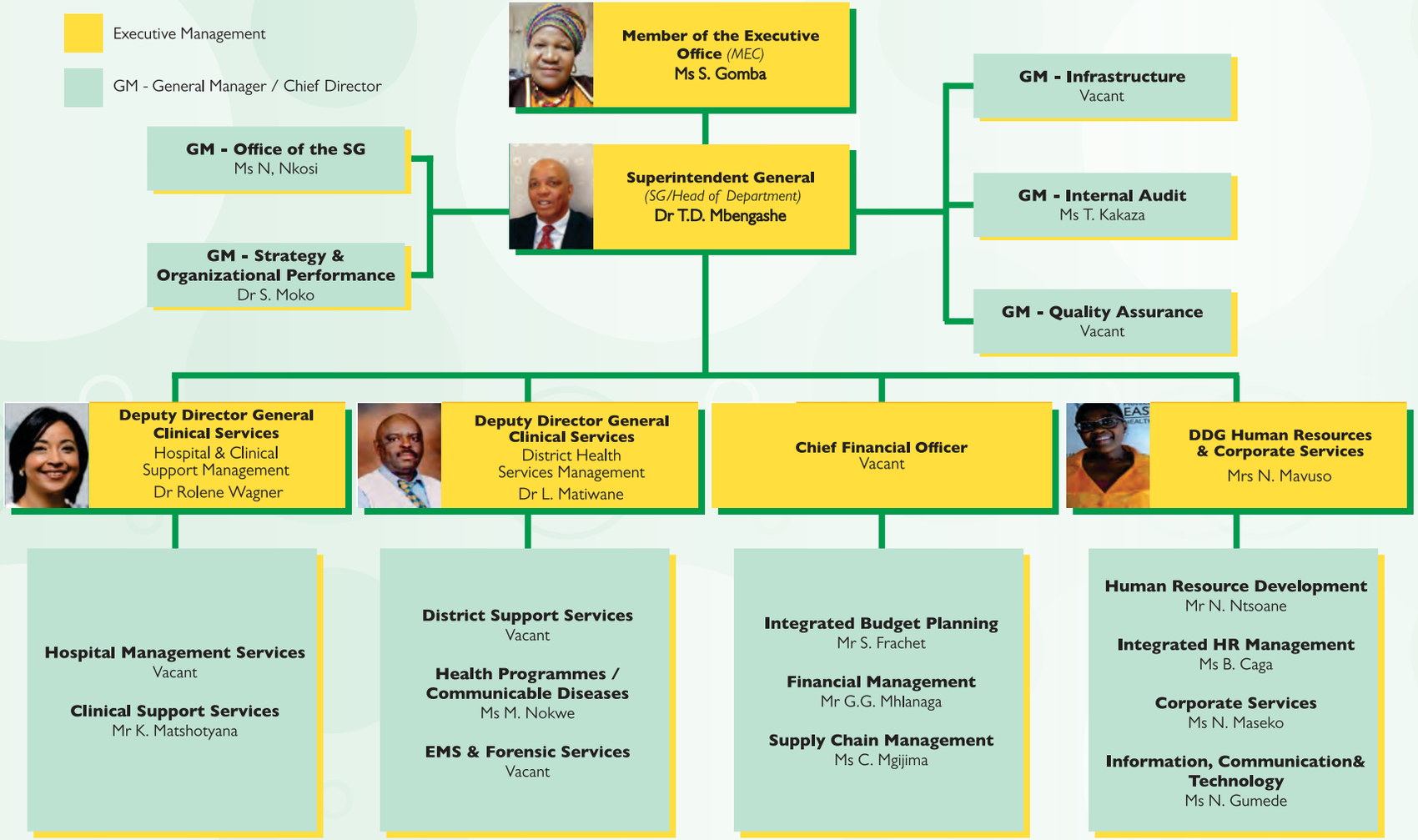


Table 4. Annual turnover rates by salary band for the period 1 April 2018 and 31 March 2019

| Salary band | Number of employees at beginning of period- 1 April 2018 | Appointments and transfers into the department | Terminations and transfers out of the department | Turnover rate |
|---|---|---|---|---|
| Lower skilled (Levels 1-2) | 5 061 | 745 | 185 | 4% |
| Skilled (Levels3-5) | 15 147 | 1 062 | 611 | 4% |
| Highly skilled production (Levels 6-8) | 10 947 | 979 | 770 | 7% |
| Highly skilled supervision (Levels 9-12) | 7409 | 474 | 592 | 8% |
| Senior Management Service Bands A | 85 | 2 | 5 | 6% |
| Senior Management Service Bands B | 15 | 0 | 1 | 7% |
| Senior Management Service Bands C | 7 | 0 | 2 | 29% |
| Senior Management Service Bands D | 1 | 0 | 0 | 0 |
| Contracts | 1 789 | 1 542 | 1 298 | 73% |
| **Total** | **40 461** | **4 804** | **3 464** | **9** |

*Data source: PERSAL*

## Annual Intake of Interns, Community Service and Post-Community Service Employees

The Department takes in this group over the period January to March each year. This includes Medical and Allied Health Interns, Community Service doctors, nurses and Allied Health Workers and Post-Community Service Bursary Holders. The group is further extended to Post Community Service Health Professionals.

For 2019/20 annual intake of Post Community Service, the department took a strategic decision to extend employment to non-bursary holders to ensure increase of staffing levels more especially to the grossly under staffed and prioritised hospitals.

## Annual Recruitment Plan 2019/20

An Annual Recruitment Plan is developed each year and for 2019/20 the department will be recruiting a very limited number of new staff members, as the revised Organogram and the Migration Plan will address the migration of staff from over-staffed facilities (based on the DHIS, WISN and scientific workload indicators) to those that are under-staffed, and the budgets will be adjusted accordingly.

## Legal Services

In order to improve management of Legal Services and the legal support throughout the Department, a Litigation Risk Register was developed, where the recurring risks as identified through the litigation trends analysis against the Department are recorded. This register is also supported by the standard operating procedures which seek to enhance effective resolution of legal disputes as they arise. The highest-level standing risk is still the number of medico-legal claims against the Department, mostly associated with maternity services, followed by non- compliance with PAJA and PAIA legislative mandates, Labour Relations Disputes and Supply Chain Management (SCM) claims for services rendered. Infrastructure or related contractual disputes are also emerging as new problematic risk.

Having alluded to the trends briefly, the Department has identified the litigation trends, associated with medico legal claims, amongst other things as topping the list. Therefore, this has necessitated a step towards a medico legal strategy and its supporting implementation plan, which is developed in line with the Minister's declarations of the Medico Legal Summit 2015, including national and provincial strategy management tool focused at proposed areas of importance of intervention. This strategy is streamlined into 3 main interventions, namely clinical (focus on strengthening of hotspots by recruitment of much needed clinicians, health technologies, rationalization of management of healthcare, administration solutions (improved document management, automated governance and support tools) and legal solutions (strengthening of legal representation and support of the Dept., fraud and corruption fighting strategies). These strategies identified and being implemented collectively and are already yielding positive results in that they are discouraging spurious claims against the State, while we have managed to identify fraudulent claims. We are pleased to state that since the implementation of part of legal strategy, we have significantly reduced contingent liability by more than R 320 Million in a short space of time. We have also seen a huge decline in litigation expenditure associated with such matters, while the influx of new claims is steadily steeping down. We are still growing stronger as we employ more strategies and revise those that are becoming outdated. We are expanding our focus to backlogs which remain a threat risk

There has been a number of matters that are now subjected to further investigation and prosecutions. The milestone covered is

impacting positively towards reduction of fraudulent claims where they have been identified. The strategy extends to legislative reforms proposed by the Department, which to a certain extent has been well received in the healthcare fraternity. This goes to the bottom of State Liability Amendment Bill, and proposed Common Law Reforms which have since bordered on unconstitutionality and hampering on Bill of Rights, in particular amongst other things Section 27 enjoyed by the public at large. The Department continues to encourage the use of alternative dispute resolution such as mediation as first port of resolution of clinical complaints contrary to litigation which will be defended vigorously, where it is embarked. The department as one of its strategies, it also rationalizing the contingent liability with an intention to reduce the same throughout, hence all the strategies under implementation are aimed at reduction of this aspect. The issue of medico legal claims, does not only affect this Department but it's a national phenomenon, which is also receiving attention at that level too. The Department is now considering automated case management system with ability to clean up the contingent liability register, by eliminating duplicates, incompleteness and inaccuracy of records, while also on the other hand PAIA automated management will be incorporated within this tool to also mitigate for challenges surround governance compliance internally and externally in this regard, having identified the root causes for PAIA, are not only within the system, but open to abuse by the public.

It is safe to mention that the Department is adopting a proactive approach to manage litigation trends, and interventions identified have started to yield positive results, while there is still a room for improvement for the Department to be fully compliant.

We cannot ignore other interventions that are clinical and administrative, considering that the critical staff for 26 hotspot facilities have since been recruited, including critical support staff, additional medical equipment, health technology and customized ambulances have been acquired. Legal Support has become critical as an ability to proactively deal with risks. The Department will be establishing the satellite office to focus on hotspots areas, while also supporting the other operational facilities, as we implement a leaner head office and strengthened operational support approach for legal support.

# 7. Provincial Service Delivery Environment

## 7.1 Service Delivery Platform

Table 5: Number of health facilities in the EC Province distributed by district

| DISTRICT | Community Based Services | Clinic | CHC | District hospital | Regional hospital | Central/Tertiary | Other |
|---|---|---|---|---|---|---|---|
| Alfred Nzo | 73 | 72 | 2 | 6 | 0 | 0 | 4 |
| Amathole | 160 | 143 | 5 | 12 | 0 | 0 | 6 |
| Buffalo City | 12 | 74 | 5 | 2 | 1 | 1 | 10 |
| Chris Hani | 147 | 152 | 7 | 14 | 1 | 0 | 9 |
| Joe Gqabi | 56 | 52 | 0 | 11 | 0 | 0 | 3 |
| NMBM | 47 | 39 | 9 | 1 | 1 | 2 | 13 |
| OR Tambo | 124 | 136 | 10 | 9 | 2 | 1 | 8 |
| Sarah Baartman | 21 | 59 | 3 | 10 | 0 | 0 | 10 |
| **EC Province** | **640** | **727**[1] | **41** | **65** | **5** | **4** | **63** |

### District Health Services

The Department provides comprehensive and integrated health services that are based on the Primary Health Care model driven through the District Health System. Various programs are implemented in order to meet the strategic goals of the department. Some of the programs are outlined below.

- **Sub-Programme District Management:** The sub-programme manages the effectiveness and functionality as well as the coordination of health services referrals, supervision, evaluation and reporting as per provincial and national policies and requirement.
- **Sub-Programme Clinics:** The sub-programme manages the provision of preventive, promotive, curative and rehabilitative care, including the implementation of priority programmes through accessible fixed clinics and mobile services in 26 sub-districts (8 Districts).
- **Sub-Programme Community Health Centres (CHCs):** The sub-programme renders 24-hour health services, maternal health at midwifery units and the provision of trauma services, as well as the integrated community-based mental health services within the down referral system.

[1] The department has a total of 731 fixed clinics but functioning currently is 727

## Piloting the National Health Insurance

## Implementation of the Ideal Clinic Realisation and Maintenance (ICRM) strategy

An Ideal Clinic is a clinic with good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes and sufficient bulk supplies, that uses applicable clinical policies, protocols, guidelines as well as partner and stakeholder support, to ensure the provision of quality health services to the community. An Ideal Clinic will cooperate with other government departments as well as with the private sector and non-governmental organisations to address the social determinants of health. Primary Health Care (PHC) facilities must be maintained to function optimally and remain in a condition that can be described as the "Ideal Clinic".

**Integrated Clinical Services Management (ICSM)** is a health-system strengthening model that builds on the strengths of South Africa's HIV programme to deliver integrated care to patients with chronic and/or acute diseases or requiring preventative services by taking a patient-centric view encompassing the full value chain of continuum of care and support. ICSM is a key focus within an Ideal Clinic.

**Ideal Clinic Status:** Status determination is conducted at two levels i.e by internal facility team, the Perfect Permanent Team for Ideal Clinic Realization and Management (PPTICRM) and the external assessors to verify the internal assessments. Of the total 772 PHC facilities in the EC Province, 299 (39%) were assessed internally. Of these and through the external assessment. 64 facilities against a target of 48, achieved an ideal status in the following categories; Gold 29, Silver 34 and one Platinum at Chris Hani district.

## Implementation of the two components of the PHC re-engineering strategy i.e Ward-Based Outreach Teams (WBOTS) and the District Clinical Specialist Teams (DCSTs).

Re-engineering of Primary Health Care (RPHC) is one of the key policy developments which is aligned to the objectives of the 10 Point Plan aimed at overhauling the health care system and improve its management. It is based on the 14 national outcomes and the Negotiated Service Delivery Agreement (NSDA) to achieve "a long and healthy life for all South Africans." RPHC is also embedded within the National Health Insurance (NHI) initiative which is aimed at increasing universal health coverage, improving the provision of maternal, children and women's health services in order to improve health outcomes.
RPHC has three streams namely:

- Ward-based PHC Outreach Teams (WBPHCOTs),
- District Clinical Specialist Teams (DCSTs), and
- The Integrated School Health Program (ISHP).

## Ward-based PHC outreach teams (WBPHCOTs)

WBPHCOTs are made up of teams that are led by a professional nurse who is the team leader, known as the Outreach Team Leader (OTL) and include 2 to 6 Community Health Workers (CHWs) and Health Promoters. The program has positively contributed to the improvement of the following indicators:

- **ANC before 20 weeks:** CHWs conduct pregnancy screening at household level, provide health education and ensure that referrals are made to facilities;
- **Post-natal visit within 6 days**: women are seen within households by community health workers within a period of 74 hours after delivery and are provided with services that ensures clinic attendance within 6 days which includes: basic assessment, health education which includes adherence counselling and referral;
- **Number of people tested/screened for HIV, Diabetes and Hypertension**: Team leaders (professional nurses) provided testing through campaigns within communities during the reporting period, and this included screening for HIV, Diabetes and Hypertension;
- **Provision of Vitamin A**: CHWs within communities are providing Vitamin A drops under the supervision of a professional nurse;
- **Under 5-year mortality rate due to Diarrhoea, Malnutrition and Pneumonia**: through the community component of the Integrated Management of Childhood Diseases (IMCI) program) the CHW are trained to assist mothers to identify these childhood illnesses in their children under the age of 5 years.

## Integrated School Health Program (ISHP)

The Integrated School Health Program (ISHP), as one of the three streams RPHC, is a Ministerial priority program. Through the Care and Support Teaching for Learning (CSTL) service platform of the Department of Education (DoE), the Department of Health (ECDOH) has provided services at schools within the Province. Contained within the CSTL are nine priorities namely, 1) Nutrition, 2) Health promotion, 3) Infrastructure, water and sanitation, 4) Social welfare services, 5) Safety and protection, 6) Psychosocial support, 7) Curriculum support, 8) Co-curriculum support and 9) Material support. The Department currently provides three of the nine CSTL priorities within the school health service package framework to the Department of Education namely: learner screening to identify and manage health barriers to learning, on-site services including the provision of Human Papilloma Virus (HPV) vaccinations, Health Education and referral services. The department has been instrumental in the establishment of the Healthy School Environment through the "Health Promoting School initiative".

## District Clinical Specialist Teams (DCSTS)

District Health Specialist Teams (DCSTs) should ideally consist of Gynaecologists, Paediatricians, Anaesthetists, Family Physicians, Advanced Midwives, Advanced Paediatric Nurses and PHC nurses. Each district should be having a team consisting of the above mentioned professionals, though it is difficult to have all the specialist in one district. The basic functions of the specialist teams are to: strengthen clinical governance at PHC level as well as in district hospitals; to ensure that treatment guidelines and protocols are available and are used; that essential equipment is available and that these are correctly used; that mortality review meetings are held, are of good quality and that recommendations from these meetings are implemented; support and supervise and mentor clinicians; and monitor health outcomes.

DCSTs in the Province have provided extensive training on the following areas of Maternal and Child Health, namely BANC, ESMOE HBB and growth monitoring amongst others. They also conduct support visits. During onsite mentoring and support visits the following interventions or trainings were emphasized and supervised as they have impact on maternal, neonatal and child mortality.

- **Booking before 20 weeks:** Clinicians were trained on pregnancy screening tool and emphasis was put on screening all women of reproductive age. Community health Care workers were trained on the pregnancy test and during household visits they do pregnancy tests and refer to the clinics those who test positive. This initiative has not -only improved early booking but has also led to early initiation of ARVs in pregnancy women.
- **MOM Connect program**: Through onsite mentoring of clinicians on the Mom Connect there is an increase in patient education and knowledge, during pregnancy and after delivery.
- **IMCI mentoring** with emphasis on plotting the child's weight on the Road to Health Card, interpretation of the findings and interventions. Provision of CHW with MUAC tapes has improved early identification
- **Mortality meetings**: DCST supported facilities by attending the mortality meetings and making valuable inputs; identifying gaps in knowledge and in the health system, providing training, assisting with development of quality improvement plans (QIPs) and monitoring the implementation of the plans.
- **Management guidelines:** Facilities were supported with new maternity guidelines, HIV guidelines, inpatient Severe Acute Malnutrition (SAM) management.
- **Ideal Clinics Realisation and Maintenance program**: DCSTs are supporting the IDEAL clinics with protocols and guidelines, and trainings like basic life support.
- **Direct Obstetric deaths:** Deaths due to direct obstetric causes have reduced due to onsite mentoring on partogram, Basic Ante Natal Care (BANC), Essential Steps in the Management of Obstetric Emergency (ESMOE), intrapartum care and availability of protocols and guidelines in the facilities.
- **Perinatal deaths**: Helping Babies Breath **(**HBB) and ESMOE training has reduced perinatal deaths. There is improvement in PCR testing coverage due to the onsite training and incorporation of HIV in the trainings done by DCSTs.
- **Severe Acute Malnutrition:** There is reduction in case fatality rate due to malnutrition because of the Growth Monitoring Program, IMCI training and availability of guidelines and protocols in the facility. Some districts have developed community growth monitoring sites.
- **Child Health:** There is evidence of early referrals to the hospitals. Facilities are also audited in Road to Heath Cards and review the Child Health Program meetings are conducted in 45 out of 72 hospitals. The audits assist with improving the quality.

The District Health Services has strengthened the participation of communities in health through the strengthening of health governance by the Provincial Health Councils and Clinic Committees throughout the Province. Provincial Health Council and Provincial Health Advisory Committee meetings were successfully held. New district portfolio councillors responsible for health were orientated on provincial health policy priorities, a provincial health governance structure model and terms of reference. Four District Health Councils were ratified by the Honourable MEC, these are Amathole, Buffalo City Metro, Nelson Mandela Metro and Chris Hani districts.

**HPRS:** In the EC Province, the National Health Insurance (NHI) is piloted in two districts i.e. Alfred Nzo and OR Tambo. The Health Patient Registration System (HPRS) is a component of the National Health Insurance (NHI) Information Systems that supports the tracking of utilisation of services and linkage to electronic health records to create a register of patients.

Standardised patient folder and filing system is the building block towards ideal health patient registration system in PHC facilities. HPRS provides key information on demographic and epidemiological data which is important for health sector planning, decision making and improved service delivery. The system makes it possible to track patients at all levels of care to improve quality and continuity of care. Progress made thus far on implementation of this systems include:

- All PHC facilities in the EC Province were supplied with computers for electronic registration of patients.
- Workshops in support of the implementation of the system were conducted in all districts; this was done with the support from the National Department of Health.
- A total of 525 000 patient clinical records procured for 48 facilities; 255 522 records were distributed by end of the financial year.

Table 6: Patient registration on HPRS in PHC facilities distributed by health districts

| DISTRICT | Population | Total HPRS Registrations, Sept 2018 | % Population registered at end Sept 2018 |
|---|---|---|---|
| Alfred Nzo | 866 646 | 564 625 | 64% |
| Amathole | 972 188 | 617 721 | 64% |
| BCM | 874 199 | 323 868 | 37% |
| Chris Hani | 818 915 | 350 575 | 43% |
| Joe Gqabi | 371 240 | 189 744 | 51% |
| NMBM | 1 298 412 | 336 585 | 26% |
| OR Tambo | 1 492 014 | 1189 682 | 80% |
| Sarah Baartman | 522 720 | 210 837 | 40% |
| **TOTAL** | **7 216 334** | **3 783 653** | **52%** |

## Mental Health Services:

Routine assessment on mental disorders of patients is done in all PHC facilities. In 2017/18, there were 295 328 mental health client visits and 3.4% of these (9 988) were clients less than 18 years old. A total of 345 patients with mental disorders were registered on the CCMDD program.

In an endeavor to strengthen the mental health services in the Province, the Department will establish a Provincial Mental Health Advisory committee and strengthen district based mental health services. Infrastructure will be improved to facilitate fully fledged 72-hour mental health observation services in the 39 listed facilities. Acute designated beds will be established in listed hospitals both at district and regional hospital level.

**Disease prevention interventions:** An integrated implementation of the influenza vaccine program improved; utilisation of the flu vaccine increased from 86.4 % in 2016/17 to 93% in 2017/18.

## Implementation of the TB and HIV 90-90-90 Strategy

- **Prevention initiatives** that work collaboratively with all sectors, through coordination of the Eastern Cape AIDS Council (ECAC), targeting the high risk population, youth and young women to prevent both TB and HIV new infections, focusing on behaviour change initiatives, and availing of HIV prevention commodities such as condoms, HIV Testing services, implementation of PMTCT and Safe Male Circumcision.

- **Case finding initiatives** that entails, amongst others, intense TB screening (Find Actively, Separate Temporarily and Treat Effectively (FAST), Lateral Flow Lipoarabinomannan (LF-LAM) and HIV testing in build-up activities towards and during events such as First Things First Campaign, Rotary Family Health Days, World AIDS Day and TB Day, in collaboration with other sectors such as supporting partners, ECAC.

- **Treatment initiation initiatives** such as Universal Test and Treat (UTT) to scale up initiation of patients on treatment as well as the shortened regimen (nine months) for the management of Multi-Drug Resistant TB (MDR TB) patients.

## District Hospitals

There are 66 district hospitals that attend to emergency care, adult and child inpatient and outpatient care, obstetric care as well as several general and specialist services. In 2016/17 there were 245, 478 inpatient separations and 1, 225, 515 patients were seen in outpatient departments at district hospitals, 434, 644 were patients who were not referred from PHC services but went straight to the hospitals.

Hospital boards from eight (8) district hospitals were appointed by the Honourable MEC. Board members were orientated and inducted on two new policies namely, Hospital Board Establishment, Functionality, Management and Support; Policy on Payment of Travelling Cost for Hospital Board Members. 56 board members signed Declaration of Interest, Commitment Certificate (Acceptance of Voluntary Governance Responsibility) and Confidentiality Certificates.

## Provincial Hospitals and Specialised Hospital Services

In preparation for full NHI implementation, EC hospitals will have a triple aim: delivering optimal patient outcomes; ensuring a positive experience at our facilities; and cost-effective and efficient care. The value proposition we will be putting to our communities is that our hospitals will deliver the best possible outcomes for our patients – safe, effective and reliable care- and of a quality standard that satisfies our communities.

All hospitals will focus on reducing possible avoidable causes of death and minimising risk of incidents that are associated with hospitalisation world-wide – nosocomial infection, pressure ulcers, patient falls and medication errors. Mothers and children will remain a priority area of intervention. Whilst the Department has demonstrated some improvements in addressing admin- and personnel-related factors that may contribute to maternal and child deaths, and will continue to ensure we have the knowledge, skills and infrastructure in place to manage pregnancy and labour; going forward, the engagement of pregnant mothers and the community will receive more attention as there is a need to ensure mothers book for antenatal care, come for follow-ups, understand the warning signs of pregnancy and then act on these signs so that we are able to intervene and support high risk pregnancies.

Recognising the increasing burden of trauma and injuries, the Department will strengthen our triage and surgical capability at hospitals with a focus on ensuring we are able to do safe caesarean sections, emergency laparotomies and surgical debridement of open wounds at the appropriate level of care.

The global trend of escalating non-communicable diseases is evident in our country and our Province. Diseases of life-style such as obesity, hypertension and diabetes result, inevitably, in costly hospital admissions for complications such as stroke, renal failure, heart disease.

On the one hand, the Department will continue to build hospital capability to provide treatment for these diseases, but this will go hand in hand with active patient and community engagement to promote healthy lifestyle choices, prevent ill health and manage chronic diseases better.

Cancers such as breast and cervical cancers in women, oesophageal and prostate cancers in men and colon cancers in both sexes, predominate oncology presentations at our facilities. The Department will continue to build our capability to screen early for these cancers, improve access to treatment in the eastern part of our Province for oncology care, and foster closer ties with our communities to raise awareness about the risk factors of commonly occurring cancers.

The tragedies our country has had to bear regarding people living with mental illness has been a sober reminder that there is much work to be done, not only for communities to understand mental health issues better, but for us to render services that consistently meet the standards founded on the principles of human rights enshrined in our Constitution and demanded from us in the Mental Health Act of 2002. The Department is happy to report that all EC regions have active Mental Health Review Boards whose oversight will be relied upon to ensure we render good quality mental healthcare.

In the next five years, community-based approach to rendering mental healthcare will be promoted, seeking to strengthen access to appropriate services at the appropriate level of care. Addressing the inequities of mental healthcare will be a focus area, to ensure our most disadvantaged communities have access to 72-hour acute psychiatric care at designated facilities, as well as services that speak to the burden of mental disease. Mental illness associated with substance abuse is a public health concern, and partnerships will be explored to render the relevant services to prevent and treat substance abuse effectively.

Finally, in the context of global escalation in healthcare costs and increasing demand for care because of shifting disease burdens, the shrinking healthcare funding envelope requires that all hospitals render cost-effective and cost-efficient care. Hospitals CEOs and their management teams will begin to see themselves as social entrepreneurs whose aim is to promote social wellbeing whilst at the same time deploying entrepreneurial solutions to the challenges we face. Case management will be strengthened to ensure minimal lengths of stay in hospital for our patients; and appropriate bed utilisation rates at facilities. Projects to generate revenue, optimise revenue collection and incentivized revenue retention will be incubated as the competitive edge for public sector hospitals over private enterprises will be on good quality care at lower cost. Investments in appropriate capital plant, buildings and medical equipment and strategic human resourcing must translate into improved patient outcomes, better patient experience and increased throughput; in other words, a good return on the investment of public funds. Activity-based budgeting and resource allocation will be explored to incentivise facilities' management to collect good quality data that allows better performance management and improve controls.

In keeping with the fourth industrial revolution, ICT will be used to improve healthcare service delivery effectiveness and efficiency. The innovative EC developed Hospital Management System (HMS) and HPRS will be rolled out to key hospitals within

the next five years. Better patient record management will have multiple benefits -better continuity of care of our patients within and between EC facilities, as our clinicians will have rapid access to patient clinical data, results of investigations done and treatment plans; and also decrease waiting times for patient folders in admission areas and for medication from our pharmacies.

## Regional Hospitals

The Province provides a full package of general specialist services from the five (5) regional hospitals (Dora Nginza, Cecilia Makiwane, Mthatha Regional, Frontier Regional and St. Elizabeth hospitals). The regional hospitals also provide a platform for research and training of health workers.

Two Hospital Boards (Mthatha Regional and Cecilia Makiwane Hospital) were appointed and are functional. There were 93, 854 inpatient separations and 667, 483 patients were seen in outpatient departments at regional hospitals, 155, 807 were patients who were not referred.

## TB Hospitals

There are now ten (10) specialised TB hospitals in the Province and 13 decentralised sites, for the Community based management of MDR-TB patients on Ambulatory care. Rationalisation of Nkqubela and Fort Grey was done and the process was completed with no adverse effects to the patients.

## Psychiatric Hospitals

There are 4 psychiatric hospitals (Elizabeth Donkin, Komani, Tower and Fort England) and 3 regional hospitals (Mthatha, Cecilia Makiwane and Dora Nginza hospitals) have psychiatric units. Two district hospitals (Holy Cross and St Barnabas Hospital) currently don't have functioning psychiatric units/wards as they are still under renovation. These facilities collectively attended to 31, 816 inpatient separations and 169, 564 patient contacts at outpatient departments.

## Tertiary Hospital Services

There are two (2) tertiary hospitals namely: Livingstone and Frere Hospitals. In 2016/17 the two hospitals had 78 785 inpatient separations and 684 227 patients were seen in outpatient departments at regional hospitals, 27 043 were patients who were not referred

## Central Hospital (Nelson Mandela Academic Hospital (NMAH)

Nelson Mandela Academic Hospital is the only central hospital and is also the teaching hospital of the Walter Sisulu University Medical School. In the current financial year, there were 18 678 inpatient separations and 174 242 patients were seen in outpatient departments, a total of 13 726 were patients who were not referred. Outreach by NMAH specialist teams to Regional and District hospitals to improve capacity at this level is aimed at decreasing up-referral from lower level hospitals.

## Forensic Pathology Services (FPS)

Specialised forensic pathology services are rendered from eighteen forensic pathology facilities across the Province in order to establish the circumstances and causes surrounding unnatural death. 94% (8391/8911) of post-mortems were performed within 72 hours during the 2016/17 financial year.

## Emergency Medical Services (EMS)

The Department has a total of 447 ambulances in its fleet, and only about 250 are operational at any point in time as some vehicle spend extended time at repair shops around the Province. The poor state of roads in some parts of the Province remains one of the reasons why the ambulance fleet tend to break down often. It also reduces the lifespan of the vehicles in the EMS fleet. The Province has few operational vehicles against a high demand for emergency medical services, especially the pre-hospital service (from community to hospital). This impacts negatively on efficiency indicators relating to ambulance response time both in the rural and urban areas. Only 32% and 56% of calls in urban and rural settings respectively are responded to within national norms and standards.

A total of 68 replacement Planned Patient Transport, which are 35-seater buses, were procured successfully and distributed to the districts during the 2018/19 FY. These vehicles are used to transport patients from district level hospitals to tertiary, specialised hospitals. The department received 124 replacement ambulances during the previous financial year. These ambulances are replacing the old fleet or ambulances that have been written off due to accidents and other damages.

### Health Care Support Services

This programme renders quality, effective and efficient transversal (orthotic & prosthetic, rehabilitation, laboratory, social work services and radiology services) and pharmaceutical to the communities of the Eastern Cape. Health Care support services consists of two sub-programs: Transversal Health Services and pharmaceutical Services.

### Transversal Health Services consists of:

- The orthotic & prosthetic (O&P) services is provided from three existing O&P centres, the centres are based within the three Hospitals namely the PE Provincial Hospital, in East London at Frere Hospital, and in Mthatha at Bedford Orthopaedic Hospital. The prescriptions received from medical professionals and the referrals especially from the outreach programme determine the need for the service.
- Rehabilitation health and disability, laboratory, social work and radiological services are rendered at all Hospitals and/or community health centres.

### Pharmaceutical Services

- Coordinates the full spectrum of the Pharmaceutical Management Framework including medicine selection, supply, distribution and utilization.
- Pharmaceutical standards development and monitoring for health facilities and the two medical depots are coordinated under this programme

**CCMDD**: The central chronic medicines dispensing and distribution (CCMDD) programme is one of the provincial government's initiative to improve access to life saving medicines in the rural communities of our Province. The programme is expected to reduce waiting times and minimize the cost incurred by patients when travelling to health facilities to collect their medicines. The programme grew tremendously during 2017/18 FY achieving 52% increase from the previous financial year 2016/17; a total of 80 054 new patients were enrolled with an overall total of 235 065 patients.

- **External Pick-up Points**: By end of the FY, there were 120 external pick up points which include Clicks retail stores, private pharmacies, and the SA Post office. This has given the patients the option to collect medicines even after formal business hours and over the weekends.

**Adherence clubs**: The CCMDD programme is using 571 adherence clubs as part of the differentiated care strategy in the management of HIV&AIDS

## 7.2 Improve Financial Management

The Department has managed to establish a track record for obtaining unqualified annual financial statements. This has been a great achievement, especially in the light of the fact that audit intensity has increased, as well as the regulatory environment having intensified.

2017 mid-year population estimates showed a net migration out of the province, this resulted in further reductions in the departmental equitable share resource envelope over the 2019 MTEF. Despite the shrinking fiscal envelope, the department continued to protect the non-negotiable (medicine, medical supplies, laboratory services and blood services, and others) as determined by the National Minister of Health. In order to do this, the department had to reprioritize from non-core items (catering, travel and subsistence, venues and facilities, etc.) to ensure that sufficient funding is available for the non-negotiable items.

Spending in recent financial years has consistently varied by less than 1 per cent from budget. The financial management systems employed have been continually refined and improved over the years and the following management tools have been central to the Department's success:

- The cascading system of provincial, district and institutional cost containment committees (PCCCs) enables the weekly monitoring of expenditure against the budget and cash flow allocations, providing programme, sub programme and grant management oversight for internal assessments.
- The Approved Post List (APL) has succeeded to contain human resource expenditure.
- Internal financial control units have institutionalised internal control mechanisms to perform routine checks on all payments as well as other financial activities.
- The increase in the transversal contracts reduces work load and irregular procurement.

### Strategies to Improve Budget Implementation and Cost Containment

The posts scrutinised and approved for filling will continue with the Provincial Coordinating Monitoring Team (PCMT) as well as the persal centralisation of codes in Provincial Treasury (PT) for authorising transactions.

The implementation of the Department's approved revised organogram will continue as well as ensuring that allocation of budgets to SCOA line items continue reflecting the application of the cost containment measures as issued by the National Treasury as per Instructions 2, 3 and 4 of 2017/18 and Provincial Treasury (PT) Instruction Note 4 of 2017/18, where spending on non-essential items must be kept at bare minimum or decreasing.

The department will continue to enhance its revenue enhancement strategy thus ensuring own revenue maximisation in terms of the Own Revenue targets over the 2019 MTEF in Table 1 above, taking into account the weak economic growth and continued fiscal consolidation.

## Relevant Court Rulings – Settlement of Medico-Legal Claims

Medico-legal claims against the department remain the most significant contingent liabilities, having a significant, on-going impact on the operations or service delivery obligations of the Department.

The medico legal pressures are unfunded and unbudgeted for. As court orders, the department has no option but to pay these from the available cash flow. This invariably results in the shifting of funds from core services delivery items such as compensation of employees and medicines, to non-core being household claims against the state and consultants and professional services: legal costs.

This has the impact of primarily reducing the ability of the department to fund vacant posts and increasing the year end accruals for goods and services.

The department is implementing its Local Economic Development Implementation Strategy (LEDIS) which aligns to the Eastern Cape Treasury issued Instruction Note No.7 of 2016/17 on Implementation of Local Development Procurement Framework which amongst others provides for the focused procurement of the following:

- Goods and services that a readily available and manufactured in the Province;
- Procuring from National Contracts;
- Goods and services sourced from suppliers outside the Province;
- Clustering of projects;
- Use of Cooperatives;
- Local Labour Contracting;
- Break-out Procurement; and
- Reducing barriers to entry for local suppliers.

Eastern Cape Department of Health identified commodities for immediate implementation of the framework as well as identification of future interventions which will have a positive impact towards the provincial local development goals. These commodities include patient food, facility maintenance services, linen and patient clothing, furniture, soft services including security, cleaning and gardening services, medical waste management and transportation and cleaning material.

## Strengthen Information Management

The AG identified risks related to inaccurate reporting of actual achievements in the annual report as well as non-adherence with DHMIS policy and SOPs based on the findings. An Audit Improvement Plan (AIP) was developed to address the weaknesses and is currently being implemented, in addition a system of Routine Data Quality Assessments (RDQA) was developed and implemented during the 2017/18 year, and this resulted in an ICT MPAT score of 4 which the department will maintain.

The department will roll out e-signatures, PABX system upgrades and skype for business projects to improve communication and create efficiencies. An invoice tracking system to improve supplier payments will be developed and the department will further upgrade its server and WAN environments to improve the stability of the server environment and enhance disaster recovery. To improve the EMS response times, the department plans to develop the EMS call dispatching system.

As part of a National initiative, through the National Department of Health the CSIR conducted a phase 1 assessment of all patient management / patient administration systems throughout South Africa to assess system compliance to the National normative standards framework. The departmentally developed Hospital Management System Version 2 (HMS2) was assessed as part of this initiative and will now continue into a phase 2 assessment in the near future during which the ECDOH development team will be able to work with the CSIR team in a lab environment where the system can be refined to comply

with the Normative standard technical requirements.
The full HMS2 system functionality means that one single patient file is used to record all patient encounters with no recreation of records. The system is functional at Frere hospital and is being rolled out to Livingstone, Cecelia Makhiwane, and Nelson Mandela Academic Hospitals.

The implementation of a Province-wide broadband service by the OTP will significantly improve internet and network connectivity throughout the Department.

## Infrastructure Delivery

The ECDOH infrastructure delivery is conducted through Infrastructure Delivery Management System (IDMS) as Stipulated in the Division of Revenue Act of 2015. IDMS is coordinated by National Treasury Department (NT) through its Infrastructure Delivery Improvement Programme (IDIP). The IDIP is a capacity building programme of the South African government designed to address problems relating to the planning and management of public sector infrastructure delivery. IDMS is derived from a number of key pieces of legislation that govern infrastructure. These include the Constitution of the Republic of South Africa (1996), Public Finance Management Act (1999), Government Immovable Asset Management Act (GIAMA) (2007), Intergovernmental Relations Framework Act (2005), Construction Industry Development Board (CIDB) Act (2000), the Division of Revenue Act (published annually), as well as legislation applicable to municipalities.

The CIDB has introduced the concept of the Gateway Process to further improve efficiencies in the delivery management of infrastructure (Refer to the CIDB"s Practice Note 22 of 2010). These principles have been embedded into the IDMS.

A gateway process designed around a set of gates that are strategically located within an infrastructure asset management cycle has the potential to:

- Enable projects to be more accurately scoped and costed at an earlier stage in the asset life cycle
- Reduce time and cost overruns
- Improve alignment of service delivery with available funds
- Improve procurement discipline
- Manage risks more effectively
- Reinforce responsibility and accountability for decisions
- Enable projects to be better aligned with policies and objectives.

Such control gates also enable project risk to be contained within the confines of an organ of state's risk appetite. The information upon which a decision is based at a control gate and the decisions made can be audited to ensure that projects remain within an organization's mandate, are justifiable and realize value for money.

## Infrastructure Backlogs

The Eastern Cape Department of Health has obligations of providing health facilities to the entire population. Furthermore, the department cannot deliver its mandate without the asset base that is the platform for such service delivery. Backlogs are difficult to address due to the bottlenecks created by the funding mechanisms. Backlogs are easily identified and quantified, however the unit is unable to implement due to the limited funds and restrictive funding models.

The pace at which the gap between the current and desired level of service can be reduced is fiscal constraints dependent on the availability of budget to address these issues. Based on current infrastructure allocations, it is un-likely that current backlogs will be addressed during this MTEF period.

## Alignment to Government Outcomes

The changing health trends and demands have huge impact on infrastructure planning and budgeting. The consequences are that some changes must be made to existing facilities: rearrange them to suite the current health interventions; add crisis and counselling centres for domestic violence and HIV victims; day wards and day operating theatres; provision of new facilities for new formal settlements and cater for the expected population growth. Adequate clinical accommodation will assist in the Province being able to deliver and offer an effective service.

## 8. Legislative Mandates and New Policy Initiatives

The legislative mandate of the Department is derived from the Constitution and several pieces of legislations passed by Parliament. In terms of the Constitutional provisions, the Department is guided by the following sections and schedules, among others:

- Section 27 (1): "Everyone has the right to have access to – (a) health care services, including reproductive health care;
- (3) No one may be refused emergency medical treatment"
- Section 28 (1): "Every child has the right to … basic health care services…"
- Schedule 4 which lists health services as a concurrent national and provincial legislative competency.

There are three main legislations that fall under the Minister of Health's portfolio. These are:

- Mental Health Care Act (17 of 2002), which provides a legal framework for mental health in the Republic and, in particular, the admission and discharge of mental health patients in mental health institutions, with an emphasis on the observation of human rights for mentally ill patients;
- National Health Act (61 of 2003) which provides a framework for a uniform structured health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services, and;
- Nursing Act, of 2005, which provides for the regulation of the nursing profession

The following legislation may have an impact on implementation of APP, however there are no guarantees at this stage if it will do so but the legislation will be looked at with great scrutiny to establish the obligation arising therein: namely:

- Protection of Personal Information Act
- Financial Services Laws General Amendment Act
- Promotion of Administrative Justice Act.
- National Health Insurance Bill

## 9. Expenditure Estimates

Table 7: Summary of Provincial payments and estimates by programme: Health

| R thousand | Outcome 2015/16 | Outcome 2016/17 | Outcome 2017/18 | Main appropriation 2018/19 | Adjusted appropriation 2018/19 | Revised estimate 2018/19 | Medium-term estimates 2019/20 | Medium-term estimates 2020/21 | Medium-term estimates 2021/22 | % change from 2018/19 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. Administration | 668,261 | 706,937 | 589,458 | 695,199 | 774,203 | 776,315 | 714,361 | 738,913 | 731,414 | (8.0) |
| 2. District Health Services | 9,516,426 | 10,420,604 | 11,342,496 | 12,031,947 | 12,171,900 | 12,683,602 | 12,862,682 | 13,788,802 | 14,807,443 | 1.4 |
| 3. Emergency Medical Services | 946,270 | 1,067,653 | 1,279,087 | 1,284,612 | 1,349,735 | 1,296,903 | 1,393,057 | 1,484,970 | 1,480,926 | 7.4 |
| 4. Provincial Hospital Services | 4,927,742 | 3,250,197 | 3,488,361 | 3,857,135 | 3,967,355 | 3,571,408 | 4,090,782 | 4,325,104 | 4,564,463 | 14.5 |
| 5. Central Hospital Services | 823,221 | 2,913,621 | 3,471,073 | 3,447,737 | 3,510,699 | 4,044,185 | 3,626,551 | 3,856,235 | 3,979,372 | (10.3) |
| 6. Health Sciences and Training | 769,372 | 749,372 | 727,692 | 885,346 | 880,512 | 762,491 | 929,809 | 965,335 | 991,446 | 21.9 |
| 7. Health Care Support Services | 93,129 | 101,861 | 99,998 | 125,512 | 126,552 | 108,118 | 125,835 | 133,162 | 128,355 | 16.4 |
| 8. Health Facilities Management | 1,199,522 | 1,295,934 | 1,274,514 | 1,372,071 | 1,244,570 | 1,310,632 | 1,446,555 | 1,296,016 | 1,269,728 | 10.4 |
| **Total payments and estimates** | **18,943,943** | **20,506,179** | **22,272,679** | **23,699,560** | **24,025,525** | **24,553,654** | **25,189,632** | **26,588,537** | **27,953,147** | **2.6** |

Table 8: Summary of Provincial payments and estimates by economic classification: Health

| R thousand | Outcome 2015/16 | 2016/17 | 2017/18 | Main appropriation | Adjusted appropriation 2018/19 | Revised estimate | Medium-term estimates 2019/20 | 2020/21 | 2021/22 | % change from 2018/19 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Current payments** | **17,091,967** | **18,669,958** | **20,347,078** | **21,982,246** | **22,336,821** | **22,303,125** | **23,255,076** | **24,805,044** | **26,186,602** | 4.3 |
| Compensation of employees | 12,562,282 | 13,454,333 | 14,558,949 | 15,860,413 | 16,140,454 | 16,181,178 | 16,962,268 | 18,282,295 | 19,402,920 | 4.8 |
| Goods and services | 4,522,995 | 5,206,207 | 5,784,042 | 6,121,833 | 6,196,367 | 6,113,821 | 6,292,808 | 6,522,749 | 6,783,682 | 2.9 |
| Interest and rent on land | 6,690 | 9,418 | 4,087 | – | – | 8,126 | – | – | – | (100.0) |
| **Transfers and subsidies to:** | **571,824** | **558,634** | **689,345** | **287,404** | **288,928** | **877,738** | **296,705** | **315,455** | **332,805** | **(66.2)** |
| Provinces and municipalities | 13,229 | 8,451 | 313 | 1,200 | 1,200 | 1,200 | – | – | – | (100.0) |
| Departmental agencies and accounts | 35,417 | 18,877 | 11,013 | 12,479 | 11,856 | 11,856 | 13,733 | 17,060 | 17,998 | 15.8 |
| Non-profit institutions | – | – | 7,278 | 18,145 | 19,570 | 18,423 | 15,000 | 13,589 | 14,336 | (18.6) |
| Households | 523,178 | 531,306 | 670,741 | 255,580 | 256,302 | 846,259 | 267,972 | 284,806 | 300,471 | (68.3) |
| **Payments for capital assets** | **1,280,152** | **1,277,587** | **1,236,256** | **1,429,910** | **1,399,776** | **1,372,791** | **1,637,851** | **1,468,038** | **1,433,740** | **19.3** |
| Buildings and other fixed structures | 881,906 | 654,895 | 637,152 | 810,500 | 875,234 | 924,483 | 980,582 | 800,719 | 749,928 | 6.1 |
| Machinery and equipment | 397,400 | 622,692 | 599,104 | 619,410 | 524,542 | 448,308 | 657,269 | 667,319 | 683,812 | 46.6 |
| Software and other intangible assets | 846 | – | – | – | – | – | – | – | – | |
| **Total economic classification** | **18,943,943** | **20,506,179** | **22,272,679** | **23,699,560** | **24,025,525** | **24,553,654** | **25,189,** | **26,588,537** | **27,953,147** | **2.6** |

Table 7 and 8 above show the summary of payments and estimates per programme and economic classification. The total payments grew from R18.943 billion in 2015/16 to a revised estimate of R24.553 billion in 2018/19. In 2019/20, the budget is projected to grow by 2.6 per cent from R24.553 billion to R25.189 billion when compared to the 2018/19 revised estimate as a result of increase in conditional grants.

Compensation of employees shows a growth of 4.8 per cent from R16.181 billion to R16.962 billion when compared to the 2018/19 revised estimate as a result of the payment of backlog overtime for EMS officials, pay progression, Improvement of Condition of Service (ICS), and the introduction of the Human Resource Capacitation Grant.

Goods and services show a positive growth of 2.9 per cent from R6.113 billion to R6.292 billion when compared to the 2018/19 revised estimate due to the national adjustments on Provincial Equitable Share (PES) formula.

Transfers and subsidies show a negative growth of 66.2 per cent from R877.738 million to R296.705 million when compared to the 2018/19 revised estimate due to payment of medico legal claims.

Payments for capital assets show a positive growth of 19.3 per cent from R1.372 billion to R1.637 billion when compared to the 2018/19 revised estimate due to additional funding on infrastructure.

# PART B
# PROGRAMME AND SUB-PROGRAMME PLANS

# PROGRAMME 1

# Health Administration & Management

# Programme 1
## Health Administration and Management

The Health Administration and Management programme comprises of two main components: the administration component, which refers to the Executive Authority and lies with the Office of the Member of Executive Council (MEC); and the second component, which is the Management of the organisation and is primarily the function of the Office of the Superintendent General.

### 1.1 Sub-Programme: Health Administration - Office of the Mec

#### Sub - Programme Purpose
To provide political and strategic direction to the Department by focusing on transformation and change management.

#### Priorities for the Next Three Years
- Give political and strategic direction to the Department;
- Engage all governance structures of the Department, i.e. Hospital boards, Clinic Committees, Provincial Health Council, and Lilitha Education Nursing Council.

#### Strategic Goal Being Addressed:
- **Strategic Goal 2:** Improved quality of care



#### Provincial Strategic Objectives, Annual and Quarterly Targets for Office of the Mec

Table 9: Provincial Strategic Objectives, Indicators, Annual & Quarterly Targets for Sub-Programme 1.1 - Office of the MEC

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| Provide political and strategic direction to the Department by focusing on transformation on and change management | **Strategic Objective: Strategic Leadership and accountability by 2019** | | | | | | | | | | | | |
| | Number of statutory documents tabled at Legislature | Categorical Quarterly | 6 statutory documents | 6 statutory documents | 6 statutory documents | **6** | **8 statutory documents** | - | **1** | **2** | **5** | 8 statutory documents | 8 statutory documents |

## 1.2 Sub-Programme: Health Management

### Sub-Programme Purpose

To manage human, financial, information and infrastructure resources. This is where all the policy, strategic planning and development, coordination, monitoring and evaluation, including regulatory functions of head office, are located.

The management component under the Superintendent General's supervision is comprised of three clusters with their sub-components (branches) as listed below:

### Finance Branch

- Financial Management Services
- Integrated Budget Planning and Expenditure Review
- Supply Chain Management (SCM)

### Corporate Services Branch

- Information, Communication and Technology (ICT)
- Human Resource Management (HRM)
- Human Resource Development (HRD)
- Corporate Services
- Infrastructure
- Internal Audit
- Strategy & Organisational Performance

### Hospital and Clinical Support Management Branch

- Hospital Services
- Clinical Support Services
- Quality Assurance

### District Health Services Management Branch

- District Health Services
- Communicable Diseases
- Health Programmes

### Priorities for the Next Three Years

- To facilitate effective human resources planning development and management in order to improve provision of health services
- To implement corporate systems to support the service delivery imperatives of the department
- To achieve an unqualified regulatory audit opinion

### Strategic Goal Being Addressed:

**Strategic Goal 2**: Improved quality of care

## Provincial Strategic Objectives, Annual & Quarterly Targets for Sub-Programme 1.2

Table 10: Provincial Strategic Objectives, Indicators, Annual & Quarterly Targets for Sub-Programme 1.2

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| Unqualified audit opinion from the Auditor General by 2019 | **Strategic Objective 2.1: Unqualified audit opinion achieved by 2019** | | | | | | | | | | | | |
| | 2.1.1 Audit opinion from Auditor-General | Categorical Annual | Unqualified Audit Opinion | Unqualified Audit Opinion | Unqualified Audit Opinion | Unqualified Audit Opinion | **Unqualified Audit Opinion** | - | - | - | **Unqualified** | Unqualified Audit Opinion | Unqualified Audit Opinion |
| | 2.1.4 Level 3 MPAT | Qualitative Annual | Level 3 MPAT performance | Level 3 MPAT performance | Level 2.8 MPAT performance | Level 3 MPAT performance | **Level 3 MPAT performance** | - | - | - | **Level 3 MPAT performance** | Level 3 MPAT performance | Level 3 MPAT performance |
| Implement web based district health information system at 90% of all facilities by 2019 | **Strategic Objective 2.2: 100 % of health facilities connected to web – based DHIS through broadband by 2019** | | | | | | | | | | | | |
| | 2.2.1 Percentage of Hospitals with broadband access | % Quarterly | 86.5% | 97.7% | 100% | 100% | **100%** | **100%** | **100%** | **100%** | **100%** | 100% | 100% |
| | *Numerator* | | 77 | 87 | 89 | 89 | **89** | **89** | **89** | **89** | **89** | 89 | 89 |
| | *Denominator* | | 89 | 89 | 89 | 89 | **89** | **89** | **89** | **89** | **89** | 89 | 89 |
| | 2.2.2 Percentage of fixed PHC facilities with broadband access | % Quarterly | 60.3% | 65% | 71% | 56% | **100%** | **65%** | **80%** | **97.5%** | **100 %** | 100% | 100% |
| | *Numerator* | | 466 | 503 | 351 | 428 | **768** | **499** | **614** | **756** | **768** | 772 | 772 |
| | *Denominator* | | 772 | 772 | 772 | 768 | **768** | **768** | **768** | **768** | **768** | 772 | 772 |

## 1.3 Reconciling Performance Targets with Expenditure Trends and Budgets

Table 11: Summary of payments and estimates by sub programme 1: Administration

| R thousand | Outcome 2015/16 | 2016/17 | 2017/18 | Main appropriation | Adjusted appropriation 2018/19 | Revised estimate | Medium-term estimates 2019/20 | 2020/21 | 2021/22 | % change from 2018/19 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. Office Of The MEC | 6,947 | 6,502 | 6,056 | 9,870 | 12,713 | 12,785 | 8,917 | 9,536 | 8,259 | (30.3) |
| 2. Management | 661,314 | 700,435 | 583,402 | 685,329 | 761,490 | 763,530 | 705,444 | 729,377 | 723,155 | (7.6) |
| **Total payments and estimates** | **668,261** | **706,937** | **589,458** | **695,199** | **774,203** | **776,315** | **714,361** | **738,913** | **731,414** | **(8.0)** |

Table 12: Summary of payments and estimates by economic classification: Programme 1: Administration

| R thousand | Outcome 2015/16 | 2016/17 | 2017/18 | Main appropriation | Adjusted appropriation 2018/19 | Revised estimate | Medium-term estimates 2019/20 | 2020/21 | 2021/22 | % change from 2018/19 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Current payments** | **651,792** | **689,969** | **580,128** | **687,185** | **723,628** | **723,508** | **706,007** | **730,325** | **722,854** | (2.4) |
| Compensation of employees | 429,886 | 386,413 | 390,869 | 440,856 | 444,906 | 438,406 | 474,224 | 510,412 | 536,683 | 8.2 |
| Goods and services | 221,375 | 302,924 | 188,964 | 246,329 | 278,722 | 284,795 | 231,783 | 219,913 | 186,171 | (18.6) |
| Interest and rent on land | 531 | 632 | 295 | – | – | 307 | – | – | – | (100.0) |
| **Transfers and subsidies to:** | **2,838** | **6,768** | **3,226** | **1,613** | **1,878** | **3,022** | **1,703** | **1,797** | **1,896** | **(43.6)** |
| Households | 2,838 | 6,768 | 3,226 | 1,613 | 1,878 | 3,022 | 1,703 | 1,797 | 1,896 | (43.6) |
| **Payments for capital assets** | **13,631** | **10,200** | **6,104** | **6,401** | **48,697** | **49,785** | **6,651** | **6,791** | **6,664** | **(86.6)** |
| Buildings and other fixed structures | – | – | – | – | – | – | – | – | – | |
| Machinery and equipment | 12,785 | 10,200 | 6,104 | 6,401 | 48,697 | 49,785 | 6,651 | 6,791 | 6,664 | (86.6) |
| Software and other intangible assets | 846 | – | – | – | – | – | – | – | – | |
| **Total economic classification** | **668,261** | **706,937** | **589,458** | **695,199** | **774,203** | **776,315** | **714,361** | **738,913** | **731,414** | **(8.0)** |

Tables 11 and 12 above show the summary of payments and estimates from 2015/16 to 2018/19 and over the 2019 MTEF period per sub-programme and economic classification. The programme's total expenditure increased from R668.261 million in 2015/16 to a revised estimate of R776.315 million in 2018/19. In 2019/20, the budget decreases by 8 per cent from R776.315 million to R714.361 million when compared to the 2018/19 revised estimate.

Compensation of employees and goods and services, which make up current payments, are the major cost drivers of the programme. Compensation of employees shows a positive growth of 8.2 per cent from R438.406 million to R474.224 million when compared to the 2018/19 revised estimate due provision of ICS, pay progression and critical vacant funded posts.

Goods and services show a negative growth 18.6 per cent from R284.795 million to R231.783 million when compared to the 2018/19 revised estimate due to reprioritisation efforts for cost containment measures and national adjustments as a result of revision of PES formula.

Transfers and subsidies show a negative growth of 43.6 per cent from R3.022 million to R1.703 million when compared to the 2018/19 revised estimate due to reduction in the payment of leave gratuities.

Payments for capital assets show a negative growth of 86.6 per cent from R49.785 million to R6.651 million when compared to the 2018/19 revised estimate due to payment of ICT accounts in relation to maintenance of computer equipment, SITA data lines, desktops and computers, network for BAS, LOGIS and PERSAL.

## 1.4 Risk Management

Below are the key risks that may affect the realization of the strategic objectives in Programme 1 and the measures designed to mitigate their impact

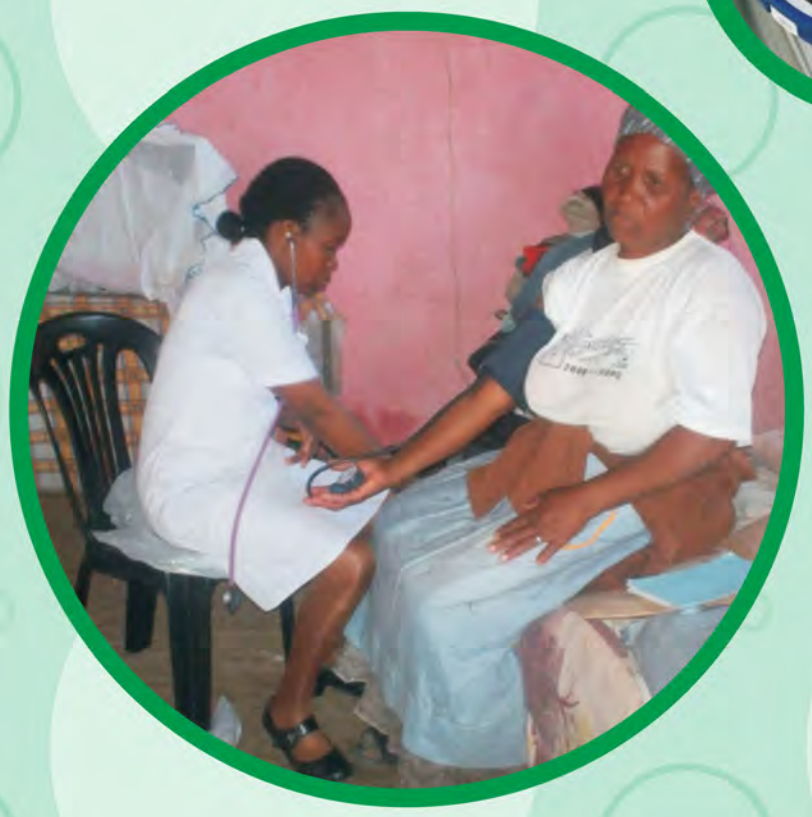
Table 13: Risk and Mitigating factors for programme 1

| RISK IDENTIFIED | RISK MITIGATION |
|---|---|
| **Inadequate Supply Chain Management process** | • Implementation of SCM policy and procedure manual<br>• Monthly review of contract and commitment register<br>• Implementation of document management system<br>• Enforce compliance to SCM delegations & Consequence management |
| **Ineffective human resources management**<br>• Strike and Protest Action<br>• Lack timeous filling of replacements and funded posts<br>• High levels of absenteeism due to illness and incapacity<br>• High staff turnover | • HR Delegations register monitored monthly to ensure compliance<br>• Recruitment time reduced to 3 months<br>• HR Management Information System (HR MIS) in place<br>• Annual Intake Plan updated and fully functional<br>• Implementation<br>• Employee dissatisfaction<br>• of interventions to address staff attitude<br>• Maintain lower vacancy rate<br>• Registrar Program remains operational<br>• Employee Relations Training Unit is fully functional<br>• Increase outreach of the Employee Wellness Programme (to 3% utilization rate)<br>• Improve implementation of Occupational Health and Safety |
| **Inadequate provision of ICT (Information communication technology) services and governance of the environment** | Implementation of:<br>• ICT Strategy<br>• Capital infrastructure and connectivity<br>• Business Continuity Plan & ICT Disaster Recovery Plan<br>• Continuous Improvement plan |

| Table 13: Risk and Mitigating factors for programme 1 | |
|---|---|
| **RISK IDENTIFIED** | **RISK MITIGATION** |
| **Perpetration of fraudulent and corrupt activities**<br>• SCM - Irregular tender award<br>• HR - Irregular appointments<br>• Finance - Misuse of user ID's<br>• Assets - Misuse of state vehicle and equipment<br>• Clinical - Theft of medicines and patient records | • Report for blacklisting of suppliers to Treasury<br>• Consequence management<br>• Verification of employee qualifications & Periodic vetting of staff<br>• Implementation of fraud prevention plan at levels;<br>• Strengthening of security at the medicines depot and facilities. |
| **Budget constraints (pressures on baseline)** | • Enhance revenue collection strategies<br>• Reduce fruitless and wasteful expenditure<br>• PCCCM / DCCCM reports<br>• Strengthen compliance by Pre- audit services |

# PROGRAMME 2

# District Health Services



# Programme 2
# District Health Services (DHS)

## Programme Purpose

To ensure the delivery of primary health care services through the implementation of the District Health System.

### Programme Description

The District Health Service (DHS) programme is responsible for the management of health services in the eight (8) districts of the Province. The services offered are mainly preventive and minor curative, maternal, child and women's health and nutrition, HIV and AIDS, STI and TB (HAST), prevention and control of chronic diseases, public health / other community-based services such waste management, and coroner services. These are offered through the following service delivery platforms: community Health Clinics, Community Health Centres (CHCs) and District Hospitals

Based on the current structure, the DHS programme is composed of nine sub-programmes, namely:

2.1 District Management
2.2 Community Health Clinics
2.3 Community Health Centres (CHCs)
2.4 Community-based Services
2.5 Public Health / Other Community Based Services
2.6 HIV & AIDS, STI and TB (HAST) Control
2.7 Maternal, Child and Women's Health & Nutrition
2.8 Coroner Services
2.9 District Hospitals

### Priorities for the Next Three Years

- To implement the model for the delivery of health services in the Eastern Cape based on the re-engineering of primary health care (PHC) services
- To implement and strengthen NHI preparatory phase in the pilot district
- To prevent and reduce morbidity and mortality related to TB, HIV/AIDS and STIs
- To reduce perinatal, infant and child mortality and maternal mortality within the Province
- To improve early detection and management of people with chronic conditions

### Key interventions targeted by District Management Team to strengthen implementation in the Districts and enable implementation of District Health Plan

- Proper implementation of HPRS to address long waiting times
- Establish fast lanes to address long waiting times
- Strengthen implementation of CCMDD
- Strengthen implementation of Community Based Services
- Institutionalize integrated clinical services management (ICSM) across the PHC platform

### Key interventions targeted by Provincial Head Office to support and build capacity in all Districts to enable implementation of their District Health Plan

### Governance, Leadership & Management

- Strengthening of leadership and management of Primary Health Care facilities and district hospitals in the implementation of Ideal Health Facilities Realisation and Maintenance (IHRM) initiative by developing guidelines on integrated approach in PHC supervision and programme management through the District Perfect Permanent Team;
- Appointment of Operational Managers and development of an induction program on facility management;
- Allocation of Infrastructure and medical equipment budget dedicated to prioritised gaps as identified by the district to enhance the quality of care.
- Facilitate community participation in health planning, provisioning and monitoring by appointment and training of health governance structures, clinic committees and District Health Council.

## Quality Care

- Allocate budget for six priority areas for quality standard.

## Health Information Management

- Institutionalise District Health Information Management System (DHIMS) Policy and Standard Operating Procedures (SOP's)
- Strengthen effective implementation of Health Patient Registration System (HPRS).
- Implement TBHIV integration system in all the districts

## Strategic Goals being Addressed:

**Strategic goal 1**: Prevent and reduce the disease burden and promote health
**Strategic goal 2**: Improved quality of care
**Strategic goal 3:** Universal Health Care Coverage

## Service Delivery Platform for DHS

Table 14: District Health Service facilities by health district in 2018/19

| HEALTH DISTRICT | FACILITY TYPE | NO | POPULATION[3] | POPULATION PER PHC FACILITY[3] | PER CAPITA UTILIZATION [3] |
|---|---|---|---|---|---|
| ALFRED NZO | Non-fixed clinics[1] | 9 | | 7 779 | 2.1 |
| | Fixed clinics[2] | 72 | | 11930 | 2.2 |
| | CHCs | 2 | | 46 745 | 2.2 |
| | SUB-TOTAL CLINICS + CHCS | 74 | | 11 607 | 2.2 |
| | DISTRICT HOSPITALS | 6 | 866 646 | | |
| AMATHOLE | Non-fixed clinics[1] | 28 | | 2 222 | 2.1 |
| | Fixed clinics[2] | 143 | | 6 707 | 2.5 |
| | CHCs | 5 | | 34 341 | 2.6 |
| | SUB-TOTAL CLINICS + CHCS | 148 | | 6 526 | 2.5 |
| | DISTRICT HOSPITALS | 12 | 972 188 | | |
| BUFFALO CITY METRO | Non-fixed clinics[1] | 12 | | 2 049 | 2.5 |
| | Fixed clinics[2] | 74 | | 11 677 | 2.8 |
| | CHCs | 5 | | 56 231 | 2.8 |
| | SUB-TOTAL CLINICS + CHCS | 79 | | 10 938 | 2.8 |
| | DISTRICT HOSPITALS | 2 | 874 199 | | |
| SARAH BAARTMAN | Non-fixed clinics[1] | 30 | | 1 763 | 3.4 |
| | Fixed clinics[2] | 59 | | 8 727 | 3.5 |
| | CHCs | 3 | | 12 409 | 3.2 |
| | SUB-TOTAL CLINICS + CHCS | 62 | | 8 305 | 3.5 |
| | DISTRICT HOSPITALS | 10 | 522 720 | | |
| CHRIS HANI | Non-fixed clinics[1] | 29 | | 1 900 | 2.5 |
| | Fixed clinics[2] | 152 | | 5 320 | 3.0 |
| | CHCs | 7 | | 13 147 | 3.1 |
| | SUB-TOTAL CLINICS + CHCS | 159 | | 5 121 | 3.0 |
| | DISTRICT HOSPITALS | 14 | 818 915 | | |
| NELSON MANDELA METRO | Non-fixed clinics[1] | 13 | | 2 675 | 2.5 |
| | Fixed clinics[2] | 39 | | 31 975 | 3.1 |
| | CHCs | 9 | | 33 653 | 3.1 |
| | SUB-TOTAL CLINICS + CHCS | 48 | | 26 647 | 3.1 |
| | DISTRICT HOSPITALS | 1 | 1 298 412 | | |
| O.R. TAMBO | Non-fixed clinics[1] | 11 | | 7 186 | 2.6 |
| | Fixed clinics[2] | 136 | | 10 986 | 2.8 |
| | CHCs | 10 | | 148 306 | 2.7 |
| | SUB-TOTAL CLINICS + CHCS | 146 | 1 492 014 | 10 986 | 2.8 |

| Table 14: District Health Service facilities by health district in 2018/19 | | | | | |
|---|---|---|---|---|---|
| **HEALTH DISTRICT** | **FACILITY TYPE** | **NO** | **POPULATION[3]** | **POPULATION PER PHC FACILITY[3]** | **PER CAPITA UTILIZATION [3]** |
| | DISTRICT HOSPITALS | 9 | | | |
| **JOE GQABI** | Non-fixed clinics[1] | 19 | | 1 881 | 2.5 |
| | Fixed clinics[2] | 52 | | 7 068 | 2.7 |
| | CHCs | 0 | | 0 | |
| | SUB-TOTAL CLINICS + CHCS | 52 | | 7 068 | 2.7 |
| | DISTRICT HOSPITALS | 11 | 371 240 | | |
| **PROVINCE** | Non-fixed clinics[1] | 152 | | 2 701 | 2.5 |
| | Fixed clinics[2] | 727 | | 6 614 | 2.8 |
| | CHCs | 41 | | 30 631 | 2.8 |
| | SUB-TOTAL CLINICS + CHCS | 768 | | 6 614 | 2.8 |
| | DISTRICT HOSPITALS | 65 | 7 216 334 | | |

Source: Population – DHIS population figures. Total Number of Facilities – DHIS 2017/18 1. Non-fixed clinics should include mobile and satellite clinics (exclude visiting points). 2. Fixed clinics operated by Provincial Government must include gateway clinics and state aided Hospitals that provide Level 1 care. 3. PHC facility headcounts and Hospital inpatient separations should be used for per capita utilisation.

## 2.1 Sub – Programme: District Management

### Sub-Programme Purpose

The sub-programme manages the effectiveness, functionality and the coordination of health services, referrals, supervision, evaluation and reporting as per provincial and national policies and requirements.

### Provincial Strategic Objectives Indicators, Annual and Quarterly Targets for DHS Sub-Programmes 2.1

Table15: Programme performance indicators for District Management sub programmes 2.1

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| Ensure total population is utilizing public Primary Health Care facilities at least 3 times a year by 2019 | Strategic objective 1.1 PHC utilisation rate increased to 3 visits per person per year in all facilities by 2019 | | | | | | | | | | | | |
| | 1.1.1 PHC utilisation rate – Total[2] | No. Quarterly | 2.7 | 2.7 | 2.3 | 2.3 | **2.5** | **2.5** | **2.5** | **2.5** | **2.5** | 2.5 | 2.5 |
| | *Numerator* | | 18 207 610 | 18 096 847 | 16 418 041 | 17 587 424 | **17 918 165** | **[3]4 479 541** | **4 479 541** | **4 479 541** | **4 479 541** | 17 918 165 | 17 918 165 |
| | *Denominator* | | 6 692 804 | 6 741 704 | 7 167 266 | 7 216 334 | **7 167 266** | **7 167 266** | **7 167 266** | **7 167 266** | **7 167 266** | 7 167 266 | 7 167 266 |

[2] Utilisation rate: annualized indicator, you multiply numerator by 4 to get the actual number of visits

## 2.2 Sub-Programme: Clinics

### Sub- Programme Purpose

The sub-programme manages the provision of preventive, promotive, curative and rehabilitative care, including the implementation of priority health programmes through accessible fixed clinics, outreach services (reengineering of PHC services) and mobile services in 26 sub-districts.

### Provincial Strategic Objectives Indicators, Annual and Quarterly Targets for DHS Sub-Programmes 2.2

Table 16: Programme performance indicators for Clinics, sub programmes 2.2

| Strategic Objective Statement | Programme Performance Indicator 2019/20 | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| Ensure all PHC facilities are conditionally compliant by 2017 and fully compliant to National Core Standards by 2019 | **Strategic objective 2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019** | | | | | | | | | | | | |
| | 2.3.22 Ideal clinic (IC) status rate | % Annually | New indicator | New indicator | New indicator | 10.8% | **19.9%** | - | - | - | **19.9%** | 20.6% | 29.5% |
| | *Numerator* | | | | | 79 (17 new) | **145** | | | | **145** | 150 | 200 |
| | *Denominator* | | | | | 731 | **727** | | | | **727** | 727 | 727 |
| Ensure all PHC facilities are conditionally compliant by 2017 and fully compliant to National Core Standards by 2019 | **Strategic objective 2.4 Patient experience of care rate satisfaction rate increased to more than 75% in health services by 2019** | | | | | | | | | | | | |
| | 2.4.27 Complaints resolution within 25 working days rate | % Quarterly | New indicator | New indicator | New indicator | 97.6% | **85%** | **85%** | **85%** | **85%** | **85%** | 85% | 85% |
| | *Numerator* | | | | | 4837 | | | | | | | |
| | *Denominator* | | | | | 4 955 | | | | | | | |

## 2.3 Sub – Programme: Community Health Centers (CHCS)

### Sub – Programme Purpose

The sub-programme renders 24-hour health services, maternal health at midwifery units, provision of trauma services and the integration of community-based mental health services within the down referral system.

### Provincial Strategic Objectives Indicators, Annual and Quarterly Targets for DHS Sub-Programmes 2.3

Table 17: Programme performance indicators for CHCs, sub programmes 2.3

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| Ensure all PHC facilities are conditionally compliant by 2017 and fully compliant to National Core Standards by 2019 | **Strategic objective 2.4 Patient experience of care rate satisfaction rate increased to more than 75% in health services by 2019** | | | | | | | | | | | | |
| | 2.4.27 Complaints resolution within 25 working days rate | % Quarterly | New indicator | New indicator | New indicator | 100% | **85%** | **85%** | **85%** | **85%** | **85%** | 85% | 85% |
| | *Numerator* | | | | | 124 | | | | | | | |
| | *Denominator* | | | | | 124 | | | | | | | |

## 2.4 Sub-Programme: Community Based Services – Disease Prevention and Control (Non-Communicable Diseases)

### Sub - Programme Purpose

The Community-based Services sub-programme manages the implementation of the Community-based Health Services Framework. This includes:

- Implementation of disease-prevention strategies at a community level
- Promoting healthy lifestyles through health education and support
- Providing chronic and geriatric services including rehabilitation as a supportive service
- Providing oral health services at a community level (including schools and old age homes)
- Strengthening the prevention of mental disorders, substance, drug, and alcohol abuse to reduce unnatural deaths

### Strategic Goal Being Addressed:

**Strategic goal 1:** Prevent and reduce the disease burden and promote health; and
**Strategic goal 2:** Improved quality of care

## Provincial Strategic Objectives, Indicators, Annual and Quarterly Targets For DPC

Table 18: Performance indicators for Disease Prevention and Control sub – programme for 2.4

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| Reduce hypertension and diabetes incidence by 2019 | **Strategic objective 1.2 Screening coverage of chronic illnesses increased to more than a million by 2019** | | | | | | | | | | | | |
| | 1.4. 1 Clients 40 years and older screened for hypertension | No Quarterly | New indicator | New indicator | 1 915 398 | 1 472 060 | **1 500 000** | **375 000** | **375 000** | **375 000** | **375 000** | 1 585 632 | 1 6000 00 |
| | 1.4.2 Clients 40 years and older screened for diabetes | No Quarterly | New indicator | New indicator | 2 140 599 | 1 824 893 | **1 542 304** | **385 575** | **385 575** | **385 575** | **385 575** | 1 582 200 | 1 600 000 |
| Increase the number of people treated for mental disorders by 2019 | 1.4.3 Mental disorders screening rate | % Quarterly | 2.2% | 6.5% | 15% | 25% | **20%** | **20%** | **20%** | **20%** | **20%** | 20% | 20% |
| | *Numerator* | | | 1 176 690 | 2 518 835 | 2 893 559 | **3 283 608** | **820 902** | **820 902** | **820 902** | **820 902** | 3 283 608 | 3 283 608 |
| | *Denominator* | | | 18 076 847 | 16 418 041 | 4 396 856 | **16 418 041** | **4 104 510** | **4 104 510** | **4 104 511** | **4 104 510** | 16 418 041 | 16 418 041 |

Note: Malaria is not endemic in the Eastern Cape

## 2.5 Sub-Programme: Public Health / Other Community Based Services

### Sub- Programme Purpose

The Other Community Services sub-programme manages the devolution of municipal health service from the Department of Health to the district municipalities and metros, (health care waste management and other hazardous substances control)

### Strategic Goal Being Addressed:

**Strategic goal 1:** Prevent and reduce the disease burden and promote health

### Provincial Strategic Objectives, Indicators, Annual and Quarterly Targets For Public Health / Other Community Based Services

Table 19: Performance indicators for Public Health / Other Community Based Services sub – programme 2.5

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| Ensure that all facilities comply with SANS waste disposal requirements when segregating waste | **Strategic objective 2.5 100% Compliance with the Waste Management Act by 2019** | | | | | | | | | | | | |
| | 2.5.1 Percentage of hospitals complying with SANS waste disposal requirements | % Quarterly | 100% | 100% | 85% | 85.4% | **100%** | **100%** | **100%** | **100%** | **100%** | 100% | 100% |
| | *Numerator* | | 89 | 89 | 76 | 76 | **89** | **89** | **89** | **89** | **89** | 89 | 89 |
| | *Denominator* | | 89 | 89 | 89 | 89 | **89** | **89** | **89** | **89** | **89** | 89 | 89 |

## 2.6 Sub-Programme: HIV & AIDS, STI & TB (HAST) Control

### Sub – Programme Purpose

To control the spread of HIV infection, reduce and manage the impact of the disease to those infected and affected in line with PDP goals, and to control the spread of TB, manage individuals infected with the disease and reduce the impact of the disease in the communities.

### Key interventions targeted by District Management Team to strengthen implementation in the Districts and enable implementation of District Health Plan

- Monitor and strengthen implementation of support by partners
- Re-test all pregnant women who were negative on the first visit and at delivery
- Educate communities, families and primary care givers on importance of child adherence to treatment and TB treatment completion
- Strengthen data management

### Key interventions targeted by Provincial Head Office to support and build capacity in all Districts to enable implementation of their District Health Plan

- **Prevention initiative** that work collaboratively with all sections, through coordination of the Eastern Cape AIDS Council (ECAC), targeting the high risk population, youth and young women to prevent both TB and HIV new infections. Focus on behaviour change initiative, and avail HIV prevention commodities such as condoms, HIV testing services (HTS). Implementation of (MPTCT) and safe male circumcision
- **Case finding initiative** that entails, amongst others intensive screening of TB (Find Actively, Separate Temporarily (FAST) and Treat Effectively) lateral flow Lipoarabinomannan LF-LAM) and HIV testing in build-up activities toward and during events such as First Things First Campaign. Rotary family health days, World Aids Day and TB Day in collaboration with other sectors
- **Treatment initiation initiatives** Universal Test and Treat (UTT) to scale up initiation of patients to treatment as well as the shortened regimen (nine months) for the management of multi-Drug resistant TB (MDR TB) patients
- **Differentiated Care initiative** that entails the implementation of the Adherence Clubs and Central Chronic Medication Dispensing Distribution(CCMDD)

### Strategic Goal Being Addressed:

**Strategic goal 1:** Prevent and reduce the disease burden and promote health

## Situational Analysis Indicators for HIV & AIDS, STIS and TB Control

Table 20: Situation analysis indicators for HIV & AIDS, STIs and TB Control sub – programme

| Programme performance indicators | Type | Province-wide value 2017/18 | Alfred Nzo 2017/18 | Amathole 2017/18 | BCM 2017/18 | Chris Hani 2017/18 | Sarah Baartman 2017/18 | Nelson Mandela 2017/18 | OR Tambo 2017/18 | Joe Gqabi 2017/18 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1.5.1 ART Client remain on ART end of month –total | No | **452 072** | 67 883 | **58 671** | 56 807 | **55 142** | 24 852 | **57 947** | 105 532 | **25 238** |
| 1.5.2 TB/HIV co-infected client on ART rate | % | **94.5** | 97.2 | **96.6** | 90.2 | **96.9** | 95.3 | **94.6** | 94.5 | **88.9** |
| 1.5.3 HIV test done – total | No | **1 726 702** | 221 157 | **389 677** | 153 711 | **214 517** | 94 738 | **228 091** | 360 413 | **64 398** |
| 1.5.4 Male condom distributed | No | **61 256 400** | 4 063 200 | **8 275 400** | 3 261 600 | **10 180 100** | 6 054 000 | **10 528 000** | 13 608 900 | **5 285 200** |
| 1.5.6 Medical male Circumcision-Total | No | **8 782** | 2840 | **355** | 517 | **528** | 378 | **1147** | 2954 | **63** |
| 1.6.1 TB client 5yrs and older start on treatment rate | % | **109** | 116.6 | **103** | 85.5 | **111.5** | 107.3 | **101** | 136.1 | **115.1** |
| 1.6.2 TB client treatment success rate | % | **80.3** | | **79.9** | 83.1 | | 71.6 | **79.6** | 85.1 | **76.6** |
| 1.6.3 TB client lost to follow up rate | % | **0.5** | | **0.6** | 0.7 | | 0.5 | **0.7** | 0 | **0.4** |
| 1.6.4 TB death rate | % | **6.4** | | **7** | 5.4 | | 6.8 | **6.5** | 3.2 | **8.4** |

## Provincial Strategic Objectives, Indicators, Annual and Quarterly Targets for HAST

Table 21: Performance indicators for HIV & AIDS, STI AND TB Control sub – programme 2.6

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| Progressively ensure all HIV positive patients eligible for treatment are initiated on ART | **Strategic objectives 1.5 HIV infection rate reduced by 15% by 2019** | | | | | | | | | | | | |
| | 1.5.1 ART Client remain on ART end of month – total | No. Quarterly | 361 166 | 414 733 | 452 072 | 483 806 | **635 706** | **521 567** | **559 328** | **597 090** | **635 706** | 708 928 | 782 150 |
| | 1.5.2 TB/HIV co-infected client on ART rate | % Quarterly | New indicator | 97.3% | 97% | 92.7% | **95%** | **95%** | **95%** | **95%** | **95%** | 95% | 95% |
| | *Numerator* | | | 18 748 | 17 690 | 3 692 | **17 859** | **4 464** | **4 465** | **4 465** | **4 465** | 17 859 | 17 859 |
| | *Denominator* | | | 19 274 | 18 273 | 3 983 | **18 798** | **4 699** | **4 699** | **4 700** | **4 700** | 18 798 | 18 798 |
| | 1.5.3 HIV test | No. | 1 696 368 | 1 932 800 | 1 726 | 1 361 600 | **1 748 488** | **437 122** | **437 122** | **437 122** | **437 122** | 1 748 488 | 1 748 488 |

Table 21: Performance indicators for HIV & AIDS, STI AND TB Control sub – programme 2.6

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| | done – total | Quarterly | | | 702 | | | | | | | | |
| Reduce HIV Incidence to more 50% by2019 | 1.5.4 Male Condoms distributed | No. Quarterly | 2 442 061 | 119 498 754 | 61 256 400 | 62 052 116 | **108 675 419** | **27 168 854** | **27 168 855** | **27 168 855** | **27 168 855** | 108 675 419 | 108 675 419 |
| | 1.5.6 Medical male Circumcision-Total[4] | No. Quarterly | 10 029 | 56 859 | 60 835 | 7 478 | **30 841** | **2 891** | **11 360** | **2 891** | **13 699** | 26 926 | 26 926 |
| Increase TB cure rate to more 50% by 2019 | **Strategic objectives 1.6 TB death rate reduced by 30% in 2019** | | | | | | | | | | | | |
| | 1.6.1 TB client 5yrs and older start on treatment rate | % Quarterly | New Indicator | New Indicator | 106 % | 103% | **95%** | **95%** | **95%** | **95%** | **95%** | 96% | 97% |
| | Numerator | | | | 29 956 | 24 387 | **28 500** | **7 125** | **7 125** | **7 125** | **7 125** | 29 000 | 29 500 |
| | Denominator | | | | 27 473 | 23 938 | **30 000** | **7 500** | **7 500** | **7 500** | **7 500** | **30 100** | **30 300** |
| | 1.6.2 TB client treatment success rate | % Quarterly | 83.7% | 84.8% | 86% | 78.4% | **85%** | **85%** | **85%** | **85%** | **85%** | 86% | 86% |
| | *Numerator* | | 18 400 | 14 948 | 12 027 | 8 191 | **37 912** | **9 478** | **9 478** | **9 478** | **9 478** | 37825 | 37868 |
| | *Denominator* | | 21 990 | 17 633 | 14 009 | 10 438 | **44488** | **11122** | **11122** | **11122** | **11122** | 44500 | 4550 |
| | 1.6.3 TB client lost to follow up rate | % Quarterly | 6.8% | 7.1% | 6.8% | 8.3% | **7%** | **7%** | **7%** | **7%** | **7%** | 6.5% | 6% |
| | *Numerator* | | 1 500 | 1 252 | 3 031 | 868 | **3114** | **779** | **779** | **778** | **778** | 2893 | 2673 |
| | *Denominator* | | 21 990 | 17 633 | 44 356 | 10 438 | **44488** | **11 122** | **11 122** | **11 122** | **11 122** | 44500 | 44550 |
| | 1.6.4 TB death rate | % Quarterly | 5.2% | 5.3% | 4.4% | 6.2% | **6%** | **6%** | **6%** | **6%** | **6%** | 5% | 5% |
| | *Numerator* | | 1 140 | 936 | 614 | 647 | **2 669** | **667** | **667** | **668** | **667** | 2225 | 2228 |

[4] The 2019/20 target for MMC indicator includes TMC with MMC Target (12 000)

| Table 21: Performance indicators for HIV & AIDS, STI AND TB Control sub – programme 2.6 | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Strategic Objective Statement** | **Programme Performance Indicator** | **Indicator Type & Reporting frequency** | **Audited/ Actual Performance** | | | **Estimated Performance** | **Medium Term Targets** | | | | | | |
| | | | **2015/16** | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2019/20 QUARTERLY TARGETS** | | | | **2020/21** | **2021/22** |
| | | | | | | | | **Q1** | **Q2** | **Q3** | **Q4** | | |
| | *Denominator* | | 21 990 | 17 633 | 14 009 | 10 438 | **44 488** | **11 122** | **11 122** | **11 122** | **11 122** | 44 500 | 44550 |
| Combat TB by ensuring all MDR – TB patients are initiated on treatment by 2019 | 1.6.6 TB MDR treatment success rate[5] | % Quarterly | 37% | 49.7% | 51% | 62.5% | **60%** | **60%** | **60%** | **60%** | **60%** | 60% | 60% |
| | *Numerator* | | 725 | 823 | 930 | 158 | **1 382** | **345** | **346** | **346** | **345** | 1451 | 1451 |
| | Denominator | | 1 981 | 1655 | 1 826 | 253 | **2304** | **576** | **576** | **576** | **576** | 2419 | 2419 |

[5] MDR-TB patients are diagnosed by facilities and are sent to the MDR-TB Hospitals for initiation of treatment. It is not possible to obtain this information for each district, and we are only able to get reports

## 2.7 Maternal, Child and Women's Health and Nutrition (MCWH&N)

### Sub – Programme Purpose

To reduce mother, new born and child mortality through strengthened maternal and child as well as nutrition health services across the Eastern Cap e Province

### Key interventions targeted by District Management Team to strengthen implementation in the Districts and enable implementation of District Health Plan

- Ensure availability of tracer medicines at all times
- Conduct cluster clinical audits and performance reviews
- Identify pregnant woman at household by WBOT for early booking and referral
- Review Planned Patient Transport for high risk clinics
- Establish and strengthen structured high-risk clinics for early detection and reduction of complications
- Capacitate doctors and nurses on ESMOE

### Key interventions targeted by Provincial Head Office to support and build capacity in all Districts to enable implementation of their District Health Plan

- PHC Reengineering Strategy with special emphasis on District Clinical Specialist Team (DCSTs) that gives support to maternal.
- Integrated School Health (ISH) policy implemented in collaboration with Department of Education.
- Leaner behavior change programme launched with the Departments of Education and Social Development to provide services and contraceptives.
- Emergency Medical and Rescue Services (EMRS) for pregnant women
- Clustering od district hospitals to perform 24hr caesarean sections
- Building capacity of doctors on sexual reproductive health rights programme
- Implementation of Reach Every District (RED) Strategy in all districts to increase immunisation coverage in communities. The RED strategy is an Immunisation strategy to Reach Every Child (REC)

### Strategic Goals Being Addressed:

**Strategic goal 1:** Prevent and reduce the disease burden and promote health

## Situational Analysis Indicators for Maternal, Child and Women's Health and Nutrition (MCWH&N)

Table 22: Situational Analysis Indicators for MCWH&N sub – programme 2.7

| Programme performance indicators | Type | Province-wide value 2017/18 | Alfred Nzo 2017/18 | Amathole 2017/18 | BCM 2017/18 | Chris Hani 2017/18 | Sarah Baartman 2017/18 | Nelson Mandela 2017/18 | OR Tambo 2017/18 | Joe Gqabi 2017/18 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1.7.1 Antenatal 1st visit before 20 weeks rate | % | **65%** | 47.8% | **70.8%** | 66.9% | **68.2%** | 69.8% | **66.7%** | 66.8% | **64.6%** |
| 1.7.2 Mother postnatal visit within 6 days rate | % | **63%** | 54.8% | **108.7%** | 43.2% | **69.2** | 66.4% | **66%** | 57.1% | **67.5%** |
| 1.8.1 Infant 1st PCR test positive around 10 weeks rate | % | **1.2%** | 1.7% | **1.1%** | 0.62% | **1.7%** | 0.98% | **0.82%** | 1.3% | **1.9%** |
| 1.8.2 Immunisation under 1-year coverage | | **68.4** | 73.6 | **59.5** | 63 | **70.4** | 55.8 | **58.1** | 84.7 | **64.2** |
| 1.8.3 Measles 2nd dose coverage | | **65.8** | 68.6 | **58.3** | 62.8 | **73.8** | 55 | **53.4** | 78.3 | **64** |
| 1.8.5 Diarrhoea case fatality under 5 years rate | % | **3.6%** | 5.5% | **2.4%** | 1.9% | **1.8%** | 2.5% | **2.1%** | 7.3% | **4.9%** |
| 1.8.6 Pneumonia case fatality under 5 years rate | % | **3.7%** | 5.8% | **1.7%** | 0.6% | **2.7%** | 0.33% | **3%** | 7.4% | **2.9%** |
| 1.8.7 Severe acute malnutrition case fatality under 5 years rate | % | **12%** | 10.9% | **11.4%** | 13.6% | **11.5%** | 1.2% | **4.1%** | 18.6% | **2%** |
| 3.4.2 School Grade 1 – learners screened | | **46744** | 3120 | **6571** | 2853 | **8289** | 2802 | **4482** | 14287 | **4340** |
| 3.4.3 School Grade 8 learners screened | No | **26716** | 2029 | **2218** | 268 | **4437** | 3302 | **2808** | 9100 | **2554** |
| 1.7.6 Delivery in 10 to 19 years in facility rate | No | **15.4** | 24.7 | **17.3** | 6.6 | **16.7** | 13.7 | **7.7** | 20 | **16.5** |
| 1.7.4 Couple year protection rate (int.) | | **48.6** | 29.6 | **47.8** | 33.9 | **64.7** | 66.9 | **51.4** | 49 | **60** |
| 1.2.4 Cervical cancer screening coverage 30 years and older | | **63.2** | 38.1 | **75.6** | 85.3 | **69.1** | 55.6 | **51.3** | 67.4 | **56.2** |
| 1.8.10 Human Papilloma Virus Vaccine 1st dose coverage | No | **57 286** | 9 359 | **8 502** | 6 026 | **5491** | 3 094 | **7 105** | 15 291 | **3 459** |
| 1.8.11 Human Papilloma Virus Vaccine 2nd dose coverage | No | **44 637** | 7 049 | **6 211** | 5 376 | **3 871** | 2 165 | **5 260** | 12 517 | **3 218** |
| 1.8.9 Neonatal death in facility rate | Per 1000 | **14/1000** | 12.2 | **8.5** | 16.8 | **12** | 10.2 | **12.5** | 17.3 | **11.5** |
| 1.7.5 Maternal mortality in facility ratio | per 100 000 Live Births | **128/ 100 000** | 63.1 | **55.6** | 99.7 | **148** | 143.5 | **128.3** | 198.7 | **20.3** |

## Provincial Strategic Objectives, Indicators, Annual and Quarterly Targets For Maternal, Child and Women's Health And Nutrition

Table 23: Performance indicators for Maternal, Child and Women's Health and Nutrition sub – programme 2.7

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| Ensure 80% of mothers receive post antenatal care and exclusive breast feeding by 2019 | **Strategic objectives 1.7 Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019** | | | | | | | | | | | | |
| | 1.7.1 Antenatal 1st visit before 20 weeks rate | % Quarterly | 59.7% | 63.8% | 65% | 62% | **70%** | **70** | **70** | **70** | **70** | 70 | 70 |
| | *Numerator* | | 65 053 | 67 292 | 70 962 | 54 333 | **76 612** | **19 153** | **19 153** | **19 153** | **19 153** | 76 612 | 76 612 |
| | *Denominator* | | 108 895 | 105 472 | 109 447 | 87 622 | **109 447** | **27 361** | **27 362** | **27 362** | **27 362** | 109 447 | 109 447 |
| | 1.7.2 Mother post-natal visit within 6 days rate | % Quarterly | 58.2% | 60% | 63% | 66.6% | **67%** | **67%** | **67%** | **67%** | **67%** | 68% | 68% |
| | *Numerator* | | 61 800 | 59 497 | 63 752 | 51 949 | **73 329** | **18 332** | **18 332** | **18 333** | **18 332** | 74 423 | 74 423 |
| | *Denominator* | | 106 244 | 99 623 | 109 447 | 78 031 | **109 447** | **27 361** | **27 362** | **27 362** | **27 362** | 109 447 | 109 447 |
| Progressively ensure all HIV positive patients eligible for treatment are initiated on ART by 2019 | 1.7.3 Antenatal client start on ART rate | % Quarterly | 94% | 93.3% | 86.6% | 93.7% | **95%** | **95%** | **95%** | **95%** | **95%** | 95% | 95% |
| | *Numerator* | | 19 122 | 16 581 | 12 985 | 8 803 | **14 247** | **3 561** | **3 562** | **3 562** | **3 562** | 14 247 | 14 247 |
| | *Denominator* | | 20 370 | 17 772 | 14 997 | 9 395 | **14 997** | **3 749** | **3 749** | **3 750** | **3 749** | 14 997 | 14 997 |
| | **Strategic objectives 1.8 Child Mortality Reduced to less than 34 per 1000 population by 2019** | | | | | | | | | | | | |
| Reduce mother to child transmission rate to 2% by 2019 | 1.8.1 Infant PCR test positive around 10 weeks rate | % Quarterly | New indicator | 1.6% | 1.2% | 1.3.% | **1%** | **1%** | **1%** | **1%** | **1%** | 1% | 1% |
| | *Numerator* | | | 214 | 244 | 194 | **200** | **50** | **50** | **50** | **50** | 200 | 200 |
| | *Denominator* | | | 13 584 | 20 084 | 15 883 | **20 084** | **5 021** | **5 021** | **5 021** | **5 021** | 20 084 | 20 084 |
| Ensure 90% of children are vaccinated and monitored for growth by 2019 | 1.8.2 Immunisation under 1-year coverage | % Quarterly | 86.1% | 78.6% | 69% | 70.3 **%** | **90%** | **90%** | **90%** | **90%** | **90%** | 90% | 90% |
| | *Numerator* | | 118 192 | 103 757 | 111 191 | 114 429 | **146 133** | **146 133** | **146 133** | **146 133** | **146 133** | 146 133 | 146 133 |
| | *Denominator* | | 137 328 | 131 801 | 16 2 370 | 162 773 | **162 370** | **162 370** | **162 370** | **162 370** | **162 370** | 162 370 | 162 370 |
| | 1.8.3 Measles | % | 81% | 91.6% | 66% | 64.8% | **90%** | **90%** | **90%** | **90%** | **90%** | 90% | 90% |

Table 23: Performance indicators for Maternal, Child and Women's Health and Nutrition sub – programme 2.7

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| | 2nd dose coverage | Quarterly | | | | | | | | | | | |
| | *Numerator* | | 114 371 | 125 914 | 109 211 | 108 505 | **149 877** | **149 877** | **149 877** | **149 877** | **149 877** | 149 877 | 149 877 |
| | *Denominator* | | 141 882 | 137 503 | 166 530 | 167 446 | **166 530** | **166 530** | **166 530** | **166 530** | **166 530** | 166 530 | 166 530 |
| | 1.8.5 Diarrhoea case fatality Under 5 years rate | % Quarterly | 3.6% | 3.7% | 3.6% | 2.6% | **2.8%** | **2.8 %** | **2.8 %** | **2.8 %** | **2.8 %** | 2.8% | 2.8% |
| | *Numerator* | | 256 | 212 | 125 | 80 | **98** | **25** | **24** | **24** | **25** | 98 | 98 |
| | *Denominator* | | 7 032 | 5 727 | 3 491 | 2 985 | **3 491** | **872** | **873** | **873** | **873** | 3 491 | 3 491 |
| | 1.8.6 Pneumonia case fatality under 5 years rate | % Quarterly | 3.7% | 3% | 3.7% | 3.2% | **3 %** | **3 %** | **3 %** | **3 %** | **3 %** | 3 % | 3 % |
| | *Numerator* | | 257 | 188 | 144 | 109 | **117** | **29** | **29** | **29** | **30** | 117 | 117 |
| | *Denominator* | | 7 012 | 6 232 | 3 909 | 3 348 | **3 909** | **977** | **977** | **977** | **977** | 3 909 | 3 909 |
| | 1.8.7 Severe acute malnutrition death under 5 years rate | % Quarterly | 10.1% | 10.2% | 12% | 9.9% | **9%** | **9%** | **9%** | **9%** | **9%** | 7% | 7% |
| | *Numerator* | | 284 | 226 | 161 | 93 | **123** | **30** | **31** | **31** | **31** | 95 | 95 |
| | *Denominator* | | 2 819 | 2 221 | 1 363 | 939 | **1 363** | **340** | **341** | **341** | **341** | 1 363 | 1 363 |
| Ensure quintile 1&2 schools are providing school health services by 2019 | **Strategic objectives 3.4 40% of Quintile 1&2 school screened by Integrated School Health (ISH) Teams in 2019** | | | | | | | | | | | | |
| | 3.4.2 School Grade 1 – learners screened | No Quarterly | 40 531 | 33 854 | 46 744 | 24 380 | **48 178** | **9 310** | **14 934** | **14 934** | **9000** | 59 280 | 59 280 |
| | 3.4.3 School Grade 8 learners screened | No Quarterly | 12 586 | 18 801 | 26 716 | 13 238 | **30 820** | **7 876** | **8 988** | **9 978** | **3 978** | 40 688 | 40 688 |
| Reduce Maternal Mortality Ratio to 215 per 100 | **Strategic objectives 1.7 Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019** | | | | | | | | | | | | |
| | 1.7.6 Delivery in 10 to 19 years in | % Quarterly | New Indicator | New Indicator | 15.4% | 16.5% | **10%** | **10%** | **10%** | **10%** | **10%** | 10% | 10% |

Table 23: Performance indicators for Maternal, Child and Women's Health and Nutrition sub – programme 2.7

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| 000 live births 2019 | facility rate | | | | | | | | | | | | |
| | *Numerator* | | | | 15 474 | 12 875 | **10 075** | **10 075** | **10 075** | **10 075** | **10 075** | 10 075 | 10 075 |
| | *Denominator* | | | | 100 759 | 78 031 | **100 759** | **100 759** | **100 759** | **100 759** | **100 759** | 100 759 | 100 759 |
| | 1.7.4 Couple year protection rate (int.) | % Quarterly | 53.6% | 54.6% | 49% | 68.7% | **65%** | **65%** | **65%** | **65%** | **65%** | 68% | 68% |
| | *Numerator* | | 955 064 | 980 539 | 916 626 | 326 335 | **1 221 398** | **1 221 398** | **1 221 398** | **1 221 398** | **1 221 398** | 1 277 770 | 1 277 770 |
| | *Denominator* | | 1 780 807 | 1 796 910 | 1 879 074 | 1 897 817 | **1 879 074** | **1 879 074** | **1 879 074** | **1 879 074** | **1 879 074** | 1 879 074 | 1 879 074 |
| Ensure that at least 48% of all women 30 years and older are screened once every 10 years | **Strategic objectives 1.2 Screening coverage of chronic illnesses increased to more than a million by 2019** | | | | | | | | | | | | |
| | 1.2.4 Cervical cancer screening coverage 30 years and older | % Quarterly | 57.4% | 60.9% | 60.3% | 80.7% | **70%** | **70%** | **70%** | **70%** | **70%** | 70% | 70% |
| | *Numerator* | | 85 017 | 91 936 | 92 782 | 120 096 | **107 689** | **26 922** | **26 922** | **26 923** | **26 922** | 107 689 | 107 689 |
| | *Denominator* | | 147 556 | 150 874 | 153 842` | 148 844 | **153 842** | **153 842** | **153 842** | **153 842** | **153 842** | 153 842 | 153 842 |
| | **Strategic objectives 1.13 Reduced death rate by 10% from NCDs by 2019** | | | | | | | | | | | | |
| Administer HPV vaccine to 80% of school going grade 4 girls by 2019. | 1.8.10 Human Papilloma Virus Vaccine 1st dose | No. Annual | 65 761 | 64 592 | 57 286 | 50 972 | **58 158** | - | - | - | **58 158** | 62 852 | 62 852 |
| | 1.8.11 Human Papilloma Virus Vaccine 2nd dose | No. Annual | New Indicator | 55 553 | 44 637 | 57 123 | **57 123** | - | **57 123** | - | - | 62 852 | 62 852 |
| | **Strategic objectives 1.8 Child Mortality Reduced to less than 34 per 1000 population by 2019** | | | | | | | | | | | | |
| Ensure 90% of children are vaccinated and monitored for growth by 2019 | 1.8.8 Vitamin A dose 12-59 months coverage | % Quarterly | 63.5% | 62% | 53% | 55.1% | **60%** | **60%** | **60%** | **60%** | **60%** | 64% | 65% |
| | *Numerator* | | 741 185 | 710 182 | 722 793 | 742 290 | **817 404** | **817 404** | **817 404** | **817 404** | **817 404** | 871 897 | 1 021 755 |
| | *Denominator* | | 1 168 102 | 1 145 395 | 1 362 340 | 1 347 170 | **1 362** | **1 362** | **1 362** | **1 362** | **1 362** | 1 362 340 | 1 362 |

Table 23: Performance indicators for Maternal, Child and Women's Health and Nutrition sub – programme 2.7

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| | | | | | | | **340** | **340** | **340** | **340** | **340** | | 340 |
| Ensure 90% of children are vaccinated and monitored for growth by 2019 | 1.8.9 Neonatal death in facility rate | per 1000 live births Quarterly | 12.8 / 1000 | 10.8/1000 | 14/1000 | 13/1000 | **11/1000** | **11/1000** | **11/1000** | **11/1000** | **11/1000** | 11/1000 | 11/1000 |
| | *Numerator* | | 1 370 | 1 098 | 1 390 | 315 | **1108** | **277** | **277** | **277** | **277** | 277 | 277 |
| | *Denominator* | | 107 214 | 101 468 | 100 803 | 21 861 | **100 803** | **25 200** | **25 200** | **25 200** | **25 200** | 25 200 | 25 200 |
| Reduce Maternal Mortality Ratio to 215 per 100 000 live births 2019 | **Strategic objectives 1.7 Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019** | | | | | | | | | | | | |
| | 1.7.5 Maternal mortality in facility ratio | Per 100,000 live births Quarterly | 135.2/100 000 | 135/100 000 | 128/ 100 000 | 101/100 000 | **105/100 000** | **105/100 000** | **105/100 000** | **105/100 000** | **105/100 000** | 105/100 000 | 105/100 000 |
| | *Numerator* | | 145 | 137 | 138 | 79 | **107** | **26** | **26** | **27** | **26** | 106 | 106 |
| | *Denominator* | | 107 214 | 101 468 | 107 595 | 78 069 | **101 468** | **24 367** | **24 367** | **24 367** | **24 367** | 101 468 | 101 468 |

## 2.8 Sub-Programme: Coroner Services

### Sub-Programme Purpose

- To strengthen the capacity and functionality of forensic pathology institutions within the Province and facilitate access to forensic pathology services at all material times.
- The Coroner Services sub-programme renders forensic pathology services in order to establish the circumstances and causes surrounding unnatural deaths.

### Strategic Goal Being Addressed:

**Strategic goal 1:** Improved quality of care

### Provincial Strategic Objectives, Indicators, Annual and Quarterly Targets for Coroner Services

Table 24: Performance indicators for Coroner Services Sub–programme 2.8

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| Ensure post-mortem turnaround time has improved by 2019 | **Strategic objective 1.9 Post – mortems conducted within 72hrs increased to 95% by 2019** | | | | | | | | | | | | |
| | 1.9.1 Percentage of post-mortem performed within 72 hours | % Quarterly | 93% | 94% | 94% | 96% | **95%** | **95%** | **95%** | **95%** | **95%** | 95% | 95% |
| | *Numerator* | | 10 017 | 8 391 | 9732 | 2 908 | **9 805** | **2 451** | **2 451** | **2 452** | **2 451** | 9 805 | 9 805 |
| | *Denominator* | | 10 811 | 8 911 | 10 322 | 3 039 | 10 322 | **2 580** | **2 581** | **2 581** | **2 580** | 10 322 | 10 322 |

## 2.9 Sub Programme: District Hospitals

### Sub-Programme Purpose

To provide comprehensive and quality district Hospital services to the people of the Eastern Cape Province.

### Key interventions targeted by District Management Team to strengthen implementation in the Districts and enable implementation of District Health Plan

- Recruitment and retention of doctors and nurses in district hospitals especially those in rural areas
- In service training on monitoring of Foetal Heart on admission and during labour
- Monitor vital signs every 4 hours e.g. blood pressure, pulse and temperature
- Review Planned Patient Transport for high risk clinics
- Revive In-Reach & Outreach Programme to support District hospitals

### Key interventions targeted by Provincial Head Office to support and build capacity in all Districts to enable implementation of their District Health Plan

- To facilitate the implementation of National Core Standards assessment in district hospitals by collating National Core Standards Assessments, analyze report and provide feedback to district hospitals.
- Allocation of community service, post community service health professionals and bursary holders to all hospitals focusing mainly in rural areas.
- To encouraged district hospitals to constantly engage on perinatal meetings.
- To request budget in order to procure medical equipment that is a needed in District Hospitals.
- Upgrading security services in district hospitals through the installation of comprehensive security solutions (cameras and access control)

### Strategic Goal Being Addressed:

**Strategic goal 1:** Prevent and reduce the disease burden and promote health
**Strategic goal 2:** Improved quality of care

## Provincial Performance Indicators, Annual and Quarterly Targets for District Hospitals

Table 25: Performance indicators for District Hospitals sub – programme 2.9

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| | **Strategic objectives 2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019** | | | | | | | | | | | | |
| Ensure all facilities are conditionally compliant by 2017 and fully compliant (75%-100%) to National Core Standards by 2019 | 2.3.1 Hospital achieved 75% and more on National Core Standards self-assessment rate | % Quarterly | New Indicator | New Indicator | 39.3% | 28.7% | **42%** | **9%** | **15%** | **18%** | **42%** | 42% | 44% |
| | *Numerator* | | | | 26 | 19 | **27** | **6** | **10** | **12** | **27** | 27 | 29 |
| | *Denominator* | | | | 66 | 66 | **66** | **66** | **66** | **66** | **66** | 66 | 66 |
| Ensure total population is utilizing District Hospitals through referral system by 2019 | **Strategic Objective 1.10 80% of Hospitals meeting national efficiency targets by 2019** | | | | | | | | | | | | |
| | 1.10.1 Average Length of Stay | No. of Days | 5.1 days | 5 days | 4.9 days | 4.8 days | **4.5 days** | **4.5 days** | **4.5 days** | **4.5 days** | **4.5 days** | 4.5 days | 4.5 days |
| | 1.10.6 Inpatient Bed Utilisation Rate | % Quarterly | 57.2% | 56% | 55% | 54.8% | **58%** | **58%** | **58%** | **58%** | **58%** | 60% | 62% |
| | Numerator | | 1 264 514 | 1 226 237 | 1 211 494 | 913 249 | **1 283 678** | **320 919** | **320 910** | **320 910** | **320 919** | 1 327 942 | 1 372 208 |
| | Denominator | | 2 209 313 | 2 188 445 | 2 213 238 | 1 665 312 | **2 213 238** | **553 309** | **553 310** | **553 310** | **553 309** | 2 213 238 | 2 213 238 |
| | 1.10.12 Expenditure per patient day equivalent (PDE) | R Quarterly | R3,317 | R3 346 | R2,528 | R2,924 | **3,039** | **3,039** | **3,039** | **3,039** | **3,039** | 3,191 | 3,191 |
| Ensure all district Hospitals are conditionally compliant by 2017 | **Strategic objectives 2.4 Patient satisfaction rate increased to more than 75% in health services by 2019** | | | | | | | | | | | | |
| | 2.4.26 Complaint Resolution | % Quarterly | 99.6% | 90.5% | 98% | 99% | **85%** | **85%** | **85%** | **85%** | **85%** | 85% | 85% |

| Table 25: Performance indicators for District Hospitals sub – programme 2.9 | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Strategic Objective Statement** | **Programme Performance Indicator** | **Indicator Type & Reporting frequency** | **Audited/ Actual Performance** | | | **Estimated Performance** | **Medium Term Targets** | | | | | | |
| | | | **2015/16** | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2019/20 QUARTERLY TARGETS** | | | | **2020/21** | **2021/22** |
| | | | | | | | | **Q1** | **Q2** | **Q3** | **Q4** | | |
| | **Strategic objectives 2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019** | | | | | | | | | | | | |
| and fully compliant (75%-100%) to National Core Standards by 2019 | within 25 working days rate | | | | | | | | | | | | |
| | *Numerator* | | 3 301 | 2 914 | 2 886 | 1610 | | | | | | | |
| | *Denominator* | | 3 314 | 3 219 | 2 950 | 1625 | | | | | | | |

## 2.10 Reconciling Performance Targets with Expenditure Trends and Budgets

Table 26: Summary of payments and estimates by sub programme: District Health Services

| | **Outcome** | | | **Main appropriation** | **Adjusted appropriation** | **Revised estimate** | **Medium-term estimates** | | | **% change from** |
|---|---|---|---|---|---|---|---|---|---|---|
| **R thousand** | **2015/16** | **2016/17** | **2017/18** | | **2018/19** | | **2019/20** | **2020/21** | **2021/22** | **2018/19** |
| 1. District Management | 729,615 | 866,726 | 881,476 | 884,813 | 906,533 | 948,701 | 946,779 | 1,015,524 | 1,071,378 | (0.2) |
| 2. Community Health Clinics | 1,874,174 | 2,163,846 | 2,420,417 | 2,344,722 | 2,348,727 | 2,596,116 | 2,451,659 | 2,606,121 | 2,770,297 | (5.6) |
| 3. Community Health Centres | 904,933 | 1,019,053 | 948,991 | 1,246,933 | 1,257,622 | 1,149,443 | 1,307,341 | 1,395,895 | 1,473,070 | 13.7 |
| 4. Community Based Services | 408,868 | 439,968 | 524,720 | 551,266 | 590,991 | 524,633 | 616,872 | 660,516 | 697,055 | 17.6 |
| 5. Other Community Services | 39,613 | 46,494 | 81,360 | 68,040 | 65,765 | 64,107 | 82,898 | 74,493 | 78,604 | 29.3 |
| 6. Hiv/Aids | 1,583,403 | 1,745,442 | 2,045,769 | 2,098,633 | 2,105,798 | 2,110,699 | 2,397,703 | 2,657,743 | 2,972,861 | 13.6 |
| 7. Nutrition | 28,497 | 24,226 | 24,872 | 52,837 | 43,532 | 55,896 | 41,778 | 40,108 | 42,314 | (25.3) |
| 8. Coroner Services | 80,783 | 94,818 | 100,885 | 106,090 | 106,377 | 108,970 | 112,078 | 118,545 | 125,096 | 2.9 |
| 9. District Hospitals | 3,866,540 | 4,020,031 | 4,314,006 | 4,678,613 | 4,746,555 | 5,125,037 | 4,905,575 | 5,219,856 | 5,576,768 | (4.3) |
| **Total payments and estimates** | **9,516,426** | **10,420,604** | **11,342,496** | **12,031,947** | **12,171,900** | **12,683,602** | **12,862,682** | **13,788,802** | **14,807,443** | **1.4** |

Table 27: Summary of payments and estimates by economic classification: District Health Services

| R thousand | Outcome 2015/16 | 2016/17 | 2017/18 | Main appropriation | Adjusted appropriation 2018/19 | Revised estimate | Medium-term estimates 2019/20 | 2020/21 | 2021/22 | % change from 2018/19 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Current payments** | **9,245,513** | **10,103,932** | **11,038,627** | **11,824,746** | **12,001,371** | **12,139,581** | **12,641,221** | **13,594,106** | **14,602,039** | **4.1** |
| Compensation of employees | 6,859,019 | 7,454,008 | 7,809,396 | 8,600,082 | 8,757,110 | 8,701,517 | 9,255,147 | 9,866,456 | 10,491,365 | 6.4 |
| Goods and services | 2,384,924 | 2,649,499 | 3,227,910 | 3,224,664 | 3,244,261 | 3,433,103 | 3,386,074 | 3,727,650 | 4,110,674 | (1.4) |
| Interest and rent on land | 1,570 | 425 | 1,321 | – | – | 4,961 | – | – | – | (100.0) |
| **Transfers and subsidies to:** | **160,709** | **175,939** | **182,610** | **63,473** | **64,322** | **451,622** | **86,185** | **62,083** | **65,497** | **(80.9)** |
| Provinces and municipalities | 13,229 | 8,451 | 313 | 1,200 | 1,200 | 1,200 | – | – | – | (100.0) |
| Departmental agencies and accounts | 17,302 | 11,138 | – | – | – | – | – | – | – | |
| Non-profit institutions | – | – | 7,278 | 18,145 | 19,570 | 18,423 | 15,000 | 13,589 | 14,336 | (18.6) |
| Households | 130,178 | 156,350 | 175,019 | 44,128 | 43,552 | 431,999 | 71,185 | 48,494 | 51,161 | (83.5) |
| **Payments for capital assets** | **110,204** | **140,733** | **121,259** | **143,728** | **106,207** | **92,399** | **135,276** | **132,613** | **139,907** | **46.4** |
| Buildings and other fixed structures | – | – | – | – | – | – | – | – | – | |
| Machinery and equipment | 110,204 | 140,733 | 121,259 | 143,728 | 106,207 | 92,399 | 135,276 | 132,613 | 139,907 | 46.4 |
| **Total economic classification** | **9,516,426** | **10,420,604** | **11,342,496** | **12,031,947** | **12,171,900** | **12,683,602** | **12,862,682** | **13,788,802** | **14,807,443** | **1.4** |

*Tables 26 and 27 above show the summary of payments and estimates for District Health Services per sub-programme and economic classification.* The programme's total expenditure increased from R9.516 billion in 2015/16 to a revised estimate of R12.683 billion in 2018/19. In 2019/20, the budget increases by 1.4 per cent from R12.683 billion to R12.862 billion when compared to the 2018/19 revised estimate.

Compensation of employees and goods and services, which make up current payments, are the major cost drivers of the programme. Compensation of employees shows a positive growth of 6.4 per cent from R8.701 billion to R9.255 billion when compared to the 2018/19 revised estimate due to the additional funds received for the Human Resource Capacitation Grant (HRCG). Goods and services show a negative growth 1.4 per cent from R3.433 billion to R3.386 billion when compared to the 2018/19 revised estimate due to a high revised estimate resulting from the payment of accruals for Medicine and Property payments.

Transfers and subsidies show a negative growth of 80.9 per cent from R451.622 million to R86.185 million when compared to the 2018/19 revised estimate due to high revised estimates in 2018/19 as a result of payment of medico legal claims. Payments for capital assets show a positive growth of 46.4 per cent from R92.399 million to R135.276 million when compared to the 2018/19 revised estimate due to additional funding on infrastructure.

## 1.4 Risk Management

**Below are key risks that may affect the realization of the strategic objectives in programme 2 and measures designed to mitigate its impact**

Table 28: Risks and Mitigating factors for District Health Services for programme 2

| RISK IDENTIFIED | RISK MITIGATION |
|---|---|
| **Sub-optimal care within maternal and neonatal services** | • To develop one additional maternity home at Amathole District. (Thafalofefe hospital)<br>• Revive & strengthen district hospital neonatal units (increase resources and training).<br>• Capacity building on all policy imperatives<br>• Strengthen of sexual reproductive health and rights(e.g. reduction of teenage pregnancy) |
| **Sub-optimal management of child health** | • Increase coverage of fully fledged WBOT teams.<br>• Community mobilization and advocacy on key child health issues<br>• Accelerate training of health care workers (Health professionals, Community Health Care workers) on key childhood issues<br>• Catch-up campaigns to increase immunization coverage |
| **Inadequate prevention, early detection and management of non-communicable diseases(Hypertension, Diabetics, Cancer, asthma, epilepsy, eye health, geriatrics, mental health, substance abuse, oral health, healthy lifestyle.** | • National NCD strategic plan<br>• Co-ordinate implementation of Integrated chronic diseases management model (ICDM) to be initiated in all PHC facilities that are identified as ideal clinics (not 80)80 ideal clinics and roll out to all PHC facilities<br>• Co-ordinate training of Primary Care 101<br>• Avail NCD guidelines and policies in all (not just 80)80 ideal clinics and roll out to all PHC facilities<br>• Facilitate provision of basic equipment in 80(all, not just 80) ideal clinics<br>• Through health promotion and partners (Stakeholder engagement) co-ordinate social mobilization and screening in communities, PHC facilities and OPD's<br>• Provincial NCD quarterly information sharing meetings<br>• District reviews, monitoring and support of poor performing districts. |
| **Inadequate number of health professionals (Professionals, nurses and doctors) Primary Health Care Services.** | • Implementation of the ideal clinic realization and maintenance (ICRM)<br>• PHC facility supervision monitoring<br>• Appointment of Operational Managers at PHC facilities<br>• Monitor the implementation of NHI Readiness in Alfred Nzo and OR Tambo |
| **Noncompliance to Health Service Standards.** | • Implementation of National Core Standards<br>• Client experience of care surveys<br>• Monitoring of hospital efficiency indicators<br>• Support and strengthen hospital governance structures<br>• Re classification of hospitals with less than 50 beds |
| **Non adherence to treatment by patients on TB (including MDR and XDR-TB), HIV&AIDS, and STIs' medication.** | • Out Reach vehicles have been budgeted for in order to assist districts to trace clients that have missed their appointments.<br>• Continuous capacity building and mentoring will be provided for health care works on TB and HIV in order to provide quality counselling of clients.<br>• Scale up the provision of community based care and support<br>• There will be continuous in social mobilization activities in the districts, targeting communities where there are challenges of compliance to raise awareness on TB and HIV<br>• More eligible MDR TB clients will be initiated on the 9 months' regimen which is a shorter period for treatment of MDR |

| Table 28: Risks and Mitigating factors for District Health Services for programme 2 | |
|---|---|
| **RISK IDENTIFIED** | **RISK MITIGATION** |
| | and will improve lost to follow up |
| **Inadequate management of client with HIV,TB & STI** | Patient Related factors:<br>- Implementation of quarterly advocacy communication social mobilisation and marketing of HAST programmes (ACSM)<br><br>Medical Related factors:<br>- Training of health professionals on HAST policy guidelines<br>- Support high volume facilities to conduct clinical audits quarterly in all district<br><br>Administrative Systems:<br>- Ensure implementation of annual recruitment plan<br>- Submission of quarterly reviews with partners<br>- Conduct Monitoring support visits quarterly<br>- Develop and implement programme related activities as per business plan |

# PROGRAMME 3

# Emergency Medical & Patient Transport Services


# Programme 3
# Emergency Medical Services (EMS)

## 3.1 Programme Purpose

To render an efficient, effective and professional emergency medical services as well as planned patient transport services including disaster management services to the citizens of the Eastern Cape Province.

### Priorities for the Next Three Years

Improve call taking and dispatching ability by rolling out the computerized call-taking and dispatching system initially to the Alfred Nzo, OR Tambo and the Chris Hani EMS Centres.
Strengthen EMS services for inter Hospital, XDR /MDR and Maternity transfers

### Key interventions:

The key intervention areas to be included in this plan include

- Strengthen referral system and emergency care transportation services (EMS),
- Increase availability of operational vehicles for emergency care services
- Improve the skills of EMS personnel
- Ensure compliance with EMS regulations

### Strategic Goals Being Addressed:

**Strategic goal 3:** Universal Health Coverage

## Situational Analysis for the EMS

Table 29: Situation Analysis Indicators for the EMS

| Programme performance indicators | Frequency of reporting (quarterly /annually) | Type | Province-wide value 2017/18 | Alfred Nzo 2017/18 | Amathole 2017/18 | BCM 2017/18 | Chris Hani 2017/18 | Sarah Baartman 2017/18 | Nelson Mandela 2017/18 | OR Tambo 2017/18 | Joe Gqabi 2017/18 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 3.6.1 EMS P1 urban response under 15 minutes rate | Quarterly | % | 31.6% | - | - | **11.4%** | - | - | 45.7% | - | - |
| 3.6.2 EMS P1 rural response under 40 minutes rate | Quarterly | % | 56.2% | **62.5%** | 20.4% | - | 54.5% | **64.3%** | ?? | **56.9%** | 49.4% |
| 3.6.3 EMS inter-facility transfer rate | Quarterly | % | 30.5% | **69.6%** | 62.4% | **30.6%** | 12.7% | **20.5%** | 23.8% | **26.5%** | 7% |

## Provincial Strategic Objectives, Indicators, Annual and Quarterly Target for EMS

Table 30: Performance Indicators for EMS

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS Q1 | Q2 | Q3 | Q4 | 2020/21 | 2021/22 |
| Ensure all ambulances respond within the National Norms by2019 | **Strategic Objective 3.6: Proportion of EMS response time improved to 85% by 2019** | | | | | | | | | | | | |
| | 3.6.1 EMS P1 urban response under 15 minutes rate | % Quarterly | 55% | 41% | 31.6% | 34.1% | **55%** | **55%** | **55%** | **55%** | **55%** | 60% | 60% |
| | *Numerator* | | 17 210 | 14 285 | 13 617 | 11 022 | **23 725** | **5 931** | **5 931** | **5 932** | **5 931** | 21 032 | 21 032 |
| | *Denominator* | | 31 370 | 35 054 | 43 138 | 32 334 | **43 138** | **10 784** | **10 785** | **10 785** | **10 784** | 35 054 | 35 054 |
| | 3.6.2 EMS P1 rural response under 40 minutes rate | % Quarterly | 47.3% | 58% | 56.2% | 52% | **65%** | **65%** | **65%** | **65%** | **65%** | 70% | 70% |
| | *Numerator* | | 38 951 | 57 946 | 50 118 | 36 488 | **57 920** | **14 480** | **14 480** | **14 480** | **14 480** | 70 070 | 70 070 |
| | *Denominator* | | 82 294 | 100 101 | 89 109 | 70 180 | **89 109** | **22 277** | **22 277** | **22 278** | **22 277** | 100 101 | 100 101 |
| | 3.6.3 EMS inter-facility transfer rate | % Quarterly | 29.4% | 34% | 30.% | 32.4% | **30%** | **30%** | **30%** | **30%** | **30%** | 25% | 25% |
| | *Numerator* | | | 207 027 | 188 316 | 111 759 | **185 522** | **46 380** | **46 381** | **46 381** | **46 380** | 154 602 | 154 602 |
| | *Denominator* | | | 618 295 | 618 409 | 345 150 | **618 409** | **154 602** | **154 602** | **154 603** | **154 602** | 618 409 | 618 409 |

## 3.2 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

Table 31: Summary of payments and estimates by sub programme: Emergency Medical Services

| R thousand | Outcome 2015/16 | 2016/17 | 2017/18 | Main appropriation | Adjusted appropriation 2018/19 | Revised estimate | Medium-term estimates 2019/20 | 2020/21 | 2021/22 | % change from 2018/19 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. Emergency Transport | 880,349 | 884,039 | 1,041,871 | 1,166,758 | 1,223,820 | 1,073,828 | 1,171,128 | 1,357,301 | 1,356,164 | 9.1 |
| 2. Planned Patient Transport | 65,921 | 183,614 | 237,216 | 117,855 | 125,915 | 223,075 | 221,929 | 127,669 | 124,762 | (0.5) |
| **Total payments and estimates** | **946,270** | **1,067,653** | **1,279,087** | **1,284,612** | **1,349,735** | **1,296,903** | **1,393,057** | **1,484,970** | **1,480,926** | **7.4** |

Table 32: Summary payments and estimates by economic classification: Emergency Medical Services

| R thousand | Outcome 2015/16 | 2016/17 | 2017/18 | Main appropriation | Adjusted appropriation 2018/19 | Revised estimate | Medium-term estimates 2019/20 | 2020/21 | 2021/22 | % change from 2018/19 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Current payments** | **821,116** | **975,306** | **1,115,425** | **1,147,640** | **1,227,222** | **1,189,366** | **1,230,473** | **1,329,640** | **1,329,624** | **3.5** |
| Compensation of employees | 639,431 | 712,944 | 933,626 | 812,429 | 922,436 | 998,781 | 881,223 | 954,783 | 1,007,615 | (11.8) |
| Goods and services | 181,662 | 262,362 | 181,799 | 335,212 | 304,786 | 190,585 | 349,250 | 374,857 | 322,009 | 83.3 |
| Interest and rent on land | 23 | – | – | – | – | – | – | – | – | |
| **Transfers and subsidies to:** | **2,321** | **2,562** | **2,100** | **3,226** | **4,079** | **3,759** | **3,407** | **3,594** | **3,792** | **(9.4)** |
| Households | 2,321 | 2,562 | 2,100 | 3,226 | 4,079 | 3,759 | 3,407 | 3,594 | 3,792 | (9.4) |
| **Payments for capital assets** | **122,833** | **89,785** | **161,562** | **133,746** | **118,434** | **103,778** | **159,177** | **151,736** | **147,510** | **53.4** |
| Buildings and other fixed structures | – | – | – | – | – | – | – | – | – | |
| Machinery and equipment | 122,833 | 89,785 | 161,562 | 133,746 | 118,434 | 103,778 | 159,177 | 151,736 | 147,510 | 53.4 |
| **Total economic classification** | **946,270** | **1,067,653** | **1,279,087** | **1,284,612** | **1,349,735** | **1,296,903** | **1,393,057** | **1,484,970** | **1,480,926** | **7.4** |

Tables 31 and 32 above show the summary of payments and estimates for Emergency Medical Services per sub-programme and economic classification. The programme's total expenditure increased from R946.270 million in 2015/16 to a revised estimate of R1.296 billion in 2018/19. In 2019/20, the budget increases by 7.4 per cent from R1.296 billion to R1.393 billion when compared to the 2018/19 revised estimate.

Compensation of employees shows a negative growth of 11.8 per cent from R998.781 million to R881.223 million when compared to the 2018/19 revised estimate due to the high revised estimate as a result of the once off backlog overtime payments.

Goods and services show a positive growth 83.3 per cent from R190.585 million to R349.250 million when compared to the 2018/19 revised estimate due to the reprioritisation of funds to fleet management from finance lease under payments of capital assets.
Transfers and subsidies show a negative growth of 9.4 per cent from R3.759 million to R3.407 million when compared to the 2018/19 revised estimate due to payment of leave gratuities.

Payments for capital assets show a positive growth of 53.4 per cent from R103.778 million to R159.177 million when compared to the 2018/19 revised estimate due reprioritisation of funds to fleet management from finance lease under payments of capital assets.

## 3.3 Risk Management

Below are the key risks that may affect the realization of the strategic objectives Programme 3: EMS and the measures designed to mitigate their impact. .

Table 33: Risk and Mitigating factors for programme 3

| RISK IDENTIFIED | RISK MITIGATION |
|---|---|
| Inadequate EMS Services. | • Filing of Strategic Posts<br>• Induction and training of personnel<br>• Ensure the implementation of the Electronic Call taking and dispatching system<br>• Replacement of EMS Vehicles |

# PROGRAMME 4

# Provincial Hospital Services

# Programme 4
# Provincial Hospital Services (Regional and Specialised)

## 4.1 Programme Purpose

To provide cost-effective, good quality secondary hospital services and specialised services, which include psychiatry and TB Hospital services.

### Programme Description
### Sub-Programme 4.1

General (Regional) Hospital Services: Rendering of Hospital services at general specialist level and providing a platform for research and the training of health workers

- Cecilia Makiwane
- Frontier
- St Elizabeth
- Dora Nginza
- Mthatha

### Sub-Programme 4.2

TB Hospital Services: To convert current tuberculosis Hospitals into strategically placed centres of excellence in which a small percentage of patients may undergo Hospitalization under conditions that allow for isolation during the intensive phase of treatment, as well as the application of the standard multi-drug resistant (MDR) protocols

- Jose Pearson
- Nkqubela
- Majorie Parish
- PZ Meyer
- Majorie Parks
- Winter Berg
- Osmond
- Khotsong
- Empilweni
- Themba

### Sub-Programme 4.3

Psychiatric Mental Hospital Services: Rendering a specialist psychiatric Hospital service for people with mental illness and intellectual disability and providing a platform for training of health workers and research

- Elizabeth Donkin Psychiatric Hospital
- Komani Psychiatric Hospital
- Tower Psychiatric Hospital – provide long-term
- Cecilia Makiwane Hospital acute psychiatric Unit
- Holy Cross Hospital acute psychiatric Unit
- Mthatha Regional Hospital acute psychiatric Unit
- Dora Nginza Hospital: 72-hour observation Unit plus

### Priorities for the Next Three Years

- To strengthen the capacity and functionality of regional Hospitals within the Province to improve health outcomes
- To improve mother and child health and contributing towards the achievement of SDGs
- To improve clinical management of TB patients
- To strengthen the functionality of psychiatric Hospitals within the Province in order to improve outcomes for clients through the use of effective treatments and rehabilitation programmes
- To implement the National Core Standards engaging SMME contractors in health facilities management projects

## Key interventions:

The key intervention areas to be included in this plan include

- All hospitals will focus on reducing possible avoidable causes of death and minimising risk of incidents that are associated with hospitalisation
- The Department will strengthen the triage and surgical capability at hospitals
- Improve access to treatment in the eastern part of the Province for oncology care
- render mental health services that consistently meet the standards founded on the principles of human rights
- Improve healthcare service delivery effectiveness and efficiency

## Strategic Goals Being Addressed

- **Strategic goal 1**: Prevent and reduce the disease burden and promote health
- **Strategic goal 2**: Improved quality of care

## Provincial Strategic Objectives, Indicators, Annual and Quarterly Targets for Provincial Hospital Services

Table 34: Performance indicators for Regional Hospitals sub – Programme 4.1

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting Frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| Ensure all regional Hospitals are conditionally compliant (50%-75%) by 2017 and fully compliant (75%-100%) to National Core Standards by 2019 | | | | | | | | | | | | | |
| | 2.3.2 Hospital achieved 75% and more on National Core Standards self-assessment rate | % Quarterly | 100% | 100% | 80% | 100% | **100%** | **-** | **20%** | **40%** | **40%** | 100% | 100% |
| | *Numerator* | | 5 | 5 | 4 | 5 | **5** | | **1** | **2** | **2** | 5 | 5 |
| | *Denominator* | | 5 | 5 | 5 | 5 | **5** | | **5** | **5** | **5** | 5 | 5 |
| Improve management of patients to optimize average length of stay by 2019 | **Strategic Objective 1.10: 80% of Hospitals meeting national efficiency targets by 201920** | | | | | | | | | | | | |
| | 1.10.2 Average length of stay | Days Quarterly | 5.5 days | 5.5 days | 5.8 days | 5.8 days | **5.5 days** | **5.5 days** | **5.5 days** | **5.5 days** | **5.5 days** | 5.5 days | 5.5 days |
| Ensure total population is utilizing Hospitals through referral system by 2019 | 1.10.7 Inpatient bed utilisation rate | % Quarterly | 67% | 64% | 68% | 71.3% | **75%** | **75%** | **75%** | **75%** | **75%** | 75% | 75% |
| | *Numerator* | | 532 879 | 516 669 | 528 803 | 405 654 | **581 371** | **154 342** | **145 343** | **145 343** | **145 343** | 108 702 | 434 808 |
| | *Denominator* | | 797 126 | 807 438 | 775 162 | 569 158 | **775 162** | **193 790** | **193 790** | **193 791** | **193 791** | 144 936 | 579 744 |
| Improve cataract surgery rate to 1300/1 000 000 by 2019 | **Strategic Objective 1.3: NCD coverage increased to 1300/1 000 000 through management of chronic illnesses by 2019** | | | | | | | | | | | | |
| | 1.3.1 Cataract surgery rate (Uninsured Population) | Per 1000 000 Quarterly | 565/ 1000 000 | 913/ 1000 000 | 718/1 000 000 | 705/ 1000 000 | **1300/ 1000 000** | **200/ 1000 000** | **600/ 1 00 000** | **900/ 1 000 000** | **1300/ 1000 000** | 1300/ 100 000 | 1300/ 100 000 |
| | *Numerator* | | - | - | 1 872 | 4576 | **8 443** | **1 298** | **3 896** | **5 845** | **8 443** | 8 443 | 8 443 |
| | *Denominator* | | | | 6 307 194 | 6 494 701 | **6 494 701** | **6 494 701** | **6 494 701** | **6 494 701** | **6 494 701** | 6 494 701 | 6 494 701 |
| Ensure the 80% Hospital expenditure increase to cover the uninsured population by 2019 | 1.10.13 Expenditure per patient day | R Quarterly | R1,705 | R1,895 | R3,349 | R3,445 | **R3,500** | **R3,500** | **R3,500** | **R3,500** | **R3,500** | R3,500 | R3,500 |

Table 34: Performance indicators for Regional Hospitals sub – Programme 4.1

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting Frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| | equivalent (PDE) | | | | | | | | | | | | |
| Ensure all regional Hospitals are conditionally compliant by 2017 and fully compliant (75%-100%) to National Core Standards by 2019 | **Strategic Objective 2.4: Patient satisfaction rate increased to more than 75% in health services by 2019** | | | | | | | | | | | | |
| | 2.4.29 Complaint resolution within 25 working days rate | % Quarterly | 99.2 % | 92% | 98% | 97.5% | **85%** | **85%** | **85%** | **85%** | **85%** | 85% | 85% |
| | Numerator | | | | 666 | 503 | | | | | | | |
| | Denominator | | | | 678 | 516 | | | | | | | |

## 4.2 Sub – Programme: Specialised TB Hospitals

### Strategic Goals Being Addressed

**Strategic goal 1:** Prevent and reduce the disease burden and promote health
**Strategic goal 2**: Improved quality of care

### Provincial Strategic Objectives, Indicators, Annual and Quarterly Targets for Specialised Tb Hospitals

Table 35: Indicators and Annual Targets for Specialised Tb Hospitals sub – programme 4.2

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting Frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| Ensure all TB Hospitals are conditionally compliant by 2017 and fully compliant (75%-100%) to National Core Standards by 2019 | **Strategic Objective 2.3: Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019** | | | | | | | | | | | | |
| | 2.3.3 Hospital achieved 75% and more on National Core Standards self-assessment rate | % Quarterly | 100% | 100% | 50% | 50% | **60%** | - | **30%** | **30%** | - | 70% | 80% |
| | *Numerator* | | 11 | 11 | 5 | 5 | **6** | - | **3** | **3** | - | 7 | 8 |
| | *Denominator* | | 11 | 11 | 10 | 10 | **10** | - | **10** | **10** | - | 10 | 10 |
| Improve management of patients to optimize average length of stay by 2019 | **Strategic Objective 1.10: 80% of Hospitals meeting national efficiency targets by 2019** | | | | | | | | | | | | |
| | 1.10.3 Average length of stay | Days Quarterly | 94.2 days | 94.2 days | 77 days | 73.4 days | **80 days** | **80 days** | **80 days** | **80 days** | **80 days** | 70 days | 60 days |
| Ensure total population is utilizing Hospitals through referral system by 2019 | 1.10.8 Inpatient bed utilisation rate | % Quarterly | 60.3% | 60.3% | 50% | 45.6% | **60%** | **60%** | **60%** | **60%** | **60%** | 60% | 60% |
| | *Numerator* | | 353 768 | 326 478 | 262 129 | 177 526 | **313 678** | **78 419** | **78 420** | **78 420** | **78 419** | 246 365 | 246 365 |
| | *Denominator* | | 547 499 | 541 658 | 522 798 | 389 345 | **522 798** | **130 699** | **130 699** | **130 700** | **130 700** | 410 609 | 410 609 |
| Ensure the 80% Hospital expenditure increase to cover the uninsured population by 2019 | 1.10.14 Expenditure per patient day equivalent (PDE) | R Quarterly | R5,737 | - | R1,626 | R 1,722 | **R1,758** | **R1,758** | **R1,758** | **R1,758** | **R1,758** | R1,800 | R1,800 |

| Table 35: Indicators and Annual Targets for Specialised Tb Hospitals sub – programme 4.2 | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Strategic Objective Statement** | **Programme Performance Indicator** | **Indicator Type & Reporting Frequency** | **Audited/ Actual Performance** | | | **Estimated Performance** | **Medium Term Targets** | | | | | | |
| | | | **2015/16** | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2019/20 QUARTERLY TARGETS** | | | | **2020/21** | **2021/22** |
| | | | | | | | | **Q1** | **Q2** | **Q3** | **Q4** | | |
| Ensure all TB Hospitals are conditionally compliant by 2017 and fully compliant (75%-100%) to National Core Standards by 2019 | **Strategic Objective 2.4: Patient satisfaction rate increased to more than 75% in health services by 2019** | | | | | | | | | | | | |
| | 2.4.30 Complaint resolution within 25 working days rate | % Quarterly | 100% | 100% | 95.9% | 100% | **85%** | **85%** | **85%** | **85%** | **85%** | 85% | 85% |
| | Numerator | | | 107 | | 48 | | | | | | | |
| | Denominator | | | 107 | | 48 | | | | | | | |

## 4.3 Sub – Programme: Specialised Psychiatric Hospitals

### Sub- Programme Priorities

- Development of District Mental Health Specialist teams
- Creating of Mental Health Units in District, Regional and Tertiary Hospitals
- Screening of Mental Health patients at PHC and district levels
- Re capacitation of the clinical cadre on Mental Health Programmes

### Strategic Goals Being Addressed

**Strategic goal 1:** Prevent and reduce the disease burden and promote health
**Strategic goal 2:** Improved quality of care

### Key interventions:

The key intervention areas to be included in this plan include

- Establish provincial district, PHC capacity for mental health services
- Strengthen prevention of mental disorders, substance, drug and alcohol abuse
- Provide sufficient resources for mental health

## Provincial Strategic Objectives, Indicators, Annual and Quarterly Targets for Specialised Psychiatric Hospitals

Table 36: Indicators and Annual Targets for Specialised Psychiatric Hospitals sub – programme 4.3

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting Frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| Ensure all psychiatric Hospitals are conditionally compliant by 2017 and fully compliant (75%-100%) to National Core Standards by 2019 | **Strategic Objective 2.4: Patient satisfaction rate increased to more than 75% in health services by 2019** | | | | | | | | | | | | |
| | 2.3.4 Hospital achieved 75% and more on National Core Standards self-assessment rate | % Quarterly | 100% | 100% | 100% | 66.7% | **100%** | **-** | **100%** | **100%** | **-** | 100% | 100% |
| | *Numerator* | | | 3 | 3 | 2 | **3** | | **2** | **3** | | 3 | 3 |
| | *Denominator* | | | 3 | 3 | 3 | **3** | | **3** | **3** | **-** | 3 | 3 |
| | **Strategic Objective 2.4: Patient satisfaction rate increased to more than 75% in health services by 2019** | | | | | | | | | | | | |
| | 2.4.31 Complaint resolution within 25 working days rate | % Quarterly | 100% | 48% | 100% | 100% | **85%** | **85%** | **85%** | **85%** | **85%** | 85% | 85% |
| | Numerator | | | 24 | 73 | 39 | | | | | | | |
| | Denominator | | | 50 | 73 | 39 | | | | | | | |

## 4.4 Reconciling Performance Targets with Expenditure Trends and Budgets

Table 37: Summary of payments and estimates by sub programme: Provincial Hospital Services

| R thousand | Outcome 2015/16 | 2016/17 | 2017/18 | Main appropriation | Adjusted appropriation 2018/19 | Revised estimate | Medium-term estimates 2019/20 | 2020/21 | 2021/22 | % change from 2018/19 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. General (Regional) Hospitals | 4,002,196 | 2,382,538 | 2,685,261 | 2,781,425 | 2,867,183 | 2,626,036 | 2,965,892 | 3,111,138 | 3,292,655 | 12.9 |
| 2. Tb Hospitals | 356,953 | 271,424 | 303,673 | 378,749 | 383,229 | 386,539 | 382,180 | 409,000 | 436,336 | (1.1) |
| 3. Psychiatric Mental Hospitals | 568,593 | 596,235 | 499,427 | 696,961 | 716,943 | 558,833 | 742,710 | 804,966 | 835,472 | 32.9 |
| **Total payments and estimates** | **4,927,742** | **3,250,197** | **3,488,361** | **3,857,135** | **3,967,355** | **3,571,408** | **4,090,782** | **4,325,104** | **4,564,463** | **14.5** |

Table 38: Summary of payments and estimates by economic classification: Provincial Hospital Services

| R thousand | Outcome 2015/16 | 2016/17 | 2017/18 | Main appropriation | Adjusted appropriation 2018/19 | Revised estimate | Medium-term estimates 2019/20 | 2020/21 | 2021/22 | % change from 2018/19 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Current payments** | **4,709,596** | **3,090,685** | **3,209,342** | **3,802,413** | **3,922,691** | **3,319,975** | **4,063,581** | **4,297,384** | **4,535,218** | **22.4** |
| Compensation of employees | 3,912,037 | 2,405,489 | 2,511,845 | 2,998,034 | 2,986,943 | 2,484,617 | 3,285,336 | 3,597,516 | 3,816,562 | 32.2 |
| Goods and services | 793,466 | 683,794 | 695,326 | 804,378 | 935,748 | 832,770 | 778,245 | 699,868 | 718,656 | (6.5) |
| Interest and rent on land | 4,093 | 1,402 | 2,171 | – | – | 2,588 | – | – | – | (100.0) |
| **Transfers and subsidies to:** | **194,337** | **135,561** | **266,501** | **18,013** | **18,013** | **219,811** | **11,817** | **13,141** | **13,864** | **(94.6)** |
| Households | 194,337 | 135,561 | 266,501 | 18,013 | 18,013 | 219,811 | 11,817 | 13,141 | 13,864 | (94.6) |
| **Payments for capital assets** | **23,809** | **23,951** | **12,518** | **36,710** | **26,651** | **31,622** | **15,384** | **14,579** | **15,381** | **(51.4)** |
| Buildings and other fixed structures | – | – | – | – | – | – | – | – | – | |
| Machinery and equipment | 23,809 | 23,951 | 12,518 | 36,710 | 26,651 | 31,622 | 15,384 | 14,579 | 15,381 | (51.4) |
| **Total economic classification** | **4,927,742** | **3,250,197** | **3,488,361** | **3,857,135** | **3,967,355** | **3,571,408** | **4,090,782** | **4,325,104** | **4,564,463** | **14.5** |

Tables 37 and 38 above shows the summary of payments and estimates for Provincial Hospital Services per sub-programme and economic classification. The programme's total expenditure decreased from R4.927 billion in 2015/16 to a revised estimate of R3.571 billion in 2018/19. In 2019/20, the budget increases by 14.5 per cent from R3.571 billion to R4.090 billion when compared to the 2018/19 revised estimate.

Compensation of employees shows a positive growth of 32.2 per cent from R2.484 billion to R3.285 billion when compared to the 2018/19 revised estimate due the low revised estimates resulting from the process of de-complexing of facilities for employees that were paid under this programme and being allocated to the Programme 5: Central Hospital Services.

Goods and services show a negative growth of 6.5 per cent from R832.770 million to R778.245 million when compared to the 2018/19 revised estimate *due to reprioritisation of non-core items for the implementation of cost containment measures.*

Transfers and subsidies show a negative growth of 94.6 per cent from R219.811 million to R11.817 million when compared to the 2018/19 revised estimate due *to a high revised estimate as a result of payment of Medico Legal Claims.*

Payments for capital assets show a negative growth of 51.4 per cent from R31.622 million to R15.384 million when compared to the 2018/19 revised estimate, due *reprioritised budget to core items such as Inventory: Medical supplies and Property payments under Goods and services.*

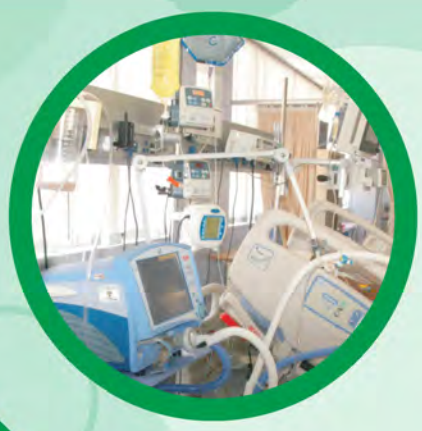
## 4.5 Risk Management

Below are key risks that may affect the realization of the strategic objectives in programme 4 and measures designed to mitigate its impact.

Table 39: Risk and Mitigating factors for programme 4

| RISK IDENTIFIED | RISK MITIGATION |
|---|---|
| Inadequate Secondary and Tertiary services | • Filling of Strategic Posts<br>• Induction and training of personnel<br>• Peer Reviews on National Core Standards<br>• Implementation of national Core Standards |

# PROGRAMME 5
# Central & Tertiary Hospitals



# Programme 5:
# Central & Tertiary Hospitals

## 5.1 Programme Purpose for Central Hospitals

To strengthen and continuously develop the modern tertiary services platform to adequate levels in order to be responsive to the demands of the specialist service needs of the community of the Eastern Cape Province. There are two Tertiary Hospitals and one Central Hospital in the Eastern Cape Province:

### Programme Descriotion
### Sub-Programmes

Central Hospital: Nelson Mandela Academic Hospital
`

### Priorities for the Next Three Years

- To strengthen oncology services
- To strengthen institutional capacity to deliver relevant and quality services at appropriate levels
- To improve institutional functionality and effectiveness by ensuring that efficiency indicators are fully achieved

### Key Interventions:

The key intervention areas to be included in this plan include
- All hospitals will focus on reducing possible avoidable causes of death and minimising risk of incidents that are associated with hospitalisation
- The Department will strengthen the triage and surgical capability at hospitals
- Improve access to treatment in the eastern part of the Province for oncology care
- render mental health services that consistently meet the standards founded on the principles of human rights
- Improve healthcare service delivery effectiveness and efficiency

### Strategic Goals Being Addressed

**Strategic goal 1:** Prevent and reduce the disease burden and promote health
**Strategic goal 2:** Improved quality of care

## Provincial Strategic Objectives, Indicators, Annual and Quarterly Targets for Central Hospitals

Table 40: Indicators and Annual Targets for Central Hospital sub – programme 5.1

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| Ensure all central Hospitals are conditionally compliant (50%-75%) by 2017 and fully compliant (75%-100%) to National Core Standards by 2019 | **Strategic Objective 2.3: Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019** | | | | | | | | | | | | |
| | 2.3.5 Hospital achieved 75% and more on National Core Standards self-assessment rate | % Quarterly | New Indicator | 100% | 100% | 86% | **100%** | **-** | **100%** | **100%** | **-** | 100% | 100% |
| Improve management of patients to optimize average length of stay by 2019 | **Strategic Objective 1.10: 80% of Hospitals meeting national efficiency targets by 2019** | | | | | | | | | | | | |
| | 1.10.4 Average length of stay | Days Quarterly | 8.2 days | 11.1 days | 9 days | 8.9days | **8days** | **8days** | **8days** | **8days** | **8days** | 8days | 8days |
| Ensure total population is utilizing Hospitals through referral system by 2019 | 1.10.10 Inpatient bed utilisation rate | % Quarterly | 75.6% | 83.8% | 79% | 83% | **83%** | **83%** | **83%** | **83%** | **83%** | 83% | 83% |
| Numerator | | | 456 638 | 229 968 | 218 522 | 172 723 | **227 540** | **227 540** | **227 540** | **227 540** | **227 540** | 227 540 | 227 540 |
| Denominator | | | 604 202 | 274 145 | 274 145 | 207 525 | **274 145** | **274 145** | **274 145** | **274 145** | **274 145** | 274 145 | 274 145 |
| Ensure the 80% Hospital expenditure increase to cover the uninsured population by | 1.10.16 Expenditure per patient day equivalent (PDE) | R Quarterly | R3,412 | R3,948 | R 3,472 | R4,147 | **R4,586** | **R4,586** | **R4,586** | **R4,586** | **R4,586** | R4,953 | R4,953 |

Table 40: Indicators and Annual Targets for Central Hospital sub – programme 5.1

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| 2019 | | | | | | | | | | | | | |
| Ensure all central Hospitals are conditionally compliant by 2017 and fully compliant (75%-100%) to National Core Standards by 2019 | **Strategic Objective 2.4: Patient satisfaction rate increased to more than 75% in health services by 2019** | | | | | | | | | | | | |
| | 2.4.32 Complaint resolution within 25 working days rate | % Quarterly | 100% | 100% | 98% | 100% | **85%** | **85%** | **85%** | **85%** | **85%** | 85% | 85% |
| | Numerator | | | | 218 | 238 | | | | | | | |
| | Denominator | | | | 223 | 238 | | | | | | | |

## 5.2 Sub-Programme Purpose for Tertiary Hospital Services

To strengthen and continuously develop the modern tertiary services platform to adequate levels in order to be responsive to the demands of the specialist service needs of the community of the Eastern Cape Province. There are two Tertiary Hospitals and one Central Hospital in the Eastern Cape Province:

### Sub-Programmes

- Tertiary Hospitals
- Livingstone Hospital
- Frere Hospital

### Priorities for the Next Three Years

- To strengthen oncology services
- To strengthen institutional capacity to deliver relevant and quality services at appropriate levels
- To improve institutional functionality and effectiveness by ensuring that efficiency indicators are fully achieved

### Strategic Goals Being Addressed

**Strategic goal 1:** Prevent and reduce the disease burden and promote health
**Strategic goal 2:** Improved quality of care

## Provincial Strategic Objectives, Indicators, Annual and Quarterly Targets for Tertiary Hospital Services

Table 41: Indicators and Annual Targets for Tertiary Hospital Services sub – programme 5.2

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| Ensure all tertiary Hospitals are conditionally compliant by 2017 and fully compliant (75%-100%) to National Core Standards by 2019 | **Strategic Objective 2.3: Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019** | | | | | | | | | | | | |
| | 2.3.6 Hospital achieved 75% and more on National Core Standards self-assessment rate | % Quarterly | New Indicator | 100% | 100% | 50% | **100%** | **-** | **50%** | **100%** | **-** | 100% | 100% |
| | *Numerator* | | | 2 | 2 | 1 | **2** | **-** | **1** | **2** | | 2 | 2 |
| | *Denominator* | | | 2 | 2 | 2 | **2** | **-** | **2** | **2** | | 2 | 2 |
| Improve management of patients to optimize average length of stay by 2019 | **Strategic Objective 1.10: 80% of Hospitals meeting national efficiency targets by 2019** | | | | | | | | | | | | |
| | 1.10.5 Average length of stay | Days Quarterly | 5.8 days | 5.7 days | 6 days | 4.8 days | **6 days** | **6 days** | **6 days** | **6 days** | **6 days** | 6 days | 6 days |
| Ensure total population is utilizing Hospitals through referral system by 2019 | 1.10.11 Inpatient bed utilisation rate | % Quarterly | 75.6% | 74.8% | 75% | 77.3% | **75%** | **75%** | **75%** | **75%** | **75%** | 75% | 75% |
| | *Numerator* | | 467,127 | 452 728 | 725 699 | 367235 | **725 699** | **181 424** | **181 425** | **181 425** | **181 425** | 455 143 | 455 143 |
| | *Denominator* | | 589,357 | 605 236 | 967 599 | 481579 | **967 599** | **241 899** | **241 900** | **241 900** | **241 900** | 606 858 | 606 858 |
| Ensure the 80% Hospital expenditure increase to cover the uninsured population by 2019 | 1.10.17 Expenditure per patient day equivalent (PDE) | R Quarterly | R3412 | R3,357 | R3,303 | R3 ,733 | **R3,878** | **R3,878** | **R3,878** | **R3,878** | **R3,878** | R3,878 | R3,878 |

Table 41: Indicators and Annual Targets for Tertiary Hospital Services sub – programme 5.2

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| Ensure all tertiary Hospitals are conditionally compliant by 2017 and fully compliant (75%-100%) to National Core Standards by 2019 | **Strategic Objective 2.4: Patient satisfaction rate increased to more than 75% in health services by 2019** | | | | | | | | | | | | |
| | 2.4.33 Complaint resolution within 25 working days rate | % Quarterly | 100% | 95% | 95% | 98.3% | **85%** | **85%** | **85%** | **85%** | **85%** | 85% | 85% |
| | *Numerator* | | | | 277 | 173 | | | | | | | |
| | *Denominator* | | | | 292 | 176 | | | | | | | |

## 5.3 Sub-Programme Purpose for Specialised Tertiary Hospital

To strengthen and continuously develop the modern tertiary services platform to adequate levels in order to be responsive to the demands of the specialist service needs of the community of the Eastern Cape Province. There is one Specialised Tertiary Hospital in the Eastern Cape Province:

### Sub-Programmes

Specialised Tertiary Hospitals
- Fort England (specialised psychiatric Hospital)

### Priorities for the Next Three Years

- To strengthen institutional capacity to deliver relevant and quality services at appropriate levels
- To improve institutional functionality and effectiveness by ensuring that efficiency indicators are fully achieved

### Strategic Goals Being Addressed

**Strategic goal 1:** Prevent and reduce the disease burden and promote health
**Strategic goal 2:** Improved quality of care

## Provincial Strategic Objectives, Indicators, Annual and Quarterly Targets for Specialised Tertiary Hospital Services

Table 42: Indicators and Annual Targets for Specialised Tertiary Hospital sub – programme 5.3

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| Ensure all psychiatric Hospitals are conditionally compliant by 2017 and fully compliant (75%-100%) to National Core Standards by 2019 | **Strategic Objective 2.3: Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019** | | | | | | | | | | | | |
| | 2.3.7 Hospital achieved 75% and more on National Core Standards self- - assessment rate | % Quarterly | New Indicator | New Indicator | 100% | 100% | **100%** | **-** | **100%** | **100%** | **-** | 100% | **100%** |
| | **Strategic Objective 2.4: Patient satisfaction rate increased to more than 75% in health services by 2019** | | | | | | | | | | | | |
| | 2.4.34 Complaint resolution within 25 working days rate | % Quarterly | New Indicator | 48% | 100% | 100% | **85%** | **85%** | **85%** | **85%** | **85%** | 85% | 85% |
| | *Numerator* | | | | 40 | **22** | | | | | | | |
| | *Denominator* | | | | 40 | **22** | | | | | | | |

## 5.4 Reconciling Performance Targets with Expenditure Trends and Budgets

Table 43: Summary of payments and estimates by sub-programme: Central & Tertiary Hospitals

| | Outcome | | | Main appropriation | Adjusted appropriation | Revised estimate | Medium-term estimates | | | % change from |
|---|---|---|---|---|---|---|---|---|---|---|
| R thousand | 2015/16 | 2016/17 | 2017/18 | | 2018/19 | | 2019/20 | 2020/21 | 2021/22 | 2018/19 |
| 1. Central Hospital Services | 262,945 | 997,233 | 1,084,905 | 1,124,285 | 1,134,949 | 1,238,634 | 1,202,539 | 1,210,087 | 1,231,676 | (2.9) |
| 2. Provincial Tertiary Services | 560,276 | 1,916,388 | 2,386,168 | 2,323,452 | 2,375,750 | 2,805,551 | 2,424,012 | 2,646,148 | 2,747,696 | (13.6) |
| **Total payments and estimates** | **823,221** | **2,913,621** | **3,471,073** | **3,447,737** | **3,510,699** | **4,044,185** | **3,626,551** | **3,856,235** | **3,979,372** | **(10.3)** |

Table 44: Summary of payments and estimates by economic classification: Central & Tertiary Hospitals

| | Outcome | | | Main appropriation | Adjusted appropriation | Revised estimate | Medium-term estimates | | | % change from |
|---|---|---|---|---|---|---|---|---|---|---|
| R thousand | 2015/16 | 2016/17 | 2017/18 | | 2018/19 | | 2019/20 | 2020/21 | 2021/22 | 2018/19 |
| **Current payments** | **721,876** | **2,769,476** | **3,331,701** | **3,323,084** | **3,384,174** | **3,909,737** | **3,515,798** | **3,707,567** | **3,823,127** | **(10.1)** |
| Compensation of employees | 242,355 | 1,954,815 | 2,375,151 | 2,349,996 | 2,381,774 | 2,957,670 | 2,386,505 | 2,605,306 | 2,759,180 | (19.3) |
| Goods and services | 479,521 | 812,194 | 956,250 | 973,088 | 1,002,400 | 951,797 | 1,129,293 | 1,102,261 | 1,063,947 | 18.6 |
| Interest and rent on land | – | 2,467 | 300 | – | – | 270 | – | – | – | (100.0) |
| **Transfers and subsidies to:** | **9** | **41,278** | **81,281** | **17,900** | **17,900** | **40,757** | **–** | **29,596** | **31,224** | **(100.0)** |
| Households | 9 | 41,278 | 81,281 | 17,900 | 17,900 | 40,757 | – | 29,596 | 31,224 | (100.0) |
| **Payments for capital assets** | **101,336** | **102,867** | **58,091** | **106,753** | **108,625** | **93,691** | **110,753** | **119,072** | **125,021** | **18.2** |
| Buildings and other fixed structures | 2,461 | – | – | 3,000 | 3,000 | 126 | – | – | – | (100.0) |
| Machinery and equipment | 98,875 | 102,867 | 58,091 | 103,753 | 105,625 | 93,565 | 110,753 | 119,072 | 125,021 | 18.4 |
| **Total economic classification** | **823,221** | **2,913,621** | **3,471,073** | **3,447,737** | **3,510,699** | **4,044,185** | **3,626,551** | **3,856,235** | **3,979,372** | **(10.3)** |

Tables 43 and 44 above show the summary of payments and estimates for Central Hospital Services per sub-programme and economic classification. The programme's total expenditure increased from R823.221 million in 2015/16 to a revised estimate of R4.044 billion in 2018/19. In 2019/20, the budget decreases by 10.3 per cent from R4.044 billion to R3.626 billion when compared to the 2018/19 revised estimate.

Compensation of employees shows a negative growth of 19.3 per cent from R2.957 billion to R2.386 billion when compared to the 2018/19 revised estimate due to the high revised estimates resulting from the process of de-complexing of facilities for employees that were paid under Programme 4: Provincial Hospital Services and being allocated to the Programme 5: Central Hospital Services.

Goods and services show a positive growth 18.6 per cent from R951.797 million to R1.129 billion when compared to the 2018/19 revised estimate *due reprioritisation and national adjustments of PES formula.*

Transfers and subsidies show a negative growth of 100 per cent from R40.757 million to zero budget on households.

## 5.5 Risk Management

Below are key risks that may affect the realization of the strategic objectives in programme 5 and measures designed to mitigate its impact.

Table 45: Risk and Mitigating factors for programme 5

| RISK IDENTIFIED | RISK MITIGATION |
|---|---|
| Inadequate Secondary and Tertiary services | • Filling of Strategic Posts<br>• Induction and training of personnel<br>• Peer Reviews on National Core Standards<br>• Implementation of national Core Standards RIS |

# PROGRAMME 6

# Health Sciences & Training

# Programme 6
## Health Sciences and Training (HST)

### 6.1 Programme Purpose

To develop a capable health workforce for the Eastern Cape provincial health system as part of a quality people value stream.

#### Priorities for the Next Three Years

Manage the bursary scheme effectively to ensure a flow of health professionals in to the department

#### Strategic Goals Being Addressed

**Strategic goal 2:** Improved quality of care

### Provincial Strategic Objectives, Indicators, Annual and Quarterly Targets for Health Sciences And Training

Table 46: Indicators and Annual Targets for Health Science and Training

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| Increase enrolment of Medicine, Nursing and Pharmacy students annually by 10% per annum. | **Strategic objective 2.6 First year Health professional students receiving bursaries by 2019** | | | | | | | | | | | | |
| | 2.6.1 Number of Bursaries awarded for first year medicine students | No Annually | 20 | 13 | 97 | 10 | **10** | **-** | **-** | **-** | **10** | 50 | 50 |
| | 2.6.2 Number of Bursaries awarded for first year nursing students | No Annually | 894 | 350 | 351 | 350 | **350** | **-** | **-** | **-** | **350** | 350 | 350 |

## 6.2 Reconciling Performance Targets with Expenditure Trends and Budgets

Table 47: Summary of payments and estimates by sub-programme: Health Sciences & Training

| | Outcome | | | Main appropriation | Adjusted appropriation | Revised estimate | Medium-term estimates | | | % change from |
|---|---|---|---|---|---|---|---|---|---|---|
| R thousand | 2015/16 | 2016/17 | 2017/18 | | 2018/19 | | 2019/20 | 2020/21 | 2021/22 | 2018/19 |
| 1. Nursing Training Colleges | 290,679 | 285,627 | 276,980 | 326,371 | 326,389 | 288,436 | 344,888 | 365,089 | 375,461 | 19.6 |
| 2. Ems Training College | 13,574 | 10,657 | 13,873 | 18,764 | 15,521 | 13,734 | 17,982 | 17,077 | 17,078 | 30.9 |
| 3. Bursaries | 198,856 | 186,239 | 141,117 | 175,700 | 175,621 | 148,083 | 184,728 | 194,535 | 203,748 | 24.7 |
| 4. Other Training | 266,263 | 266,849 | 295,722 | 364,512 | 362,981 | 312,238 | 382,211 | 388,634 | 395,159 | 22.4 |
| **Total payments and estimates** | **769,372** | **749,372** | **727,692** | **885,346** | **880,512** | **762,491** | **929,809** | **965,335** | **991,446** | **21.9** |

Table 48: Summary of payments and estimates by economic classification: Health Science & Training

| | Outcome | | | Main appropriation | Adjusted appropriation | Revised estimate | Medium-term estimates | | | % change from |
|---|---|---|---|---|---|---|---|---|---|---|
| R thousand | 2015/16 | 2016/17 | 2017/18 | | 2018/19 | | 2019/20 | 2020/21 | 2021/22 | 2018/19 |
| **Current payments** | **550,018** | **541,960** | **562,753** | **679,006** | **686,503** | **594,220** | **712,072** | **737,677** | **754,927** | **19.8** |
| Compensation of employees | 418,577 | 470,198 | 468,511 | 562,303 | 552,722 | 511,582 | 577,680 | 631,684 | 666,428 | 12.9 |
| Goods and services | 131,441 | 71,762 | 94,242 | 116,703 | 133,781 | 82,638 | 134,392 | 105,993 | 88,499 | 62.6 |
| Interest and rent on land | – | – | – | – | – | – | – | – | – | |
| **Transfers and subsidies to:** | **211,519** | **196,341** | **153,526** | **183,179** | **182,636** | **158,743** | **193,393** | **205,244** | **216,532** | **21.8** |
| Provinces and municipalities | – | – | – | – | – | – | – | – | – | |
| Departmental agencies and accounts | 18,115 | 7,739 | 11,013 | 12,479 | 11,856 | 11,856 | 13,733 | 17,060 | 17,998 | 15.8 |
| Households | 193,404 | 188,602 | 142,513 | 170,700 | 170,780 | 146,887 | 179,660 | 188,184 | 198,534 | 22.3 |
| **Payments for capital assets** | **7,835** | **11,071** | **11,413** | **23,161** | **11,373** | **9,528** | **24,344** | **22,414** | **19,987** | **155.5** |
| Buildings and other fixed structures | – | – | – | – | – | – | – | – | – | |
| Machinery and equipment | 7,835 | 11,071 | 11,413 | 23,161 | 11,373 | 9,528 | 24,344 | 22,414 | 19,987 | 155.5 |
| **Total economic classification** | **769,372** | **749,372** | **727,692** | **885,346** | **880,512** | **762,491** | **929,809** | **965,335** | **991,446** | **21.9** |

Tables 54 and 55 above show *the* summary of payments and estimates for Health Sciences and Training per sub-programme and economic classification. The programme's total expenditure decreased from R769.372 million in 2015/16 to a revised estimate of R762.491 million in 2018/19. In 2019/20, the budget increases by 21.9 per cent from R762.491 million to R929.809 billion when compared to the 2018/19 revised estimate.

Compensation of employees shows a positive growth of 12.9 per cent from R511.582 million to R577.680 million when compared to the 2018/19 revised estimate due to the ICS adjustment, pay progression and filling of critical vacant posts.

Goods and services show a positive growth 62.6 per cent from R82.638 million to R134.392 million when compared to the 2018/19 revised estimate *due reprioritisation and national adjustment of PES formula.*

Transfers and subsidies show a positive growth of 21.8 per cent from R158.743 million to R193.393 million when compared to the 2018/19 revised estimate due reprioritisation of funds to cater for Cuban Program.

Payments for capital assets show a positive growth of 155.5 per cent from R9.528 million to R24.344 million when compared to the 2018/19 revised estimate due to additional funding for medical equipment.

## 6.3 Risk Management

Below are the key risks that may affect the realization of the strategic objectives Programme 6 and the measures designed to mitigate their impact. .

Table 49: Risk and Mitigating factors for programme 6

| RISK IDENTIFIED | RISK MITIGATION |
|---|---|
| Lack of absorption of graduated bursary students by ECDoH, as they should be as per their bursary agreement, due to no posts being available resulting in the ECDoH writing off the bursary obligation | To implement the strategy to ensure that there are sufficient posts available for bursary holders each year; graduates who do not want to work for the Department are handed over to the Debt Collection Unit of the Finance Cluster for the collection of the full outstanding amounts |
| Lack of appropriate candidates for critical postgraduate skills shortage programme | Continued implementation of the Registrar Program and the Clinical Teaching Platform to attract and retain core clinical skills |
| Reduced number of registrars graduating into specialists due to new requirement of a Masters dissertation prior to registration as specialist | Improved support of registrars with their research work, including protected time to allow them space to focus and submit their dissertations |

# PROGRAMME 7

# Health Care Support Services

# Programme 7:
# Health Care Support Services (HCSS)

## 7.1 Programme Purpose

To render quality, effective and efficient transversal health (orthotic & prosthetic, rehabilitation, laboratory, social work services and radiological services) and pharmaceutical services to the communities of the Eastern Cape. Health Care Support Services consist of two sub-programmes: Transversal Health Services and Pharmaceutical Services.

### Programme Description

Transversal Health Services consists of:

- The orthotic & prosthetic (O&P) services sub-programme, which has three existing O&P centres. The centres are based within the three Hospitals namely the PE Provincial Hospital, in East London at Frere Hospital, and in Mthatha at Bedford Orthopaedic Hospital. The prescriptions received from medical professionals and the referrals especially from the outreach programme determine the need for the service.
- Rehabilitation, laboratory, social work and radiological services are rendered at all Hospitals and/or community health centres.

Pharmaceutical Services is responsible for

- Coordination of the full spectrum of the Pharmaceutical Management Framework including drug selection, supply, distribution and utilization.
- Pharmaceutical standards development and monitoring for health facilities and the two medical depots are coordinated under this programme.

### Priorities for the Next Three Years

- To improve systems for the provision of assistive devices and rehabilitation services to eligible persons
- To strengthen systems to ensure uninterrupted availability of essential medicines at all levels
- Improve Management and Governance of Pharmaceutical Services

### Key interventions:

The key intervention areas to be included in this plan include

- Strengthen rehabilitation services at District Hospitals and PHC facilities
- Collaborating with partners and other sectors to improve availability of assistive devices
- Improve efficiency in medicines supply chain
- Ensure adequate infrastructure for medicines storage at depot and health facilities.
- Ensure compliance with Good Pharmacy Practice Standards

### Strategic Goals Being Addressed

**Strategic goal 1:** Prevent and reduce the disease burden and promote health
**Strategic goal 2:** Improve Quality of Care

## Provincial Strategic Objectives, Indicators, Annual and Quarterly Targets for Health Care Support Services

Table 50: Additional Provincial Performance Indicators for Health Care Support Services

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| Ensure that eligible applicants that require rehabilitation services are supplied | **Strategic objective 1.11 95% of clients eligible for assistive devices provided with wheelchairs, hearing aids, prostheses & orthoses by 2019** | | | | | | | | | | | | |
| | 1.11.1 Wheelchair issued rate | % Quarterly | 92.5% | 88%[6] | 53% | 34% | **60%** | **10%** | **30%** | **50%** | **60%** | 60% | 60% |
| | *Numerator* | | 8 061 | 2 523 | 1 537 | 469 | **1500** | **250** | **750** | **1250** | **1500** | 1500 | 1500 |
| | *Denominator* | | 8 715 | 2 863 | 2 890 | 1 378 | **2 500** | **2 500** | **2 500** | **2 500** | **2 500** | 2 500 | 2 500 |
| | 1.11.2 Hearing aids issued rate | % Quarterly | 173% | 81% | 44% | 100% | **70%** | **10%** | **40%** | **60%** | **70%** | 70% | 70% |
| | *Numerator* | | 5 405 | 2 110 | 1 427 | 625 | **1 400** | **200** | **800** | **1200** | **1 400** | 1 400 | 1 400 |
| | *Denominator* | | 3 130 | 2 592 | 3211 | 625 | **2 000** | **2 000** | **2000** | **2000** | **2000** | 2 000 | 2 000 |
| Ensure that all essential drugs are available at all times in the depots and supply turnaround time is achieved | **Strategic objective 1.12 95% availability of essential drugs in all health facilities by 2019** | | | | | | | | | | | | |
| | 1.12.1 Percentage of order fulfilment of essential drugs at the depots. | % Quarterly | 84% | 84% | 84% | 71.1% | **90%** | **90%** | **90%** | **90%** | **90%** | 90% | 90% |
| | *Numerator* | | 366 124 | 366 124 | 649 999 | 126 792 | **598 787** | **149 696** | **149 697** | **149 697** | **149 697** | 624 449 | 624 449 |
| | *Denominator* | | 435 864 | 435 664 | 772 662 | 178 157 | **665 319** | **166 329** | **166 330** | **166 330** | **166 330** | 693832 | 693832 |
| | 1.12.2 Essential medicines stock-out rate at the depots | % Quarterly | <11% | <5% | <5% | 35% | **<5%** | **<5%** | **<5%** | **<5%** | **<5%** | <5% | <5% |
| | *Numerator* | | <2 | <2 | <2 | 21 | **<3** | **<3** | **<3** | **<3** | **<3** | <3 | <3 |
| | *Denominator* | | 39 | 39 | 39 | 60 | **60** | **60** | **60** | **60** | **60** | 60 | 60 |

[6] In 2015/16 and 2016/17 the department embarked on a project to address the backlog

## 7.2 Reconciling Performance Targets with Expenditure Trends and Budgets

Table 51: Summary of payments and estimates by sub - programme: Health Care Support Services

| R thousand | Outcome 2015/16 | 2016/17 | 2017/18 | Main appropriation | Adjusted appropriation 2018/19 | Revised estimate | Medium-term estimates 2019/20 | 2020/21 | 2021/22 | % change from 2018/19 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. Orthotic & Prosthetic Services | 33,744 | 44,545 | 36,270 | 54,333 | 55,107 | 35,736 | 54,143 | 57,258 | 54,699 | 51.5 |
| 2. Medicine Trading Account | 59,385 | 57,316 | 63,728 | 71,180 | 71,445 | 72,382 | 71,692 | 75,904 | 73,656 | (1.0) |
| **Total payments and estimates** | **93,129** | **101,861** | **99,998** | **125,512** | **126,552** | **108,118** | **125,835** | **133,162** | **128,355** | **16.4** |

Table 52: Summary of payments and estimates by economic classification: Health Care Support Services

| R thousand | Outcome 2015/16 | 2016/17 | 2017/18 | Main appropriation | Adjusted appropriation 2018/19 | Revised estimate | Medium-term estimates 2019/20 | 2020/21 | 2021/22 | % change from 2018/19 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Current payments** | **90,664** | **100,608** | **99,397** | **124,936** | **125,550** | **107,619** | **124,456** | **132,534** | **127,960** | **15.6** |
| Compensation of employees | 50,586 | 55,972 | 52,707 | 64,602 | 64,767 | 59,212 | 68,045 | 73,731 | 77,787 | 14.9 |
| Goods and services | 40,078 | 44,636 | 46,690 | 60,334 | 60,783 | 48,407 | 56,411 | 58,803 | 50,173 | 16.5 |
| Interest and rent on land | – | – | – | – | – | – | – | – | – | |
| **Transfers and subsidies to:** | **91** | **185** | **34** | **–** | **100** | **13** | **200** | **–** | **–** | **1438.5** |
| Households | 91 | 185 | 34 | – | 100 | 13 | 200 | – | – | 1438.5 |
| **Payments for capital assets** | **2,374** | **1,068** | **567** | **577** | **902** | **486** | **1,179** | **628** | **395** | **142.6** |
| Buildings and other fixed structures | – | – | – | – | – | – | – | – | – | |
| Machinery and equipment | 2,374 | 1,068 | 567 | 577 | 902 | 486 | 1,179 | 628 | 395 | 142.6 |
| Software and other intangible assets | – | – | – | – | – | – | – | – | – | |
| **Payments for financial assets** | **–** | **–** | **–** | **–** | **–** | **–** | **–** | **–** | **–** | |
| **Total economic classification** | **93,129** | **101,861** | **99,998** | **125,512** | **126,552** | **108,118** | **125,835** | **133,162** | **128,355** | **16.4** |

Tables 51 and 52 above show a summary of payments and estimates for Health Care Support Services per sub-programme and economic classification. The programme's total expenditure increased from R93.129 million in 2015/16 to a revised estimate of R108.118 million in 2018/19. In 2019/20, the budget increases by 16.4 per cent from R108.118 million to R125.835 million when compared to the 2018/19 revised estimate.

Compensation of employees shows a positive growth of 14.9 per cent from R59.212 million to R68.045 million when compared to the 2018/19 revised estimate due to ICS adjustments, pay progression and filling of critical vacant post.

Goods and services show a positive growth 16.5 per cent from R48.407 million to R56.411 million when compared to the 2018/19 revised estimate *due the low revised estimate resulting from reprioritisation to fund critical core-items.*

## 7.3 Risk Management

Below are key risks that may affect the realization of the strategic objectives in programme 7 and measures designed to mitigate its impact. .

Table 53: Risk and Mitigating factors for programme 7

| RISK IDENTIFIED | RISK MITIGATION |
|---|---|
| Inconsistent medicine supply and availability | • Roll out Remote Demander Module for electronic medicines and consumables ordering.<br>• Roll out Rx Solution for electronic medicine stock management<br>• Capacity building and recruitment of pharmacist assistant<br>• Medicine supply management training |

# PROGRAMME 8
# Health Facilities Management

# Programme 8
# Health Facilities Management (HFM)

## 8.1 Programme Purpose

To improve access to health care services through provision of new health facilities, upgrading and revitalisation, as well as maintenance of existing facilities, including the provision of appropriate health care equipment.

The programme has 5 sub-programmes, which is supports namely:

- Community Health Facilities
- Emergency Medical Services
- District Hospital Services
- Provincial Hospital services
- Other facilities

### PRIORITIES FOR THE NEXT THREE YEAR MTEF

- To facilitate and provide infrastructural support in order to ensure adequate facilities for health services platform
- Renovation and refurbishment of existing structures to ensure compliance with norms and standards
- To assist in the devolution of maintenance to districts and provided governance structures.
- To facilitate general building maintenance to all immovable assets under the departments inventory
- To facilitate the provision and maintenance of health technology equipment
- To facilitate the provision and maintenance of all plant & machinery
- To ensure the implementation of treasury local content by engaging SMME suppliers when contracting

### STRATEGIC GOALS BEING ADDRESSED

**Strategic goal 2:** Improve Quality of Care

## Provincial Strategic Objectives, Indicators, Annual and Quarterly Targets for Health Facilities Management

Table 54: Provincial performance indicators for Health Facilities Management

| Strategic Objective Statement | Programme Performance Indicator | Indicator Type & Reporting frequency | Audited/ Actual Performance | | | Estimated Performance | Medium Term Targets | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2019/20 QUARTERLY TARGETS | | | | 2020/21 | 2021/22 |
| | | | | | | | | Q1 | Q2 | Q3 | Q4 | | |
| Compliance with Norms & Standards for all new Infrastructure Projects by 2019 | **Strategic objective 2.7 Health facilities refurbished to comply with the National norms and standards by 2019** | | | | | | | | | | | | |
| | 2.7.1 Number of health facilities that have undergone major refurbishment project in NHI pilot district | No. Annual | 9 major | 10 major | 5 major | 3 major | **2 major** | - | - | **2 major** | | 2 major | 2 major |
| | 2.7.2 Number of health facilities that have undergone minor refurbishment project in NHI pilot district | No. Annual | 320 minor | 70 minor | 0 minor | 90 minor | **7 minor** | - | - | **7 minor** | - | 7 minor | 7 minor |
| | 2.7.3 Number of health facilities that have undergone major refurbishment project outside NHI pilot District | No. Annual | New indicator | 13 major | 4 major | 7 major | **3 major** | - | - | - | **3 major** | 3 major | 3 major |
| | 2.7.4 Number of health facilities that have undergone minor refurbishment project outside NHI pilot District | No. Annual | New indicator | 70 minor | 1010 minor | 17 minor | **38 minor** | **10 minor** | **10 minor** | **10 minor** | **8 minor** | 40 minor | 40 minor |

## 8.2 Reconciling Performance Targets with Expenditure Trends and Budgets

Table 55: Summary of payments and estimates by programme 8: Health Facilities Management

| R thousand | Outcome 2015/16 | 2016/17 | 2017/18 | Main appropriation | Adjusted appropriation 2018/19 | Revised estimate | Medium-term estimates 2019/20 | 2020/21 | 2021/22 | % change from 2018/19 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. Community Health Facilities | 404,918 | 246,170 | 155,394 | 193,283 | 181,252 | 154,200 | 234,824 | 226,441 | 182,942 | 52.3 |
| 2. Emergency Medical Rescue Services | 7 | – | 281 | – | – | 136 | – | – | – | (100.0) |
| 3. District Hospital Services | 310,025 | 429,957 | 752,511 | 641,624 | 630,953 | 680,610 | 639,617 | 565,739 | 680,376 | (6.0) |
| 4. Provincial Hospital Services | 449,514 | 479,573 | 289,282 | 468,385 | 361,105 | 403,115 | 519,876 | 472,797 | 384,010 | 29.0 |
| 5. Other Facilities | 35,058 | 140,234 | 77,046 | 68,779 | 71,260 | 72,571 | 52,238 | 31,039 | 22,400 | (28.0) |
| **Total payments and estimates** | **1,199,522** | **1,295,934** | **1,274,514** | **1,372,071** | **1,244,570** | **1,310,632** | **1,446,555** | **1,296,016** | **1,269,728** | **10.4** |

Table 56: Summary of payments and estimates by economic classification: Health Facilities Management

| R thousand | Outcome 2015/16 | 2016/17 | 2017/18 | Main appropriation | Adjusted appropriation 2018/19 | Revised estimate | Medium-term estimates 2019/20 | 2020/21 | 2021/22 | % change from 2018/19 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Current payments** | **301,392** | **398,022** | **409,705** | **393,236** | **265,683** | **319,119** | **261,468** | **275,811** | **290,853** | **(18.1)** |
| Compensation of employees | 10,391 | 14,494 | 16,844 | 32,111 | 29,796 | 29,393 | 34,108 | 42,407 | 47,300 | 16.0 |
| Goods and services | 290,528 | 379,036 | 392,861 | 361,125 | 235,887 | 289,726 | 227,360 | 233,404 | 243,553 | (21.5) |
| Interest and rent on land | 473 | 4,492 | – | – | – | – | – | – | – | |
| **Transfers and subsidies to:** | **–** | **–** | **67** | **–** | **–** | **11** | **–** | **–** | **–** | **(100.0)** |
| Households | – | – | 67 | – | – | 11 | – | – | – | (100.0) |
| **Payments for capital assets** | **898,130** | **897,912** | **864,742** | **978,835** | **978,887** | **991,502** | **1,185,087** | **1,020,205** | **978,875** | **19.5** |
| Buildings and other fixed structures | 879,445 | 654,895 | 637,152 | 807,500 | 872,234 | 924,357 | 980,582 | 800,719 | 749,928 | 6.1 |
| Machinery and equipment | 18,685 | 243,017 | 227,590 | 171,335 | 106,653 | 67,145 | 204,505 | 219,486 | 228,947 | 204.6 |
| **Total economic classification** | **1,199,522** | **1,295,934** | **1,274,514** | **1,372,071** | **1,244,570** | **1,310,632** | **1,446,555** | **1,296,016** | **1,269,728** | **10.4** |

Tables 55 and 56 above show the summary of payments and estimates for Health Facilities Management per sub-programme and economic classification. The programme's total expenditure increased from R1.199 billion in 2015/16 to a revised estimate of R1.310 billion in 2018/19. In 2019/20, the budget increases by 10.4 per cent from R1.310 billion to R1.446 billion when compared to the 2018/19 revised estimate.

Compensation of employees shows a positive growth of 16 per cent from R29.393 million to R34.108 million when compared to the 2018/19 revised estimate in order to improve capacitation within the programme.

Goods and services show a negative growth 21.5 per cent from R289.786 million to R227.360 million when compared to the 2018/19 revised estimate due the low revised estimate as a result of delays of payments to contracts relating to the maintenance of infrastructure and machinery and equipment.

Payments for capital assets show a positive growth of 19.5 per cent from R991.502 million to R1.185 billion when compared to the 2018/19 revised estimate due to the additional funding on Health Revitalisation Facilities Grant.

## 8.3 Risk Management

Below are key risks that may affect the realization of strategic objectives of the programme 8 and measures designed to mitigate its impact.

**Table 57: Risk and Mitigating factors for programme 8**

| RISK IDENTIFIED | RISK MITIGATION |
|---|---|
| Inadequate provision of Infrastructure | • Improve Human Resource capacitation within the unit<br>• Inclusion of Remedial measures specifically in regard to the application of penalties for poor performing agents and professionals<br>• Strengthening and monitoring compliance to SLAs'<br>• Monitor the terms of contracts |

# PART C
# LINKS TO OTHER PLANS

# Links to the Long Term Infrastructure and Other Capital Plans

Table 58: Summary of provincial infrastructure payments and estimates by category

| R thousand | Outcome 2015/16 | Outcome 2016/17 | Outcome 2017/18 | Main appropriation 2018/19 | Adjusted appropriation 2018/19 | Revised estimate 2018/19 | Medium-term estimates 2019/20 | Medium-term estimates 2020/21 | Medium-term estimates 2021/22 | % change from 2018/ 19 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Existing infrastructure assets** | **1,092,345** | **1,119,557** | **980,099** | **1,089,980** | **910,335** | **926,938** | **1,034,446** | **939,326** | **811,484** | **11.6** |
| Maintenance and repairs | 301,397 | 389,290 | 457,918 | 501,125 | 360,559 | 340,976 | 482,756 | 392,419 | 385,398 | 41.6 |
| Upgrades and additions | 773,265 | 717,167 | 378,129 | 196,600 | 196,881 | 246,673 | 217,861 | 238,376 | 85,992 | (11.7) |
| Rehabilitation and refurbishment | 17,683 | 13,100 | 144,052 | 392,255 | 352,895 | 339,289 | 333,829 | 308,532 | 340,093 | (1.6) |
| **New infrastructure assets** | **107,177** | **176,377** | **294,415** | **392,980** | **453,503** | **422,639** | **345,311** | **293,540** | **327,414** | **(18.3)** |
| **Infrastructure transfers** | **–** | **–** | **–** | **–** | **–** | **–** | **–** | **–** | **–** | |
| Current | – | – | – | – | – | – | – | – | – | |
| Capital | – | – | – | – | – | – | – | – | – | |
| **Infrastructure payments for financial assets** | **–** | **–** | **–** | **–** | **–** | **–** | **–** | **–** | **–** | |
| **Infrastructure leases** | **–** | **–** | **–** | **–** | **–** | **–** | **–** | **–** | **–** | |
| **Non infrastructure** | **–** | **–** | **–** | **102,111** | **93,732** | **90,810** | **276,898** | **273,149** | **338,391** | **204.9** |
| **Total department infrastructure** | **1,199,522** | **1,295,934** | **1,274,514** | **1,585,071** | **1,457,570** | **1,440,387** | **1,656,655** | **1,506,016** | **1,477,289** | **15.0** |

**Departmental infrastructure payments**: Table 58 above shows summary of infrastructure expenditure per category from 2015/16 to 2019 MTEF. Infrastructure spending increased from R1.199 billion in 2015/16 to a revised estimate of R1.440 billion in 2018/19 and the spending has been focusing on maintenance of existing infrastructure and procurement of equipment as opposed to the building new structures.

The infrastructure budget shows a positive growth of 15 per cent from R1.440 billion in 2018/19 to R1.656 billion in 2019/20 when compared to the revised estimate due to the low revised estimate and additional allocation on the infrastructure grant.

The budget over the 2019 MTEF will focus on commissioning of existing hospitals and clinics, medical equipment maintenance and Community Health Centre and Clinics renovations, refurbishments, alterations and additions.

**Maintenance**: In terms of the norms of infrastructure maintenance, a minimum of 2.5 per cent of the replacement value of assets should be allocated for maintenance or 20 per cent of the total Infrastructure Allocation of which the department has allocated 29 per cent for maintenance for 2019/20. Over and above, in an effort to address all challenges of setting realistic funding percentages, the National Department of Health has put the maintenance category on its list of non-negotiable items.

**Non – infrastructure items**: A total budget of R276.898 million is allocated in 2019/20 for the maintenance of medical equipment under Goods and services

# 10. Conditional Grants

## 10.1 Health Professionals Training and Development Grant

| Name conditional grant | Purpose of the grant | Performance indicators | National Indicator targets for 2017/18 | Provincial Indicator targets for 2019/20 |
|---|---|---|---|---|
| Health Professionals Training and Development | Support Provinces to fund services costs associated with the training of health science trainees on the public service platform | Availability of Business Plans. Available for 2018/19 | 1 Provincial Consolidated business plans and 4 Facility Business Plans | Approved business plan submitted |
| | | Number of site visits. | Number facility site visits will be confirmed after 28 February 2019 | 10<br>Nelson Mandela Central Hospital<br>Mthatha General Hospital<br>Livingston & PE Provincial Hospitals<br>Health resource Centres x 5<br>Frere Hospital<br>Fort England<br>St. Elizabeth<br>Dora Nginza Hospital<br>Frontier Hospital<br>Cecilia Makiwane Hospital |
| | | Availability of quarterly & annual performance report. | 1 Annual performance reports Number of quarterly reports will be confirmed after 28 February 2019 | 4 quarterly reports & 1 annual report submitted |
| | | Number of audit findings | Minimum 5 to 10 | 0 |

## 10.2 Comprehensive HIV/AIDS Grant

| Name conditional grant | Purpose of the grant | Performance indicators | National Indicator targets for 2017/18 | Provincial Indicator targets for 2019/20 |
|---|---|---|---|---|
| Comprehensive HIV Aids Conditional Grant | To enable the health sector to develop an effective response to HIV/AIDS and TB<br>To support the Department with the PEPFAR transition process. | Number of patients on ART remaining in care | 4 943 618 | 635 706 |
| | | Number of Antenatal Care (ANC) clients initiated on life-long ART | 172 164 | 14 247 |
| | | Number of babies Polymerase Chain Reaction (PCR) tested at 10 weeks | 160,000 | 200 |
| | | Number of HIV positive clients screened for TB | 869 991 | 17 859 |
| | | Number of HIV positive patients that started on IPT | 695 993 | 55 100 |
| | | Number of HIV tests done | 10 000 000 | 1 748 488 |
| | | Number of Medical Male Circumcisions performed | 650 000 | 30 841 |

## 10.3 National Tertiary Services Grant

| Name conditional grant | Purpose of the grant | Performance indicators | National Indicator targets for 2017/18 | Provincial Indicator targets for 2019/20 |
|---|---|---|---|---|
| National Tertiary services | To ensure provision of tertiary health services for all South African citizens | • Approved Service Level Agreements (SLA)<br>• Availability of Business Plans.<br>• Number of site visits.<br>• Availability of quarterly & annual performance report. | • 9 SLA<br>• 39 Business Plans<br>• 9 (Provincial office visits combined with facilities) + 37(facilities + provincial office) = 46 annual site visits<br>• 9 Annual performance reports and 39 quarterly reports (provincial<br>• consolidation + provincial office + facility reports) | • 1 SLA<br>• 1 Approved Business Plan<br>• 4 Quarterly Reports<br>• 1 Annual Report Submitted<br>• 1 Provincial Combined Facility Visit<br>• 1 Quarterly Visit to each of the 4 Benefiting Facilities |
| | To compensate tertiary facilities for the costs associated with the provision of these services | 100% Expenditure at the end of financial year. | • First Quarter 25%<br>• Second Quarter 50%<br>• Third quarter 75%<br>• Fourth quarter 100% Expenditure. | • 100% Expenditure at the end of financial year |

## 10.4 Health Facility Revitalisation Grant

| Name conditional grant | Purpose of the grant | Performance indicators | National Indicator targets for 2017/18 | Provincial Indicator targets for 2019/20 |
|---|---|---|---|---|
| Health Facility Revitalization Grant | • To help accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in health including: health technology (HT),<br>• Organisational design (OD) systems and quality assurance (QA)<br>• To enhance capacity to deliver health infrastructure | Approved Annual Implementation plans for both Health Facility Revitalization Grant and National Health Grant | Availability of approved Annual Implementation Plans (AIP) for all projects funded from National Health grant and Health Facility Revitalization Grant | • A signed and approved AIP 2018/19 submitted to NDOH. |
| | | Monitoring number of projects receive funding from Health Facility Revitalization Grant and National Health Grant | Monitor implementation of all conditional grant funded projects | • 59 Projects funded by HFRG to be implemented on 2018/19 B4.<br>• Monthly Infrastructure Reporting Model (IRM) and Quarterly Progress Report is submitted to NDOH, NT and PT. |

## 11. Public Entities

The department of Health does not have any Public Entities

## 12. Public-Private Partnerships (PPPS)

## Public-Private Partnerships

| Name of PPPs | Purpose | Outputs | Current annual budget | Date of Termination | Measures to ensure smooth transfer of responsibilities |
|---|---|---|---|---|---|
| 1. Humansdorp PPP | To construct a 30-bed private facility, enlarge current entrance and administration, enlarge causality and out-patient ward, including two consulting rooms and a dentist room, upgrade and/or build two new operating theatres, a new CSSD, an new radiology unit and a new laboratory | 30-bed Hospital<br>Upgraded existing clinical areas | R3,400,669 | 27 June 2023<br>20-year period | Management of contract by the department assisted by national and provincial<br>Treasury |
| 2. Port Alfred and Settlers Hospital PPP | To build and/or upgrade 30 private beds, private pharmacy, private administration, two private consulting rooms, 60 public beds, public outpatient facility, public pharmacy, public administration, Shared services facilities, maternity ward, radiology, casualty, theatres, CSSD, kitchen and staff facilities, mortuary, stores, linen areas, plant and workshop areas | 30 private-bed and 60 public bed Hospital<br>Upgraded existing clinical areas<br>Upgraded existing administration, kitchen and staff and general areas | Budget combined = R51,453,033 | 7 May 2022- 15-year period | Management of contract by the department assisted by national and provincial<br>Treasury |

# 13. Technical Indicator Descriptions Provincial APP 2019/20

## Programme 1

### Health Administration & Management

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Provide political and strategic direction to the Department by focusing on transformation on and change management | Number of statutory documents tabled at Legislature | Statutory documents submitted and tabled at the Provincial Legislature | Tracks the number of statutory documents submitted and tabled at the Provincial Legislature | Copies of the document | Not applicable | Unavailability of statutory documents | Output | Categorical | Quarterly | No | Compliance with legislative requirements | Office of the MEC |
| 2.1 Clean audit opinion achieved by 2019 | 2.1.1 Audit opinion from Auditor General | Audit opinion for Provincial Departments of Health for financial performance | To strengthen financial management monitoring and evaluation | Documented Evidence: Annual Report Auditor General's Report | N/A Categorical | N/A | Outcome | Categorical | Annual | No | Unqualified Audit Opinion from the Auditor General | Chief Financial Officers of Provincial Departments of Health |
| | 2.1.2 Level 4 MPAT | The level of compliance (out of 4 levels in the tool) that the department of health has to achieve. | The tool is used by the Presidency to monitor compliance by departments with the 4 management practice domains. | MPAT report | The tool has Structured Questionnaires | Minimal as there are controls | Output | Categorical | Annual | No | Level 3 | GM: SOP |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.2 100% of health facilities connected to web-based DHIS through broadband by 2019 | 2.2.1 Percentage of Hospitals with broadband access | Percentage of Hospitals with broadband access | To track broadband access to hospitals | Network reports that confirm availability of broadband; OR Network rollout report for sites that are not yet live | **Numerator:** Total Number of hospitals with minimum 2 Mbps connectivity<br><br>**Denominator** Total Number of Hospitals | NA | Output | Percentage | Quarterly | No | Higher Proportion of broadband access is more favorable for connectivity to ensure that South African health system can implement the eHealth Programme | ICT Directorate / Chief Directorate |
| | 2.2.2 Percentage of fixed PHC facilities with broadband access | Percentage of fixed PHC facilities with broadband access | To ensure broadband access to PHC facilities | Network reports that confirm availability of broadband; OR Network rollout report for sites that are not yet live | **Numerator:** Total Number of fixed PHC facilities with minimum 1Mbps connectivity<br><br>**Denominator** Total Number of fixed PHC Facilities | NA | Output | Percentage | Quarterly | No | Higher Proportion of broadband access is more favorable for connectivity | ICT Directorate / Chief Directorate |

# Programme 2

# District Health Services (DHS)

## Sub Programme 2.1: District Development

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.1 PHC utilisation rate increased to 3 visits per person per year in all facilities by 2019 | 1.1.1 PHC utilisation rate - total | Average number of PHC visits per year per person in the population. | Monitors PHC access and utilisation. | Daily Reception Headcount register (or HPRS where available) and DHIS<br><br>Denominator: Stats SA | **Numerator:** SUM ([PHC headcount under 5 years] + [PHC headcount 5-9 years] + [PHC headcount 10-19 years] + [PHC headcount 20 years and older])<br>**Denominator:** Sum([Population - Total)] | Dependent on the accuracy of estimated total population from Stats SA | Output | Number | Quarterly | No | Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system. A lower uptake may indicate underutilization of facility | DHS Manager |

## Sub Programme 2.2: Clinics

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019 | 2.3.22 Ideal clinic (IC) status rate | Fixed PHC health facilities have obtained Ideal Clinic status (platinum, silver, gold) | Monitors outcomes of self (Ideal clinics) assessments to ensure they are ready for inspections conducted by Office of Health Standards Compliance. | Ideal Clinic review tools | **Numerator:** SUM ([Ideal Clinic status]) **Denominator**: SUM ([Fixed PHC clinics/fixed CHCs/CDCs]) | None | Process/Activity | Percentage | Annual | No | Higher Ideal clinic status rates ensures clinics will have positive outcomes and is ready for inspections conducted by Office of Health Standards Compliance. | District Health Services and Quality Assurance Directorates |
| 2.4 Patient experience of care increased to more than 75% in health services by 2019 | 2.4.27 Complaint resolution within 25 working days rate | Complaints resolved within 25 working days as a proportion of all complaints resolved | Monitors the time frame in which the public health system responds to complaints | DHIS, complaints register, | **Numerator:** SUM ([Complaint resolved within 25 working days]) **Denominator:** SUM([Complaint resolved]) | Accuracy of information is dependent on the accuracy of time stamp for each complaint | Quality | Percentage | Quarterly | No | Higher percentage suggest better management of complaints in PHC Facilities | Quality Assurance |

## Sub Programme 2.3: CHC'S

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.4 Patient experience of care increased to more than 75% in health services by 2019 | 2.4.27 Complaint resolution within 25 working days rate | Complaints resolved within 25 working days as a proportion of all complaints resolved | Monitors the time frame in which the public health system responds to complaints | DHIS, complaints register, | **Numerator:** SUM ([Complaint resolved within 25 working days])<br><br>**Denominator:** SUM([Complaint resolved]) | Accuracy of information is dependent on the accuracy of time stamp for each complaint | Quality | Percentage | Quarterly | No | Higher percentage suggest better management of complaints in PHC Facilities | Quality Assurance |

## 2.4 Sub-Programme: Community Based Services: Disease Prevention and Control (DPC)

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator (Input etc.) | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.2 Screening coverage of chronic illnesses increased to more than a million by 2019 | 1.2.1 Clients 40 years and older screened for hypertension | Number of clients not on treatment for hypertension screened for hypertension in PHC clinics and OPD | This should assist with increasing the number of clients detected and referred for treatment | PHC Comprehensive Tick Register | SUM ([Client 40 years and older screened for hypertension]) | The new data collection tools may not exist all facilities | Process/ Activity | Sum of Number | Quarterly | No | Greater number of people screened for high blood pressure | CD: health Programmes |
| | 1.2.2 Clients 40 years and older screened for diabetes | Number of clients not diagnosed and not on treatment for diabetes screened for diabetes in PHC clinics and OPD | This should assist with increasing the number of clients with diabetes detected and referred for treatment | PHC Comprehensive Tick Register | SUM([Client 40 years and older screened for diabetes]) | The new data collection tools may not exist all facilities | Process/ Activity | Sum of Number | Quarterly | No | Greater number of people screened for raised blood glucose levels | NCD Programme Manager |
| | 1.2.3 Mental disorders screening rate | Clients screened for mental disorders (depression, anxiety, dementia, psychosis, mania, suicide, developmental disorders, behavioral disorders and substance use | Monitors access to and quality of mental health services in PHC facilities | PHC Comprehensive Tick Register | **Numerator:** SUM ([PHC client screened for mental disorders]) **Denominator:** SUM([PHC headcount under 5 years]) + SUM([PHC headcount 5 years and older]) | The new data collection tools may not exist all facilities | Process/ Activity | Percentage | Quarterly | No | Higher percentage of for mental disorders screening | NCD Programme Manager |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator (Input etc.) | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | disorders at PHC facilities | | | | | | | | | | |

## 2.5 Sub-Programme: Other Community Services

| Strategic Objectives | Indicator nam | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicato | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.5 100% Compliance with the Waste Management Act by 2019 | 2.5.1 Percentage of hospitals complying with SANS waste disposal requirements | This measure hospitals that dispose waste in line with SANS 10248 regulation as a proportion of the total health facilities. | To track compliance of hospitals with SANS 10248 regulation on waste management. | Waste disposal management. | **Numerator** Number of Hospitals that dispose waste in line with SANS 10248 regulation at a given reporting period.<br><br>**Denominator:** Number of Hospitals during same time period. | No specific limitations anticipated | Output | Percentage | Quarterly | No | Compliance with waste management for purposes of infection control and sustaining a healthy environment. | GM: PHP |

## 2.6 Sub-Programme: HIV & AIDS, STI & TB (HAST) Control

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.5 HIV infection rate reduced by 15% by 2019 | 1.5.1 ART Client remain on ART end of month –total | Total clients remaining on ART (TROA) are the sum of the following: - Any client on treatment in the reporting month- Any client without an outcome reported in the reporting month Clients remaining on ART equals [new starts (naive) + Experienced (Exp) + Transfer in (TFI) + Restart] minus [Died (RIP) + loss to follow-up (LTF) + Transfer out (TFO)] | Monitors the total clients remaining on life-long ART at the month | ART Register; Tiered System; DHIS | SUM([ART adult remain on ART end of period])+SUM([ART child under 15 years remain on ART end of period]) | None | Output | Number | Quarterly | No | Higher total indicates a larger population on ART treatment | HIV/AIDS Programme Manager |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1.5.2 TB/HIV co-infected client on ART rate | TB/HIV co-infected clients on ART as a proportion of all HIV positive TB clients | All co-infected clients must be on ART to reduce mortality. This includes clients already on ART at TB treatment initiation and those started on ART during TB treatment. Monitors ART coverage for TB clients | ETR/Tier.Net TB register; | **Numerator:** SUM ([TB/ HIV co-infected client on ART]) **Denominator:** SUM([TB client known HIV positive]) | Availability of data in ETR.net, TB register, patient records | Outcome | Percentage | Quarterly | No | Higher proportion of TB/HIV co-infected on ART treatment will reduce co-infection rates | TB/HIV manager |
| 1.5 HIV infection rate reduced by 15% by 2019 | 1.5.3 HIV test done - Total | Total number of HIV Tests done in all age groups | Monitors the impact of the pandemic and assists in better planning for effective combating of HIV and AIDS and decreasing the burden of diseases from TB | PHC Comprehensive Tick Register; HTS Register (HIV Testing Services) or HCT module in TIER.Net | SUM ([Antenatal client HIV 1st test]) +SUM ([ Antenatal client HIV re-test ]) + SUM ([HIV test 19-59 months]) + SUM ([HIV test 5-14 years]) + SUM ([HIV test 15 years and older (excl. ANC)]) | Dependent on the accuracy of facility register | Process | Number | Quarterly | No | Higher percentage indicate increased population knowing their HIV status. | HIV/AIDS Programme Manager |
| | 1.5.4 Male Condom distributed | Male condoms distributed from a | Monitors distribution of male condoms for | Bin/ Stock card | SUM([Male condoms distributed]) | None | Process | Number | Quarterly | No | Higher number indicated better | HIV/AIDS Cluster |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | primary distribution site to health facilities or points in the community (e.g. campaigns, non-traditional outlets, etc.). | prevention of HIV and other STIs, and for contraceptive purposes. Note research indicates that only around 60% of distributed condoms are used for intended purpose. Primary distribution sites (PDS) must report to sub-districts on a monthly basis on how many male condoms were distributed to the sub-district in reporting month | | | | | | | | distribution (and indirectly better uptake) of condoms in the Province | |
| | 1.5.6 Medical male circumcision - total | Medical male circumcisions performed - total | Monitors medical male circumcisions performed | MMC Register, DHIS | SUM ([Medical male circumcision 10-14 years])+([Medical | Assumed that all MMCs reported on | Output | Number | Quarterly | No | Higher number indicates greater | HIV/AIDS Programme Manager |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | male circumcision 15 years and older rate ]) | DHIS are conducted under supervision | | | | | availability of the service or greater uptake of the service | |
| 1.6 TB death rate reduced by 30% in 2019 | 1.6.1 TB client 5 years and older start on treatment rate | TB client 5 years and older start on treatment as a proportion of TB symptomatic client 5 years and older test positive | Monitors initial loss to follow up and effectiveness of linkage to treatment and care strategies | TB identification (suspect) Register/ Tier.Net PHC Comprehensive Tick Register | Numerator SUM ([ TB client 5 years and older start on treatment])<br><br>Denominator: SUM ([ TB symptomatic client 5 years and older tested positive]) | - Accuracy dependent on quality of data from reporting facility | Process/ Activity | Percentage | Quarterly | No | Screening will enable early identification of TB suspect in health facilities | TB Programme Manager |
| | 1.6.2 TB client treatment success rate | TB clients successfully completed treatment (both cured and treatment completed) as a proportion of ALL TB clients started on treatment. This applies to ALL TB clients (New, Retreatment, Other, pulmonary | Monitors success of TB treatment for ALL types of TB. This follows a cohort analysis therefore the clients would have been started on treatment at least 6 months prior | ETR/.Net Tick Register | **Numerator:** SUM ([TB client successfully completed treatment])<br>**Denominator:** SUM([TB client start on treatment)] | Accuracy dependent on quality of data from reporting facility | Outcome | Percentage | Quarterly | No | Higher percentage suggests better treatment success rate. | TB Programme Manager |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | and extra pulmonary) | | | | | | | | | | |
| | 1.6.3 TB Client loss to follow up rate | TB clients who are lost to follow up (missed two months or more of treatment) as a proportion of TB clients started on treatment. This applies to ALL TB clients (New, Retreatment, Other, pulmonary and extra-pulmonary). | Monitors the effectiveness of the retention in care strategies. This follows a cohort analysis therefore the clients would have been started on treatment at least 6 months prior | ETR/ Tier.Net TB Register | **Numerator** SUM [TB client lost to follow up]<br><br>**Denominator**: SUM ([ TB client start on treatment]) | Accuracy dependent on quality of data from reporting facility | Outcome | Percentage | Quarterly | No | Lower levels of interruption reflect improved case holding, which is important for facilitating successful TB treatment | TB Programme Manager |
| | 1.6.4 TB Client death rate | TB clients who died during treatment as a proportion of TB clients started on treatment. This applies to ALL TB clients (New, Retreatment, | Monitors death during TB treatment period. The cause of death may not necessarily be due to TB. This follows a cohort analysis therefore the | ETR/Tier.Net TB Register | **Numerator:** SUM ([TB client died during treatment]) **Denominator:** SUM([TB Client start on treatment]) | Accuracy dependent on quality of data from reporting facility | Outcome | Percentage | Quarterly | No | Lower levels of death desired | TB Programme Manager |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Other, pulmonary and extra pulmonary) | clients would have been started on treatment at least 6 months prior | | | | | | | | | |
| | 1.6.6 TB MDR treatment success rate | TB MDR client successfully completing treatment as a proportion of TB MDR confirmed clients started on treatment | Monitors success of MDR TB treatment | DR TB Register and captures in EDR. Web | **Numerator** SUM ([TB MDR client successfully complete treatment])<br><br>**Denominator**: SUM ([TB MDR confirmed client start on treatment]) | Accuracy dependent on quality of data submitted health facilities | Outcome | Percentage | Quarterly | No | Higher percentage indicates a better treatment rate | TB Programme Manager |

## 2.7 Sub-Programme: Maternal, Child and Women's Health and Nutrition (MCWH&N)

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.7 Maternal Mortality Ratio Reduced to less than 105 per 100 000 population by 2019 | 1.7.1 Antenatal 1st visit before 20 weeks rate | Women who have a booking visit (first visit) before they are 20 weeks into their pregnancy as proportion of all antenatal 1st visits | Monitors early utilisation of antenatal services | PHC Comprehensive Tick Register | **Numerator:** SUM ([Antenatal 1st visit before 20 weeks]) **Denominator:** SUM ([Antenatal 1st visit 20 weeks or later]) + SUM ([Antenatal 1st visit before 20 weeks]) | Accuracy dependent on quality of data submitted health facilities | Process | Percentage | Quarterly | No | Higher percentage indicates better uptake of ANC services | MNCWH programme manager |
| | 1.7.2 Mother postnatal visit within 6 days rate | Mothers who received postnatal care within 6 days after delivery as proportion of deliveries in health facilities | Monitors access to and utilisation of postnatal services. May be more than 100% in areas with low delivery in facility rates if many mothers who delivered outside health | PHC Comprehensive Tick Register | **Numerator:** SUM ([Mother postnatal visit within 6 days after delivery]) **Denominator:** SUM([Delivery in facility total]) | Accuracy dependent on quality of data submitted health facilities | Process | Percentage | Quarterly | No | Higher percentage indicates better uptake of postnatal services | MNCWH programme manager |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | facilities used postnatal visits within 6 days after delivery | | | | | | | | | |
| | 1.7.3 Antenatal client start on ART rate | Antenatal clients who started on ART as a proportion of the total number of antenatal clients who are HIV positive and not previously on ART | Monitors implementation of PMTCT guidelines in terms of ART initiation of eligible HIV positive antenatal clients. | ART Register, Tier.Net | **Numerator:** SUM ([Antenatal client start on ART])<br><br>**Denominator:** Sum([Antenatal client known HIV positive but NOT on ART at 1st visit]) + SUM([Antenatal client HIV 1st test positive]) + SUM ([Antenatal client HIV re-test positive]) | Accuracy dependent on quality of data Reported by health facilities | Output | Percentage | Quarterly | No | Higher percentage indicates greater coverage of HIV positive clients on HIV Treatment | MNCWH programme manager |
| 1.8 Child Mortality Reduced to less than 34 per 1000 population by 2019 | 1.8.1 Infant PCR test positive around 10 weeks rate | Infants tested PCR positive for follow up test as a proportion of Infants PCR tested around 10 weeks | Monitors PCR positivity rate in HIV exposed infants around 10 weeks | PHC Comprehensive Tick Register | **Numerator** SUM [Infant PCR test positive around 10 weeks **Denominator:** SUM([Infant PCR test | Accuracy dependent on quality of data submitted health facilities | Output | Percentage | Quarterly | No | Lower percentage indicate fewer HIV transmissions from mother to child | PMTCT Programme |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | around 10 weeks]) | | | | | | | |
| | 1.8.2 Immunisation under 1 year coverage | Children under 1 year who completed their primary course of immunization as a proportion of population under 1 year. | The child should be counted once as fully immunised when receiving the last vaccine in the course (Usually PCV 3 vaccine) AND if there is document proof of all required vaccines (BCG, OPV1, Dtap-IPV-HIP-HBV1, 2,3 PCV 1,2,3 RV1,2 and measles 1) on the road to health card / booklet AND the child is under 1-year-old. | PHC Comprehensive Tick Register<br><br>Denominator: StatsSA | **Numerator** SUM ([Immunised fully under 1 year new]) **Denominator:** SUM ([Female under 1 year]) + SUM ([Male under 1 year]) | Road to Health charts are not retained by Health facility. Reliant on under 1 population estimates from Stats SA, and accurate recording of children under 1 year who are fully immunised at facilities (counted only ONCE when last vaccine is administered) | Output | Percentage | Quarterly | No | Higher percentage indicate better immunisation coverage | EPI Programme manager |
| | 1.8.3 Measles 2nd dose coverage | Children 1 year (12 months) who received | Monitors protection of children against | PHC Comprehensive Tick Register | **Numerator** SUM ([Measles 2nd dose]) | Accuracy dependent on quality of data submitted | Output | Percentage | Quarterly | No | Higher coverage rate indicate greater | EPI |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | measles 2nd dose, as a proportion of the 1 year population. | measles. Because the 1st measles dose is only around 85% effective the 2nd dose is important as a booster. Vaccines given as part of mass vaccination campaigns should not be counted here | Denominator: Stats SA | **Denominator**: SUM([Female 1 year]) + SUM([Male 1 year]) | health facilities | | | | | protection against measles | |
| | 1.8.5 Diarrhea case fatality under 5 years rate | Diarrhea deaths in children under 5 years as a proportion of diarrhea separations under 5 years in health facilities | Monitors treatment outcome for children under 5 years who were separated with diarrhea | Ward register | **Numerator:** SUM ([Diarrhea death under 5 years]) **Denominator :** SUM([Diarrhea separation under 5 years]) | Reliant on accuracy of diagnosis / cause of death Accuracy dependent on quality of data submitted health facilities | Impact | Percentage | Quarterly | No | Lower children mortality rate is desired | MNCWH Programme manager |
| | 1.8.6 Pneumonia case fatality under 5 years rate | Pneumonia deaths in children under 5 years as a proportion of pneumonia separations | Monitors treatment outcome for children under 5 years who were | Ward Register | **Numerator:** SUM ([Pneumonia death under 5 years]) **Denominator :** | Accuracy dependent on quality of data submitted health facilities | Impact | Percentage | Quarterly | No | Lower children mortality rate is desired | MNCWH Programme manager |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | under 5 years in health facilities | separated with pneumonia | | SUM([Pneumonia separation under 5 years]) | | | | | | | |
| | 1.8.7 Severe acute malnutrition case fatality under 5 years rate | Severe acute malnutrition deaths in children under 5 years as a proportion of severe acute malnutrition (SAM) under 5 years in health facilities | Monitors treatment outcome for children under 5 years who were separated with Severe acute malnutrition (SAM) | Ward register | **Numerator:** SUM ([Severe acute malnutrition (SAM) death in facility under 5 years]) **Denominator:** SUM([Severe Acute Malnutrition under 5 years in facility | Accuracy dependent on quality of data submitted health facilities | Impact | Percentage | Quarterly | No | Lower children mortality rate is desired | MNCWH Programme manager |
| 3.4 40% of Quintile 1&2 school screened by Integrated School Health (ISH) Teams in 2019 | 3.4.2 School Grade 1 learners screened | Proportion of Grade 1 learners screened by a nurse in line with the ISHP service package | Monitors implementation of the Integrated School Health Program (ISHP) | School Health data collection forms | SUM [School Grade 1 - learners screened} | None | Process | Number | Quarterly | No | Higher percentage indicates greater proportion of school children received health services at their school | School health services |
| | 3.4.3 School Grade 8 learners screened | Proportion of Grade 8 learners screened by a nurse in line | Monitors implementation of the Integrated School Health | **Numerator** School Health data collection forms | SUM [School Grade 8 - learners screened] | None | Process | Number | Quarterly | No | Higher percentage indicates greater proportion of | School health services |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | with the ISHP service package | Program (ISHP) | | | | | | | | school children received health services at their school | |
| 1.7 Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019 | 1.7.6 Delivery in 10 to 19 years in facility rate | Deliveries to women under the age of 20 years as proportion of total deliveries in health facilities | Monitors the proportion of deliveries in facility by teenagers (young women under 20 years). | Delivery Register | **Numerator** SUM [Delivery 10–14 years in facility] + [Delivery 15–19 years in facility] **Denominator**: SUM([Delivery in facility total]) | None | Process | Percentage | Quarterly | No | Lower percentage indicates better family planning | HIV and Adolescent Health |
| | 1.7.4 Couple Year Protection Rate (Int) | Women protected against pregnancy by using modern contraceptive methods, including sterilisations, as proportion of female population 15-49 year. Couple year protection are the total of (Oral pill cycles | Monitors access to and utilisation of modern contraceptives to prevent unplanned pregnancies. Serves as proxy for the indicator contraceptive prevalence rate by monitoring trends | PHC Comprehensive Tick Register | **Numerator** (SUM ([Oral pill cycle]) / 15) + (SUM ([Medroxyprogesterone injection]) / 4) + (SUM ([Norethisterone enanthate injection]) / 6) + (SUM ([IUCD inserted]) * 4.5) + (SUM([Male condoms | Accuracy dependent on quality of data submitted health facilities | Outcome | Percentage | Quarterly | No | Higher percentage indicates higher usage of contraceptive methods. | MCWH&N Programme |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | / 15) + (Medroxyprogesterone injection / 4) + (Norethisterone enanthate injection / 6) + (IUCD x 4.5) + (Sub dermal implant x 2.5) + Male condoms distributed / 120) + (Female condoms distributed / 120) + (Male sterilisation x 10) + (Female sterilisation x 10). | between official surveys | | distributed]) / 120) + (SUM([Sterilisation - male]) * 10) + (SUM([Sterilisation - female]) * 10) + (SUM([Female condoms distributed]) / 120) + (SUM([Sub-dermal implant inserted]) * 2.5) **Denominator:** (SUM {[Female 15-44 years]} + SUM {[Female 45-49 years]}) /12 | | | | | | | |
| 1.2 Screening coverage of chronic illnesses increased to more than a million by 2019 | 1.2.4 Cervical cancer screening coverage 30 years and older | Cervical smears in women 30 years and older as a proportion of the female population 30 | Monitors implementation of policy on cervical screening and ART policy | PHC Comprehensive Tick Register OPD tick register Denominator: StatsSA | **Numerator** SUM ([Cervical cancer screening 30 years and older]) | Reliant on population estimates from Stats SA, and Accuracy dependent on quality of data submitted | Output | Percentage | Quarterly | No | Higher percentage indicate better cervical cancer coverage | MNCWH Programme Manager |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | years and older years. These women must be screened for cervical cancer every 10 years | | | **Denominator:** (SUM([Female 30-34 years]) + SUM([Female 35-39 years]) + SUM([Female 40-44 years]) + SUM([Female 45 years and older])) / 10 | health facilities | | | | | | |
| 1.8 Child Mortality Reduced to less than 34 per 1000 population by 2019 | 1.8.10 Human Papilloma Virus Vaccine 1st dose | Grade 4 girl leaners 9 years and older vaccinated with 1st dose of the HPV vaccine during the first round as proportion of grade 4 girls 9 years and older in a year. | N/A<br>This indicator will provide overall yearly coverage value which will aggregate as the campaign progress and reflect the coverage so far | Campaign tools | SUM ([Agg_ Girl 09 yrs HPV 1st dose]) + SUM ([Agg_Girl 10 yrs HPV 1st dose]) + SUM ([Agg_Girl 11 yrs HPV 1st dose]) + SUM ([Agg_Girl 12 yrs HPV 1st dose]) + SUM([Agg_Girl 13 yrs HPV 1st dose]) + SUM([Agg_Girl 14 yrs HPV 1st dose]) + SUM([Agg_Girl 15 yrs and older HPV 1st dose]) | None | Output | Number | Annually | No | Higher percentage indicate better coverage | MNCWH Programme Manager |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | |
| | 1.8.11 Human Papilloma Virus Vaccine 2nd dose | Grade 4 girl leaners 9yrs and older vaccinated with the 2nd dose of the HPV vaccine during second round as a proportion of grade 4 girls 9 years and older in a year | N/A This indicator will provide overall yearly coverage value which will aggregate as the campaign progress and reflect the coverage so far | Campaign tools | SUM([Agg_ Gir 9 years HPV 2nd dose]) + SUM([Agg_Girl 10 yrs HPV 2nd dose]) + SUM([Agg_Girl 11 yrs HPV 2nd dose]) + SUM([Agg_Girl 12 yrs HPV 2nd dose]) + SUM([Agg_Girl 13 yrs HPV 2nd dose]) + SUM([Agg_Girl 14 yrs HPV 2nd dose]) + SUM([Agg_Girl 15 years and older HPV 2nd dose]) | None | Output | Number | Annually | No | Higher percentage indicate better coverage | MNCWH Programme Manager |
| | 1.8.8 Vitamin A dose 12-59 months coverage | Children 12-59 months who received vitamin A 200,000 units, every six months as a proportion of | Monitors vitamin A supplementation to children aged 12-59 months. The denominator is multiplied by 2 because | PHC comprehensive tick register | **Numerator** SUM ([Vitamin A dose 12-59 months]) **Denominator:** (SUM ([Female 1 year]) + SUM ([Female 02- | PHC register is not designed to collect longitudinal record of patients. The assumption is the that the | Output | Percentage | Quarterly | No | Higher proportion of children 12-29 months who received Vit. A will increase health | MNCWH Programme Manager |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | population 12-59 months. | each child should receive supplementation twice a year | | 04 years]) + SUM ([Male 1 year]) + SUM([Male 02-04 years])) * 2 | calculation proportion of children would have received two doses based on this calculation | | | | | | |
| 1.7 Maternal Mortality Ratio Reduced to less than 105 per 100 000 population by 2019 | 1.7.5 Maternal mortality in facility ratio | Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 100,000 | This is a proxy for the population-based maternal mortality ratio, aimed at monitoring trends in health facilities between official surveys. Focuses on obstetric causes (around 30% of all maternal mortality). Provides indication of health system results in terms of | Maternal death register, Delivery Register | **Numerator** SUM ([Maternal death in facility]) **Denominator:** SUM([Live birth in facility])+SUM( [ Born alive before arrival at facility]) | Completeness of reporting | Impact | Ratio per 100 000 live births | Quarterly | No | Lower maternal mortality ratio in facilities indicate on better obstetric management practices and antenatal care | MNCWH Programme Manager |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | live births in facility | prevention of unplanned pregnancies, antenatal care, delivery and postnatal services | | | | | | | | | |
| 1.8 Child Mortality Reduced to less than 34 per 1000 population by 2019 | 1.8.9 Neonatal death in facility rate | Infants 0-28 days who died during their stay in the facility as a proportion of live births in facility | None Monitors treatment outcome for admitted children under 28 days | Delivery register, Midnight report | **Numerator** SUM ([Inpatient death 0-7days]) + SUM ([Inpatient death 8 -28 days])<br><br>**Denominator:** SUM([Live birth in facility]) | Quality of reporting | Impact | per 1000 live births | Quarterly | No | Lower death rate in facilities indicate better obstetric management practices and antenatal and care | MNCWH Programme Manager |

## 2.7 Sub-Programme: Coroner Services

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.9 Post – mortems conducted within 72hrs increased to 95% by 2019 | 1.9.1 Percentage of post-mortem performed within 72 hours | Measures number of post-mortems performed by Forensic Pathologists within a period of 3 days of receiving the body from the SAPS as a percentage of the total number of bodies received | Tracks the turn-around time for Post Mortems. | Death register | **Numerator** Number of cold bodies with post-mortem performed within 72 hrs. of receipt of body **Denominator:** Total number of cold bodies received from SAPS (expressed as percentage) | Depended on accuracy of Forensic Pathology services data base. | Output | Percentage | Quarterly | No | Improved and short turn-around times for post mortems. | GM: PHP |

## 2.8 Sub – Programme District Hospitals

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019 | 2.3.1 Hospital achieved 75% and more on National Core Standards (NCS) self - assessment rate | Hospital that achieved a performance of 75% or more on National Core Standards (NCS) self - assessment rate | Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance | NCS review tools | **Numerator:** SUM ([Hospital achieved 75% and more on National Core Standards self -assessment]) **Denominator:** SUM([Hospitals conducted National Core Standards self - assessment]) | Reliability of data provided | Quality | Percentage | Quarterly | No | Higher assessment indicates commitment of facilities to comply with NCS | Quality assurance |
| 1.10 80% of Hospitals meeting national efficiency targets by 2019 | 1.10.1 Average Length of Stay | The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of day clients, Inpatient discharges, | Monitors effectiveness and efficiency of Inpatient management. Proxy indicator because ideally it should only include Inpatient days for those clients separated during the | Midnight census register | **Numerator:** SUM ([Inpatient days total x 1]) + ([Day patient total x 0.5]) **Denominator: Inpatient separations**: SUM ([Inpatient deaths – total]) + [(inpatient discharges – total]) + ([inpatient | High levels of efficiency could hide poor quality | Efficiency | Days (number) | Quarterly | No | A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care. High ALOS might reflect | District Health Services |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Inpatient deaths and Inpatient transfers out. Include all specialties | reporting month. Use in all hospitals and CHCs with Inpatient beds | | transfers out – total]) | | | | | | inefficient quality of care | |
| | 1.10.6 Inpatient Bed Utilisation Rate | Inpatient bed days used as proportion of maximum Inpatient bed days (inpatient beds x days in period) available. Include all specialties | Monitors effectiveness and efficiency of inpatient management | Midnight census register | **Numerator:** Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) **Denominator** SUM (Inpatient bed days (inpatient beds * 30.42) available | Accurate reporting sum of daily usable beds | Efficiency | Percentage | Quarterly | No | Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient utilization of the facility | District Hospitals |
| | 110.12 Expenditure per patient day equivalent (PDE) | Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency | Monitors effective and efficient management of inpatient facilities. (Note that *0.5 is the same as division by 2 and * | BAS report Midnight census | **Numerator:** SUM ([Expenditure - total]) **Denominator:** SUM ([In patient Days total *1]) +([ day patient total * 0.5]) + | Accurate reporting sum of daily usable beds | Outcome | Number (Rand) | Quarterly | No | Lower rate indicating efficient use of financial resources. | Hospital Services Manager |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | headcount + OPD headcount total) * 0.33333333 | 0.33333333 is the same as division by 3 | | ([OPD headcount not referred new x 0.3333333])+ SUM([OPD headcount referred new x 0.333333])+([OPD headcount follow-up x 0.3333333])+([ Emergency head count total x 0.3333333]) | | | | | | | |
| 2.4 Patient satisfaction rate increased to more than 75% in health services by 2019 | 2.4.26 Complaint resolution within 25 working days rate | Complaints resolved within 25 working days as a proportion of all complaints resolved | Monitors the time frame in which the public health system responds to complaints | Complaints register | **Numerator:** SUM ([Complaint resolved within 25 working days]) **Denominator:** SUM([Complaint resolved]) | Accuracy of information is dependent on the accuracy of time stamp for each complaint | Quality | Percentage | Quarterly | No | Higher percentage suggest better management of complaints in Hospitals | Quality Assurance |

# Programme 3:

## Emergency Medical Services (EMS)

| Strategic Objective | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3.6: Proportion of EMS response time improved to 85% by 2019 | 3.6.1 EMS P1 urban response under 15 minutes rate | EMS 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 that the first dispatched medical resource arrives on scene | Monitors compliance with the norm for critically ill or injured patients to receive EMS within 15 minutes in urban areas | Patient report form and communications Centre (vehicle control form) | **Numerator:** SUM ([EMS P1 urban response under 15 minutes])<br><br>**Denominator:** SUM ([EMS P1 urban calls]) | Accuracy dependent on quality of data from reporting EMS station | Output | Percentage | Quarterly | No | Higher percentage indicate better response times in the urban areas | EMS Manager |
| | 3.6.2 EMS P1 rural response | EMS P1 calls in rural locations with | Monitors compliance with the norm for critically ill | Patient report form and communications | **Numerator:** SUM ([EMS P1 rural response | Accuracy dependent on quality of data from | Output | Percentage | Quarterly | No | Higher percentage indicate better | EMS Manager |

| Strategic Objective | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | under 40 minutes rate | response times under 40 minutes as a proportion of EMS P1 rural call | or injured patients to receive EMS within 40 minutes in rural areas | Centre (vehicle control form) . | under 40 minutes]) **Denominator:** SUM([EMS P1 rural calls]) | reporting EMS station | | | | | response times in the rural areas | |
| | 3.6.3 EMS inter-facility transfer rate | Inter-facility (from one inpatient facility to another facility) transfers as proportion of total EMS patients transported | Monitors use of ambulances for inter-facility transfers as opposed to emergency responses | Patient report form and communications Centre (vehicle control form) | **Numerator** SUM ([EMS inter-facility transfer]) **Denominator** SUM([EMS clients total]) | Accuracy dependent on the reliability of data recorded on the Efficiency Report at EMS stations and emergency headcount reported from hospitals. | Output | Percentage | Quarterly | No | Lower percentage desired. The target is the CSP target of 10% (8:2) of acute patient contacts and measures whether capacity exists at the appropriate level of care. | EMS Manager |

# Programme 4

## Sub-Programme 4.1: Regional Hospitals

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019 | 2.3.2 Hospital achieved 75% and more on National Core Standards (NCS) self-assessment rate | Hospital that achieved a performance of 75% or more on National Core Standards (NCS) self -assessment rate | Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance | NCS review tools | **Numerator**: SUM ([Hospital achieved 75% and more on National Core Standards self -assessment]) **Denominator:** SUM([Hospitals conducted National Core Standards self -assessment]) | Reliability of data provided | Quality | Percentage | Quarterly | No | Higher assessment indicates commitment of facilities to comply with NCS | Quality assurance |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.10 80% of Hospitals meeting national efficiency targets by 2019 | 1.10.2 Average Length of Stay | The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all specialties | Monitors effectiveness and efficiency of Inpatient management. Proxy indicator because ideally it should only include Inpatient days for those clients separated during the reporting month. Use in all hospitals and CHCs with Inpatient beds | DHIS, midnight census | **Numerator** Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) **Denominator** SUM([inpatient deaths-total])+([inpatient discharges-total])+([inpatient transfers out-total]) | High levels of efficiency y could hide poor quality | Efficiency | Days (number) | Quarterly | No | A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care. High ALOS might reflect inefficient quality of care | Regional Hospital |
| | 1.10.7 Inpatient Bed Utilisation Rate | Inpatient bed days used as proportion of maximum Inpatient bed days (inpatient beds x days in period) available. Include all specialties | Monitors effectiveness and efficiency of inpatient management | Midnight census register | **Numerator:** Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) **Denominator** SUM (Inpatient bed days (inpatient beds * 30.42) available | Accurate reporting sum of daily usable beds | Efficiency | Percentage | Quarterly | No | Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels. Lower bed utilization rate indicates | Hospital services |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | inefficient utilization of the facility | |
| 1.3 NCD coverage increased to 1300/1000 000 through management of chronic illness | 1.3.1 Cataract surgery rate (uninsured population) | Clients who had cataract surgery per 1 million uninsured populations. The population will be divided by 12 in the formula to make provision for annualisation | Monitors access to cataract surgery. | Facility registers, patient registers | **Numerator:** Sum ([Cataract surgery total]) **Denominator:** Sum ([Total population]) – Sum([Total population (medical aid)]) | Accuracy dependent on quality of data from health facilities | Quality | Rate per 1 Million | Quarterly | No | Higher levels reflect a good contribution to sight restoration, especially amongst the elderly population. | GM: Hospital Services |
| 1.10 80% of Hospitals meeting national efficiency targets by 2019 | 1.10.13 Expenditure per patient day equivalent (PDE) | Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD headcount total) * 0.33333333 | Monitors effective and efficient management of inpatient facilities. (Note that *0.5 is the same as division by 2 and * 0.33333333 is the same as division by 3 | BAS report Midnight census | **Numerator:** SUM ([Expenditure - total]) **Denominator:** SUM ([In patient Days total *1]) +([ day patient total * 0.5]) + ([OPD headcount not referred new x 0.3333333])+ SUM([OPD headcount referred new x 0.333333])+([OPD | Accurate reporting sum of daily usable beds | Outcome | Number (Rand) | Quarterly | No | Lower rate indicating efficient use of financial resources. | Hospital Services Manager |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | headcount follow-up x 0.3333333])+([ Emergency head count total x 0.3333333]) | | | | | | | |
| 2.4 Patient Experience of Care increased to more than 75% in health services by 2019 | 2.4.29 Complaint resolution within 25 working days rate | Complaints resolved within 25 working days as a proportion of all complaints resolved | Monitors the time frame in which the public health system responds to complaints | Complaints register | **Numerator:** SUM ([Complaint resolved within 25 working days]) **Denominator:** SUM([Complaint resolved]) | Accuracy of information is dependent on the accuracy of time stamp for each complaint | Quality | Percentage | Quarterly | No | Higher percentage suggest better management of complaints in Hospitals | Quality Assurance |

## Sub-Programme 4.2: Specialised TB Hospitals

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019 | 2.3.3 Hospital achieved 75% and more on National Core Standards self - assessment rate | Hospital that achieved a performance of 75% or more on National Core Standards (NCS) self - assessment rate | Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance | NCS review tools | **Numerator:** SUM ([Hospital achieved 75% and more on National Core Standards self -assessment]) **Denominator:** SUM([Hospitals conducted National Core Standards self -assessment]) | Reliability of data provided | Quality | Percentage | Quarterly | No | Higher assessment indicates commitment of facilities to comply with NCS | Quality assurance |
| 1.10 80% of Hospitals meeting national efficiency targets by 2019 | 1.10.3 Average length of stay | The average number of client days an admitted client spends in hospital before separation. Inpatient | Monitors effectiveness and efficiency of Inpatient management. Proxy indicator because ideally it | Midnight census register | **Numerator:** SUM ([Inpatient days total x 1]) + ([Day patient total x 0.5]) **Denominator:** | High levels of efficiency y could hide poor quality | Efficiency | Days (number) | Quarterly | No | A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also | GM:DHS |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | separation is the total of day clients, Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all specialties | should only include Inpatient days for those clients separated during the reporting month. Use in all hospitals and CHCs with Inpatient beds | | **Inpatient separations**: SUM ([Inpatient deaths – total]) + [(inpatient discharges – total]) + ([inpatient transfers out – total]) | | | | | | compromise quality of hospital care. High ALOS might reflect inefficient quality of care | |
| | 1.10.8 Inpatient Bed Utilisation Rate | Inpatient bed days used as proportion of maximum Inpatient bed days (inpatient beds x days in period) available. Include all specialties | Monitors effectiveness and efficiency of inpatient management | Midnight census register | **Numerator:** Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) **Denominator** SUM (Inpatient bed days (inpatient beds * 30.42) available | Accurate reporting sum of daily usable beds | Efficiency | Percentage | Quarterly | No | Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient utilization of the facility | Hospital Services Manager |
| | 1.10.14 Expenditure per patient | Average cost per patient day | Monitors effective and efficient | BAS report Midnight census | **Numerator:** | Accurate reporting | Outcome | Number (Rand) | Quarterly | No | Lower rate indicating efficient use | Hospital Services Manager |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | day equivalent (PDE) | equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD headcount total) * 0.33333333 | management of inpatient facilities. (Note that *0.5 is the same as division by 2 and * 0.33333333 is the same as division by 3 | | SUM ([Expenditure - total]) **Denominator:** SUM ([In patient Days total *1]) +([ day patient total * 0.5]) + ([OPD headcount not referred new x 0.3333333])+ SUM([OPD headcount referred new x 0.333333])+([OPD headcount follow-up x 0.3333333])+([ Emergency head count total x 0.3333333]) | sum of daily usable beds | | | | | of financial resources. | |
| 2.4 Patient Experience of Care increased to more than 75% in health services by 2019 | 2.4.30 Complaint resolution within 25 working days rate | Complaints resolved within 25 working days as a proportion of all complaints resolved | Monitors the time frame in which the public health system responds to complaints | Complaints register | **Numerator:** SUM ([Complaint resolved within 25 working days]) | Accuracy of information is dependent on the accuracy of time stamp for each complaint | Quality | Percentage | Quarterly | No | Higher percentage suggest better management of complaints in Hospitals | Quality Assurance |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | **Denominator:** SUM([Complaint resolved]) | | | | | | | |

## Sub-Programme 4.3: Specialised Psychiatric Hospitals

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2.3:** Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019 | 2.3.4 Hospital achieved 75% and more on National Core Standards self - assessment rate | Hospital that achieved a performance of 75% or more on National Core Standards (NCS) self - assessment rate | Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance | NCS review tools | **Numerator**: SUM ([Hospital achieved 75% and more on National Core Standards self - assessment]) **Denominator:** SUM([Hospitals conducted National Core Standards self - assessment]) | Reliability of data provided | Quality | Percentage | Quarterly | No | Higher assessment indicates commitment of facilities to comply with NCS | Quality assurance |
| **2.3:** Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019 | 2.4.31 Complaint resolution within 25 working days rate | The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of day clients, Inpatient discharges, | Monitors effectiveness and efficiency of Inpatient management. Proxy indicator because ideally it should only include Inpatient days for those clients separated during the | Midnight census register | **Numerator:** SUM ([Inpatient days total x 1]) + ([Day patient total x 0.5]) **Denominator: Inpatient separations**: SUM ([Inpatient deaths – total]) + [(inpatient discharges – total]) + ([inpatient | High levels of efficiency y could hide poor quality | Efficiency | Days (number) | Quarterly | No | A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care. High ALOS might reflect | Quality Assurance |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Inpatient deaths and Inpatient transfers out. Include all specialties | reporting month. Use in all hospitals and CHCs with Inpatient beds | | transfers out – total]) | | | | | | inefficient quality of care | |
| | | Inpatient bed days used as proportion of maximum Inpatient bed days (inpatient beds x days in period) available. Include all specialties | Monitors effectiveness and efficiency of inpatient management | Midnight census register | **Numerator:** Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) **Denominator** SUM (Inpatient bed days (inpatient beds * 30.42) available | Accurate reporting sum of daily usable beds | Efficiency | Percentage | Quarterly | No | Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient utilization of the facility | |
| | | Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD | Monitors effective and efficient management of inpatient facilities. (Note that *0.5 is the same as division by 2 and * 0.33333333 is | BAS report Midnight census | **Numerator:** SUM ([Expenditure - total]) **Denominator:** SUM ([In patient Days total *1]) +([ day patient total * 0.5]) + ([OPD headcount not referred new x 0.3333333])+ | Accurate reporting sum of daily usable beds | Outcome | Number (Rand) | Quarterly | No | Lower rate indicating efficient use of financial resources. | |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | headcount total) * 0.33333333 | the same as division by 3 | | SUM([OPD headcount referred new x 0.333333])+([OPD headcount follow-up x 0.3333333])+([ Emergency head count total x 0.3333333]) | | | | | | | |
| | | Complaints resolved within 25 working days as a proportion of all complaints resolved | Monitors the time frame in which the public health system responds to complaints | Complaints register | **Numerator:** SUM ([Complaint resolved within 25 working days]) **Denominator:** SUM([Complaint resolved]) | Accuracy of information is dependent on the accuracy of time stamp for each complaint | Quality | Percentage | Quarterly | No | Higher percentage suggest better management of complaints in Hospitals | |

# Programme 5

## Sub-Programme 5.1: Central Hospitals

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019 | 2.3.5 Hospital achieved 75% and more on National Core Standards self - assessment rate | Hospital that achieved a performance of 75% or more on National Core Standards (NCS) self - assessment rate | Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance | NCS review tools | **Numerator**: SUM ([Hospital achieved 75% and more on National Core Standards self - assessment]) **Denominator:** SUM([Hospitals conducted National Core Standards self - assessment]) | Reliability of data provided | Quality | Percentage | Quarterly | No | Higher assessment indicates commitment of facilities to comply with NCS | Quality assurance |
| 1.10 80% of Hospitals meeting national efficiency | 1.10.4 Average Length of Stay | The average number of client days an admitted client spends in hospital | Monitors effectiveness and efficiency of Inpatient management | Midnight census register | **Numerator :** SUM ([Inpatient days total x 1]) + ([Day | High levels of efficiency could hide poor quality | Efficiency | Days (number) | Quarterly | No | A low average length of stay reflects high levels of efficiency. But | District Health Services |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| targets by 2019 | | before separation. Inpatient separation is the total of day clients, Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all specialties | . Proxy indicator because ideally it should only include Inpatient days for those clients separated during the reporting month. Use in all hospitals and CHCs with Inpatient beds | | patient total x 0.5]) **Denominator: Inpatient separations**: SUM ([Inpatient deaths – total]) + [(inpatient discharges – total]) + ([inpatient transfers out – total]) | | | | | | these high efficiency levels might also compromise quality of hospital care. High ALOS might reflect inefficient quality of care | |
| | 1.10.10 Inpatient Bed Utilisation Rate | Inpatient bed days used as proportion of maximum Inpatient bed days (inpatient beds x days in period) available. Include all specialties | Monitors effectiveness and efficiency of inpatient management | Midnight census register | **Numerator**: Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) **Denominator** SUM (Inpatient bed days (inpatient beds * 30.42) available | Accurate reporting sum of daily usable beds | Efficiency | Percentage | Quarterly | No | Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient | District Health Services |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | utilization of the facility | |
| | 1.10.16 Expenditure per patient day equivalent (PDE) | Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD headcount total) * 0.33333333 | Monitors effective and efficient management of inpatient facilities. (Note that *0.5 is the same as division by 2 and * 0.33333333 is the same as division by 3 | BAS report Midnight census | **Numerator:** SUM ([Expenditure - total]) **Denominator:** SUM ([In patient Days total *1]) +([ day patient total * 0.5]) + ([OPD headcount not referred new x 0.3333333])+ SUM([OPD headcount referred new x 0.333333])+([ OPD headcount follow-up x | Accurate reporting sum of daily usable beds | Outcome | Number (Rand) | Quarterly | No | Lower rate indicating efficient use of financial resources. | District Health Services. |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | 0.3333333])+ ([ Emergency head count total x 0.3333333]) | | | | | | | |
| 2.4 Patient Experience of Care increased to more than 75% in health services by 2019 | 2.4.32 Complaint resolution within 25 working days rate | Complaints resolved within 25 working days as a proportion of all complaints resolved | Monitors the time frame in which the public health system responds to complaints | Complaints register | **Numerator:** SUM ([Complaint resolved within 25 working days]) **Denominator:** SUM([Complaint resolved]) | Accuracy of information is dependent on the accuracy of time stamp for each complaint | Quality | Percentage | Quarterly | No | Higher percentage suggest better management of complaints in Hospitals | Quality Assurance |

## Sub-Programme 5.2: Tertiary Hospitals

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019 | 2.3.6 Hospital achieved 75% and more on National Core Standards self - assessment rate | Hospital that achieved a performance of 75% or more on National Core Standards (NCS) self - assessment rate | Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance | NCS review tools | **Numerator**: SUM ([Hospital achieved 75% and more on National Core Standards self -assessment]) **Denominator:** SUM([Hospitals conducted National Core Standards self - assessment]) | Reliability of data provided | Quality | Percentage | Quarterly | No | Higher assessment indicates commitment of facilities to comply with NCS | Quality assurance |
| 1.10 80% of Hospitals meeting national efficiency targets by 2019 | 1.10.5 Average Length of Stay | The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of day clients, Inpatient discharges, Inpatient | Monitors effectiveness and efficiency of Inpatient management. Proxy indicator because ideally it should only include Inpatient days for those clients separated during the | Midnight census register | **Numerator:** SUM ([Inpatient days total x 1]) + ([Day patient total x 0.5]) **Denominator: Inpatient separations**: SUM ([Inpatient deaths – total]) + [(inpatient discharges – total]) + ([inpatient | High levels of efficiency y could hide poor quality | Efficiency | Days (number) | Quarterly | No | A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care. High ALOS might reflect | District Health Services |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | deaths and Inpatient transfers out. Include all specialties | reporting month. Use in all hospitals and CHCs with Inpatient beds | | transfers out – total]) | | | | | | inefficient quality of care | |
| | 1.10.11 Inpatient Bed Utilisation Rate | Inpatient bed days used as proportion of maximum Inpatient bed days (inpatient beds x days in period) available. Include all specialties | Monitors effectiveness and efficiency of inpatient management | Midnight census register | **Numerator:** Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) **Denominator** SUM (Inpatient bed days (inpatient beds * 30.42) available | Accurate reporting sum of daily usable beds | Efficiency | Percentage | Quarterly | No | Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient utilization of the facility | District Health Services |
| | 1.10.17 Expenditure per patient day equivalent (PDE) | Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD | Monitors effective and efficient management of inpatient facilities. (Note that *0.5 is the same as division by 2 and * 0.33333333 is | BAS report Midnight census | **Numerator:** SUM ([Expenditure - total]) **Denominator:** SUM ([In patient Days total *1]) +([ day patient total * 0.5]) + ([OPD headcount not referred new x | Accurate reporting sum of daily usable beds | Outcome | Number (Rand) | Quarterly | No | Lower rate indicating efficient use of financial resources. | District Health Services. |

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsi-bility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | headcount total) * 0.33333333 | the same as division by 3 | | 0.3333333])+ SUM([OPD headcount referred new x 0.333333])+([OPD headcount follow-up x 0.3333333])+([ Emergency head count total x 0.3333333]) | | | | | | | |
| 2.4 Patient Experience of Care increased to more than 75% in health services by 2019 | 2.4.33 Complaint resolution within 25 working days rate | Complaints resolved within 25 working days as a proportion of all complaints resolved | Monitors the time frame in which the public health system responds to complaints | Complaints register | **Numerator:** SUM ([Complaint resolved within 25 working days]) **Denominator:** SUM([Complaint resolved]) | Accuracy of information is dependent on the accuracy of time stamp for each complaint | Quality | Percentage | Quarterly | No | Higher percentage suggest better management of complaints in Hospitals | Quality Assurance |

## Sub-Programme 5.3: Specialised Tertiary Hospital

| Strategic Objectives | Indicator name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019 | 2.3.7 Hospital achieved 75% and more on National Core Standards self - assessment rate | Hospital that achieved a performance of 75% or more on National Core Standards (NCS) self - assessment rate | Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance | NCS review tools | **Numerator:** SUM ([Hospital achieved 75% and more on National Core Standards self - assessment]) **Denominator:** SUM([Hospitals conducted National Core Standards self - assessment]) | Reliability of data provided | Quality | Percentage | Quarterly | No | Higher assessment indicates commitment of facilities to comply with NCS | Quality assurance |
| | 2.4.34 Complaint resolution within 25 working days rate | Complaints resolved within 25 working days as a proportion of all complaints resolved | Monitors the time frame in which the public health system responds to complaints | Complaints register | **Numerator:** SUM ([Complaint resolved within 25 working days]) **Denominator:** SUM([Complaint resolved]) | Accuracy of information is dependent on the accuracy of time stamp for each complaint | Quality | Percentage | Quarterly | No | Higher percentage suggest better management of complaints in Hospitals | Quality Assurance |

# Programme 6

## Performance Indicators for Health Sciences and Training

| Strategic Objectives | Indicator Name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.6 First year Health professional students receiving bursaries by 2019 | 2.6.1 Number of Bursaries awarded for first year medicine students | Number of new medicine students provided with bursaries by the provincial department of health | Tracks the numbers of medicine students sponsored by the Province to undergo training as future health care providers | Bursary contracts | Number of Bursaries awarded for first year medicine students<br><br>No denominator | Data quality depends on good record keeping by both the Provincial DoH and Health Science Training institutions | Input | No. | Annual | no | Higher numbers of students provided with bursaries are desired, as this has the potential to increase future health care providers | Human Resources Development Programme Manager |
| | 2.6.2 Number of Bursaries awarded for first year nursing students | Number of basic nursing students enrolled in nursing colleges and universities and offered bursaries by the provincial department of health | Tracks the numbers of medicine students sponsored by the Province to undergo training as future health care providers | SANC Registration form | Number of Bursaries awarded for first year nursing students<br><br>No denominator | Data quality depends on good record keeping by both the Provincial DoH and Health Science Training institutions | Input | No. | Annual | Yes | Higher numbers of students provided with bursaries are desired, as this has the potential to increase future health care providers | Human Resources Development Programme Manager |

# Programme 7

## Performance Indicators for Health Care and Support

| Strategic Objectives | Indicator Name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.11 95% of clients eligible for assistive devices provided with wheelchairs, hearing aids, prostheses & orthoses by 2019 | 1.11.1 Wheelchair issued rate | Wheelchairs issued as a proportion of the applications for wheelchairs received | Planning and budgeting of services | PHC comprehensive tick register, Tick register OPD, | **Numerator:** SUM ([Wheelchair issued - new]) **Denominator:** SUM([Wheelchair applications]) | Dependent on accuracy of DHIS | Output with special focus to access | Percentage | Quarterly | No | Higher percentage reflects improved service delivery and increased access to wheelchairs | Clinical Support Manager |
| | 1.11.2 Hearing aids issued rate | Hearing aids issued as a proportion of the applications for hearing aids receive | Planning and budgeting of services | PHC comprehensive tick register, Tick register OPD, | **Numerator:** SUM ([Hearing aids issued - new]) **Denominator:** SUM([Hearing aid applications received]) | Dependent on accuracy of DHIS | Output with special focus to access | Percentage | Quarterly | No | Higher percentage reflects improved service delivery and increased access to hearing aids | Clinical Support Manager |
| 1.12 95% availability of essential drugs in all health | 1.12.1 Percentage of order fulfilment of essential | Drug orders fulfilled completely | Ensure availability of essential drugs in all facilities | MEDSAS | **Numerator:** Number of order fulfilled completely | Poor maintenance of stock levels by the depot | Output | Percentage | Quarterly | No | Availability of essential drugs at all facilities | Pharmaceutical Services Manager |

| Strategic Objectives | Indicator Name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| facilities by 2019 | drugs at the depots. | | | | **Denominator :** Number of orders received x 100 | | | | | | | |
| | 1.12.2 Essential medicines stock-out rate at the depots | Mange number of essential medicine on stock | Ensure availability of essential drugs at the depots | MEDSAS | **Numerator:** *number of essential medicines out of stock*<br><br>**Denominator :** *Total number of essential medicines* | Poor maintenance of essential medicines stock levels at the depot | Output | Percentage | Quarterly | No | Availability of essential medicine at the depot | Pharmaceutical Services Manager and Depot managers |

## Programme 8

## Health Facilities Management

| Strategic Objectives | Indicator Name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.7 Health facilities refurbished to comply with the National norms and standards by 2019 | 2.7.1 Number of health facilities that have undergone major refurbishment in NHI Pilot District | Number of existing health facilities in NHI Pilot District where Capital, Scheduled Maintenance, (Management Contract projects only) have been completed (excluding new and replacement facilities). | Tracks overall improvement and maintenance of existing facilities. | Practical Completion Certificate Capital infrastructure project list, Scheduled Maintenance project list, and Management Contract projects). | Number of health facilities in NHI Pilot District that have undergone major refurbishment | Accuracy dependent on reliability of information captured on project lists. | Input | Number | Annual | No | A higher number will indicate that more facilities were refurbished. | Chief Director: Infrastructure and Technical Management |
| | 2.7.2 Number of health facilities that have undergone minor refurbishmen | Number of existing health facilities in NHI Pilot District where Professional | Tracks overall improvement and maintenance of existing facilities. | Job card/ invoice, Professional Day-to-day Maintenance project list (only Managemen | Number of health facilities in NHI Pilot District that have undergone | Accuracy dependent on reliability of information captured on project lists. | Input | Number | Annual | No | A higher number will indicate that more facilities were refurbished. | Chief Director: Infrastructure and Technical Management |

| Strategic Objectives | Indicator Name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | t in NHI Pilot District | Day-to-day Maintenance projects (Management Contract projects only) have been completed (excluding new and replacement facilities). | | t Contract projects). | minor refurbishment | | | | | | | |
| | 2.7.3 Number of health facilities that have undergone major refurbishment outside NHI Pilot District | Number of existing health facilities outside NHI Pilot District where Capital, Scheduled Maintenance, (Management Contract projects only) have been completed (excluding new and replacement facilities). | Tracks overall improvement and maintenance of existing facilities. | Practical Completion Certificate Capital infrastructure project list, Scheduled Maintenance project list, and Contract projects). | Number of health facilities outside NHI Pilot District that have undergone major refurbishment | Accuracy dependent on reliability of information captured on project lists. | Input | Number | Annual | No | A higher number will indicate that more facilities were refurbished. | Chief Director: Infrastructure and Technical Management |

| Strategic Objectives | Indicator Name | Short Definition | Purpose /Importance | Source | Calculation Method | Data Limitations | Type of Indicator | Calculation Type | Reporting Cycle | New Indicator | Desired Performance | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2.7.4 Number of health facilities that have undergone minor refurbishment outside NHI Pilot District | Number of existing health facilities outside NHI Pilot District where Professional Day-to-day Maintenance projects (Management Contract projects only) have been completed (excluding new and replacement facilities). | Tracks overall improvement and maintenance of existing facilities. | Job card / invoice, Professional Day-to-day Maintenance project list (only Management Contract projects). | Number of health facilities outside NHI Pilot District that have undergone minor refurbishment | Accuracy dependent on reliability of information captured on project lists. | Input | Number | Annual | No | A higher number will indicate that more facilities were refurbished. | Chief Director: Infrastructure and Technical Management |

# 14. Conclusion

This is the Final draft 2019/20 Annual Performance Plan of the Department, which stands as a proposal to accelerate service delivery towards the achievement of its vision and mission as set out in the 2015/16-2019/20 strategic plan.

The department is committed to supporting districts and the facilities to achieve the agreed targets.

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