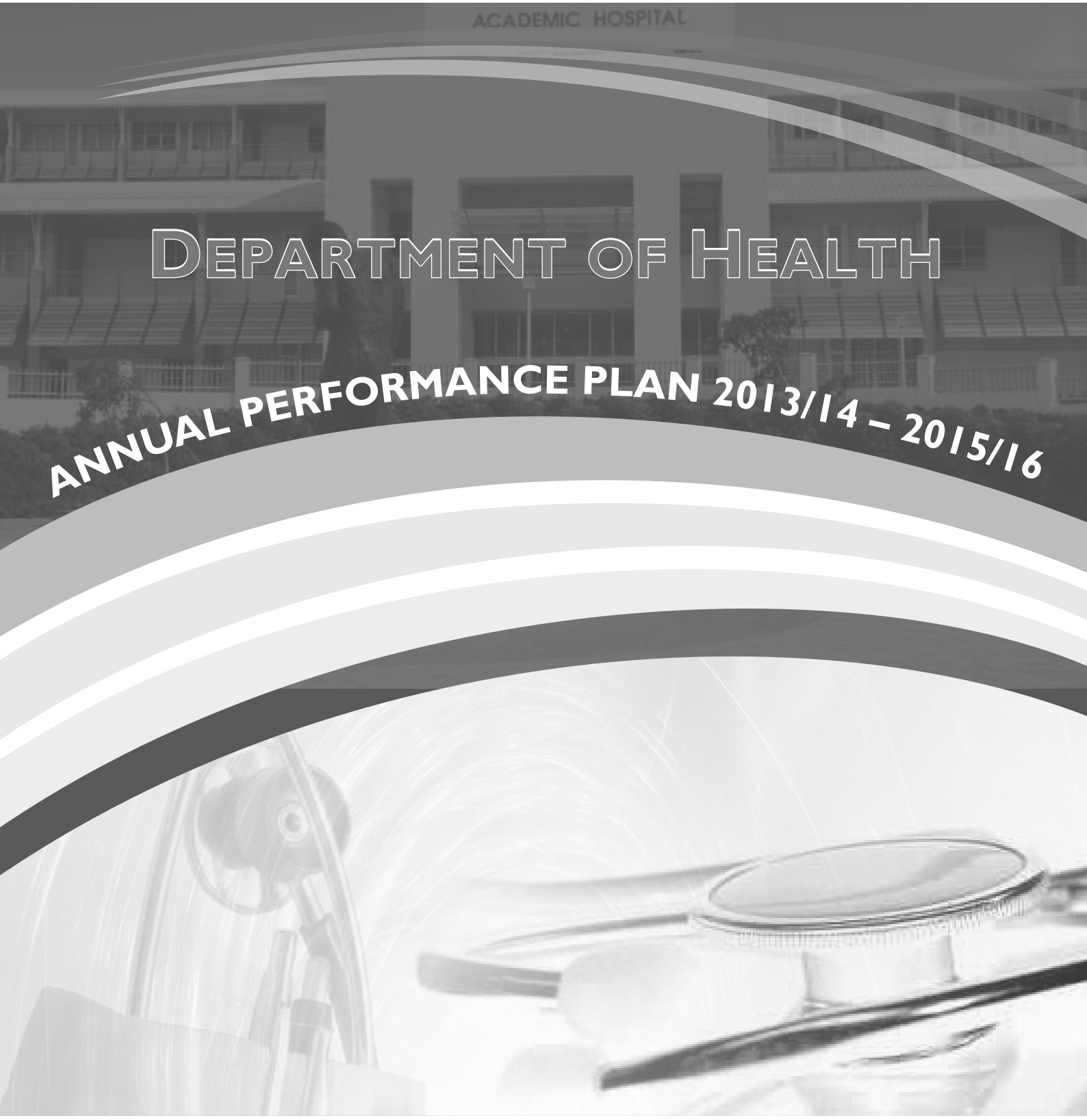
Province of the
EASTERN CAPE
HEALTH




# Department of Health

# ANNUAL PERFORMANCE PLAN 2013/14 – 2015/16

*United in achieving quality health care for all*

PGDP EASTERN CAPE 2004 - 2014
*Ikamva eliqaqambileyo!*

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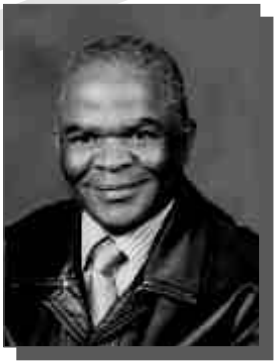
# ACRONYMS

| | |
|---|---|
| AFB | Acid Fast Busily |
| ART | Antiretroviral Therapy |
| ARV | Antiretroviral |
| APP | Annual Performance Plan |
| BANC | Basic Antenatal Care Services |
| BAS | Basic Accounting Systems |
| BCM | Buffalo City Metro |
| CDCs | Community Day Centres |
| CHCs | Community Health Centres |
| CIMCI | Community Integrated Management of Childhood Illnesses |
| COE | Compensation of Employees |
| CTOP | Choice on Termination of Pregnancy |
| DHIS | District Health Information System |
| DHS | Demographic Health Survey |
| DOTS | Directly Observed Treatment Support |
| EC | Eastern Cape |
| ECPHC | Eastern Cape Provincial Health Council |
| ECSECC | Eastern Cape Socio-Economic Consultative Status |
| ELHC | East London Hospital Complex |
| ELHC | East London Hospital Complex |
| EMRS | Emergency Medical Rescue Services |
| EMS | Emergency Medical Services |
| ESMOE | Essential Steps in the Management of Obstetric Emergency |
| FY | Financial Year |
| GEMS | Government Employee Medical Scheme |
| HCT | HIV Counseling and Testing (page 4) |
| HIV/AIDS | Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome |
| HPDT | Health Professionals and Training Grant |
| HPTD | Health Professionals Training and Development Grant |
| HSRC | Human Science Research Council |
| HTA | High Transmission Area |
| ICT | Information Communication Technology |
| IDIP | Infrastructure Delivery Improvement Program |
| IMCI | Integrated Management of Childhood Illnesses |
| IMR | Infant Mortality Rate |
| IPT | Isoniazid Preventive Therapy |
| IT | Information Technology |
| IUCD | Intrauterine Cervical Device |
| IYM | In - Year Monitoring |
| KZN | Kwa-Zulu Natal |

| | |
|---|---|
| LP | Limpopo |
| MCWH & N | Maternal Child Women Health & Nutrition |
| MDG | Millennium Developmental Goals |
| MDR | Multi Drug Resistance |
| MEDSAS | Medicine Provisioning System |
| METROs | Medical Emergency Transport and Rescue Organizations |
| MHC | Mthatha Hospital Complex |
| MOU | Maternal Obstetric Units |
| MPAT | Management Performance Assessment Tool |
| MTEF | Medium Term Expenditure Framework |
| MTSF | Medium Term Strategic Framework |
| NC | North Cape |
| NCCEMD | National Committee on Confidential Enquiries on Maternal Deaths |
| NHC | National Health Council |
| NHI | National Health Insurance |
| NIMART | Nurse Initiated Management of ART |
| NMM | Nelson Mandela Metro |
| NSDA | Negotiated Service Delivery Agreement |
| NTSG | National Tertiary Services Grant |
| NTSG | National Tertiary Services Grant |
| NW | North West |
| O&P | Orthotic and Prosthetic |
| OPD | Out-Patient Department |
| OSD | Occupational Specific Dispensation |
| OTP | Office of the Premier |
| PCR | Polarised Chain Reaction |
| PCV | Pneumococcal Vaccine |
| PDE | Patient day Equivalent |
| PDE | Patient Day Equivalents |
| PEHC | Port Elizabeth Hospital Complex |
| PEHC | Port Elizabeth Hospital Complex |
| PERSAL | Personnel and salaries |
| PGDP | Provincial Growth and Development Plan |
| PMR | Perinatal Mortality Rate |
| PMSU | Project Management Support Unit |
| PMTCT | Prevention of Mother to Child Transmission |
| PSS | Patient Satisfaction Survey |
| QA | Quality Assurance |
| QIPS | Quality Improvement Plan |
| RDM | Remote Demander Module |
| RED | Reach Every District |
| RPHC | Revitalisation of Primary Health Care |
| RPHC | Revitalization of PHC |

| | |
|---|---|
| RSDP | Rationalised Service Delivery Platform |
| RSDP | Revitilised Service Delivery Platform |
| RV | Rota Virus |
| SANBS | South African National Blood Services |
| SANS | South African National Standards |
| SDIP | Service Delivery Improvement Plan |
| SLA | Service Level Agreement |
| SMME | Small, Medium and Micro Enterprise |
| SOPs | Standard Operation Procedures |
| TB | Tuberculosis |
| TROA | Total Remaining on Art |
| TMC | Traditional Male Circumcision |
| VPN | Virtual Private Network |
| XDR | Extreme Drug Resistance |

# 1. FOREWORD BY THE HON. MEC FOR HEALTH



The department's Annual Performance Plan (APP) for 2013/15-2015/16 represents our strategic objectives implementation delivered in the next MTEF period. The department was allocated R16, 584, 328, a negative growth of 2.7% from the previous budget allocation, and this will put great strain on our ability to execute our responsibilities. In 2011, I signed the declaration that embraces institutionalisation and mainstreaming of Innovation and Knowledge Management throughout the department. This purports to encourage and entrench the concept of innovation in the coal face of health service delivery to improve business processes. Implementation of the developed Innovation and Knowledge Management strategy will promote sharing of resources through development of innovative systems.

This plan has continued to focus on our mandate of improving the health profile of the people of the EC province. It is encouraging that indicators show we have reached 60years of life expectancy; our APP plan has built on this positive direction. To realize this ultimate goal we have prioritized the achievement of the Ten Point Plan through the strengthening of Health System. During this term of government, Re-engineering of the PHC has been prioritized and the department will roll-out this program to other districts. The establishment of ward-based PHC Teams only forms the basic building blocks, we also need to strengthening their work at community level including household profiling and dealing with referrals. The other identified critical service delivery areas relate to the strengthening of Emergency Medical Services, Pharmaceutical and Hospital services. The department has identified the development of the critical capability in these areas as fundamental if we are to realize quality services and impacting on the goals.

This APP marks the second year of our NHI Pilot in the O R Tambo district and as part of the rolling out this intervention; focus will be on building the GP contracting model, the Supply Chain Management and strengthening of our system. The pilot has given us a golden opportunity to not only improve our system but also test good service delivery models in our readiness for the ultimate implementation of NHI.

The department has the responsibility to support the country effort in the realization of their international responsibility by the acceleration achievement of the Millenium Development Goals (MDGs). While we are celebrating the positive trends in TB cure rates, decline in maternal and child mortality, we are consciously aware of the enormity of the remaining task, and plan will focus on critical programs to accelerate these trends to get even higher achievements. The department is part of the broader community of providers in the implementation of our Provincial Strategic Plan (PSP) in our response to mitigate the HIV&AIDS and TB. Our programs have been geared towards achieving the goals of the PSP. Implementation of the revised HIV&AIDS policy that was announced by our President on the 1st December 2009 has realized improvement in our outcomes. The dedicated HIV&AIDS and TB Conditional Grant has given us the necessary and critical resource base to plan for achieving better results. We will also roll out the De-institutionalization and Decentralization policy framework for managing TB patients closer to their homes. We will continue to work with our partners and stakeholders to roll-out this. The TB treatment success rate has been increasing over the years, and by the end of the New Year the department is targeting 80% success rate.

The department will build on the strategic intervention we made in mitigating challenges around maternal and child mortality, and these include the decentralization of ambulances, the building of halfway houses to improve access to these services by people from deep rural areas, as well as implementing the 10 recommendations from the Confidential Committee on Enquiry to Maternal Deaths (CCEMD).

The department has gone through a detailed plan of our Infrastructure Projects so that there is streamlined project management, reporting and tracking of budget. We are expanding our infrastructure platform to maximize access to health facilities by revamping the existing facilities through infrastructure maintenance and rapid provision of engineering services. In 2013/14 we have targeted to renovate 80 clinics and provide engineering services to an additional 114 facilities in the province. In addition to this, a total of five Nursing Colleges will also undergo a vigorous renovation as there is a greater need to produce a Health professional cadre of good quality. We continue to provide training and enhance skills of our staff to equip them for better service provision. The Annual Performance Plan will become our yearly guide for improving our skills and in the 2013/14 financial year we will continue to train the 3868 students enrolled at the Lilitha College as nurses. A further 200 nurses from the current team will be trained as midwives as means to address the shortage of midwives in the province. In addition to the existing 1000 bursars, 300 new bursaries will be awarded for the training of doctors, pharmacists and other health specialists.

In conclusion, the 2013/14-2015/16 Annual performance Plan is confirmation of the commitment of the Eastern Cape Department of Health to meet its constitutional mandate. . This plan reflects our purpose for existence, in the translation of the National Health Act to practical health programs, improvement of access to services through the implementation of the RPHC, and realization of our global community objectives through achieving MDG objectives.

**S. Gqobana, MPL**
**MEC for Health, Eastern Cape Province**

## 2. STATEMENT BY THE HEAD OF DEPARTMENT

This plan describes the intended performance of the department over the Medium Term Expenditure Framework (MTEF) period in line with the prescripts of the Public Finance Management Act, (Act no. 1 of 1999 as amended) and Treasury regulations. Part A of the Annual Performance Plan uses a broad analysis to outline the strategic issues facing the department at corporate level. Part B shows how the department intends to spend its limited and constratined resources to implement the plan. The allocation for 2013/14 is R16, 584, 328, and this shows a negative growth of 2.7% which will put a strain in the achievement of the planned initiatives, and therefore a lot of creativity is needed on the department in executing our mandate.

The pressing need to realize the objectives of the National Service Deliver Agreement (NSDA), the Millennium Development Goals (MDG's) and the goals of Provincial Growth and Development Strategy (PGDS) remain utmost in our endeavours in striving for a better life for all EC citizens. Our plans will continue to put emphasis on reducing the burden of disease among our people. The Department will continue to:

- Strengthen efforts in reducing maternal mortality and deaths in children under the age of five through the Saving Mothers Saving Babies special project, School health programme, household visits by PHC and clinical specialist teams as well as other initiatives;
- Deliver on the HIV Strategic Plan initiatives in order to reduce the number of new infections and combating the spread of HIV and Aids. Further training on Nurse Initiated Management of ART will see 75 000 new HIV positive clients put on ART programme during 2013/14 financial year and an anticipated total of 315 000 clients on this programme as we strive to further extend life expectancy.
- Implement tested interventions, in the Eastern Cape Health Facilities including progressive introduction and promotion of use of GeneXpert as a diagnostic tool for TB, promoting compliance with infection control measures in TB hospitals as well as promoting social compact in the fight against TB.
-

The department will continue to maintain a zero tolerant stance towards incidences of fraud and corruption. ECDoH has as such been very active in investigating all allegations of fraud and corruption received.

During the current financial year, the LOGIS system was implemented in 14 HUBS and in the new FY the Department will focus on the utilisation of this system to ensure transparency and compliance with PFMA regulations. The system will further improve turn-around times and facilitates monitoring of service provider payments. Further targeted supply chain management reforms include prioritisation and award of mid-term contracts for purchase of technical equipment & maintenance, security services and for buying patient food. Whilst minimising wastage, these reforms are meant to prevent fraudulent activities whilst on the other hand improving supply chain management processes for better service delivery and outputs.

The department is striving to improve the quality of services delivery platform in line with the national mandate. This will be achieved through the communication to all facilities of a vigorous plan for the implementation of the Core Standards with emphasis on the six priority areas which includes improving cleanliness, waiting times, infection control, patient safety, attitudes and availability of medicines. An integrative approach coordinated by the Quality Health Care Assurance Systems teaming up with District Health , Hospital Services, and Primary Health Care will be used to achieve better outcomes. Primary Health Care facilities will be prioritized for the purpose of improving the Quality of Care at this level in line with the national priority of re-engineering Primary Health Care.

In the next financial year the Remote Demander Module (RDM) will be implemented at both PE and Mthatha depots as part of the pharmaceutical benefit improvement plan. This is an expansion of the depot management system (Medsas) to allow its clients electronic access to the system to register their demands, follow the demands through the issuing process at the depot and apply financial control over their demands. The system will alleviate a lot of pressure on the depots and will be of tremendous benefit to the recipients. Connectivity at site or demander level via cabling or otherwise wireless in order to connect at the depot will ensure efficient functionality of this system.
The implementation of the RX Solution will be rolled out to the NHI pilot district, the OR Tambo
District to ensure stock management and dispensing capability to curb stock out problems.

Key information technology (IT) requirements will focus in the following areas:

- Ensuring connectivity in the major procurement sites (14 HUBS) to improve the procurement process and transversal systems (Finance and HR).
- Improving clinic connectivity to better computing capacity for the implementation of the Patient Registration. As NHI pilot site, the project will be prioritising 50 sites in the OR Tambo district and will focus on data, voice and video connectivity.
- An automated referral register has been developed to better understand and manage the patient referral patterns and will be implemented from April 2013.

With the financial position faced by the Department, it has become imperative to rethink the Human resource strategic direction with regards to huge cost drivers including cost of employment (COE). Currently, COE consumes up to 64,3% of the Department's budget thereby leaving 35,7% towards health service delivery including infrastructure development and maintenance. Consequently, the Department continues to struggle with the timeous payment of certain employee benefits, inability to fill critical posts, etc. To remedy this situation and move towards an optimal staff compliment especially in key service areas, the Department is working towards COE stabilisation measures in collaboration with the Office of the Premier (OTP) and the Provincial Treasury. These measures entail:

- A comprehensive budget analysis predicated upon a zero based budget. This process, which will culminate in a new budget baseline for COE in the ECDoH, will be undertaken by a ECDOH team made-up of OTP, Provincial Treasury and may solicit assistance of National DOH & Treasury, should the need arise.
- As the department is striving towards a clean PERSAL system and a 10% vacancy rate, an employee verification and head-count process will inform the correction of link-codes to both budget and accurate allocation to relevant components. This will further allow for employee document update, management and control as well as improving compliance with the National Minimum Information Requirements (NMIR).
- A cost containment and revenue generation mechanism will also be developed to plug leakages and to generate more revenue from the services rendered by the Department.

In conclusion, as the Head and the Accounting officer of the Eastern Cape Department of Health, I wish to personally endorse this Annual Performance Plan. I wish to express my sincere gratitude to the Honourable Member of the Executive Council for his continued support and commitment to improving the lives of the people of the Eastern Cape. The plan will be renewed annually to reflect on our achievements on the stated pre-determined objectives as well as the financial capacity at the disposal of this department.

**Mr M.D. Qwase**
**Acting Superintendent General**
**Eastern Cape Department of Health**

## 3. Official Sign Off of the Provincial APP

It is hereby certify that 2012/13 – 2014/15 Annual Performance Plan:

- Was developed by the Provincial Department of Health in Eastern Cape Province
- Was prepared in line with the current Strategic Plan of the Department of Health of Eastern Cape Province under the guidance of the Hon. MEC S. Gqobana
- Accurately reflects the performance targets which the Provincial Department of Health in Eastern Cape Province will endeavour to achieve given the resources made available in the budget for 2013/14 – 2015/16.

Mr S. Kaye
**Acting Chief Financial Officer** **Signature**

Date: 15/03/2013

Dr T. Mjekevu
**Head Official Responsible for Planning** **Signature**

Date: 15/03/2013

Mr M.D. Qwase
**Acting Accounting Officer** **Signature**

Date: 15/03/2013

**APPROVED BY:**

Hon S. Gqobana, MPL
**MEC For Health** **Signature**

Date: 15/03/2013

# PART A

## Strategic Overview

# 4. PART A: STRATEGIC OVERVIEW

## 4.1 VISION

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

## 4.2 MISSION

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

## 4.3 VALUES

The Department's activities will be anchored on the following values in the next five years and beyond:

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

## 4.4 STRATEGIC GOALS

The department is maintaining its five strategic goals as developed in the 2010/11-2014/15 Strategic Plan. The strategic objectives have however been revised in line with the implementation of the Minister's Negotiated Service Delivery Agreement (NSDA), National Health Council Priorities, the Provincial Strategic Framework on Health. The revised strategic objectives and targets will be detailed in the addendum that is submitted as an annexure to this Annual Performance Plan. The Department has therefore five strategic goals which will be implemented for the current term of government. These are:

01. To facilitate a functional quality driven Public Health System that provides an integrated and seamless package of health services and is responsive to customer needs.
02. To combat and reduce the impact of TB and HIV/AIDS with a special focus on preventing the emergence of drug – resistant strains.
03. To improve and strengthen the mother and child health services.
04. To combat and reduce diseases of lifestyle and mental condition.
05. To enhance institutional capacity through effective leadership, governance, accountability and efficient and effective utilization of resources.

**TABLE A1: STRATEGIC GOALS**

| STRATEGIC GOAL | GOAL STATEMENT | RATIONALE | EXPECTED OUTCOMES |
|---|---|---|---|
| **1. Public Health System** | To facilitate a functional quality driven Public Health System that provides an integrated and seamless package of health services and is responsive to customer needs. | The Provincial Public health system is still developmental and undermined by poverty, inequality and inadequate basic services.<br><br>This matter is a Constitutional requirement.<br><br>There is a critical need to balance the focus between Primary Health Care and Tertiary Services and further addressing the continuum of patient care as well as the patient referral system. | **By 2015, the organisation should demonstrate the following outcomes:**<br>• Functional District health system characterised by well managed and effective Clinics, CHCs, District and Specialised Hospitals,<br>• Each district to have a fully functional EMS Metro Centre.<br>• Fully functional Regional and Tertiary Hospitals. |
| **2. TB and HIV/AIDS** | To combat and reduce the impact of TB and HIV/AIDS with a special focus on preventing the emergence of drug – resistant strains. | Recent Health Statistics indicate that TB is number one killer disease and regardless of the intervention currently implemented, there is an increasing TB incidence and prevalence within the Province.<br><br>TB and HIV & AIDS also form part of the MDGs and the province is mandated to report on them. | **By 2015, the organisation should demonstrate the following outcomes:**<br>• Reduction of HIV prevalence<br>• High coverage of ARV<br>• Increase in the TB cure rate<br>• Reduction of TB Incidence<br>• Arrest rate progression to MDR/XDR |
| **3. Mother and Child Health** | To improve and strengthen the mother and child health services. | Women and children are the most vulnerable groups of the population and they form 50-60% of morbidity. There is a need to address sexual, reproductive health and rights<br><br>Maternal & Child Health are part of the MDGs and the province is mandated to report on them. | **By 2015, the organisation should demonstrate the following outcomes:-**<br>• Reduction of maternal morbidity<br>• Reduction of maternal mortality<br>• Reduction of infant mortality<br>• Reduction of <5 child morbidity<br>• Reduce no of under-weight children <5 – nutrition/social needs cluster<br>• Greater awareness of women's sexual and reproductive rights |

| STRATEGIC GOAL | GOAL STATEMENT | RATIONALE | EXP |
|---|---|---|---|
| **4. Non-communicable Diseases and Mental Conditions** | To combat and reduce diseases of lifestyle and mental condition. | Non-communicable diseases are increasingly forming a greater part of morbidity & mortality<br><br>There is a growing incidence of non-communicable diseases<br><br>Hypertension is within the top five of mortality and morbidity conditions in the Eastern Cape province.<br><br>Failure to prevent and detect early chronic diseases lead to increased costs of managing chronic diseases | **By 2015, the organisation should demonstrate the following outcomes:**<br>• Reduction in incidence of mental conditions.<br>• Reduction in re-admissions of mental patients.<br>• Reduction in substance abuse.<br>Reduce complications in hypertension and diabetes<br>• Improved health promotion activities<br>Reduce incidence of obesity<br>• Reduction in morbidity, mortality resulting from circumcision<br>• Reduction in epilepsy and asthma morbidity<br>• Reduction in morbidity and mortality of the most common cancers (breast, cervix, prostrate, oesophagus and lungs) |
| **5. Institutional Capacity** | To enhance institutional capacity through effective leadership, governance, accountability and efficient and effective utilization of resources. | Value for money<br><br>Effective governance and accountability<br><br>Leadership and Stewardship<br><br>Improving business processes and utilization of resources<br><br>Learning Organisation<br><br>Organisational Performance | **By 2015, the organisation should demonstrate the following outcomes:**<br>• Unqualified audit opinion received from the Auditor General<br>• Effective leadership and audit<br>• Effective planning and monitoring system<br>• Achievement of norms and standards ratios<br>• Fully fledged and independent Lilitha College of Nursing that is able to produce ready, able and capable nurses to service the health system.<br>• Fully fledged EMRS college that is able to produce ready, able and capable EMRS Practitioners to service the health system |

## 4.5 SITUATION ANALYSIS

### 2.1.1 Overview of the service delivery environment for 2011/12

#### Demographic information

The Eastern Cape Province is spread over an area of 168,966 km2 and constitutes 13.8% of the total SA land area. The 2011 Census data showed that the province has a population of 6,562,053(Table A2.3). The largest proportions of the population are concentrated at OR Tambo and Nelson Mandela Metro Districts with 20.8% and 17.6% of the total population respectively. Joe Gqabi District has the smallest population constituting 5.3%. Approximately 61.1% of the population is younger than 30 years and 11.7% of these are under the age of 5 years.

About 88% (5 856 276) of the EC population is serviced by the public health sector, as medical aid coverage in this province is only 12%.

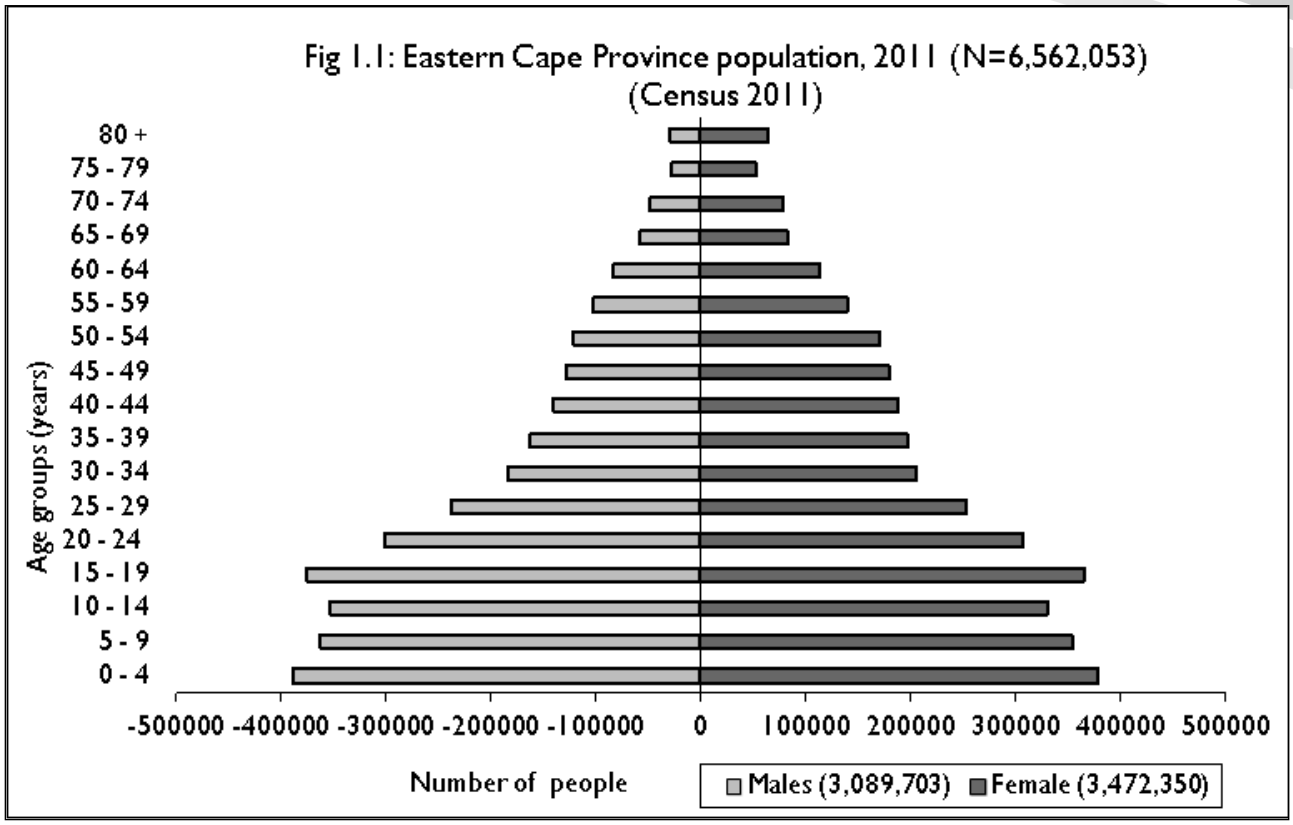
**Table A2: EC population distributed by health districts, 2011**

| District | Total population[1] | % Total EC population | Females[1] | Males[1] | % Urban population[2] | % Rural population[2] |
|---|---|---|---|---|---|---|
| A Nzo DM | 801,344 | 12.2 | 434,857 | 366,488 | 2 | 98 |
| Amathole DM | 892,637 | 13.6 | 473,389 | 419,247 | 39 | 61 |
| Buffalo City | 755,200 | 11.5 | 396,644 | 358,557 | 96.5[3] | 3.63 |
| Chris Hani DM | 795,461 | 12.1 | 418,823 | 376,638 | 39 | 61 |
| Cacadu DM | 450,584 | 6.9 | 230,338 | 220,246 | 27.2 | 72.8 |
| Joe Gqabi DM | 349,768 | 5.3 | 184,325 | 165,443 | 2.1 | 97.9 |
| N Mandela Bay | 1,152,115 | 17.6 | 599,121 | 552,994 | 91.1 | 8.9 |
| OR Tambo DM | 1,364,943 | 20.8 | 734,856 | 630,088 | 37.9 | 62.1 |
| Province | 6,562,053 | 100.0 | 3,472,353 | 3,089,701 | 30 | 70 |

*Source: [1]StatsSA Census 2011; [2]Source for % Urban & Rural population – Statssa CS 2007; [3] ECSECC, 2009*

The key developmental indicators for the province that influence health status and outcomes are shown in Table A2 below. The major constraint in the department relates to the huge vacancy rate that poses a threat to the delivery of adequate services in health facilities as a result of budget constraints. By the end of the 2011/12 financial year, the vacancy rate for clinical service was 56%. Table A3 shows the status of the key personnel that are required to deliver health services in the province. The departmental organogram is however, under review as many of the posts are contract and/ or unfunded.

[1] *Data source: Community survey, 2010*




Implications on service delivery due to the fact that 61% of the Eastern Cape population is less than 30 years old age:

- High demand for basic services
  - healthcare e.g. maternal & child care
  - Education i.e. produce relevant skills needed for the development of the province
  - Social services like social grants and other basic services.

- Strain on government to provide employment or opportunities to participate in wealth creation.
  - Some may be excluded from participated in wealth creation
  - Balance between public & private sector.
  - Minimize migration of critical skills to other provinces.

- Capacity of the state to deliver services can be over-stretched.

- Recreational opportunities
  - Encourage youth to stay away from unhealthy activities

**Table A 3: Key developmental indicators in the Eastern Cape Province**

| Indicator | Year | Eastern Cape |
|---|---|---|
| **Demographic indicators** | | |
| Population density (people per $km^2$) | 2009 | 39.1 |
| Average household size | 2007 | 4.1 |
| % public sector dependant population | 2007 | 92.9 |
| % of households for which the usual place of consultation is a public facility | 2010 | 79.7 |
| Total fertility rate (No. of children per woman) | 2006-2011 | 2.8 |
| Life expectancy at birth (females) | 2006-2011 | 55.5 |
| Life expectancy at birth (males) | 2006-2011 | 50.3 |
| % disabled population | 2010 | 12.4 |
| **Socio-economic indicators** | | |
| % of households classified as poor (monthly expenditure <R2500) | 2010 | 79.3 |
| % of persons with medical aid coverage | 2010 | 12.1 |
| % of households with informal housing | 2007 | 7.4 |
| % households using electricity for cooking | 2007 | 45.3 |
| % of households using wood/coal for cooking | 2010 | 20.9 |
| % of households with access to piped water | 2007 | 70.8 |
| % of households with no water supply infrastructure | 2010 | 26 |
| % of population 20 years and older with no schooling | 2010 | 8.5 |
| % of households with access to a functioning basic sanitation facility | 2010 | 61.1 |
| % of households with no toilets | 2010 | 16.3 |

**Data sources: Statssa 2009, SAHR 2008, DHIS - facility-based data, Community survey 2007*

### Overview of Departmental Performance

The key developmental indicators for the province that influence health status and outcomes are shown in Table A 4 below. The major constraint in the department relates to the huge vacancy rate that poses a threat to the delivery of adequate services in health facilities as a result of budget constraints. By the end of the 2011/12 financial year, the vacancy rate for clinical service was 56%. Table A3 shows the status of the key personnel that are required to deliver health services in the province. The departmental organogram is however, under review as many of the posts are contract and/ or unfunded.

**Table A 4: Key indicators reflecting service platform during 2011/12**

| INDICATORS | 2011 /12 PLANNED OUTPUT | 2011 /12 ACTUAL OUTPUT |
|---|---|---|
| Medical officers per 100,000 people | 21.4 | 23 |
| Professional nurses per 100,000 people | 132.5 | 144 |
| Pharmacists per 100,000 people | 8.5 | 6 |
| Vacancy rate for professional nurses | 33 | 63.3% |
| Vacancy rate for doctors | 38 | 43.6% |
| Vacancy rate for medical specialists | 48 | 57.8% |
| Vacancy rate for pharmacists | 43 | 54.1% |

**Table A 5: Key provincial service volumes (actual), 2009/10 – 2012/113**

| Indicator | 2009/10 (actual) | 2010/11 (actual) | 2011/12 (actual) | 2012/13 (estimate) |
|---|---|---|---|---|
| PHC headcount - Total | 17 662 518 | 17 662 518 | 18 047 654 | 18 681 477 |
| OPD Headcount | 1 023 848 | 1 067 666 | 1 145 320 | 1 167 844 |
| Separations District Hospitals | 288 278 | 294 618 | 295 864 | 298 072 |
| Separations Regional Hospitals | 31 980 | 32 535 | 31 176 | 30 455 |
| Separations Tertiary/ Central Hospitals | 174 114 | 186 712 | 192 414 | 189 054 |

**Table A 5: Key provincial service volumes (actual), 2009/10 – 2012/113**

| Key Service Delivered | 2007/08 | 2008/09 | 2009/10 | 2010/11 | 2011/12 |
|---|---|---|---|---|---|
| Total antenatal clinic visits | 457 022[1] | 458,081[1] | 465 225 | 456 193 | 464 377 |
| Total deliveries | | | 117 213 | 120 746 | 128 194 |
| TB Patients on Directly Observed Treatment Short-course | 356 129[2] | 415 259[2] | | | |
| Hypertension visits | 1 831 915 | 2 131 635 | 2 289 687 | 1 609 393 | 536 144 |
| Diabetes visits | 444 122 | 479 578 | 557 249 | 394 713 | 145 419 |
| Referred to doctor (from clinic) | 406 541 | 457 987 | 448 138 | 278 887 | [2]3802 |
| HIV tests conducted (excluding tests in Antenatal Clinics) | 241 652 | 344 505 | 575 792 | 1 019 792 | 1 089 282 |
| Male condom distributed | 19 950 786 | 22 761 216 | 25 200 487 | 30 404 275 | 31 494 278 |
| Female condom distributed | 733 856 | 1 277 257 | 1 206 009 | 861 126 | 359 436 |
| Total PHC head count | 16 452 991 | 17 671 355 | 1 023 848 | 1 067 666 | 1 145 320 |
| Psychiatric illness visits | 323 347 | 341 997 | 342 289 | 282 157 | 161 086 |
| New STIs treated | 197 512 | 205 099 | 205 391 | 195 603 | 200 611 |
| Vitamin supplements issued to children and mothers | 493 802[3] | 612 810[3] | 649 707 | 642 434 | 745 882 |
| Immunization: Hep B total doses | 282 511[5] | 276 470[5] | 294 813 | 243 992 | 255 912 |
| Measles total doses | 222 740[6] | 257 352[6] | 292 804 | 233 825 | 231 659 |
| OPV total doses | 309 591[7] | 322 336[7] | 260 212 | 136 966 | 122 803 |
| Assistive devices issued (Wheel chairs, hearing aids, orthoses, prostheses) | 4 734 | 8 861 | 15 174 | 12 381 | 15 851 |

1. The total numbers for ante natal for 2007-2011 include both the first and follow up visits
2. The total numbers for TB patients on DOTS for 2007-2011include both patients from facilities and communities.
3. The total numbers for 2007-2011include Vitamin A supplement to non-breast fed infants from 0-5 months, supplement from 6-11 months, 12-59 months and supplement to women within 8 weeks after delivery.
4. The total numbers for DTP for 2007-2011include both the first and the third doses
5. The total numbers for HepB for 2007-2011include both the first and the third doses
6. The total numbers for Measles for 2007-2011 include both the first and the second doses
7. The total numbers for OPV for 2007-2011include both the first and the third doses

[2] *Reflects changes in NIDS*

### 4.5.2 Socio-Economic Profile

Currently 64.4% of people in the province live in poverty; the province has a 49.8% poverty rate with an unemployment rate of 52.6%. Approximately 87.9% of the population of the Eastern Cape is not insured and thus relies on the public health services for health care. The Eastern part of the Eastern Cape is strongly affected by the high unemployment rate that stands at44% in Alfred Nzo District and 27.6% in OR Tambo districts. High unemployment rate might be due to the fact that this region is predominantly rural. The introduction of the National Health Insurance Scheme will go a long way to address and ensure access to individuals who currently do not have choice to access health care.

**Table A7: Socio – Economic Profile per District, 2011**

| District | Populatio | Size of area ($km^2$)[1] | Poverty Rate (%)[2] | Poverty gap(Rand million)[2] | Urbanization Rate (%)[2] | Unemployment Rate (%)[2] | Illiterate (%)[2] |
|---|---|---|---|---|---|---|---|
| Alfred Nzo | 801,344 | 6866 | 63 | 765 | 5.5 | 44 | 51 |
| Amathole | 892,637 | 23593 | 53 | 1899 | 39.1 | 44 | 43 |
| Buffalo City MM | 755,200 | 2,515 | 35 | 541 | - | 25 | 15 |
| Cacadu | 450,584 | 58272 | 37 | 284 | 70.5 | 20 | 32 |
| Chris Hani | 795,461 | 36723 | 53 | 1159 | 31.1 | 35 | 46 |
| Nelson Mandela Metro | 1,152,115 | 1942 | 32 | 666 | 93.7 | 30 | 10 |
| Joe Gqabi | 349,768 | 25687 | 58 | 596 | 28.4 | 30 | 46 |
| OR Tambo | 1,364,943 | 15535 | 62 | 2599 | 7 | 41 | 48 |
| Eastern Cape | 6,562,053 | 169063 | 49.8 | 7967 | 38.1 | 37.4 | 34.5 |

[1]*Census 2011; 2ECSECC April 2012*

## NEGOTIATED SERVICE DELIVERY AGREEMENT (NSDA)

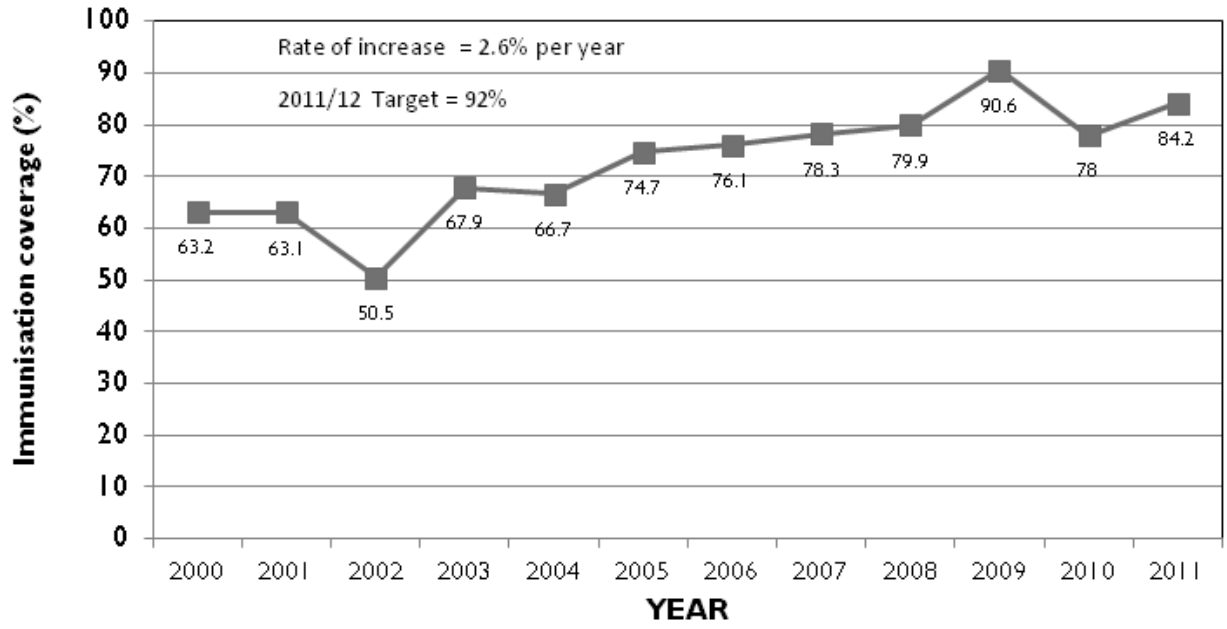
## OUTCOME 2: A LONG AND HEALTHY LIFE FOR ALL SOUTH AFRICANS

### Output 1: Increasing life expectancy

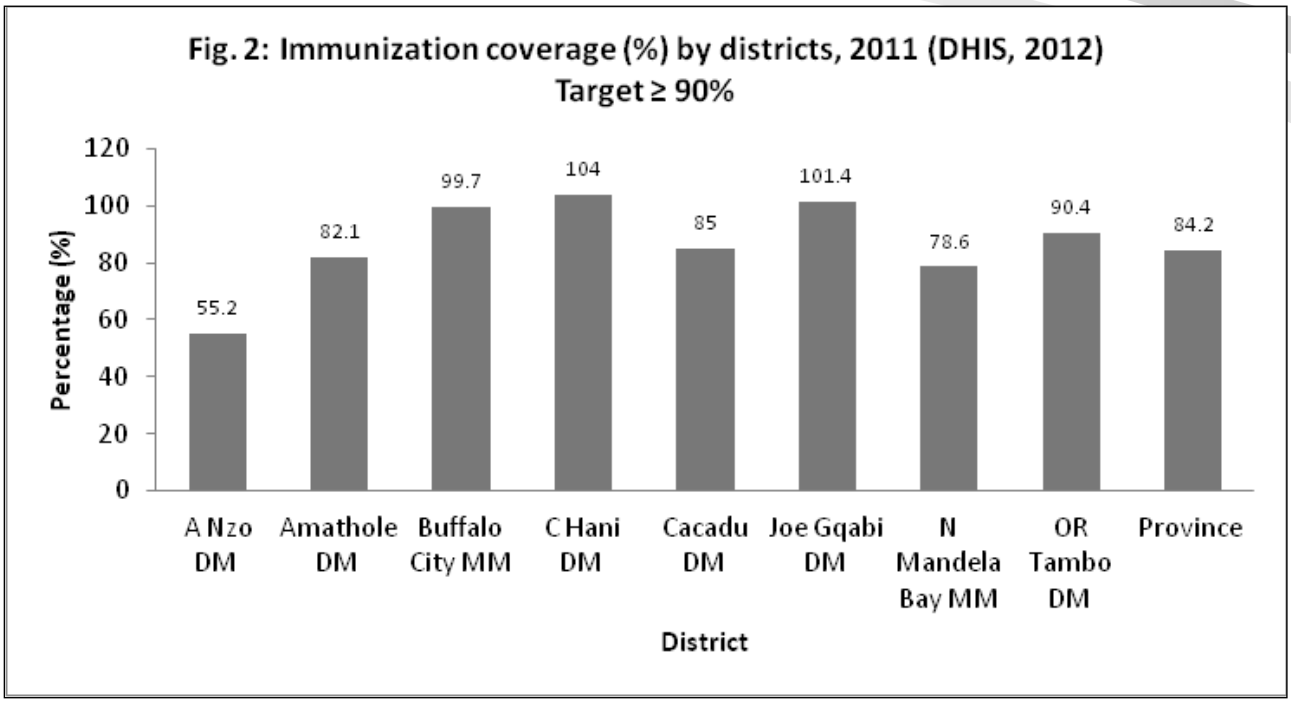
#### Immunisation coverage

Until 2010, the immunisation coverage rate among children less than one year had been increasing by 2.6% per annum on average from 63.2% in 2000 to 90.6% in 2009. From 2010 however, the rate of increase declined especially in the month of August and December 2010. This may be attributed to the public service strike which occurred during the July to August period. Against a target of 92% in 2011/12, the programme performed at 84.2%. The target for the year was not achieved; however, the performance improved from that achieved in 2010 (Figure 1). Chris Hani and Alfred Nzo Districts had the highest and lowest coverage rates of 104% and 55.2%, respectively (Figure 2). Four districts in the province, namely A Nzo, Amathole, Cacadu and Nelson Mandela MM, achieved less than the national target of 90%. However, in all seven districts the coverage of newly introduced rotavirus (RV) (to prevent diarrhea in children) and pneumococcal (PCV) vaccines is increasing with 77.6% and 80.9% coverage respectively.

**Figure 1: Immunisation coverage on children under one year, 2000 - 2011 (DHIS, 2012)**




[3] *Immunisation coverage rate is defined as the number of children who have received all vaccinations up to and including measles 1 as per the Expanded Programme on Immunisation vaccine schedule, expressed as a percentage of the total EC population under 1yr.*




**Continuous unavailability of vaccines** at both the depots and at a facility level is the major challenge that contributed to the decline in 2010 and continues to present a challenge in 2011/12. In addition, limited cold chain capacity poses a problem since the facilities cannot keep adequate stock (depending on population) due to challenges with refrigeration. The department is engaging with the supplier in order to increase supplies to match the provincial demand. Drug management has improved due to the appointment of pharmacists whilst donation of PCV13 vaccine by the National Department of Health (NDOH) also contributed to the improvement.

Not all children are reached due to **hard to reach areas.** The province is implementing the Reach Every District (RED) strategy with the assistance of UNFPA. Whilst lack of transport is a challenge, UNFPA has assisted the department by hiring vehicles to conduct the outreach programme in order to do mop-up. There is in addition vigorous strengthening of the IMCI programme through training of service providers at facility level.

Coverage reported at over 100% indicates a need to explore data quality and challenges with data management. Data quality is mainly influenced by unavailability of data capturers at facility level, connectivity challenges and poor data supervision. A data quality improvement plan has been developed that proposes electronic capturing of data at the health facility level and therefore includes strengthening connectivity in EC health facilities.

### Non-communicable diseases

***Hypertension:*** During the year under review, hypertension visits comprised 72.2% (534 146) of the total chronic care visits in PHC facilities. Approximately three and a half in every 100 clients (3.5%) aged above five years visiting Primary Health Care (PHC) facilities in the EC province presented with hypertension. This translates to a total of 534 146 client visits with hypertension during in 2011/12. For every 1000 clients above the age of 5 years visiting the PHC facilities, three were put on treatment for hypertension; this translates to a total of 39 266 new hypertensive clients put on treatment.

***Diabetes mellitus:*** During the 2011/12 financial year, diabetes mellitus visits comprised 19.5% (143 987) of the total chronic care visits in PHC facilities. Approximately 10 in every 1000 clients aged above five years visiting Primary Health Care (PHC) facilities in the EC province presented with diabetes. This translates to a total of 143 987 client visits with diabetes mellitus during the reporting period. For every 10 000 clients above the age of 5 years visiting the PHC facilities, eight were put on diabetes mellitus treatment for the first time; this translates to a total of 12 398 new diabetes mellitus clients put on treatment.

In line with the national requirement, the department is revitalising the PHC approach and is establishing PHC teams that will provide community-based services and visit households to provide basic PHC services including screening for chronic conditions where possible for the purposes of early detection and referral to appropriate levels of care and also to identify treatment defaulters. Health promotion activities will include educating the communities through campaigns about strategies to prevent chronic diseases, the need to comply with treatment and the establishment of support groups. The training of a cadre of community-based health practitioners is one of the key strategies to strengthen the PHC approach.

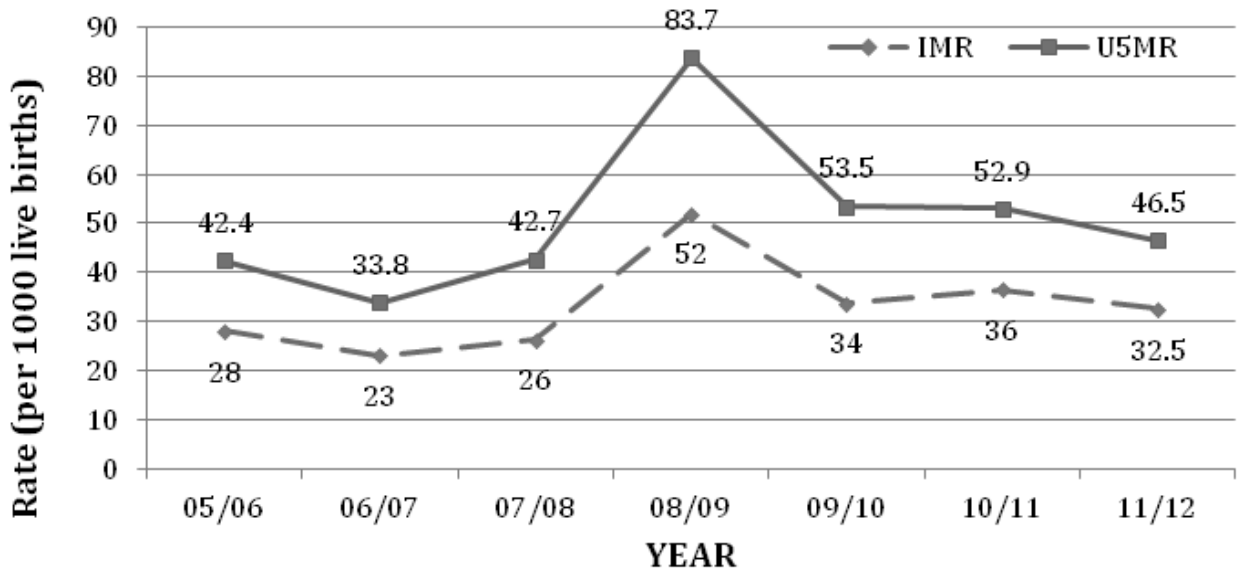
**Output 2: Decreasing Maternal and Child mortality**

**Sub-output 2.1: Reducing infant and child mortality**

**Infant Mortality**

The trend of public health facility infant mortality in the Eastern Cape shows a general increase over the past 6 years, as demonstrated in Figure 3. The infant Mortality Rate (IMR) has risen at an average of 1.69 deaths per thousand lives births between 2005/6 and 2011/12. It peaked at 52 deaths with a significant spike in 2008/09. The subsequent year, however witnessed an equally sharp decline, and IMR has since begun to stabilize. The most recent IMR in Eastern Cape, reported for 2011/12, was 32.5 deaths per 1000 live births. Strengthening and increasing mitigation responses is essential to accelerate a reduction in IMR.

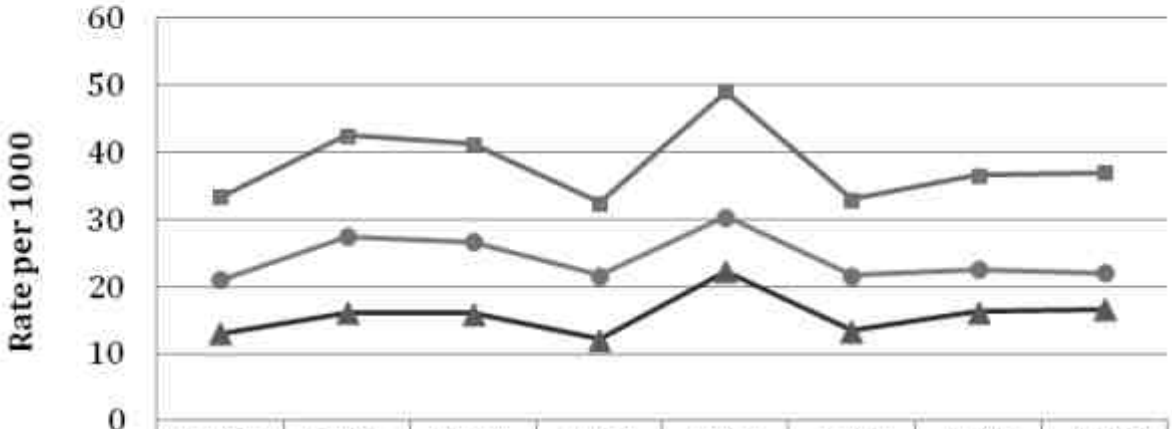
Figure 3: Public Facility-based Infant and Under-5 mortality rate, 2005/06 to 2011/12 (DHIS, 2012)




A closer analysis of IMR reveals that perinatal, neonatal and stillbirth rates in public health facilities have remained consistent for a considerable number of years. As shown in Figure 4, these mortality rates follow a similar trend, demonstrating no considerable decrease. In 2011/12, perinatal mortality rate 37, stillbirth rate at 22 and neonatal mortality rate at 16.7 per 1000 live births.

[4] *Infant Mortality Rate is the number of deaths of infants under 1 year of age per 1000 live births.*
[5] *Perinatal mortality rate is the number of stillbirths and deaths within the first week of life per 1000 live births.*
[6] *Stillbirth mortality rate is the number of deaths of a fetus after 20 weeks gestation or 500g per 1000 live births.*
[7] *Neonatal mortality rate is the number of deaths of neonates up to 28 days of life per 1000 live births.*

**Figure 4: Trends in public health facility based perinatal and neonatal mortality rates, 2004/05-2011/12 (DHIS, 2012)**



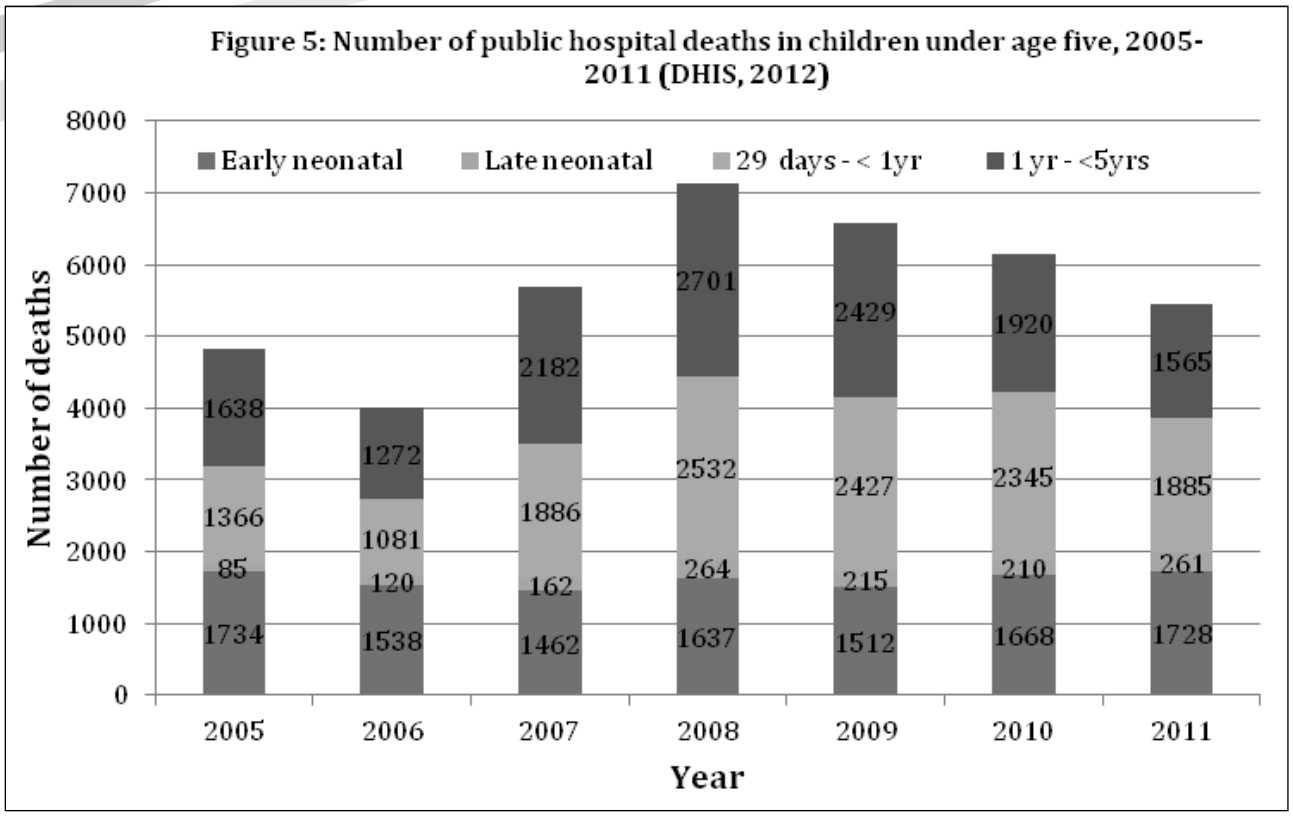

| | 04/05 | 05/06 | 06/07 | 07/08 | 08/09 | 09/10 | 10/11 | 11/12 |
|---|---|---|---|---|---|---|---|---|
| PNMR | 33.4 | 42.5 | 41.2 | 32.5 | 49 | 33.0 | 36.6 | 37.0 |
| NNMR | 13.1 | 16.1 | 16 | 12.2 | 22.3 | 13.4 | 16.3 | 16.7 |
| Still Birth | 21 | 27.4 | 26.7 | 21.7 | 30.4 | 21.6 | 22.5 | 22.0 |

**Under-five Mortality**

The rate of under-five mortality in public hospitals in the Eastern Cape follows a somewhat similar trend to the infant mortality rate, only on a slightly larger scale. It has risen at an average of 2.18 deaths per 1000 live births since 2005/06. The U5 mortality rate [8] peaked at 83.7 in 2008/09 and most recently was reported at 46.5 deaths per 1000 live births in 2011/12 (Figure 3).

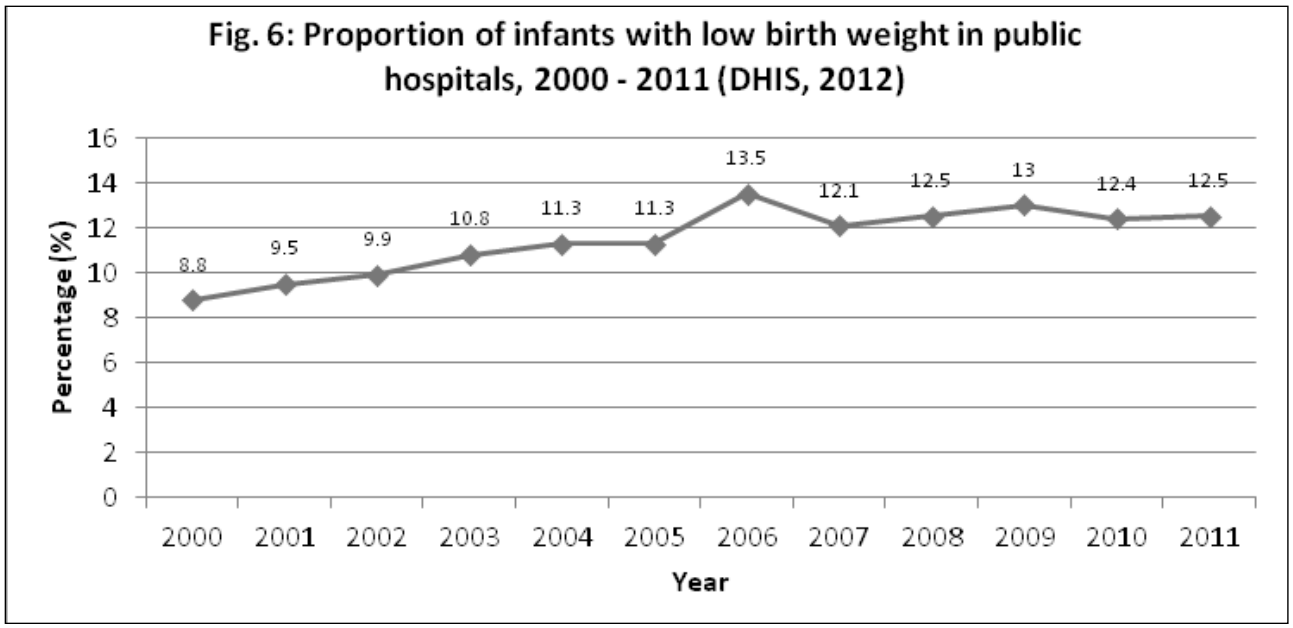
Figure 5 displays the actual number of deaths in children under age five, stratified by pertinent stages of development. The overall trend in the number of under-5hospital deaths shows a slight but consistent annual decrease after peaking in 2008. Mortality remains the lowest amongst late neonatal infants, followed by early neonatal infants. Proportionally, 29 day to <1 year of age mortality remained lower than 1 year to <5 years of age from 2005-2009, however a notable shift occurred in 2010. In both 2010 and 2011 the 29 day to 1 year mortality rate became higher than 1 year to <5yrs mortality rates.

[8] *Under 5 mortality rate is the number of deaths of children under 5 years of age per 100 live births.*




**Interventions on risk factors for under-five mortality**

***Low birth weight:*** As a significant determinant of neonatal mortality, it is essential to monitor trends in low birth weight. During the period from 2000 to 2009 the proportion of infants with low birth weight in Eastern Cape gradually increased to 13.5%. As shown in Figure 6, low birth weight has plateaued since 2009, and was reported at 12.5% in 2011 (Figure 6).




***Increasing immunisation coverage:*** To significantly reduce infant and child mortality, as well as the childhood burden of disease, the ECDoH has concentrated efforts on increasing immunisation coverage of children under-one year. From 63.2% in 2000, coverage was increased substantially, peaking at 90.6% in 2009 (Figure 1).

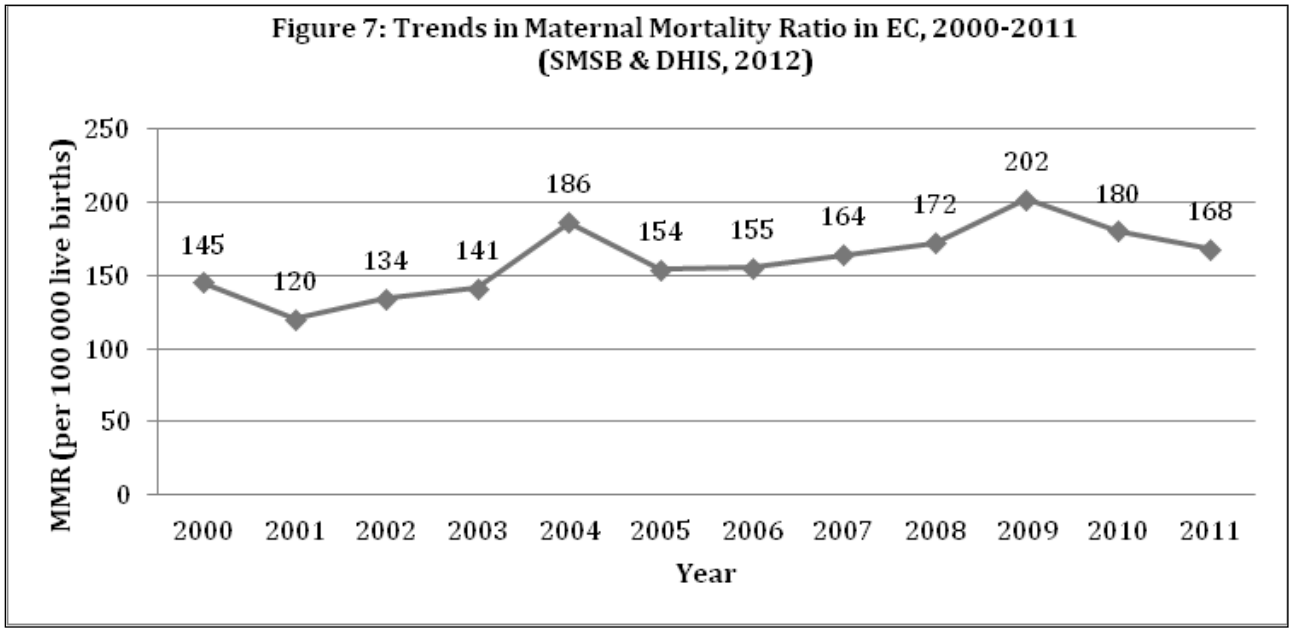
Circumstantial challenges with pharmaceutical services were responsible for a drop in coverage to 78% in 2010. The introduction of the new vaccine schedule led to undesirably frequent stock-outs and the unavailability of vaccines to provide services. Mitigation strategies have been put in place to improve the human resources and the supply chain management for EC's two pharmaceutical depots as well as to strengthen service delivery.

Concentrated efforts have increased immunization coverage among the under-1 from 78% in 2010 to 84.2% in 2011. The Chris Hani and Joe Gqabi districts reported the highest immunization coverage i.e. 104% and 101.4% respectively. However, there is a concern with the immunization coverage which is above 100%. This challenge with high immunization (<00%) identifies a need to explore data quality, challenges with data management and the impact of migration within the districts.

***Reducing infections:*** To reduce cases of diarrheal and respiratory diseases, the National Department of Health piloted rotavirus and pneumococcal vaccines in the Eastern Cape. Officially incorporated into a revised EPI schedule in 2009, coverage of both vaccines has steadily increased. Coverage of the rotavirus and pneumococcal vaccines has reached 77.6 and 80.9% respectively.

**Sub-output 2.2: Reducing maternal deaths**

As demonstrated in Figure 7, the Maternal Mortality Ratio (MMR) in EC rose steadily from 2000, peaking in 2009 at 202 deaths per 100 000 live births. It has since begun to decline and is reported at 168/100 000 for 2011/12. The actual number of maternal deaths (Table A8) follows a similar trend, rising slightly above the MMR after 2003. The




[9] *Maternal Mortality Ratio (MMR) is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy. This ratio is expressed per 100 000 live births.*

**Table A8: Trends in the number of maternal deaths and maternal mortality ratio per 100 000 live births in EC (2001-2011) (DHIS, 2012).**

| Year | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Maternal Mortality Ratio | 120 | 134 | 141 | 186 | 154 | 155 | 164 | 172 | 202 | 180 | 168 |
| Maternal Deaths | 103 | 119 | 129 | 209 | 181 | 182 | 199 | 223 | 269 | 229 | 210 |

The primary causes of maternal deaths were (NDoH, 2012):

- Non-pregnancy related infections – mainly resulting from AIDS
- Complications of hypertension
- Obstetric haemorrhage
- Pregnancy-related sepsis
- Pre-existing maternal disease

**Output 3: Combating HIV and AIDS and decreasing the burden of tuberculosis**

**Sub-output 3.1: HIV and AIDS**

Since 1990, HIV prevalence rate among pregnant women in the EC has increased significantly since 1990. The prevalence rate began to pleateau in 2006 however, at 29.1%. The following 5 years showed minimial variance, with the latest prevalence (for 2011) reported at 29.1% (Figure 8). Stratified by district, HIV prevalence remains highest in Buffalo City Metro at 33.9%, followed closely by Joe Gqabi at 29.6% and Chris Hani District at 29.6%(Table A9). This is contrary to the findings of the past years where OR Tambo and or Nelson Mandela Metro reported the highest prevalence. It is important to note that when stratified by age, the HIV prevalance rate of pregnant women aged 15-24 has decreased from 21.8% in 2010 to 20.7% in 2011(1.1% decrease)(ECP HIV & Syphilis Sentinel Survey, 2012). The results of this particular age demographic demonstrate a possible stablization of new HIV infections.

The Human Science Research Council (HSRC) data shows an increase in HIV prevalence in the general population from 2.4% in 1996 to 10.3% in 2010. The epidemic appeared to have reached its maturity stage in the general population as it was observed among the ANC attendees.

[10] *HIV prevalence rate refers to the percentage of people tested in a select population who were found to be infected with HIV.*

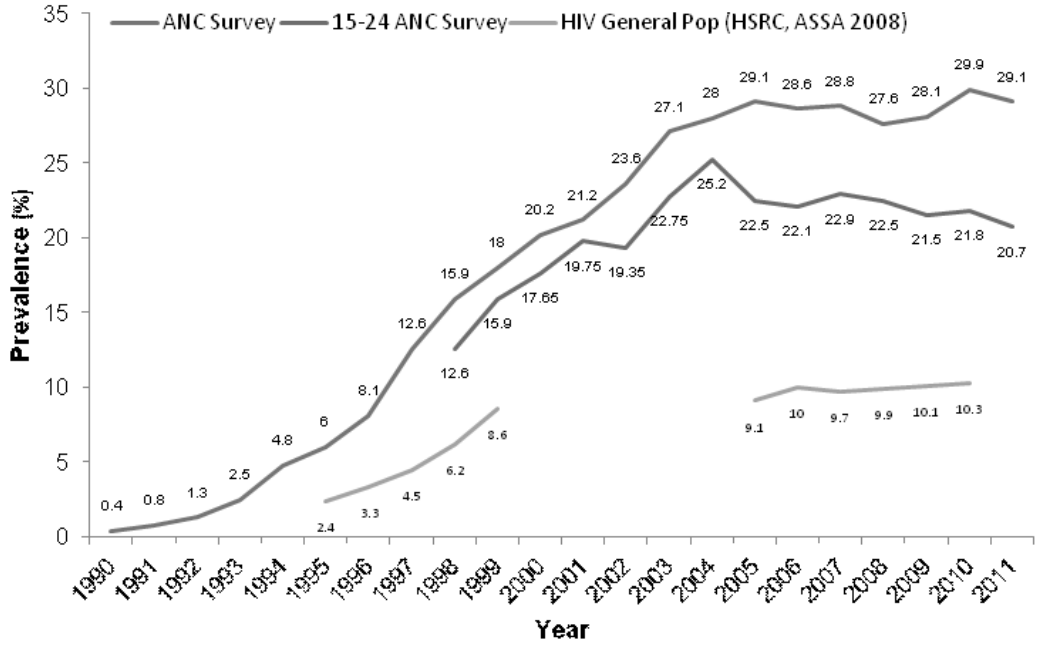



Figure 8: HIV prevalence among ANC attendees in Eastern Cape, 1990-2011
(ECDoH, HSRC, HST 2012)

**Table A9: HIV prevalence (%) among antenatal care attendees in the Eastern Cape, 2007 - 2011 (ECDoH, 2012)**

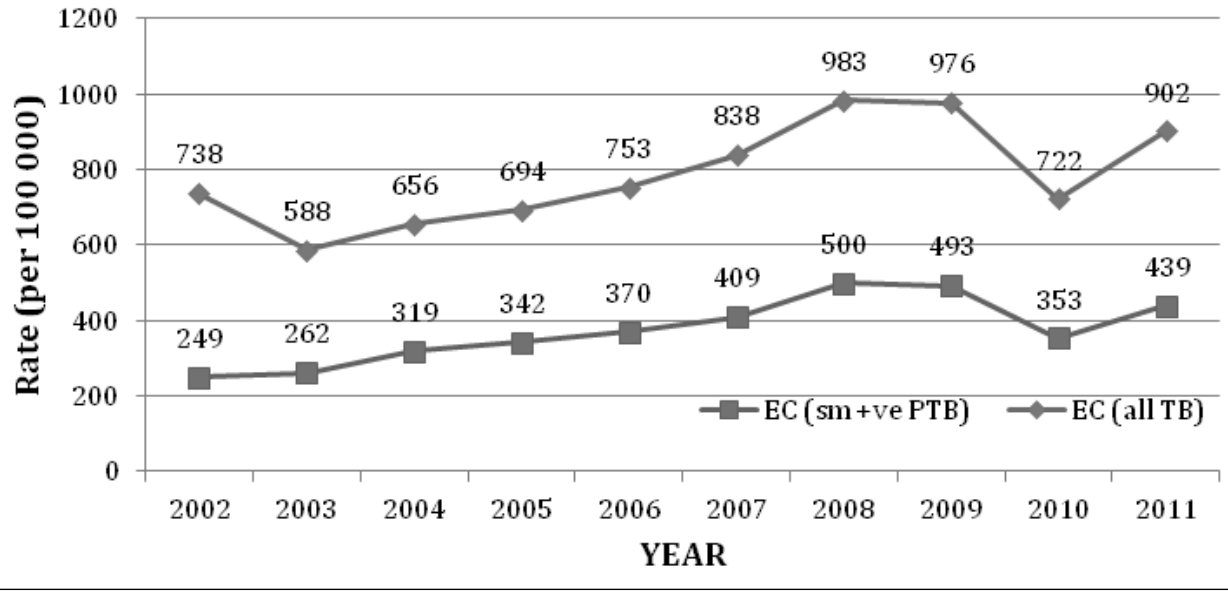
| District | 2007 | | 2008 | | 2009 | | 2010 | | 2011 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | % | CI (95%) | % | CI (95%) | % | CI (95%) | % | CI (95%) | % | CI (95%) |
| **Alfred Nzo** | 27.2 | 22.0 – 32.9 | 28.9 | 23.4 – 34.9 | 25.2 | 20.6-30.3 | 30.4 | 25.5-35.7 | 28.9 | 24.6 -33.1 |
| **Amathole** | 25.6 | 21.8-29.7 | 25 | 21.4 – 28.9 | 23.5 | 20.0-27.4 | 30.5 | 26.5-34.7 | 28.3 | 24.3 – 32.2 |
| **Buffalo City Metro** | 32.4 | 28.6 – 36.5 | 27.4 | 23.9 – 31.2 | 30.7 | 27.0-34.7 | 32.7 | 28.7-36.9 | 33.9 | 30.0-37.9 |
| **Cacadu** | 20.1 | 15.4-25.3 | 23.8 | 19.0-29.3 | 24.3 | 19.2-30.1 | 20.7 | 16.1-26.0 | 25.7 | 20.3-31.1 |
| **Chris Hani** | 30.2 | 26.5-34.2 | 27 | 23.3-31.1 | 27.1 | 23.2-31.3 | 30.1 | 26.3-34.2 | 29.3 | 25.2-33.4 |
| **Joe Gqabi** | 29.5 | 23.6-35.9 | 21.9 | 16.6-28.0 | 23.5 | 17.8-30.0 | 30.2 | 24.4-36.5 | 29.6 | 23.7-35.5 |
| **Nelson Mandela** | 28.96 | 25.8-32.3 | 29.1 | 25.9-32.4 | 30.7 | 27.5-34.1 | 29.0 | 25.6-32.6 | 28.1 | 24.7-31.5 |
| **OR Tambo** | 30.1 | 27.2-33.2 | 30 | 27.2 – | 30.1 | 27.4-33.0 | 31.2 | 28.2-34.3 | 28.2 | 25.3-31 |
| **EC Province** | 28.8 | 26.9-30.8 | 27.6 | 26.2-29.0 | 28.1 | 26.1 – | 29.9 | 28.2-31.7 | 29.1 | 27.7-30.5 |

*Source: Eastern Cape Department of Health, 2012*

**Sub-output 3.2: Tuberculosis**

The incidence rate of smear positive (+ve) PTB has risen at an alarming rate from 249 cases per 100 000 in 2002 to 500 in 2008. The incidence of all TB cases models a similarly steep growth in this timeframe, reaching a peak of 983 cases per 100 000 in 2008 (Figure 10). It is important to note that the significant 27% drop reported for both smear positive and all TB incidence rates in 2010 was largely influenced by insufficient and poorly coordinated sources of data. It is essential to recognize that TB incidence rates in Eastern Cape actually remained quite high. Since 2009, TB incidence has begun to plateau and even slightly decrease, but not nearly to the extent the data from 2010 alludes to.

**Figure 9: TB Incidence in the Eastern Cape Province, 2002-2011 (DHIS, 2012)**

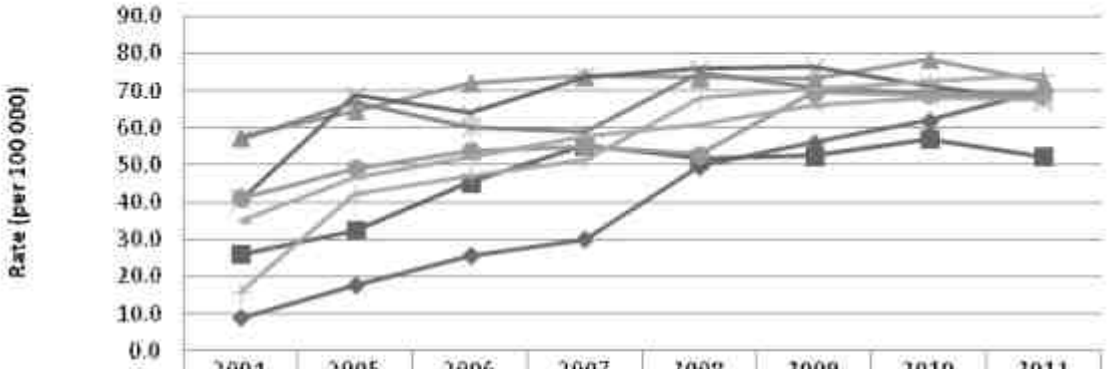



The number of new TB clients with smears testing positive for TB bacilli were reported at 439 cases per 100 000 in 2011, whereas all new cases diagnosed with TB were reported at 902 per 100 000. A high prevalence of HIV/AIDS and poor social determinants of health have contributed largely to the spread of infection. All cases of TB in the province have begun a general progressive decline since 2008, falling to a rate of 722 cases per 100, 000 in 2010. However, there was an increase which was observed in 2011.

As shown in figure 10, the number of TB clients on TB treatment cured for the first time (TB cure rate) in Eastern Cape has substantially improved since 2004. The cure rate has increased from 34.9% in 2004 to 67.7% in 2011. Stratified by district, variation exists in the rate of increase; however each district demonstrates a marked improvement in reported TB cure rate.

[11] *TB incidence is the number of newly diagnosed TB clients in EC expressed per 100 000 population.*
[12] *TB cure rate is the percentage of clients on TB treatment cured at first attempt.*

**Figure 10: TB Cure Rates in the Eastern Cape Province by Health District, 2004-2011 (ETR.Net 2012) Target ⊥ 85%**




| | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|
| A Nzo | 9.0 | 17.8 | 25.7 | 30.1 | 49.7 | 56 | 62 | 70 |
| Amathole | 26.1 | 32.4 | 45.4 | 55.3 | 51.7 | 52.5 | 57 | 52.2 |
| Cacadu | 57.6 | 64.5 | 72.1 | 74 | 73.5 | 73.1 | 78.4 | 72.6 |
| C Hani | 40.8 | 68.7 | 64 | 73.7 | 75.9 | 76.2 | 71.3 | 67.2 |
| Joe Gqabi | 57.0 | 66.9 | 60.2 | 58.8 | 74.7 | 71 | 69.4 | 68.4 |
| NMMM | 41.2 | 49.1 | 53.8 | 55.1 | 52.8 | 69.6 | 69 | 69.8 |
| OR Tambo | 15.9 | 42.1 | 47.1 | 51.5 | 68 | 70.6 | 72.4 | 74.3 |
| Province | 34.9 | 46.8 | 52 | 57.7 | 60.9 | 66 | 67.9 | 67.7 |

**Output 4: Strengthening Health Systems**

**Sub-Output 4.1: Re-Engineering the Primary Health Care System (RPHC)**

**Primary Health Care Re-engineering**

"Overhauling the healthcare system" is one of the critical areas in the Health Sector 10 Point Plan (which is the translation of Strategic Priority Five in the MTSF government strategic framework for its term of government) and also forms the fourth output in the Negotiated Service Delivery Agreement ("strengthening the effectiveness of the health system"). The primary health care re-engineering project is being implemented in three of the seven health districts, namely OR Tambo, Chris Hani and NMMM. Progress on the key elements of the RPHC approach is briefly outlined below.

***Ward-based PHC outreach teams:*** A number of PHC teams were established in 3 sub-districts in 2010/11, that is Nelson Mandela Metro, Intsika Yethu and King Sabata Dalindyebo. A further rollout was done to Ngcobo, Mnquma, Nyandeni, Makana, Senqu and Mbashe in the 2012/13 financial year. The composition of the established core teams vary amongst sub-districts and mainly consist of a professional nurse, enrolled nurses, enrolled nursing assistants, oral hygienist and community health workers. However, these teams are inadequate as they lack key elements from other government departments. The department will expand the Ward Based Teams to all sub-districts in the province in 2013/14.

***School health teams:*** Working closely with the Departments of Basic Education and Social Development, the department has revised the School Health Policy in line with the national requirements. These teams will first focus on schools in quintiles 1 and 2 and a selected range of services including administration of vitamin A and provision of oral health services. It is expected that these teams will work in tandem with ward-based PHC outreach teams.

The major challenges that are experienced in the establishment of these teams are human resources and transport availability. The department is looking into various strategies to address this; these include employing retired nurses to complement the teams, working closely with the PHC facilities and integrating some of the services. Twenty retired nurses were employed to provide school health services for both primary & high schools whilst 24 schools integrated oral health services into school health services. Without the Fleet Africa contract that ended in January 2012, the department has yet to come up with a strategy to administer its own transport considering budget constraints.

***District Specialist Teams:*** The function of these teams is to strengthen clinical governance at the PHC level as well as in district hospitals; to ensure that treatment guidelines and protocols are available and are used; to ensure that essential equipment is available and correctly used; and to ensure that mortality review meetings are held, are of good quality and that recommendations from these meetings are implemented. It is expected that these teams will also work closely with the PHC teams.

The department has commenced with the establishment of these teams, and the process to recruit professionals for the District Specialist Teams is driven at the national level working closely with the provinces. Critical priority in the establishment of District Specialist Team is directed towards OR Tambo which is the NHI Pilot in the province.

The department believes strongly that building a strong PHC foundation will strengthen the overall healthcare system. There is a focused drive towards building these teams and the department has a strong collaborative program with Letsema Circle (an organization that builds capacity in the communities through engagement and empowerment).

### Strengthening of Hospital Services

The National Department of Health has published a Government Gazette on the Policy on Management of Hospitals. The purpose of this policy is to ensure that management of hospitals is underpinned by the principles of effectiveness, efficiency and transparency. The specific objectives of the policy are:

- To ensure implementation of applicable legislation and policies to improve functionality of hospitals;
- To ensure appointment of competent and skilled hospital managers;
- To provide for the development of accountability frameworks;
- To ensure training of managers in leadership, management and governance.

The implementation process commenced with the national department driven audit on all hospital managers, to ensure they qualify with the minimum requirements of these positions. This was followed with the advertisement of CEO posts in all those hospitals that have vacancies. There is a parallel process to manage the re-deployment of managers who do not qualify with the requirements of this policy.

The National Department of Health has also published a Government Gazette on the Designation of Public Hospitals. The intention here is to ensure that hospital services are streamlined through clearly defined levels of hospitals according to their sizes and specifically defined roles in service delivery. This policy is also aligned with the Policy on Management of Hospitals.

***Rationalized Service Delivery Platform (RSDP):*** The Eastern Cape Province has submitted to the National Department of Health its Rationalized Service Delivery Platform (RSDP) as the basis of hospital designation in the province. This input will go into the revised Government Gazette to ensure that RSDP is fully aligned with the national policy.

### Implementation of NHI District Pilots

National Health Insurance (NHI) is one of the key deliverables in the Health Sector 10 Point Plan. Although the NHI policy development precedes the current reporting period, decision and allocation of 10 district NHI pilots was finalized during this financial year.

The National Health Council, after reviewing technical reports (data covering a range of factors in each district) decided to choose OR Tambo District as an NHI pilot. This pilot will run for the next 5 years focusing on the development of the health system including capacity readiness by these districts to contract services, to provide quality services and to strengthen governance issues.

The pilot will be funded through an NHI Conditional Grant that will commence during the 2012/13 financial year. The department has started with the preparation of the province and will be establishing a project team to manage this important project.

**Sub-Output: Improved Health Infrastructure Availability**

The department is currently focusing on eradicating backlog which is significantly extensive. On buildings alone the estimated replacement value is R22 billion. The industry norm for preventative maintenance is 2.5% (conservative) and this translates to a budget of at least R550 million per annum that is required for maintenance. In the 2012/13 financial year, the buildings maintenance budget allocation is R122, 5million i.e only 22.2% of baseline requirement. Improving health infrastructure is a key component of the NHI service delivery requirement and the department intends to focus on the rehabilitation and refurbishment activities from now moving forward.

The following factors play an important role in hampering Departmental progress in addressing building backlogs; and these are:

- Equitable share budget allocated for these projects is sacrificed and cut every year for other Departmental priorities.
- First line maintenance strategy (preventative maintenance) should be done at the facility level; organisational development and management is required to support this. However, the available funds allocated are generally used for crisis management.
- The department needs to complete its existing contracted commitments on new and/or on upgrade projects to release more funds for maintenance and refurbishment of existing infrastructure.
- Generally maintenance activities had not been conducted for some years and now the maintenance backlog has escalated to higher levels of larger refurbishment and upgrading projects.

The department is addressing the condition assessment to develop a strategy moving forward.

The 2012/13 financial year budget allocation for mechanical and electrical equipment maintenance is R213,5 million. The department intends to focus on this activity from now moving forward as this is the NHI service delivery requirement as well.

The key factors that hamper progress on maintenance of equipment are the following:

- Expenditure is mostly on term contracts (mechanical and electrical) and clinical equipment to address needs as they occur
- As indicated earlier this is funded from equitable share which gets cut every year
- Supply Chain Management challenges prevail (specifications, crisis management, term tenders etc.)
- Most equipment is old, outdated and non-functional and needs replacement; new equipment is expensive
- There is a need to sustain an asset management system and condition assessment strategy

The Infrastructure Delivery Management System (IDMS) has been designed to enable the management of the property portfolio. The department is currently aligning its infrastructure programme to this programme and will manage its implementation strategy with this system. The National Department of Health is currently developing a Project Management Information System (PMIS) which is designed to enable the department to manage the infrastructure implementation programme in a more effective and efficient manner. In addition, the Department is focusing at capacitating the infrastructure section with technical skilled personnel.

**Sub-Output 4.4.5: Improved Human Resources for Health**

Strengthening information on the workforce: The department has made some strides towards a clean-up of Persal i.e. clearing all unfunded posts in terms of DPSA guidelines and ensuring employee job position matches that of the post the employee occupies. Progress has been made in updating employee information in terms of qualifications, previous experience and performance management.

Determination of clearer targets: The department has established an HR Planning Committee in line with Regulations which will advise department on issues relating to HR Planning and will champion development of strategies on attraction and retention of staff to bridge the gap between demand and supply. The Committee has identified attraction and retention strategy as a priority and a Task Team within the HR Planning Team will action the development and consolidation of the strategy:-

- The HR Plan has been reviewed and aligned to DPSA Framework and to the Departmental Strategy and a draft HR Plan has been submitted for approval. The plan identifies priorities, challenges and weaknesses in strategic areas of human resources and an action plan to address these is part of the plan.
- It reflects a consolidated HR profile to address the gap between the skill's need, in line with the need and priorities of the department. To address this, there is still need to create a balance between need and resources.

A new strategic process, structures and mechanisms for a renewed health workforce: The department has started a process towards the realignment of its structure to be aligned to the National Gazette on reclassification of hospitals to ensure appropriateness and functioning of the department and hospitals, based on the PHC approach and addressing the NHI as a priority. The department forms part of the broader task team led by NDoH in establishing standard staffing norms and generic structures for health in the country, so that provincial functions are aligned to the National Health Department structure.

**Sub-Output 4.4.6: Strengthening Financial Management (Monitoring & Evaluation)**

Strengthening and improvement of financial management is one of key focus areas. Over the past 3years the department implemented interventions that were designed to improve the financial outcome of the department. This entailed improving accounting practices and control environment, introducing Generally Recognised Accounting Practices (GRAP) best practices, ensuring integrity of financial data and implementing systems and controls. The result was the turnaround of the audit opinion from disclaimer to qualified opinion.

During the year under review the department continued to improve on internal controls around revenue management, Cash and banking, debtor and liability management, asset management and the management of general Ledger accounts. Monthly reviews and reporting of financial data and reconciliations were conducted; quarterly interim financial statements were prepared and submitted to Provincial Treasury. Monitoring and oversight of financial activities performed at the districts, including budget and expenditure was done. This resulted in the reduction on qualification paragraphs from the previous financial year.

The challenge that still faces the department in the area of financial management is the lack of skilled, proficient and competent resources. The moratorium placed on the employment of permanent staff resulting in the reliance and usage of interns and contract workers. Lack of funding to fill vacant posts.

**Sub-Output 4.4.7: Improving Healthcare Financing through Implementation of National Health Insurance**

The identification of OR Tambo District Municipality as the pilot site for NHI has also been noted to be an achievement, which is most certainly going to improve the health care services in that region.

Communication and information sharing with various stakeholders has commenced as a premise and a commencement point for the planning and roll-out process of the National Health Insurance. Engagement has been spread across the various stakeholders within the province targeting political, labour, multi-sectoral, private health practitioners, traditional healers and internal management structures. A few of these include the Eastern Cape Political and Technical Munimec, Cabinet budget Committees, Provincial Treasury, OR Tambo District Municipality, Mhlontlo Councillors, NAFCOC, SAMA (GPs) and State Owned Enterprises.

Early success and gains have been achieved through the School Health Services, wherein Nurses have been deployed to schools at all Sub Districts and are already doing the School Health Services though ISHP. Although not sufficient teams have been identified and allocated to all districts and are making a notable difference. Furthermore, strides are being made through the Community Health Care Workers programme, Ward based teams have been identified for each sub district within OR Tambo , out of 143 wards 25 have ward based outreach teams that are functional. 197 CHCW have undergone a 10 day training theory & 5 day practical training under the supervision of a Prof Nurse, where they have been trained on aspects such as Clinic Cards, Road to Health Cards, Immunisation schedules etc.

**Sub-Output 4.4.8: Strengthening Health Information Systems**

A new strategy that focuses on facilities as centres of focus has been developed and is being implemented. It is based on proper record management, collation of data at facility level and quality control. It is being tested in three districts which are O.R. Tambo, Joe Gqabi and Amathole before it is rolled out to other districts. This strategy has been presented to NDoH and approved as a way forward for other provinces to adopt as well. It is based on the new national health information policy but adapted for Eastern Cape Province. The strategy emphasises the capturing of data at facility level and verification of data at that level; it therefore requires personnel and computer equipment resources to be concentrated at the local level. The Department has developed monitoring mechanisms for the strategy in the form of checklists at every level to ensure that it is monitored throughout the chain of information generation. The strategy also put emphasis on the accountability of managers at every level for information generation and the affirmation of the output. The pillars of the strategy are the strengthening of information at the point of generation, the rationalisation of data collection tools, resourcing of every level of the chain and the monitoring and evaluation of the strategy through auditing.

**OGRESS TOWARDS THE HEALTH RELATED MILLENIUM DEVELOPMENT GOALS (MDG) AND PROGRESS REQUIRED BY TIONS IN 2015**

| GOAL | TARGET | INDICATOR | BASELINE - EASTERN CAPE PROGRESS IN 2004-2009 | SOURCE OF DATA | EASTE REQ PROGRE |
|---|---|---|---|---|---|
| eme Poverty | Halve, between 1990 and 2015, the proportion of people who suffer from hunger | Prevalence of underweight children (under five years) | 0.5 % (11953) of children under 5 are underweight<br><br>29 165 children suffered from malnutrition in 2007 (National). | District Health Information System (DHIS), National DoH, 2008<br>Development Indicators Mid-term Review, published by the Presidency, RSA, 2008 | Not more th children pres health Facilit underweight |
| Mortality | Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate | Under-five mortality rate | 78 per 1000 | South Africa Demographic and Health Survey (SADHS) 2003 | 26 per 1000 |
| | | Infant mortality rate | 67 per 1000 | SADHS 2003 | 22.1 per 100 |
| | | % household with access to safe drinking water and sanitation | 73.2 % | District Health Barometer 2007/08 | 90 %( not in CONTROL) |
| Mortality | Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate | Proportion of one-year-old children immunised against measles | 86.8 % in District Health Information System (DHIS), ECDoH, 2008. | District Health Information System (DHIS), National DoH, 2007 | 100% |

| GOAL | TARGET | INDICATOR | BASELINE - EASTERN CAPE PROGRESS IN 2004-2009 | SOURCE OF DATA | EASTE REQ PROGRE |
|---|---|---|---|---|---|
| rnal Health | Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate | Maternal mortality ratio | 168 per 100,000 in 2011in the EC.<br>147 per 100 000(National) | Saving Mothers Saving Babies (2012 data) | 36,8 per 100 |
| | | Proportion of births attended by skilled health personnel | 86% | SADHS 2003 | 100% |
| | | Visits before 20 weeks | 27.9% | District Health Information System (DHIS), ECDoH, 2008 | |
| nd AIDS, her diseases | Have halted by 2015, and begin to reverse the spread of HIV and AIDS | HIV prevalence among 15-to 24-year-old pregnant women | 29.1 % in 2011 | Eastern Cape HIV and Syphilis Prevalence Survey, 2012 | 9.5 (or less) in prevalenc |
| | Have halted by 2015, and begin to reverse the spread of HIV and AIDS | Contraceptive prevalence rate<br>Women Year Protection Rate | 62.4% | SADHS 2003<br><br>DHIS | 85% |
| | | VCT uptake rate | 80 % | District Health Information System (DHIS), ECDoH, 2008 | |
| | Have halted by 2015, and begin to reverse the incidence of malaria and other major diseases | Proportion of tuberculosis cases detected and cured under directly observed treatment, short-course (DOTS) | 64% | District Health Information System (DHIS), ECDoH, 2008, | 85% |

| GOAL | TARGET | INDICATOR | BASELINE - EASTERN CAPE PROGRESS IN 2004-2009 | SOURCE OF DATA | EASTE REQ PROGRE |
|---|---|---|---|---|---|
| | | TB cue rate | 67.7% in 2011 | District Health Information System (DHIS), ECDoH, 2012 | 78% |
| | | Clients under DOTS. | 90.8 % | District Health Information System (DHIS), ECDoH, 2008 | |
| | | Sputum conversion rate | 56.1 | District Health Information System (DHIS), ECDoH, 2008 | |

### 4.6.1 NATIONAL HEALTH SYSTEMS (NHS) PRIORITIES FOR 2009-2014: THE 10 POINT PLAN

**Table A12: NATIONAL HEALTH SYSTEMS PRIORITIES FOR 2009-2014: (THE 10 POINT PLAN)**

| PRIORITY | KEY ACTIVITIES |
|---|---|
| 1. Provision of Strategic leadership and creation of Social compact for better health outcomes | • Ensure unified action across the health sector in pursuit of common goals |
| | • Mobilize leadership structures of society and communities |
| | • Communicate to promote policy and buy in to support government programs |
| | • Review of policies to achieve goals |
| | • Impact assessment and program evaluation |
| | • Development of a social compact |
| | • Grassroots mobilization campaign |
| 2. Implementation of National Health Insurance (NHI) | • Finalisation of NHI policies and implementation plan |
| | • Immediate implementation of steps to prepare for the introduction of the NHI, e.g. Budgeting, Initiation of the drafting of legislation |
| 3. Improving the Quality of Health Services | • Focus on 18 Health districts |
| | • Refine and scale up the detailed plan on the improvement of Quality of services and directing its immediate implementation |
| | • Consolidate and expand the implementation of the Health Facilities Improvement Plans |
| | • Establish a National Quality Management and Accreditation Body |
| 4. Overhauling the health care system and improving its management | • Identify existing constitutional and legal provisions to unify the public health service;<br>• Draft proposals for legal and constitutional reform |
| | • Draft proposals for legal and constitutional reform |
| | • Development of a decentralised operational model, including new governance arrangements |
| | • Training managers in leadership, management and governance |
| | • Decentralization of management |
| | • Development of an accountability framework for the public and private sectors |
| 5. Improved Human Resources Planning Development and Management | • Refinement of the HR plan for health |
| | • Re-opening of nursing schools and colleges |
| | • Recruitment and retention of professionals, including urgent collaboration with countries that have excess of these professionals |
| | • Specify staff shortages and training targets for the next 5 years |

| PRIORITY | KEY ACTIVITIES |
|---|---|
| | • Make an assessment of and also review the role of the Health Professional Training and Development Grant (HPTDG) and the National Tertiary Services Grant (NTSG) |
| | • Manage the coherent integration and standardisation of all categories of Community Health Workers |
| 6. Revitalization of infrastructure | • Urgent implementation of refurbishment and preventative maintenance of all health facilities |
| | • Submit a progress report on Revitalization |
| | • Assess progress on revitalization |
| | • Review the funding of the Revitalization program and submit proposals to get the participation of the private sector to speed up this program |
| 7. Accelerated implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases | • Implementation of PMTCT, Paediatric Treatment guidelines<br>• Implementation of Adult Treatment Guidelines<br>• Urgently strengthen programs against TB, MDR-TB and XDR-TB |
| 8. Mass mobilisation for the better health for the population | • Intensify health promotion programs |
| | • Strengthen programmes focusing on Maternal, Child and Women's Health |
| | • Place more focus on the programs to attain the Millennium Development Goals (MDGs) |
| | • Place more focus on non-communicable diseases and patients' rights, quality and provide accountability |
| 9. Review of drug policy | • Complete and submit proposals and a strategy, with the involvement of various stakeholders |
| | • Draft plans for the establishment of a State-owned drug manufacturing entity |
| 10. Strengthening Research and Development | • Commission research to accurately quantify Infant mortality |
| | • Commission research into the impact of social determinants of health and nutrition |
| | • Support research studies to promote indigenous knowledge systems and the use of appropriate traditional medicines |

### 4.6.2 PROVINCIAL CONTRIBUTION TOWARDS THE HEALTH SECTOR NEGOTIATED SERVICE DELIVERY AGREEMENT (NSDA)

The government has agreed on 12 key outcomes as the key indicators for its program of action for the period 2010 to 2014. Relevant to the Health Sector in Outcome 2 which prioritise the improvement of the health status of the entire population and therefore contribute to the Government's vision of "A Long and Healthy life for All South Africans" To realise this vision government has identified four strategic outputs which the Health Sector must achieve and these are:

**Output 1:**
Increasing life expectancy

**Output 2:**
Decreasing Maternal and Child mortality

**Output 3:**
Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis

**Output 4:**
Strengthening Health System Effectiveness – with a focus on:

- Revitalisation of Primary Health care
- Health Care financing and Management
- Human Resources for Health
- Quality of Health and the Accreditation of Health Establishments
- Health Infrastructure
- Information, Communication and Technology and Health Information Systems

## PROVINCIAL CONTRIBUTION TOWARDS THE ACHIEVEMENT OF THE FOUR NSDA OUTPUTS

### 1: INCREASING LIFE EXPECTANCY

| AL PRIORITIES | PLANNED PROVINCIAL STRATEGIES AND | STATUS 2012/13 | PROVINCIAL TARGET (2014/15) | NATIONAL (2014/ |
|---|---|---|---|---|
| early detection and of people with ditions and those ance at community social mobilisation of | Diabetes mellitus detection rate | 0.9% (138 710/ 15 412 219) | 1% (154 892/ 15 489 162) | |
| | Hypertension detection rate | 3.0% (462 367/ 15 412 219) | 3.0% (464 675/ 15 489 162) | |
| | Cataract surgery rate | 1027 (6 850/ 6 671 956) | 1030 (6 906/ 6 705 265) | |

### DECREASING MATERNAL AND CHILD MORTALITY

| AL PRIORITIES FOR 2013/14 | PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES | STATUS 2012/13 | PROVINCIAL TARGET (2014/15) | NATIONA (20 |
|---|---|---|---|---|
| d strengthen the mother lth services within the Province | Immunization coverage under 1 year | 85.0% (110 316/ 129 783) | 90% (118 846/ 132 051) | |
| | Infant 1st PCR positive within 2 months rate | 3.2% (615/ 19 214) | 2.8% (568/ 20 303) | |
| | Antenatal visits before 20 weeks rate | 36.0% (53 999/ 149 998) | 42.0% (64 214/ 152 890) | |
| | Cervical cancer screening coverage | 38.2% (51 687/ 1 353 066) | 42.0% (58 320/ 1 388 567) | |
| | Public Health Facility Maternal Mortality | 111/ 100 000 (131/ 117 | 105/100 000 (128/ 121 715) | 270/ 100 000 |
| | Delivery rate for women under 18 years | 10.3% (12 181/ 118 266) | 10.3% (12 432/ 120 700) | |
| | Child under 1 year mortality infanility rate | 50/1000 (1 298/25 954) | 35/1000 (914/ 26 116) | 36/1 000 live |
| | Inpatient death under 5 years rate | 53/1000 (1 540/ 30 793 | 35/ 1000 (1 094/ 31 259) | 50/1 000 live |

## 3: COMBATING HIV AND AIDS AND DECREASING THE BURDEN OF DISEASE FROM TUBERCULOSIS

| AL PRIORITIES FOR 2013/14 | PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES | STATUS 2012/13 | PROVINCIAL TARGET (2014/15) | NATION (20 |
|---|---|---|---|---|
| d reduce the impact of IDS with a special focus the emergence of drug ains. | Total clients remaining on ART (TROA) at the end of the month | 240 000 (51 456 new) | 390 000 (75 new) | 2.5 million |
| | Percentage of TB/HIV co-infected patients started on Cotrimoxazole | 83% (17 610/ 21 217) | 90% (22 214/ 25 243) | |
| | Percentage of TB cases tested for HIV | 85% (51 000/ 60 000) | 90% (54 000/ 60 000 | |
| | Percentage of MDR-TB co-infected patients started on ART | 100% (600/ 600) | 100% (720/ 720) | 85% |
| | TB new client treatment success rate | 77% (16 351/ 21 235) | 82% (17 797/ 22 528) | 85% |
| | TB (new pulmonary) defaulter rate | 7.8% (1680/ 21 500) | 6,5% (1546/ 21477) | <5% |

## 4: STRENGTHENING HEALTH SYSTEM EFFECTIVENESS

### eering the Primary Health Care System

| AL PRIORITIES FOR 2013/14 | PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES | STATUS 2012/13 | PROVINCIAL TARGET (2014/15) | NATIONA (201 |
|---|---|---|---|---|
| t the model for the alth services in Eastern n the Revitalised Primary (PHC) approach by<br><br>ccess to comprehensive Package | Primary Health Care Utilisation Rate | 2.8<br>(18 681 477/6 671 956) | 2.8<br>(18 774 742/ 6705 265) | 3.5 |
| | Number of PHC teams established | 265 | 297 (32 new) | 30% populati target level 7660 perso households |
| | School health service coverage in OR Tambo district | Not measured | 27% (439/ 1625) | 95% Quintile 95% of all Qui |
| | Number of District Specialist Team members (DSTM) established | 11 | 21 | 80% of total gynaecologis team & 100% districts |
| | Percentage of CHCs providing oral health services | 46%<br>(19/ 41) | 48% (20/42) | |
| | Percentage facilities receiving their order supplies from depots within 5 days | 85% | 90% | |

**nproving Patient Care and Satisfaction**

| AL PRIORITIES FOR 2013/14 | PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES | STATUS 2012/13 | PROVINCIAL TARGET (2014/15) | NATION (20 |
|---|---|---|---|---|
| e implementation of nt safety program ffective tion of the National e Standards for Health. | Ensure that the users of Public Health Services highly satisfied with the services received Patient Satisfaction rate | 50% (50 410/ 100 820) - District Hospital users | 65% (66 190/ 101 830) - District Hospital users | 70% |
| | | 50% (6 262/ 10 437) - Regional Hospital users | 65% (6 517/ 10 862)- Regional Hospital users | |
| | | 60% (7 823/ 13 039) - TB Hospital users | 65% (12 568/ 12 568)- TB Hospital users | |
| | | 60% (12 509/ 20849) - Mental Hospital users | 61% (13 304/21 810) - Mental Hospital users | |
| | | 60% (45 263/75 439) - Tertiary Hospital users | 70% (53 210/ 76 014) - Tertiary Hospital users | |

**tion of Health Services Facilities for Compliance**

| AL PRIORITIES FOR 2013/14 | PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES | STATUS 2012/13 | PROVINCIAL TARGET (2014/15) | NATION (20 |
|---|---|---|---|---|
| e implementation of nt safety program ffective tion of the National e Standards for Health. | Assess all the Public Health Facilities for compliance with the core standards | 400 PHC Facilities | 404 PHC Facilities | |
| | | 66 District Hospitals | 66 District Hospitals | |
| | | 3 Regional Hospitals | 2 Regional Hospitals | |
| | | 11 TB Hospitals | 11 TB Hospitals | |
| | | 3 Mental Hospitals | 4 Mental Hospitals | |
| | | 7 Tertiary Hospitals | 7 Tertiary Hospitals | |

**l Health Infrastructure Availability**

| AL PRIORITIES FOR 2013/14 | PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES | STATUS 2012/13 | PROVINCIAL TARGET (2014/15) | NATION (20 |
|---|---|---|---|---|
| nd provide infrastructural ms of the construction of ings and the upgrading of structures for health very, as well as other building requirements. | Renovation of clinics | 144 | 100 | |
| | Upgrading of Clinics, Community Health Centres, District & Tertiary Hospitals | 5 Clinics<br>10 District Hospitals<br>3 TB Hospitals<br>2 Provincial and Tertiary | 34 Clinics<br>50 District Hospitals<br>3 TB Hospitals<br>2 Provincial and Tertiary | |
| | Revitalisation of hospitals | 5 hospitals | 20 hospitals | |
| | Upgrading of water & sanitation plants | 4 | 21 | |
| | Provision of engineering services (electro-mechanical) | 20 Facilities | 114 Facilities | |

**l Human Resources for Health**

| AL PRIORITIES FOR 2013/14 | PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES | STATUS 2012/13 | PROVINCIAL TARGET (2014/15) | NATION (20 |
|---|---|---|---|---|
| % effective HR planning, nd management | Payment of employees exit benefits within 3 months of termination | 80% | 100% | |
| implementation of the d internship (workplace rogrammes. | Intake of nurse students | 1508 | 1930 | Additional 5 |
| | Give bursaries to students from the province to study clinical fields | 1380 | 1380 | |
| | Train Clinical associate students | 60 graduated | 30 | |
| | Train Intermediate Life Support Practitioners | 68 graduated | 68 | |
| | Train Rescue Practitioners | 60 graduated | 60 | |

**ening Financial Management (Monitoring & Evaluation)**

| AL PRIORITIES FOR 2013/14 | PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES | STATUS 2012/13 | PROVINCIAL TARGET (2014/15) | NATION (20 |
|---|---|---|---|---|
| t and institutionalize gement strategy inclusive ancial controls in order e service delivery of the | Proportion of invoices paid within 30 days | 50% | 100% | |
| | Percentage of over expenditure | 2% | 1% | |
| | Number of procurement hubs established | 9 | 14 | |

**g Healthcare Financing Through Implementation of National Health Insurance**

| AL PRIORITIES FOR 2013/14 | PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES | STATUS 2012/13 | PROVINCIAL TARGET (2014/15) | NATION (20 |
|---|---|---|---|---|
| implementation of NHI at least one Health | Amount (Rand value) of revenue generated | R81,394m | R97 981m | |
| | Number of GPs contracted with RPHC programme | 0 | 48 | |

**ening Health Information Systems (Information, Communication and Technology)**

| AL PRIORITIES FOR 2013/14 | PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES | STATUS 2 012/13 | PROVINCIAL TARGET (2014/15) | NATIO TARG |
|---|---|---|---|---|
| t corporate systems to e service delivery the Department. | Number of District Hospitals (Prioritised in RSDP) with reliable connectivity | 18 | 26 | |

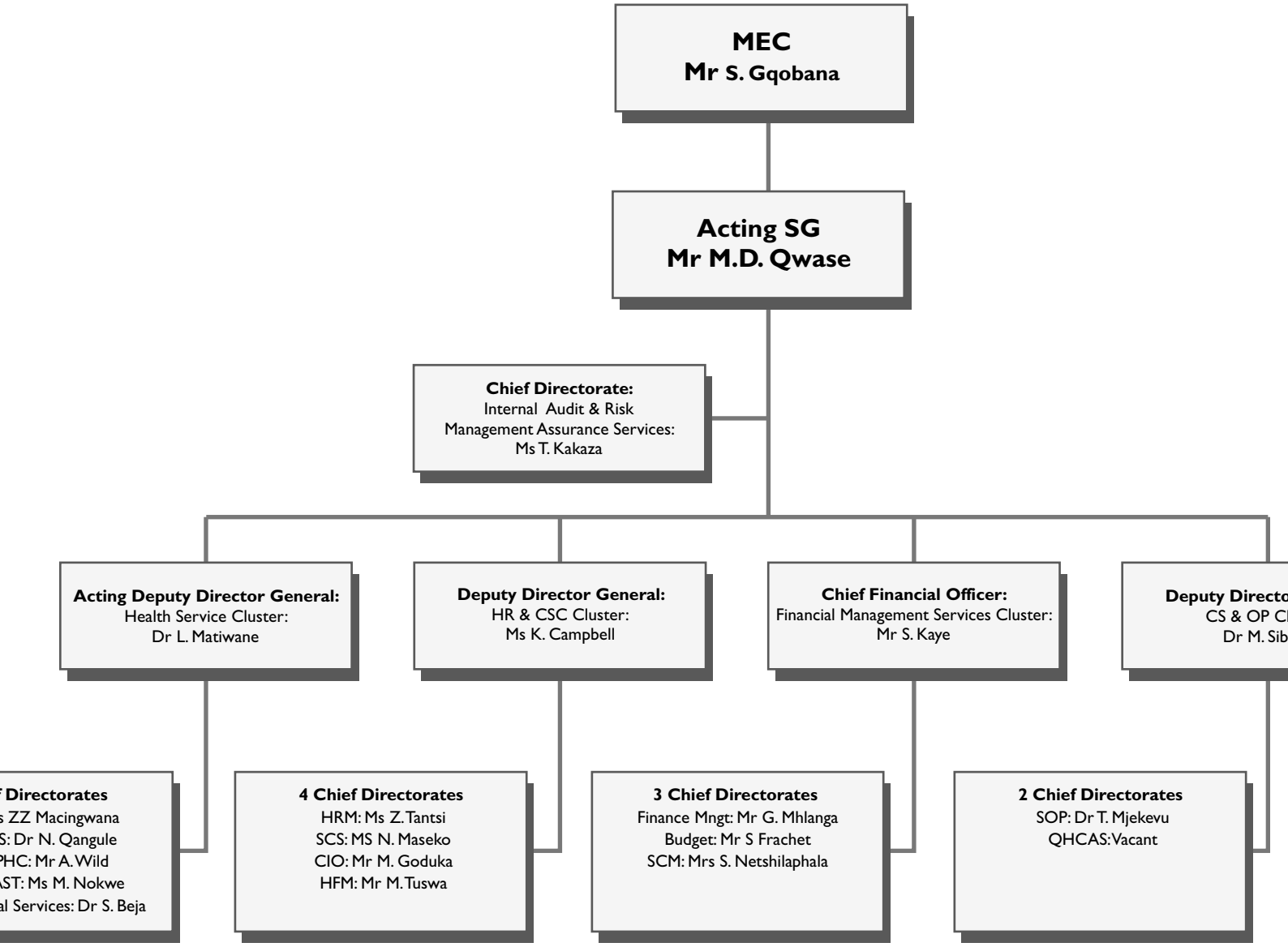
### 4.6.3 PROVINCIAL PRIORITIES

In line with the MTSF, the Eastern Cape Provincial Strategic Framework (PSF) was developed and adopted by the Provincial Executive Council in June 2009. By taking its cue from the MTSF, the province identified eight priorities out of the ten which became the area of focus for the term of office. The Department is aligning it's focus to that of the Province. The eight priorities include inter alia the following:

- Speeding up growth and transforming the economy to create decent work and sustainable livelihoods
- Massive programme to build social and economic infrastructure
- Rural development, land and agrarian reform and food security
- Strengthen Education, skills and human resource base
- Improving the Health profile of the Province
- Intensifying the fight against crime and corruption
- Building a developmental state and improving the public services, and strengthening democratic institutions
- Building cohesive, caring and sustainable communities

## CIAL ORGANISATIONAL ENVIRONMENT

**nary of the Organizational structure at Head Office Level**



In its current state, the organization structure of the ECDoH seems very unstable in view of certain key management positions currently standing vacant and occupied by officials in acting capacity i.e. Head of Department (level 16), DDG: Clinical Services (level 15) and four (4) out of five (5) Chief Directors in the clinical services cluster also in acting positions. On the other hand, a total of seven (7) senior management positions (SMS) are occupied by contract staff albeit the posts are permanent on the staff establishment. Although the Department is working towards stabilising by means of permanent appointments, however it is hamstrung by the on-going organogram review which may impact on the future make-up of some of the positions. The rest of the department has relative stability in that one more DDG: HR and Corporate Services has been appointed thereby strengthening the top echelon of the Department's management. The have been are fewer or no senior /critical positions filled in an acting capacity. The situation is exacerbated by the organogram review process which is yet to be finalized, and out of which certain key components and position may be realigned. Conclusion of this process is depended on some nationally driven processes such as the generic structure model for public health services driven by the National Department of Health and the Department for Public Service and Administration (DPSA).

At the commencement of the financial year 2012/'13, the Department's budget for cost of employment (COE) was pressurized by an amount of R570 million arising from obligations such as HR accruals, provincialisation of PHC clinics, intake and absorption of internship and community service professionals, and the general annual salary adjustments. The situation is exacerbated by the continuing general shrinkage in financial resources in government, which worsens staff shortages of critical skills in the public health sector. As a result, there is an abnormally high staff vacancy rate in respect of clinical and clinical support staff

The rural nature of the province makes it difficult to attract and retain health professionals despite the introduction of the OSD, Rural Allowance, etc. As a result, the department had a vacancy rate of approximately 47.43%, before the June 2012 abolishment of unfunded vacant posts, and 11.66% after abolishment. In the clinical occupations needed to render healthcare services, the vacancy rate pre-abolishment was 56.98% and post-abolishment 14.20%.

Apart from the vastness, rural nature and unattractiveness of the province the department has a serious problem of underfunding of its organogram. The current COE budget indicator for the 2013/2014 financial year is R11 036 million, whereas the actual amount needed to fund the Post-Abolishment Establishment is R 10 016 million. The Pre-Abolishment Establishment fund required to fill the approved establishment is R 17 314 million. (Fig 1.3 c)

**Fig 12 Vacancy Rate, Pre- and Post - Abolishment of vacancies**

| Category | | Pre-Abolishment (March 2012) | | | | Post-Abolishment (November 2012) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Post Occ Classification Description | Fill | Vac | Vac % | Tot | Fill | Vac | Vac % | Tot | Diff |
| Clinical Staff | Ambulance And Related Workers | 1917 | 4932 | 72.01% | 6849 | 1873 | 47 | 2.45% | 1920 | 69.56% |
| | Chemists | 1 | 2 | 66.67% | 3 | 1 | 0 | 0.00% | 1 | 66.67% |
| | Dental Practitioners | 100 | 219 | 68.65% | 319 | 93 | 17 | 15.45% | 110 | 53.20% |
| | Dental Specialists | 0 | 1 | 100.00% | 1 | 0 | 0 | 0.00% | 0 | 100.00% |
| | Dental Therapy | 17 | 106 | 86.18% | 123 | 16 | 2 | 11.11% | 18 | 75.07% |
| | Dieticians and Nutritionists | 113 | 319 | 73.84% | 432 | 107 | 13 | 10.83% | 120 | 63.01% |
| | Emergency Services Related | 3 | 0 | 0.00% | 3 | 3 | 0 | 0.00% | 3 | 0.00% |
| | Environmental Health | 101 | 29 | 22.31% | 130 | 85 | 23 | 21.30% | 108 | 1.01% |
| | Medical Practitioners | 1325 | 1283 | 49.19% | 2608 | 1275 | 321 | 20.11% | 1596 | 29.08% |
| | Medical Specialists | 214 | 289 | 57.46% | 503 | 197 | 44 | 18.26% | 241 | 39.20% |
| | Nursing Assistants | 6029 | 4311 | 41.69% | 10340 | 5867 | 648 | 9.95% | 6515 | 31.75% |
| | Occupational Therapy | 103 | 216 | 67.71% | 319 | 98 | 13 | 11.71% | 111 | 56.00% |
| | Optometrists And Opticians | 12 | 34 | 73.91% | 46 | 11 | 2 | 15.38% | 13 | 58.53% |
| | Oral Hygiene | 19 | 104 | 84.55% | 123 | 16 | 3 | 15.79% | 19 | 68.76% |
| | Pharmacists | 341 | 420 | 55.19% | 761 | 367 | 43 | 10.49% | 410 | 44.70% |
| | Physicists | 2 | 3 | 60.00% | 5 | 4 | 0 | 0.00% | 4 | 60.00% |
| | Physiotherapy | 124 | 234 | 65.36% | 358 | 117 | 20 | 14.60% | 137 | 50.76% |
| | Professional Nurse | 9904 | 16325 | 62.24% | 26229 | 9583 | 242 | 20.17% | 12005 | 42.07% |
| | Psychologists And Vocational Counsellors | 62 | 110 | 63.95% | 172 | 60 | 4 | 6.25% | 64 | 57.70% |
| | Radiography | 363 | 363 | 50.00% | 726 | 362 | 15 | 3.98% | 377 | 46.02% |
| | Social Work And Related Professionals | 124 | 249 | 66.76% | 373 | 121 | 10 | 7.63% | 131 | 59.12% |
| | Speech Therapy And Audiology | 52 | 208 | 80.00% | 260 | 50 | 3 | 5.66% | 53 | 74.34% |
| | Staff Nurses And Pupil Nurses | 3296 | 451 | 24 | 5.05% | 3266 | 250 | 7.11% | 3516 | 38.65% |
| | Student Nurse | 1037 | 254 | 18 | 6.62% | 990 | 166 | 14.36% | 1156 | 32.84% |
| | Supplementary Diagnostic Radiographers | 13 | 14 | 1 | 6.67% | 13 | 0 | 0.00% | 13 | 48.00% |
| **C Total** | | 2527 | 33477 | 56.98% | 58749 | 2457 | 406 | 14.20% | 28641 | 42.79% |

| Category | Post Occ Classification Description | Pre-Abolishment (March 2012) | | | | Post-Abolishment (November 2012) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Fill | Vac | Vac % | Tot | Fill | Vac | Vac % | Tot | Diff |
| Clinical Support | Auxiliary And Related Workers | 1254 | 1436 | 53.38% | 2690 | 1179 | 213 | 15.30% | 1392 | 38.08% |
| | Boiler And Related Operators | 75 | 15 | 16.67% | 90 | 71 | 4 | 5.33% | 75 | 11.33% |
| | Dental Technicians | 1 | 2 | 66.67% | 3 | 2 | 0 | 0.00% | 2 | 66.67% |
| | Health Sciences Related | 758 | 122 | 13.86% | 880 | 723 | 40 | 5.24% | 763 | 8.62% |
| | Medical Technicians/Technologists | 19 | 3 | 13.64% | 22 | 15 | 4 | 21.05% | 19 | -7.42% |
| **Cs Total** | | **2107** | **1578** | **42.82%** | **3685** | **1990** | **261** | **11.59%** | **2251** | **31.23%** |
| Non-Clinical Support | Administrative Related | 453 | 75 | 14.20% | 528 | | | | 475 | 9.15% |
| | All Artisans In The Building Metal Machinery Etc. | 270 | 88 | 24.58% | 358 | | | | 272 | 17.96% |
| | Artisan Project And Related Superintendents | 12 | 5 | 29.41% | 17 | | | | 15 | 22.75% |
| | Building And Other Property Caretakers | 67 | 14 | 17.28% | 81 | 63 | 6 | 8.70% | 69 | 8.59% |
| | Bus And Heavy Vehicle Drivers | 7 | 2 | 22.22% | 9 | 6 | 1 | 14.29% | 7 | 7.94% |
| | Civil Engineering Technicians | 1 | 0 | 0.00% | 1 | 1 | 0 | 0.00% | 1 | 0.00% |
| | Cleaners In Offices Workshops Hospitals Etc. | 4952 | 673 | 11.96% | 5625 | 4776 | 317 | 6.22% | 5093 | 5.74% |
| | Client Inform Clerks(Switchb Recept Inform Clerks) | 286 | 20 | 6.54% | 306 | 274 | 17 | 5.84% | 291 | 0.69% |
| | Communication And Information Related | 74 | 14 | 15.91% | 88 | 74 | 0 | 0.00% | 74 | 15.91% |
| | Computer Programmers. | 1 | 0 | 0.00% | 1 | 1 | 0 | 0.00% | 1 | 0.00% |
| | Electrical And Electronics Engineering Technicians | 10 | 5 | 33.33% | 15 | 10 | 1 | 9.09% | 11 | 24.24% |
| | Engineering Sciences Related | 4 | 0 | 0.00% | 4 | 4 | 0 | 0.00% | 4 | 0.00% |
| | Engineers And Related Professionals | 8 | 4 | 33.33% | 12 | 8 | 0 | 0.00% | 8 | 33.33% |
| | Finance And Economics Related | 192 | 35 | 15.42% | 227 | 190 | 13 | 6.40% | 203 | 9.01% |
| | Financial And Related Professionals | 92 | 25 | 21.37% | 117 | 91 | 4 | 4.21% | 95 | 17.16% |
| | Financial Clerks And Credit Controllers | 502 | 71 | 12.39% | 573 | 486 | 21 | 4.14% | 507 | 8.25% |
| | Fire Fighting And Related Workers | 5 | 68 | 93.15% | 73 | 5 | 0 | 0.00% | 5 | 93.15% |

| Category | | Pre-Abolishment (March 2012) | | | | Post-Abolishment | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Post Occ Classification Description | Fill | Vac | Vac % | Tot | Fill | Vac | Vac % | Tot | Dif |
| Non-Clinical Support | Food Services Aids And Waiters | 896 | 163 | 15.39% | **1059** | 847 | 63 | 6.92% | **910** | 8.47% |
| | General Legal Administration & Rel. Professionals | 0 | 2 | 100.00% | **2** | 0 | 0 | 0.00% | **0** | 100.00% |
| | Head Of Department/Chief Executive Officer | 11 | 8 | 42.11% | **19** | 10 | 4 | 28.57% | **14** | 13.53% |
| | Household And Laundry Workers | 980 | 182 | 15.66% | **1162** | 966 | 55 | 5.39% | **1021** | 10.28% |
| | Household Food And Laundry Services Related | 4 | 1 | 20.00% | **5** | 3 | 1 | 25.00% | **4** | -5.00% |
| | Housekeepers Laundry And Related Workers | 45 | 15 | 25.00% | **60** | 46 | 0 | 0.00% | **46** | 25.00% |
| | Human Resources & Organisat Developm & Relate Prof | 81 | 14 | 14.74% | **95** | 78 | 4 | 4.88% | **82** | 9.86% |
| | Human Resources Clerks | 325 | 37 | 10.22% | **362** | 314 | 14 | 4.27% | **328** | 5.95% |
| | Human Resources Related | 178 | 23 | 11.44% | **201** | 169 | 16 | 8.65% | **185** | 2.79% |
| | Information Technology Related | 22 | 2 | 8.33% | **24** | 22 | 0 | 0.00% | **22** | 8.33% |
| | Inspectors Of Apprentices Works And Vehicles | 5 | 1 | 16.67% | **6** | 5 | 0 | 0.00% | **5** | 16.67% |
| | Language Practitioners Interpreters & Other Commun | 58 | 9 | 13.43% | **67** | 56 | 3 | 5.08% | **59** | 8.35% |
| | Librarians And Related Professionals | 3 | 1 | 25.00% | **4** | 3 | 0 | 0.00% | **3** | 25.00% |
| | Library Mail And Related Clerks | 109 | 16 | 12.80% | **125** | 106 | 6 | 5.36% | **112** | 7.44% |
| | Light Vehicle Drivers | 198 | 33 | 14.29% | **231** | 188 | 6 | 3.09% | **194** | 11.19% |
| | Logistical Support Personnel | 98 | 15 | 13.27% | **113** | 95 | 6 | 5.94% | **101** | 7.33% |
| | Material-Recording And Transport Clerks | 290 | 38 | 11.59% | **328** | 284 | 13 | 4.38% | **297** | 7.21% |
| | Messengers Porters And Deliverers | 901 | 127 | 12.35% | **1028** | 904 | 99 | 9.87% | **1003** | 2.48% |
| | Motor Vehicle Drivers | 40 | 3 | 6.98% | **43** | 43 | 1 | 2.27% | **44** | 4.70% |
| | Other Administrat & Related Clerks And Organisers | 1494 | 184 | 10.97% | **1678** | 1488 | 184 | 11.00% | **1672** | -0.04% |
| | Other Administrative Policy And Related Officers | 376 | 52 | 12.15% | **428** | 368 | 18 | 4.66% | **386** | 7.49% |
| | Other Information Technology Personnel. | 80 | 11 | 12.09% | **91** | 77 | 4 | 4.94% | **81** | 7.15% |

| Category | Post Occ Classification Description | Pre-Abolishment (March 2012) | | | | Post-Abolishment (November 2012) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Fill | Vac | Vac % | Tot | Fill | Vac | Vac % | Tot | Diff |
| Non-Clinical Support | Other Occupations | 1 | 0 | 0.00% | **1** | 1 | 0 | 0.00% | **1** | 0.00% |
| | Risk Management And Security Services | 4 | 0 | 0.00% | **4** | 4 | 0 | 0.00% | **4** | 0.00% |
| | Road Workers | 2 | 1 | 33.33% | **3** | 2 | 0 | 0.00% | **2** | 33.33% |
| | Safety Health And Quality Inspectors | 23 | 12 | 34.29% | **35** | 25 | 1 | 3.85% | **26** | 30.44% |
| | Secretaries & Other Keyboard Operating Clerks | 322 | 59 | 15.49% | **381** | 317 | 12 | 3.65% | **329** | 11.84% |
| | SECURITY GUARDS | 5 | 0 | 0.00% | **5** | 5 | 0 | 0.00% | **5** | 0.00% |
| | SENIOR MANAGERS | 144 | 43 | 22.99% | **187** | 136 | 12 | 8.11% | **148** | 14.89% |
| | SHOEMAKERS | 15 | 6 | 28.57% | **21** | 15 | 0 | 0.00% | **15** | 28.57% |
| | TRADE LABOURERS | 299 | 66 | 18.08% | **365** | 287 | 26 | 8.31% | **313** | 9.78% |
| | TRADE RELATED | 0 | 0 | 0.00% | **0** | 1 | 0 | 0.00% | **1** | 0.00% |
| | WORK PLANNERS | 1 | 0 | 0.00% | **1** | 1 | 0 | 0.00% | **1** | 0.00% |
| **Nc Total** | | **1394** | **2223** | **13.75%** | **16169** | **1357** | **971** | **6.68%** | **14545** | **7.07%** |
| **Grand Total** | | **4132** | **37278** | **47.43%** | **78603** | **4013** | **529** | **11.66%** | **45437** | **35.77%** |

The abolishment of posts in June 2012 as represented above was, by and large, an arbitrary exercise in that it was based on a narrow question of funded vs unfunded posts. Where the post was funded it was kept, and if not abolished. In this way, the department did not have the opportunity to scientifically determine which of the posts, despite being unfunded, it would have kept in the interests of service delivery and how they would be financed in order to be filled. Therefore, the shrinkage of up to 43% in clinical posts and 31% in clinical support areas may have been futile as many of these positions are being re-activated as the impact on service is dire.

**Fig 13 Establishment Status per Nature of Appointment**

**Nature of Appointment Breakdown**

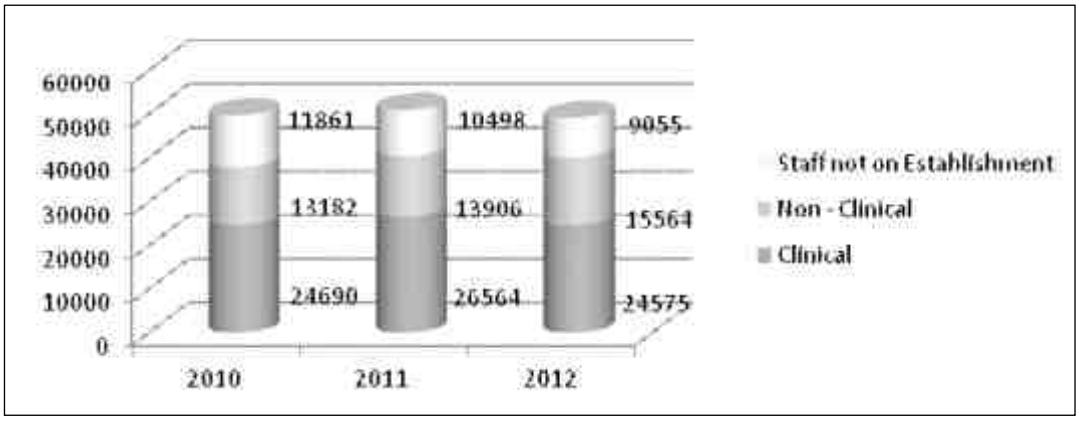
| Description | NOA | 2010 | 2011 | 2012 |
|---|---|---|---|---|
| Fixed establishment | Permanent, Probation, Temporary, Contract, Part time, Political | 37872 | 40470 | 40299 |
| Session & Casual | Session, Casual | 402 | 347 | 289 |
| Abnormal | Periodic, Abnormal | 9465 | 9058 | 8606 |
| Contract not on Fixed Establishment | Contract | 1994 | 1093 | 0 |
| **Total Staff** | | **49733** | **50968** | **49194** |

**Fig 14 Establishment Status per Functional Area**

**Establishment Status per Functional Area**

| CAT | 2010 | 2011 | 2012 |
|---|---|---|---|
| Clinical | 24690 | 26564 | 24575 |
| Non – Clinical | 13182 | 13906 | 15564 |
| Sub Total | 37872 | 40470 | 40139 |
| Staff not on Establishment (Abnormal) | 11861 | 10498 | 9055 |
| **Grand Total** | **49733** | **50968** | **49194** |

This table is similar to 1.2 above. All it does is represent the establishment according to functional area or occupational category. Again, it delineates the fixed establishment from abnormal appointments, often appointed against grants and/or goods and services.




This table simply provides a graphic illustration of the same establishment status report demonstrating the trends in fluctuating numbers in terms of the broad categories of clinical, non-clinical and abnormal appointments (staff not on the establishment). As can be seen, in 2012, figures came down drastically due to the abolishment of unfunded vacancies in 2012.

| | PRE-ABOLISHMENT | | | POST-ABOLISHMENT | | |
|---|---|---|---|---|---|---|
| Cat | Filled ('000) | Vacant ('000) | Grand Total ('000) | Filled ('000) | Vacant ('000) | Grand Total ('000) |
| Clinical | R 5 953 807.00 | R 8 209 237.24 | **R 14 163 044.24** | R 6 156 | R 1 048 673.50 | R 7 205 460.70 |
| Corporate Services | R 535 738.79 | R 247 996.18 | **R 783 734.97** | R 543 122.47 | R 52 284.45 | R 595 406.92 |
| Non-Clinical | R 2 061 137.76 | R 306 683.06 | **R 2 367 820.82** | R 2 082 | R 132 856.99 | R 2 215 183.61 |
| **Grand Total** | **R 8 550 683.55** | **R 8 763 916.48** | **R 17 314 600.03** | **R 8 782 236.28** | **R 1 233 814.94** | **R 10 016 051.23** |

This table shows the difference in cost pre and post establishment abolishment. As it can been seen, the pre-abolishment structure was more expensive than the current

## ABSENTEEISM 2012/2013

### LEAVE PER FUNCTIONAL AREA

| Category | Nr Staff | Days | Cost |
|---|---|---|---|
| Admin | 4973 | 159377.16 | R 97 570 848.77 |
| Clinical | 3577 | 97163.48 | R 105 510 880.42 |
| Clinical Support | 1559 | 45281.87 | R 16 869 529.15 |
| Ems | 1700 | 40112.76 | R 18 183 619.47 |
| General Worker | 7384 | 210520.33 | R 60 452 188.73 |
| Nursing | 19513 | 568299.7 | R 387 620 873.10 |
| SMS | 92 | 1880 | R 3 296 415.00 |
| Tech | 320 | 9097.58 | R 5 216 749.43 |
| **Grand Total** | **39118** | **1131732.88** | **R 694 721 104.07** |

This table provides a leave analysis of all types of leave per occupational class taken during the year with actual cost to the employer. The amount of man hours and rand value is obviously influence by the number of affected employees.

### LEAVE PER LEAVE CATEGORY

| Leave Category | Nr Staff | Days | Cost |
|---|---|---|---|
| Adoption/Surrogacy | 1 | 103 | R 152 726.40 |
| Discounting | 207 | 8742.36 | R 5 767 884.73 |
| Family Responsibility | 1867 | 22121 | R 13 495 223.35 |
| Gratuity | 82 | 10095.21 | R 7 401 240.53 |
| Leave Without Pay | 706 | 10882 | R 4 164 273.74 |
| Maternity | 283 | 70107 | R 39 598 043.84 |
| Occu Injury/Diseases | 27 | 1497 | R 783 498.90 |
| Perm Incapacity | 7 | 1012 | R 717 606.19 |
| Shop Steward/Off Bea | 119 | 1830 | R 982 587.61 |
| Sick-Full | 6245 | 178456.5 | R 106 919 848.95 |
| Special | 661 | 15153 | R 12 681 274.12 |
| Temp Incapacity | 280 | 30371 | R 19 619 083.09 |
| Vacation-Full | 28633 | 781362.81 | R 482 437 812.62 |
| **Grand Total** | **39118** | **1131732.88** | **R 694 721 104.07** |

This table provides a further break-down per type of leave taken during the period. As is expected, the biggest leave type taken is vacation leave, which may have a positive spin-off in terms of reduction of employer contigent liability. The second worrying trend relates to sick and incapacity leave, which may require the strengthening of integrated employee wellness programmes to further probe the causal effect.

## STAFF TURNOVER 2012/2013

| Occupational Classification Description | Exited Department | Joined Department | Rat |
|---|---|---|---|
| Administrative Related | 48 | 22 | -26 |
| All Artisans In The Building Metal Machi | 12 | 0 | -12 |
| Ambulance And Related Workers | 35 | 1 | -34 |
| Artisan Project And Related Superintendent | 2 | 1 | -1 |
| Auxiliary And Related Workers | 53 | 1 | -52 |
| Biochemistry Pharmacol. Zoology & Life S | 1 | 0 | -1 |
| Boiler And Related Operators | 2 | 0 | -2 |
| Building And Other Property Caretakers | 5 | 0 | -5 |
| Bus And Heavy Vehicle Drivers | 1 | 0 | -1 |
| Chemists | 4 | 0 | -4 |
| Cleaners In Offices Workshops Hospitals | 215 | 149 | -66 |
| Client Inform Clerks(Switch& Receipt Info | 4 | 0 | -4 |
| Conservation Labourers | 1 | 0 | -1 |
| Dental Practitioners | 21 | 11 | -10 |
| Dental Therapy | 1 | 0 | -1 |
| Dieticians And Nutritionists | 24 | 20 | -4 |
| Electrical And Electronics Engineering T | 1 | 0 | -1 |
| Emergency Services Related | 1 | 0 | -1 |
| Environmental Health | 35 | 1 | -34 |
| Farm Hands And Labourers | 2 | 0 | -2 |
| Finance And Economics Related | 3 | 1 | -2 |
| Financial And Related Professionals | 3 | 2 | -1 |
| Financial Clerks And Credit Controllers | 4 | 0 | -4 |

| Occupational Classification Description | Exited Department | Joined Department | Rate |
|---|---|---|---|
| Fire Fighting And Related Workers | 1 | 0 | -1 |
| Food Services Aids And Waiters | 36 | 0 | -36 |
| Head Of Department/Chief Executive Offic | 2 | 2 | 0 |
| Health Sciences Related | 40 | 4 | -36 |
| Household And Laundry Workers | 60 | 7 | -53 |
| Housekeepers Laundry And Related Workers | 2 | 0 | -2 |
| Human Resources & Organisat Developm & R | 1 | 0 | -1 |
| Human Resources Clerks | 10 | 0 | -10 |
| Human Resources Related | 20 | 2 | -18 |
| Language Practitioners Interpreters & Ot | 1 | 0 | -1 |
| Library Mail And Related Clerks | 2 | 0 | -2 |
| Light Vehicle Drivers | 11 | 0 | -11 |
| Logistical Support Personnel | 2 | 0 | -2 |
| Material-Recording And Transport Clerks | 7 | 1 | -6 |
| Medical Practitioners | 358 | 271 | -87 |
| Medical Specialists | 33 | 11 | -22 |
| Medical Technicians/Technologists | 3 | 0 | -3 |
| Messengers Porters And Deliverers | 20 | 20 | 0 |
| Motor Vehicle Drivers | 2 | 8 | 6 |
| Nursing Assistants | 220 | 61 | -159 |
| Occupational Therapy | 47 | 32 | -15 |
| Optometrists And Opticians | 2 | 0 | -2 |
| Oral Hygiene | 1 | 0 | -1 |
| Other Administrative & Related Clerks And O | 24 | 48 | 24 |

| Occupational Classification Description | Exited Department | Joi ned | |
|---|---|---|---|
| Other Administrative Policy And Related | 17 | 12 | -5 |
| Other Information Technology Personnel. | 2 | 0 | -2 |
| Other Occupations | 16 | 0 | -16 |
| Pharmacists | 66 | 46 | -20 |
| Physicists | 2 | 0 | -2 |
| Physiotherapy | 48 | 44 | -4 |
| Professional Nurse | 496 | 347 | -149 |
| Psychologists And Vocational Counsellors | 26 | 0 | -26 |
| Radiography | 43 | 33 | -10 |
| Safety Health And Quality Inspectors | 1 | 1 | 0 |
| Secretaries & Other Keyboard Operating C | 11 | 2 | -9 |
| Security Officers | 1 | 0 | -1 |
| Senior Managers | 9 | 2 | -7 |
| Social Sciences Supplementary Workers | 1 | 0 | -1 |
| Social Work And Related Professionals | 3 | 0 | -3 |
| Speech Therapy And Audiology | 15 | 11 | -4 |
| Staff Nurses And Pupil Nurses | 156 | 86 | -70 |
| Student Nurse | 13 | 0 | -13 |
| Supplementary Diagnostic Radiographers | 3 | 0 | -3 |
| Trade Labourers | 8 | 1 | -7 |
| **Grand Total** | **2320** | **1261** | **-1 059** |

The table illustrates the turn-over rate in terms of occupational category. As it can deduced, critical health professional categories stand at more than 60% posts that were not filled during 2012/'13 as compared to terminations during the same period. The same trend, of non-replacement can be seen even in support positions (most of which were abnormal appointments).

**STAFF TURNOVER PER NATURE OF APPOINTMENT 2012/2013**

| NOA DESCRIPTION | EXITED DEPT | JOINED DEPT | RATE |
|---|---|---|---|
| Permanent | 1600 | 860 | -740 |
| Contract | 667 | 401 | -266 |
| Temporary | 4 | 0 | -4 |
| Session | 49 | 0 | -49 |
| **Grand Total** | **2320** | **1261** | **-1 059** |

The above table illustrates that slightly more than 38% of those employees that exited the system are abnormal appointees, which is a trend in keeping with the move towards more fixed positions than abnormal appointments. It also confirms the view that the work-force is generally aged and through attrition, they exiting the system more than they are available to join the Department. With respect to many health professionals, this is due to the general mobility of this category and competition between public and private health sector.

## 4.8 LEGISLATIVE MANDATES

In carrying out its functions, the Department is governed mainly by the Acts and regulations that are listed below.

- Aged Persons Act, 81 of 1967
- Allied Health Professions Act, 63 if 1982
- Annual Division of Revenue Act
- Atmospheric Pollution Prevention Act, 45 of 1965
- Basic Conditions of Employment Act (Act No. 75 of 1997)
- Births and Deaths Registration Act, 51 of 1992
- Broad Based Black Economic Empowerment Act, 53 of 2003
- Child Care Act, 74 of 1983
- Children's Act, 30 of 2005
- Chiropractors, Homeopaths and Allied Health Service Professions Act, 63 of 1982
- Choice of Termination of Pregnancy Act (Act No. 92 of 1996, as amended)
- Compensation for Occupational Injuries and Diseases Act, 130 of 1993
- Constitution of the Republic of South Africa, 1996
- Correctional Services Act, 8 of 1959
- Criminal Procedure Act, 51 of 1977
- Dental Technicians Act, 19 of 1979
- Division of Revenue Act (Annually)
- Domestic Violence Act, 116 of 1998
- Drugs and Drug Trafficking Act, 140 of 1992
- Eastern Cape Health Act
- Employment Equity Act, 55 of 1998
- Environment Conservation Act, 73 of 1998
- Foodstuffs, Cosmetics and Disinfectants Act, 54 of 1972
- Government Immovable Asset Management Act, 19 of 2007
- Hazardous Substances Act, 15 of 1973
- Health Act, 63 of 1977
- Health Donations Fund Act, 11 of 1978
- Health Professions Act (Act No. 56 of 1974)
- Higher Education Act, 101 of 1997
- Human Tissue Act (Act No. 65 of 1983)
- Inquests Act, 58 of 1959
- Intergovernmental Relations Framework, Act 13 of 2005
- International Health Regulations Act, 28 of 1974
- Labour Relations Act (Act No. 66 of 1995)
- Local Government: Municipal Demarcation Act, 27 of 1998
- Local Government: Municipal Systems Act, 32 of 2000
- Medical Schemes Act, 131 of 1997
- Medicines and Related Substances Act (Act No. 101 of 1965, as amended)
- Medicines and Related Substances Control Amendment Act, 90 of 1997
- Mental Health Care Act (Act No. 17 of 2002)
- National Health Act (Act No. 61 of 2003)
- National Health Laboratories Services Act (Act No. 37 of 2000)
- Non-Profit Organisations Act, 71 of 1977

- Nuclear Energy Act, 46 of 1999
- Nursing Act (Act No. 33 of 2005)
- Occupational Health and Safety Act (Act No. 85 of 1993)
- Pharmacy Act (Act No. 53 of 1974, as amended)
- Preferential Procurement Policy Framework Act (Act No. 5 of 2000)
- Prevention and Treatment of Drug Dependency Act, 20 of 1992
- Promotion of Access to Information Act, 2 of 2000
- Promotion of Administrative Justice Act, 3 of 2000
- Promotion of Equality and Prevention of Unfair Discrimination Act, 4 of 2000
- Protected Disclosures Act, 26 of 2000
- Public Finance Management Act (Act No. 1 of 1999, as amended) and the Treasury Regulations
- Public Service Act (Act No. 103 of 1994) and the Public Service Regulations
- Road Accident Fund Act, 56 of 1996
- Sexual Offences Act, 23 of 1957
- Skills Development Act (Act No. 97 of 1998)
- Skills Development Levies Act, 9 of 1999
- South African Medical Research Council Act, 58 of 1991
- South African Police Services Act, 68 of 1978
- State Information Technology Agency Act, 88 of 1998
- Sterilisation Act, 44 of 1998
- The Constitution of the Republic of South Africa (Act No. 108 of 1996)
- Traditional Health Practitioners Act (Act No. 35 of 2004)
- Tobacco Products Control Act, 83 of 1993

## 4.9 OVERVIEW OF THE 2013/14 BUDGET AND MTEF ESTIMATES

**Include narrative analysis which could include the following:**

### Resource trends over the past 3 years

The Departments average annual real growth in its budget in the period 2009/10 - 2012/13 was 5.3%. It is historically known that the Department of Health has been under severe financial pressure over several years, with an estimated adverse financial position of R2.98 billion at the beginning of the financial year.

Unauthorised expenditure as at 31 March 2012 amounted to R1.31 billion and is cumulative from the 2009/10 – 2011/12 financial years.

This situation has been caused by inter alia, the magnitude of its current service delivery platform, the growth in the burden of disease provincially, the top slicing of its budgets, various unfunded and underfunded mandates (due to HROPT and OSD), cumulative past year's accruals as well as limitations in the adequate management of its cost of employment.

To address most of these challenges, the department has confirmed the centrality of government-driven transformation with financial resources that are directed to the neediest areas in terms of services.

Whilst there's general increase in the demand for public health services and escalating medical inflationary costs, the department had the responsibility to maintain its service delivery commitments and implement policy shifts imperatives. Various strategies to mitigate these risks included reprioritization of the infrastructure development and maintenance program budget and implementation of stringent prudent and financial discipline to sustain service delivery.

The department has continued to work closely with the National Department of Health and Provincial Treasury to find solutions to this challenge and has been deeply involved in extensive turnaround processes. Accordingly, the baseline realignment exercise is currently in progress with various turnaround implementation plans. The impact thereof is still a work in progress (with the impact yet to be quantified on the MTEF).

For its part, the Department continues to seek solutions (including the reversals of irregular HROPT promotions which will yield up-to R32m in savings); enforcing belt-tightening measures as part of the provincial austerity measures; as well as driving turnaround initiatives as part of the general crusade of getting all staff to go back to basics, and enforce the provincial strategy on public sector transformation through culture change.

### Projected Financial Outcome – 2012/13

The projected financial outcome to the end of the financial year is that the Department will have severe budget pressures in its Goods & Services of R674 million, of which R574 million relates to Non-Negotiable items including inter alia medical supplies including dry dispensary (R15 million), medicines (R218 million), medical waste (R0,7 million), laboratory services (R120 million), blood supply and services (R42 million), childrens' vaccines (R104 million) and HIV and Aids (R74 million).

The Department has continued services uninterrupted, to date - by allowing Medsas interfacing against zero budget balances to continue unhindered, with S43 virements or fund shifts to be processed closer to year end and/or carrying the adverse financial impact when accruals become the 1st cut of 2013/14 budget.

There will be an underspend in the Cost of Employment of approximately R235 million, which has primarily arisen as a result of the rate of terminations exceeding the rate of re-appointment as well as reprioritization in the budget adjustments estimate.

The net impact of the discussion above is that there will be a potential net overspend of R439 million in the current financial year (2. 8% of Adjusted Budget).

With regards to the overall financial position of the Department, a combined over expenditure of up to R439 million (modified cash basis) is estimated for the 2012/13 financial year - with compensation of employees not projected to over spend and goods and services byR439 million (modified cash basis). The projected over expenditure is reported as such in terms of section 39 (2) (b) of the Public Finance Management Act 1 of 1999, as amended.

The extent to which the department is able to carry accruals into the 2013/14 financial year will determine the final value of the estimated over spend on goods and services.

### Focus on levels of funding and sustainability of Health services

#### Changes from new Census Data

The 2011 census data has resulted in the equitable share portion for the Department decreasing by (R145.528 million), (R301.442 million) and (R517.715 million) respectively over the 2013 MTEF period, reflecting a total reduction of (R964, 685 million).

To cater for the more than anticipated percentage increases in the Improvements in the conditions of service (ICS), the provincial equitable has been increased by R428.924 million in 2013/14, R372.893 billion in 2014/15 and R522.034 billion in 2015/16 financial years.

#### Funding implications of current trends of service volumes

The total allocation received by the Eastern Cape Department of Health in 2012/13 is R15.16 billion. This represents an increase of R353.47 million or 2.39% from the 2011/12 adjusted appropriation of R14.81 billion. With inflation taken into consideration, the budget has in fact decreased by 1.15%.

The majority of the Department's budget has been allocated towards the Compensation of Employees (CoE) with an allocation of R 9.79 billion which represents 64.5% of the total budget.

The 2012/13 CoE budget experiences a 6.6% nominal increase and a 2.92% real increase from the 2011/12 adjusted budget of R9.18 billion.

Not only does underfunding of the CoE line item result in money being redirected away from other key line items to address CoE over expenditure, but it also has a tendency to result in the Department not filling vacant posts which places additional pressure and strain on an already overburdened labour force. As at 31 March 2012 the Department reported that of its 77 364 approved posts, only 40 439 were filled meaning that it still has 36 924 vacant posts.

Goods and Services receive R 4.11 billion or 27.1% of the total budget, This line item experiences a nominal decrease of 0.23% when compared with the 2011/12. In real terms this line item experiences a significant year-on-year decrease of 3.6%.

Highly likely that in 2012/13 there will be shortages in the supply of Goods and Services due to accruals from prior years which now need to be offset against this line item which is aggravated by it already having received less than previously required.

The pressure put on the budget by COE as well as the general body of accruals brought forward from the previous financial year will ultimately cause funding reprioritisation away from non negotiables (which represent 80% of the Department's G&S expenditure).

Review of resources (budget) trends to reflect on the ability of the Department to deliver on its Strategic Goals, Strategic objectives and Long Term Plan

Programme 2 shows very minimal growth over the MTEF, contributed mainly by decline in goods and services and this has affected the core services of the programme (e.g. laboratory services, food supplies).

Programme 4 declines in 2014 and has slow growth over the MTEF emanating from both compensation of employees and goods and services. Some items has a very huge increase (e.g. advertising from R0.116 million to R5 million, Travelling and subsistence from R4 million to R15 million.)

**Focus on changes in funding levels**

The department has been allocated a budget of R16, 584 billion for the 2013/14 financial year. The current budget shows a NEGATIVE GROWTH OF 2.7% IN REAL TERMS. (Negative Real Growth of 5.7% once National Priority Funding is excluded).

The Department has had to make large shifts away from goods to COE, with substantial risks of under-budgeting and cash-flow. There have also been large shifts away from Capex. These shifts arose from several unfunded and underfunded mandates, including HROPT, Under -funded COE: OSD Phase 1 baseline, Unfunded COE: Nurses OSD Phase 1 Arbitration Award, Unfunded COE: NHC decision for EMS personnel 2 notch increase, Underfunded COE & G&S: Provincialisation of State Aided Hospitals (PAHs), Underfunded COE & G&S: Provincialisation of PHC services in local authorities, Underfunded Pay progression; Underfunded Pay progression Underfunded OSD Therapeutics Phase 2.

The Department's 2012/13 real growth in goods and services is -12.9%, which is further exacerbated by a minimum estimated accruals of approximately R435 million from the 2012/13 financial year.

Accordingly, the Department's budgets over the MTEF are under substantial pressure, notwithstanding the potential for improved efficiencies, containing personnel costs and avoiding unfunded mandates.

The Department has benchmarked its allocations for non negotiables against the schedules received from National.

The pressure put on the budget by COE as well as the general body of accruals brought forward from the previous financial year will ultimately cause funding reprioritisation away from non negotiables (which represent 80% of the Department's G&S expenditure).

## DITURE ESTIMATES

### penditure estimates

**provincial payments and estimates by programme**

| 000 | | | | Main appropriation | Adjusted appropriation | Revised estimate | Medium-term estimates | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2009/10 | 2010/11 | 2011/12 | 2012/13 | | | 2013/14 | 2014/15 | 2015/16 |
| nistration | 623 565 | 522 081 | 545 484 | 515 411 | 542 029 | 606 554 | **635 329** | 644 384 | 675 598 |
| ct Health es | 5 581 901 | 6 607 022 | 7 285 266 | 7 413 038 | 7 685 994 | 8 158 616 | **8 240 676** | 8 688 127 | 9 244 156 |
| ency Medical es | 485 836 | 536 913 | 644 588 | 737 245 | 724 164 | 724 164 | **792 695** | 818 435 | 896 340 |
| cial Hospitals es | 3 353 416 | 3 481 188 | 3 860 254 | 3 958 611 | 4 104 162 | 4 205 535 | **4 272 604** | 4 521 376 | 4 733 588 |
| al Hospital es | 528 251 | 594 454 | 627 075 | 682 445 | 702 419 | 702 419 | **743 621** | 786 007 | 822 163 |
| Sciences and ng | 522 692 | 594 133 | 605 824 | 644 362 | 663 207 | 663 207 | **744 878** | 770 280 | 790 066 |
| Care Support es | 57 019 | 66 994 | 78 747 | 102 332 | 94 635 | 94 635 | **109 518** | 113 294 | 125 750 |
| Facilities ement | 936 391 | 870 043 | 1 245 044 | 1 112 594 | 1 217 940 | 1 217 940 | **1 045 007** | 799 225 | 850 076 |
| | **12 089 071** | **13 272 828** | **14 892 282** | **15 166 038** | **15 734 550** | **16 373 070** | **16 584 328** | **17 141 128** | **18 137 736** |

A summary of payments and estimates per programme is shown in the table above. It indicates that total payments grew from R12.1 billion in 2009/10 to a revised estimate of R16.4 billion in 2012/13. In the 2013 MTEF, the growth is from R16.8 billion to R18.7 billion.

At programme level, focus on spending continues to be on district health services, provincial hospital services, central hospital services, and health facilities management (programmes 2, 4, 5 and 8 respectively). The first 3 programmes mentioned are patient-driven service delivery programmes, whereas programme 8 focuses on facilities where these services take place. Health science and training is a health professions training and development support programme.

When comparing the revised estimates in the 2012/13 financial year and the 2013/14 estimates, all programmes, with the exception of Provincial Health Services and Health Facilities Management show varying degrees of positive growth. Department – wise there is insignificant growth at 2.46 percent.

The table below shows a summary of payments and estimates per economic classification. As depicted in the table, transfers to higher education institutions show a significant decline of 36.74 per cent from the revised estimates of 2012/13 to the estimates of 2013/14. This is due to re-aligning the use of the HPTD grant to a document issued by National Department of Health titled "Definitions and guidelines on the utilization of the HPTD Grant". There is also a decrease of 49.76 percent in transfers to households. This is due mainly to payments for medico-legal claims which were previously erroneously paid under goods and services. Being of a contingent nature makes it difficult to budget for them. The details of the increases for transfers to provinces and municipalities as well as for departmental agencies and accounts are given under programme 2.

Compensation of employees increases by 7.93 percent due to funding received for improved conditions of service and extra once off funding for HR accruals. In contrast goods and services decrease by 8.20 percent as a result of payment of accruals and the effects of the increased burden of disease.

Expenditure for payment for capital assets increases overall by 11.88 percent due to the deferment of procurement of such from the 2013/14 financial year as a result of supply chain challenges.

**mmary of Provincial Expenditure Estimates by Economic Classification**

| 000 | | | | Main appropriation | Adjusted appropriation | Revised estimate | Medium-term estimates | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2009/10 | 2010/11 | 2011/12 | 2012/13 | | | 2013/14 | 2014/15 | 2015/16 |
| ents | 10 642 926 | 11 979 868 | 13 513 689 | 13 905 324 | 14 473 618 | 15 112 138 | 15 401 787 | 16 270 153 | 17 240 548 |
| of employees | 7 397 477 | 8 390 748 | 9 480 557 | 9 790 294 | 10 229 810 | 10 229 810 | 10 956 019 | 11 358 728 | 12 181 557 |
| rvices | 3 235 131 | 3 577 468 | 4 019 162 | 4 115 030 | 4 243 808 | 4 879 171 | 4 445 768 | 4 911 425 | 5 058 991 |
| ent on land | 10 318 | 11 652 | 13 970 | - | - | 3 157 | - | - | |
| subsidies | 518 893 | 554 126 | 310 300 | 335 630 | 394 703 | 394 703 | 284 879 | 258 619 | 248 751 |
| municipalities | 201 570 | 274 281 | - | - | 8 084 | 8 084 | 19 542 | 10 099 | |
| agencies and | 210 058 | 124 999 | 42 412 | 28 650 | 29 436 | 29 436 | 53 982 | 87 555 | 60 322 |
| on | 82 293 | 123 472 | 133 974 | 201 690 | 101 845 | 101 845 | 46 759 | 52 149 | 44 608 |
| | 24 972 | 31 374 | 133 914 | 105 290 | 255 338 | 255 338 | 164 596 | 108 816 | 143 822 |
| capital assets | 926 545 | 737 746 | 1 068 184 | 925 084 | 866 229 | 866 229 | 897 662 | 612 356 | 648 437 |

| 000 | | | | Main appropriation | Adjusted appropriation | Revised estimate | Medium-term estimates | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2009/10 | 2010/11 | 2011/12 | 2012/13 | | | 2013/14 | 2014/15 | 2015/16 |
| other fixed | 712 317 | 613 738 | 830 211 | 692 096 | 659 810 | 659 810 | 588 420 | 383 620 | 407 194 |
| equipment | 214 228 | 124 008 | 237 973 | 232 988 | 206 419 | 206 419 | 302 090 | 227 988 | 241 243 |
| other ts | - | - | - | - | - | - | 7 152 | 748 | |
| inancial assets | 707 | 1 088 | 109 | - | - | - | - | - | |
| | **12 089 071** | **13 272 828** | **14 892 282** | **15 166 038** | **15 734 550** | **16 373 070** | **16 584 328** | **17 141 128** | **18 137 736** |

### 4.9.2 RELATING EXPENDITURE TRENDS TO SPECIFIC GOALS

**TABLE A16: TRENDS IN PROVINCIAL PUBLIC HEALTH EXPENDITURE (R'000)**

| Expenditure | Audited/ Actual | | | Estimate | Medium term projection | | |
|---|---|---|---|---|---|---|---|
| | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 |
| **% of Total spent on:-** | | | | | | | |
| DHS[4] | 50 | 49.8 | 48.9 | 49.8 | 49.3 | 49.2 | 49.6 |
| PHS[5] | 27.7 | 26.2 | 25.9 | 25.7 | 25.5 | 25.5 | 25.3 |
| CHS[6] | 4.4 | 4.5 | 4.2 | 4.3 | 4.6 | 4.6 | 4.5 |
| All personnel | 61.2 | 63.2 | 63.7 | 62.5 | 65.8 | 63.9 | 64.9 |
| Capital[2] | 7.7 | 5.6 | 7.2 | 5.3 | 5.9 | 6.0 | 5.8 |
| Health as % of total public expenditure | | | | | | | |

1. Current price projections for the MTEF period are not required as these figures will be the same as the Constant price projections for the same years
2. Including maintenance. Capital spending under the public works budget for health should be included. This should equal the amounts indicated in tables HFM 1 and 2 and should exclude non-HFM capital falling under the Treasury definition of Capex (i.e. more than R5, 000 and lasts more than a year).
3. The CPIX multipliers in Table A4 should be should be used to adjust expenditure in previous years to 2008/09 prices.
4. District health services; any change in content of the budget programme should be indicated.
5. Provincial hospital services or previous designation; any change in content of the budget programme should be indicated.
6. Central hospital services or previous designation; any change in content of the budget programme should be indicated.

**TABLE A17: CPIX MULTIPLIERS FOR ADJUSTING CURRENT PRICES TO CONSTANT 2007/08 PRICES**

| Financial year | Updated CPIX Multiplier as at 16 February 2009 | CPIX |
|---|---|---|
| 2006/07 | 1.20 | 5.2 |
| 2007/08 | 1.11 | 8.1 |
| 2008/09 | 1.00 | 10.8 |
| 2009/10 | 0.95 | 5.4 |
| 2010/11 | 0.90 | 5.1 |
| 2011/12 | 0.86 | 4.6 |

## KAGES OF THE 2013/14 – 2015/16 ANNUAL PERFORMANCE PLAN WITH THE NEGOTIATED SERVICE REEMENT (NSDA) & OTHER INTERNATIONAL, NATIONAL AND PROVINCIAL STRATEGIC HEALTH ERATIVES

**vincial Priority / TPP: Ten Point Plan / MDG: Millennium Development Goal**

### UT 01: INCREASING LIFE EXPECTANCY

| TPUTS | OTHER RELEVANT STRATEGIC HEALTH IMPERATIVES | CORRESPONDING PROVINCIAL STRATEGIC GOAL | CORRESPONDING STRATEGIC OBJECTIVES FOR 2011/12 | RELEVANT BUDGET PROGRAMME |
|---|---|---|---|---|
| | KPP 01: Build a strong Primary Health Care<br><br>TPP 02: Improve quality of health services<br><br>TPP 07: Attaining better health for the population | Goal 01: To facilitate a functional quality driven Public Health System that provides an integrated and seamless package of health services and is responsive to customer needs. | 1.5 To ensure efficient and effective hospital services in at least 70% of hospitals | Programme 2: District Hospitals |
| | | | 1.7 To strengthen capacity to deliver Secondary and Tertiary Services to achieve tertiary 1 level development. | Programme 4: Regional Hospital Services |
| | | | | Programme 5: Tertiary Services |
| | | | 1.9 To improve clinical support and rehabilitation services to achieve 60% of the demand | Programme 7: Clinical Support Services |
| | | | 4.1 To facilitate the eradication of blindness and achieve national cataract surgery target | Programme 2: Disease Prevention and Control |
| | | | 4.2 To facilitate the development of mental health services to achieve 60% service levels | Programme 4.3: Specialised Hospital Services |
| | | | 4.3 To facilitate the 10% reduction of morbidity and mortality from targeted non – communicable diseases and other conditions | Programme 2: Disease Prevention and Control |

## REDUCING CHILD & MATERNAL MORTALITY

| TPUTS | OTHER RELEVANT STRATEGIC HEALTH IMPERATIVES | CORRESPONDING PROVINCIAL STRATEGIC GOAL | CORRESPONDING STRATEGIC OBJECTIVES FOR 2011/12 | RELEVANT BUDGET PROGRAMME |
|---|---|---|---|---|
| :<br>Maternal<br>lity | **MDG 01:** To eradicate extreme poverty and hunger<br><br>**MDG 04:** To reduce child mortality<br><br>**MDG 05:** Improve maternal health | **Strategic Goal 03:** To improve and strengthen Mother and Child services. | 3.1 To ensure reduction of child mortality to achieve 26 per 1000 mortality in the under-five children | **Programme 2:** Maternal Child and Wome Health & Nutrition |
| | | | 3.2 To facilitate the reduction of maternal mortality to achieve 36.8 maternal mortality per 100 000 | |
| | | **Strategic Goal 01:** To facilitate a functional quality driven Public Health System that provides an integrated and seamless package of health services and is responsive to customer needs. | 1.6 To build a functional and effective Emergency Medical Services to achieve 60% of National Standards | **Programme 3:** Emergen Medical Services |

## COMBATING HIV AND AIDS AND DECREASING THE BURDEN OF DISEASE FROM TUBERCULOSIS

| TPUTS | OTHER RELEVANT STRATEGIC HEALTH IMPERATIVES | CORRESPONDING PROVINCIAL STRATEGIC GOAL | CORRESPONDING STRATEGIC OBJECTIVES FOR 2011/12 | RELEVANT BUDGET PROGRAMME |
|---|---|---|---|---|
| :<br>IIV and<br>creasing<br>disease<br>osis | **TPP 06:** Accelerated implementation of HIV and AIDS plan and reduction of mortality due to TB and associated diseases<br><br>**MDG 06:** To combat HIV & AIDS, Malaria and other diseases | **Strategic Goal 02:** To combat and reduce the impact of TB and HIV/AIDS with a special focus on preventing the emergence of drug – resistant strains. | 2.1 To combat and reduce the impact of HIV & AIDS to achieve 9.5% prevalence in 15-24-year | **Programme 2:** HIV & AIDS and STI |
| | | | 2.2 To reduce TB morbidity and mortality by achieving 85% cure rate | **Programme 2:** TB Control & Management |

STRENGTHENING HEALTH SYSTEM

| TPUTS | OTHER RELEVANT STRATEGIC HEALTH IMPERATIVES | CORRESPONDING PROVINCIAL STRATEGIC GOAL | CORRESPONDING STRATEGIC OBJECTIVES FOR 2011/12 | RELEVANT BUDGET PROGRAMME |
|---|---|---|---|---|
| **neering on) the alth** | **KPP 01:** Build a strong Primary Health Care | **Strategic Goal 01:** To facilitate a functional quality driven Public Health System that provides an integrated and seamless package of health services and is responsive to customer needs. | 1.3 To ensure revitalization of Primary Health Care in all districts | **Programme 2:** District Management |
| | | | 1.4 To ensure 60% of our health facilities provide access to Oral Health Services | **Programme 2:** Communit Based Services |
| | | | 1.10 To ensure 95% availability of essential drugs in all health facilities | **Programme 7:** Pharmaceutical Services |
| **g and** | **TPP 02:** Improve quality of health services | **Strategic Goal 01:** To facilitate a functional quality driven Public Health System that provides an integrated and seamless package of health services and is responsive to customer needs. | 1.5 To ensure efficient and effective hospital services in at least 70% of hospitals | **Programme 2:** District Hospitals |
| **tation rvices** | **TPP 02:** Improve quality of health services | **Strategic Goal 01**: To facilitate a functional quality driven Public Health System that provides an integrated and seamless package of health services and is responsive to customer needs. | 1.1 To facilitate 60% of facilities implementing quality & patient safety program | **Programme 2:**<br>2.1 District Management<br>2.9 District Hospitals<br><br>**Programme 4:**<br>4.1 General Hospitals<br>4.2 TB Hospital Services<br>4.3 Specialised Hospital Services<br><br>**Programme 5:**<br>Tertiary Hospitals |

| TPUTS | OTHER RELEVANT STRATEGIC HEALTH IMPERATIVES | CORRESPONDING PROVINCIAL STRATEGIC GOAL | CORRESPONDING STRATEGIC OBJECTIVES FOR 2011/12 | RELEVANT BUDGET PROGRAMME |
|---|---|---|---|---|
| Health | TPP 05: Revitalization of physical infrastructure | Strategic Goal 01: To facilitate a functional quality driven Public Health System that provides an integrated and seamless package of health services and is responsive to customer needs. | 1.11. To facilitate building, upgrading and maintenance of health facilities to support service delivery | Programme 8: Health Facilities Managemer |
| | | | 1.12. To ensure provision and maintenance of equipment for facilities | |
| Human Health | KPP 05: Increasing Human Resources capacity<br><br>TPP 04: Improved human resource management | Strategic Goal 05: To enhance institutional capacity through effective leadership, governance, accountability and efficient and effective utilization of resources | 5.5 To ensure 100% effective HR planning, development and management | Programme 1: Integrated Human Resource Management |
| | | | | Programme 6: Health Scienc & Training |
| ning gement | KPP 02: Initiate Income Generation<br><br>KPP 03: Reforming our Supply Chain Management system | Strategic Goal 05: To enhance institutional capacity through effective leadership, governance, accountability and efficient and effective utilization of resources. | 5.3 To provide 100% Financial Management and SCM to achieve full accountability and clean Audit | Programme1: Financial Management |
| ancing<br><br>n of th | KPP 02: Initiate Income Generation | Strategic Goal 01: To facilitate a functional quality driven Public Health System that provides an integrated and seamless package of health services and is responsive to customer needs. | 1.2 To facilitate implementation of NHI Readiness in at least one Health District | Programme 2: District Management |

| TPUTS | OTHER RELEVANT STRATEGIC HEALTH IMPERATIVES | CORRESPONDING PROVINCIAL STRATEGIC GOAL | CORRESPONDING STRATEGIC OBJECTIVES FOR 2011/12 | RELEVANT BUDGET PROGRAMME |
|---|---|---|---|---|
| ning<br>ation<br>rmation,<br>on and | KPP 04: Re-engineering our business processes | Goal 05: To enhance institutional capacity through effective leadership, governance, accountability and efficient and effective utilization of resources. | 5.4 To facilitate 80% achievement of developed and implemented corporate systems and ICT platform | Programme 1: Information Technology Services |