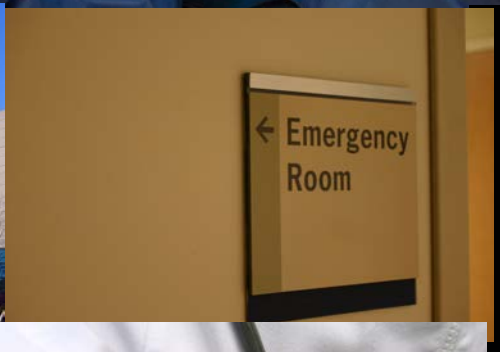
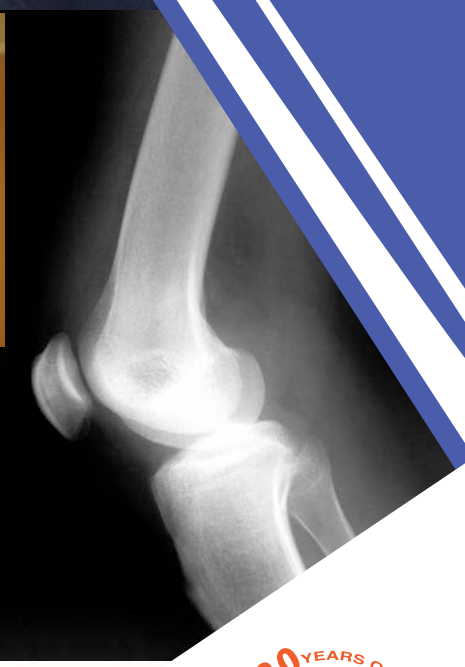
Province of the
EASTERN CAPE
HEALTH

5 YEAR STRATEGIC PLAN

2015/16 – 2019/20





20 YEARS OF FREEDOM
South Africa 1994 - 2014

United in achieving quality health care for all

Province of the
EASTERN CAPE
HEALTH

CONTENT

OF THE STRATEGIC PLAN

TABLE OF CONTENTS

PART B: PROGRAMME AND SUB-PROGRAMME PLANS

PART C: LINKS TO OTHER PLANS

LIST OF TABLES

LIST OF FIGURES

ACRONYMS

AGSA	Auditor-General SA
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BANC	Basic Antenatal Care
CoE	Compensation of Employees
CHCs	Community Health Centres
CHCWs	Community Health Care Workers
DCSTs	District Clinic Specialist Teams
DHIS	District Health Information System
DHS	District Health Services
DOTS	Directly Observed Treatment Short-Course
DPC	Disease Prevention and Control
DPSA	Department of Public Service and Administration
DM	District Municipality
EC	Eastern Cape
ECDoH	Eastern Cape Department of Health
ECSECC	Eastern Cape Socio-Economic Council
ELHC	East London Hospital Complex
EMS	Emergency Medical Services
GHS	General Household Survey
HST	Health Sciences and training
HAST	HIV & AIDS, STI and TB control
HCT	HIV Counseling and Testing
HCSS	Health Care Support Services
HFM	Health Facilities Management
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HPTD	Health Professionals Training and Development (Grant)

HRM	Human Resource Management
HRD	Human Resource Development
HRH	Human Resources For Health
ICT	Information and Communications Technology
IMR	Infant mortality rate
ISHP	Integrated School Health Programme
IT	Information Technology
MDGs	Millennium Developmental Goals
MDR-TB	Multi-drug resistant TB
MEC	Member of the Executive Council
METROs	Medical Emergency Transport and Rescue Organizations
MMC	Medical Male Circumcision
MMR	Maternal mortality ratio
MTCT	Mother-To-Child-Transmission
MOU	Maternal Obstetric Unit
MTSF	Medium Term Strategic Framework
NCDs	Non-Communicable Diseases
NCS	National Core Standards
NDoH	National Department of Health
NDP	National Development Plan
NHI	National Health Insurance
NHLS	National Health Laboratory Services
NNMR	Neonatal Mortality Rate
NSDA	Negotiated Service Delivery Agreement
NTSG	National Tertiary Services Grant
O&P	Orthotic and Prosthetic
OHH	Outreach Households
OPD	Outpatient Department
OSD	Occupational Specific Dispensation

PCV	Pneumococcal Vaccine
PDE	Patient Day Equivalent
PERSAL	Personnel and Salaries
PGDP	Provincial Growth and Development Plan
PHC	Primary Health Care
PMR	Perinatal Mortality Rate
PMTCT	Prevention Of Mother-To-Child Transmission
PSS	Patient Satisfaction Surveys
PPPs	Public-Private Partnerships
RPHC	Revitalization of PHC
RPHC	Re-engineering the Primary Health Care
SADHS	South Africa Demographic and Health Survey
SCM	Supply Chain Management
SDIP	Service Delivery Improvement Plan
SOP	Standard Operating Procedure
Stats SA	Statistics South Africa
STI	Sexually Transmitted Infection
TB	Tuberculosis
THS	Traditional Health Services
TMC	Traditional Male Circumcision
TROA	Total clients Remaining On ART
WBOTs	Ward-Based Outreach Teams

1. Foreword by the Executive Authority (Health MEC)

The Eastern Cape Health Department's Strategic Plan Document is informed by the need to provide sustainable quality healthcare services to the people of this province and consequently promote a healthier society. The Department also aims to improve the quality of care provided in health facilities to yield more added benefits and provide a universal health coverage to ensure a long and healthy life for all the people of this province.

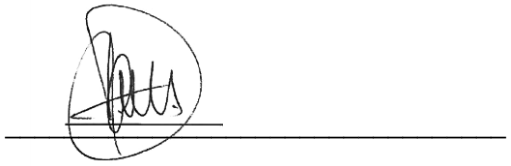
All these efforts are to ensure that provision and access to health services as a human right remain a priority of government, as declared by the African National Congress (ANC). In doing that, the Department takes note of the National Department of Health Policies and other government's policy directives. As such we will forge ahead with implementation of programmes like the National Health Insurance (NHI) project even beyond the pilot phase during the 2015-2020 Medium Term Strategic Framework (MTSF) period; this to ensure that all citizens, including the poor receive equal access to medical treatment.

In its efforts to ensure that all its citizens attain a decent standard of living through eliminating poverty and reducing inequality by 2030, government developed the National Development Plan (NDP) which is a long term strategy to be driven by various sectors of society towards attainment of the set objectives. Quality health care has been identified as one of the core elements of a decent standard of living identified in the plan and hence the need to further strengthen our primary health care. In this regard, the Department has already made significant progress in establishing Ward Based Outreach Teams (WBOTs), Integrated School Health Programme (ISHP) teams and District Clinical Specialist Teams (DCSTs) to implement the development and delivery of priority health care programmes within the province.

Over the past MTSF period, we have witnessed a significant improvement in life expectancy and seen by the decrease in HIV prevalence as a result of enforced dual therapy; increased awareness of sex education and condom use. Moving forward, the Department will continue to intensify plans to reduce the burden of disease through deliberate awareness campaigns focused on increasing treatment of all HIV and TB positive patients over the 2015-2020 MTSF period.

This five year strategic plan encompasses the importance of implementing the National Core Standards; the Ministerial priorities; and the non-negotiable standards throughout the Department and facilities in order to guarantee better patient experience with meaningful effects felt on the ground by service recipients. Our flagship Rapid Response Teams outreach project will be continually used to reach out to districts and facilities to provide immediate intervention and relief to service delivery challenges.

In conclusion, the Department appreciates the ongoing increase in the health budget by the Provincial Treasury albeit the constrained fiscal environment and is confident that with the marginal available resources for the enormous task at hand, delivery of quality, effective and efficient health care will remain its primary focus during this MTSF period. I therefore endorse the department's 2015 -2020 Strategic Plan.



Dr P.P. Dyantyi

MEC for Health

2. Statement by the Head and Accounting Officer of the Department

One of the most important developments since the tabling of the previous term's Strategic Plan has been the development of a National Development Plan (NDP). The NDP not only outlines the country's vision and developmental targets for 2030, but also provides a means to synergise efforts by the different spheres of government to better deliver services to the citizens of our country.

Accordingly, the 2015-2020 Strategic Plan is premised on the following policy imperatives:

- **Outcome 2 of government's 14 outcomes** which speaks to, "A long and healthy life for all South Africans";
- **Chapter 10 of the NDP** that speaks to, "Provision of affordable access to quality health care while promoting health and well-being";
- **ANC's 2014 election Manifesto** that highlights the following on Health:
- Implement the next phase of the NHI through a creation of a publicly funded & administered NHI fund, strengthen & expand the free primary care programme, improve management of public hospitals & reduce the costs of private health care;
- Intensify the campaign against HIV/AIDS to ensure at least 4.6 mil people are on anti-retrovirals, & expand the male circumcision & HIV counseling & testing programme; and
- Ensure chronic medication is available and delivered closer to where patients live.
- **Provincial Medium Term Strategic Framework (MTSF)** which envisages an improved health profile for the province.

Over the previous MTSF period, the department registered significant improvements particularly around financial management and audit related matters. This period saw the department improve from years of disclaimed audit opinions to qualified audit opinions for the 2011/12, 2012/13 and 2013/14 financial years. The qualification matters have significantly reduced to the point where the department is confident that it will achieve an unqualified during the 2015-2020 MTSF period. The department also strengthened governance and managerial accountability by filling almost all vacant positions in executive and top management positions.

As a bid to improve service delivery, the department implemented a Rapid Response Team (RRT) programme to unblock challenges which continued to give the department bad publicity. This programme saw top management and other key officials from Head Office visiting districts and facilities on a monthly basis to deal with service delivery blockages at various points of service. The intervention ensured management visibility in facilities and resulted in improvement being noted in our facilities. Furthermore, the intervention also helped instil a sense of rapid response in how districts and facilities conduct their day to day operations.

Governance and accountability has been strengthened with the department having decentralised Finance, HR and SCM delegations to districts and CEOs of big facilities. In line with these delegations, Senior Managers are held accountable around key KPAs of Finance, Human Resources, Service Delivery and Data and audit matters.

Despite the massive progress made in the past 20 years in improving health care in the country and the province as a whole, much still needs to be done to meet the health related Millennium Development Goals (MDGs) and the realisation of Vision 2030. The general quality of public health care, the condition of some of our health facilities as well as challenges with accessing health care facilities are but some of the challenges that continue to confront the department. The planning processes that the department has undertaken for this MTSF, have taken these challenges into account and further devised strategies of how to address these.

Over the 2015-2020 MTSF, the department will continue to focus on prevention and reduction of the disease burden and promotion of health, improved quality of care and universal health coverage. More attention will be

given to turning around all the facilities especially those that are poorly performing around the National Core Standards. Furthermore, the following MEC's priorities which she pronounced when taking office in May 2014 will also be addressed:

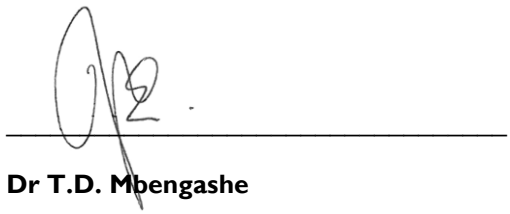
- Increased service delivery levels;
- Improved quality of service;
- Increase productivity of staff;
- Payment of benefits to terminated employees to be effected within 3 months of termination;
- Payment of municipalities and SMMEs within 30 days; and
- Logging of patient complaints and responding to complainants within 5 working days.

The key support programmes (HR, Finance and SCM Chain management) will be strengthened for effectively support the Clinical programmes in delivering on these priorities. SCM and ICT have been identified as key enablers in the value chain for a seamless delivery of goods and services; from the identification of needs by users, procurement of such goods and services in an efficient and effective manner, timeous and compliant payment of suppliers, recording of related assets as well as proper document management for audit purposes. The department will be pursuing this integrated SCM approach to ensure that goods and services are delivered in an efficient and cost effective manner and are linked to the demands of users in facilities.

The department will continue with outreach to districts and facilities through the RRT programme to ensure implementation of key priorities. Progress in this regard will be monitored at the highest level in the department by the Member of the Executive Committee (MEC), the Accounting Officer and top Management through monthly reporting. Comprehensive quarterly reviews will also be undertaken to inform strengthening of plans moving forward.

The 2015-2020 MTSF priorities will be delivered against the backdrop of a shrinking fiscal envelope and as such, an extensive reprioritisation process will be undertaken to ensure that these priorities are accommodated within the current baseline. Part of the reprioritisation will include review of the service delivery model as the areas of Compensation of Employees is the biggest cost driver in the department. This process is aligned to the organogram process which is at advanced stages of costing before submission to Department of Public Service and Administration for final approval.

In conclusion, as Accounting Officer, I endorse the 2015 -2020 Strategic Plan as the department's roadmap to achieving, "A quality service to the people of the Eastern Cape, promoting a better life for all".



Dr T.D. Mbengashe

Superintendent General

3. Official Sign Off of the Strategic Plan

It is hereby certified that the Strategic Plan:

Was developed by the Provincial Department of Health in Eastern Cape Province

Was prepared in line with relevant policies, legislation and other mandates of the Department of Health in the Eastern Cape Province under the guidance of the Hon. MEC P.P. Dyantyi; and

Accurately reflects the new and proposed strategic goals and objectives which the Eastern Cape Department of Health will endeavour to achieve given the resources made available in the budget for 2015/16-2019/20 financial year.

Mr S. Kaye: _____ Signature: Date: _18_/_03_/2015

Chief Financial Officer

Mrs N. Mazaleni: _____ Signature: Date: _18_/_03__/2015

Acting Head Official Responsible for Planning

Dr T.D. Mbengashe: _____ Signature: Date: _18_/03_/2015

Accounting Officer

APPROVED BY:

Hon. P.P. Dyantyi_____ Signature: Date: _18_/03_/2015

MEC for Health

PART A

A STRETIGIC 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, emphasising 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 LEGISLATIVE AND OTHER MANDATES

4.4.1 Constitutional Mandates

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

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

4.4.2 Legislation falling under the Minister of Health's portfolio

- **Medicines and Related Substances Act, 101 of 1965**
  Provides for the registration of medicines and other medicinal products to ensure their safety, quality and efficacy, and also provides for transparency in the pricing of medicines

- **Foodstuffs, Cosmetics and Disinfectants Act, 54 of 1972 (As amended)**

  Provides for the regulation of foodstuffs, cosmetics and disinfectants, particularly quality standards that must be complied with by manufacturers, as well as the importation and exportation of these items

- **Hazardous Substances Act, 15 of 1973**

  Provides for the control of hazardous substances, particularly those emitting radiation.

- **Occupational Diseases in Mines and Works Act, 78 of 1973**

  Provides for medical examinations on (of?) persons suspected of having contracted occupational diseases, especially in mines, and for compensation in respect of those diseases

- **Pharmacy Act, 53 of 1974 (As amended)**

  Provides for the regulation of the pharmacy (pharmaceutical?) profession, including community service by pharmacists

- **Health Professions Act, 56 of 1974 (As amended)**

  Provides for the regulation of health professions, in particular medical practitioners, dentists, psychologists and other related health professions, including community service by these professionals

- **Dental Technicians Act, 19 of 1979**

  Provides for the regulation of dental technicians and for the establishment of a council to regulate the profession

- **Allied Health Professions Act, 63 of 1982 (As amended)**

  Provides for the regulation of health practitioners such as chiropractors, homeopaths, etc., and for the establishment of a council to regulate these professions

- **Human Tissue Act, 65 of 1983**

  Provides for the administration of matters pertaining to human tissue

- **National Policy for Health Act, 116 of 1990**

  Provides for the determination of national health policy to guide the legislative and operational programmes of the health portfolio

- **SA Medical Research Council Act, 58 of 1991**

  Provides for the establishment of the South African Medical Research Council and its role in relation to health research

- **Academic Health Centres Act, 86 of 1993**

  Provides for the establishment, management and operation of academic health centers

- **Choice on Termination of Pregnancy Act, 92 of 1996 (As amended)**

  Provides a legal framework for the termination of pregnancies based on choice under certain circumstances

- **Sterilisation Act, 44 of 1998**

  Provides a legal framework for sterilizations, including for persons with mental health challenges

- **Medical Schemes Act, 131 of 1998**

  Provides for the regulation of the medical schemes industry to ensure consonance with national health objectives

- **Tobacco Products Control Amendment Act, 12 of 1999 (As amended)**

  Provides for the control of tobacco products, the prohibition of smoking in public places and of the advertisements of tobacco products, as well as the sponsoring of events by the tobacco industry

- **National Health Laboratory Service Act, 37 of 2000**

  Provides for a statutory body that offers laboratory services to the public health sector

- **Council for Medical Schemes Levy Act, 58 of 2000**

  Provides a legal framework for the Council to charge medical schemes certain fees

- **Mental Health Care Act, 17 of 2002**

  Provides a legal framework for mental health in the Republic and, in particular, the admission and discharge of mental health patients in mental health institutions, with an emphasis on the observation of human rights for mentally ill patients

- **National Health Act, 61 of 2003**

  Provides a framework for a uniform structured health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services. The objects of the Act are to:
  - unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa;
  - provide for a system of co-operative governance and management of health services within national guidelines, norms and standards, in which each province, municipality and health district must address questions of health policy and delivery of quality health care services;
  - establish a health system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognised standards of research and a spirit of enquiry and advocacy which encourage public participation;
  - promote a spirit of co-operation and shared responsibility among public and private health professionals, providers and other relevant sectors within the context of national, provincial and district health plans.

- **Nursing Act, of 2005**

  Provides for the regulation of the nursing profession

4.4.3 Other legislations in terms of which the Department operates includes the following:

- **Child Care Act, 74 of 1983**

  Provides for the protection of the rights and well-being of children

- **Occupational Health and Safety Act, 85 of 1993**

  Provides for the requirements that employers must comply with in order to create a safe working environment for employees in the workplace.

- **Compensation for Occupational Injuries and Diseases Act, 130 of 1993**

  Provides for the compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment and for death resulting from such injuries or diseases.

- **Constitution of the Republic of South Africa Act, 108 of 1996**
  Pertinent sections provide for the rights of access to health care services, including reproductive health and emergency medical treatment.
- **Employment Equity Act, 55 of 1998**

  Provides for the measures that must be put into operation in the workplace in order to eliminate discriminatory practices as well as to promote affirmative action.

- **State Information Technology Act, 88 of 1998**

  Provides for the creation and administration of an institution responsible for the state's information technology systems.

- **Skills Development Act, 97of 1998**

  Provides for the measures that employers are required to take to improve the levels of the skills of employees in their workplaces.

- **Public Finance Management Act, 1 of 1999**

  Provides for the administration of state funds by functionaries, their responsibilities and incidental matters.

- **Promotion of Access to Information Act, 2 of 2000**

  Amplifies the Constitutional provision pertaining to accessing information under the control of various bodies.

- **Promotion of Administrative Justice Act, 3 of 2000**

  Amplifies the Constitutional provisions pertaining to administrative law by codifying it.

- **Promotion of Equality and the Prevention of Unfair Discrimination Act, 4 of 2000**

  Provides for the further amplification of the Constitutional principles of equality and the elimination of unfair discriminatory practices.

- **The Division of Revenue Act, 7 of 2003**

  Provides for the manner in which revenue generated may be disbursed.

- **Integrated Anti-poverty Strategy of the Eastern Cape**
  The vision of the strategy is to place empowerment of people at the centre

- **Eastern Cape Rural Development Strategy 'Ilima Labantu'**
  Aims at bringing about sustainable growth and development in order to improve the quality of life of all, particularly the rural poor

4.5 SITUATIONAL ANALYSIS

The Eastern Cape Province (ECP) is spread over an area of 169,063 km2 and constitutes 13.8% of the total SA land area. In 2014, Statistics South Africa (Stats SA) estimated that a total of 6.8 million people (12.5% of the populations in South Africa) live in the Eastern Cape Province[1].

Table 1: Population distribution by health districts, 2014 mid-year estimates

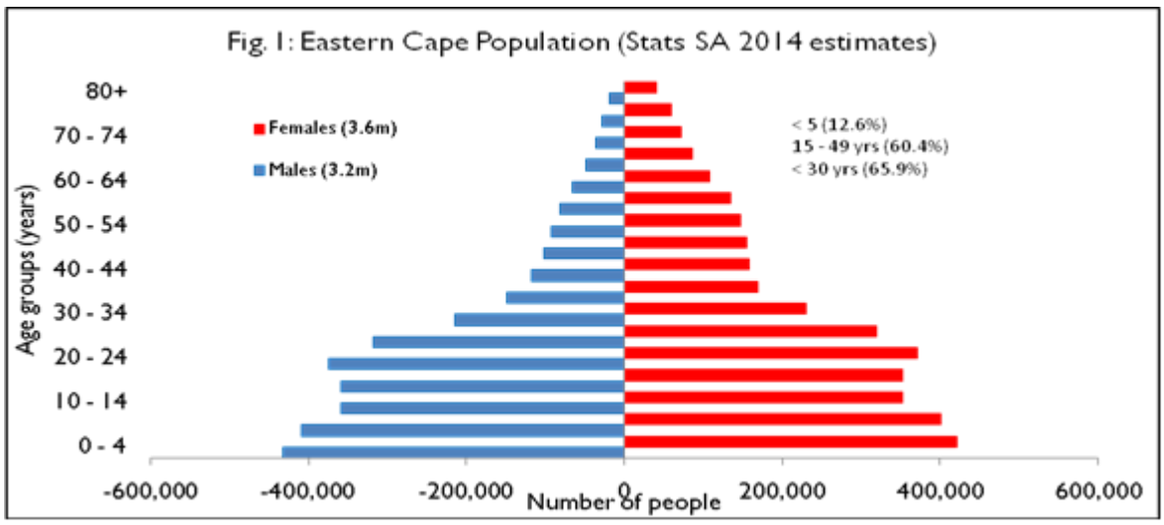
	Total population[1]	Males	Females	% population	Size of area(km2)[2]
A Nzo DM	849 876	378 269	471 607	12.5	6866
Amathole DM	918 392	419 660	498 732	13.5	23593
Buffalo City Metro	769 480	358 152	411 328	11.3	2,515
Sarah Baartman DM	469 564	227 208	242 356	6.9	58272
Chris Hani DM	821 187	377 791	443 396	12.1	36723
Joe Gqabi DM	362 913	166 808	196 105	5.3	1942
N Mandela Bay MM	1 202 095	572 349	629 746	17.7	25687
OR Tambo DM	1 401 064	635 751	765 313	20.6	15535
Eastern Cape	6 794 571	3 135 988	3 658 583	100	169,063

[1]StatsSA 2014 estimates; [2]ECSECC April 2012

The estimates show that 53.9% of the population was females and 46.1% were males. Majority of the population lives in OR Tambo district (20.8%) followed by Nelson Mandela Metro (17.6%). The lowest percentage of the population was in Joe Gqabi district and Sarah Baartman districts with 5.3% and 6.9% respectively.

[1] Statistics South Africa. Mid-year population estimates 2014: Statistical Release P0302.

Population pyramid



The Eastern Cape Province has a young population with 65.9% of the population under the age of 30 years. This means that the capacity of the state to provide basic services is overstretched because of the high demand of basic services which includes education, health care services, social services, employment opportunities, and housing.

4.5.1 Socio – Economic Profile

Table 2: Socio-economic profile (%) per District in Eastern Cape Province

District	Poverty Rate(1)	Urbanization Rate(1)	Unemployment Rate(2)	No schooling (20 + yrs)(2)	Medical Aid coverage (3)	Formal Housing (2)	Piped Water in dwelling (2)	Toilet with sewage connect (2)
Alfred Nzo	70.8	2.0	43.5	32.5	3.5	41.0	5.6	5.1
Amathole	66.0	39.0	42.9	13.5	8.7	52.6	12.1	14.8
Buffalo City Metro	49.0	96.5	35.1	11.0	14.7	72.5	52.6	68.8
Sarah Baartman	40.5	27.2	24.9	7.5	14.6	85.7	51.0	63.8
C Hani	65.5	39.0	39.0	13.9	5.9	61.9	23.4	31.2
Joe Gqabi	52.1	2.1	35.4	28.2	5.0	60.3	17.6	23.8
NM Metro	46.0	91.1	36.6	6.7	29.4	87.2	74.1	87.4
OR Tambo	62.0	37.9	44.1	36.7	4.6	43.5	8.9	10.6
Eastern Cape	57.2	30.0	37.4	10.5	10.8	63.2	32.8	40.4
1ECSECC 2012; 2StatsSA 2013 (Census 2011 Municipal Factsheet); 3HST 2013 (DHB 2012/13)								

The Eastern Cape Province is characterized by low socio-economic status and high levels of under-development. It is predominantly rural (70%) with low percentage of households having access to piped water (32.8%) and sewage connection coverage (40.4%). In 2012, ECSECC estimated that the poverty rate for the province was 57.2% and highest rates were observed in Alfred Nzo (70.8%), Amathole (66%), Chris Hani (65.5%) and OR Tambo (62%)

districts. These districts with high poverty rate reported high unemployment rates, i.e. in OR Tambo (44.1%), Alfred Nzo (43.5%), and Amathole (42.9%) districts. High urbanization rates were observed in Buffalo City Metro and Nelson Mandela Metro. There is low medical aid coverage (10.8%) especially in those districts with low socio-economic status.

Table 3: Key developmental indicators in the Eastern Cape Province

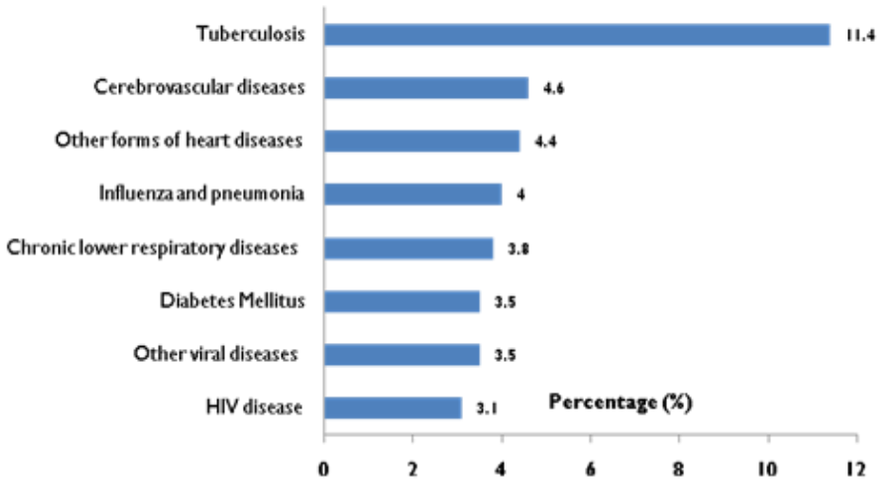
Key developmental Indicators in the Eastern Cape		
	2011	2013
Demographic Indicators		
Population density (2001, 2011)	35.0	39.9
Total fertility Rate (no. of children per woman)	3.69 (2001 – 2006)	3.13 (2011 – 2016)
Life expectancy at birth (females) (years)	50.2 (2001-2006)	59.0 (2011-2016)
Life expectancy at birth (males) (years)	46.7 (2001-2006)	53.0 (2011-2016)
People living disabilities (≥ 5 years) (%)	6.1	6.2
Average household size (number)	4.2	3.9
Socio-economic Indicators (%)		
Unemployment Rates (%)	37.4	27.8
Youth Unemployment Rates (%)	47.3	-
Adult literacy rate (≥ 20 years) (%)	89.7	90.5
Medical Aid Coverage (%)	10.9	10.5
Formal dwelling	63.2	59.0
Households using electricity for cooking	75.0	71.5
Access to Piped Water	85.6	86.4
Refuse removal (once a week)	41.0	35.2
Flush toilets connected to the sewage system or septic tank, and pit toilet with ventilation	65.5	71.2
Households with no toilet or using bucket system	15.8	10.0
Sources: Stats SA (2004, 2011, 2014) and GHS 2014, Labor Force Survey 2014		

The total fertility estimates for the periods 2001-2006 and 2011 – 2016 show a slight decline in the Eastern Cape. The life expectancy is expected to improve by 8.8 years among females and 6.3 years among males in the same period. Since 2001 to 2011, there was an improvement in the provision of household services and reduction of unemployment rates and illiteracy rates. However, these low socio-economic statuses still impose a high demand of basic services by the population from the state.

4.5.2 BURDEN OF DISEASE /EPIDEMIOLOGICAL PROFILE

Underlying causes of mortality

Figure 2. The leading underlying natural causes of mortality in the Eastern Cape, 2011 (StatsSA 2014)



The leading cause of mortality was TB (11.4%) followed by cerebrovascular diseases (4.6%), other forms of heart diseases (4.4%) and influenza and pneumonia (4.0%). HIV disease was the 8th leading cause of mortality in the Eastern Cape Province.

Under-5 child mortality

Fig. 3. Leading causes of Infant Mortality in South Africa, 2011 (Stats SA 2014)

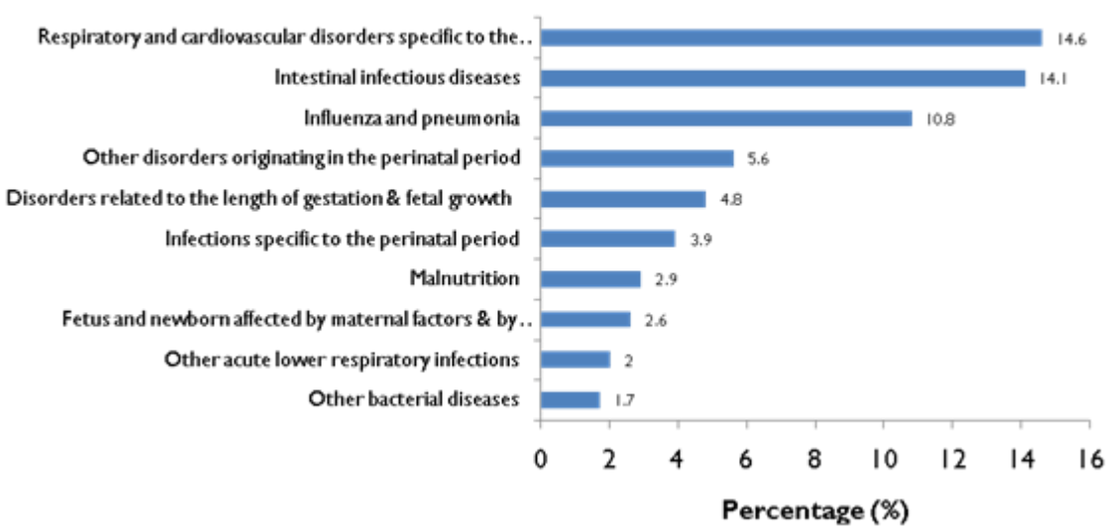
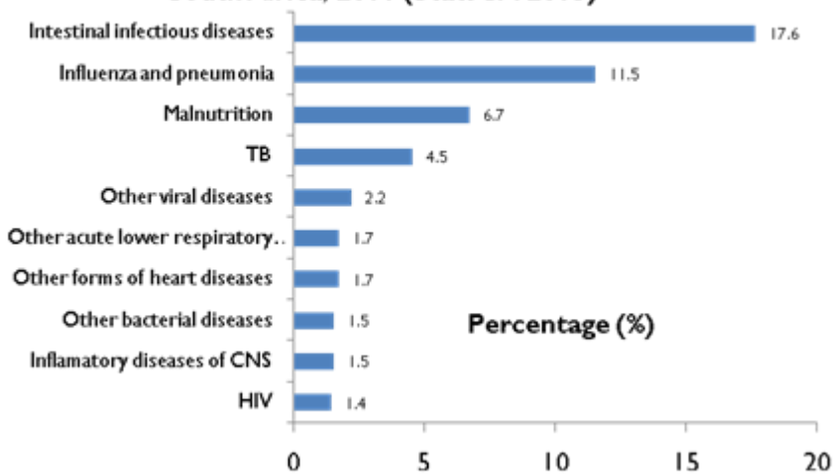


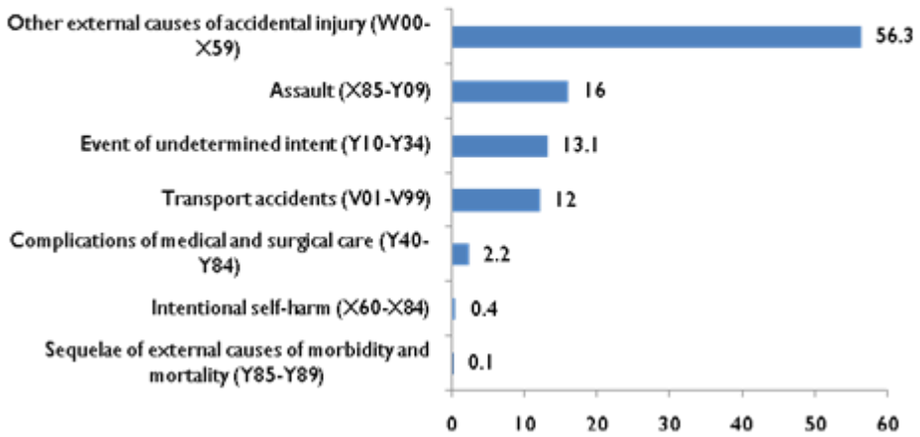
Fig. 4. The leading causes of child (1 - 4 yrs) mortality in South Africa, 2011 (Stats SA 2013)



In 2011, infant mortality in the province was due to respiratory and cardiovascular diseases of perinatal origin (14.6%), intestinal tract diseases (14.1%), and Influenza and pneumonia (10.8%). Intestinal infectious diseases (17.6%), influenza & pneumonia (11.5%) and malnutrition (6.7%) were the leading causes of child (1-4 years) mortality. In 2008, the department introduced the rotavirus and pneumococcal vaccines which are expected to reduce the burden of disease attributed to diarrheal, pneumonia and other related diseases.

Non-natural causes of mortality

Fig. 5. Underlying non-natural causes of death in the Eastern Cape, 2011 (StatsSA 2014)



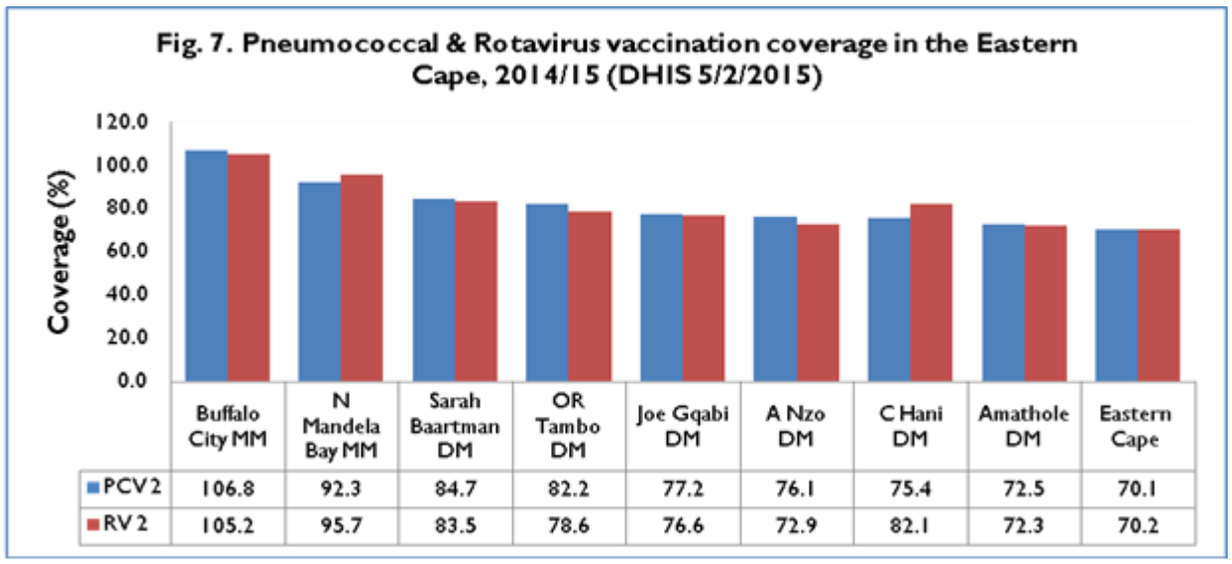
In 2011, non-natural causes were accounted for 9% of all deaths in the province (Stats SA 2013) of which 56.3% of those were due to other external causes of accidental injury, followed by assault at 16%, events of undetermined intent at 13.1% and transport accidents at12%.

4.5.3 Review of progress towards Chapter 10 of the National Development Plan

Goal 1: Average male and female life expectancy at birth increased

Statistics South Africa estimated that during the 2011 to 2016 period, the life expectancy at birth was 59.3 years for females and 53.7 years for males. The province has a responsibility to increase the life expectancy of the population and this requires multi-sectoral interventions.

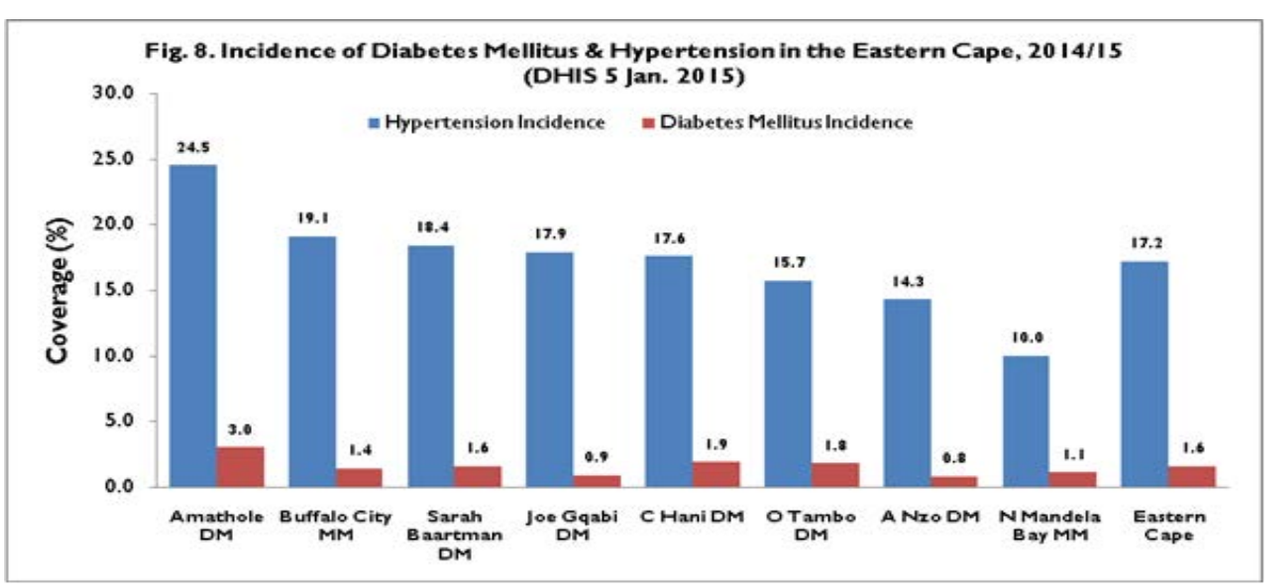
Immunization coverage



There was a 12.7% decline of the vaccination coverage, from 87% in 2012/13 to 74.3% in 2013/14. The province has not achieved the target (≥90%) from 2010/11 to 2013/14. Two vaccines were introduced into the country, and these were aimed at reducing the incidence of diarrheal diseases and pneumonia and other related conditions. The coverage of the second dose for pneumococcal vaccine was 80.6% and 80.8% for the rotavirus vaccine. The only district which achieved the coverage above 90% was Buffalo City Metro. All the other districts reported the coverage less than 90% with the exception Nelson Mandela Metro on the rotavirus vaccine.

GOAL 4: Significantly reduce prevalence of non-communicable chronic diseases

During the 2013/14 financial year, the incidence of diabetes mellitus and hypertension were 1.1% and 12.2% respectively. The incidence of hypertension was 29.1% in OR Tambo followed by Joe Gqabi (26.0%) and Buffalo City Metro (22.7%) with Nelson Mandela Metro having the lowest prevalence. The incidence of diabetes mellitus was 3.2% in OR Tambo and 2% in Buffalo City Metro, Amathole and Sarah Baartman districts. The lowest diabetes mellitus incidence was seen in Alfred Nzo district.



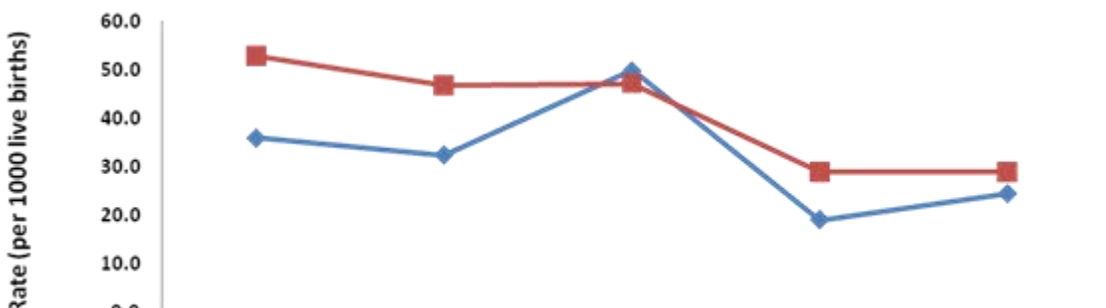
There is a need to continue with health promotion and community based services to improve screening for chronic conditions for the purposes of early detection and referral to the appropriate levels of care and identify treatment defaulters.

GOAL 3: Reduce maternal, infant and child Mortality

Infant mortality

The trend of public health facility infant mortality rate (IMR) shows a decrease from 36.0 per 1,000 live births in 2010/11 to 49.9 per 1,000 live births in 2012/13. The most recent infant mortality rate (IMR) showed a decline from 49.9 per 1,000 live births in 2012/13 to 19.1 per 1,000 live births in 2013/14 and increased to 24.5 per 1,000 live births in 2014/15. A similar trend was observed in under-five mortality, which had decreased from 52.9 per 1,000 live births in 2010/11 to 47.2 per 1,000 live births in 2012/13. Again, there was a decline from 47.2 per 1,000 live births in 2012/13 to 29.0 per 1,000 live births in 2014/15.

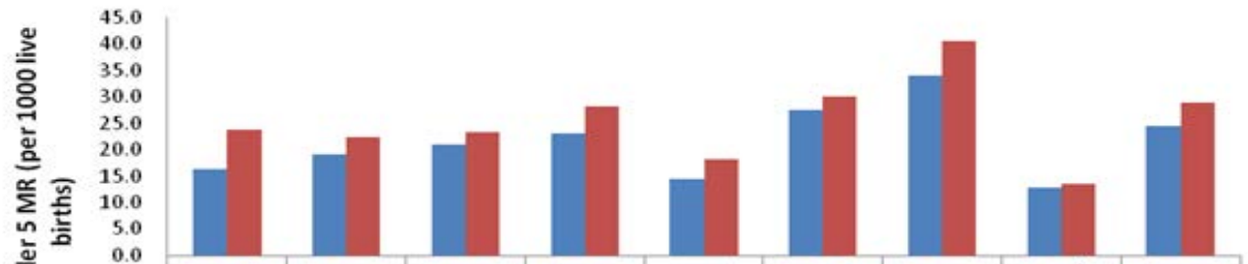
Fig.9. Infant and under 5 yr mortality rate in the Eastern Cape, 2010/11-2014/15 (DHIS 5-2-2015)



	2010/11	2011/12	2012/13	2013/14	2014/15
Infant	36.0	32.5	49.9	19.1	24.5
Under 5	52.9	46.9	47.2	29.0	29.0

Figure 10 below suggested that the highest infant and child mortality rates (34.1 and 40.5 per 1000 live births respectively) were observed in OR Tambo district. The lowest infant mortality rate (19.1 per 1000 live births) and under 5 mortality rate (29.0 per 1000 live births) were reported in Sarah Baartman district.

Fig. 10. Infant and child mortality rate in health facilities by districts in the EC, 2014/15 (DHIS Feb 2015)

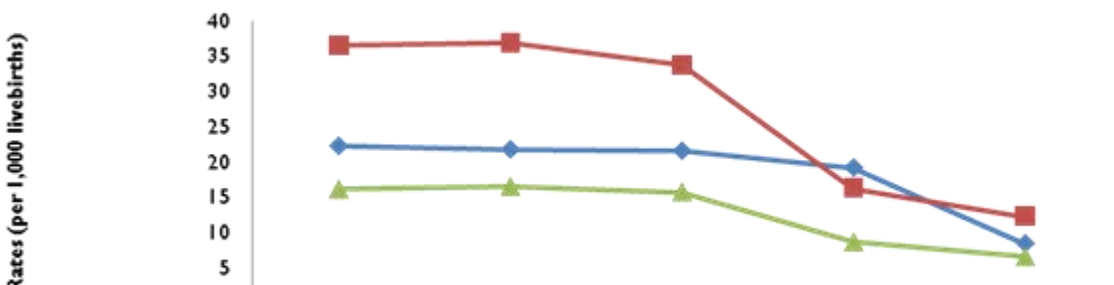


	A Nzo DM	Amathole DM	Buffalo City MM	C Hani DM	Joe Gqabi DM	N Mandela Bay MM	O Tambo DM	Sarah Baartman DM	Eastern Cape
Infant	16.4	19.2	20.9	23.0	14.4	27.5	34.1	12.7	24.5
Under-5	23.7	22.3	23.2	28.3	18.2	30.1	40.5	13.5	29.0

Stillbirths, perinatal and neonatal mortality

A closer analysis of the infant mortality rate reveals that perinatal, neonatal and stillbirth rates in public health facilities have remained consistent for a considerable number of years with the exception of 2013/14. As shown in Figure 11, these mortality rates follow a similar trend, demonstrating no significant decrease. In 2012/13, the perinatal mortality rate was 33.8[2], the stillbirth rate[3] was 21.8, and the neonatal mortality rate[4] was 15.9 per 1,000 live births. There was a decline in stillbirths, perinatal and neonatal mortality which occurred during 2011/12 to 2014/15. However, there was a dramatic decline which occurred during 2013/14 and 2014/15.

Fig. 11. Stillbirths, perinatal & neonatal mortality rates in public health facilities, Eastern Cape, 2010/11-2014/15 (5-2-2015)



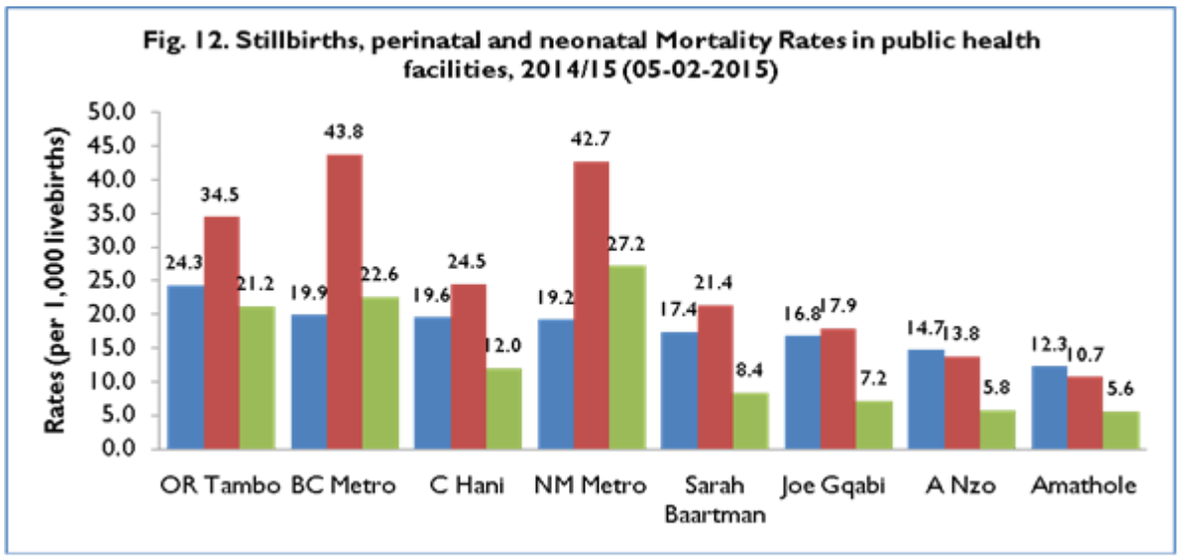
	2010/11	2011/12	2012/13	2013/14	2014/15
Still births	22.5	22	21.8	19.4	8.6
Perinatal mortality	36.6	37	33.8	16.4	12.4
Neonatal mortality	16.3	16.7	15.9	8.8	6.7

Figure 12 suggested that Nelson Mandela Metro, Buffalo City Metro reported the highest perinatal and neonatal mortality rates. The highest percentage of stillbirths was observed in OR Tambo followed by Buffalo City Metro and Sarah Baartman districts.

[2] Stillbirth mortality rate is the number of deaths of a fetus after 20 weeks' gestation or 500g per 1,000 live births

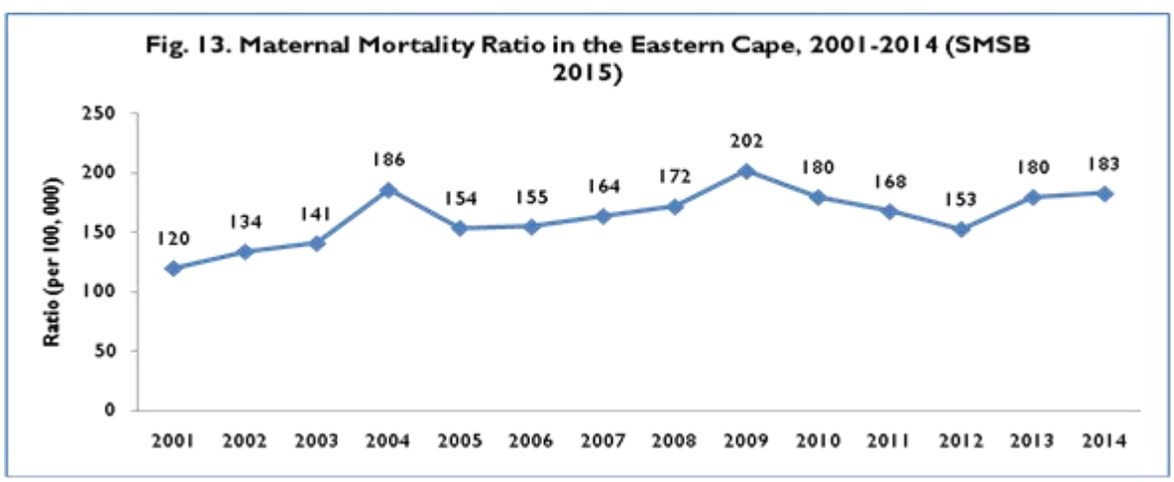
[3] Stillbirth mortality rate is the number of deaths of a fetus after 20 weeks' gestation or 500g per 1,000 live births

[4] 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



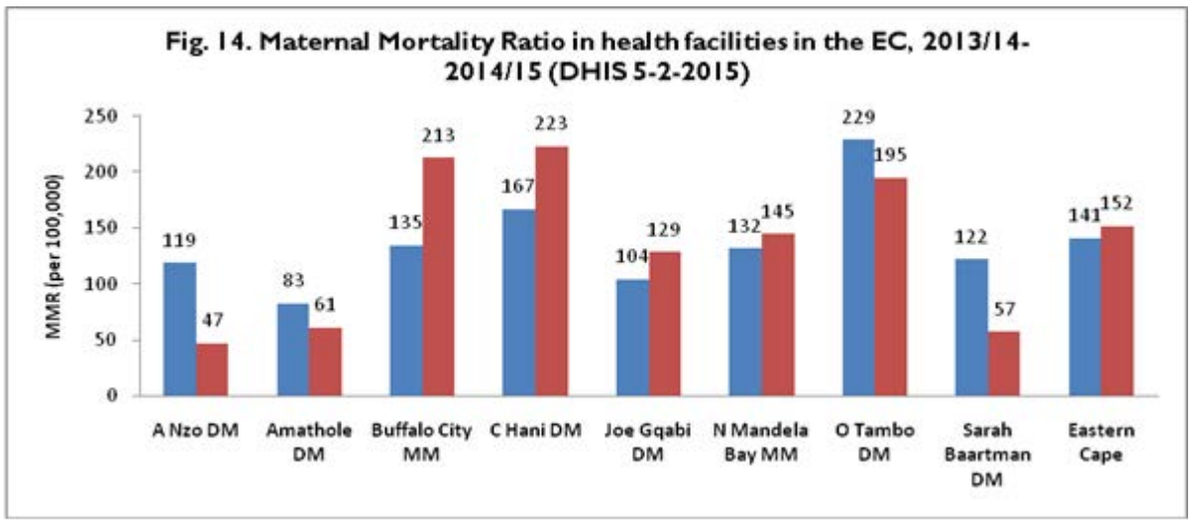
Reducing maternal deaths

Maternal Mortality Rate



As shown in Figure 13, the maternal mortality ratio (MMR)[5] in the Eastern Cape declined from 202 per 100,000 live births in 2009 to 153 per 100,000 live births in 2012. However, an increase occurred from 153 in 2012 to 180 per 100,000 live births in 2013. However, there was an increase which was observed in 2013 where the maternal mortality ratio has increased to 180 per 100,000 live-births.

[5] 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.



District Health Information System (DHIS) data shows that in 2013/14 the highest maternal mortality rate in health facilities was observed in OR Tambo district (228.9 per 100,000 live-births) followed by Chris Hani (166.7 per 100,000) and Buffalo City Metro (134.7 per 100,000). Amathole (82.7 per 100,000) and Joe Gqabi (104.4 per 100,000) reported the lowest maternal mortality rate compared to the other districts. In 2014/15 the high MM Ratios (223, 213 and 195 per 100,000 live births) were reported in Chris Hani, Buffalo City and OR Tambo districts and the low MMRs (47, 57 and 61 per 100,000 live births) were in Alfred Nzo, Sarah Baartman and Amathole districts.

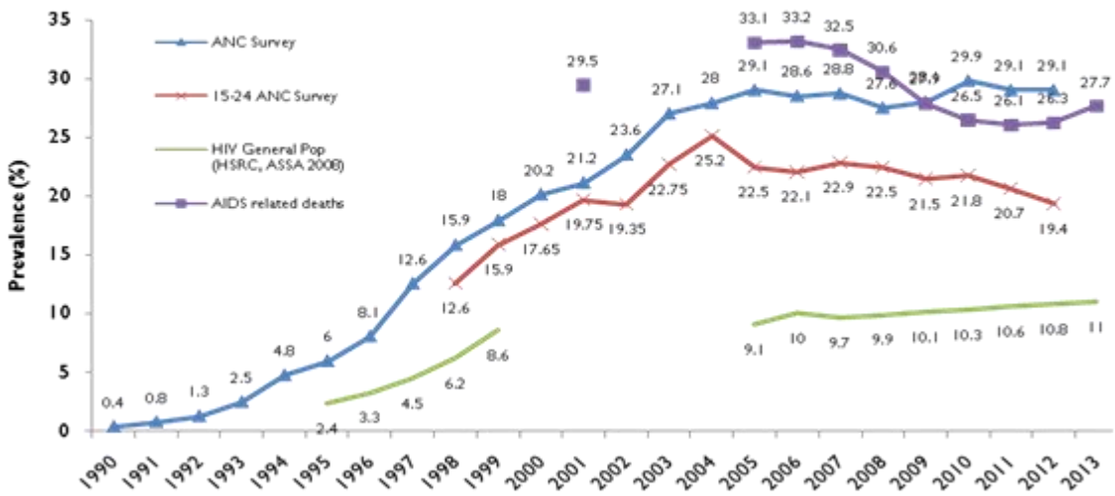
The primary causes of maternal deaths were (NDoH 2012):

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

Combating HIV and AIDS and decreasing the burden of tuberculosis

HIV prevalence & AIDS-related deaths

Fig. 15. HIV prevalence among ANC attendees in Eastern Cape, 1990-2013 (ECDoH 2013, HSRC, HST 2013)



From 2003 to 2013, there was no significant change in the HIV prevalence among the antenatal care (ANC) attendees (15 to 49 years age group). A similar trend was observed in the general population where the HIV prevalence remained between 10% and 11% from 2006 to 2013. However, there was a 5.8% decline in HIV prevalence among the 15 to 24 years age group (ANC attendees) during the 2004 to 2012 period. The decline in HIV prevalence is as a result of interventions such as implementation of dual therapy, use of condoms for both family planning and HIV/STI prevention, increased awareness on sex education program which have been implemented in partnership with supporting partners such as Love life, Soul City (targeting school going youth between the ages of 15-24) and an integrated approach in partnership with Department of Education. These initiatives are to sustain and further improve and sustain the picture by introducing and promoting female condom.

Another positive outcome was the decrease in mortality attributed to HIV &AIDS related causes i.e. from 33.1% in 2005 to 27.7% in 2013. The concern was that there was an increase in AIDS-related deaths which occurred between 2012 and 2013. The noted increase in AIDS-related deaths is attributed to TB/HIV co-infection and poor adherence to treatment. The intervention to address the concern is the introduction of a single drug agent, Fixed Dose Combination, increasing the CD4 initiation threshold from 350 to 500 CD4 and putting the HIV positive pregnant on lifelong treatment.

HIV prevalence by district

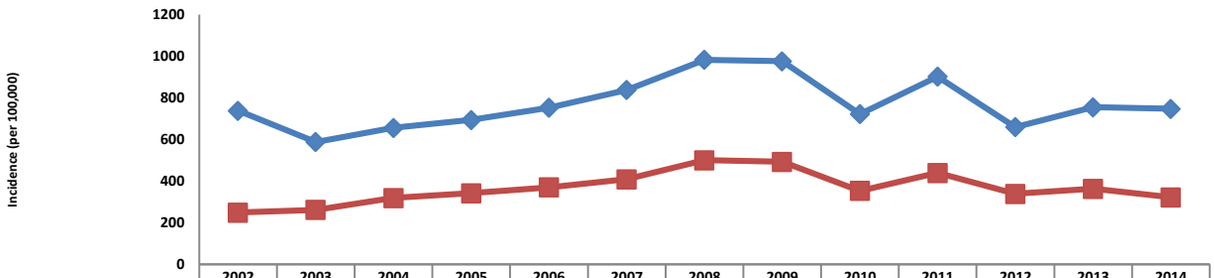
In 2012, there was no significant increase of HIV prevalence in the province. However, Joe Gqabi reported the highest HIV prevalence followed by Buffalo City Metro, Amathole and OR Tambo districts. The limitation of this data is lack of information about the HIV incidence. Joe Gqabi is in the borders of Lesotho and Free State. Buffalo City is highly congested urban areas with people migrating from old Transkei areas. OR Tambo is attributed to repatriated Ex-Miners and labor migration to Gauteng. ARV treatment works on increasing life expectancy for People Living with AIDS. Interventions include establishment of intervention of three High Transmission Area Wellness sites. Currently these sites are in the N2 belt in Port Elizabeth, East London and Mthatha. Intensification of patient education and support through radio talks, and establishment of adherence clubs in partnership with Eastern Cape AIDS Council.

Table 4: HIV prevalence (%) among antenatal care attendees in the Eastern Cape, 2009-2012 (ECDoH, 2012)

HIV prevalence among ANC attendees in the Eastern Cape, 2009 – 2012 (ECDoH 2013)								
District / Metro	**2009**		**2010**		**2011**		**2012**	
	%	**CI (95%)**	**%**	**CI (95%)**	**%**	**CI (95%)**	**%**	**CI (95%)**
Alfred Nzo	25.2	20.6-30.3	30.4	25.5-35.7	28.9	24.6-33.1	24.9	21.0- 29.2
Amatole	23.5	20.0-27.4	30.5	26.5-34.7	28.3	24.3-32.2	31.4	27.7- 35.4
Buffalo City Metro	30.7	27.0-34.7	32.7	28.7-36.9	33.9	30.0-37.9	33.1	29.4- 37.0
Sarah Baartman	24.3	19.2-30.1	20.7	16.1-26.0	25.7	20.3-31.1	25.0	20.0- 30.5
Chris Hani	27.1	23.2-31.3	30.1	26.3-34.2	29.3	25.2-33.4	29.4	25.8- 33.3
Joe Gqabi	23.5	17.8-30.0	30.2	24.4-36.5	29.6	23.7-35.5	35.8	29.9- 42.0
Nelson Mandela Metro	30.7	27.5-34.1	29.0	25.6-32.6	28.1	24.7-31.5	24.4	21.5- 27.5
OR Tambo	30.1	27.4-33.0	31.2	28.2-34.3	28.2	25.3-31	30.2	27.4- 33.1
Eastern Cape	**28.1**	**26.7-29.5**	**29.9**	**28.5-31.4**	**29.1**	**27.7-30.5**	**29.1**	**27.8- 30.4**

GOAL 2: Progressively improve TB prevention and cure

Fig. 16. TB incidence in the Eastern Cape, 2002-2014 (ETR.Net, DHIS 2015)

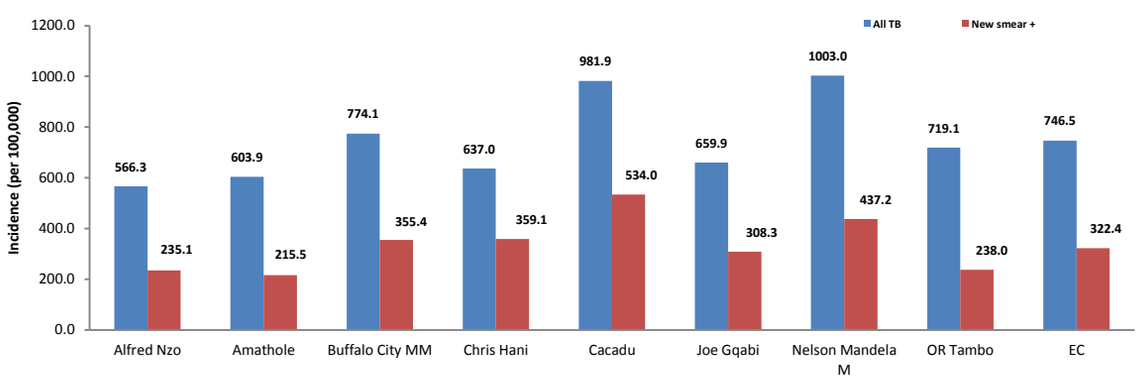


	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
All TB	738	588	656	694	753	838	983	976	722	902	660	755	747
PTB new smear +	249	262	319	342	370	409	500	493	353	439	339	363	322

There was an increase in pulmonary TB new smear positive and all TB cases from 2002 to 2013. There was a decrease in all TB cases from 983 cases per 100,000 in 2008 to 660 cases per 100,000 in 2012. However, there was an increase from 660 per 100,000 in 2012 to 755 per 100,000 populations. There was also a decrease in PTB new smear positive cases from 500 per 100,000 in 2008 to 363 per 100,000 in 2012. Similar to all TB cases, there were was an increase in new smear positive incidence from 339 per 100,000 in 2012 to 363 per 100,000.

As from 2011, during introduction of gen-expert, an intensive case finding was embarked on, whereby the TB index was traced and all the household members screened and tested. A circular was drafted and circulated to the districts informing the facilities to take two specimens from the suspects; the first one will be used for expert tests and second one as a baseline smear if the specimen is positive.

Fig. 17. TB incidence by district in the EC, 2014 (ETR.Net, DHIS 2015)

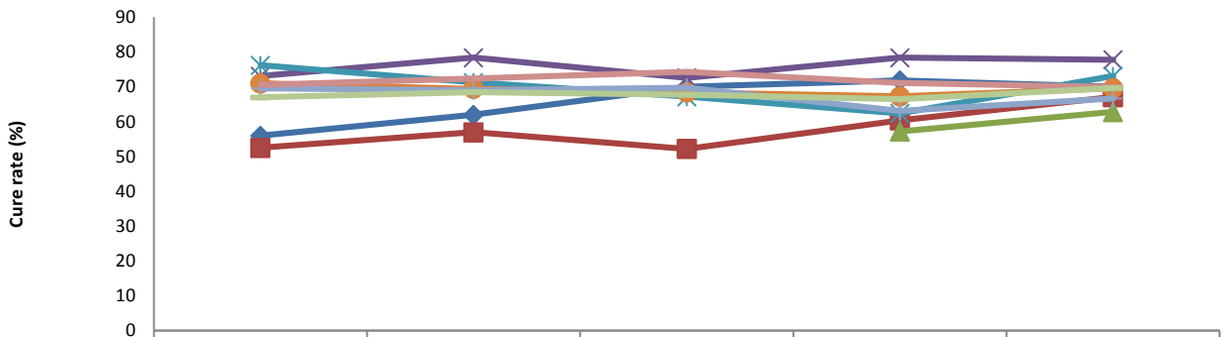


For the year 2014, the incidence of all new TB cases and new smear positive TB cases was 747 per 100,000 and 322 per 100,000 populations respectively. Nelson Mandela Metro and Sarah Baartman reported the incidence which was above 900 per 100,000 with the lowest incidence reported in Alfred Nzo district. The highest new smear positive TB incidence was observed in Sarah Baartman followed by Nelson Mandela Metro, Chris Hani and Buffalo City Metro. Sarah Baartman has farming areas and employ seasonal workers which have high mobility.

As they move around they infect each other. They also default treatment and it becomes difficult to trace them, their lifestyle also has a negative impact. Use of alcohol, smoking and the high rate of poverty in the area. The Department is strengthening relations with farmers so that they allow health education to take place in their farms. The department is engaging partners and strengthening IEC as part of its interventions.

Treatment Outcomes

Fig.18. TB cure rate by district in the Eastern Cape, 2009-2013 (ETR.Net, DHIS 2015)



	2009	2010	2011	2012	2013
A Nzo	56	62	70	71.9	70
Amathole	52.5	57	52.2	60.4	67.1
BCM				57.2	62.8
Cacadu	73.1	78.4	72.6	78.4	77.8
C Hani	76.2	71.3	67.2	62.4	73.1
Joe Gqabi	71	69.4	68.4	67.3	69.6
NMM	69.6	69	69.8	63.1	66.7
OR Tambo	70.6	72.4	74.3	71.1	69.9
EC	67	68.5	67.8	66.5	69.7

There is an improvement in the cure rates for TB cases from 67% in 2009 to 69.7% in 2013 in the Eastern Cape. There was an improvement in the cure rates in five districts in particular in 2013 when compared to 2012, i.e. Amathole, Buffalo City, Chris Hani, Joe Gqabi and Nelson Mandela. This was as a result of the integration of TB and HIV so that all HIV positive patients are screened, tested for TB and those that are having TB disease are put on treatment. Partners (NGOs) were also involved to assist in the tracing of interrupters so that they can continue with the treatment. Patient education at facility level was intensified and the strengthening of DOT / buddy.

The cure rate for Buffalo City Metro which was previously presented under Amathole was 62.8% in 2013, from 57.2% in 2012.

Fig.19. Treatment outcomes for the new TB cases who didn't complete treatment or not evaluated in the Eastern Cape, 2013 (ETR.Net 2015)

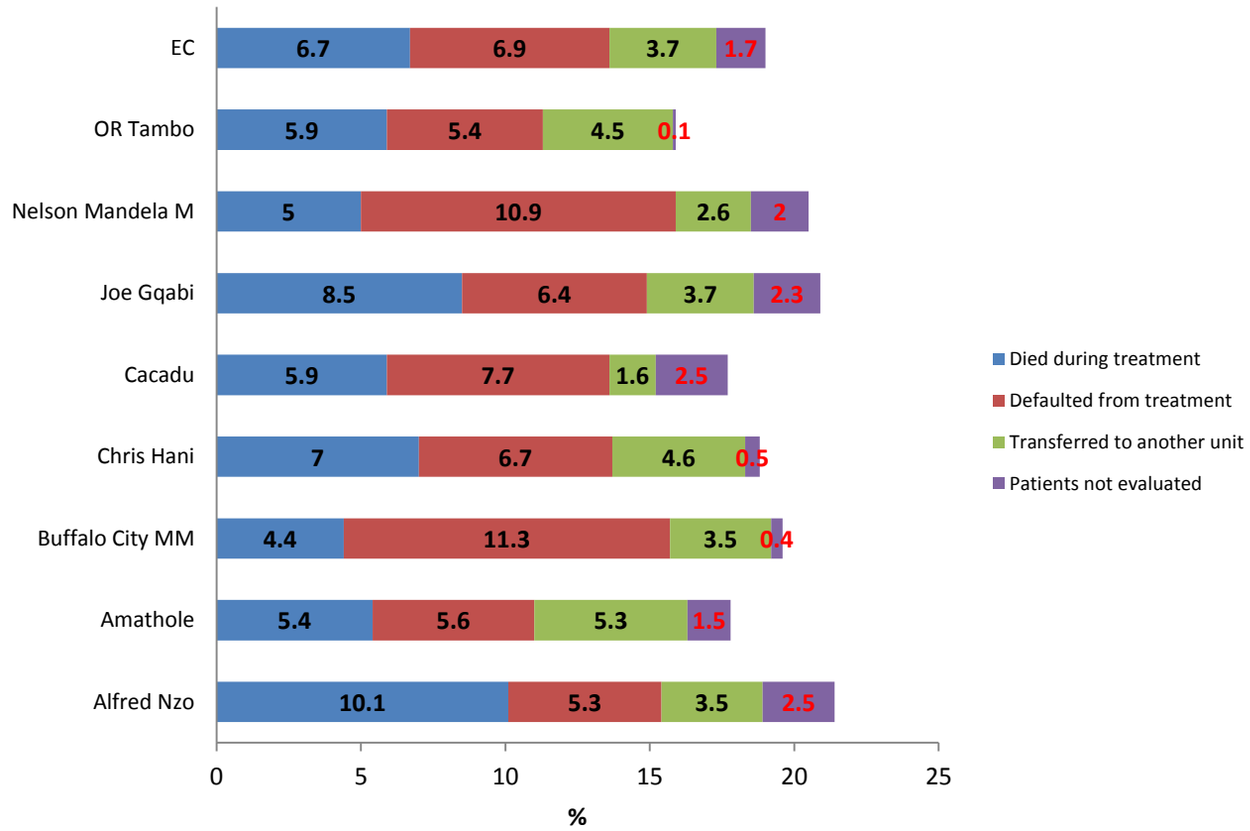


Figure 19 above shows the treatment outcome of those new TB patients who did not complete treatment. In 2013, there were 6.7% deaths among the TB cases, 3.7% were transferred, 6.9% defaulted and 1.7% of those cases were not evaluated. The highest percentage of TB patients who died while on treatment was reported in Alfred Nzo district

GOAL 7: Primary healthcare teams provide care to families and communities

PHC Re-engineering

As part of strengthening the Primary Health Care system, a number of Ward Based Outreach Teams (WBOT) teams have been established in all 8 districts so as to assist registering households. The table below indicates the status core in the province.

Table 5: PHC teams established per sub-district

District	Sub-district	Number of wards	No. of h/holds	Baseline number of existing teams	Existing teams (30 December 2014)
	Maluti	26		0	17
	Umzimvubu	76		3	32
	Total	**102**	169,260	**3**	**49**
Amathole	Amahlathi	38		16	32
	Mbashe	31		6	29
	Mnquma	31		2	19
	Nkonkobe	25		2	17
	Total	**127**	237,776	**32**	**97**
Buffalo City		**50**	223,568	**6**	**14**
Cacadu	Camdeboo	21		0	5
	Kouga	29		0	4
	Makana	24		5	16
	Total	**74**	125,637	**5**	**25**
Chris Hani	Emalahleni	17		7	25
	Engcobo	20		4	15
	Lukhanji	31		6	36
	Intsika Yethu	21		13	33
	Inxuba Yethemba	14		14	14
	Sakhisizwe	9		9	9
	Total	**112**	210,852	**53**	**132**
Joe Gqabi	Elundini	17		1	7
	Maletswai	11		1	7
	Senqu	19		5	8
	Total	**47**	97,778	**7**	**22**
Nelson Mandela	A	24		2	15
	B	15		3	10
	C	21		0	6
	Total	**60**	324,293	**5**	**31**
OR Tambo	KSD	35		9	20
	Mhlontlo	26		2	26
	Nyandeni	51		6	42
	Qaukeni	31		6	26
	Total	**143**	298,224	**23**	**114**
TOTAL		**715**	1,687,388	**128**	**484**

GOAL 8: Universal health care coverage

National Health Insurance (NHI)

The National Health Insurance (NHI) is intended to bring about reform that will improve service provision with the ultimate goal to provide a social response to health problems. This will result in the overall decrease in the burden of disease, and is driven by an overarching intent and moral obligation to ensure social justice with regards to the saving of lives in line with Chapter 27 of the Constitution. Furthermore, the NHI is meant to promote equity and efficiency so as to ensure that all South Africans have access to affordable, quality healthcare services regardless of their socio-economic status.

The province is currently piloting NHI Readiness in the OR-Tambo District and is gearing to launch a second Pilot District during the 2015/16 Financial Year in Alfred Nzo. The OR- Tambo District was allocated with a Conditional Grant Budget during the 14/15 financial year amounting to R7m, and is charged with the mandate to achieve the strategic goal of which is *to 'Improve the performance of the District Health System through testing service delivery and provision innovations in preparation for the implementation of National Health Insurance (NHI)'*. Wherein the Province has been focusing on the four main outcomes listed below, inclusive of the current performance as follows:

Strengthened district capacity for monitoring and evaluation, including research/impact assessment reports of selected interventions.

The Province has been fortunate to have recently appointment a dedicated DDG: NHI, who is expected to drive the project activities at the O.R.Tambo pilot Site, this would also include the appointment of a Deputy Director: NHI M&E who will also bolster the monitoring and evaluation activities already commencing.

Strengthened coordination and integration of existing Municipal Ward-based Outreach teams within pilot districts. Existing Municipal Ward-based Outreach Teams are functional and their composition and performance is characterised as follows:

- **District Clinical Specialist Teams**: 5 out of 7 District Clinical Specialist Teams (DCST) Members have been appointed, and will support the district and WBOTS with the development and delivery of priority health care programmes.
- **GP Contracting:** 48 GPs have confirmed interest to participate in the NHI Pilot; but appointment is on hold pending National Department of Health and HR processes.
- **Integrated School Health Programme**: The ISHP led by School Health Nurses, has seen the procurement of of 3 PHC Vehicles, the incorporation of SGBs and has also partnered with the Department of Education (DOE) to focus on Quintile1 & Quintile 2 schools on a sexual reproduction campaign to reduce teenage pregnancy of school children and identification of disabled children
- **CHCWs**: At least 70% of the active CHCWs have been equipped with tool kits and training manuals.
- **Social Compact:** Over 100 additional Nurses have been appointed at the Pilot Site, in order to bolster the implementation of National Core Standards (NCS) with a focus on 6 Core Priorities. Furthermore, implementation of the Rapid Response, a MEC Initiative, and awarding of bursaries to students to study pharmacy, dentistry and implementation of the Cuban Medical Programme will add to the NHI readiness activities already on the ground

Strengthened Supply Chain Management

An electronic SCM Document Management Solution and High Volume Scanners and Heavy Duty Printers have been procured and implementation is being rolled out at the District office and 4 Sub District Offices in O R Tambo. All supply chain management documents are in the process of being converted to electronic documents for ease of accessibility and audit improvement in lieu of NHI readiness.

Strengthened monitoring and evaluation of direct delivery of chronic medication to patients.

Through the assistance of the Health Systems Trust (HST), the district has appointed a CCMDD Pharmacist to plan and monitor impact of the project. Furthermore a service provider has been identified to assist with an electronic solution for the monitoring of the direct distribution of chronic medication

The NHI Conditional Grant pilot site objectives have since been reviewed for the remaining MTEF period and will now focus on the following:

- Improve systems for preventive health, community involvement and home based care, through the existing Municipal Ward-based Outreach Teams equipped to collect relevant data for better management of households in order to prevent illnesses
- Streamline Supply Chain Management processes in order to optimise Value for Money of Non Negotiables
- Monitoring and evaluation of the NHI activities undertaken in readiness of roll-out at OR-Tambo District

It must be noted that, the grant funding as per Division of Revenue Act is limited only to these readiness activities, but is however, not limited from adding additional activities which will be funded from other sources.

There is still a long way to go with the NHI project, and still has many obstacles to overcome, with many lessons to learn. Whilst, pending the adoption of the NHI White Paper, there is a real need for a thorough review of the NHI activities with a view towards a better organized and more concerted partnership at all levels of management (National, Provincial & District), including external Multi-Sectoral Partners in order to realize significant gains in the coming financial year.

Infrastructure Delivery

The infrastructure improves access to health care services through provision of new health facilities, upgrading and revitalisation, as well as maintenance of existing facilities, including the provision of appropriate health care equipment. A number of capital and maintenance projects that includes health technology services are being rolled out in the entire provinces. The projects main focus is on community health facilities, emergency medical services, district hospital services and provincial or tertiary hospital services. The concentration of the development infrastructure projects is in the OR Tambo NHI pilot region.

Table 6: District Hospitals

There are 65 district hospitals, distributed as follows:

District	No of district hospitals	Population
Chris Hani Health District	14	795 461
Amathole Health District	12	892 636
Joe Gqabi Health District	11	349 768
Sarah Baartman	10	450 584
OR Tambo Health District	9	1 364 944
Alfred Nzo	6	801 345
Buffalo City	2	755 201
Nelson Mandela	1	1 152 115
TOTAL	**65**	**6 562 054**

District Hospitals are further sub-divided into:

- 24 Revitalised Service Delivery Platform (RSDP)
- 41 Community Health Hospitals, and
- 1 Chronic sick hospital.

Governance Structures

Term of office for 40 of the 65 District Hospital Boards expired on the 30th September 2014. The positions were advertised. The process of filling vacancies commenced in October 2014.

Referral System for District Hospitals

The referral System for the District Hospitals is as follows:

Level 1: Community-based Health Care Teams: This level consists of Ward-based Outreach Teams, Community Health Workers and Health Posts, who perform the following functions, but not limited to:

- Identifying health needs and refer to the clinic or the district hospital, depending on the need and determined appropriate level of care
- Providing community based health care services
- Planning for health care services' needs

Level 1: Clinic or Primary Health Care Facility: This level consists of clinics which:

- Render promotive, preventative and rehabilitative services
- Render primary and curative services
- Carry out health promotion services
- Render supervisory support services to community based health care activities.
- Render outreach services
- Conduct continuous in service training
- Refer patients to the next level of health care according to the set referral criteria and services needs in the community
- Provide medicine dispensing services

Level 1: Community Health Centre: Functions at this level may vary depending on the availability of a doctor and primary diagnostic services e.g. X-ray and laboratory Services. The Community Health Centre:

- Renders promotive, preventive and rehabilitation services to the communities
- Renders Primary, curative and medicine dispensing services
- Renders supportive supervisory services to the community based health care providers
- Conducts in-service training
- Conducts operational research
- Plans and budgets for the facility needs
- Refers patients to the next level of health care according to the set referral criteria
- Supports Clinics

Level 1: District Hospital: The district hospital renders 24 hour health care services as determined by the legislative framework, District Health System's Norms and Standards for District Hospitals Government Gazette No. 9570 and Referral Policy of the Eastern Cape Department of Health

Level 2: Regional Hospital: This is the level between the district and central hospitals, which provides both secondary and tertiary health care. It carries out its functions as determined by the legislative framework, Government Gazette No. 9570 and Referral Policy of the Eastern Cape Department of Health

Level 2: Specialized Hospitals: This is the level provides specialized services, such as TB Hospitals as determined by the legislative framework, Government Gazette No. 9570 and Referral Policy of the Eastern Cape Department of Health
Level 3: Tertiary Hospital: This is the level between Class 1 and national level which provides both secondary and tertiary health care. It carries out its functions as determined by the legislative framework, Government Gazette No. 9570 and Referral Policy of the Eastern Cape Department of Health

Level 4: Central Hospital: This is the highest level of health care which provides highly specialized health care services. It links up with other national and international health care providers. It carries out its functions as determined by the legislative framework, Government Gazette No. 9570 and Referral Policy of the Eastern Cape Department of Health

Table 7: Review of Progress towards the Health-Related Millennium Development Goals (MDGs)

MDG GOAL	TARGET	INDICATOR	SOURCE OF DATA	BASELINE (2009)	PROGRESS TO DATE (2014)	TARGET 2015/16
Goal 1: Eradicate Extreme Poverty And Hunger	Halve, between 1990 and 2015, the proportion of people who suffer from hunger	Prevalence of underweight children (under five years)	DHIS(2014)	13.5%	13.7%	11%
Goal 4: Reduce Child Mortality	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	Under-five mortality rate	DHIS(2014) SADHS	83.7 per 1000	29.0 per 1000	26/1000
		Infant mortality rate	SADHS	52.0 per 1,000	24.5 per 1000	22.1/1000
		Proportion of one-year-old children immunised against measles	DHIS(2014)	86.8%	80%	90%
Goal 5: Improve Maternal Health	Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate	Maternal mortality ratio	National Confidential Enquiries into Maternal Deaths, 2002-2004 (SMSBs +DHIS(2014)	202	180	112/100,000
		Proportion of births attended by skilled health personnel	SADHS 2003	86%	89%	100%
Goal 6: Combat HIV and AIDS, Malaria and other diseases	Have halted by 2015, and begin to reverse the incidence of HIV/AIDS, Malaria and other major diseases	HIV prevalence among 15- to 24-year-old pregnant women	National HIV and Syphilis Prevalence Survey of South Africa 2007	21.5%	29.1%	12.1%
		Contraceptive prevalence rate	SADHS 2003	62.4%	29.2%	63%
		Proportion of tuberculosis cases detected and cured under directly observed treatment, short-course (DOTS)	DHIS, 2008	64% (415,2592)	79.9%	82%

4.6 ORGANISATIONAL ENVIRONMENT

The department is mandated to deliver quality healthcare to the people of the Eastern Cape. Therefore, the Human Resources and Corporate Services Cluster needs to ensure that professional plans are in place for the production, recruitment and retention of sufficient healthcare workers and that the principle of equity of access is applied throughout the province.

In order to ensure the achievement of this target, it is essential that workforce planning is done from a scientific perspective to ensure that the healthcare service delivery needs are reflected in the organisational structure – and in particular, that the department has the right skills mix of employees, based on workload variables and which are equitably distributed throughout the province.

The province takes direction from the National Department of Health in terms of human resources management, development and planning. Health workforce planning is essential for ensuring a consistent supply of the correct cadres of health professionals, based on need, into the system. The department has aligned its priorities to the National Department of Health's "Human Resources for Health (HRH) Strategy for the Health sector 2012/13-2016/17" and in particular, to the three thematic concerns listed below:

Theme I: The supply of health professionals and equity of access

In order to ensure that supply meets demand, the department has set plans in place that will ensure a seamless flow from "production" to "appointment" in order to meet the mandated service delivery needs

- The department has set up an Annual Intake Committee to coordinate and manage the annual intake of Interns, Community Service and Post-Community Service applicants with the specific goal of ensuring that district health services are covered
- The department has provided new leadership and management for the Registrar Program and this program will continue to strengthen the provision of specialist services at the tertiary and regional hospitals
- The department has signed Service Level Agreements with various academic institutions to ensure in order to ensure the continuous supply of critical health professionals
- The department has a program for the recruitment of foreign-qualified doctors and works through the Foreign Health Workforce Management directorate of the National Department of Health and Africa Health Placements for the placement of doctors at district and regional hospitals
- Through a process of re-prioritization of the COE budget allocation, the department has managed to include key posts (both clinical and non-clinical) in the Annual Recruitment Plans and to fill them within the budget
- In order to ensure a coordinated approach to planning the department is implementing a stratified approach to planning by using the WISN (Workload Indicators Staffing Norms) guidelines for the organisational establishment and is in the process of implementing a human resources strategic planning tool as per the NDOH guidelines
- A new HR Management Information System (HR MIS) has been developed to enable the department to improve the management and accuracy of the data on the PERSAL system and this report is submitted together with the monthly PERSAL reports

Theme II: Education, training and research

- The department has significantly strengthened the education and training of medical doctors by increasing its capacity to send a higher number of students to Cuba to study medicine
- Education and training has been strengthened by the revitalization of the Clinical Teaching Platform, and the Department has appointed clinical staff to provide the necessary on-site capacity-building in various clinical categories at hospitals
- The Regional Training Centres have been taken over by the department and plans are underway to revitalize these facilities in order to bring them to the required standard of training
- The department has revitalized the Registrar Program and the target is increasing exponentially in order to strengthen specialist numbers and this is also used as a retention strategy
- The department has entered into Service Level Agreements with academic institutions for clinical and non-clinical educational and training programs to strengthen both clinical and non-clinical management
- The department is fully supportive of Continuing Professional Develop and such training is included in the annual Workforce Skills Plans

Theme III: The working environment of the health workforce

- The department has undertaken a focused Change and Culture Management initiative in order to focus on aspects of workplace culture, ethics and diversity management and provides continuous training workshops
- Management and leadership training is provided through an external service provider – this is based on the Minister of Health's identification of management and leadership in the health sector, at all levels, as being the 'Priority Number 1' for HRH – and this is being facilitated through the University of Fort Hare, Nelson Mandela Metropolitan University the University of Pretoria
- The department has re-aligned the HR and Corporate Services in order to meet the internal client needs and to improve levels of internal service to all employees at all health facilities and Head Office
- There is close collaboration between the Corporate Services directorate of this cluster and Infrastructure in terms of office space for Head Office and Districts as well as accommodation planning and provision for core health professionals at the health facilities
- The department has strengthened the Performance Management Development System and will continue to do so by ensuring that all employees sign performance contracts, are reviewed in accordance with the prescripts and that this is loaded on to Persal and has issued circulars to the effect that unless loaded on to PERSAL within the given deadline, consequences will follow; the PMDS Moderating Committee has met regularly and is close to completing the backlogs for the 2012/13 and 2013/14 years
- The department has launched the Consequence Management intervention and is providing training, through the newly established Employee Relations Training Unit, to all managers, HR officials and employees to ensure compliance with regulations and job requirements
- The Employee Wellness Unit will undertake an Employee Satisfaction survey annually in order to determine areas that need to be addressed to ensure a healthy and satisfied workforce and to include these issues in to the Human Resources Plans

4.7 Summary of the Organisational Structure

The Department of Health has revised the organogram to focus fully on health care service delivery and has developed a new Service Delivery Model. The revised organogram resulted in an "ideal" organogram that would have provided an ideal work environment with a full staff complement. However, as the ideal organogram proved to be unaffordable, the challenge is to bring the cost of the organogram within the departmental budget allocation. This process is currently underway and encompasses an exercise of streamlining the Head Office as the main objective of this is to have a 'lean' Head Office and to strengthen and build the capacity at district level by deploying officials to the districts. This will bolster the achievements of targets such as the Primary Healthcare Re-engineering, the National Health Insurance, the Negotiated Service Delivery Agreement (NDSA), the Ten Point Plan for Health and the "Human Resources for Health (HRH) Strategy for the Health sector 2012/13-2016/17" of the NDOH.

As a first step towards reducing the cost of the organogram, the Head Office structure has reduced the number of its Clusters from five to three. The three Clusters are listed below as evidence of the "leaner" Head Office:

(i) The Clinical Cluster, headed by a Deputy Director General
(ii) The Finance Cluster, headed by a Chief Financial Officer
(iii) The Human Resources & Corporate Services Cluster, headed by a Deputy Director General

The process of fitting the organogram into the budget is underway and the final product will be presented through the normal channels to the relevant authorities.

Figure 20: Organisational Structure

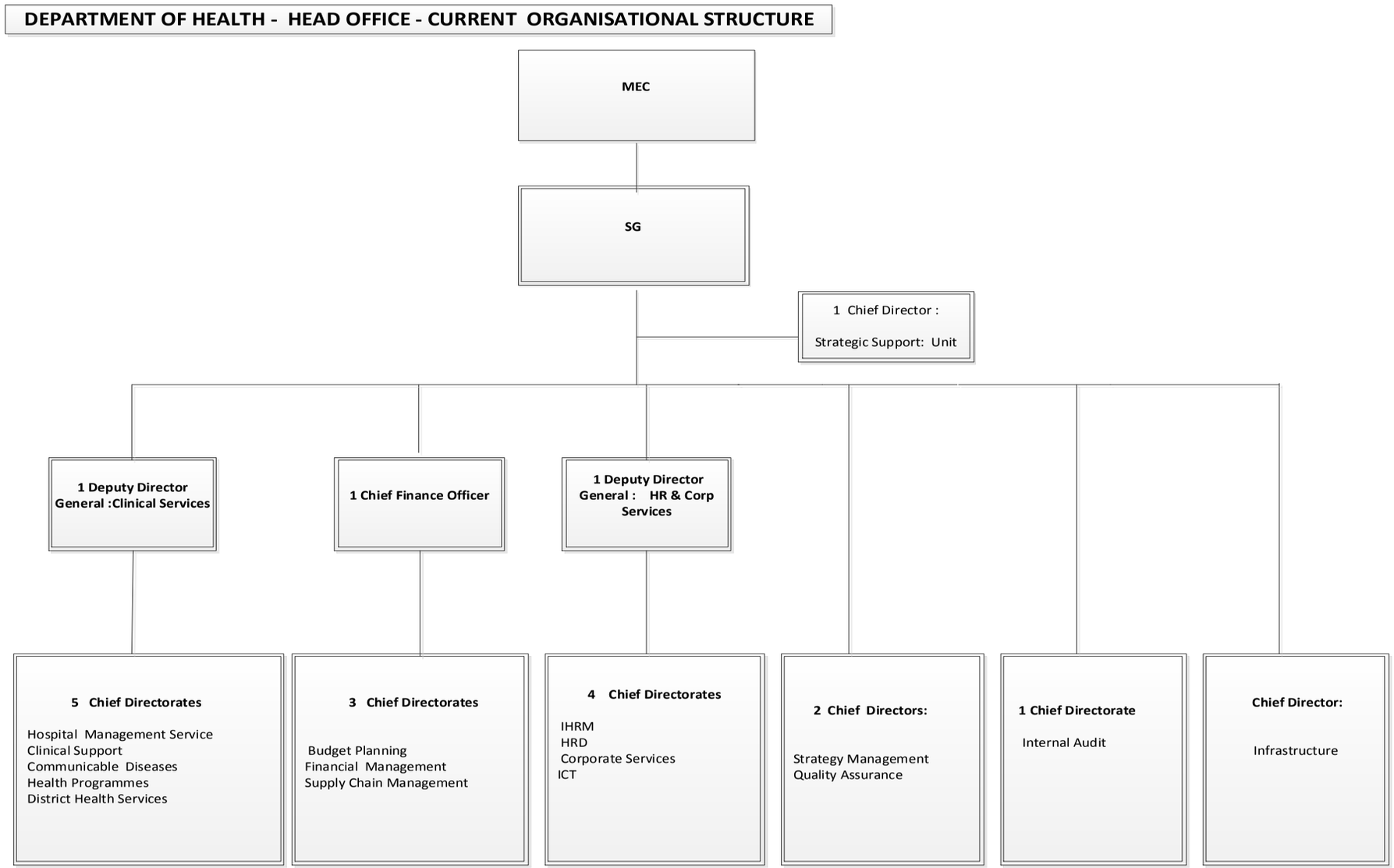


FIGURE 1

4.6.2 Provincial Service Delivery Environment

Table 8: Impact Indicators and Targets

Impact Indicator	Baseline (2009[6])	Baseline (2012[7])	2019 Targets (South Africa)	2013 Baseline (Province)	2019 Target (Province)
Life expectancy at birth: Total	56.5 years	60.0 years (increase of 3,5years)	63 years by March 2019 (increase of 3 years)	56.5	62
Life expectancy at birth: Male	54.0 years	57.2 years (increase of 3,2 years)	60.2 years by March 2019 (increase of 3 years)	53.0	56
Life expectancy at birth: Female	59.0 years	62.8 years (increase of 3,8years)	65.8 years by March 2019 (increase of 3years)	59.0	62
Under-5 Mortality Rate (U5MR)	56 per 1,000 live-births	41 per 1,000 live-births (25% decrease)	23 per 1,000 live-births by March 2019 (20% decrease)	29.0 per 1000 live births	20/1000
Neonatal Mortality Rate	-	14 per 1000 live births	6 per 1000 live births	8.8 per 1000 live births	10/1000
Infant Mortality Rate (IMR)	39 per 1,000 live-births	27 per 1,000 live-births (25% decrease)	18 per 1000 live births	19.1 per 1000 live births	16/1000
Child under 5 years diarrhea case Fatality rate	-	4.2%	<2%	5.1	4.0
Child under 5 years severe acute malnutrition case fatality rate	-	9%	<5%	12.4%	5%
Maternal Mortality Ratio	304 per 100,000 live-births	269 per 100,000 live-births	Downward trend <100 per 100,000live-births by March 2019	180 per 100, 000live-births	100/100 000

[6] Medical Research Council (2013): Rapid Mortality Surveillance (RMS) Report 2012
[7] Medical Research Council (2013): Rapid Mortality Surveillance (RMS) Report 2012

Table 9: Medium Term Strategic Framework (MTSF) 2014-2019

Alignment between NDP Goals 2030, Priority interventions proposed by NDP 2030 and Sub-outcomes of MTSF 2014-2019

NDP Goals 2030	NDP Priorities 2030	Sub-Outcomes 2014-2019 (MTSF)	ECDoH Strategic Objectives	Page in the document
Average male and female life expectancy at birth increased to 70 years	a. Address the social determinants that affect health and diseases d. Prevent and reduce the disease burden and promote health	HIV & AIDS and Tuberculosis prevented and successfully Managed	1.5 HIV infection rate reduced by 50% by 2019	60
Tuberculosis (TB) prevention and cure progressively improved;			1.6 TB death rate reduced by 50% in 2019	61
Maternal, infant and child mortality reduce		Maternal, infant and child mortality reduced	1.8 Child Mortality Reduced to less than 34 per 1000 population by 2019	61
			1.7 Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019	61
Prevalence of Non-Communicable Diseases reduced by 28%			1.2 Screening coverage of chronic illnesses increased to 90 000 by 2019	60
Health systems reforms completed	b. Strengthen the health system	Improved health facility planning and infrastructure delivery	2.7 (721)Health facilities refurbished to comply with the National norms and standards by 2019	91
	c. Improve health information systems	Efficient Health Management Information System for improved decision making	2.2 50% of health facilities connected to web-based DHIS through broadband by 2019	53
	h. Improve quality by using evidence	Improved quality of health care	2.3 Health facilities assessed for compliance with National Core Standards increased to 60% by 2019	59,71,77,78
			2.4 Patient satisfaction rate increased to 75% in health services by 2019	59,71,77,78
Primary health care teams deployed to provide care to families and communities		Re-engineering of Primary Health Care	3.2 100% Ward Based Outreach Teams (WBOT) coverage by 2019	60
Universal health coverage	e. Financing universal healthcare	Universal Health coverage	3.3 100% District clinical specialist	60

NDP Goals 2030	NDP Priorities 2030	Sub-Outcomes 2014-2019 (MTSF)	ECDoH Strategic Objectives	Page in the document
achieved	coverage	achieved through implementation of National Health Insurance	team (DCSTs) coverage for all Districts by 2019	
			3.1 Two districts piloting NHI implementation by 2019	59
Posts filled with skilled, committed and competent individuals	f. Improve human resources in the health sector g. Review management positions and appointments and strengthen accountability mechanisms	Improved human resources for health	2.6.Fifty (50) first year medical students receiving bursaries by 2019	83
		Improved health management and leadership	2.1 Unqualified audit opinion achieved by 2019	53

4.6.2 SITUATIONAL ANALYSIS ON HEALTH PERSONNEL IN 2014/15

Table A1: Health Personnel in 2014/15

Categories	Number employed	% of total employed	Number per 100,000 people	Number per 100,000 uninsured people[2]	Vacancy rate[5]	% of total personnel budget	Annual cost per staff member (R)
Medical officers[3]	1,237	4.0	18	21	41.2	10.2	529,844.68
Medical specialists	201	0.7	3	3	26.6	1.6	645,877.71
Dentists[3]	86	0.3	1	1	42.3	0.7	546,906.79
Dental specialists	0	0.0	0.0	0.0	0	0	0
Professional nurses	9,465	30.6	142	161	29.3	29.5	241,581.65
Enrolled nurses	3,239	10.5	48	55	9.5	4.1	125,965.46
Enrolled nursing auxiliaries	5,825	18.9	87	99	11.5	6.2	102,863.12
Student nurses	997	3.2	15	17	13.8	0.9	81,157.86
Pharmacists[3]	501	1.6	7	9	6.2	1.8	359,331.99
Physiotherapists	91	0.3	1	2	61.9	0.4	198,954.34
Occupational therapists	80	0.3	1	1	59.0	0.4	200,757.8
Radiographers	331	1.1	5	6	26.8	0.9	226,042.68
Emergency medical staff	1,875	6.1	28	32	2.6	2.4	136,119.66
Dieticians & nutritionists	91	0.3	1	2	48.9	0.4	216,488.39
Community caregivers (even though not part of the ECDoH staff establishment)	6,876	22.3	103	117			
Total	**30,895**	**100**				**100**	

Data source: PERSAL

STRATEGIC GOALS

The department is aligning its strategic goals to those agreed upon by the national Department of Health as goals that will guide the health sector plan for the 2014-2019 government cycle. The strategic objectives are in line with the implementation of the National Development Plan, the Medium Term Strategic Framework (MTSF) and the National Health Council Priorities. The department therefore has three strategic goals, aligned to the eight strategic goals of the National Department of Health that will be implemented for the 2015/16-2019/20 term of government. These are:

Strategic Goals

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

4.7 EXPENDITURE ESTIMATES

Table A2: Expenditure estimates and economic classification: Health Administration and Management

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2014/15
R thousand	2011/12	2012/13	2013/14		2014/15		2015/16	2016/17	2017/18	
1. Administration	545 484	536 731	619 349	627 658	659 455	652 736	625 488	658 760	690 444	(4.2)
2. District Health Services	7 285 266	7 953 629	8 659 522	8 674 057	8 755 061	8 856 488	9 338 285	9 700 799	10 331 079	5.4
3. Emergency Medical Services	644 588	619 525	812 946	798 435	890 940	883 222	971 832	989 247	1 038 709	10.0
4. Provincial Hospitals Services	3 860 254	3 979 016	4 304 081	4 530 784	4 476 206	4 521 415	4 691 674	4 950 553	5 198 112	3.8
5. Central Hospital Services	627 075	657 170	774 269	786 007	796 341	811 405	803 770	838 458	890 973	(0.9)
6. Health Sciences And Training	605 824	579 964	650 152	770 384	776 050	757 816	751 910	802 681	838 225	(0.8)
7. Health Care Support Services	78 747	84 309	97 779	114 161	117 464	104 957	102 648	123 456	129 629	(2.2)
8. Health Facilities Management	1 245 044	1 192 168	1 130 157	1 207 526	1 207 526	1 224 719	1 210 307	1 376 935	1 445 781	(1.2)
Total payments and estimates	**14 892 282**	**15 602 512**	**17 048 255**	**17 509 012**	**17 679 043**	**17 812 758**	**18 495 913**	**19 440 889**	**20 562 952**	3.8

% change from 2014/15 to 2015/16

Table above shows the summary of payments and estimates per programme and indicates that total payments grew from R14.892 billion in 2011/12 to a revised estimate of R17.813 billion in 2014/15. Over the 2015 MTEF, the budget is projected to grow from R18.496 billion to R20.563 billion.

When comparing the 2014/15 revised estimate with the 2015/16 estimates, only Programmes 2, 3 and 4, which are the core service delivery Programmes and account for a bulk of the department's budget, show positive growth.

Summary of payments and estimates by economic classification

R thousand	Outcome 2011/12	Outcome 2012/13	Outcome 2013/14	Main appropriation 2014/15	Adjusted appropriation 2014/15	Revised estimate 2014/15	Medium-term estimates 2015/16	Medium-term estimates 2016/17	Medium-term estimates 2017/18	% change from 2014/15
Current payments	**13 513 689**	**14 335 921**	**15 499 838**	**16 087 012**	**16 103 272**	**16 231 000**	**16 908 366**	**17 790 647**	**18 848 877**	4.2
Compensation of employees	9 480 557	9 827 471	10 698 250	11 608 363	11 647 569	11 687 924	12 393 421	12 949 834	13 603 614	6.0
Goods and services	4 019 162	4 504 154	4 797 005	4 478 649	4 455 703	4 540 915	4 514 944	4 840 813	5 245 263	(0.6)
Interest and rent on land	13 970	4 296	4 583	–	–	2 161	–	–	–	(100.0)
Transfers and subsidies to:	**310 300**	**394 486**	**387 171**	**229 836**	**373 198**	**390 540**	**332 493**	**239 447**	**248 431**	(14.9)
Provinces and municipalities	–	7 928	23 202	10 099	16 895	17 771	14 069	5 157	2 427	(20.8)
Departmental agencies and accounts	42 412	24 428	40 541	60 859	80 908	31 055	48 740	63 283	66 447	56.9
Higher education institutions	133 974	101 770	46 759	–	–	–	25 000	–	–	
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–	
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–	
Non-profit institutions	–	–	–	–	–	–	–	–	–	
Households	133 914	260 361	276 669	158 878	275 395	341 714	244 685	171 007	179 557	(28.4)
Payments for capital assets	**1 068 184**	**872 088**	**1 073 406**	**1 192 164**	**1 202 573**	**1 191 218**	**1 255 054**	**1 410 795**	**1 465 644**	5.4
Buildings and other fixed structures	830 211	598 417	554 097	736 984	672 448	689 232	760 184	929 264	997 031	10.3
Machinery and equipment	237 973	273 671	518 661	454 432	529 377	501 553	494 870	481 531	468 613	(1.3)
Heritage Assets	–	–	–	–	–	–	–	–	–	
Specialised military assets	–	–	–	–	–	–	–	–	–	
Biological assets	–	–	–	–	–	–	–	–	–	
Land and sub-soil assets	–	–	–	–	–	–	–	–	–	
Software and other intangible assets	–	–	648	748	748	433	–	–	–	(100.0)
Payments for financial assets	**109**	**17**	**87 840**	–	–	–	–	–	–	
Total economic classification	**14 892 282**	**15 602 512**	**17 048 255**	**17 509 012**	**17 679 043**	**17 812 758**	**18 495 913**	**19 440 889**	**20 562 952**	3.8

% change from 2014/15 to 2015/16

The table above shows the summary of payments and estimates per economic classification from 2011/12 to 2017/18. Compensation of Employees and Goods and Services are the key cost drivers of the department. Between 2014/15 and 2015/16, Compensation of Employees grow by 6 per cent and Goods and Services decrease by 0.6 per cent. The minimal decrease in Goods and Services is due to the reduction of a portion of the budget for NHLS as a result of shifting the function to the national department.

Transfers and subsidies show a significant decrease of 14.9 per cent from the revised estimates of R390.540 million in 2014/15 to R332.493 million in 2015/16. This is due mainly to payments for bursaries for non-employees, leave gratuities and medico-legal claims. The contingent nature of medico legal claims makes it difficult to budget for. Expenditure for payment for capital assets shows an overall increase of 5.4 per cent

PART B

PROGRAMME 1:
ADMINISTRATION

1. PROGRAMME 1: ADMINISTRATION

Programme purpose: This programme comprises of two sub-programmes namely, the Office of the Member of the Executive Council (MEC) and Management. It consists of two sub-programmes as follows:

1.1 OFFICE OF THE MEC

Programme Purpose: To provide political and strategic direction to the department by focusing on transformation and change management.

1.2 MANAGEMENT

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

1.3 PROGRAMME STRUCTURE

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

Finance Cluster

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

Corporate Services Cluster

- Information, Communication and Technology (ICT)
- Human Resource Management (HRM)
- Human Resource Development (HRD)
- Corporate services

Clinical cluster

- District health services
- Hospital Services
- Communicable diseases
- Health Programmes
- Clinical support services

1.4 STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES

Strategic goal (s) being addressed:

Strategic goal 2: Improved quality of care

Table ADMIN 1: Provincial strategic objectives, strategic action and performance indicators and expected outcomes for Health Administration and Management 2019 /20

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	INDICATORS (FOR APP PURPOSES)	BASELINE	PROVINCIAL TARGET BY 2019/20
2.1 Unqualified audit opinion achieved by 2019	Unqualified Audit opinion from the Auditor General by 2019	2.1.1 Audit opinion from Auditor-General	New Indicator	Unqualified audit report
	Achievement of Level 4 MPAT performance	2.1.2 Level 4 MPAT	Level 2	Level 4 MPAT performance report
2.2 50% of health facilities connected to web-based DHIS through broadband by 2019	Implement web based district health information system at 90% of all facilities by 2019	2.2.1 Percentage of hospitals with broadband access	New Indicator	100%
		2.2.2 Percentage of fixed PHC facilities with broadband access	New Indicator	100%

1.5 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table Admin2: Expenditure estimates: Administration

R thousand	Outcome 2011/12	Outcome 2012/13	Outcome 2013/14	Main appropriation 2014/15	Adjusted appropriation 2014/15	Revised estimate 2014/15	Medium-term estimates 2015/16	Medium-term estimates 2016/17	Medium-term estimates 2017/18	% change from 2014/15
1. Office Of The Mec	6 647	5 918	7 866	7 908	7 908	7 590	9 773	9 271	9 735	28.8
2. Management	538 837	530 813	611 483	619 750	651 547	645 146	615 715	649 489	680 709	(4.6)
Total payments and estimates	**545 484**	**536 731**	**619 349**	**627 658**	**659 455**	**652 736**	**625 488**	**658 760**	**690 444**	(4.2)

% change from 2014/15 to 2015/16

Summary of departmental payments and estimates by economic classification: P1 – Administration

R thousand	Outcome 2011/12	Outcome 2012/13	Outcome 2013/14	Main appropriation 2014/15	Adjusted appropriation 2014/15	Revised estimate 2014/15	Medium-term estimates 2015/16	Medium-term estimates 2016/17	Medium-term estimates 2017/18	% change from 2014/15
Current payments	**539 910**	**523 425**	**554 049**	**620 296**	**621 849**	**616 654**	**617 583**	**651 546**	**682 869**	0.2
Compensation of employees	288 964	288 929	326 729	356 813	377 660	380 977	388 061	431 702	453 287	1.9
Goods and services	248 266	232 698	225 820	263 483	244 189	235 265	229 522	219 844	229 582	(2.4)
Interest and rent on land	2 680	1 798	1 500	–	–	412	–	–	–	(100.0)
Transfers and subsidies to:	**275**	**2 361**	**19 577**	**1 327**	**3 119**	**2 295**	**1 388**	**1 452**	**1 525**	**(39.5)**
Households	275	2 361	19 577	1 327	3 119	2 295	1 388	1 452	1 525	(39.5)
Payments for capital assets	**5 211**	**10 928**	**44 900**	**6 035**	**34 487**	**33 787**	**6 517**	**5 762**	**6 050**	**(80.7)**
Machinery and equipment	5 211	10 928	44 412	5 287	33 739	33 354	6 517	5 762	6 050	(80.5)
Software and other intangible assets	–	–	488	748	748	433	–	–	–	(100.0)
Payments for financial assets	**88**	**17**	**823**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**545 484**	**536 731**	**619 349**	**627 658**	**659 455**	**652 736**	**625 488**	**658 760**	**690 444**	**(4.2)**

% change from 2014/15 to 2015/16

Tables above show the summary of payments and estimates per sub-programme and economic classification for Programme1: Administration. Expenditure increased from R545.484 million in 2011/12 to a revised estimate of R652.736 million in the 2014/15 revised estimates. The programme shows a negative growth of 4.2 per cent in 2015/16 which has been brought about by the end of additional funding received for SCM Reform project.

1.6 RISK MANAGEMENT

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

Risk	Mitigating factors
Financial resources (insufficient budget)	Audit Improvement Plan and implementation reports Strengthening of compliance MPAT/ FCMM Fill vacancy for senior positions Revision of standard operating procedures Excel training for finance staff Training for district personnel on accruals and payment of creditors within 30 days
Inadequate Inventory Management	Logis Inventory component to be implemented at Institutions Facilities logistical capacity, e.g.. Warehousing to be improved. Staff assisted with Logis implementation and comprehensively trained.
Poor leadership and institutional culture e.g. silo behavior	Financial Misconduct Committee Critical Leadership Positions (executive posts) to be filled
Inefficient and ineffective Supply Chain Management process	SCM reform plan and implementation reports Implementation and utilisation of LOGIS Training on revised policy and SOPs Training of BID Committees Professionalization of the SCM Function Implementation of term contracts for frequently used items(patient food, Stationery & Travel, medical equipment) Restrict / Removal of suppliers related to officials transacting with the department
Ineffective Human resources management	HR Delegations have been released to all districts Production level staff can be appointed at district level The Annual Recruitment Plan is updated annually The vacancy rate has been reduced by 10% Strengthening of compliance with MPAT/ FCMM Staff are replaced within three months The Registrar Program produces sufficient specialists and the number of medical students sent to Cuba has increased by around 90 students per annum since 2012/13 The HR Accruals project has paid 75% of all claims A special unit has been established to pay leave gratuities within three months of employees exiting the system The PMDS Moderating Committee has cleared 90% of all performance reviews for SMS and levels 12 and below The Annual Recruitment Plan includes the recruitment of local, foreign and the NDOH-based Cuban Doctor program A special Employee Relations Training Unit has been established and training is done across the province The PMDS Unit manages the contracting of employees The HPTD Grant manages clinical training. Persal cleanup project is progressing well through the implementation of the HR MIS tool
Inadequate provision of ICT (information communication	ICT Governance Implementation Plan Reports Currently expanding on WAN connectivity Finalizing the implementation of data centres services

Risk	Mitigating factors
technology) services and governance of the environment. Inadequate business enterprise architecture	Migrating from Novel directory services to Microsoft active directory Filling of critical vacancies within ICT directorate

PROGRAMME 2:
DISTRICT HEALTH SERVICES (DHS)

2. PROGRAMME 2: DISTRICT HEALTH SERVICES

PROGRAMME PURPOSE

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

PROGRAMME DESCRIPTION

The District Health Service (DHS) programme is composed of nine sub-programmes, namely:

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

PROGRAMME STRUCTURE

2.1-2.3 DISTRICT MANAGEMENT, CLINICS AND COMMUNITY HEALTH CENTRES

PURPOSE

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

2.2 **Clinics:** The sub-programme manages the provision of preventive, promotive, curative and rehabilitative care, including the implementation of priority health programmes through accessible fixed clinics and mobile services in 26 sub-districts.

2.3 **Community Health Centres (CHCs):** The sub-programme renders 24-hour health services, maternal health at midwifery units and the provision of trauma services, as well as the integration of community-based mental health services within the down referral system.

Table DHS1: Provincial strategic objectives, strategic action and performance indicators and expected Outcomes for District Health Services 2019/20

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	INDICATOR	BASELINE	TARGET 2019/20
3.1 Two districts piloting NHI implementation by 2019	Ensure proper implementation of NHI by 2019	3.1.1 Number of districts piloting NHI interventions	New Indicator	2
		3.1.2 Establish NHI Consultation Fora	New Indicator	3
2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Ensure all facilities are conditionally compliant (50%-75%) by 2017 and fully compliant (75%-100%) to National Core Standards by 2019	2.3.19 Percentage of fixed PHC Facilities scoring above 80% on the ideal clinic dashboard.	New Indicator	100%
		2.3.2 National core standards self-assessment rate (District Hospitals)	75%	85%
		2.3.7 Quality improvement plan after self-assessment rate (District Hospitals)	91.6%	100%
		2.3.13 Percentage of District Hospitals compliant with all extreme and vital measures of the national core standards	New Indicator	50%
2.4 Patient experience of Care rate increased to more than 75% in health services by 2019	Ensure 80% of users visiting PHC facility are satisfied with the health services by 2019	2.4.1 Patient experience of Care survey rate (PHC)	73%	86%
		2.4.8 Patient experience of Care rate (PHC facilities)	New Indicator	70%
	Improve management of patients to optimize average length of stay by 2019	2.4.2 Patient experience of Care survey rate (District Hospitals)	New Indicator	100%
		2.4.9 Patient experience of Care Rate (District Hospitals)	60%	80%
	Ensure all PHC facilities are fully compliant to National Core standards by 2019	2.4.15 Complaints resolution rate (PHC)	New Indicator	97%
		2.4.22 Complaint resolution within 25 working days rate (PHC)	72.7%	90%
	Ensure all district hospitals are conditionally compliant (50%-75%) by 2017 and fully compliant (75%-100%) to National Core Standards by 2019	2.4.16 Complaints resolution rate (District Hospitals)	New Indicator	95%
		2.4.23 Complaint Resolution within 25 working days rate (District Hospitals)	83.5	90%

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	INDICATOR	BASELINE	TARGET 2019/20
3.2 100% Ward Based Outreach Teams (WBOT) coverage by 2019	Appoint Ward Based Outreach Teams (WBOTs) in 23 Rural Districts (as classified by the Dept. of Rural Development) by 2019	3.2.1 OHH registration visit coverage	140.9%	40%
		3.2.2 Number of ward-based outreach teams appointed	349	726 (40 new)
3.3 100% District clinical specialist team (DCSTs) coverage for all Districts by 2019	Fully fleshed District Clinical Specialist Teams appointed in all districts by 2019	3.3.1 Number of Districts with District Clinical Specialist Teams (DCSTs)	New Indicator	8
1.1 PHC utilisation rate increased to 3 visits per person per year in all facilities by 2019	Ensure total population is utilizing public Primary Health Care facilities at least 3 times a year by 2019	1.1.1 PHC utilisation rate (annualised)	2.6	3
3.5 Reduction of the traditional Male circumcision mortality to less than 10 by 2019	Reduce mortality ratio to 0/1000 among traditional male circumcision by 2019	3.5.1 Mortality rate among traditional male circumcision initiates(expressed per 1000 initiates)	0.14 per 1000	0 per 1000
1.2 Screening coverage of chronic illnesses increased to 90 000 by 2019	Reduce hypertension and diabetes incidence by 2019	1.2.1 Clients screened for hypertension – 25 years and older	New Indicator	90 000
		1.2.2 Clients screened for Diabetes – 5 years and older	New Indicator	90 000
		1.2.4 Clients screened for mental disorders	New Indicator	1.2
	Ensure that at least 48% of all women 30 years and older are screened once every 10 years.	1.2.3 Cervical cancer screening coverage	44.1%	70%
1.4 Mental health service platform increased to 55% of hospitals by 2019	Increase number of patient treated for mental health disorder by 2019	1.4.1 Clients treated for mental disorders	New Indicator	55%
		1.4.2 Number of District Mental Health Teams established	New Indicator	8
2.5 100% Compliance with the Waste Management Act by 2019	Ensure that all facilities comply with SANS waste disposal requirements when segregating waste	2.5.1 Percentage of health facilities complying with SANS waste disposal requirements	78.5	100%
1.5 HIV infection rate reduced by 50% by 2019	Progressively ensure all HIV positive patients eligible for treatment are initiated on ART by 2019	1.5.1 Total clients remaining on ART	288	785 911
		1.2.2 Client tested for HIV (incl. ANC)	923 407	1 430 000
	Reduce HIV Incidence to 50% by 2019	1.5.3 Male condom distribution rate (annualized)	19%	55%
		1.5.4 Female condom distribution rate (annualized)	0.6%	3%

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	INDICATOR	BASELINE	TARGET 2019/20
		1.5.5 Medical male circumcision performed – Total	6 815	140 000
1.6 TB death rate reduced by 50% in 2019	Increase TB cure rate to 50% by 2019	16.1 TB symptoms 5 years and older screened rate	New Indicator	90%
		1.6.2 TB client treatment success rate	68.2%	85%
		1.6.3 TB client lost to follow rate	78.3%	5%
		1.6.4 TB death rate	6.7%	5%
	Combat TB by ensuring all MDR – TB patients are initiated on treatment by 2019	1.6.5 TB MDR confirmed treatment initiation rate	90%	92%
		1.6.6 TB MDR treatment success rate	New Indicator	60%
1.7 Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019	Ensure 80% of mothers receive post antenatal care and exclusive breast feeding by 2019	1.7.1 Antenatal first visit before 20 weeks rate	44.3%	65%
		1.7.2 Mother post natal visit within 6 days rate	54.6%	75%
	Progressively ensure all HIV positive patients eligible for treatment are initiated on ART by 2019	1.7.3 Antenatal clients initiated on ART rate	New Indicator	95%
		1.7.4 Couple year protection rate (Annualised)	28%	72%
	Reduce Maternal Mortality Ratio to 215 per 100 000 live births by 2019	1.7.5 Maternal mortality in facility ratio	84.5/100 000	100/100 000
1.8 Child Mortality Reduced to less than 34 per 1000 population by 2019	Reduce mother to child transmission rate to 2% by 2019	1.8.1 Infant first PCR test positive around 6 weeks rate	New Indicator	0.7%
	Ensure 90% of children are vaccinated and monitored for growth by 2019	1.8.2 Immunization coverage under 1 year (annualised)	73.3%	90%
		1.8.3 Measles 2nd dose coverage	67.6%	90%
		1.8.4 DTap – IPV-HepB-Hib3- Measles 1st dose drop-out rate	-0.3%	0.7%
		1.8.5 Child under 5 years diarrhea case fatality rate	6.3/1000	4.0/1000
		1.8.6 Child under 5 years pneumonia case fatality rate	5.7/1000	5.5/1000
		1.8.7 Child under 5 years acute malnutrition	13.0%	5%

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	INDICATOR	BASELINE	TARGET 2019/20
		case fatality rate		
	Ensure 90% of children are vaccinated and monitored for growth by 2019	1.8.8 Vitamin A dose 12-59 months coverage(annualised)	43%	70%
	Ensure 90% of children are vaccinated and monitored for growth by 2019	1.8.9 Inpatient early neonatal death rate	14.1/1000	10/1000
	Administer HPV vaccine to 80% of school going grade 4 girls by 2019.	1.8.10 Human Papiloma Virus vaccine 1st dose coverage	New Indicator	96%
3.4 40% of Quintile 1&2 school screened by Integrated School Health (ISH) Teams in 2019	Ensure 100% of quintile 1&2 schools are providing school health services by 2019	3.4.1 School grade R screening coverage	New Indicator	30%
		3.4.2 School grade 1 screening coverage	New Indicator	40%
		3.4.3 School grade 8 screening coverage	New Indicator	40%
1.9 Post – mortems conducted within 72hrs increase to 90% by 2019	Ensure postmortem turnaround time has improved by 2019	1.9.1 Percentage of post-mortems performed within 72 hours	73%	90%
1.10 80% of hospitals meeting national efficiency targets by 2019	Ensure total population is utilizing District Hospitals through referral system by 2019	1. 10.1 Average Length of Stay (District Hosp)	5.3	4.5
		1. 10.6 Inpatient Bed Utilisation Rate (District Hosp)	59.5%	70%
		1. 10.12 Expenditure per patient day equivalent (PDE) (District Hosp)	1,938	3,039

2.4 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table DHS5: Expenditure estimates: District Health Services

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2014/15
R thousand	2011/12	2012/13	2013/14		2014/15		2015/16	2016/17	2017/18	
1. District Management	605 689	564 948	645 815	632 325	597 881	616 795	631 604	679 987	713 824	2.4
2. Community Health Clinics	1 398 826	1 727 461	1 761 055	1 668 661	1 667 526	1 732 416	1 794 014	1 852 520	1 945 154	3.6
3. Community Health Centres	731 172	769 231	811 453	787 916	828 810	842 419	888 503	925 663	971 953	5.5
4. Community Based Services	398 640	432 991	434 343	479 066	434 988	423 440	460 606	560 350	588 368	8.8
5. Other Community Services	88 711	116 298	111 153	138 948	96 159	96 608	111 805	117 206	123 066	15.7
6. Hiv/Aids	923 969	1 032 872	1 301 780	1 460 844	1 460 844	1 461 750	1 609 367	1 775 590	2 002 178	10.1
7. Nutrition	56 516	61 949	38 848	65 735	64 508	65 156	47 219	46 896	49 941	(27.5)
8. Coroner Services	85 045	74 935	79 817	83 350	80 405	79 619	85 476	91 314	95 880	7.4
9. District Hospitals	2 996 698	3 172 944	3 475 258	3 357 212	3 523 940	3 538 285	3 709 691	3 651 273	3 840 715	4.8
Total payments and estimates	**7 285 266**	**7 953 629**	**8 659 522**	**8 674 057**	**8 755 061**	**8 856 488**	**9 338 285**	**9 700 799**	**10 331 079**	5.4

% change from 2014/15 to 2015/16

Summary of departmental payments and estimates by economic classification: P2 – District Health Services

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2014/15
R thousand	2011/12	2012/13	2013/14		2014/15		2015/16	2016/17	2017/18	
Current payments	**7 150 396**	**7 761 365**	**8 337 559**	**8 547 309**	**8 547 738**	**8 644 845**	**9 152 005**	**9 565 832**	**10 196 341**	5.9
Compensation of employees	5 164 809	5 491 540	5 963 706	6 357 396	6 453 082	6 449 235	6 866 055	7 078 884	7 435 816	6.5
Goods and services	1 982 659	2 269 206	2 373 831	2 189 913	2 094 656	2 195 046	2 285 950	2 486 948	2 760 525	4.1
Interest and rent on land	2 928	618	22	–	–	564	–	–	–	(100.0)
Transfers and subsidies to:	**103 076**	**123 784**	**155 250**	**52 018**	**128 755**	**139 927**	**93 249**	**51 480**	**51 066**	**(33.4)**
Provinces and municipalities	–	7 928	23 202	10 099	16 895	17 771	14 069	5 157	2 427	(20.8)
Departmental agencies and accounts	42 412	18 719	34 210	24 386	71 627	21 774	20 840	27 140	28 497	(4.3)
Higher education institutions	18 210	32 990	46 759	–	–	–	–	–	–	
Households	42 454	64 147	51 079	17 533	40 233	100 382	58 340	19 183	20 142	(41.9)
Payments for capital assets	**31 794**	**68 480**	**124 802**	**74 730**	**78 568**	**71 716**	**93 031**	**83 487**	**83 671**	**29.7**
Buildings and other fixed structures	7 383	–	–	–	–	–	–	–	–	
Machinery and equipment	24 411	68 480	124 802	74 730	78 568	71 716	93 031	83 487	83 671	29.7
Payments for financial assets	**–**	**–**	**41 911**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**7 285 266**	**7 953 629**	**8 659 522**	**8 674 057**	**8 755 061**	**8 856 488**	**9 338 285**	**9 700 799**	**10 331 079**	5.4

% change from 2014/15 to 2015/16

Table above shows the summary of payments and estimates for Programme 2: District Health Services per sub-programme. The programme shows significant growth from R7.285 billion in 2011/12 to a revised estimate of R8.856 billion in 2014/15. In 2015/16, the budget for the programme grows by 5.4 per cent, to R9.338 billion.

The second table above shows the summary of payments and estimates for per economic classification Expenditure on Compensation of Employees shows a growth of 6.5 per cent whilst Goods and Services grow by 4.1 per cent (from the 2014/15 revised estimate to 2015/16).

2.5 RISK MANAGEMENT

Below are key risks that may affect the realisation of the strategic objectives in Programme 2 and measures designed to mitigate its impact.

Risk	Mitigating factors
Inadequate Primary Health Care Services	Gap assessment of PHC for compliance with the six priority areas report Training - (Clinic Supervisors, DCST training plan) Review of the Clinic and CHC Committees
Non adherence to treatment for patients on TB (including MDR and XDR-TB), HIV&AIDS, and STIs' medication.	Monthly monitoring if all HIV patients on treatment at our facilities are provided with adherence counseling by: • Viral load testing; and • Auditing of Adult clinical Record. Monitoring of sputum conversion rates for patients with Susceptible TB (conducted at 2 monthly and 5 monthly intervals) by auditing of: • Patients Blue card/ and • Electronic TB register Monthly monitoring of sputum and culture conversion rates for patients with drug resistant TB by auditing of : • Patients yellow card/ and • Electronic drug resistant TB register
Inadequate management of non-communicable diseases (Hypertension, Diabetes, Cancer ,asthma, epilepsy. mental health, substance abuse, geriatrics oral health, health promotion etc.)	Non- Communicable Disease Control meetings Training of trainers by NDOH on PHC 101 Providing of the basic equipment to certain institutions Roll out of the RPHC-Ward Based approach(School Health ,District Specialist Teams) Community Dialogues and awareness campaign on Health Lifestyles
Poor implementation of maternal, child and neonatal health	Contracting of 73 Nurses for programme assistance Purchasing of 40 Immunisation refrigerators Employment of District Specialist Teams (advances mid-wives, paediatric nurses etc. Integrated approach in working with NGOs e.g. RMCH
Inadequate Quality Assurance process	Filling of critical vacant posts included in the Annual Recruitment Plan (ARP)
Poor patient information and systems	Setting up of Data Quality Index Employment of Data Captures Setting up of Information Governance Structures

PROGRAMME 3:
EMERGENCY MEDICAL SERVICES (EMS)

3. PROGRAMME 3: EMERGENCY MEDICAL SERVICES (EMS)

PROGRAMME PURPOSE

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

3.1 PROGRAMME STRUCTURE

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

Table EMS 1: Provincial strategic objectives, strategic action and performance indicators and expected outcomes for Emergency Medical Services 2019/20

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	INDICATOR	BASELINE	TARGET 2019/20
3.6 Proportion of EMS response time improved to 85% by 2019	Ensure all ambulances respond within the National Norms by 2019	3.6.1 EMS P1 urban response under 15 minutes rate	41%	85%
		3.6.2 EMS P1 rural response under 40 minutes rate	56%	85%
		3.6.3 EMS inter-facility transfer rate	New indicator	50%

3.2 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table EMS 2: Expenditure estimates: Emergency Medical Services

R thousand	Outcome 2011/12	Outcome 2012/13	Outcome 2013/14	Main appropriation 2014/15	Adjusted appropriation 2014/15	Revised estimate 2014/15	Medium-term estimates 2015/16	Medium-term estimates 2016/17	Medium-term estimates 2017/18	% change from 2014/15
1. Emergency Medical Services	633 797	603 708	784 898	775 063	807 578	800 821	888 537	906 819	947 810	11.0
2. Planned Patient Transport	10 791	15 817	28 048	23 372	83 362	82 401	83 295	82 428	90 899	1.1
Total payments and estimates	**644 588**	**619 525**	**812 946**	**798 435**	**890 940**	**883 222**	**971 832**	**989 247**	**1 038 709**	10.0

% change from 2014/15 to 2015/16

Summary of departmental payments and estimates by economic classification: P3 – Emergency Medical Services

R thousand	Outcome 2011/12	Outcome 2012/13	Outcome 2013/14	Main appropriation 2014/15	Adjusted appropriation 2014/15	Revised estimate 2014/15	Medium-term estimates 2015/16	Medium-term estimates 2016/17	Medium-term estimates 2017/18	% change from 2014/15
Current payments	**597 125**	**539 700**	**665 956**	**680 079**	**739 855**	**736 810**	**844 309**	**834 386**	**876 105**	14.6
Compensation of employees	347 043	366 492	461 400	403 508	494 102	502 402	524 719	521 567	547 645	4.4
Goods and services	249 966	173 208	204 556	276 571	245 753	234 408	319 591	312 819	328 460	36.3
Interest and rent on land	116	–	–	–	–	–	–	–	–	
Transfers and subsidies	**68**	**1 857**	**1 939**	**2 654**	**2 654**	**3 368**	**2 776**	**2 904**	**3 049**	(17.6)
Households	68	1 857	1 939	2 654	2 654	3 368	2 776	2 904	3 049	(17.6)
Payments for capital assets	**47 395**	**77 968**	**127 324**	**115 702**	**148 431**	**143 044**	**124 746**	**151 957**	**159 555**	(12.8)
Machinery and equipment	47 395	77 968	127 324	115 702	148 431	143 044	124 746	151 957	159 555	(12.8)
Payments for financial assets	**–**	**–**	**17 727**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**644 588**	**619 525**	**812 946**	**798 435**	**890 940**	**883 222**	**971 832**	**989 247**	**1 038 709**	10.0

% change from 2014/15 to 2015/16

Table EMS 5 above shows the summary of payments and estimates for Emergency Medical Services according to sub-programmes. Expenditure grew substantially from R644.588 million in 2011/12 to a revised estimate of R883.222 million in 2014/15 due to funding received for the provision of additional ambulances and the employment of related personnel. When comparing the revised estimate of 2014/15 with the 2015/16 allocation, there is an increase of 10 per cent.

Table above on economic classification shows the summary of payments and estimates for Emergency Medical Services according to economic classification. From 2014/15 to 2015/16, expenditure on Goods and Services is increases by 36.3 per cent as a result of the carry through costs of acquiring the additional ambulances.

3.3 RISK MANAGEMENT

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

Risk	Mitigating factors
Inadequate EMS Services	Audit Improvement Plan DHIS workshop for EMS personnel Improvement of radio communication network Filling of critical vacant posts at supervisory and management levels within the districts Process of computerising Mthatha EMS control centre EMS vehicle tracking system installed Up skilling of EMS personnel with regards to driving Training of EMS personnel Improvement/upgrading of EMS bases

PROGRAMME 4:
PROVINCIAL HOSPITAL SERVICES (REGIONAL AND SPECIALISED)

4 PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES (REGIONAL AND SPECIALISED)

PROGRAMME PURPOSE

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

SUB-PROGRAMMES

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

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

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

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

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

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

4.1 STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR REGIONAL HOSPITALS

Table RH 1: Provincial strategic objectives, strategic action and performance indicators and expected outcomes for Regional Hospitals 2019/20

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	INDICATOR	BASELINE	TARGET 2019/20
2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Ensure all regional hospitals are conditionally compliant (50%-75%) by 2017 and fully compliant (75%-100%) to National Core Standards by 2019	2.3.2. National Core Standards self-assessment rate	New Indicator	100%
		2.3.8 Quality improvement plants after self-assessment rate	New Indicator	100%
		2.3.13 Percentage of Hospitals compliant with all extreme and vital measures of the national core standards	New Indicator	60%
2.4 Patient experience of Care rate increased to more than 75% in health services by 2019	Improve management of patients to optimize average length of stay by 2019	2.4.3 Patients experience of care survey rate	New Indicator	80%
		2.4.10 Patients experience of care rate	New Indicator	75%
	Ensure all regional hospitals are conditionally compliant (50%-75%) by 2017 and fully compliant (75%-100%) to National Core Standards by 2019	2.4.17 Complaints resolution rate	New Indicator	98%
		2.4.24 Complaint resolution within 25 working days rate	83.3%	90%
1.10 80% of hospitals meeting national efficiency targets by 2019	Improve management of patients to optimize average length of stay by 2019	1.10.2 Average length of stay	5.2days	4.6days
	Ensure total population is utilizing hospitals through referral system by 2019	1.10.7 Inpatient bed utilization rate	66.5%	75%
	Ensure the 80% hospital expenditure increase to cover the uninsured population by 2019	1.10.13 Expenditure per patient day equivalent (PDE)	R1,965	R3,051
1.3 NCD coverage increased to 1300/1000 000 through management of chronic illnesses by 2019	Improve cataract surgery rate to 1300/100 000 by 2019	1.3.1 Cataract surgery rate (Uninsured Population)	1029/100 000	1300/100 000

4.2 STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR SPECIALISED TB HOSPITALS

Table TB 2: Provincial strategic objectives, strategic action and performance indicators and expected outcomes for TB Hospitals 2019 /20

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	INDICATOR	BASELINE	TARGET 2019/20
2.3 Health facilities assessed for compliance with National Core Standards increased to 60% by 2019	Ensure all TB hospitals are conditionally compliant (50%-75%) by 2017 and fully compliant (75%-100%) to National Core Standards by 2019	2.3.3 National Core Standard self-assessment rate	New Indicator	100%
		2.3.9 Quality improvement plans after self-assessment rate	New Indicator	100%
		2.3.15 Percentage of Hospitals compliant with all extreme and vital measures of the national core standards	New Indicator	60%
2.4 Patient experience of Care rate increased to more than 75% in health services by 2019	Improve management of patients to optimize average length of stay by 2019	2.4.4 Patients experience of care survey rate	New Indicator	80%
		2.4.11 Patients experience of care rate	30%	75%
	Ensure all TB hospitals are conditionally compliant (50%-75%) by 2017 and fully compliant (75%-100%) to National Core Standards by 2019	2.4.18 Complaints resolution rate	New Indicator	98%
		2.4.25 Complaint resolution within 25 working days rate	65.4%	90%
1.10 80% of hospitals meeting national efficiency targets by 2019	Improve management of patients to optimize average length of stay by 2019	1.10.3 Average length of stay	106.4days	103 days
	Ensure total population is utilizing hospitals through referral system by 2019	1.10.8 Inpatient bed utilisation rate	65%	70%
	Ensure the 80% hospital expenditure increase to cover the uninsured population by 2019	1.10.14 Expenditure per patient day equivalent (PDE)	R1,045	R1150

4.3 STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR SPECIALISED PSYCHIATRIC HOSPITALS

Table SPH 3: Provincial strategic objectives, strategic action and performance indicators and expected outcomes for Specialised Psychiatric Hospitals 2019/20

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	INDICATOR	BASELINE	TARGET 2019/20
2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Ensure all psychiatric hospitals are conditionally compliant (50%-75%) by 2017 and fully compliant (75%-100%) to National Core Standards by 2019	2.3.4 National Core Standards self-assessment rate	New Indicator	75%
		2.3.10 Quality improvement plans after self-assessment rate	New Indicator	80%
		2.3.16 Percentage of Hospitals compliant with all extreme and vital measures of the national core standards	New Indicator	50%
2.4 Patient experience of Care rate increased to more than 75% in health services by 2019	Improve management of patients to optimize average length of stay by 2019	2.4.5 Patient experience of Care survey rate	New Indicator	100%
		2.4.12 Patient experience of Care rate	60%	75%
	Ensure all psychiatric hospitals are conditionally compliant (50%-75%) by 2017 and fully compliant (75%-100%) to National Core Standards by 2019	2.4.19 Complaints resolution rate	New Indicator	98%
		2.4.26 Complaint resolution within 25 working days rate	84.6%	98%
1.10 80% of hospitals meeting national efficiency targets by 2019.	Improve management of patients to optimize average length of stay by 2019	1.10.9 Inpatient bed utilization rate	84.5%	85%
	Ensure the 80% hospital expenditure increase to cover the uninsured population by 2019	1.10.15 Expenditure per patient day equivalent (PDE)	R1,289	R1,619

4.4 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table PHS 4: Expenditure Estimates: Provincial Hospital Services

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2014/15
R thousand	2011/12	2012/13	2013/14		2014/15		2015/16	2016/17	2017/18	
1. General (Regional) Hospitals	3 039 179	3 141 797	3 412 339	3 546 445	3 515 339	3 573 052	3 720 396	3 876 941	4 070 820	4.1
2. Tuberculosis (TB) Hospitals	329 467	330 235	349 582	402 794	399 549	401 404	384 918	457 595	480 475	(4.1)
3. Psychiatric Hospitals	491 608	506 984	542 160	581 545	561 318	546 959	586 360	616 017	646 818	7.2
Total payments and estimates	**3 860 254**	**3 979 016**	**4 304 081**	**4 530 784**	**4 476 206**	**4 521 415**	**4 691 674**	**4 950 553**	**5 198 112**	3.8

% change from 2014/15 to 2015/16

Summary of departmental payments and estimates by economic classification: P4 – Provincial Hospital Services

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2014/15
R thousand	2011/12	2012/13	2013/14		2014/15		2015/16	2016/17	2017/18	
Current payments	**3 834 096**	**3 909 663**	**4 179 598**	**4 486 740**	**4 383 211**	**4 425 721**	**4 611 369**	**4 911 835**	**5 157 458**	4.2
Compensation of employees	3 171 127	3 145 076	3 298 299	3 701 084	3 624 317	3 653 107	3 860 431	4 096 430	4 301 252	5.7
Goods and services	662 564	764 358	880 346	785 656	758 894	771 763	750 938	815 405	856 207	(2.7)
Interest and rent on land	405	229	953	–	–	851	–	–	–	(100.0)
Transfers and subsidies to:	**10 230**	**50 062**	**76 725**	**11 619**	**59 570**	**65 229**	**52 153**	**17 311**	**18 177**	(20.0)
Households	10 230	50 062	76 725	11 619	59 570	65 229	52 153	17 311	18 177	(20.0)
Payments for capital assets	**15 928**	**19 291**	**34 051**	**32 425**	**33 425**	**30 465**	**28 151**	**21 407**	**22 477**	(7.6)
Buildings and other fixed structures	–	–	–	–	2 000	1 500	–	–	–	(100.0)
Machinery and equipment	15 928	19 291	33 891	32 425	31 425	28 965	28 151	21 407	22 477	(2.8)
Software and other intangible assets	–	–	160	–	–	–	–	–	–	
Payments for financial assets	**–**	**–**	**13 707**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**3 860 254**	**3 979 016**	**4 304 081**	**4 530 784**	**4 476 206**	**4 521 415**	**4 691 674**	**4 950 553**	**5 198 112**	3.8

% change from 2014/15 to 2015/16

The summary of payments and estimates for Provincial Hospital Services per sub-programme and economic classification are depicted in tables above. From 2011/12 to 2014/15, expenditure for this programme increased from R3.860 billion to a revised estimate of R4.521 billion due to ICS adjustments and the need to mitigate the spread of TB and the burden of diseases. The programme will grow by 3.8 per cent in 2015/16 from the revised estimates of R4.521 billion in 2014/15.

The budgets for Psychiatric/Mental Hospitals and Regional Hospitals grow by 7.2 per cent and 4.1 per cent, respectively. These growth rates are driven by the increase in the burden of disease. Compensation of Employees increases by 5.7 per cent from a revised estimate of R3.653 billion in 2014/15 to R3.860 billion in 2015/16. Expenditure on Goods and Services decreases by 2.7 per cent to R750.938 million in 2015/16 when compared to the revised estimate of R771.763 million in 2014/15 as a result of a portion of the NHLS function moving to the national department. Transfers to Households decreases by 20 per cent in 2015/16 due to the high number of contingent liabilities associated with medico-legal claims that were paid in the current financial year. The decrease of 7.6 per cent in Machinery and Equipment is due to the department reclassifying the lease of vehicles which are paid as finance leases in Payments for Capital Assets.

4.5 RISK MANAGEMENT

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

Risk	Mitigating factors
Inadequate Secondary and Tertiary services	Audit improvement plan reports Cluster meeting and CEO forums strengthened Appointment of specialists and clinical governance directors Availability of domains Commissioning of Cecilia Makiwane regional hospital Construction of resource Centre at St Elizabeth AME Unit, OPD and paediatrics at Frontier Development of paediatric oncology services at Frontier

PROGRAMME 5:
TERTIARY & CENTRAL HOSPITALS

5 PROGRAMME 5: TERTIARY & CENTRAL HOSPITAL SERVICES

PROGRAMME PURPOSE

To strengthen and continuously develop the modern tertiary services platform to adequate levels in order to be responsive to the demands of the specialist service needs of the community of the Eastern Cape Province.

There are two Tertiary Hospitals and one Central Hospital in the Eastern Cape Province:

5.1 Tertiary:

- Frere Hospital
- Livingstone Hospital
- Fort England

5.2 Central:

- Nelson Mandela Academic Hospital

5.1 STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR TERTIARY HOSPITAL

Table THS 1: Provincial strategic objectives, strategic action and performance indicators and expected outcomes for Tertiary Hospitals 2019/20

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	INDICATOR	BASELINE	TARGET 2019/20
2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Ensure all tertiary hospitals are conditionally compliant (50%-75%) by 2017 and fully compliant (75%-100%) to National Core Standards by 2019	2.3.5 National Core Standards self-assessment rate	New Indicator	100%
		2.3.11 Quality improvement plans after self-assessment rate	New Indicator	100%
		2.3.17 Percentage of Hospitals compliant with all extreme and vital measures of the national core standards	New Indicator	100%
2.4 Patient experience of Care rate increased to more than 75% in health services by 2019	Improve management of patients to optimize average length of stay by 2019	2.4.6 Patient experience of Care survey rate	New Indicator	90%
		2.4.13 P Patient experience of Care	New Indicator	80%

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	INDICATOR	BASELINE	TARGET 2019/20
		rate		
	Ensure all tertiary hospitals are conditionally compliant (50%-75%) by 2017 and fully compliant (75%-100%) to National Core Standards by 2019	2.4.20 Complaints resolution rate	79.2%	98%
		2.4.27 Complaint resolution within 25 working days rate	79.2%	98%
1.10 80% of hospitals meeting national efficiency targets by 2019.	Improve management of patients to optimize average length of stay by 2019	1.10.4 Average length of stay	6.4days	5.5days
	Ensure total population is utilizing hospitals through referral system by 2019	1.10.10 Inpatient bed utilization rate	75.6%	75%
	Ensure the 80% hospital expenditure increase to cover the uninsured population by 2019	1.10.16 Expenditure per patient day equivalent (PDE)	R1971	R2,825

5.2 STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR CENTRAL HOSPITAL

Table CH 2: Provincial strategic objectives, strategic action and performance indicators and expected outcomes for Central Hospitals 2019/20

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	INDICATOR	BASELINE	TARGET 2019/20
2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Ensure all central hospitals are conditionally compliant (50%-75%) by 2017 and fully compliant (75%-100%) to National Core Standards by 2019	2.3.6 National Core Standards self-assessment rate	New Indicator	100%
		2.3.12 Quality improvement plans after self-assessment rate	New Indicator	100%
		2.3.18 Percentage of Hospitals compliant with all extreme and vital measures of the national core standards	New Indicator	100%
2.4 Patient experience of Care rate increased to more than 75% in health services by 2019	Improve management of patients to optimize average length of stay by 2019	2.4.7 Patient experience of Care survey rate	New Indicator	98%
		2.4.14 Patient experience of Care rate	60%	90%
	Ensure all central hospitals are conditionally compliant (50%-75%) by	2.4.21 Complaints resolution rate	New Indicator	98%
		2.4.28 Complaint resolution within 25	79.2%	98%

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	INDICATOR	BASELINE	TARGET 2019/20
	2017 and fully compliant (75%-100%) to National Core Standards by 2019	working days rate		
1.10 80% of hospitals meeting national efficiency targets by 2019.	Improve management of patients to optimize average length of stay by 2019	1.10.5 Average length of stay	6.4days	5.5days
	Ensure total population is utilizing hospitals through referral system by 2019	1.10.11 Inpatient bed utilisation rate	75.6%	75%
	Ensure the 80% hospital expenditure increase to cover the uninsured population by 2019	1.10.17 Expenditure per patient day equivalent (PDE)	R1,971	R2,800

5.3 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table C&TH 3: Expenditure estimates: Central & Tertiary Hospitals

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2014/15
R thousand	2011/12	2012/13	2013/14		2014/15		2015/16	2016/17	2017/18	
1. Provincial Tertiary Services	627 075	657 170	774 269	786 007	796 341	811 405	803 770	838 458	890 973	(0.9)
Total payments and estimates	**627 075**	**657 170**	**774 269**	**786 007**	**796 341**	**811 405**	**803 770**	**838 458**	**890 973**	(0.9)

% change from 2014/15 to 2015/16

Summary of departmental payments and estimates by economic classification: P5 – Central Hospital Services

R thousand	Outcome 2011/12	Outcome 2012/13	Outcome 2013/14	Main appropriation 2014/15	Adjusted appropriation 2014/15	Revised estimate 2014/15	Medium-term estimates 2015/16	Medium-term estimates 2016/17	Medium-term estimates 2017/18	% change from 2014/15
Current payments	**553 070**	**587 390**	**661 377**	**669 266**	**678 821**	**698 692**	**718 912**	**752 150**	**800 350**	2.9
Compensation of employees	141 107	179 833	213 019	224 971	226 867	229 039	242 387	255 476	268 250	5.8
Goods and services	411 962	407 554	448 358	444 295	451 954	469 624	476 525	496 674	532 100	1.5
Interest and rent on land	1	3	–	–	–	29	–	–	–	(100.0)
Transfers and subsidies to:	**–**	**–**	**5**	**13 112**	**2 212**	**2 212**	**–**	**–**	**–**	(100.0)
Households	–	–	5	13 112	2 212	2 212	–	–	–	(100.0)
Payments for capital assets	**74 005**	**69 780**	**112 887**	**103 629**	**115 308**	**110 501**	**84 858**	**86 308**	**90 623**	(23.2)
Buildings and other fixed structures	11 423	23 158	858	–	6 000	6 000	–	–	–	(100.0)
Machinery and equipment	62 582	46 622	112 029	103 629	109 308	104 501	84 858	86 308	90 623	(18.8)
Payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**627 075**	**657 170**	**774 269**	**786 007**	**796 341**	**811 405**	**803 770**	**838 458**	**890 973**	(0.9)

% change from 2014/15 to 2015/16

Tables above show that expenditure increased from R627.075 million in 2011/12 to a revised estimate of R811.405 million in 2014/15. Over the MTEF, allocations grow from R803.770 million to R890.973 million. Comparing the 2014/15 revised estimates with the 2015/16 allocations shows a decrease of 0.9 per cent as a result of a reduction in the NTSG grant.

The major cost drivers for the programme are Compensation of Employees and Goods and Services. Expenditure on Compensation of Employees grows by 5.8 per cent and Goods and Services increases by 1.5 per cent when the 2014/15 revised estimates are compared with the 2015/16 estimates.
Expenditure for Payments of Capital Assets in 2015/16 decreases by 23.2 per cent due to the reduction in the NTSG grant.

5.4 RISK MANAGEMENT

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

Risk	Mitigating factors
Inadequate Secondary and Tertiary services	CEO forums and meetings Availability of domains Customer satisfaction survey reports Commissioning of MRI scanners for tertiary hospitals Development of a cath lab at Nelson Mandela Academic hospital Paediatrics and Neonatal ICU at Frere Hospital Development of paediatrics oncology services at Frontier

PROGRAMME 6:
HEALTH SCIENCES AND TRAINING (HST)

PROGRAMME 6: HEALTH SCIENCES AND TRAINING (HST)

PROGRAMME PURPOSE

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

6.1 STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR HEALTH SCIENCES AND TRAINING

Table HST 1: Provincial strategic objectives, strategic action and performance indicators and expected outcomes for Health Sciences and Training 2019/20

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	INDICATORS	BASELINE	TARGET 2019/20
2.6 Fifty (50) first year medical student receiving bursaries by 2019	Increase enrollment of Medicine, Nursing and Pharmacy students annually by 10% per annum.	2.6.1 Number of Bursaries awarded for first year medical students	54	65
		2.6.2 Number of Bursaries awarded for first year nursing students	New Indicator	500

6.2 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table HST 2: Expenditure Estimates: Health Sciences and Training

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2014/15
R thousand	2011/12	2012/13	2013/14		2014/15		2015/16	2016/17	2017/18	
1. Nursing Training Colleges	296 131	290 229	293 489	319 948	288 753	287 763	305 418	328 822	345 263	6.1
2. Ems Training College	2 650	4 435	4 872	5 904	14 204	13 842	14 233	14 799	15 539	2.8
3. Bursaries	71 060	86 866	86 631	121 629	174 584	174 944	134 829	138 527	145 453	(22.9)
4. Other Training	235 983	198 434	265 160	322 902	298 508	281 267	297 430	320 533	331 970	5.7
Total payments and estimates	**605 824**	**579 964**	**650 152**	**770 384**	**776 050**	**757 816**	**751 910**	**802 681**	**838 225**	(0.8)

% change from 2014/15 to 2015/16

Summary of departmental payments and estimates by economic classification: P6 – Health Science and Training

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2014/15
R thousand	2011/12	2012/13	2013/14		2014/15		2015/16	2016/17	2017/18	
Current payments	**390 723**	**356 482**	**506 834**	**586 575**	**579 653**	**561 373**	**550 777**	**616 262**	**642 485**	(1.9)
Compensation of employees	324 974	312 871	388 111	495 242	413 931	415 921	447 810	492 673	517 307	7.7
Goods and services	65 576	43 533	118 722	91 333	165 722	145 452	102 967	123 589	125 178	(29.2)
Interest and rent on land	173	77	1	–	–	–	–	–	–	
Transfers and subsidies	**196 368**	**216 311**	**123 173**	**149 106**	**176 547**	**177 205**	**182 727**	**166 300**	**174 615**	3.1
Departmental agencies and accounts	–	5 709	6 331	36 473	9 281	9 281	27 900	36 143	37 950	200.6
Higher education institutions	115 764	68 780	–	–	–	–	25 000	–	–	
Households	80 604	141 823	116 842	112 633	167 266	167 924	129 827	130 157	136 665	(22.7)
Payments for capital assets	**18 712**	**7 171**	**10 019**	**34 703**	**19 850**	**19 238**	**18 405**	**20 119**	**21 125**	(4.3)
Machinery and equipment	18 712	7 171	10 019	34 703	19 850	19 238	18 405	20 119	21 125	(4.3)
Payments for financial assets	**21**	**–**	**10 126**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**605 824**	**579 964**	**650 152**	**770 384**	**776 050**	**757 816**	**751 910**	**802 681**	**838 225**	(0.8)

% change from 2014/15 to 2015/16

The summary of payments and estimates for Health Science and Training per sub-programme and economic classification are shown in tables above. Total payments grew from R605.824 million in 2011/12 to a revised estimate of R757.816 million in 2014/15. Expenditure for the programme is estimated to decrease by 0.8 percent from a revised estimate of R757.816 million in 2014/15 to R751.910 million in 2015/16 as a result of the reduction in the HPTD grant.

The decrease of 29.2 per cent in 2015/16 under Goods and Services is due to the reprioritisation exercise undertaken in 2014/15 in order to fund the Cuban Doctor Programme.

Transfers to departmental agencies and accounts increase by 200.6 per cent as a result of the revised contribution to be made to the Health and Welfare Sector Education and Training (HWSETA). Transfers to Households decrease by 22.7 per cent which puts pressure on the Cuban Doctor Programme.

6.3 RISK MANAGEMENT

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

Risk	Mitigating factors
Inability to spend or commit HPTD grant before year end	Stringent adherence to the HPTD Grant Business Plan and close monitoring of expenditure against budget
Community services cycle – delay in the appointment process on available posts	Closer management of the Annual Intake process to ensure that the intake planning process is complete at least six months prior to placement and to ensure that all intakes are paid within the same month of starting their jobs
Lack of absorption of graduated bursary students by ECDoH, as they should be per their bursary agreement, due to no posts being available, resulting in the ECDoH writing off the bursary obligation	The implement of the strategy to ensure that there are sufficient posts available for bursary holders each year; graduates who do not want to work for the department are handed over to the Debt Collection Unit of the Finance Cluster for the collection of the full outstanding amounts
Budgeting constraints – delays in infrastructure improvements to Lilitha Nursing College (poor conditions negatively impacting on the ability to learn)	A comprehensive infrastructure plan that includes funding for the upgrading of the colleges
Lack of appropriate candidates for critical postgraduate skills shortage programmes	Continued implementation of the Registrar Program and the Clinical Teaching Platform to attract and retain core clinical skills

PROGRAMME 7:
HEALTH CARE SUPPORT SERVICES (HCSS)

7. PROGRAMME 7: HEALTH CARE SUPPORT SERVICES (HCSS)

PROGRAMME PURPOSE

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

7.1 Transversal Health Services consists of:

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

7.2 Pharmaceutical Services

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

7.3 STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES HEALTH CARE SUPPORT SERVICES

Table HCSS1: Provincial strategic objectives, strategic action and performance indicators and expected outcomes for Health Care Support Services 2019/20

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	INDICATORS	BASELINE	TARGET 2019/20
1.11 95% of clients eligible for assistive devices provided with wheelchairs, hearing aids, prostheses by 2019	Ensure that eligible applicants that require rehabilitation services are supplied	1.11.1 Percentage of eligible applicants supplied with Wheel chairs	21.5%	70%
		1.11.2 Percentage of eligible applicants supplied with Hearing aids	47.2%	75%
		1.11.3 Percentage of eligible applicants supplied with prostheses	28.4%	60%
		1.11.4 Percentage of eligible applicants supplied with orthoses	86.9%	100%

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	INDICATORS	BASELINE	TARGET 2019/20
1.12 95% availability of essential drugs in all health facilities by 2019	Ensure that all essential drugs are available at all times in the depots and are supply turnaround time is achieved	1.12.1 Percentage of order fulfillment of essential drugs at the depots.	86%	90%
		1.12.2 Tracer drugs stock out rate at the depot	<2.5%	<4%
		1.12.3 Percentage of supplies to depot received within contract lead time	88%	87%

7.4 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table HCSS 2: Expenditure estimates: Health Care Support Services

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2014/15
R thousand	2011/12	2012/13	2013/14		2014/15		2015/16	2016/17	2017/18	
1. Orthotic And Prosthetic Services	31 684	32 108	36 789	38 983	38 983	36 230	40 868	41 021	43 072	12.8
2. Medicine Trading Account	47 063	52 201	60 990	75 178	78 481	68 727	61 780	82 435	86 557	(10.1)
Total payments and estimates	**78 747**	**84 309**	**97 779**	**114 161**	**117 464**	**104 957**	**102 648**	**123 456**	**129 629**	(2.2)

% change from 2014/15 to 2015/16

Summary of departmental payments and estimates by economic classification: P7 – Health Care Support Services

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2014/15
R thousand	2011/12	2012/13	2013/14		2014/15		2015/16	2016/17	2017/18	
Current payments	**76 426**	**81 844**	**92 053**	**112 700**	**115 562**	**103 152**	**99 761**	**122 937**	**129 084**	(3.3)
Compensation of employees	35 437	35 154	39 358	54 549	50 810	47 632	53 958	59 102	62 057	13.3
Goods and services	40 989	46 690	52 694	58 151	64 752	55 520	45 803	63 835	67 027	(17.5)
Interest and rent on land	–	–	1	–	–	–	–	–	–	
Transfers and subsidies to:	**270**	**111**	**–**	**–**	**341**	**304**	**200**	**–**	**–**	(34.2)
Households	270	111	–	–	341	304	200	–	–	(34.2)
Payments for capital assets	**2 051**	**2 354**	**2 180**	**1 461**	**1 561**	**1 501**	**2 687**	**519**	**545**	79.0
Buildings and other fixed structures	–	–	–	–	–	–	–	–	–	
Machinery and equipment	2 051	2 354	2 180	1 461	1 561	1 501	2 687	519	545	79.0
Payments for financial assets	**–**	**–**	**3 546**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**78 747**	**84 309**	**97 779**	**114 161**	**117 464**	**104 957**	**102 648**	**123 456**	**129 629**	(2.2)

% change from 2014/15 to 2015/16

Tables above depict a summary of payments and estimates per sub programme and economic classification. Expenditure increased significantly from R78.747 million in 2011/12 to a revised estimate of R104.957 million in 2014/15. Over the 2015 MTEF, payments are projected to increase from R102.648 million in 2015/16 to R129.629

million in 2017/18. The budget for this programme will be used to improve the effectiveness of health systems by providing relevant support services to core service delivery areas.

The increase in Compensation of Employees of 13.3 per cent from 2014/15 to 2015/16 is as a result of the prioritised conversion of contracted employees to permanent employees. Goods and Services show a decrease of 17.5 per cent due to the reprioritisation of the budget for courier services under Programme 2 in the HIV/AIDS sub-programme. In addition, it was also used to fund mobile clinics

7.5. RISK MANAGEMENT

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

Risk	Mitigating factors
Poor medicine supply services	Audit improvement plan for the depot Filling of critical vacant posts at Depot's and institutions Roll out of direct deliveries DHIS reports on medicine availability

PROGRAMME 8:
HEALTH FACILITIES MANAGEMENT (HFM)

8. PROGRAMME 8: HEALTH FACILITIES MANAGEMENT (HFM)

PROGRAMME PURPOSE

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

The programme consists of four sub-programmes:

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

8.1 STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR HEALTH FACILITIES MANAGEMENT

Table HFM 1: Provincial strategic objectives, strategic action and performance indicators and expected outcomes for Health Facilities Management 2019/20

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	INDICATORS	BASELINE	TARGET 2019/20
2.7 (721)Health facilities refurbished to comply with the National norms and standards by 2019	Compliance with Norms & Standards for all new Infrastructure Projects by 2019	2.7.1 Number of health Facilities that have undergone major refurbishment	New Indicator	75 major
		2.7.2 Number of health Facilities that have undergone minor refurbishment	New Indicator	646 minor
		2.7.2 Establish Service Level Agreements (SLA) with department of Public Works (and any other implementing agents)	New Indicator	2

8.2 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table HFM 2: Expenditure estimates: Health Facilities Management

R thousand	Outcome 2011/12	2012/13	2013/14	Main appropriation	Adjusted appropriation 2014/15	Revised estimate	Medium-term estimates 2015/16	2016/17	2017/18	% change from 2014/15
1. Community Health Facilities	103 446	151 774	426 142	466 644	429 773	437 035	532 100	640 311	595 933	21.8
2. Emergency Medical Rescue Services	12 807	1 122	460	–	–	9	–	–	–	(100.0)
3. District Hospital Services	371 824	529 753	339 459	350 783	223 782	220 565	305 455	431 556	567 127	38.5
4. Provincial Hospitals Services	734 526	481 202	254 077	361 114	490 986	510 641	349 755	288 068	259 721	(31.5)
5. Other Facilities	22 441	28 317	110 019	28 985	62 985	56 469	22 997	17 000	23 000	(59.3)
Total payments and estimates	**1 245 044**	**1 192 168**	**1 130 157**	**1 207 526**	**1 207 526**	**1 224 719**	**1 210 307**	**1 376 935**	**1 445 781**	(1.2)

% change from 2014/15 to 2015/16

Summary of departmental payments and estimates by economic classification: P8 – Health Facilities Management

R thousand	Outcome 2011/12	2012/13	2013/14	Main appropriation	Adjusted appropriation 2014/15	Revised estimate	Medium-term estimates 2015/16	2016/17	2017/18	% change from 2014/15
Current payments	**371 943**	**576 052**	**502 412**	**384 047**	**436 583**	**443 753**	**313 649**	**335 699**	**364 184**	(29.3)
Compensation of employees	7 096	7 575	7 628	14 800	6 800	9 611	10 000	14 000	18 000	4.0
Goods and services	357 180	566 907	492 678	369 247	429 783	433 837	303 649	321 699	346 184	(30.0)
Interest and rent on land	7 667	1 571	2 106	–	–	305	–	–	–	(100.0)
Transfers and subsidies to:	**13**	**–**	**10 502**	**–**	**–**	**–**	**–**	**–**	**–**	
Households	13	–	10 502	–	–	–	–	–	–	
Payments for capital assets	**873 088**	**616 116**	**617 243**	**823 479**	**770 943**	**780 966**	**896 658**	**1 041 236**	**1 081 597**	14.8
Buildings and other fixed structures	811 405	575 259	553 239	736 984	664 448	681 732	760 184	929 264	997 031	11.5
Machinery and equipment	61 683	40 857	64 004	86 495	106 495	99 234	136 474	111 972	84 566	37.5
Payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**1 245 044**	**1 192 168**	**1 130 157**	**1 207 526**	**1 207 526**	**1 224 719**	**1 210 307**	**1 376 935**	**1 445 781**	(1.2)

% change from 2014/15 to 2015/16

The table above shows the summary of payments and estimates per sub-programme. Total payments decreased from R1.245 billion in 2011/12 to a revised estimate of R1.225 billion in 2014/15. A decrease of 1.2 per cent is evident when comparing the 2014/15 revised estimates with the 2015/16 estimate.

Table above on economic classification shows the summary of payments and estimates for Health Facilities Management according to economic classification. The major cost driver for the programme is Payments for Capital Assets which shows growth of 14.8 per cent from the 2014/15 revised estimate to 2015/16. More significantly, the budget for Machinery and equipment increases by 37.5 per cent to cater for the commissioning of the Cecilia Makiwane Hospital. Expenditure on Compensation of Employees increases by 4 per cent in 2015/16 from the 2014/15 revised estimate.

Expenditure on Goods and Services, which includes funding spent on contracts relating to the maintenance of infrastructure and machinery and equipment, shows a fluctuating trend from 2011/12 to the 2014/15 revised estimate. There is a 30 per cent decrease from the 2014/15 revised estimate of R433.837 million to the R303.649 million estimates for 2015/16.

8.3 RISK MANAGEMENT

Risk	Mitigating factors
Inadequate infrastructure health facilities	Infrastructure Audit Improvement Plan Rapid response team reports analysed for identification of gaps Infrastructure Delivery Management System Service level agreements signed with implementing agents National Treasury -standard norms for infrastructure staff

PART C

LINKS TO OTHER PLANS

9. PART C: LINKS TO OTHER PLANS

9.1 LINKS TO THE LONG-TERM INFRASTRUCTURE AND OTHER CAPITAL PLANS

R thousand	Outcome 2011/12	Outcome 2012/13	Outcome 2013/14	Main appropriation 2014/15	Adjusted appropriation 2014/15	Revised estimate 2014/15	Medium-term estimates 2015/16	Medium-term estimates 2016/17	Medium-term estimates 2017/18	% change from 2014/15
New infrastructure assets	**265 392**	**217 753**	**186 017**	**327 295**	**327 295**	**286 517**	**405 984**	**566 164**	**618 903**	**41.7**
Existing infrastructure assets	**979 652**	**974 415**	**933 639**	**880 231**	**880 231**	**938 202**	**804 324**	**810 771**	**826 878**	**(14.3)**
Upgrades and additions	688 815	502 298	502 696	480 441	480 441	452 848	465 492	614 114	536 031	2.8
Refurbishment and rehabilitation	26 800	9 600	7 848	27 000	27 000	51 763	2 500	23 000	–	(95.2)
Maintenance and repair	264 037	462 517	423 095	372 790	372 790	433 591	336 332	173 657	290 847	(22.4)
Infrastructure transfers	**–**	**–**	**10 501**	**–**	**–**	**–**	**–**	**–**	**–**	
Current	–	–	10 501	–	–	–	–	–	–	
Capital	–	–	–	–	–	–	–	–	–	
Infrastructure payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Infrastructure leases	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Total department infrastructure	**1 245 044**	**1 192 168**	**1 130 157**	**1 207 526**	**1 207 526**	**1 224 719**	**1 210 308**	**1 376 935**	**1 445 781**	**(1.2)**

1. Total provincial infrastructure is the sum of "Capital" plus "Recurrent maintenance".

Table above shows the summary of infrastructure expenditure per category from 2011/12 to 2017/18. The table shows that spending on infrastructure decreased from R1.245 billion in the 2011/12 financial year to a revised estimate of R1.225 billion in 2014/15. The allocations on infrastructure over the 2015 MTEF represent a shift in the department's approach from building new facilities to the refurbishment and maintenance of existing facilities, with emphasis on primary health care facilities.

Maintenance

The norms of infrastructure maintenance calls for a budget allocation that is at least 2.5 per cent of the replacement value of assets. The assessments of the condition and history of the departmental assets is not very satisfactory, which impacts negatively on setting realistic percentages on funding for infrastructure maintenance.

In an effort to address this challenge, the National Department of Health (NDoH) has put maintenance on its list of non-negotiables. Table 9 shows that a substantial portion of the entire infrastructure budget will attempt to address backlogs in the maintenance of both infrastructure and machinery and equipment.

10. CONDITIONAL GRANTS

10.1 NATIONAL HEALTH INSURANCE GRANT

Name of conditional grant	Purpose of the grant	Performance indicators	National Indicator targets for 2015/16	Provincial Indicator Targets
National Health Insurance	• PART A: Direct (NHI Pilot Districts) • To improve the performance of the District Health System through testing service delivery and provision innovations in readiness for the implementation of National Health Insurance (NHI); • Test innovations in health services delivery and provision for implementing NHI, allowing for each district to interpret and design innovations relevant to its specific context in line with the vision for realising universal health coverage for all; • To undertake health system strengthening activities in identified focus areas; • To assess the effectiveness of interventions/activities undertaken in the district funded through this grant.	• 10 pilot districts across the country • Approved business plans for all 10 pilot districts • Quarterly and annual performance reports • Consolidated annual performance evaluation report	• Approved business plans for all 10 pilot districts • Consolidated quarterly performance reports submitted to National Treasury • Consolidated annual performance evaluation report submitted to National Treasury	• Approved business plan • 4 quarterly reports • 1 Annual Report submitted

10.2 HEALTH PROFESSIONS TRAINING AND DEVELOPMENT GRANT

Name conditional grant	Purpose of the grant	Performance indicators	National Indicator targets for 2015/16	Provincial Indicator targets for 2015/16
Health Professional Training and Development	Support provinces to fund services costs associated with the training of health science trainees on the public service platform	Availability of Business Plans.	9 Provincial Consolidated business plans. Number of facility business plans will be confirmed after 28 February 2015.	Approved business plan submitted
		Number of site visits.	Number facility site visits will be confirmed after 28 February 2015.	10 • Nelson Mandela Central Hospital • Mthatha General Hospital • Livingston & PE Provincial Hospitals • Health resource Centres x 5 • Frere Hospital • Fort England • St. Elizabeth • Dora Nginza Hospital • Frontier Hospital • Cecilia Makiwane Hospital
		Availability of quarterly & annual performance report.	9 Annual performance reports Number of quarterly reports will be confirmed after 28 February 2015.	4 quarterly reports & 1 annual report submitted
		Number of audit findings	Minimum 5 to 10	0

10.3 COMPREHENSIVE HIV/AIDS GRANT

Name conditional grant	Purpose of the grant	Performance indicators	National Indicator targets for 2015/16	Provincial Indicator targets for 2015/16
COMPREHENSIVE HIV AIDS CONDITIONAL GRANT	To enable the health sector to develop an effective response to HIV/AIDS and TB To support the Department with the PEPFAR transition process.	Number of patients on ART remaining in care	3,800,000	355 531
		Number of Antenatal Care (ANC) clients initiated on life-long ART	93,000	25 000
		Number of babies Polymerase Chain Reaction (PCR) tested at 6 weeks	160,000	25 000
		Number of HIV positive clients screened for TB	861,071	113 072
		Number of HIV positive patients that started on IPT	387,297	51 540
		Number of HIV tests done	11,000,000	1 300 648
		Number of Medical Male Circumcisions performed	1,600,000	49 000

10.4 NATIONAL TERTIARY SERVICES GRANT

Name conditional grant	Purpose of the grant	Performance indicators	National Indicator targets for 2015/16	Provincial Indicator targets for 2015/16
National Tertiary services	To ensure provision of tertiary health services for all South African citizens	•9 Service Level Agreements (SLA) •Availability of Business Plans. •Number of site visits. •Availability of quarterly & annual performance report. •Number of audit findings	• 9 SLA • 39 Business Plans • 9 (Provincial office visits combined with facilities) + 37(facilities + provincial office) = 46 annual site visits • 9 Annual performance reports and 39 quarterly reports (provincial consolidation + provincial office + facility reports) • Minimum of 3 audits	• 1 SLA • 1 Approved Business Plan • 4 Quarterly Reports • 1 Annual Report Submitted • 1 Provincial Combined Facility Visit • 1 Quarterly Visit to each of the 4 Benefiting Facilities • Minimum 1 Audit
	To compensate tertiary facilities for the costs associated with the provision of these services	100% Expenditure at the end of financial year.	• First Quarter 25% • Second Quarter 50% • Third quarter 75% • Fourth quarter 100% Expenditure.	• 100% Expenditure at the end of 15/16

10.5 HEALTH FACILITY REVITALISATION GRANT

Name conditional grant	Purpose of the grant	Performance indicators	National Indicator targets for 2015/16	Provincial Indicator targets for 2015/16
Health Facility Revitalisation Grant	• To help accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in health including: health technology (HT), organisational design (OD) systems and quality assurance (QA) • To enhance capacity to deliver health infrastructure	Approved Annual Implementation plans for both Health Facility Revitalisation Grant and National Health Grant	Availability of approved Annual Implementation Plans (AIP) for all projects funded from National Health grant and Health facility Revitalisation Grant	• A signed and approved AIP 2015/16 submitted to NDOH.
		Monitoring number of projects receive funding from Health Facility Revitalisation Grant and National Health Grant	Monitor implementation of all conditional grant funded projects	• 90 Projects funded by HFRG to be implemented on 2015/16 B4. • Monthly Infrastructure Reporting Model (IRM) and Quarterly Progress Report is submitted to NDO, NT and PT.

11. PUBLIC ENTITIES

The department of Health does not have any Public Entities

12. PUBLIC-PRIVATE PARTNERSHIPS (PPPs)

Name of PPP	Purpose	Outputs	Current annual budget	date of termination	Measures to ensure smooth transfer of responsibilities
1. Humansdorp PPP	To construct a 30-bed private facility, enlarge current entrance and administration, enlarge causality and out-patient ward, including two consulting rooms and a dentist room, upgrade and/or build two new operating theatres, a new CSSD, an new radiology unit and a new laboratory	30-bed hospital Upgraded existing clinical areas	R3,400,669	27 June 2023 20-year period	Management of contract by the department assisted by national and provincial Treasury
2. Lusikisiki St Elizabeth Hospital PPP	To design, construct and financing of serviced accommodation for clinical staff at St Elizabeth Hospital	Staff quarters for clinical staff	PPP process discontinued	PPP process discontinued due to unavailability of land	Not applicable
3. Port Alfred and Settlers Hospital PPP	To build and/or upgrade 30 private beds, private pharmacy, private administration, two private consulting rooms, 60 public beds, public outpatient facility, public pharmacy, public administration, Shared services facilities, maternity ward, radiology, casualty, theatres, CSSD, kitchen and staff facilities, mortuary, stores, linen areas, plant and workshop areas	30 private-bed and 60 public-bed hospital Upgraded existing clinical areas Upgraded existing administration, kitchen and staff and general areas	Budget combined = R51,453,033	7 May 2022 15-year period	Management of contract by the department assisted by national and provincial Treasury

13. CONCLUSION

The 2015/16-2019/20 strategic plan lays out the three strategic goals that the department has identified for the five year period. These have been linked to key strategic objectives, indicators and the targets that the Department seeks to achieve in the five years commencing in April 2015. Whilst only the key objectives are listed in this document, a more detailed plan is reflected in the 2015/16-2017/18 Annual Performance Plan (APP), the Operational Plan of the department and the 8 District Health Plans DHPs).

The Strategic Plan of the Department also details priorities that are in the Provincial Medium Term Strategic Framework (PMTSF) to ensure coordination, planning, and monitoring of provincial activities in collaboration with other departments in the province. This seeks to achieve effective implementation of the National Development Plan health goals as detailed in Chapter 10 of the NDP.

Due to the enormity of the task at hand and the continued shrinking of the resources, creativity in effective and efficient utilising of these resources remains key and therefore much more needs to be done. The department will thus stringently monitor and review progress in the implementation of this Strategic Plan.

Appendix 2
Outcome 2: A long and healthy life for all South Africans

1. National Development Plan 2030 vision and trajectory

The National Development Plan (NDP) 2030 envisions a health system that works for everyone and produces positive health outcomes, and is accessible to all. By 2030, South Africa should have:

(a) Raised the life expectancy of South Africans to at least 70 years;
(b) Produced a generation of under-20s that is largely free of HIV;
(c) Reduced the burden of disease;
(d) Achieved an infant mortality rate of less than 20 deaths per thousand live births, including an under-5 Mortality rate of less than 30 per thousand;
(e) Achieved a significant shift in equity, efficiency and quality of health service provision;
(f) Achieved universal coverage;
(g) Significantly reduced the social determinants of disease and adverse ecological factors.

The overarching outcome that the country seeks to achieve is ***A Long and Healthy Life for All South Africans.*** The NDP asserts that by 2030, it is possible to have raised the life expectancy of South Africans (both males and females) to at least 70 years. Over the next 5-years, the country will harness all its efforts - within and outside - the health sector, to achieve this outcome. Key interventions to improve life expectancy include addressing the social determinants of health; promoting health; as well as reducing the burden of disease from both Communicable Diseases and Non-Communicable Diseases. An effective and responsive health system is essential bedrock for attaining this.

Both the NDP 2030 and the World Health Organization (WHO) converge around the fact that a well-functioning and effective health system is an important bedrock for the attainment of the health outcomes envisaged in the NDP 2030. Equitable access to quality healthcare will be achieved through various interventions that are outlined in this strategic document and will be realisable through the implementation of National Health Insurance. The trajectory for the 2030 vision, therefore, commences with strengthening of the health system, to ensure that it is efficient and responsive, and offers financial risk protection. The critical focus areas proposed by the NDP 2030 are consistent with the WHO perspective.

2. Constraints and Strategic Approach

Following the advent of the democratic dispensation in 1994, progressive policies were introduced to transform the health system into an integrated, comprehensive national health system. Despite this, and significant investment and expenditure, the South African health sector has largely been beset by key challenges inclusive of:

(a) a complex, quadruple burden of diseases;
(b) serious concerns about the quality of public health care;
(c) an ineffective and inefficient health system;
(d) ineffective operational management at the coalface; and (e) spiralling private health care costs.

As a result, quality health care has mostly been accessible to those who can afford and access it, and not those who need it. Until recently, South Africa's performance against key health indicators has consistently compared poorly with other countries with similar or less levels of investment and expenditure. In 2009, the current Ministry of Health embarked on a massive reform focusing on strengthening health system effectiveness by addressing health management and personnel challenges, financing challenges, and quality of care concerns. Major milestones have been achieved.

2.1. The gains made

Empirical evidence highlights several gains made by the democratic government towards improving the health status of all South Africans. These include the following:

(a) An increase in overall life expectancy from 57.1 years in 2009 to 61.3 years in 2012[1].
(b) A decrease in the Under-5 mortality rate (U5MR) from 56 deaths per 1 000 live births in 2009, to 41 deaths per 1 000 live births in 2012
(c) A decrease in the Infant Mortality Rate (IMR) from 39 deaths per 1 000 live births in 2009, to 27 deaths per 1 000 live births in 2012.
(d) A decrease in mother-to-child transmission (MTCT) of HIV from 8.5% in 2008, to 3.5% in 2010 and to 2.7% in 2011.
(e) An increase in the number of people initiated on antiretroviral therapy from 47 000 in 2004[2] to 2.4million in 2013[2].
(f) A decrease in the total number of people dying from AIDS from 300 000 in 2010 to 270 000 in 2011.
(g) A 50% decline in the number of aged 0-4 years who acquired HIV between 2006 and 2011.
(h) A 50% decrease in the number of people acquiring HIV infection, from 700 000 in the 1990's to 350 000 in 2011.
(i) A 25% decrease in the annual number of infants and children younger than 5 years dying in the past two years.

Recent empirical evidence reflects that the estimated overall prevalence of HIV in South Africa increased from 10.6% in the 2008 to 12.2% in 2012, a trend attributed to the combined effects of a successfully expanded antiretroviral treatment (ART) programme and new infections[3]. This evidence also confirms that the availability and use of ART has increased survival among HIV-infected individuals. Furthermore, HIV prevalence among youth aged 15-24 years has declined from 8.7% in 2008 to 7.3% in 2012. The country's successful PMTCT programme has also resulted in a further decrease in HIV infection levels amongst infants 12 months and younger, from 2.0% in 2008 to 1.3% in 2012[4].All these gains must be protected and consolidated during the 2014-2019 planning and implementation cycle.

[1] Medical Research Council (2013): Rapid Mortality Surveillance (RMS) Report 2012 [2] Johnson, LF (2012): ِAccess to Antiretroviral Treatment In South Africa 2004 ت2011پ the Southern African Journal of HIV Medicine, Vol 13, No 1, 2012

[2] National DoH (2013): Annual Report 2012/13, Pretoria

[3] Shisana, O, Rehle, T, Simbayi LC, Zuma, K, Jooste, S, Zungu N, Labadarios, D, Onoya, D et al. (2014) South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press.

[4] Shisana, O, Rehle, T, Simbayi LC, Zuma, K, Jooste, S, Zungu N, Labadarios, D, Onoya, D et al. (2014) South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press.

3. NDP priorities to achieve the Vision

The NDP sets out nine long-term health goals for South Africa. Five of these goals relate to improving the health and well-being of the population, and the other four deal with aspects of health systems strengthening. These are as follows:

(a) Average male and female life expectancy at birth increased to 70 years;
(b) Tuberculosis (TB) prevention and cure progressively improved;
(c) Maternal, infant and child mortality reduced;
(d) Prevalence of Non-Communicable Diseases reduced by 28%
(e) Injury, accidents and violence reduced by 50% from 2010 levels;
(f) Health systems reforms completed;
(g) Primary health Care (PHC) teams deployed to provide care to families and communities;
(h) Universal Health Coverage (UHC) achieved; and
(i) Posts filled with skilled, committed and competent individuals.

The NDP 2030 states explicitly that there are no quick fixes for achieving the nine goals outlined above. The NDP also identifies a set of nine priorities that highlight the key interventions required to achieve a more effective health system, which will contribute to the achievement of the desired outcomes. These priorities include: addressing the social determinants that affect health and diseases; strengthening the health system; improving health information systems; preventing and reducing the disease burden and promoting health; achieving universal healthcare coverage though the implementation of NHI, improving human resources in the health sector; reviewing management positions and appointments and strengthening accountability mechanisms; improving quality by using evidence and creating meaningful public-private partnerships

4. Management of implementation

The implementation of the strategic priorities for steering the health sector towards Vision 2030 should continue to be managed by the Implementation Forum for Outcome 2*: "A long and healthy life for all South Africans*", which is the National Health Council (NHC). This Implementation Forum consists of the Minister of Health and the 9 Provincial Members of the Executive Council (MECs) for Health. The Technical Advisory Committee of the NHC (TAC-NHC) functions as the Technical Implementation Forum. The TAC-NHC consists of the Director-General of the National Department of Health (DoH) and the Provincial Heads of Department (HoDs) of Health in the 9 Provinces. Both the Implementation Forum and the Technical Implementation Forum should enhance the participation of government departments responsible for line functions that are social determinants of health, such as; clean water and proper sanitation; appropriate housing; quality education and decent employment, which alleviates poverty levels.

Table 1: Activities, indicators and targets for the implementation of NHI

	Actions	Minister Responsible	Indicators	Baselines[1]	Targets
1	Phased implementation of the building blocks of NHI	Minister of Health	National Health Insurance (NHI) Bill produced	None	Draft National Health Insurance Bill gazetted for public consultation in 2014/15 National Health Insurance law passed by 2015/16
			NHI fund created	None	Funding Modality for the National Health Insurance Fund including budget reallocation for the district primary health care (PHC) personal health services developed in 2014/15 NHI fund created by 2016/17
			Review and expand progressively NHI Pilot project to other districts	10 NHI pilot districts established across the Country	10 NHI pilot districts across the country in 2014/15 Review and expand progressively to other districts (Number to be determine based on review)
2	Establishment of NHI fora for engagement of non-state actors	Minister of Health	No of NHI Fora Established	None	9 Provincial NHI Fora established in 2014/15
3	Strengthen the input from patients on their experience of the health services	Minister of Health	No of Dialogues with patients groups on NHI	None	9 Provincial Dialogues with patient groups on NHI in 2014/15 and each year thereafter

[1] Estimated performance of the health sector for 2013/14, as reflected in the Annual Performance Plan of the National DoH for 2014/15

	Actions	Minister Responsible	Indicators	Baselines[1]	Targets
4	Reform of Central Hospitals and increase their capacity for local decision making and accountability to facilitate semiautonomy.	Minister of Health	No. of central hospitals with reformed management and governance structures as per the prescripts	None	All 10 central hospitals with reformed management and governance structures according to the prescripts by 2019

5.2. Sub-outcome 2: Improved quality of health care

Improved quality of care is an important building block for NHI. During 2012/13, an audit of all 3,880 public health facilities was completed by an independent organisation. The National Health Amendment Bill, which provides the important legal framework for the establishment of an independent Office of Health Standards and Compliance, was assented to by the President in September 2013. Key focus during the 2014-2019 MTSF should be devoted to accelerating the establishment and operationalisation of the Office of Health Standards Compliance. Table 2 below reflects the key actions required from the health sector to achieve this.

Table 2: Key actions, indicators and targets for enhancing Quality of Care

	Actions	Minister responsible	Indicators	Baselines[2]	Targets
1	Establish an operational Office of Health Standards Compliance (OHSC)	Minister of Health	Regulations for the functioning of the OHSC promulgated and implemented	Board of the OHSC established in January 2014	Finalise regulation for the functioning of the OHSC in 2014/15 Regulations promulgated for the functioning of the OHSC implemented from 2015/16
2	Appointment of the Ombudsperson and establishment of a functional office.	Minister of Health	Establish functional Ombuds Person Office	Board of the OHSC established in January 2014	Functional Ombuds Person office established by March 2015

[2] Estimated performance of the health sector for 2013/14, as reflected in the Annual Performance Plan of the National DoH for 2014/15

	Actions	Minister responsible	Indicators	Baselines[2]	Targets
3	Improve compliance with National Core Standards	Minister of Health	Proportion of Regional, Tertiary and Central Hospitals compliant with the extreme and vital measures of the national core standards for health facilities	Non-compliance with extreme and vital measures of the National Core Standards	100% compliance with National Core Standards in 5 Central Hospitals in 2014/15 100% compliance National Core Standards in 10 Central, 17 Tertiary, 46 Regional and 63 Specialised Hospitals by 2019
4	Monitor the existence of and progress on annual and regular plans that addresses breaches of quality, safety and compliance in all public sector	Minister of Health	Percentage of Health Establishments that have developed an annual Quality Improvement Plan (QIP) based on a self- assessment (gap assessment) or OHSC inspection	40%	45% in 2014/15 95% by 2019
5	Improve the acceptability, quality and safety of health services by increasing user and community feedback and involvement	Minister of Health	Patient satisfaction surveys rate (proportion of health facilities that conduct patient satisfaction surveys at least once a year)	65%	70% in 2014/15 100% by 2019
			Patient satisfaction rate	New Indicator	82,2[3] in 2014/15 90% by 2019

[3] .In the 2013 General Household Survey conducted by Statistics South Africa (Stats SA), 82.2% of users of public health care facilities reported being satisfied with the services provided, while 60.5% of the respondents reported being very satisfied with the service provided. A total of 98% of users of private health facilities were satisfied with the services provided, while 94% were very satisfied.

5.3. Sub-outcome 3. Implement the re-engineering of Primary Health Care

A strong PHC service delivery platform is the heartbeat for the implementation of NHI. The health sector has developed and begun implementing a reengineered PHC model, which consists of three streams, namely: creation and deployment of ward-based PHC Outreach Teams; establishment of District Clinical Specialist Teams and strengthening of Integrated School Health Services. The health sector has begun establishing municipal Wardbased PHC Teams across all 9 Provinces. These teams are led by a professional nurse, and have 6 Community Health Care (CHWs) each. These teams are providing a range of community-based health promotion and disease prevention programmes including strengthening nutrition interventions. Their brief includes supporting and promoting health in households and community settings such as at crèches, Early Childhood Centres, and old age homes.

The establishment of District Clinical Specialist Teams has also commenced. These teams consist of: a Principal Obstetrician and Gynaecologist; Principal Paediatrician; an Anaesthetist; Principal Family Physician; Principal Midwife; Advanced Paediatric nurse and Principal PHC nurse. A national school health policy was developed, in a partnership programme between the National DoH, the Department of Basic Education (DBE) and the Department of Social Department. The NDP 2030 is supportive of health sector's model of PHC re-engineering. Table 10 below reflects the key actions required from the health sector for accelerating the re-engineering of PHC. Table 10 below reflects the specific actions required from the health sector and other relevant sectors during the MTSF cycle 2014-2019.

Another major social and public health problem facing South Africa is the high burden of disease from violence and injuries. The country has an injury death rate of 158 per 100 000, which is twice the global average of 86,9 per 100 000 population and higher than the African average of 139,5 per 100 000[4]. (Key drivers of the injury death rates are intentional injuries due to interpersonal violence (46% of all injury deaths) and road traffic injuries (26%), followed by suicide (9%), fires (7%), drowning (2%), falls (2%) and poisoning (1%). It also stretches state resources in other sectors, such as the South African Police, the Criminal Justice System and the Welfare Sector. A need exists to implement a comprehensive and intersectoral response to combat violence and injury, and significantly reduce the country's injury death rate. This should be led by the Ministers of Police; Justice and Correctional Services; and Transport, with the Minister of Health playing a supporting role. The root causes of violence and injuries fall outside of the health system. However, these social ills place a huge strain on the limited resources of the health system.

Social determinants of health are defined as the economic and social conditions that influence the health of people and communities, and include employment, education, housing, water and sanitation, and the environment. The priority interventions recommended by the NDP 2030 to address the social determinants of health require the health sector and its implementation partners to:
(a) Implement a comprehensive approach to early life, which includes strengthening of existing child survival programmes; (b) ensure collaboration across sectors; and
(c) promote healthy diets and physical activity.

The prevalence of Non-Communicable Diseases (NCD), such as cardiovascular diseases, diabetes, chronic respiratory conditions, cancer, kidney disease and muscular-skeletal conditions, has increased globally, and in South Africa. Modifiable risk factors for NCDs, which are also emphasized in the NDP 2030 and the National Strategic Plan for NCDs 2013-2017, produced by the health sector in 2012, include the following: (a) tobacco use;
(b) physical inactivity; (c) unhealthy diets; and (d) harmful use of alcohol.

The National Strategic Plan for NCDs 2013-2017 reflects 10 goals and associated targets that must be achieved by 2020. Combating NCDs requires behaviour change and lifestyle change, which are extremely difficult to implement. Full participation of all government departments is required to meet the set targets. A need exists for the health

[4] National DoH and Health Policy Initiative (2012): Integrated Strategic Framework for the Prevention of Injury and Violence in South Africa, Pretoria.

sector to establish the National Health Commission (NHC) which will be an intersectoral platform to promote healthy lifestyles, encourage prevention of diseases and promote health care; and which will also enforce health regulations.

Table 3 below reflects the specific and concrete actions required from the health sector and its implementation partners to strengthen primary health care services, to address the social determinants of health and other interventions that have an impact on NCDs, during the MTSF cycle 2014-2019.

Table 3: Key actions, indicators and targets for Re-engineering PHC (Including Non-Communicable Diseases and Mental Health)

	Actions	Minister Responsible	Indicators	Baselines	Targets
1	Expand coverage of wardbased primary health care outreach teams (WBPHCOTs)	Minister of Health	Number of functional WBPHCOTs	1063 functional WBPHCOTs	1500 functional WBPHCOTs in 2014/15 3000 functional WBPHCOTs by 2019
2	Accelerate appointment of District Clinical Specialist Teams	Minister of Health	Number of Districts with fully fledged District Clinical Specialist Teams appointed	34/52 Districts with at least 3 members of District Clinical Specialist Teams	40 districts in 2014/15 52 Districts by 2019
3	Expand and strengthen integrated school health services	Minister of Health Minister of Basic Education	School Grade 1 screening coverage (annualised)	7%	30% in 2014/15 60% by 2019
			School Grade 8 screening coverage (annualised)	4%	25% in 2014/15 50% by 2019
4	Ensure quality primary health care services with optimally functional clinics by developing all clinics into Ideal Clinics	Minister of Health	Number of primary health care clinics in the 52 districts that qualify as Ideal Clinics	None-	50 clinics in 2014/15 1500 clinics in the 52 districts (70%) qualify as Ideal Clinics by 2019

	Actions	Minister Responsible	Indicators	Baselines	Targets
5	Improve intersectional collaboration with a focus on population wide interventions (to promote healthy lifestyles in the whole population) and community based interventions (to promote healthy lifestyles in communities) and addressing social and economic determinants of Non-Communicable Diseases	Primary responsibility: Minister of Health Supporting Ministers: • Minister of Basic Education • Minister of Correctional Services • Minister of Justice and Constitutional Development • Minister of Social Development • Minister of Trade and Industry Minister of Transport	Establish the National Health Commission	None	Consultations with key government departments, civil society and other key stakeholders to facilitate the establishment of the intersectoral forum in 2014/15 National Health Commission established and fully functional by March 2019
6	Reduce risk factors for Non-Communicable Diseases (NCDs) by designing and implementing a mass mobilization strategy focusing on healthy options, including the reduction of obesity	Minister of Health	% of women who are obese	61% in 2014	51% in 2019 (10% reduction)
			% of men who are obese	31% in 2014	21% in 2019 (10% reduction)
			% of children under five who are obese	25% in 2012	15% in 2019 (10% reduction)
7	Improve awareness of and management of prevalence of NCDs through screening and counselling for high blood pressure and raised blood glucose levels	Minister of Health	Number of people counselled and screened for high blood pressure	None (New Indicator)	500 000 in 2014/15 5 million people screened for high blood pressure and referred for treatment where necessary by 2019

	Actions	Minister Responsible	Indicators	Baselines	Targets
			Number of people counselled and screened for raised blood glucose levels	None (New Indicator)	500 000 in 2014/15 5million people screened for raised blood glucose levels and referred for treatment where necessary by 2019
8	Expand rehabilitation services	Minister of Health	Proportion of health facilities accessible to people with disabilities	Draft framework and model for rehabilitation services produced	15 Districts implementing the framework and model for rehabilitation services in 2014/15 80% of all health facilities are accessible to people with disabilities and are meeting the 5 compulsory criteria of accessibility by 2019
			Proportion of Health Facilities providing rehabilitation services	Draft framework and model for rehabilitation services produced	Draft framework and model for rehabilitation services developed and approved in 2014/15 80% of all health facilities providing rehabilitation services by 2019

	Actions	Minister Responsible	Indicators	Baselines	Targets
			Number of Health Districts providing community based rehabilitation	Draft framework and model for rehabilitation services produced	52 Districts where Community Based Rehabilitation Services are available by 2019 Fully constituted rehabilitation teams inclusive of community based rehabilitation workers available in 52 Districts by 2019
9	Screen the population for mental health disorders	Minister of Health	Percentage people screened for mental disorders	25% of people with mental disorders screened (prevalence of mental disorders is estimated at 16.5% of the population) s	25% of the prevalent population screened for mental disorders in 2014/15 35% of the prevalent population screened for mental disorders by 2019
			Percentage of people treated for mental disorders	25% of the prevalent population with mental disorder treated	25% of the prevalent population screened for mental disorders in 2014/15 35% of prevalent population treated for mental disorders by 2019
10	Contribute to a comprehensive and intersectoral response by government to violence and injury, and to ensure action	The Ministers of Police; Justice and Correctional Services; and Transport, with the Minister of Health playing a supporting role	Implementation of a comprehensive and intersectoral response to combat violence and injury, and significantly reduce the country's injury death rate	Integrated Strategic Framework for the Prevention of Injury and Violence in South Africa produced in March 2012	Comprehensive and intersectoral response to combat violence and injury, and significantly reduce the country's injury death rate implemented by 2019

5.4. Sub-outcome 4: Reduced health care costs

The NDP 20130 identifies a need for the development and implementation of mechanisms to improve the efficiency and control of health care costs. These mechanisms include primary care gate-keeping; demand management strategies such as appropriate self-care and user fees; rationing, diagnostic and therapeutic protocols; preferred providers; managed care and reimbursement strategies (capitation or global budgets instead of feefor-service). Mechanisms will be implemented to improve efficiencies and control the spiralling costs of health care. Reforms will also be implemented to reform private health care to bring costs down.

Table 4: Key actions, indicators and targets to reduce health care costs

	Actions	Minister Responsible	Indicators	Baselines	Targets
1	Establish a National Health Pricing Commission to regulate health care in the private sector	Minister of Health	National Health Pricing Commission established	None	Draft National Pricing Commission Bill gazetted for public consultation in 2014/15 National Health Pricing Commission established by 2017/18

5.5. Sub-outcome 5: Improved human resources for health

The NDP 2030 highlights the disparity in the distribution of health care providers between the public and private sectors in South Africa. The NDP emphasizes that the shortage of trained health workers and CHWs to provide health-promoting, disease preventing and curative services, is a major obstacle to service delivery. A new strategy for community-based services has been developed by the health sector, known as the re-engineering of Primary Health Care. The NDP accentuates the need to prioritise the training of more midwives, and distribute them to appropriate levels in the health system. This will contribute significantly to improving maternal, neonatal and child health.

The NDP articulates a concern about the training of specialists in South Africa, which encourages the continued production of system specialists, and is not consistent with the needs of the country. A major change in the training and distribution of specialists is proposed. This should include speeding up the training of community specialists in five specialist areas namely: medicine; surgery including anaesthetics; obstetrics; paediatrics and psychiatry. Training of specialists should include compulsory placement in resource-scarce regions, under the supervision of Provincial specialists.
Measures will be implemented to ensure adequate availability of well qualified, appropriately skilled and competent Human Resources for Health. The number of doctors trained locally and abroad will be doubled, at an average of 2,000 doctors a year. The Cuban Medical Training programme will be strengthened to ensure successful integration of medical students returning from Cuba to complete their training in South Africa .The revitalisation and resourcing of nursing colleges will be prioritised and recruitment of nurse trainees increased.

Table 5: Key actions, indicators and targets for improving Human Resource production, development and management

	Actions	Minister Responsible	Indicators	Baselines[5]	Targets
1	Increase production of Human Resources of Health	Minister of Health and Minister of Higher Education and Training	Intake of Medicine Students increased	1 767 new medical[6] students 961 medical students enrolled into the RSA- Cuba programme	2 000 new medical students enrolled annually (on average) by 2019
			Number of nursing colleges accredited to offer the new nursing curriculum	None	5 public nursing colleges accredited to offer the new nursing qualification in 2014/15 All 220 public nursing colleges by 2019
2	Finalise and adopt norms for the provision of Human Resource for Health	Minister of Health Minister of Finance Minister of Higher Education and Training	Norms for the provision of Human Resources for Health finalised and adopted	Draft guidelines for the development of Primary Health Care staffing norms are available	Draft guidelines for the development of Primary Health Care staffing norms are adopted in 2014/15 Norms for all levels of health care adopted by 2016
3	Produce, cost and implement Human Resource for Health Plans	Minister of Health Minister of Finance	Number of Provincial Human Resources for Health Plans produced	None	9 x Provincial Human Resources for Health Plans published by 2016/17, informed by national norms

5.6. Sub-outcome 6: Improved health management and leadership

The NDP 2030 identifies an important need to ensure that people who lead health institutions must have the required leadership capability and high level of technical competence in a clinical discipline.

Central hospitals are national assets and, as integral parts of universities, are primary training platforms for health professionals. The health sector will ensure that their governance, funding and management becomes a national public sector competency and that they play their role as part of a seamless referral system. Management and related capacity of central hospitals will be enhanced to enable them to deliver services efficiently and effectively.

[5] Estimated performance of the health sector for 2013/14, as reflected in the Annual Performance Plan of the National DoH for 2014/15.
[6] Health Data Advisory and Coordination Committee (HDACC) Report No.2, version June 2014

A key important area that also requires strengthening is financial management in the health sector. At the end of 2012/13, three health departments, the National DoH, the Western Cape and North West Departments of Health, received an unqualified audit opinion from the AGSA. Concerted effort must be made to increase this figure to at least 7/9 by 2019. Key interventions include:

(a) Improving financial management and audit outcomes in the health sector
(b) Improve Health District governance and strengthen management and leadership of the district health system
(c) Development of a training programme for Hospital CEOs and PHC Facility Managers
(d) Implementation of a knowledge hub which includes a web based interactive information system with information on innovative improvements and
(e) Establishing a national and international link of practising Health Managers
(f) Establishing a coaching and mentoring program for Health Managers

Table 6: Key actions, indicators and targets for improving health management and leadership

	Actions	**Minister Responsible**	**Indicators**	**Baselines**[7]	**Targets**
1	Improve financial management skills and outcomes for the health sector	Minister of Health	Number of Health Departments receiving unqualified audit reports from the Auditor-General of South Africa (AGSA)	3 Health Departments in 2012/13 (National DoH; North West and Western Cape)	4 health departments receiving unqualified audit reports from the AGSA for 2013/14 (National DoH and 3 Provincial DoHs) in 2014/15 5 health departments by 2017/18 (1 National and 4 Provincial DoHs) by 2019 7 Departments by 2019 (1 National and 6 Provincial DoHs) National DoH receiving a clean audit report from the AGSA by 2018/19

[7] Estimated performance of the health sector for 2013/14, as reflected in the Annual Performance Plan of the National DoH for 2014/15

	Actions	Minister Responsible	Indicators	Baselines[7]	Targets
2	Improve Health District governance and strengthen management and leadership of the district health system	Minister of Health	Number of primary health care facilities with functional clinic committees/ district hospital boards	2256 primary health care facilities with functional clinic committees/ district hospital boards	Implementation strategy for establishing functional clinic committees approved in 2014/15 Monitoring and evaluation system implemented in 2014/15 3760 primary health care facilities with functional clinic committees/ district hospital boards by 2019
3	Improve Health District governance and strengthen management and leadership of the district health system	Minister of Health	Number of districts with appropriate management structures for primary health care facilities	None	Appropriate management structures for primary health care facilities approved and resources secured in 2014/15 52 districts with uniform management structures for primary health care facilities by 2019
4	Ensure equitable access to specialised health care by increasing the training platform for medical specialists	Minister of Health	Number of gazetted hospitals providing the full package of tertiary services	None	17 gazetted tertiary hospitals providing the full package of Tertiary 1 services by 2019
5	Establish the Academy for Leadership and Management in Health to address skills gap at all levels of the health care system	Minister of Health	Training programme for Hospital CEOs and PHC Facility Managers developed	Health Management and Leadership Academy established in 2012	Dedicated training programme for Hospital CEOs, Hospitals Management Teams, District Mangers, District Management Teams and PHC Facility Managers developed by March 2016 90% of Hospitals CEOs, District Managers and PHC Facility Managers trained by 2019

	Actions	Minister Responsible	Indicators	Baselines[7]	Targets
		Minister of Health	Establish a national and international link of practising Health Managers	Health Management and Leadership Academy established in 2012	National and international link of practising Health Managers established by March 2016 90% of Hospitals CEOs, District Managers and PHC Facility Managers benefitting from the national and international link by 2019
		Minister of Health	Establish a coaching and mentoring program for Health Managers	None	Coaching and mentoring programme established by March 2016 90% of Hospitals CEOs, District Managers and PHC Facility Managers benefiting from the coaching and mentoring programme, resulting in improvements in service delivery by 2019
		Minister of Health	Knowledge hub developed and functional	None	Knowledge hub developed and functional by March 2017 60% of Hospitals CEOs, District Managers and PHC Facility Managers benefitting from the knowledge hub by March 2019

5.7. Sub-outcome 7: Improved health facility planning and infrastructure delivery

To improve health facility planning and infrastructure delivery a more systematic and professional approach to infrastructure delivery was introduced by the health sector, this entailed the establishment of a Project Management Support Unit, with 8 key works streams for accelerated delivery. The work streams focus on: Planning and Design; Procurement; Construction; Maintenance; Nursing Colleges; Public-Private Partnerships; Capacity Building Strategic Project Management. The pace of infrastructure delivery will be accelerated using alternative methods of delivery where possible to accelerate progress. Teams for health facility planning and infrastructure delivery will be strengthened. Under the NHI, 213 new clinics and community health centres and 43 hospitals will be built and over 870 health facilities in all 11 NHI pilot districts will undergo major and minor refurbishments. This will later be extended to all other districts.

Table 7: Key actions, indicators and targets for improved health facility planning and accelerated infrastructure delivery

	Key Action	Minister Responsible	Indicator	Baselines[8]	Targets
1	Improve the quality of health infrastructure in South Africa by ensuring that all health facilities are compliant with facility norms and standards	Minister of Health	Percentage of facilities that comply with gazetted infrastructure Norms & Standards	None	Health facility norms and standards developed and gazetted by March 2015 100% of new facilities comply with gazetted infrastructure Norms and Standards by 2019
2	Construct new clinics, community health centres and hospital	Minister of Health	Number of additional clinics and community health centres constructed	0	5 CHCs to be completed by March 2016) 213 by 2019
			Number of additional hospitals constructed or revitalised	0	4 hospitals to be completed by March 2015 43 hospitals by 2019
3	Undertake major and minor refurbishment of health facilities	Minister of Health	Number of health facilities that have undergone -major and minor refurbishment	95 health facilities	150 health facilities in 2014/15 870 health facilities by 2019

[8] Estimated performance of the health sector for 2013/14, as reflected in the Annual Performance Plan of the National DoH for 2014/15

	Key Action	Minister Responsible	Indicator	Baselines[8]	Targets
4	Strengthen partnership with the Department of Public Works to accelerate infrastructure delivery	Minister of Health	Number of Provincial Departments of Health that have established Service Level Agreements (SLAs) with Departments of Public Works	None	4 Provincial Departments by-March 2015 9 Provincial Departments by 2016

5.8. Sub-outcome 8: HIV & AIDS and Tuberculosis prevented and successfully managed

Strategies and actions to combat the HIV&AIDS epidemic are outlined in the National Strategic Plan (NSP) on HIV, STIs and TB 2012-2016, which was produced by the South African National AIDS Council (SANAC), chaired by the Deputy President of South Africa. The NDP 2030 recognises the pivotal role of the NSP on HIV, STIs and TB 2012-2016 in harnessing the efforts of all sectors of society towards reducing the burden of disease from HIV and AIDS and Tuberculosis.

The NSP 2012-2016 has adopted as a 20-year vision, the four zeros advocated by the Joint United Nations Programme on HIV and AIDS (UNAIDS). It, therefore, entails the following targets for South Africa:

- zero new HIV and TB infections
- zero new infections due to vertical transmission
- zero preventable deaths associated with HIV and TB
- zero discrimination associated with HIV and TB.

With respect to achieving an "HIV-free" generation of under-20s, the NSP 2012-2016 has two pertinent objectives namely Strategic Objective 1 and Strategic Objective 2. Strategic Objective 1 (SO 1) of the NSP 2012-2016 focuses specifically on addressing the structural, social, economic and behavioural factors that drive the HIV and TB epidemics. Strategic Objective 2 (SO 2) is focused on primary strategies to prevent sexual and vertical transmission of HIV and STIs, and to prevent TB infection and disease, using a combination of prevention approaches. The NSP 2012-2016 defines combination prevention as a mix of biomedical, behavioural, social and structural interventions that will have the greatest impact on reducing transmission and mitigating susceptibility and vulnerability to HIV, STIs and TB. This implies that different combinations of interventions will be designed for the different key populations. The NSP 2012-2016 identifies a total of 7 sub-objectives for HIV, STI and TB prevention, which if effectively implemented will yield the desired effect of reducing new HIV and TB infections:

Strategic Objective (SO) 3 of the NSP 2012-2016 outlines pertinent interventions to reduce morbidity and mortality from AIDS related causes and Tuberculosis. SO 3 focuses on sustaining health and wellness, and achieving a significant reduction in deaths and disability as a result of HIV and TB infection through universal access to accessible, affordable and good quality diagnosis, treatment and care.

The health sector will implement diverse interventions to deal with the burden of TB. Screening, treatment and prevention will be strengthened in the following vulnerable groups:

(a) **Correctional Services** - 150 000 inmates in the 242 correctional services, and the families of those who test positive,
(b) **Mineworkers** - A total of the 500 000 mineworkers and the families of those found positive
(c) **Peri-mining communities** - 600 000 communities in the peri-mining communities
(d) **Schools and households** - intensified screening of TB in schools and households using primary ward-based outreach teams

The public health sector will decentralise the management of MDR. The decentralisation will enable the sector to implement an approach similar to that used to address the burden of diseases from HIV, for instance, the Nurse Initiated Management of Antiretroviral therapy (NIMART), which enables nurses to diagnose and manage accordingly. Multi-Drug Resistant (MDR) sites will expanded from less than 100 currently to 2500 in the next 3 years, to expand access to as many people as possible – using nurses in the decentralised sites to help manage this. Table 8 below reflects the specific actions required from the health sector and its implementation partners to reduce mortality from AIDS related causes and Tuberculosis (TB).

Table 8: Key actions, indicators and targets for the prevention and successful management of HIV&AIDS and Tuberculosis

	Action	**Minister Responsible**	**Indicator**	**Baselines[9] 15**	**Target**
1	Maximise opportunities for testing and screening to ensure that everyone in South Africa has an opportunity to test for HIV and to be screened for TB at least once annually	Minister of Health	Number of men and women 15–49 tested for HIV	8.9 million (2012/13)	10 million in 2014/[10] 50 million by March 2019
			Number of people screened for TB	8 million (in 2011)	6 million in 2014/15 30 million by March 2017 40 million by March 2019
2	Maximise opportunities for testing and screening to ensure that everyone in South Africa's Correctional Facilities is tested for HIV and screened for TB at least annually	Minister of Health Minister of Justice and Correctional Services	Percentage of correctional services centres conducting routine TB screening	23% (56/242)	50% in 2014/15 (121/242) in 2014/15 95% (230/242) by 2019
3	Increase access to a preventive package of sexual and reproductive health (SRH) services, including includes medical male circumcision and provision of both male and female condoms	Minister of Health	Number of male condoms distributed	387 million (in 2012/13)[11]	600 000 000 in 2014/15 One billion by March 2019

[9] Estimated performance of the health sector for 2013/14, as reflected in the Annual Performance Plan of the National DoH for 2014/15.
[10] South African National AIDS Council (SANAC): National Strategic Plan on HIV, STIs and TB 2012-2016
[11] Health Systems Trust, District Health Barometer, 2012/13

	Action	Minister Responsible	Indicator	Baselines[9] 15	Target
1	Maximise opportunities for testing and screening to ensure that everyone in South Africa has an opportunity to test for HIV and to be screened for TB at least once annually	Minister of Health	Number of men and women 15–49 tested for HIV	8.9 million (2012/13)	10 million in 2014/[10] 50 million by March 2019
			Number of people screened for TB	8 million (in 2011)	6 million in 2014/15 30 million by March 2017 40 million by March 2019
2	Maximise opportunities for testing and screening to ensure that everyone in South Africa's Correctional Facilities is tested for HIV and screened for TB at least annually	Minister of Health Minister of Justice and Correctional Services	Percentage of correctional services centres conducting routine TB screening	23% (56/242)	50% in 2014/15 (121/242) in 2014/15 95% (230/242) by 2019
			Number of female condoms distributed	5,1 million (2010/11)[12]	5 million in 2014/15 25 million by March 2019
			Number of men medically circumcised	600 000 (2012/13)	1 million in 2014/15 5 million by March 2019
4	Implement essential interventions to reduce HIV mortality	Minister of Health	HIV Mortality	34.6% in 2011	17.3% by March 2017 (50% reduction)
5	Improve the effectiveness and efficiency of the TB control programme	Minister of Health	TB new client treatment success rate	79%	82% in 2014/15 >85% by 2019
6	Improve TB treatment outcomes	Minister of Health	TB (new pulmonary) defaulter rate	6%	6% in 2014/15 <5% by 2019

[12] South African National AIDS Council (SANAC): National Strategic Plan on HIV, STIs and TB 2012-2016

	Action	Minister Responsible	Indicator	Baselines[9] 15	Target
1	Maximise opportunities for testing and screening to ensure that everyone in South Africa has an opportunity to test for HIV and to be screened for TB at least once annually	Minister of Health	Number of men and women 15–49 tested for HIV	8.9 million (2012/13)	10 million in 2014/[10] 50 million by March 2019
			Number of people screened for TB	8 million (in 2011)	6 million in 2014/15 30 million by March 2017 40 million by March 2019
2	Maximise opportunities for testing and screening to ensure that everyone in South Africa's Correctional Facilities is tested for HIV and screened for TB at least annually	Minister of Health Minister of Justice and Correctional Services	Percentage of correctional services centres conducting routine TB screening	23% (56/242)	50% in 2014/15 (121/242) in 2014/15 95% (230/242) by 2019
7	Implement interventions to reduce TB mortality	Minister of Health	TB Death Rate	6%	6% in 2014/15 <3% by 2019 (50% reduction)
8	Improve the effectiveness and efficiency of the MDR-TB control programme	Minister of Health	Number of professional nurses trained to initiate MDR-TB treatment	5	25 in 2014/15 400 Professional Nurses trained to initiate MDR-TB treatment by 2019
9	Combat MDR TB by ensuring access to treatment	Minister of Health	MDR-TB confirmed treatment initiation rate	56%	60% in 2014/15 80% by 2019
		Minister of Health	MDR treatment success rate	42%	50% in 2014/15 >65% by 2019

5.9. Sub-outcome 9: Maternal, infant and child mortality reduced

South Africa has a high maternal mortality ratio (MMR), largely attributable to HIV and AIDS. The country's efforts to reduce maternal deaths date back to 1997, when the then Minister of Health established the National Committee of Confidential Enquiry into Maternal Deaths (NCCEMD), which was the first on the African continent. The NCCEMD has since released five triennial reports. A positive development is that South Africa's MMR, both population-based and institutional, reflect a downward trend. Annual data from the NCCEMD reflect that institutional MMR has decreased from 188.9 per 100 000 live births in 2009 to 146.7 per 100 000 live births in 2012. South Africa's 2013 Millennium Development Goals (MDG) country report reflects MMR as 269 per 100 000. Estimates from the Rapid Mortality Surveillance (RMS) system of the Medical Research Council and the University of Cape Town place South Africa's MMR for 2010 at 269/100 000.

As is the case with MMR, Infant Mortality Rates (IMR) in South Africa reflect a decline. IMR in South Africa has decreased from 39 deaths per 1 000 live births in 2009, to 27 deaths per 1 000 live births in 2012. Similarly, the Under-5 mortality rate decreased from 56 deaths per 1 000 live births in 2009, to 41 deaths per 1 000 live births in 2012.

With respect to under-nutrition, the South African National Health and Nutrition Examination Survey, conducted by the Human Sciences Research Council found that found that young children youngest boys and girls (0–3 years of age) had the highest prevalence of stunting (26.9% in boys and 25.9% in girls), which was significantly different from the other age groups, with the lowest prevalence in the group aged 7–9 years (10.0% and 8.7% for boys and girls, respectively). It was also found that among boys, rural informal areas had significantly more stunting (23.2%) than urban formal areas (13.6%). Furthermore, girls living in urban informal areas had the highest prevalence of stunting (20.9%) and those in urban formal areas, the lowest (10.4%), the difference in prevalence being significant.

Table 9 below shows the key actions, indicators and targets to reduce maternal, infant and child mortality.

	Actions	Minister responsible	Indicators	Baselines[13]	Target
1.	Improve the implementation of Basic Antenatal Care	Minister of Health	Antenatal visits before 20 weeks rate	50.6%	65% in 2014/15 70% by 2019
			Proportion of mothers visited within 6 days of delivery of their babies	74.8%	90% in 2014/15 80% by 2019
2.	Expand the PMTCT coverage to pregnant women	Minister of Health	Antenatal client initiated on ART rate	90%	95% in 2014/15 98% by 2019
			Infant 1st Polymerase Chain Reaction (PCR) test positive around 6 week rate	2.5%	2% in 2014/15 <1.5% by 2019

[13] Estimated performance of the health sector for 2013/14, as reflected in the Annual Performance Plan of the National DoH for 2014/15

	Actions	Minister responsible	Indicators	Baselines[13]	Target
3.	Protect children against vaccine preventable diseases	Minister of Health	Immunisation coverage under 1 year (annualised)	94%	90% in 2014/15 95% by 2019
			DTaP-IPV/HIV 3-Measles 1st dose dropout rate	8%	7% in 2014/15 <5% by 2019
			Measles 2nd dose coverage	81.8%	85% in 2014/15 95% by 2019
			Confirmed measles case incidence per million total population	<5 per 1,000,000	<4 per 1,000,000 in 2014/15 <1 per 1,000,000 by 2019
		Minister of Health	Child under 5 years diarrhoea case fatality rate	4.2%	3,5% in 2014/15 <2% by 2019
		Minister of Health	Child under 5 years severe acute malnutrition case fatality rate	9%	8% in 2014/15 5% by 2019
4.	Expand and strengthen integrated school health services	Minister of Health Minister of Basic Education	School Grade 1 screening coverage (annualised)	7%	30% in 2014/15 60% by 2019
			School Grade 8 screening coverage (annualised)	4%	25% in 2014/15 50% by 2019
5.	Expand access to sexual and reproductive health by expanding availability of contraceptives and access to cervical and HPV cancer screening services	Minister of Health	Couple year protection rate	36%	55% in 2014/15 80% by 2019
		Minister of Health	Cervical cancer screening Coverage (amongst women)	55%	60% in 2014/15 70% by 2019
		Minister of Health	Human Papilloma Virus coverage 1st dose ((HPV Vaccine Coverage amongst 9 and 10 year old girls)	None (new indicator)	80% in 2014/15 90% by 2019

5.10. Sub-outcome 10: Efficient Health Management Information System developed and implemented for improved decision making

The NDP 2030 emphasizes the widely accepted fact that credible data are necessary for decision-making and regular system-wide monitoring. The NDP 2030 accentuates the need to implement effective health information systems. Key interventions include: prioritizing the development and management of effective data systems; integrating the national health information system with the provincial, district, facility and community-based information systems; establishing national standards for integrating health information systems; undertaking regular data quality audits, developing human resources for health information; strengthening the use of information; focusing access on web based and mobile data entry and retrieval linked to the existing DHIS; and investing in improving data quality. Diverse health information systems exist in the public sector, which play a key role in tracking the performance of the health system. However, these systems have various limitations, including: lack of interoperability between different systems; inability to facilitate harmonious data exchange; prevalence of manual systems and lack of automation.

Table 10: Key actions, indicators and targets for the development of an integrated and well-functioning national patient-based information system

	Key Actions	Minister Responsible	Indicators	Baselines[14]	Targets
1	Develop a complete System design for a National Integrated Patient based information system	Minister of Health	System design for a National Integrated Patient based information system completed	Health Normative Standards Framework for eHealth produced and gazetted in terms of the National Health Act (61 of 2003) in 2014	Business architecture for a National Integrated Patient Based Information System developed in 2014/15 System design for a National Integrated Patient based information system completed by March 2018 National Integrated Patient based information system implemented from April 2018
		Minister of Telecommunications & Postal Services	Percentage of hospitals implementing an integrated ICT Health System through broadband access		80% by 2019

[14] Estimated performance of the health sector for 2013/14, as reflected in the Annual Performance Plan of the National DoH for 2014/15

6. Impact (or outcome) Indicators

Table 11 below reflects the key impacts expected from the interventions of the health sector during 2014-2019.

Impact Indicator	Minister responsible	Baseline 2009[15]	Baseline[16] 2012	2019 targets
Life expectancy at birth: Total	Minister of Health	56.5 years	60.0 years (increase of 3,5years)	63 years by March 2019 (increase of 3 years)
Life expectancy at birth: Male	Minister of Health	54.0 years	57.2 years (increase of 3,2 years)	60.2 years by March 2019 (increase of 3 years)
Life expectancy at birth: Female	Minister of Health	59.0 years	62.8 years (increase of 3,8years)	65.8 years by March 2019 (increase of 3years)
Under-5 Mortality Rate (U5MR)	Minister of Health	56 per 1,000 live-births	41 per 1,000 live-births (25% decrease)	23 per 1,000 live-births by March 2019 (20% decrease)
Neonatal Mortality Rate	Minister of Health	-	14 per 1000 live births	6 per 1000 live births
Infant Mortality Rate (IMR)	Minister of Health	39 per 1,000 live-births	27 per 1,000 live-births (25% decrease)	18 per 1000 live births
Child under 5 years diarrhoea case Fatality rate	Minister of Health	-	4.2%	<2%
Child under 5 years severe acute malnutrition case fatality rate	Minister of Health	-	9%	<5%
Maternal Mortality Ratio	Minister of Health	304 per 100,000 live-births	269 per 100,000 live-births	Downward trend <100 per 100,000live-births by March 2019

[15] Medical Research Council (2013): Rapid Mortality Surveillance (RMS) Report 2012
[16] Medical Research Council (2013): Rapid Mortality Surveillance (RMS) Report 2012

NOTES

Fraud prevention line: 0800 701 701
24 hour Call Centre: 0800 032 364
Website: www.ecdoh.gov.za