

2021-22

ANNUAL **PERFORMANCE** PLAN

TABLE OF CONTENTS

FOREWORD BY THE EXECUTIVE AUTHORITY 7
MEMBER OF THE EXECUTIVE COUNCIL 8
STATEMENT BY THE HEAD AND ACCOUNTING OFFICER OF THE DEPARTMENT 9
OFFICIAL SIGN-OFF OF THE ANNUAL PERFORMANCE PLAN 2020/21 10

PART A: OUR MANDATE 12
LEGISLATIVE AND POLICY MANDATES (NATIONAL HEALTH ACT, AND OTHER LEGISLATION) 12
HEALTH SECTOR POLICIES AND STRATEGIES OVER THE FIVE-YEAR PLANNING PERIOD 14

PART B: STRATEGIC FOCUS 18
1. VISION 18
2. MISSION 18
3. VALUES 18
4. DIAGNOSTIC ANALYSIS 18
5. EXTERNAL ENVIRONMENTAL ANALYSIS 19
6. ORGANISATIONAL ENVIRONMENT 41

PART C – MEASURING OUR PERFORMANCE (PROVINCIAL DOH APP PER BUDGET PROGRAMME) 49
PROGRAMME 1: HEALTH ADMINISTRATION AND MANAGEMENT 49
PROGRAMME 2: DISTRICT HEALTH SERVICES (DHS) 59
PROGRAMME 3: EMERGENCY MEDICAL SERVICES (EMS) 79
PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES (REGIONAL AND SPECIALISED) 85
PROGRAMME 5: CENTRAL & TERTIARY HOSPITALS 91
PROGRAMME 6: HEALTH SCIENCES AND TRAINING (HST) 99
PROGRAMME 7: HEALTH CARE SUPPORT SERVICES (HCSS) 104
PROGRAMME 8: HEALTH FACILITIES MANAGEMENT (HFM) 110

10. CONDITIONAL GRANTS 117
11. PUBLIC ENTITIES 119
APP TIDS FOR PROVINCIAL DOH 121
CONCLUSION 152

ABBREVIATIONS AND ACRONYMS

AIP	Audit Intervention Plan
APP	Annual Performance Plan
ART	Antiretroviral Therapy
BANC	Basic Ante Natal Care
BOD	Burden of disease
CCMDD	Central Chronic Medicine Dispensing and Distribution
CEO	Chief Executive officer
CF	Case Fatality
CFO	Chief Financial Officer
CHCs	Community Health Centres
CHW	Community Health worker
CIDB	Construction Industry Development Board
CMH	Cecilia Makhiwane Hospital
COE	Compensation of Employees
COVID 19	Corona Virus
CP	Cerebral Palsy
CSSD	Central Sterile Supply Department
CQI	Continuous Quality Improvement
DCSTs	District Clinical Specialist Teams and General Practitioner
DDG	Deputy Director General
DDM	District Development Model
DHIS	District Health Information System
DHIMS	District Health Information Management System
DHS	District Health Services
DM	District Municipality
DMT	District Management Team
DOH	Department of Health
DS-TB	Drugs Susceptible Tuberculosis
EC	Eastern Cape
ECDoH	Eastern Cape Department of Health
ECAC	Eastern Cape AIDS Council
ECSECC	Eastern Cape Socio-Economic Consultative Council
EDR-TB	Extreme Drug Resistance Tuberculosis
EMS	Emergency Medical Services
EPWP	Expanded Public Works Programme
EPRE	Estimate of the Provincial Revenue and Expenditure
ESMOE	Essential Steps in the Management of Obstetric Emergency
ETR	Electronic TB Register
GIAMA	Government Immovable Asset Management Act
GP	General Practitioner
HAST	HIV & AIDS, STI and TB control
HCSS	Health Care Support Services
HFM	Health Facilities Management
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HLP	Health Action Plan
HMS	Hospital Management System
HPRS	Health Patient Registration System
HST	Health Sciences and Training
HPTD	Health Professionals Training and Development (Grant)
HRM	Human Resource Management
HRD	Human Resource Development
HRH	Human Resources for Health
HT	Health Technology
ICRM	Ideal Clinic Realisation and Maintenance
ICSM	Integrated Clinical Services Management
ICT	Information and Communications Technology
IDMS	Infrastructure Delivery Management System
IDIP	Infrastructure Delivery Improvement Programme
IDPs	Integrated Development Plans
IMCI	Integrated Management of Childhood Diseases
IMR	Infant Mortality Rate
IPC	Infection Prevention and Control
ISHP	Integrated School Health Programme
LEDIS	Local Economic Development Implementation Strategy
MAC	Ministerial Advisory Committee
MDGs	Millennium Developmental Goals
MDR-TB	Multi-Drug Resistant TB
MEC	Member of the Executive Council
METROs	Medical Emergency Transport and Rescue Organizations
MLSIP	Medico Legal Strategy Implementation Plan
MMR	Maternal Mortality Ratio
MOU	Maternal Obstetric Unit

MPL	Member of Provincial Legislature
MRC	Medical Research Council
MTCT	Mother-To-Child-Transmission
MTSF	Medium Term Strategic Framework
MTEF	Medium Term Expenditure Framework
NCCEMD	National Committee on Confidential Evaluation on Maternal Deaths
NCDs	Non-Communicable Diseases
NCS	National Core Standards
NDoH	National Department of Health
NDP	National Development Plan
NGO	Non-Governmental Organisation
NHA	National Health Act
NHI	National Health Insurance
NHLS	National Health Laboratory Services
NHP	National Health Plan
NSDA	Negotiated Service Delivery Agreement
NTSG	National Tertiary Services Grant
OD	Organisational Development
O&P	Orthotic and Prosthetic
OHH	Outreach Households
OHS	Occupational health and safety
OPD	Outpatient Department
OTP	Office of the Premier
PAJA	Promotion of Administration Justice Act
PAIA	Promotion of Access to Information Act
PCR	Polymerase Chain Reactive
PDE	Patient Day Equivalent
PDMT	Provincial District Management Team
PDP	Provincial Development Plan
PEC	Patient experience of care
PFMA	Public Finance Management Act
PEPFAR	Presidential Emergency Programme Fund for Aids Relief
PERSAL	Personnel and Salaries
PGDP	Provincial Growth and Development Plan
PHC	Primary Health Care
PMIS	Project Management Information System
PMTCT	Prevention of Mother-To-Child Transmission
PMTSF	Provincial Medium-Term Strategic Framework
PPE	Personal Protective Equipment
PPPs	Public-Private Partnerships
PPTICRM	Perfect Permanent Team for Ideal Clinic Realization and Management
PSI	Patient Safety Incident
PT	Provincial Treasury
QIPs	Quality Improvement Plans
RDP	Reconstruction and Development Programme
RPHC	Re-engineering the Primary Health Care System
SADHS	South African Demographic Household Survey
SAHR	South African Human Rights
SARS- Cov	Severe Acute Respiratory Syndrome Corona Virus
SD	Status Determinations
SDGs	Sustainable Development Goals
SCM	Supply Chain Management
SIU	Special Investigating Unit
SLA	Service Level Agreement
SLU	Specialised Litigation Unit
SOP	Standard Operating Procedure
SOPA	State of the Province Address
SVS	Stock Visibility Solution
Stats SA	Statistics South Africa
TB	Tuberculosis
THIS	TB HIV Information System
TROA	Total clients remaining On ART
TV	Television
UHC	Universal Health coverage
WHO	World Health Organisation

LIST OF TABLES

Table 1: Alignment of MTSF Impact, Outcomes and Pillars from Presidential and Provincial summit 16
Table 2: Population Distribution by health district municipality , 2019 estimates 22
Table 3: Socio-economic indicators by District in Eastern Cape Province 23
Table 3 (B): Number of positive SARS-Cov-2 cases, recoveries and deaths, as of 21 Mar 2021 25
Table 4: Facility type per district....27
Table 5: Key provincial service volumes, 2015/16-2019/20....28
Table 6A: Hospital efficiencies....30
Table 6B: Hospital efficiencies....30
Table 7: Hospital Efficiency Indicators....30
Table 8. Hospital case management indicators....30
Table 9: Top Most cancers in men in EC. 38
Table 10: Most common cancers in the Eastern Cape....38
Table 11: Six core standards....39
Table 12: Patient experience of care....40
Table 13 (a): Ideal Clinic Services....40
Table 13(b): Ideal Hospital Services....41
Table 14: Summary of payments and estimates by programme. 45
Table 15: Summary of provincial payments and estimates by economic classification. 46
Table16: Outcomes, Outputs and Output indicators for the next MTEF for the Office of the MEC 49
Table 17: Outcomes, Outputs and Output indicators for the next MTEF for Health Management 51
Table 18: Summary of payments and estimates by sub programme: Programme 1: Administration....54
Table 19: Summary of payments and estimates by economic classification: P1 – Administration....54
Table 20: Key Risks and mitigating factors 56
Table 21: Outcomes, Outputs and Output indicators for the next MTEF for District Management 60
Table 22: Outcomes, Outputs and Output indicators for the next MTEF for Clinics....61
Table 23: Outcomes, Outputs and 0utput Indicators for the next MTEF for CHCs....62
Table 24: Outcomes, Outputs and 0utput indicators for the next MTEF for Non communicable diseases....63
Table 25: Outcomes, Outputs and Outputs indicators for the next MTEF for Other community base services....64
Table 26: Outcomes, Outputs and Output indicators for the next MTEF for HAST....66
Table 27: Outcomes, Outputs and Output indicators for the next MTEF for MCWH&N 69
Table 28: Outcomes, Outputs and Output indicators for the next MTEF for Coroner Services....73
Table 29: Outcomes, Outputs and Output indicators for the next MTEF for District Hospital....74
Table 30: Summary of payments and estimates: P2 - District Health Services 75
Table 31: Summary of payments and estimates by economic classification: P2 - District Health Services....76
Table 32: Key Risks and mitigating factors 77
Table 33: Outcomes, Outputs and Output indicators for the next MTEF for EMS....80
Table 34: Summary of payments and estimates: P3 - Emergency Medical Services....81
Table 35: Summary of payments and estimates by economic classification: P3 - Emergency Medical Services....82
Table 36: Key Risks and mitigating factors 83
Table 37: Outcomes, Outputs and Output indicators for the next MTEF for Regional Hospital....86
Table 38: Outcomes, Outputs and Output indicators for the next MTEF for Specialised TB Hospital 87
Table 39: Outcomes, Outputs and Output indicators for the next MTEF for Specialised Psychiatric Hospitals....88
Table 40: Summary of payments and estimates: Programme 4 - Provincial Hospital Services 89
Table 41: Summary of payments and estimates by economic classification: P4 - Provincial Hospital Services 89
Table 42: Key Risks and mitigating factors 89
Table 43: Outcomes, Outputs and Output indicators for the next MTEF for Central Hospital....92
Table 44: Outcomes, Outputs and Output indicators for the next MTEF for Tertiary Hospitals 93
Table 45: Outcomes, Outputs and Output indicators for the next MTEF for Specialised Tertiary Hospital....94
Table 46: Summary of payments and estimates: P5 - Central Hospital Services 95
Table 47: Summary of payments and estimates by economic classification: P5 - Central Hospital Services....96
Table 48: Key Risks and mitigating factors 97
Table 49: Outcomes, Outputs and Output indicators for the next MTEF for Health Science and Training....99
Table 50: Summary of payments and estimates: P6 - Health Sciences and Training....100
Table 51: Summary of payments and estimates by economic classification: P6 - Health Sciences and Training....101
Table 52: Key Risks and mitigating factors 102
Table 53: Outcomes, Outputs and Output indicators for the next MTEF for Health care support....105
Table 54: Summary of payments and estimates: P7 - Health Care Support Services....107
Table 55: Summary of payments and estimates by economic classification: P7 - Health Care Support Services 107
Table 56: Key Risks and mitigating factors 108
Table 57: Outcomes, Outputs and Output indicators for the next MTEF for Health facilities management....110
Table 58: Summary of payments and estimates: P8 - Health Facilities Management....113
Table 59: Summary of payments and estimates by economic classification: P8 - Health Facilities Management....114
Table 60: Key Risks and mitigating factors 115
Table 61: Departmental infrastructure payments....116
Table 62: Health professions training and development grant....117
Table 63: Comprehensive HIV/AIDS grant....118

Table 64: National Tertiary Services grant....118
Table 65: Health facility revitalisation grant....118
Table 66: Public-private partnerships....120
Table 67: Technical Indicator Data Set....121

LIST OF FIGUREURES

Figure 1: National development plan....15
Figure 2: Sustainable development Goals....15
Figure.3 Map of the EC....19
Figure 4: Eastern Cape population estimates by year....19
Figure 5: Population pyramid....20
Figure 6: Projections of EC population age 60 years and older....21
Figure 7: Estimated Life Expectancy at Birth for the EC Province....22
Figure 8: Percentage people in poverty....23
Figure 9 : Poverty headcount by district in the EC....24
Figure 10: Broad causes of death by district....26
Figure 11: Incidence of SARS-Cov-2 cases by epidemiological week, as of 21 Mar. 2021 25
Figure 12: Map showing EC Public health facilities 26
Figure 13: PHC utilisation rate....28
Figure 14: Expenditure per Capita and Headcount....29
Figure 15: 909090 Cascades....31
Figure 16: TB incidence in EC 2009-2019....31
Figure 17: Distribution of new pulmonary TB patients per 100 000 population by EC district (Source: ETR) 32
Figure 18: TB treatment success rate distributed by districts 32
Figure 19 : Trends in DR-TB death rate....33
Figure 20: Maternal mortality in facility ratio/100 000 FY 2015/16 - 2019/20....33
Figure 21: Maternal mortality per district 34
Figure 22 : Couple year protection rate....34
Figure 23: Perinatal mortality in facility rate 35
Figure 24: Ten leading causes of infant deaths in the EC Province, 2016 (N=1741) 35
Figure 25: Neonatal deaths in facility rate (per 1000 live births), 2015/16 – 2019/20....36
Figure 26: Case fatality rate in U5 year children distributed by cause of death....36
Figure. 27: Child <5 yrs diarrrhoea, pneumonia, severe acute malnutrition case fatality rate, 2015/16-2019/20....37
Figure. 28: Child health indicators....37
Figure 29: Organisational structure 42



FOREWORD BY THE EXECUTIVE AUTHORITY

Madam Speaker allow me to present and submit the Department of Health Annual Performance Plan for 2021/22 in this people`s assembly of the people of Eastern Cape. We present the 2021/22 financial year Annual Performance Plan during the period the world including our beloved province are engulfed and suffocated by the Coronavirus pandemic. This deadly disease has caused enormous suffering and devastation in many communities and households. Coronavirus pandemic has changed everything in the lives of peoples of the world.

On the 21 March 2021, the Eastern Cape province registered 194 886 infections since the start of the pandemic. To date 183 308 infected individuals recovered from the disease i.e. 94.1% recovery rate. Subsequently the province has experienced and recorded the highest Case Fatalities (CF) of 11 339 (5.8% case fatality rate) compared to other provinces of the Republic. This picture of deaths has shocked all of us in the province and the republic, this is a calamity of significant proportion.

The Province has started with Covid 19 vaccination, targeting to achieve herd or population immunity, ECDoH must immunise a minimum of 67% of the population. The minimum target population for vaccination is 3 874 626 persons with an optimal target of 4 497 224 million persons.

Notwithstanding the huge human suffering and loss, the advent of Coronavirus has significantly strained the minimum resources at the departmental disposal. In addition, the pandemic has hampered departmental revenue generation efforts which led to insufficient collection to contribute to the Provincial Revenue Fund to boast the provincial capability in resource allocation. The department has experienced huge budget cuts due to the negative impact of the pandemic to the entire economy due to dwindled revenue streams.

The National Health Insurance (NHI) is still the cornerstone and vehicle to deliver comprehensive quality health services to the people of Eastern Cape. Its interventions like Ward-Based Outreach Teams displayed resilience in the fights against Coronavirus. The infrastructure development at health facilities improved the capacity and resilience of the public health system in mitigation of the pandemic`s negative impact. Reduction of maternal and infant mortalities through the re-organization and strengthening of the District Clinical Specialist Team (DCSTs) in all districts and metropolitans. The implementation of the Medico-Legal Strategy is anchored on intervention that will prevent or minimise maternal and infant mortalities as follows:

- Continuous monitoring of labour,
- Caesarean section interventions for foetal distress,
- Implement national strategy on helping babies breath,
- Implementation of electronic record management system,
- Improve clinical governance,
- Supporting the designated district hospitals to have full package of services,
- Extensive use of alternative dispute resolution mechanisms driven by mediation to reduce medico legal settlements,

The department will continue consolidating and strengthening of the HIV/AIDS and Tuberculosis 90 90 90 World Health Organization (WHO) adopted strategy to stem and combat the scourge of HIV and Tuberculosis in pursuit of meeting the National Development Plan (NDP) goal of increasing life expectancy of South Africans above 70 years. The provision of single dose HIV/AIDS medicine will be fast-tracked and sustained through Central Chronic Medicine Dispensing and Distribution (CCMDD) programme for stable clients. The department will continue institutionalizing Integrated Clinical Services Management (ICSM) in an attempt to decongest the health facilities and improve access to quality health services.

Ideal Clinic Realization and Maintenance (ICRM) and Ideal Hospital (IH) programmes will be intensified and sustained through quality improvements in all facilities. All facilities will be conducting Status Determinations (SD) followed by development of Quality Improvement Plans (QIPs) to address shortcomings identified. Health Patient Registration System (HPRS) will be strengthened in all facilities for quality patient's data management. The department will invest significant resources in strengthening the Information, Communication and Technology (ICT) platform that will result in quality health information systems, good records management and automation of departmental functions and processes.

The department will pay special attention to designated groups (women, youth & people with disabilities). The department will prioritized the 50:50 equity plan in all Senior Management positions, strive to reach the 2% recruitment of people with disabilities at all levels and intensified youth services through Integrated School Health Programme and Youth Friendly services at Primary Health Care facilities.

The availability of medicines in all facilities will be continuously monitored through Stock Visibility Solution (SVS) intervention. The department shall continue improving access to medicines by strengthening the Central Chronic Medicine Dispensing and

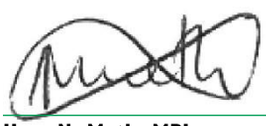
Distribution by increasing Pick Up Points near clients live and convenient. Non-Communicable diseases clients will find it easy to receive their medicines and reduce the opportunities for clients to default.

We shall improve the inter-governmental relations through participation in transversal government structures with other government departments and sectors. This will improve strategies and interventions that address the social determinants of health e.g. water & sanitation, road infrastructure, electricity, air pollution, waste management etc. We shall also consolidate and strengthen participation in the District Development Model (DDM) esp. Integrated Development Plans (IDPs).

Fighting crime and corruption remains our serious impediment and threat in implementing good clean governance and providing quality services to our people. We have put in place governance structures (Risk & Audit Committees) and integrated Audit Improvement Plan to monitor prudent financial management.

Let me extend a word of gratitude to all the departmental stakeholders who positively and constructively played a critical role in the development of the Annual Performance Plan for 2021/22. We also extend our gratitude to the philanthropic gesture of the Developmental Partners, Corporate South Africa and Non-Governmental Organizations (NGOs) for their continuous support to the department.

In closing, I would like to express my sincere appreciation to the departmental leadership and management led by acting Head of Department , Dr. Sibongile Zungu, all departmental staff who toil in pursuit of alleviating suffering and distress to the people of Eastern Cape. We are also indebted to all social partners for their sterling contribution in the delivery of health care



Hon. N. Meth, MPL
Member of the Executive Council



STATEMENT BY THE HEAD AND ACCOUNTING OFFICER OF THE DEPARTMENT

The 2021/22 Annual Performance Plan (APP) represents the second instalment of the department's 5- year strategic plan for the sixth term of government. This APP is presented against the backdrop of a severely constrained fiscal environment and significant budget cuts, a novel Covid-19 pandemic, escalating medico legal claims and an increasing burden of disease. Despite these challenges, the department is resolute on delivering on its constitutional mandate as encapsulated in section 27 of the Constitution of the Republic of South Africa.

In developing this APP, the department has taken into consideration the goals for the health sector as outlined in the National Development Plan: Vision 2030, the key pillars of the Presidential Health Summit Compact, the provincial Health Summit resolutions, the Makgotla resolutions as well as the State of the Province pronouncements. We have ensured that this alignment is achieved in order to have a single, compact plan that encapsulates all priorities and deliverables for the department in the 2021/22 financial year.

Given the constrained fiscal environment and other challenges facing the department, our plans for the 2021/22 are premised on 'doing more with less'. We have targeted programmes that will help us to bring efficiencies and reduce costs whilst also optimising our health care service delivery platform to be agile and highly effective. Thus, for the 2020/21 year and the MTEF, we will pursue the following priorities in our quest to provide optimal health outcomes for the people of the Eastern Cape Province:

- Continue to monitor the Covid-19 pandemic in the province and implement the multi-pronged Covid-19 resurgence plan aimed at curbing the spread of the Covid-19 virus whilst also mitigating against future resurgences, until population herd immunity is achieved.
- Roll out the Covid-19 vaccination programme to the targeted 4.5 million eligible population in the province. Although the vaccination programme is not an end in itself, it is a critical strategy in lessening both Covid-19 case fatalities and mortalities.
- Optimise the health service delivery platform using the hub and spoke model in order to ensure that we have the correct number, size and adequately resourced facilities with a structured referral system. This strategy aimed at achieving universal health coverage will be done with due consultation in order to ensure that all stakeholders especially the communities who are recipients of our health services, are consulted throughout.
- Informed by the department's strategy and revised service delivery platform, we will also finalise and implement the organogram with a focus on building strong districts and hospital management teams in line with the envisaged role of the districts in the National Health Insurance. We will also implement the resultant staff migration plan that will ensure that staff are placed where they are most needed, in line with their skills and competencies.
- Roll out the e-health strategy, initially targeting the 28 facilities in the hub and spoke model. This investment will ensure that we stabilize our server infrastructure, collaborate with Office of the Premier to bring broadband connectivity to all health facilities, roll out the Health Patient Registration System, Hospital Management System and electronic pharmacy system.
- Strengthen the health system to achieve high impact health outcomes by reducing costs and wastage, increase efficiencies in the procurement of goods and services through implementation of strategic sourcing initiatives, strengthen patient billing and other revenue generating initiatives and focus on pro-active and preventative maintenance of health technology and equipment.
- Strengthen maternal and child health interventions to reduce maternal and neonatal mortalities whilst also reducing adverse events that give rise to the medico legal claims.
- In collaboration with OTP and Provincial Treasury, implement the integrated medico legal strategy aimed at mitigating and vigorously defending these medico legal claims in court.
- Implement the 90-90-90 strategy for HIV and TB through the implementation of prevention initiatives, case finding, treatment initiation initiatives and viral load suppression.
- Scale up interventions to promote health and wellness, reduce non communicable diseases and strengthen mental health services through implementation of a decentralised community mental health services.

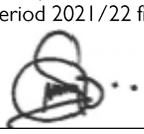
Learning from the positive experiences during our fight against the Covid-19 pandemic, we will strongly pursue partnerships with other government departments, the private sector as well as the NGO sector. We are confident that together, we will be able to do more with less. I call upon the entire health team at Head Office, in the districts and facilities to work together, share resources and do everything possible to deliver optimal health outcomes for the people of the Eastern Cape.

Lastly, I wish to take this opportunity to thank Hon. MEC Meth for her leadership and support, the Portfolio Committee on Health for their oversight, health partners and stakeholders as well as the department's staff who make it possible for us to continue providing services to the people of our province.

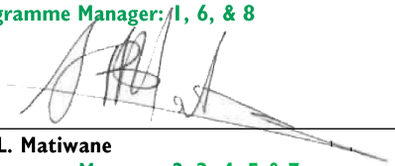
OFFICIAL SIGN-OFF OF THE ANNUAL PERFORMANCE PLAN 2020/21

It is hereby certified that this Annual Performance Plan:

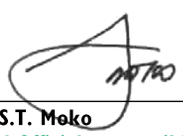
- Was developed by the management of the Eastern Cape Department of Health under the guidance of Hon. MEC for Health, Mrs N. Meth, MPL,
- Takes into account all the relevant policies, legislation and other mandates for which the Eastern Cape Province is responsible,
- Accurately reflects the outcomes and outputs which the Eastern Cape Department of Health will endeavor to achieve over the period 2021/22 financial year.



Mrs. N. Mavuso
Programme Manager: 1, 6, & 8



Dr. L. Matiwane
Programme Manager: 2, 3, 4, 5 & 7



Dr. S.T. Moko
Head Official responsible for Planning

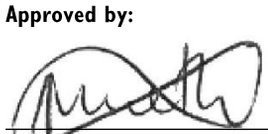


Mr. M. Daca
Chief Financial Officer



Dr. S. Zungu
Acting Accounting Officer

Approved by:



Hon. N. Meth, MPL
Member of the Executive Council



PART A

OUR MANDATE

PART A

OUR MANDATE

Constitutional Mandate

In terms of the Constitutional provisions, the Department is guided by the following sections and schedules, among others:

The Constitution of the Republic of South Africa, 1996, places obligations on the state to progressively realise socio-economic rights, including access to *(affordable and quality)* health care.

Schedule 4 of the Constitution reflects health services as a concurrent national and provincial legislative competence.

Section 9 of the Constitution states that everyone has the right to equality, including access to health care services. This means that individuals should not be unfairly excluded in the provision of health care.

People also have the right to access information if it is required for the exercise or protection of a right.

This may arise in relation to accessing one's own medical records from a health facility for the purposes of lodging a complaint or for giving consent for medical treatment; and

This right also enables people to exercise their autonomy in decisions related to their own health, an important part of the right to human dignity and bodily integrity in terms of sections 9 and 12 of the Constitutions respectively.

Section 27 of the Constitution states as follows: with regards to Health care, food, water, and social security:

(1) Everyone has the right to have access to:
  (a) Health care services, including reproductive health care.
  (b) Sufficient food and water; and
  (c) Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.
(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights; and
(3) No one may be refused emergency medical treatment.

Section 28 of the Constitution provides that every child has the right to 'basic nutrition, shelter, basic health care services and social services.

LEGISLATIVE AND POLICY MANDATES (NATIONAL HEALTH ACT, AND OTHER LEGISLATION)

Legislation falling under the Department of Health's Portfolio

National Health Act, 2003 (Act No. 61 of 2003)

Provides a framework for a 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 objectives of the National Health Act (NHA) 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 deliver quality health care services; establish a health system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognized standards of research and a spirit of enquiry and advocacy which encourage participation; promote a spirit of Co-operation and shared responsibility among public and private health professionals and providers and other relevant sectors within the context of national, provincial and district health plans; and create the foundation of the health care system, and understood alongside other laws and policies which relate to health in South Africa.

Medicines and Related Substances Act, 1965 (Act No. 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.

Hazardous Substances Act, 1973 (Act No. 15 of 1973) - Provides for the control of hazardous substances, in particular those emitting radiation.

Occupational Diseases in Mines and Works Act, 1973 (Act No. 78 of 1973) - Provides for medical examinations on persons suspected of having contracted occupational diseases, especially in mines, and for compensation in respect of those diseases.

Pharmacy Act, 1974 (Act No. 53 of 1974) - Provides for the regulation of the pharmacy profession, including community service by pharmacists.

Health Professions Act, 1974 (Act No. 56 of 1974) - 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, 1979 (Act No.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, 1982 (Act No. 63 of 1982) - Provides for the regulation of health practitioners such as chiropractors, homeopaths, etc., and for the establishment of a council to regulate these professions.

SA Medical Research Council Act, 1991 (Act No. 58 of 1991) - Provides for the establishment of the South African Medical Research Council and its role in relation to health Research.

Academic Health Centers Act, 86 of 1993 - Provides for the establishment, management, and operation of academic health centers.

Choice on Termination of Pregnancy Act, 196 (Act No. 92 of 1996) - Provides a legal framework for the termination of pregnancies based on choice under certain circumstances.

Sterilisation Act, 1998 (Act No. 44 of 1998) - Provides a legal framework for sterilisations, including for persons with mental health challenges.

Medical Schemes Act, 1998 (Act No.131 of 1998) - Provides for the regulation of the medical schemes industry to ensure consonance with national health objectives.

Council for Medical Schemes Levy Act, 2000 (Act 58 of 2000) - Provides a legal framework for the Council to charge medical schemes certain fees.

Tobacco Products Control Amendment Act, 1999 (Act No 12 of 1999) - Provides for the control of tobacco products, prohibition of smoking in public places and advertisements of tobacco products, as well as the sponsoring of events by the tobacco industry.

Mental Health Care 2002 (Act No. 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 human rights for mentally ill patients.

National Health Laboratory Service Act, 2000 (Act No. 37 of 2000) - Provides for a statutory body that offers laboratory services to the public health sector.

Nursing Act, 2005 (Act No. 33 of 2005) - Provides for the regulation of the nursing profession.

Traditional Health Practitioners Act, 2007 (Act No. 22 of 2007) - Provides for the establishment of the Interim Traditional Health Practitioners Council, and registration, training and practices of traditional health practitioners in the Republic.

Foodstuffs, Cosmetics and Disinfectants Act, 1972 (Act No. 54 of 1972) - Provides for the regulation of foodstuffs, cosmetics and disinfectants, in particular quality standards that must be complied with by manufacturers, as well as the importation and exportation of these items.

Other legislation applicable to the Department

Criminal Procedure Act, 1977 (Act No.51 of 1977), Sections 212 4(a) and 212 8(a) - Provides for establishing the cause of non-natural deaths.

Children's Act, 2005 (Act No. 38 of 2005) - The Act gives effect to certain rights of children as contained in the Constitution; to set out principles relating to the care and protection of children, to define parental responsibilities and rights, to make further provision regarding children's court.

Occupational Health and Safety Act, 1993 (Act No.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, 1993 (Act No.130 of 1993) - Provides for 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 disease.

National Roads Traffic Act, 1996 (Act No.93 of 1996) - Provides for the testing and analysis of drunk drivers.

Employment Equity Act, 1998 (Act No.55 of 1998) - Provides for the measures that must be put into operation in the workplace in order to eliminate discrimination and promote affirmative action.

State Information Technology Act, 1998 (Act No.88 of 1998) - Provides for the creation and administration of an institution responsible for the state's information technology system.

Skills Development Act, 1998 (Act No 97of 1998) - Provides for the measures that employers are required to take to improve the levels of skills of employees in workplaces.

Public Finance Management Act, 1999 (Act No. 1 of 1999) - Provides for the administration of state funds by functionaries, their responsibilities and incidental matters.

Promotion of Access to Information Act, 2000 (Act No.2 of 2000) - Amplifies the constitutional provision pertaining to accessing information under the control of various bodies.

Promotion of Administrative Justice Act, 2000 (Act No.3 of 2000) - Amplifies the constitutional provisions pertaining to administrative law by codifying it.

Promotion of Equality and the Prevention of Unfair Discrimination Act, 2000 (Act No.4 of 2000)
Provides for the further amplification of the constitutional principles of equality and elimination of unfair discrimination.

Division of Revenue Act, (Act No 7 of 2003) - Provides for the manner in which revenue generated may be disbursed.

Broad-based Black Economic Empowerment Act, 2003 (Act No.53 of 2003) - Provides for the promotion of black economic empowerment in the manner that the state awards contracts for services to be rendered, and incidental matters.

Labour Relations Act, 1995 (Act No. 66 of 1995) - Establishes a framework to regulate key aspects of relationship between employer and employee at individual and collective level.

Basic Conditions of Employment Act, 1997 (Act No.75 of 1997) - Prescribes the basic or minimum conditions of employment that an employer must provide for employees covered by the Act.

Disaster Management Act 2002 (no 57 of 2002) – establish framework to prevent, reduce the risk of disasters ; mitigating the severity of disaster , emergency preparedness , rapid and effective response to disasters and post – disaster recovery through establishment of National , Provincial and municipal disaster management center

HEALTH SECTOR POLICIES AND STRATEGIES OVER THE FIVE-YEAR PLANNING PERIOD

National Health Insurance Bill

South Africa is at the brink of effecting significant and much needed changes to its health system financing mechanisms. The changes are based on the principles of ensuring the right to health for all, entrenching equity, social solidarity, efficiency, and effectiveness in the health system in order to realise Universal Health Coverage. To achieve Universal Health Coverage, institutional and Organisational reforms are required to address structural inefficiencies; ensure accountability for the quality of the health services rendered and ultimately to improve health outcomes particularly focusing on the poor, vulnerable and disadvantaged groups.

In many countries, effective Universal Health Coverage has been shown to contribute to improvements in key indicators such as life expectancy through reductions in morbidity, premature mortality (especially maternal and child mortality) and disability. An increasing life expectancy is both an indicator and a proxy outcome of any country's progress towards Universal Health Coverage.

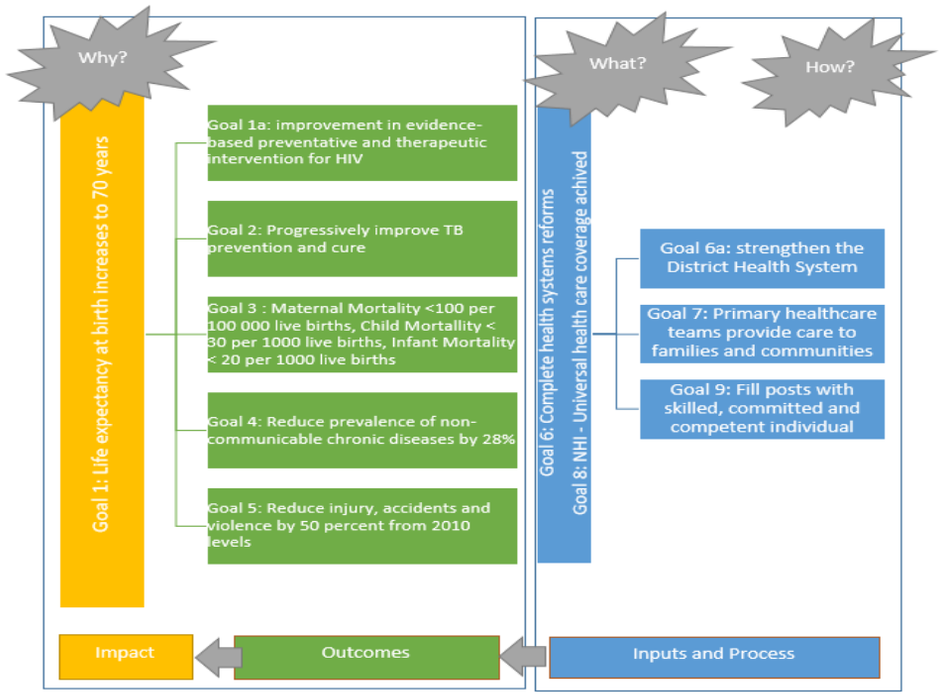
The phased implementation of National Health Insurance (NHI) is intended to ensure integrated health financing mechanisms that draw on the capacity of the public and private sectors to the benefit of all South Africans. The policy objective of NHI is to ensure that everyone has access to appropriate, efficient, affordable, and quality health services.

An external evaluation of the first phase of National Health Insurance was published in July 2019. Phase 2 of the NHI Programme commenced during 2017, with official gazetting of the National Health Insurance as the Policy of South Africa. The National Department of Health (NDOH) drafted and published the National Health Insurance Bill for public comments on 21 June 2018. During August 2019, the National Department of Health sent the National Health Insurance Bill to Parliament for public consultation.

National Development Plan (NDP): Vision 2030

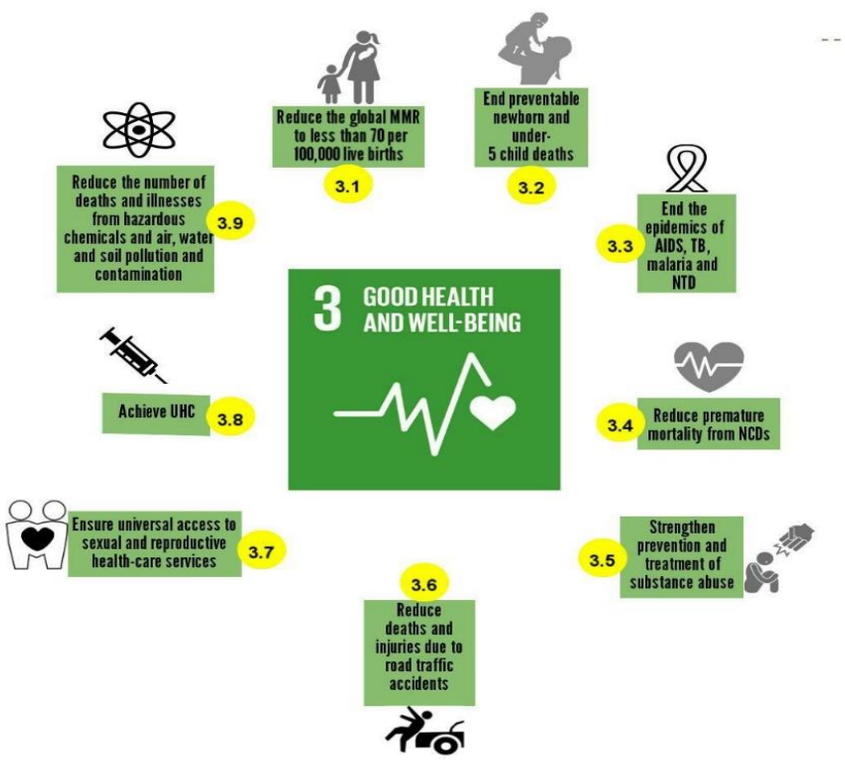
The National Development Plan (Chapter 10) has outlined 9 goals for the health system that it must reach by 2030. The NDP goals are best described using conventional public health logic framework. The overarching goal that measures impact is "Average male and female life expectancy at birth increases to at least 70 years". The next 4 goals measure health outcomes, requiring the health system to reduce premature mortality and morbidity. Last 4 goals are tracking the health system that essentially measure inputs and processes to derive outcomes.

Figure 1: National development plan



Sustainable Development Goals

Figure 2: Sustainable development Goals



Medium Term Strategic Framework and NDP Implementation Plan 2019-2024

The plan comprehensively responds to the priorities identified by cabinet of 6th administration of democratic South Africa, which are embodied in the Medium-Term Strategic Framework (MTSF) for period 2019-2024. It is aimed at eliminating avoidable and preventable deaths (*survive*); promoting wellness, and preventing and managing illness (*thrive*); and transforming health systems, the patient experience of care, and mitigating social factors determining ill health (thrive), in line with the United Nation's three broad objectives of the Sustainable Development Goals (SDGs) for health.

The table below outlines the MTSF impact, outcomes and and pillars from Presidential and Provincial summit.

Table 1: Alignment of MTSF Impact, Outcomes and Pillars from Presidential and Provincial summit

	Impact	Outcomes	Presidential Health Summit Compact Pillars	Provincial Health Summit Pillars
Survive and Thrive	Universal health coverage for all South Africans progressively achieved and all citizens protected from the catastrophic financial impact of seeking health care by 2030.	Progressive improvement in the total life expectancy of South African Reduce maternal and child mortality.	N/A	Pillar 6: Strengthen service delivery through strengthened intergovernmental collaborative government model, (Thuma mina, Operation Masiphathisane and addressing social determinants of health)
Transform		Universal Health coverage for all South Africans achieved	Pillar 4: Engage the private sector in improving the access, coverage, and quality of health services	Pillar 1. Rationalisation of health service delivery platform to facilitate National Health Insurance realisation and to address access to appropriate health services
			Pillar 6: Improve the efficiency of public sector financial management systems and processes	
			Pillar 5: Improve the quality, safety and quantity of health services provided with a focus on primary health care.	Pillar 9: Quality and safety of health services will be prioritised towards accreditation of health facilities for NHI.
			Pillar 7: Strengthen Governance and Leadership to improve oversight, accountability and health system performance at all levels	Pillar 7: Governance, leadership, monitoring & evaluation with emphasis on creation of a culture of accountability and participation by all members
			Pillar 8: Engage and empower the community to ensure adequate and appropriate community-based care	Pillar: 2 Strengthen implementation of mental health services through innovative planning, focusing on mainstreaming the mental health services and ensuring that all mental health teams are multidisciplinary at all levels.
			Pillar 1: Augment Human Resources for Health Operational Plan	Pillar: 5 Human resources for health to address the staff shortages and appropriate skills mix
			Pillar 2: Ensure improved access to essential medicines, vaccines, and medical products through better management of supply chain equipment and machinery	Pillar 3: Infrastructure planning, delivery, medical equipment, and maintenance
			Pillar 6: Improve the efficiency of public sector financial management systems and processes	Pillar 8: Small business development, financial management and innovative ways of revenue generation
			Pillar 3: Execute the infrastructure plan to ensure adequate, appropriately distributed, and well-maintained. health facilities	Pillar 3: Infrastructure planning, delivery, medical equipment, and maintenance
			Pillar 9: Develop an Information System that will guide the health system policies, strategies, and investments	Pillar 4: Development of ICT platforms, automation, and digitization of the sector through improving capacity, systems integration, disaster recovery and information security planning systems



PART B

STRATEGIC FOCUS

PART B: STRATEGIC FOCUS

1. VISION

Optimal health outcomes for the people of the Eastern Cape Province

2. MISSION

To attain universal health coverage for the people of the Eastern Cape Province, through primary health care approach utilising resources efficiently, to enable present and future generations to achieve optimal health outcomes and quality.

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
- Customer and patient satisfaction,
- Fair labor practices
- High degree of accountability
- Transparency (maintaining confidentiality code)
- Respect

4. DIAGNOSTIC ANALYSIS

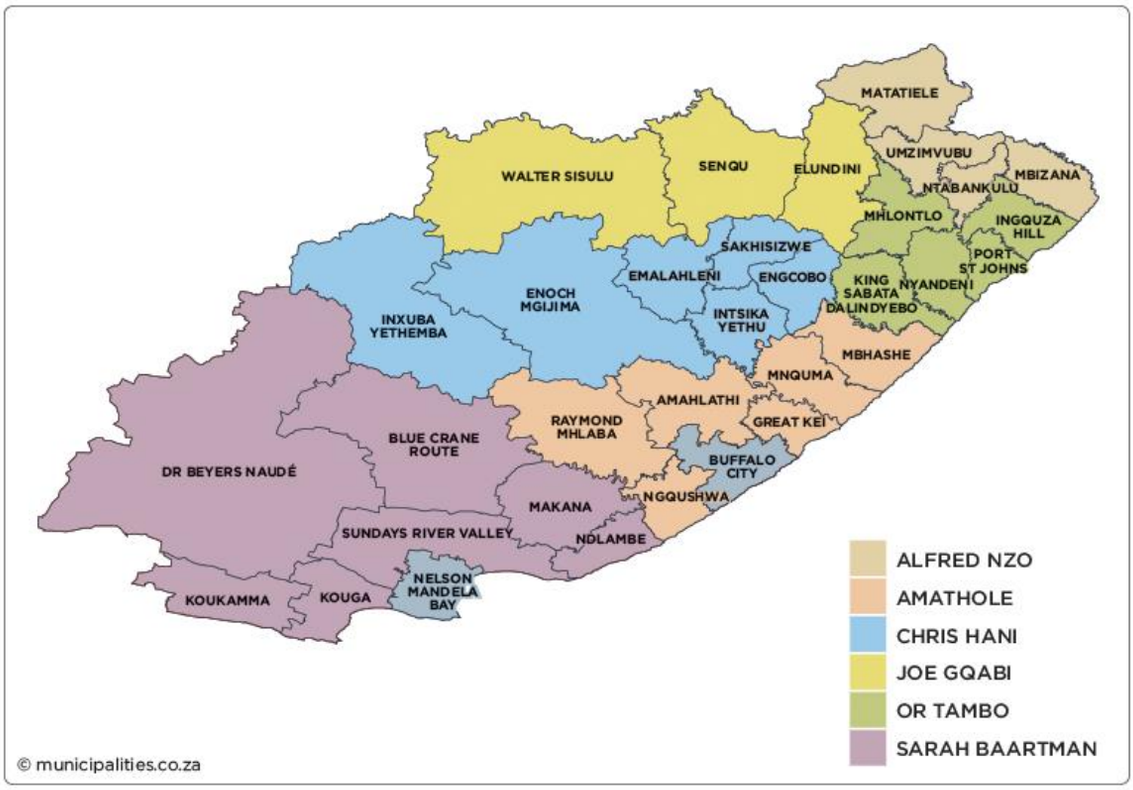
Overview of the Province

According to Stats SA 2020 mid-year estimates, Eastern Cape covers an area of 168 966km² and has a population of 6 734 001. About 36.6 % of the population are children 15 years and younger. Between the 2011 Census and the 2020 mid-year estimates, the total population of the Eastern Cape increased from 6 562 million to 6.734 million (2.6 %) and constitutes a share of 11.4% to the SA population. It is the second-largest province in South Africa by surface area and has the third largest population.

The Eastern Cape is one of South Africa's potential. The Eastern Cape's main feature is its spectacular coastline bordering the Indian Ocean The fertile Lang Kloof Valley in the south-west has enormous deciduous fruit orchards, while the Karoo interior is an important sheep-farming area. The Alexandria-Makhanda area produces pineapples, chicory, and dairy products, while coffee and tea are cultivated at Magwa. People in the former Transkei region are dependent on the farming of cattle, maize, and sorghum.

The metropolitan economies of Nelson Mandela Bay Metro and Buffalo city are based primarily on manufacturing, the most important industry being motor manufacturing. The province is the hub of South Africa's automotive industry. The Eastern Cape is divided into two metropolitan municipalities (Buffalo City Metropolitan Municipality and Nelson Mandela Bay Metropolitan Municipality) and six district municipalities, which are further subdivided into 31 local municipalities.

Figure.3 Map of the EC

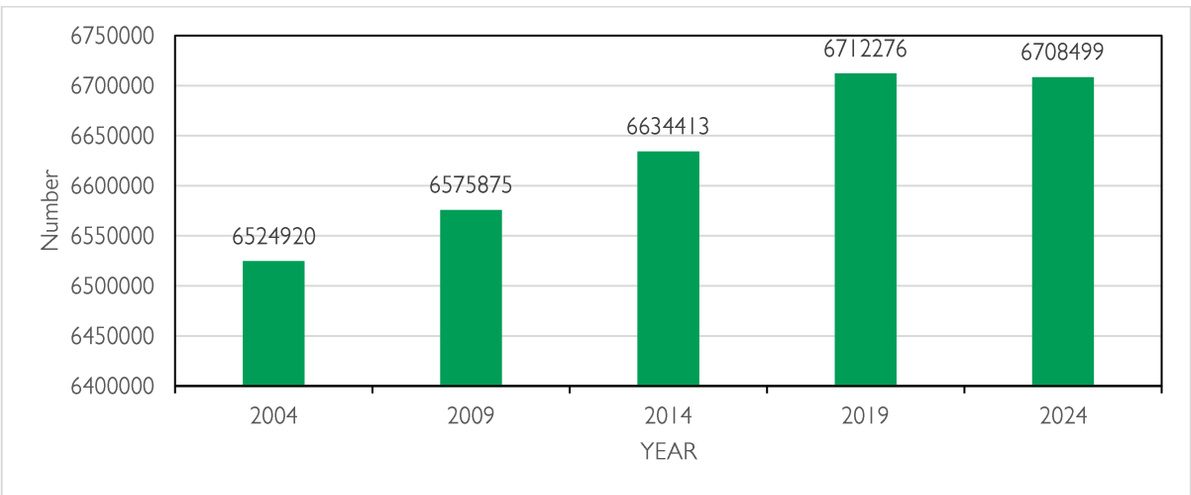


5. EXTERNAL ENVIRONMENTAL ANALYSIS

5.1 Demography

The estimated Eastern Cape population is showing an increasing trend since 2004 The total population for the EC province in 2020 peaked at 6 734 001. Further projections show year to year decrease between 2019 and 2024 (Figure 4: Statssa, 2019).

Figure 4: Eastern Cape population estimates by year.

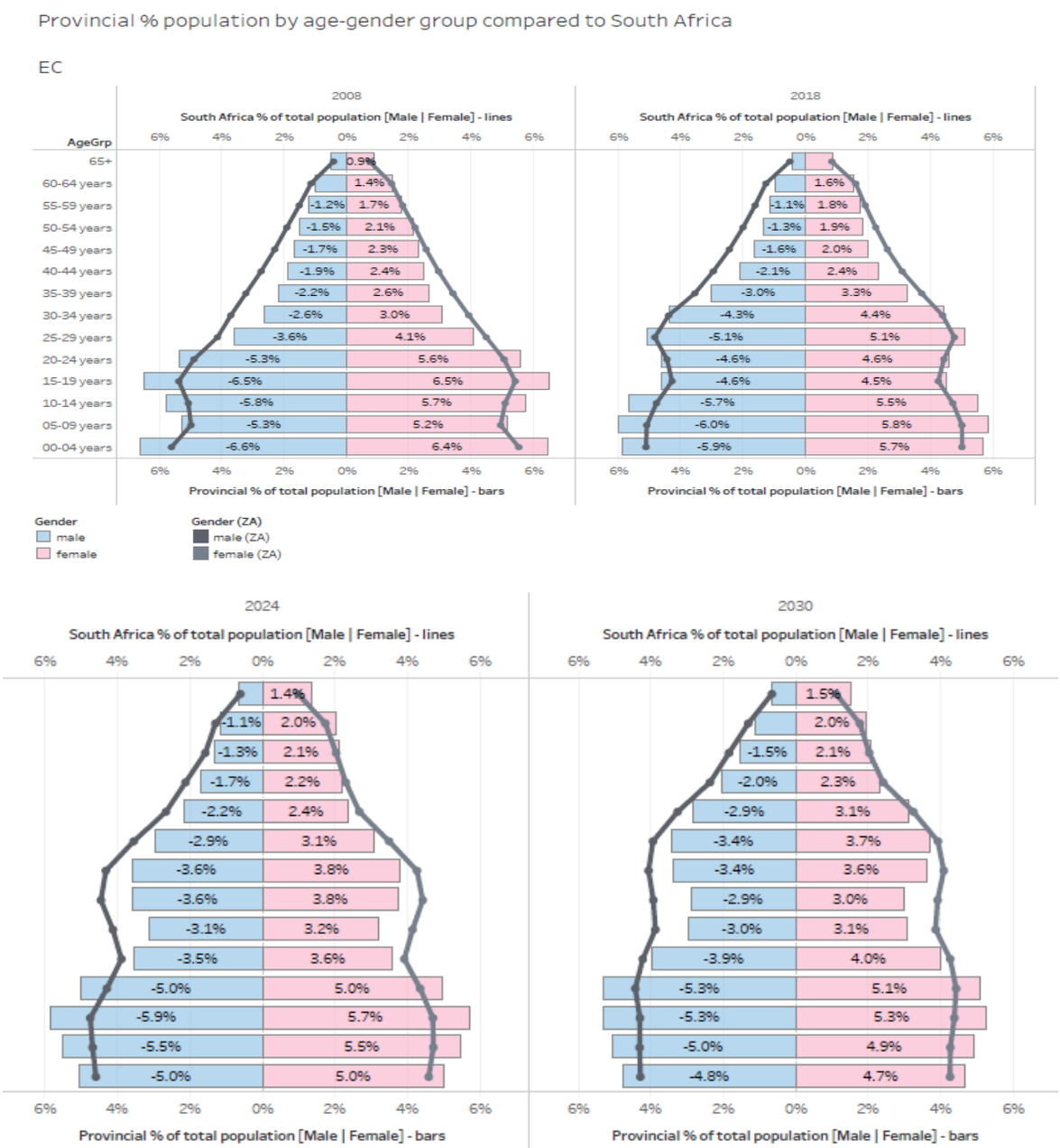


(Data source Statssa, 2019)

The EC share to national population has been showing a decreasing trend, for example, from 13% in 2009 to 11,4% ten years later in 2020. This is mainly due to the net outward migration as young people leave the province to seek employment opportunities in provinces including Gauteng and the Western Cape, whose share has been showing increasing trend during the same time period

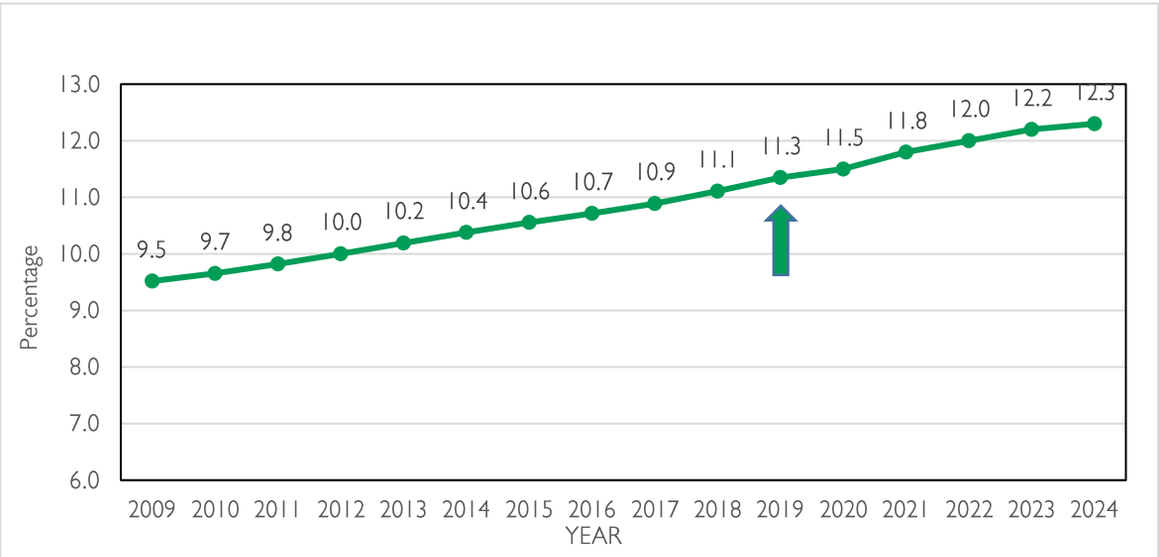
(Figure 5). The population loss to outward migration impacts negatively on the total appropriation of the EC DOH as the budget allocation is linearly correlated to the population Figureu of the Provinces.

Figure 5: Population pyramid



Nationally, the highest proportions of elderly persons aged 60 years and older were estimated for the Eastern Cape constituting 11,3% of the total EC population in 2019 and an increase to 12,3% by 2024 (Figureure 6). To note, is the inward migration of the elderly and retired population which will require provision for specific needs of the elderly including increased provision of chronic medication, specialised health care service, social grants, old age homes etc.

Figure 6: Projections of EC population age 60 years and older



(Data source: Statssa, 2019)

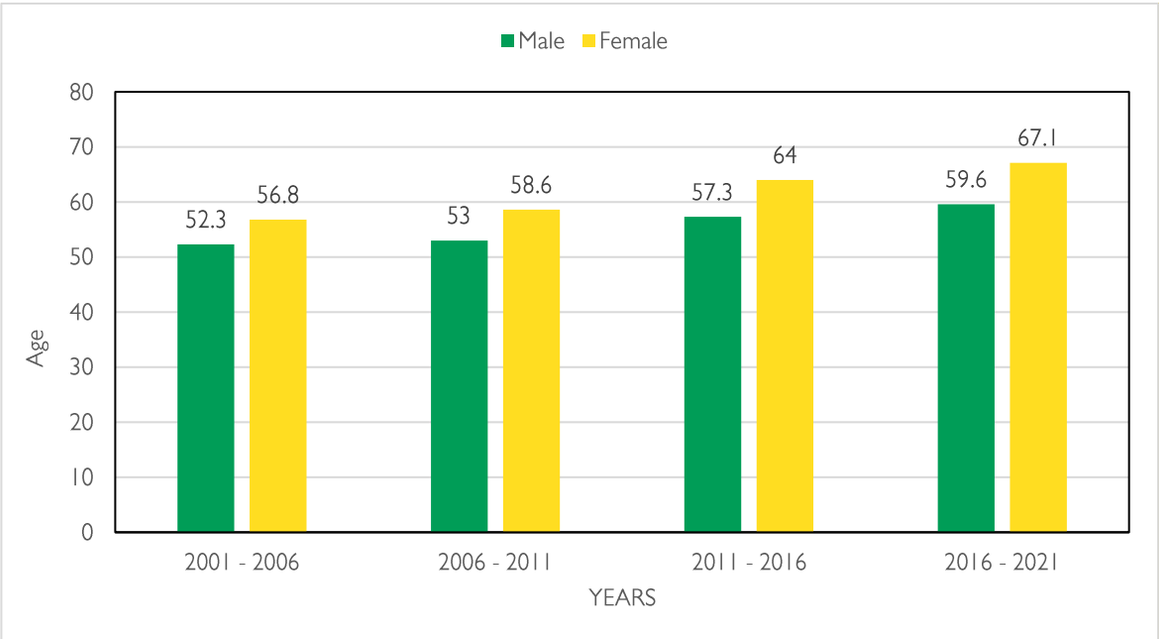
The high rate of unemployment and having the bulk of the EC population earning below poverty line has resulted in low percentage of the EC population having medical insurance (9.8 %) with majority of these concentrated in the urban EC Metros. This leaves the bulk of the population depending solely on the state for their health care needs hence the proper and efficient implementation of the NHI and universal coverage brings hope to many citizens for a better health system.

The capacity of the EC province is usually stretched due to high demand of basic services like education, health care services, social services employment opportunities and housing. These challenges especially in the OR Tambo and Alfred Nzo districts with more than a quarter of the provincial population, are exacerbated by the historical backlogs that are as a result of the previous apartheid and homeland governments.

The EC province has over the years experienced a significant decreasing trend in total fertility rate, from 3,3 in 2001 – 2006 to 2,88 in 2016 – 2021. However, contrary to the urban provinces, the EC province is among the leading provinces following Limpopo in having the highest total fertility rate relative to other provinces. The province has the high proportion of unwanted births reported at 25,9% in 1998 and 26,4% in 2016 (Statssa, 2020). Province has few employment opportunities with unemployment rate reported to have increased from 36,1% in 2018 to 37,4% during quarter 1 of 2019 and Youth employment being at 50.8% (ECSECC, 2019), low education status or having no education and poverty as well as poor access to family planning services.

The National Development Plan has set a target to increase life expectancy to 70 years and raise an AIDS-free generation of the under-20 years. The life expectancy increased incrementally across all provinces but more significantly during the period 2011–2016 mainly due to the uptake of antiretroviral therapy and efforts to meet basic needs like access to clean water, electricity and adequate housing over time in South Africa. By the years 2016-2021, the life expectancy at birth for the Eastern Cape province was estimated at ages 59,6 and 67,1 for males and females respectively (Figure 7).

Figure 7: Estimated Life Expectancy at Birth for the EC Province



(Data source: Statssa 2019)

Table 2: Population Distribution by health district municipality, 2019 estimates.

District	% of total population[1]	Total population[1]	Males[1]	Females[1]	Size of area (km^2)[2]
Alfred Nzo	12.2	826,333	361,242	465,091	10 731.2
Amathole	12.4	806,717	380,935	425,783	21 594.9
Buffalo City Metro	12.0	893,596	432,078	461,518	2 535.9
Chris Hani	11.2	743,756	352,226	391,530	36 143.5
Joe Gqabi	5.1	344,897	164,247	180,651	25 662.7
Nelson Mandela Metro	18.7	1,333,119	651,584	681,535	1 958.9
OR Tambo	21.3	1,505,128	705,877	799,251	12 095.5
Sarah Baartman	7.1	463,931	229,282	234,649	58 243.3
Eastern Cape	**100.0**	**6,917,479**	**3,277,471**	**3,640,008**	**168,966.0**
Data Sources: *[1] Stats SA mid-year population estimates 2019; [2]Population Census, 2011*					

5.2 SOCIAL DETERMINANTS OF HEALTH FOR PROVINCE AND DISTRICTS

Globally, it is recognized that health and health outcomes are not only influenced by healthcare or access to health services. They result from multidimensional and complex factors linked to the social determinants of health which include a range of social, political, economic, environmental, and cultural factors, including human rights and gender equality. Poverty, unemployment, education, housing, access to piped water and sanitation are social determinants of health that characterise the Eastern Cape Province, in particular, Alfred Nzo, Amathole, Chris Hani and OR Tambo

Addressing social determinants is a cornerstone in the National Department of Health's Primary Health Care Re-Engineering Strategy, and an approach that is embedded in the country's National Development Plan (The DOH aims to address social determinants in an integrated sector approach, through the district development model into a programme of implementable actions across levels of the health system and in co-ordination with other sectors. The implementation of the integrated school health policy, one of the four sub-programmes of the Re-engineering strategy, for example, addresses social determinants of health proximally. Its goal is "to contribute to the improvement of the general health of school-going children as well as the environmental conditions in schools and address health barriers to learning in order to improve education outcomes of access to school, retention within school and achievement at school" (Integrated School Health policy, 2012).

Unemployment rate in the province continued to increase and during quarter 3 of 2019, was reported at high rate of 36.5 % against national rate of 29.1%. Alfred Nzo and Sarah Baartman are experiencing highest rates of unemployment in the Province Job security increases health, well-being, and job satisfaction whilst job insecurity adversely affects worker's health, resulting in high stress levels, other mental health issues amongst those unemployed. Insecurities result in low self-esteem that may lead to gender-based violence as well. This may manifest in high unemployment rate in the EC Province This has important implications as, in addition to health programme-specific responses, it suggests a need for an overarching plan that appreciates the synergies possible in addressing the social determinants. Furthermore, the social determinants operate at different levels (global, national, sector-specific, and local). This

suggests that a set of different actions, operating at different levels, is required to address the social determinants. Strengthening of integrated planning by various sectors is critical to achieve the expected outcomes. Table 3 below shows the indicators for the social determinants of health in the Eastern Cape Province.

Table 3(A): Socio-economic indicators by District in Eastern Cape Province

District/ Metro	Poverty Headcount[2]	Unemployment Rate[1]	No schooling[1] (Age 20 yrs.+)	Medical Aid coverage[3]	Access to piped water[2]	Households with flush/ chemical toilet[2]
Alfred Nzo	22.0	42.1	15.0	3.8	45.9	9.5
Amathole	18.7	40.4	14.2	4.3	70.7	23.1
Buffalo City MM	7.3	32.5	5.3	22.4	97.7	71.9
Chris Hani	16.4	36.8	15.1	4.9	82.7	38.5
Joe Gqabi	13.4	32.7	15.7	5.0	74.0	37.4
N Mandela M	3.0	28.7	3.6	20.4	98.7	93.3
OR Tambo	19.2	41.0	18.4	4.2	38.9	19.1
Sarah Baartman	4.5	19.0	8.3	8.8	92.4	83.5
Eastern Cape	**12.7**	**35.1**	**11.4**	**9.8**	**75.1**	**49.1**

Source: [1]DEDEAT, Eastern Cape Socio Economic Review and Outlook 2018, [2]Stats SA CS 2016, [3]DHB 2018/19

According to statistics South Africa (2016), Eastern Cape is the poorest province in South Africa. The percentage of people living below poverty line in the province has been increasing since 2011. An estimated 72% (over 5 million) of people live in poverty in the Eastern Cape which is more than the national average of 60%. Figure 8 below outlines the poverty distribution among districts. Almost half the population in all districts live in poverty, however Alfred Nzo, OR Tambo and Amathole have highest percentage of people in poverty all above 70%.

Figure 8: Percentage people in poverty

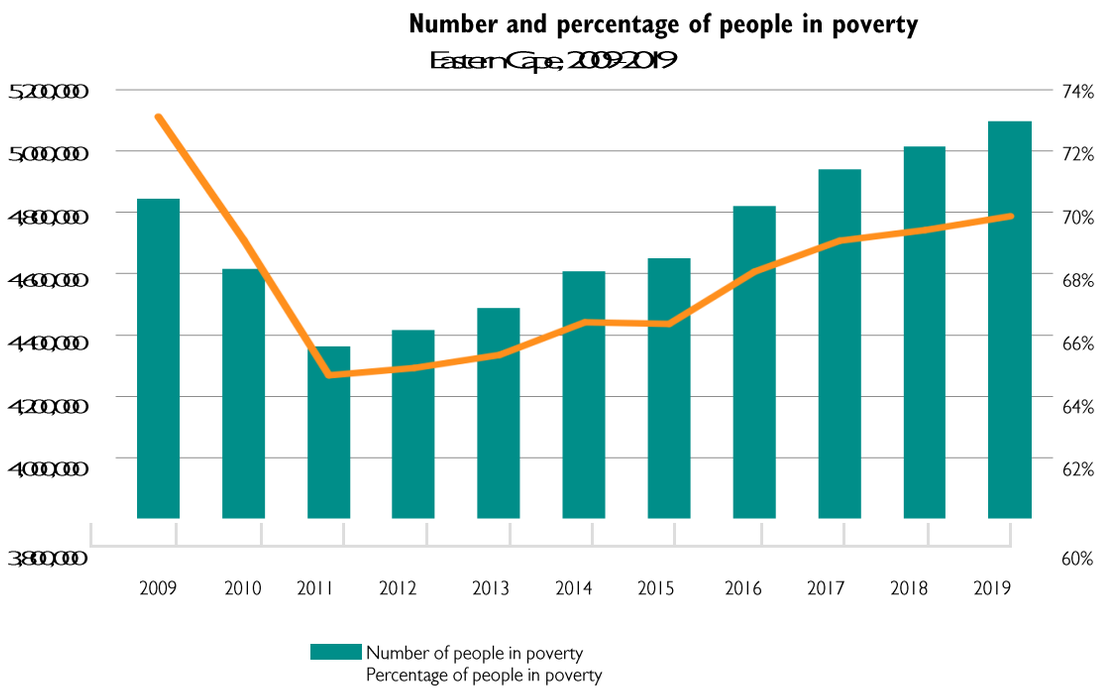
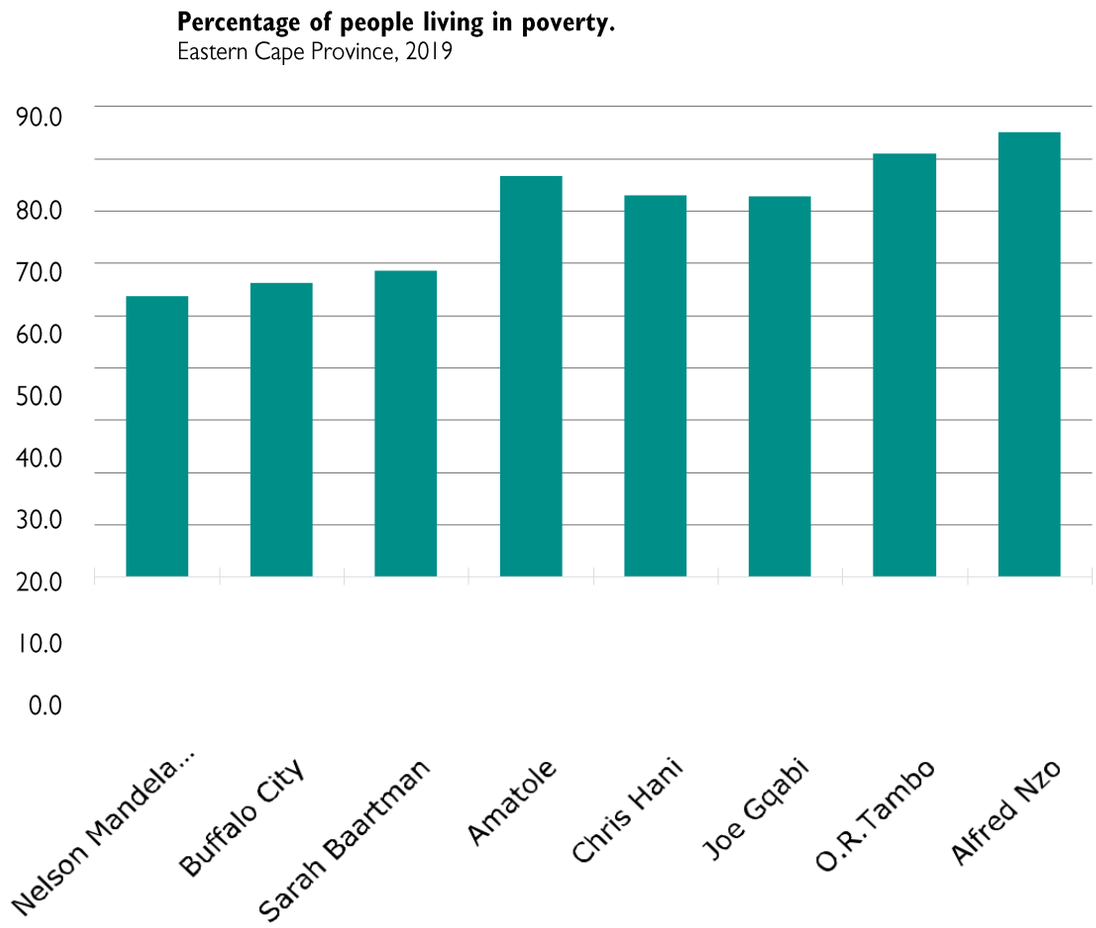


Figure 9: Poverty headcount by district in the EC



5.3 EPIDEMIOLOGY AND QUADRUPLE BURDEN OF DISEASE (BOD)

Epidemiologically, South Africa continues to be confronted with a quadruple BOD because of HIV and TB, high maternal and child morbidity and mortality, rising non-communicable diseases and high levels of violence and trauma. During the year 2020, the Province was negatively affected by the global surge of COVID 19 pandemic. Eastern Cape reported its first confirmed case of COVID-19 on the 21st of March 2020 from a rural district of Amathole.

CORONA VIRUS DISEASE 19

The first confirmed Corona virus case was announced on the 5th March 2020, by the National minister of Health in the country. The Eastern Cape Province received its first confirmed case on the 21 March 2020 from one of the rural districts of the Province. In order to deal with the threat, the Eastern Cape Department of Health set up the following systems: Firstly, activated the Provincial and District Outbreak Response Teams which are multidisciplinary and multi-sectoral in nature. Secondly, the Province together with the department developed and implemented strategies which seek to combat the covid-19 pandemic and minimise its effects to public health and the economy of the Province. All these strategies seek to early detect, isolate or quarantine, investigate, manage cases and trace the contacts.

To strengthen the Provincial response to COVID 19, a Project Management Unit (PMU) and Incident Management Team (IMT) were established. The Incident management team operated through the following work- streams:

- Community Health
- Health systems
- Human resource and leadership
- Psychosocial support
- Business Continuity
- Surveillance, strategic information, Monitoring, and evaluation

The Province is implementing phase 1 of Corona Virus vaccination which is focusing on health care workers while phase 2 will focus on the front-line workers and vulnerable populations and phase 3 the rest of the population.

SARS-Cov-2 CASES & DEATHS

In the last 24 hours, **19** new cases and **1** death were reported. One the deaths occurred more than 48 hours ago. The cumulative number of cases and deaths were **194,886** and **11,340** respectively.

Six percent (5.8%) of the cases demised, and 6.3% were males and 5.5% were females

Table 3 (B): Number of positive SARS-Cov-2 cases, recoveries and deaths, as of 21 Mar 2021

District	Cases	New Cases	Total Confirmed	Recoveries	Deaths	New Deaths		Total Deaths	CFR%	Recovery Rate	Active Cases
						*Newly Reported	**Newly occurred				
Alfred Nzo	7984	2	7986	7548	430	0	0	430	5,4	94,5	8
Amathole	19320	2	19322	18190	1102	0	0	1102	5,7	94,1	30
BC Metro	38839	9	38848	36421	2345	0	0	2345	6,0	93,8	82
Chris Hani	19521	1	19522	17979	1534	0	0	1534	7,9	92,1	9
Joe Gqabi	7511	0	7511	7085	410	0	1	411	5,5	94,3	15
NM Metro	55753	3	55756	52418	3313	0	0	3313	5,9	94,0	25
OR Tambo	22446	1	22447	21073	1362	0	0	1362	6,1	93,9	12
S Baartman	21756	1	21757	20898	843	0	0	843	3,9	96,1	16
Imported	609	0	609	598	0	0	0	0	0,0	98,2	11
Unspecified	1128	0	1128	1098	0	0	0	0	0,0	97,3	30
E. Cape	**194867**	**19**	**194886**	**183308**	**11339**	**0**	**1**	**11340**	**5,8**	**94,1**	**238**

* Deaths that occurred more than 48 hours ** Deaths which occurred within the past 48 hours of reporting

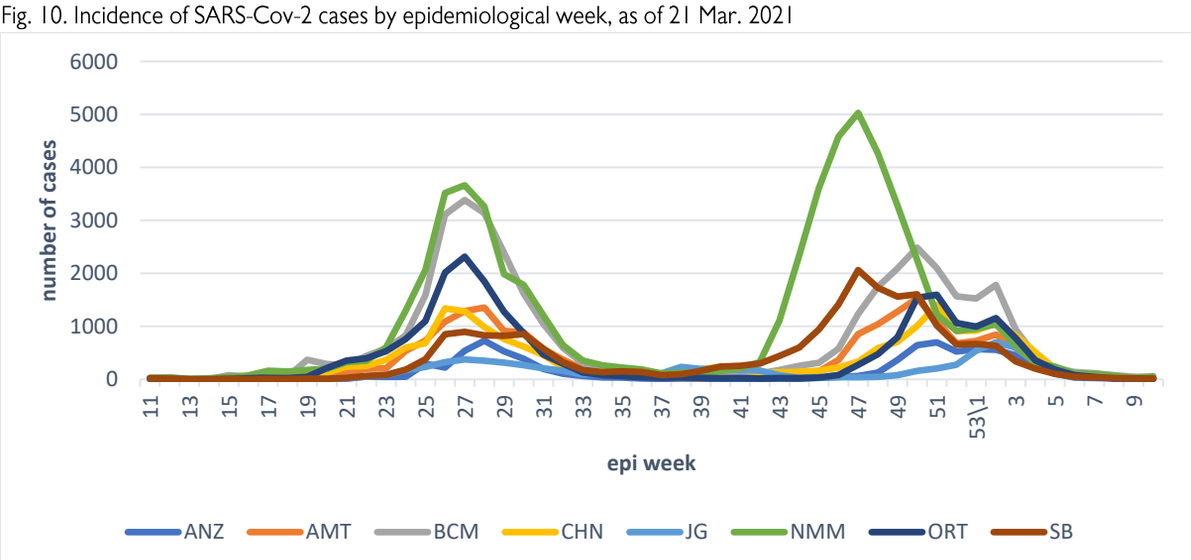
Source: EC epi report

Of the 238 active cases, 121 (50.8%) were from Amathole, BC Metro and Chris Hani, 41 (17.2%) from NM Metro and Sarah Baartman, 20 (8.4%) from Alfred Nzo and OR Tambo, and 15 (6.3%) from Joe Gqabi.
The overall provincial recovery rate was 94.1%. All the districts reported a recovery rate greater than 90%.

Incidence of SARS-Cov-2 cases

The incidence of active cases was 3.5 cases per 100,000 population. Seven (7) districts had an incidence that was less than 5% per 100,000 and the BC Metro had more than 10 per 100,000 populations. The cumulative positivity rate was 21.5%. All districts have less than a 30% positivity rate.

Fig. 10. Incidence of SARS-Cov-2 cases by epidemiological week, as of 21 Mar. 2021



The incidence of SARS-Cov-2 has significantly declined in all districts including the metros

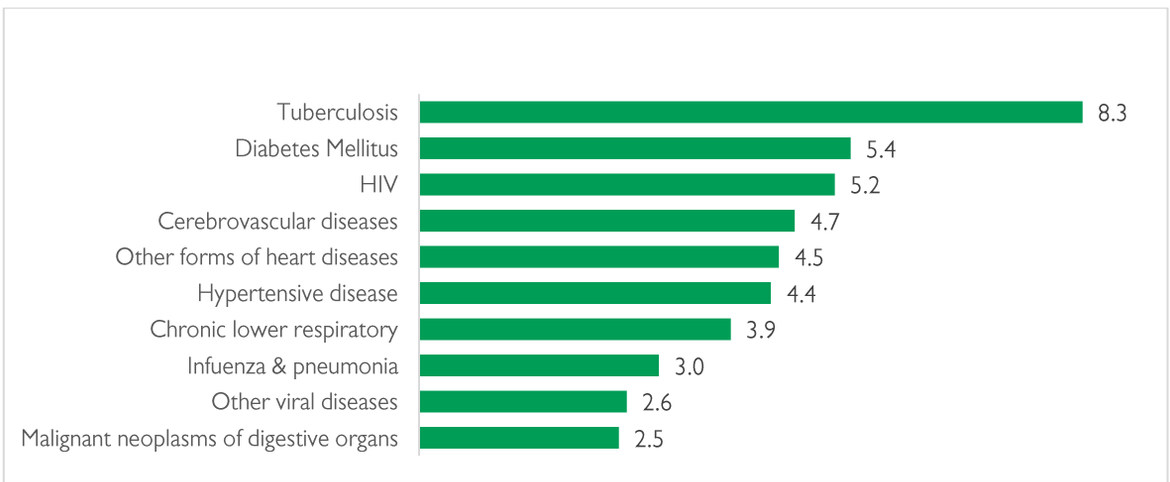
The Department is embarking on the following strategies and efforts to curb the spread of COVID 19 which among other things include:

- Strengthening risk communication, community engagement and health promotion to fight against SARS-Cov-2 coupled with increase in the visibility of health messages using mass communication, radio, TV, print media, and social media.
- Implementation of track and trace solution for contact tracing, monitoring, recording, and reporting. Regular monitoring, recording, and reporting of contacts is prioritized at all levels.
- Protecting healthcare workers who are at risk of developing severe disease from SARS-Cov-2. Instead of the elderly healthcare workers, strategically position healthcare workers who are younger and healthy as frontline workers to deal with the pandemic and Increase the knowledgeability index of healthcare workers and managers at the facility levels. This may include increasing the knowledge and confidence of healthcare workers about the disease, the Infection Prevention and Control (IPC) measures, the role of Occupational Health and safety (OHS), the use of the guidelines at the facility levels, and promotion of the use of PPE as part of the IPC package.
- Provision of isolation and quarantine services to positive cases and their contacts to minimize further transmission.
- Strengthen inpatient management of COVID 19, ensuring availability of oxygen in hospitals as a golden treatment standard.
- Roll out of COVID 19 vaccination to all targeted population.

The Causes of Mortality

Figure 10: below shows the leading causes of death by district in the EC Province in 2018. Tuberculosis (TB) remained the leading cause of natural death in our district with the exception of Nelson Mandela Metro where it was reported as the second leading cause of death. In Nelson Mandela Metro the diabetes mellitus was reported as leading cause of death. In overall TB and HIV remained the top leading causes of death in the Eastern Cape.

Figure 11: Broad causes of death by district



5.4 INTERNAL ENVIRONMENTAL ANALYSIS

5.4.1 Service Delivery Platform / Public Health services

Figure 12: Map showing EC Public health facilities

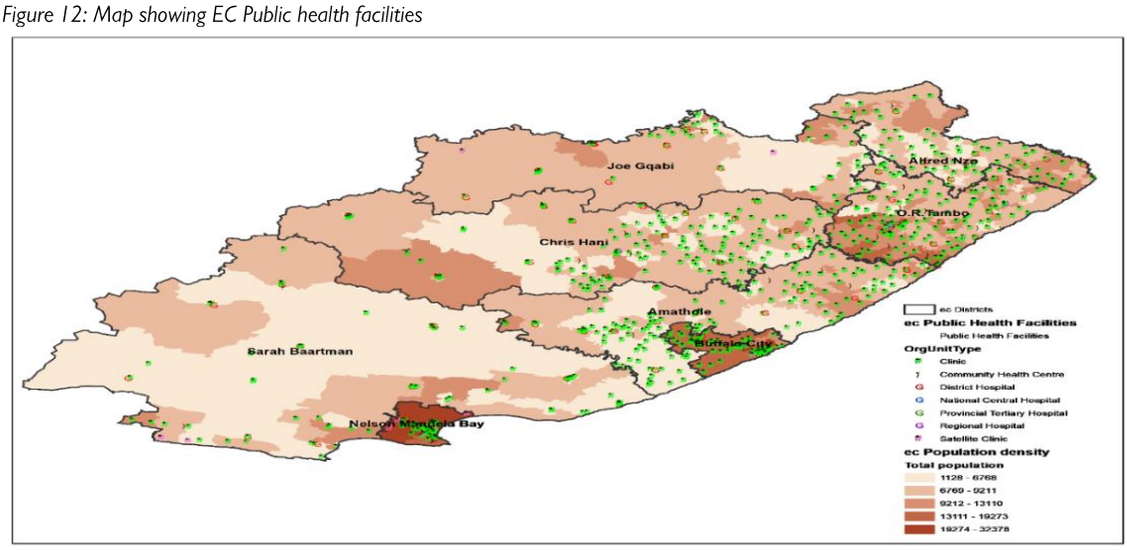


Table 4: Facility type per district

Org Unit Type	ec Alfred Nzo District Municipality	ec Amathole District Municipality	ec Buffalo City Metropolitan Municipality	ec Chris Hani District Municipality	ec Joe Gqabi District Municipality	ec Nelson Mandela Bay Municipality	ec Oliver Tambo District Municipality	ec Sarah Baartman District Municipality	Grand Total
Clinic	72	144	74	152	52	39	141	60	**734**
Community Health Centre	2	5	5	7	-	9	10	3	**41**
District Hospital	6	12	2	14	11	1	9	10	**65**
EMS Station	7	11	3	18	10	4	9	23	**85**
Mobile Service	8	23	11	54	13	7	12	26	**154**
National Central Hospital	-	-	-	-	-	-	1		**1**
Provincial Tertiary Hospital	-	-	1	-	-	2	-	-	**3**
Regional Hospital	-	-	1	1		1	2		**5**
Satellite Clinic	-	-	2	-	2	3		2	**9**
Specialised Clinic	-	-	-	-	-	1	-	-	**1**
Specialised Hospital	1	2	3	1	-	4	2	5	**18**
Grand Total	**96**	**197**	**102**	**247**	**88**	**71**	**186**	**129**	**1116**

The province has more clinics in relation to the population however there are still populations that have to walk more than 5 kilometres to access health facilities. These areas are serviced by mobile and satellite clinics. There is inequitable distribution of facilities between the districts. Urban districts have more facilities while districts like Alfred Nzo. OR Tambo, Joe Gqabi may need more facilities to ensure PHC coverage.

5.4.2 Service Delivery Outputs

The trends in key provincial service delivery outputs are shown in Table 5 below.

There has been a noticeable decline in the Primary Health Care headcount in health facilities. This may be due to the implementation of differentiated health care implementation such as ward based primary health care, centralised chronic medical dispensing and distribution and other forms of campaigns and community outreach service. The patient day equivalents in hospitals is seeing a decrease over the years. The district hospitals are showing poor efficiencies in their management with low bed utilisation rates, high average length of stay and high expenditures per patient day equivalent. However, it must be noted that to a large extent, the impact of Covid 19 on hospital efficiency indicators and their performance cannot be out ruled.

The Department is concerned about the decrease in immunisation coverage from 86.6 % in 2015/16 to 76% in 2019.

Table 5: Key provincial service volumes, 2015/16-2019/20

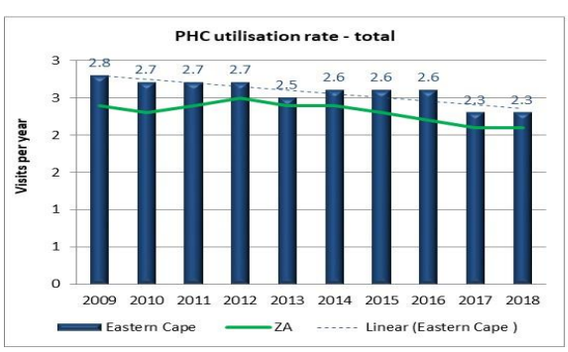
INDICATOR	2015/16	2016/17	2017/18	2018/19	2019/20
PHC headcount – Total	18 212 817	18 116 112	16 418 041	16 605 569	16 422 870
PHC headcount under 5 years	2 958 285	2 910 002	2 541 609	2 544 587	2 524 151
OPD Headcount - Total (all hospitals)	2 710 857	2 651 351	2 493 928	2 801 255	3 192 433
Deliveries in facility	106 243	99 623	100 759	104 827	107 065
Total births in facility	109 580	103 392	102 813	106 597	107 079
Hospital separations – Total	431 395	426 760	576 383	486 013	477 101
Patient Day Equivalent in district hospitals	1 788 354	1 735 819	1 888 480	1 199 660	1 715 093
*Patient Day Equivalent in provincial hospitals	724 500	713 300	702 512	726 713	765 554.
Patient Day Equivalent in specialized TB hospitals	334 502	284 782	344 814	240 474	217 166
Patient Day Equivalent in specialized Psych hospitals	439 784	417 571	383 211	331 357	328 155
BUR (% - District hospitals)	57.2%	56.0	54.7	55%	54.5%
BUR (%) Provincial Hospitals	79.3%	74.8%	77%	71%	73%
BUR (%) in specialized TB hospitals	60.3%	52.4%	50.1%	45%	41%
BUR (%) in specialized Psych hospitals	85%	86.1%	89.6%	90%	89%
Average length of stay (District hospitals)	5.1 days	5 days	4.9 days	4.7 days	4.6 days
Average length of stay (Provincial Hospitals)	5.8 days	5.7 days	6 days	5.8 days	5.8 days
Average length of stay (Specialized TB hospitals)	94.2 days	84 days	77 days	72.9 days	68 days
Average length of stay (Specialized Psych hospitals)	137.8 days	122 days	149.4 days	190.1 days	230 days
Expenditure per day Equivalent (Rand) - District hospitals)	R3 317	R3 346	R2 241	R2 680.2	R3 168.16
Expenditure per day Equivalent (Rand) - Provincial Hospitals	R3 412	R3 357	R3 303	R3 282.6	R3 759
Expenditure per day Equivalent (Rand) - specialized TB hospitals	R5 737	R1 469	R1 626	R1 707.6	R1 952.80
Expenditure per day Equivalent (Rand) - Specialized Psych hospitals	R1 076	R1 508	R1 815	R2 993	R33 195.13
New patients – Pulmonary TB	41 812	37 449	33 621	36 009	31 940
Immunisation coverage	86.6%	78.6%	67.3%	71.9%	76%
Total clients remaining on ART at end of the month	359 729	414 733	452 072	493 879	531 135
Total clients started on ART– naïve	86 678	94 802	82 811	73 339	31 392

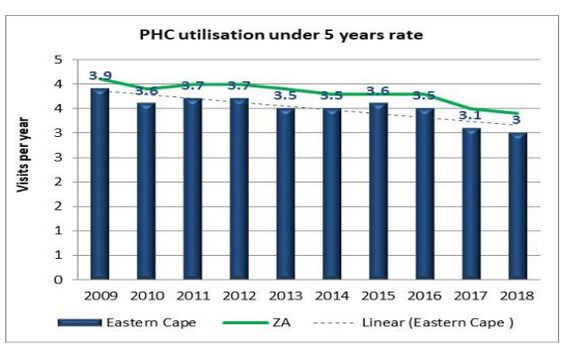
5.4.3 Universal Health Coverage (Population and Service Coverage)

PHC Utilization Rate

The primary health care (PHC) utilisation rate indicators measure the average number of PHC visits per person per year to a public PHC facility.

Figure 13: PHC utilisation rate





Key observations

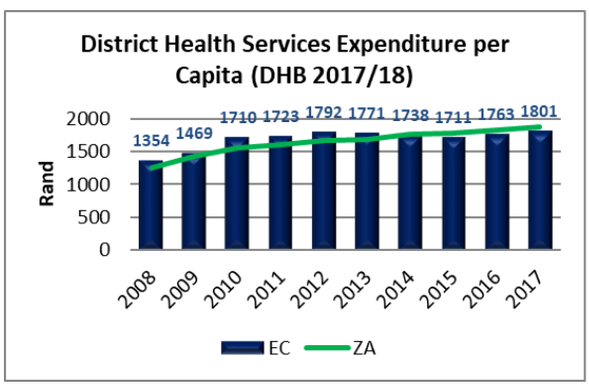
The PHC utilisation rate has been declining since 2009 for both populations of under and over 5 years. This may be attributed to the strengthened reengineering of Primary Health Care services through increased outreach services and enrolment of the stable chronic clients in Centralised Chronic Medicines Dispensing and Distribution.

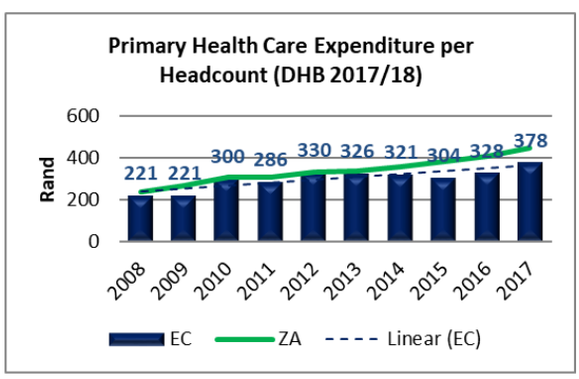
PHC Expenditure per Headcount

Figure 13 below shows PHC expenditure per headcount over the period of ten years. Expenditure per headcount in the province has increased over the period, in 2017/18, EC expenditure per headcount was R 378 while the SA average was R450 and the province with the highest cost was Gauteng at R 592. Inequities among districts was noted with Amathole expenditure per headcount at R 344 while Buffalo City was at R 428.

EC District Health Services expenditure per capita has been comparable to the national averages over the period of ten years. EC had higher districts health services expenditure between the period 2011- 2013. PHC per capita and expenditure per capita is below the national averages. In 2017/18, PHC expenditure per capita in EC was R981 against the national average of R1 155. The province has also shown inter district inequities with Alfred Nzo expenditures lowest in the whole country at R 703 while Buffalo City Metro was at R1 272.

Figure 14: Expenditure per Capita and Headcount





Hospital Care

In the context of global escalation in healthcare costs and increasing demand for care because of shifting disease burden, the shrinking healthcare funding envelope requires that all hospitals render cost-effective and cost-efficient care. Case management must be strengthened to ensure minimal lengths of stay in hospital for the patients; and appropriate bed utilisation rates at facilities. Projects to generate revenue, optimise revenue collection and incentivized revenue retention will be incubated as the competitive edge for public sector hospitals over private enterprises. These projects include provision of good quality health care at lower cost, investments in appropriate capital plant, buildings and medical equipment and strategic human resourcing which must translate into improved patient outcomes, better patient experience and increased throughput; in other words, a good return on the investment of public funds. Activity-based budgeting and resource allocation will be explored to incentivise facilities' management to collect good quality data that allows better performance management and improve controls.

In keeping with the fourth industrial revolution, ICT will be used to improve healthcare service delivery effectiveness and efficiency. The innovative EC developed Hospital Management System (HMS) and HPRS will be rolled out to key hospitals within the next five years. Better patient record management will have multiple benefits -better continuity of care of our patients within and between EC facilities, as clinicians will have rapid access to patient clinical data, results of investigations done and treatment plans; and also decrease waiting times for patient folders in admission areas and for medication from the pharmacies.

Table 6A & 6B below outlines the hospital efficiencies for different levels of hospital care, EC has a high OPD new client not referred rate across different levels of hospital care and that indicates that clients are by-passing PHC facilities and the effect of PHC re-engineering on OPD utilisation is not yet realised. A high OPD new client not referred rate value could indicate overburdened PHC facilities or a sub-optimal referral system. In light of the National Health Insurance Policy, a PHC level is the first point of contact with the health system and therefore key to ensure health system sustainability. If PHC works well and the referral system is seamless, it will result in fewer visits to specialists in referral hospitals and emergency rooms. High average length of stay high in regional, tertiary and central hospitals, coupled with low bed utilisation rates are a concern. There is an urgent need to rationalise the number of beds in districts.

The average length of stay (ALOS) in the central hospital has decreased from 9.5 to 7.7 days although this is still high. This high ALOS is attributed to the longer stay of spinal orthopaedics and neurosurgical clients. Establishment of a rehabilitation centre in the Eastern part of the Province may alleviate the challenge. The central hospital has the highest caesarean section rate at 79.3%. The EC is undertaking a project to strengthen the surrounding district hospitals to offer safe caesarean sections to alleviate the situation.

Table 6A: Hospital efficiencies

ec Eastern Cape Province	OPD new client not referred rate			Average length of stay - total			Inpatient bed utilisation rate		
Hospital Type	2017/18	2018/19	2019/20	2017/18	2018/19	2019/20	2017/18	2018/19	2019/20
District Hospital	63.1	63	63	4.9	4.7	4.6	54.7	54.9	54.3
Regional Hospital	49.2	49.1	49	5.8	5.8	5.8	68.2	70.9	73
Provincial Tertiary Hospital	11.4	13.6	13.6	6	4.8	5.6	76.6	77	76
National Central Hospital	17	15.7	15.7	7.7	7.7	8	80.8	84.8	82.4

Table 6B: Hospital efficiencies

ec Eastern Cape Province	Inpatient crude death rate			Delivery by Caesarean section rate		
Hospital Type	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
District	6.4	6.3	6	22.8	23.7	24.9
Regional	6.3	6.5	6.5	39.3	40.6	41.1
Provincial Tertiary	4.5	4.9	4.2	46	44.1	46.8
National Central1	8.9	6.7	7.3	77.3	76.9	79.3

Table 7: Hospital Efficiency Indicators

Referral Hospitals		OPD new client not referred rate			Average length of stay - total			Inpatient bed utilisation rate		
		2016/17	2017/18	2018/19	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
Regional Hospital	ec Cecilia Makiwane Hospital	37.4	35.9	35.8	5.4	6.5	6.8	54.4	62.2	61.8
	ec Dora Nginza Hospital	34.9	37.8	52.6	5.5	5.7	5.8	70.3	70.6	75.5
	ec Frontier Hospital	53.1	60.3	56.4	4.6	4.7	4.8	68.2	67.7	75.6
	ec Mthatha General Hospital	66.2	64.3	62.4	7.1	6.5	6.2	66.8	73.9	75.6
	ec St Elizabeth's Hospital	49.9	48.7	38.7	5.6	5.6	5.1	66.5	71.2	69.6
Provincial Tertiary Hospital	ec Frere Hospital	17.9	14.4	16.8	5.4	5.8	5.6	77.8	79.3	78.9
	ec Livingstone Hospital	1.4	0.34	0.77	7.5	7.7	4.4	80.3	83.1	84.3
	ec Port Elizabeth Provincial Hospital	9.3	0.93	0.8	3.6	3.5	3.4	49.3	50.1	47.7
National Central Hospital	ec Nelson Mandela Academic Hospital	16.6	17	15.7	9.5	7.7	7.7	85.1	80.8	84.8

Hospital Case Management Indicators

Table 8. Hospital case management indicators

		Inpatient crude death rate			Delivery by Caesarean section rate		
Referral Hospitals		2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
Regional Hospital	ec Cecilia Makiwane Hospital	6	6.8	7.9	43.7	49.2	49.1
	ec Dora Nginza Hospital	5.6	5.6	5.6	54.2	53	55.9
	ec Frontier Hospital	6.6	7.1	6.7	38.3	33.7	38.1
	ec Mthatha General Hospital	8.6	7.1	6.6	26.5	31.9	34.4
	ec St Elizabeth's Hospital	5.8	6.6	6.3	29.2	31.1	25.3
Provincial Tertiary Hospital	ec Frere Hospital	4.2	4.7	4.5	46	44.1	46.8
	ec Livingstone Hospital	6.9	7.2	4.7	0	0	0
	ec Port Elizabeth Provincial Hospital	1.1	1.5	1.2	0	0	0
National Central Hospital	ec Nelson Mandela Academic Hospital	8.9	6.7	7.3	77.3	76.9	79.3

HIV and AIDS & STI

Eastern Cape is currently at 91-72-86 in terms of performance against 90-90-90 across its total population. Results for each of the sub-populations vary, with adult females at 93-71-92, adult males at 89-71-72, and children at 89-71-72. For adult males and females, focus must be placed not only on initiation onto ART, but also on ensuring that clients are retained in care. There is a growing number of adults who have been previously diagnosed, but are not on ART. This includes those who had started ART and defaulted, as well as those who were never initiated. The results do show, that for women who remain on ART, suppression rates are higher.

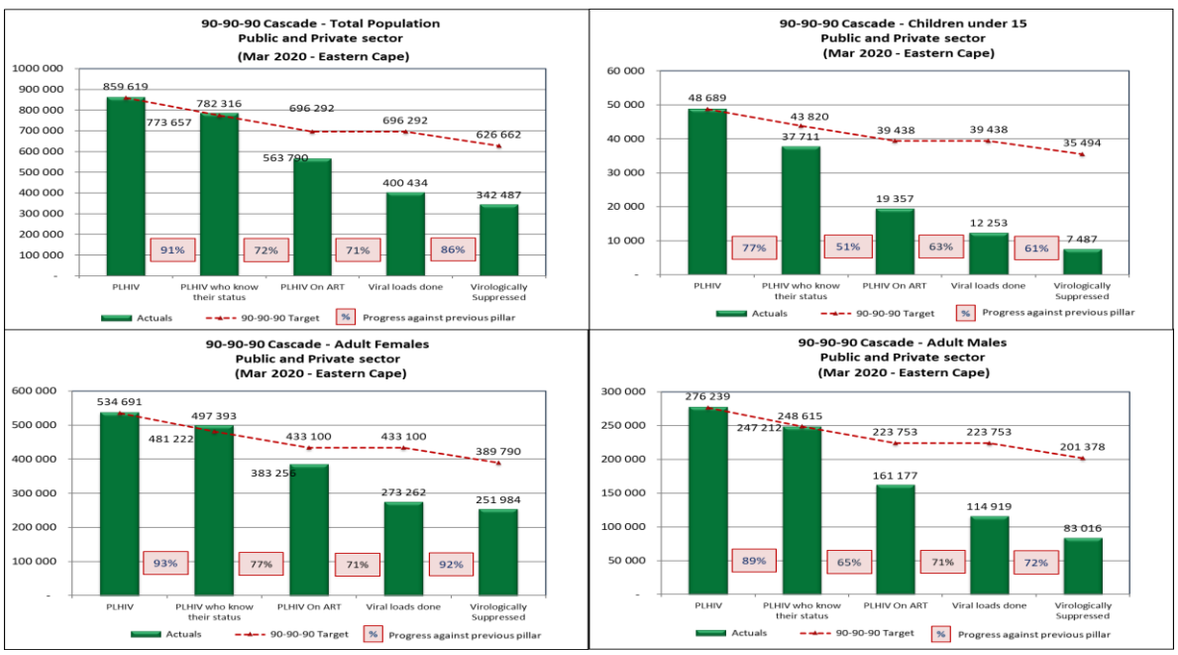
There are gaps across the cascade for children under 15 years. Case finding, ART initiation and retention have all underperformed and should be addressed through focused interventions.

To achieve 90-90-90 targets, the province must increase the number of adult men on ART by 78055, the number of adult women on ART by 87333, and the number of children on ART, by 18913, by December 2020.

Across the province, Amathole and Alfred Nzo are the closest to attaining 90-90-90 based on preliminary data collected

Figure 15: 909090 Cascades

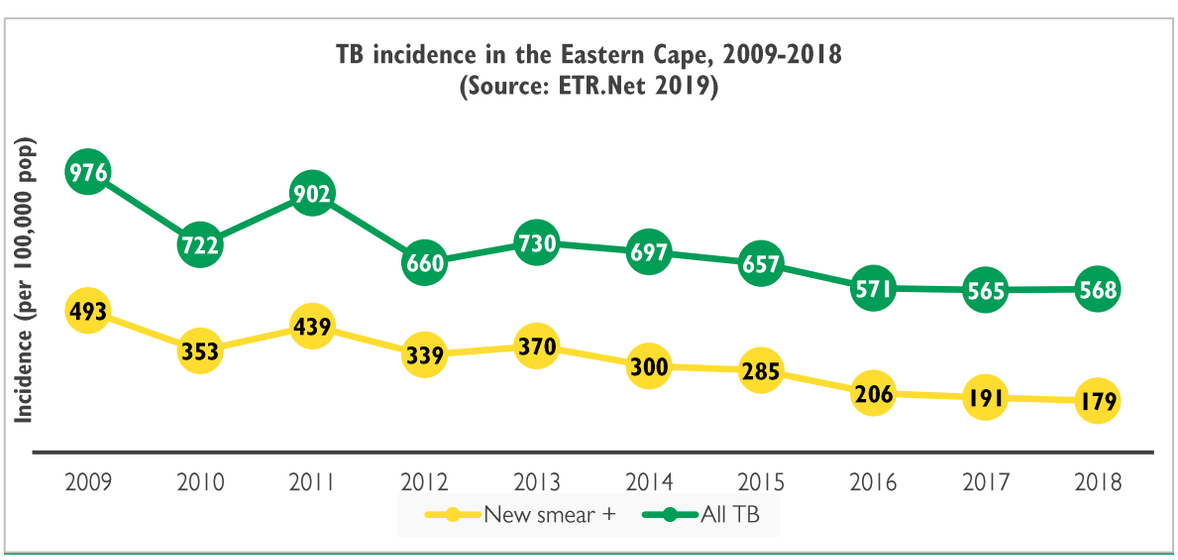
Provincial Cascade - Public and Private Sector



Tuberculosis

The newly diagnosed TB patients have been gradually decreasing in the Eastern Cape over the years (Figure 16). In 2014 there were 976 patients diagnosed with TB which decreased in 2018 to 747 in every 100 000 populations, a notable 23.4 % decrease. All the districts showed a decline in trend of new TB patients in 2018 when compared against 2014.The distribution of pulmonary TB (PTB) by districts shows that Sarah Baartman and the Nelson Mandela Metro remain with the highest incidence (745 and 691 per 100,000 populations respectively), The lowest incidence (353 per 100,000 population) was reported at Amathole district in 2018 (Figure 16).

Figure 16: TB incidence in EC 2009-2019



Whilst this is the case, both NMM and SBD had highest TB treatment success rates. This has resulted in a significant shift in NMM from TB being the leading cause of deaths to diabetes mellitus in 2016 (STATSSA, 2017). These two are amongst the three districts that met the target of 85% for TB treatment success rate and includes Joe Gqabi district (Figure 17). Whilst there is a general increase in TB treatment success rate for the EC Province from 77% in 2014 to 81.7% in 2017, two districts Amathole and BCM regressed from a good performing to a lower performing status. However, TB continues to be a leading cause of deaths in other districts and therefore the TB programme will remain a priority programme in the next five years 2020/21 to 2024/25.

Patients on treatment lost to follow up have decreased in 2018 compared to 2014 in six of the eight districts but A Nzo and SBD, the two districts that showed an increase in 2018. SBD is predominantly a farming district with patients getting lost through seasonal farming. The newly introduced National Health Insurance (NHI) Health Patient Record System (HPRS) and TB and HIV Information Systems (THIS) are meant to correct this anomaly and to track patients where they seek health services nationally.

Figure 17: Distribution of new pulmonary TB patients per 100 000 population by EC district (Source: ETR)

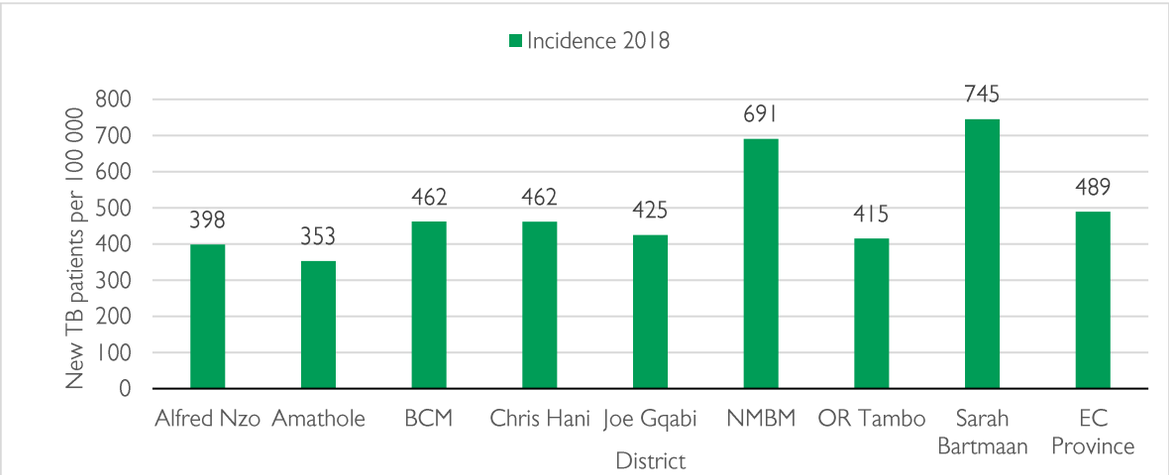
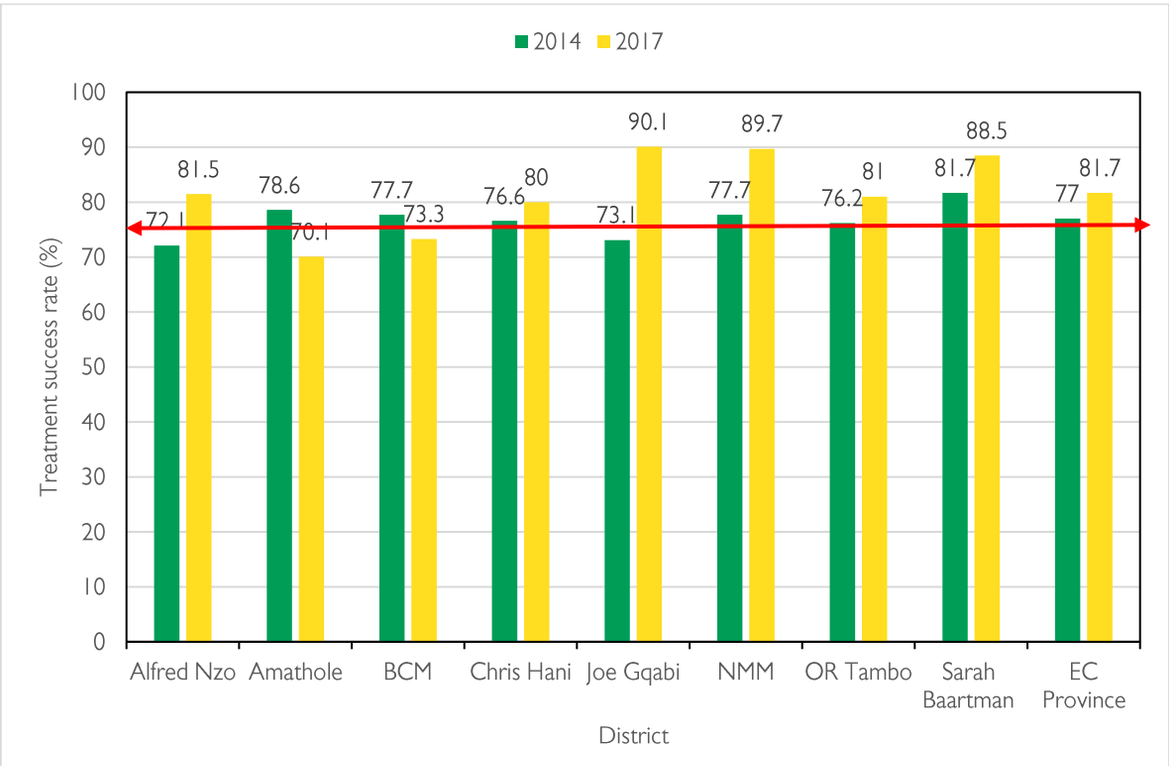
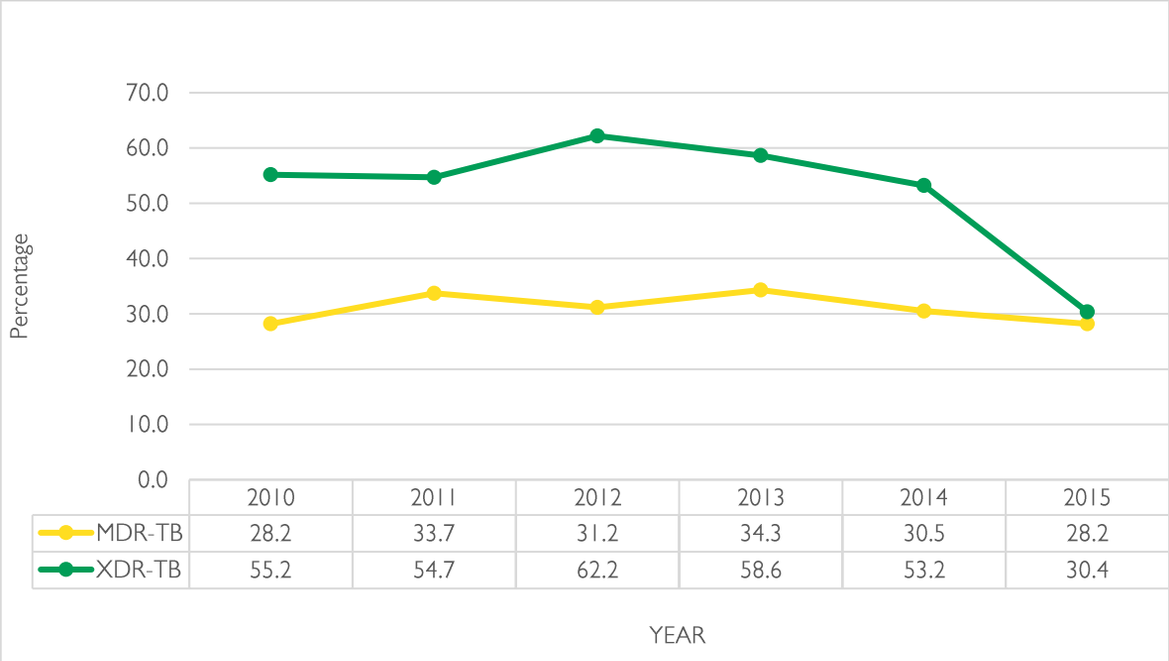


Figure 18: TB treatment success rate distributed by districts



The drug resistant TB treatment outcomes are showing encouraging trends in treatment success rate (Figureure 18) and a significant decrease in death rates (Figureure 19). This is due to new DR-TB treatment regimens that had been introduced in recent years with great success.

Figure 19: Trends in DR-TB death rate



Maternal and Women's health

Maternal mortality ratio (MMR) in health facilities is showing a steady declining trend (Figure 20). A decrease from 156/100 000 live births in 2014/15 to 107/ 100 000 in 2018 was observed. (Figure 20). BCM and OR Tambo districts recorded MMR that were higher than 100/100 000 target i.e. 158 and 123 per 100 000 live births; this is because these districts have Regional, Tertiary and Central hospitals that are referral to the district hospitals. OR Tambo with the highly specialized central hospital Nelson Mandela Academic remains the most challenged district with the highest MMR (Figure 21). Covid 19 had a negative impact on maternal mortality, data from April 2020 -December 2020 revealed an increase in maternal mortality to 138 per 100 000 live births.

Figure 20: Maternal mortality in facility ratio/100 000 FY 2015/16 - 2019/20

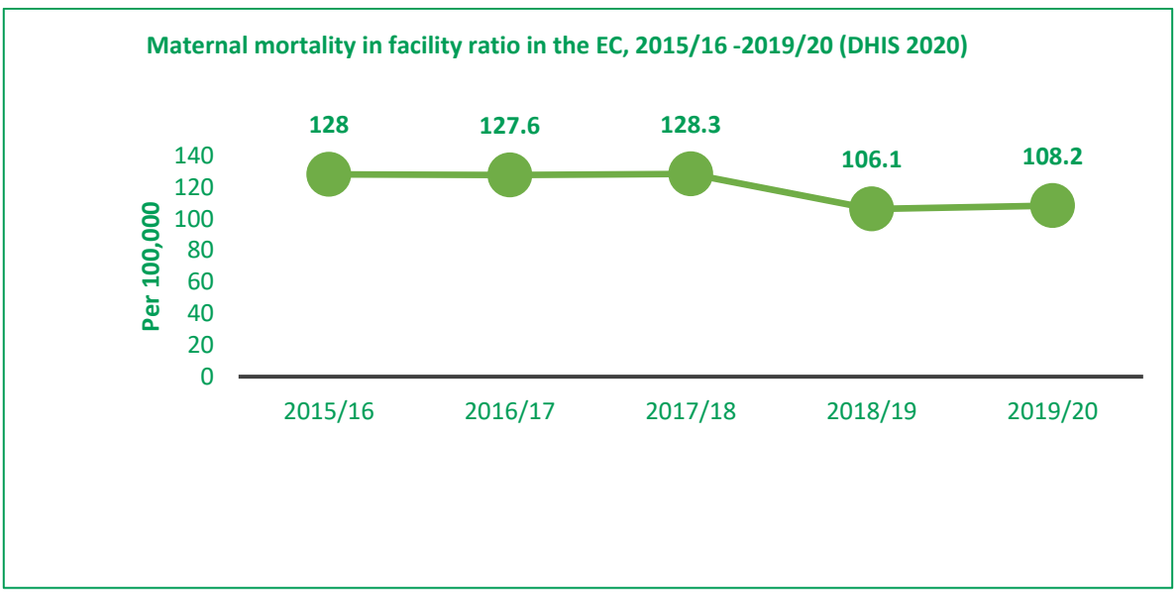
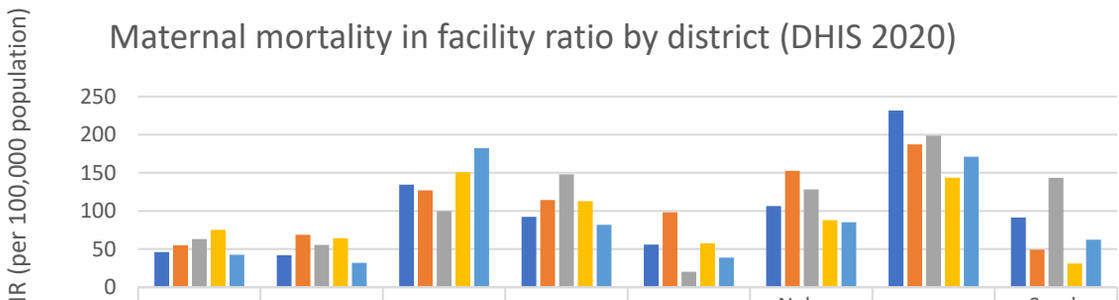


Figure 21: Maternal mortality per district

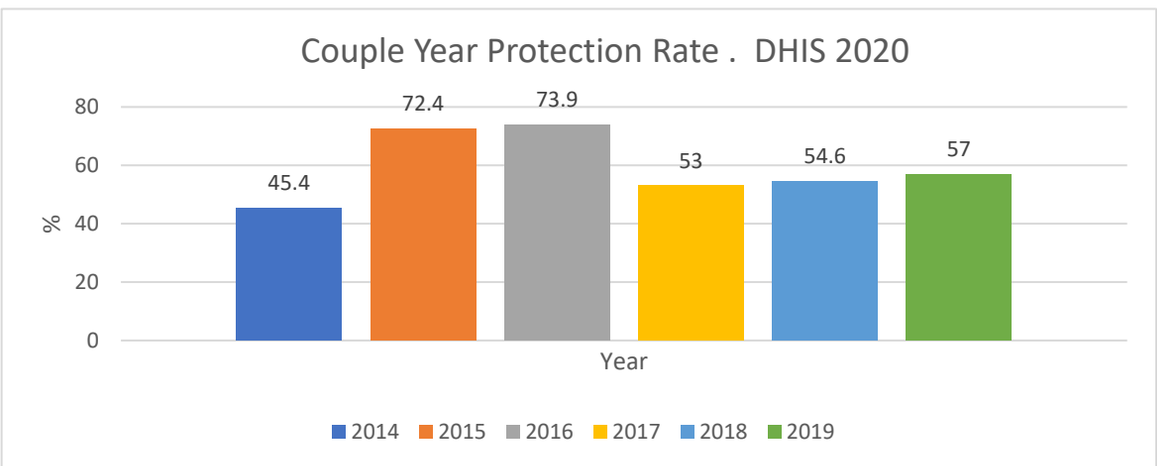


	Alfred Nzo DM	Amathole DM	Buffalo City MM	Chris Hani DM	Joe Gqabi DM	Nelson Mandela Bay M	OR Tambo DM	Sarah Baartman DM
2015/16	46.1	41.9	134.5	92.2	56	106.5	231.5	91.4
2016/17	55	68.9	127	114.3	98.4	152.5	187.4	49.2
2017/18	63.1	55.6	99.7	148	20.3	128.3	198.7	143.5
2018/19	75.3	64.3	150.7	112.9	57.6	88	143.7	31.2
2019/20	42.6	31.9	182.4	81.9	38.8	85.2	171	62.3

Maternal and Women's Health Trends

Couple year protection rate was on the increase from 2014 (45.4 %) up to 2016 (73.9%) but there was a noticeable decline thereafter to 57 in 2019.

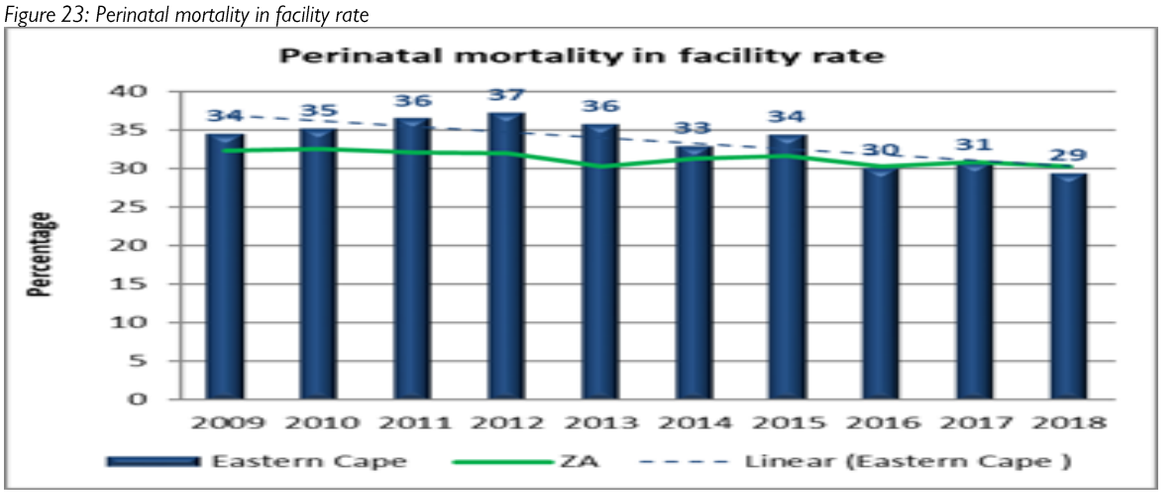
Figure 22: Couple year protection rate



Perinatal Mortality

Perinatal mortality is showing a declining trend in the Province (Figure 23)

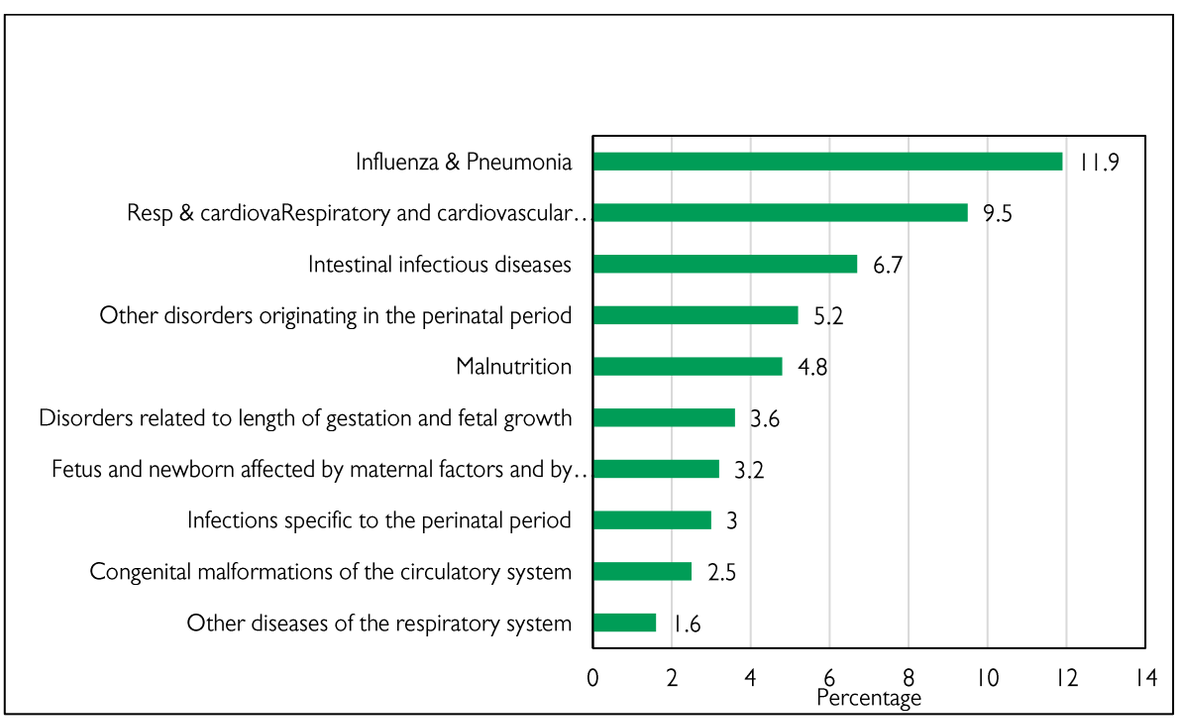
Figure 23: Perinatal mortality in facility rate



Child Health

The 10 leading causes of infant deaths in the EC Province are shown in Figure 24. Influenza & pneumonia and Respiratory & Cardiovascular conditions ranked 1st and 2nd causes of death respectively in this population group. Infant mortality rate (IMR) in facility in the EC Province decreased from 21 per 1000 in 2014/15 to 17 per 1000 live births by December 2018. The 2019/20 target for inpatient deaths of children aged 0-7 days (early neonates) of 10 per 1000 live births was achieved at end of December 2018 from 13/1000 live births in 2014/15. Inpatient deaths of infants aged 0-28 days (neonates) decreased by 33% from 18/1000 in 2014/15 to 12 per 1000 live births by end December 2018.

Figure 24: Ten leading causes of infant deaths in the EC Province, 2016 (N=1741)



Neonatal deaths in facility rate which contributes to infant mortality, showed a declining trend from 18 in 2014 to 12 per 1000 live births in December 2018 (Figure 25). Similarly, U5 case fatality rate at facility due to diarrhoea, pneumonia and severe acute malnutrition has been showing a declining trend (Figure 27).

Figure 25: Neonatal deaths in facility rate (per 1000 live births), 2015/16 – 2019/20

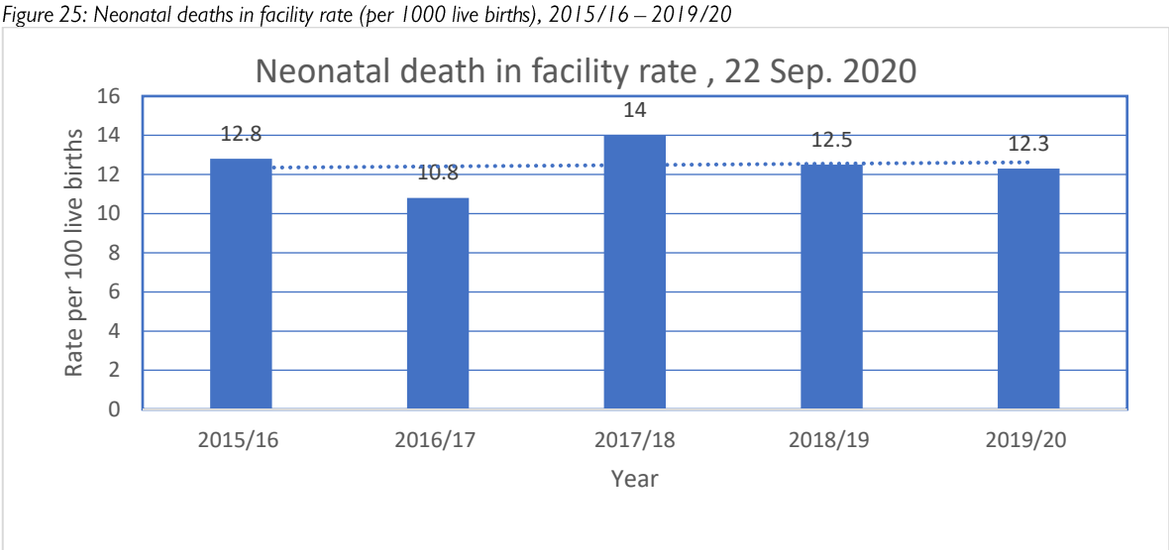
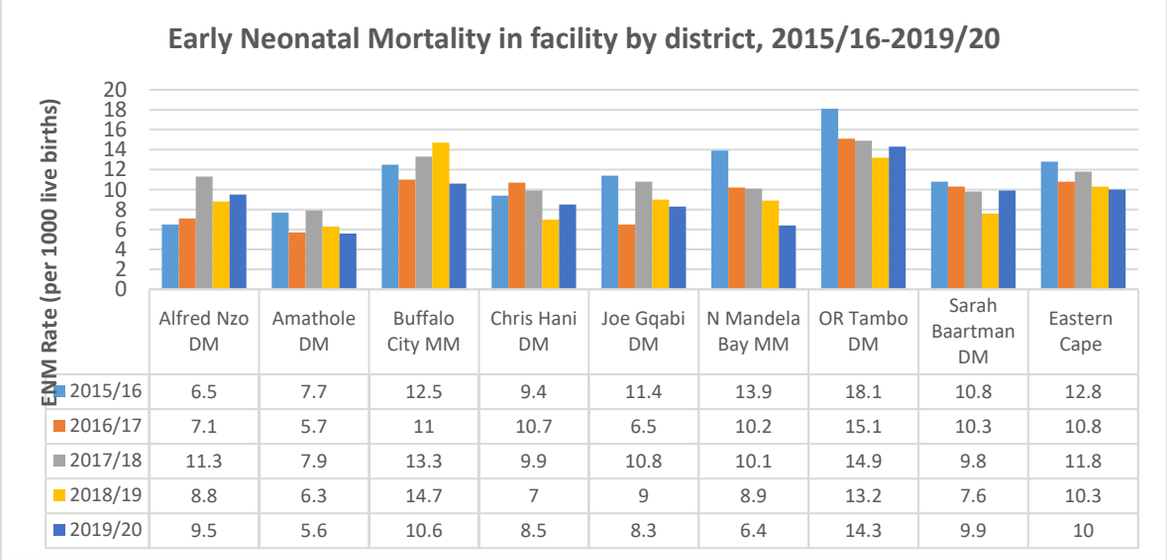


Figure 26: Case fatality rate in U5 year children distributed by cause of death.

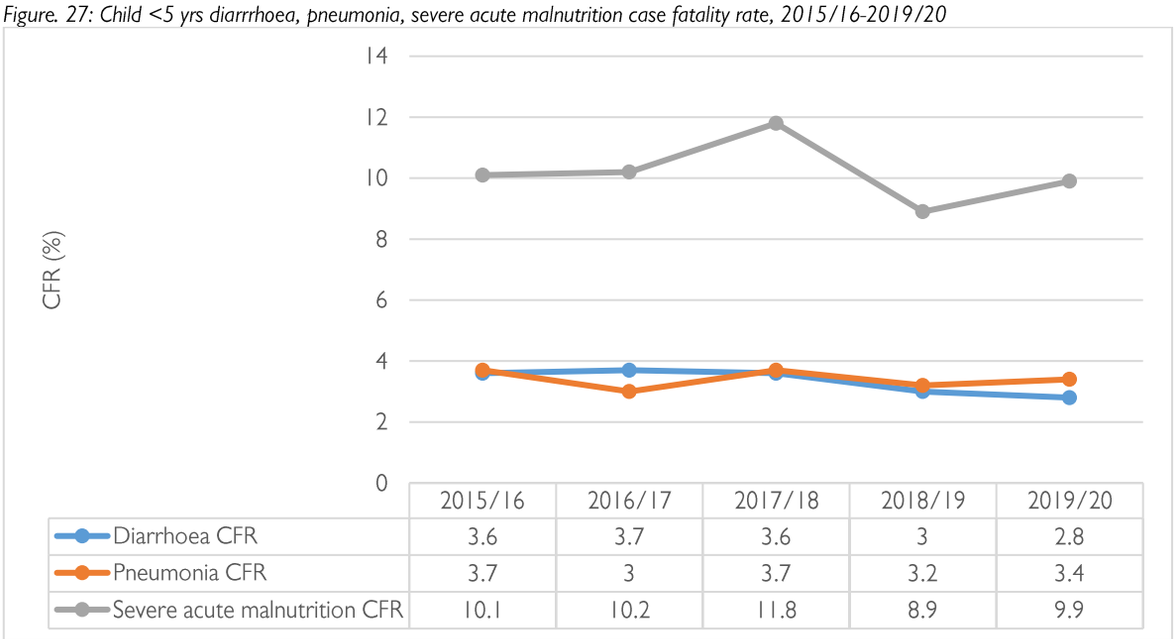


	Alfred Nzo DM	Amathole DM	Buffalo City MM	Chris Hani DM	Joe Gqabi DM	N Mandela Bay MM	OR Tambo DM	Sarah Baartman DM	Eastern Cape
2015/16	6.5	7.7	12.5	9.4	11.4	13.9	18.1	10.8	12.8
2016/17	7.1	5.7	11	10.7	6.5	10.2	15.1	10.3	10.8
2017/18	11.3	7.9	13.3	9.9	10.8	10.1	14.9	9.8	11.8
2018/19	8.8	6.3	14.7	7	9	8.9	13.2	7.6	10.3
2019/20	9.5	5.6	10.6	8.5	8.3	6.4	14.3	9.9	10

Under-5 mortality

The case fatality rate due to diarrhoea, pneumonia, and severe acute malnutrition among children under 5 years has generally been showing decline in the province, which might be associated with the child health intervention programmes. The diarrhoeal and pneumonia case fatality rate had been fluctuating between three and four percent over the five-year period under review. However, deaths due severe acute malnutrition had shown an increase in 2019/20 when compare with the previous year.

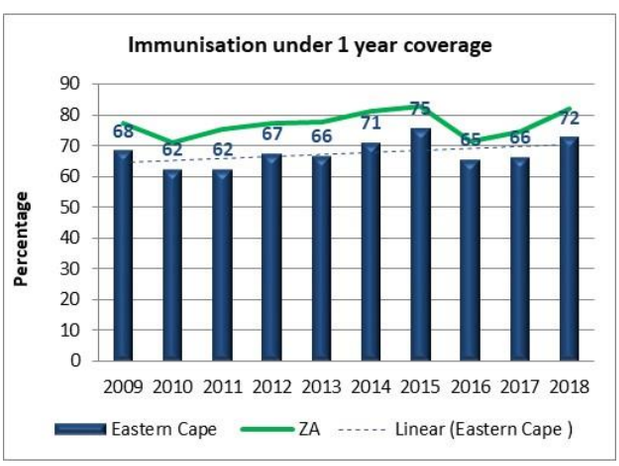
Figure. 27: Child <5 yrs diarrrhoea, pneumonia, severe acute malnutrition case fatality rate, 2015/16-2019/20

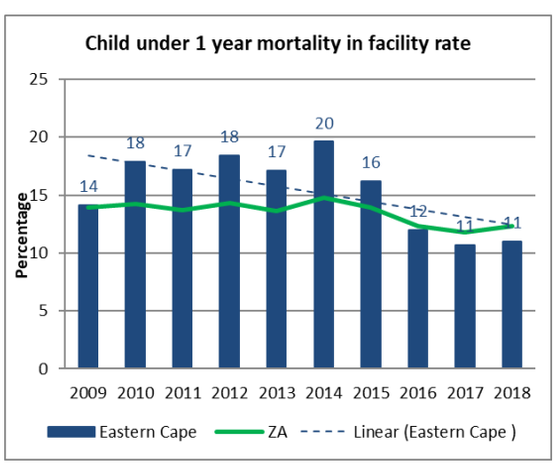


	2015/16	2016/17	2017/18	2018/19	2019/20
Diarrhoea CFR	3.6	3.7	3.6	3	2.8
Pneumonia CFR	3.7	3	3.7	3.2	3.4
Severe acute malnutrition CFR	10.1	10.2	11.8	8.9	9.9

The provincial immunisation coverage has consistently remained between 62- 75 % in the last ten years. This is below the level of desired immunity. Province experienced an outbreak of pertussis in the 2019/20 financial year, Child mortality under 1 year shows a declining trend, there is still a need to deal with lower respiratory and diarrhoeal diseases which are shown to be leading causes of infant mortality 20.6% and 20% respectively.

Figure. 28: Child health indicators





Non communicable disease

The global trend of escalating non-communicable diseases is evident in our country and our province. Diseases of lifestyle such as obesity, hypertension, and diabetes result, inevitably, in costly hospital admissions for complications such as stroke, renal failure, heart disease and blindness. COVID 19 pandemic has escalated the importance of dealing with non-communicable diseases and co morbidities. Hypertension and diabetes co morbidities were the leading causes of fatality in COVID 19 According to SADHS 2016, 13% of women and 8% of men 15 years and older are diabetic in South Africa, while hypertension prevalence was shown to be 46 % and 44% for women respectively.

Mental Health

The Department identified systemic weaknesses in the leadership and governance of mental health services in the province. The infrastructure for the psychiatric facilities has degenerated over the time and this is coupled with a bed shortage of 1600 in the Province, mostly the beds are concentrated in the western area of the Province and also due to re-demarcation, 320 beds of Mzimkhulu hospital moved to Kwa Zulu Natal. The burden of disease has shown a radical increase in substance abuse in the Province and the country, thus increasing a need for social service and rehabilitation. There is a critical need of facilities offering rehabilitation services to augment the 91 beds available from public and civil sector.

As part of strengthening the service, the National Department of Health appointed an administrator for the mental health services to support the EC. The administrator has made recommendations towards improvement of the mental health services in the province. The service platform will be strengthened through implementation of community based psychiatric services within Primary Health Care, strengthening of the 72-hour observation in district hospitals as well as focusing on the acute and chronic in- patient management. There is a plan to increase acute beds in the Eastern Part of the province targeting St Barnabas, Madzikane Ka Zulu, Holy Cross, St Patricks and Zitulele hospitals.

During the next 5 years, the department will focus on strengthening the prevention of mental disorders, substance, drug and alcohol abuse and provision of sufficient resources for mental health. Community-based approach to rendering mental healthcare will be promoted, seeking to strengthen access to appropriate services at the appropriate level of care. Addressing the inequities of mental healthcare will be a focus area, to ensure our most disadvantaged communities have access to 72-hour acute psychiatric care at designated facilities, as well as services that speak to the burden of mental disease. Mental health teams will be established. Mental illness associated with substance abuse is a public health concern, and partnerships will be explored to render the relevant services to prevent and treat substance abuse effectively.

Cancer

According to the national strategic plan on cancer, the most common cancers among men in South Africa currently are prostate cancer, Kaposi's sarcoma, lung cancer and colorectal cancer. The ranking of cancers below excludes non-melanoma skin cancer and cancers of unknown primary site.

Table 9: Top Most cancers in men in EC.

Type of cancers in men	No of cancers 1998-2002	Total %	No of cancers 2003-2007	Total %	No of cancers 2008-2012	Total %	No of cancers 2013-2017	Total %
Oesophagus	496	42.2	475	42.7	368	30.5	333	24.5
Prostate	81	6.9	105	9.4	178	14.8	321	23.6
Kaposi Sarcoma	25	1.3	42	3.8	84	7.0	133	9.8
Oral cavity	67	6.7	79	7.2	97	7.8	86	6.2
Lung	92	7.9	68	6.1	63	5.2	70	5.1
Liver	68	5.8	38	3.4	62	5.1	47	3.5
Larynx	42	3.6	49	4.4	47	3.9	43	3.2
Colo-rectum	21	1.8	25	2.3	36	3.0	37	2.7
Non-Hodgkin Lymphoma	5	0.5	11	1.0	23	1.9	23	1.7
Total Top Ten Cancers	**897**	**88.0**	**892**	**80.2**	**958**	**79.4**	**1093**	**79.4**
Other cancers in men								
Bladder	9	0.9	12	1.1	9	0.7	14	1.0
Stomach	23	2.0	13	1.2	20	1.7	13	1.0
Melanomas	10	1.0	11	1.0	6	0.5	9	0.7

Source: MRC 2018

Table 10: Most common cancers in the Eastern Cape

Type of cancers in women	No of cancers 1998-2002	Total %	No of cancers 2003-2007	Total %	No on cancers 2008-2012	Total %	No of cancers 2013-2017	Total %
Cervical Cancer	552	39 %	572	39.6	706	40.8	1153	48.6
Oesophagus	514	36.6	531	36.7	406	33.4	484	20.4
Breast Cancer	186	13.2	173	12	294	17	326	13.7
Kaposi Sarcoma	7	0.5	31	1.8	78	4.5	112	4.7
Ovary	20	1.4	21	1.4	58	3.3	78	3.3
Uterus	20	1.4	24	1.6	47	2.7	60	2.5
Colo-rectum	17	1.2	26	1.8	43	2.4	49	2.1
Liver	61	4.3	28	1.9	41	2.3	35	1.5
Non-Hodgkin Lymphoma	6	0.4	17	1.1	27	1.5	30	1.3
Lung	20	1.4	20	1.4	28	1.6	44	1.8
TOTAL TOP 10 CANCERS	**1403**	**100**	**1443**	**100**	**1728**	**100**	**2371**	**100**

Source: MRC 2016

The most common cancer in women in South Africa is breast cancer, however in the Eastern Cape, Cervical cancer is leading cancer among women and there was an increase over the period from 552 cases in (1998-2002) to 1153 during 2013 - 2017. Oesophageal cancer among women is still high although declining from 514 to 484 at the end of 2017, this decline is also seen among men although the Oesophageal cancer is still the leading cause of mortality among men.

The cervical and breast cancer prevention and promotion policies were launched in August 2017. Training of 90 doctors was conducted in July 2019. EC also launched the liquid-based cytology with improved the suitability of smears leading to improved cervical cancer screening coverage from 60.3% to 72.3 %.

Nelson Mandela National Central has opened an oncology unit that services the eastern region of the province. Plans are still in progress to install the Linac machine. A project was launched to reduce lung cancer by introducing screening services in 5 Hospitals. The program also strengthened outreach by NMAH gynae- oncologist to establish sites for colposcopy in Eastern region. The EC has increased access to colposcopy services to treat cervical pre-cancer lesions cancer to include 16 district hospitals. This has improved access and travel distances as colposcopy was only available at Nelson Mandela National Central, Frere and 2 regional hospitals CMH and Dora Nginza. A total of five thousand eight hundred and sixty-five (5865) colposcopies were done in the province during the 2018/19 financial year. The department is investing R10 million at Nelson Mandela Academic hospital to build two bunkers for 2021/22 financial year to strengthen cancer services.

Injury and Trauma

Gender based violence is rife in South Africa as shown in the South African Demographic Health survey 2016. 21% of South African women above the age of 18 years reported to have experienced domestic violence compared to 31 % in the Eastern Cape. It is also reported that this has increased over the period of lockdown during the COVID 19 peak. The Eastern Cape Provincial Development plan outlines the safety and security crime efforts that are organised in a multi-agency approach. Seventy-six (76) hospitals and five Community Health Centres (CHCs) have Thuthuzela centres run by multi stakeholders to support the victims of crime including rape. The support to victims and offenders in the correctional services are all elements of an effective crime prevention system. This also includes focused attention to rural safety programmes, drug intervention programmes and state capacity to respond to gender-based violence.

Quality of Health Care

In the current health environment of Eastern Cape, there is an increasing public clamour for access to a safe efficient health system and better-quality health for all. However, the increase in payments for medico-legal claims means that money has to be diverted away from the delivery of health care services, which further hampers the quality of care provided. This has put the spotlight on the department to perform even better and act faster to deliver on quality health care. It is against this backdrop that the department operates to develop and sustain responsiveness at all health facilities both hospitals and Primary Health Care through the development of standardized operational procedures, establishment of quality committees, strengthening patient safety Incident reporting and learning system so that data from the system will be used to develop mitigation strategies to improve quality care. Moreover, in recognition of the task ahead Quality Improvement will become part of the Quality Assurance for all the health facilities within the province.

As the pandemic continues there is a need for a robust Infection Prevention Control (IPC) support to the province to strengthen the health system capacity in terms of preparedness and response to infectious diseases including COVID 19 pandemic. Several interventions will be implemented to strengthen IPC across the province including supportive supervisory visits to provide training, mentorship and building capacity to enable healthcare workers to overcome their fears and build confidence to deal with the pandemic. Moreover, the surveillance system for Hospital Acquired Infections (HAI's) will be developed and implemented.

The Department's commitment to the delivery of high-quality health service to meet the patient and community needs of the patients is continuing. Amongst other things, these include a consumer feedback strategy which include management complaints, complements and suggestion as well as scheduled patient experience of care surveys and interventions. The strategy is guided by the national paradigm imperative of fast-tracking quality improvement in the Six Priority Areas. The main objective of the strategy seeks to guarantee the continuous effective and efficient service delivery through the embracing of Batho Pele Principles.

The National Guideline on Management Complaints, Suggestion and Compliments with accompanying web-based information system is in place to monitor implementation of framework. 448 out of 865 facilities are reporting on the web-based system. The website provides for categorisation of complaints data according to the six Core Standards and the Department performed as followed:

Table 11: Six core standards

Locality	Total	Staff Attitude	Access to Information	Physical Access	Waiting Times	Waiting List	Patient Care	Availability of Medicine	Safe and Secure Environ-ment
Province	2091	24%	4%	3%	27%	3%	27%	3%	6%
Alfred Nzo	94	29%	6%	0%	21%	0%	22%	0%	6%
Amathole	492	18%	5%	2%	28%	0%	32%	3%	11%
BCM	336	22%	6%	3%	33%	4%	18%	4%	3%
Chris Hani	79	24%	3%	5%	34%	0%	16%	0%	8%
J- Gqabi	20	30%	10%	0%	45%	0%	25%	0%	5%
NMM	428	36%	3%	3%	27%	7%	16%	4%	4%
OR Tambo	414	16%	4%	0%	23%	4%	35%	2%	6%
S. Baartman	228	30%	4%	4%	21%	0%	40%	1%	5%

In the next five years the department will improve performance with regards to reporting by health establishment to exceed the target of 80%. The improved performance envisaged will be done through onsite training of operational managers of health establishments. Performance will be monitored on quarterly basis and reports generated for management discussion. Facilities will be provided with Standard Operating Procedures to reduce complaints on waiting time, staff values and attitude as well as patient care.

The Eastern Cape Health has a legal obligation to conduct patient experience of care survey, on a regular basis, determine the experiences patients have with the healthcare they receive. By conducting rigorous patient experience of care surveys, any mismatch between the patient's expectation and the healthcare service they are receiving, is brought to the fore. The table below indicate how the Department performed in the2017/18 - 2019/20 financial year

Table 12: Patient experience of care

DISTRICT	REQUIRED SCORE %	OBTAINED SCORE % 2017/18 BASELINE	OBTAINED SCORE % 2018/19	OBTAINED SCORE % 2019/20
EC	***80%***	**72.8%**	**79.4%**	**82.9%**
NMBHD	80%	64.3%	76.6%	79.6%
Sarah Baartman		78.1%	84.9%	*87.5%*
BCM		74.6%	76.8%	81.9%
Amathole		80.2%	85.1%	*84.9%)*
Chris Hani		74.7%	80.7%	78.7%
Joe Gqabi		68.8%	76.4%	*75.5%*
OR Tambo		69.1%	79.4%	81.7%
Alfred Nzo		70.7%	80.8%	*85%*

On average, the Province achieved the set satisfaction target of 80%, in the next five years' efforts will be made to improve on the gaps through implementation of quality improvement plans.

The Province will not only focus only on one annual official PEC survey per health establishment; however, all establishments will be provided with tools to allow them to conduct their own internal small-scale survey to inform intermittent service delivery improvement.

The current department patient safety incident reports show that facilities are failing to report as required. In the financial year 18/19 only 32 % of facilities reported accordingly, whereas in 19/20 financial year the facility compliance on reporting was again at 34%. Yet evidence shows that the majority of Patient Safety Incidents can be preventable by implementing ordinary standards of care. Failure to promote a culture of reporting Patient Safety Incidents is also identified as a gap. There is also lack of timely provision of a reliable and comprehensive Patient Safety Incident database.

The performance of all level of hospitals will be measured through the Ideal hospital realisation management framework which was initiated in 19/20 financial year. Out of 65 district hospitals a total of 59 has conducted their baseline ideal hospital management framework assessment, wherein they performed in the following manner:

Table 13 (a): Ideal Clinic Services

DISTRICT	Number of PHC Facilities	Actual Ideal Clinic (ID) status achievement per year					Cumulative IC Status achievement	
		2015/16	2016/17	2017/18	2018/19	2019/20	2019/20	2019/20
Alfred Nzo	74	0	2	2	8	**4**	**16**	**21.6%**
Amathole	148	3	25	15	14	**21**	**78**	**52.7%**
Buffalo City	79	0	2	6	10	**7**	**25**	**31%**
Chris Hani	159	1	24	9	7	**2**	**43**	**27%**
Joe Gqabi	52	4	17	9	4	**1**	**35**	**67%**
NMBM	48	3	13	5	12	**8**	**50**	**80.6%**
OR Tambo	146	2	34	14	17	**11**	**76**	**52%**
Sarah Baartman	62	2	24	4	12	**8**	**50**	**80.6%**
EC Province	768	15	141	64	84	**66**	**370**	**48%**

At the end of 2019/20, 48% of facilities achieved the ideal clinic status.

Table 13(b): Ideal Hospital Services

Facility performance	Facilities score < 50 %	Facilities score 51-60 %	Facilities score 61-70%	Facilities score 71-80%	Facilities score 81-90%	Total
Number of hospitals	28	7	9	10	5	59
Overall performance per facilities	47%	12 %	15 %	17%	8%	100%

93% of hospitals in 2019/20 completed the annual returns and that has informed the planning interventions for the 2021 /22.

6. ORGANISATIONAL ENVIRONMENT

The status of human resources in the department

The impact of COVID -19 in the human resource management of the department was significant, to this effect, the department had 11 highlighted focus on automation. Development of human resource for health strategy for 2030 is prioritised to address the issues of recruiting for the changed context, recruit all-rounders and re-training of the already available staff. Human resource management needs to be client focussed with emphasis on mentoring and coaching to assist individuals to deliver outcomes.

The department is experiencing imbalances in workload within the health care professionals with high turnover in certain positions. The province has a challenge of attracting medical specialists, this is exasperated by the long appointment processes. In the next five years, the human resources will need to focus on improving the productivity through development and implementation of the 2030 human resource for health strategy; transforming the bureaucracy; automating the recruitment process to address turnaround times; Improve training model of health professionals and ensure proper skills mix within the organisation. In the coming MTEF, the department will undertake the skills audit, person to post matching and headcount analysis as well as organisational culture and climate study.

Organisational Development

The Department's Organisational structure is aligned with an improved Service Delivery Model, which has its emphasis on the Primary Health Care (PHC) approach. The department effected organizational structure changes with the aim of strengthening both District Health Services and Hospital Services. The implementation of the above will enhance decentralisation of services to the district at large and will also encourage delayering of functions and thus improve on service delivery.

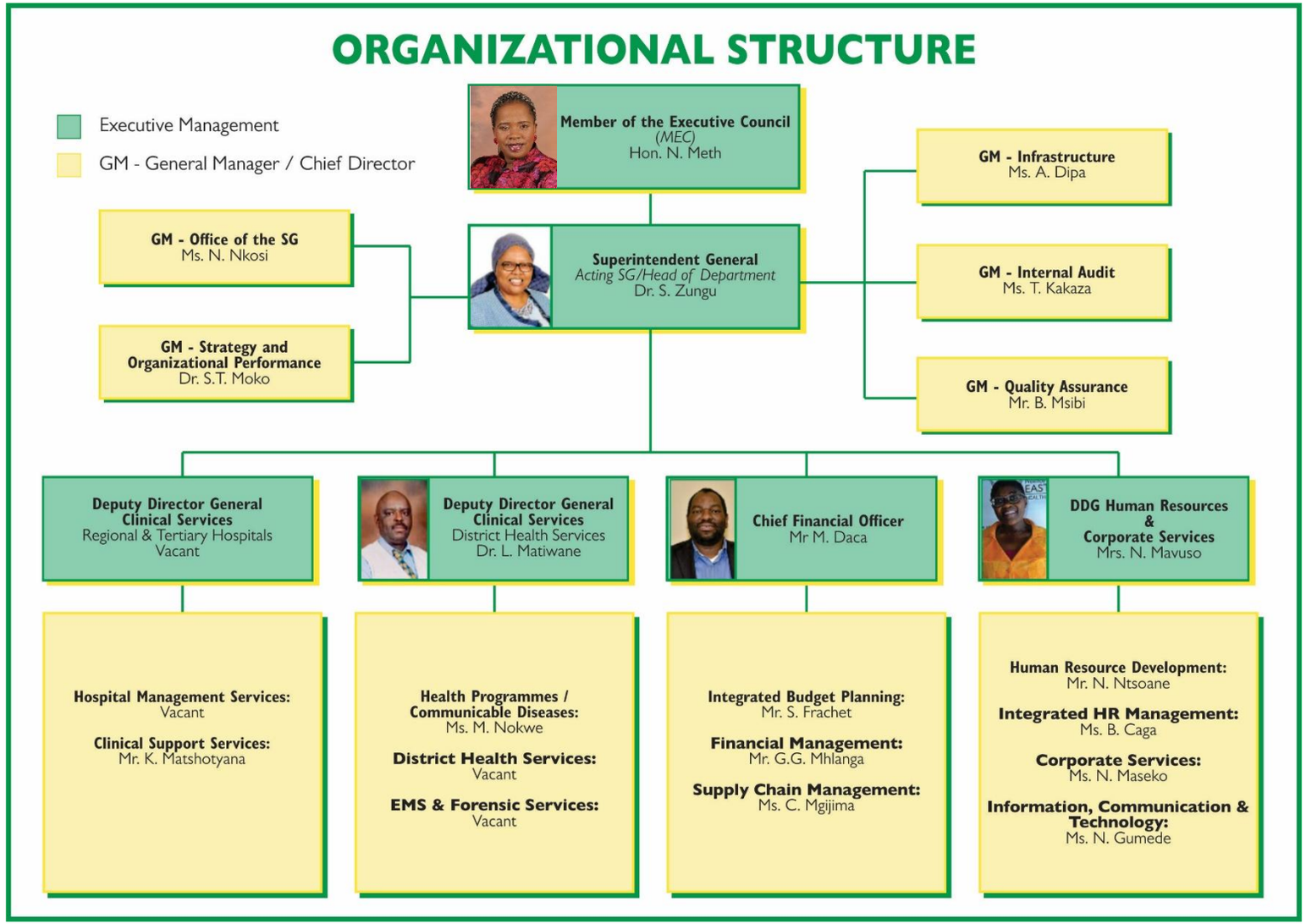
There is an intention to institutionalise the change management processes within the department to deal with poor Organisational culture and to prepare the staff for imminent changes that will be brought by revised services delivery model and implementation of National Health insurance. Stakeholder engagement will be enhanced to deal with issues of rationalisation and effective use of resource. There is a great need to invest in an innovation unit that will be hub for trend analysis environmental scanning and innovative ideas for change.

Employee Wellness

Gaps in the occupational health services of the department were laid bare by the COVID 19 pandemic. The department mandate is to care for the sick and vulnerable members of the community and therefore interventions of caring for the carers are key in delivery of quality health services, however the wellness program within the department is not institutionalised and the wellness unit does not have capacity to look after the 49 000 work force. There is a need to provide safe conducive working environment for all employees including the physically challenged employees. Employees for emergency medical services and forensic pathology services are prioritised for counselling and trauma debriefing services.

Provision of psychological interventions for COVID-related mental distress in frontline healthcare workers is prioritised through establishment of Occupational Health and Safety (OHS) hot line centre. The department is dealing with a growing concern on the physical safety and security of staff in the health facilities as well as in the ambulances as they are attacked in the line of duty by criminals.

Figure 29: Organisational structure



Information, Communication and Technology (ICT)

The department is prioritising the finalisation of the Information Communication and Technology (ICT) strategy which is aiming at creating a digitised organisation that will help standardise business processes and produce consistent information while reducing the cost of providing a world-class patient care. The e-health systems project for the Eastern Cape Department of Health aims to support the outcomes of the Department through the use of information communication technologies to promote, support and strengthen healthcare in the Province of the Eastern Cape.

The Eastern Cape Department of Health is at a turning point where an Eastern Cape Department of Health enterprise architecture is now in place and aligned to the National Department of Health digitisation strategy. This has set in motion the development and implementation of various digitisation initiatives across all levels of care that will seamlessly interface with the National Department of Health digitisation strategy to enable systems interoperability. e-Health systems involve the collection, storage, and exchange of health information via a secure network and within strict privacy safeguards, to facilitate better integration of care and to improve outcomes across the health care system.

The challenges of ICT can result in the following:

- Higher probability of litigation
- Loss of revenue due to insufficient information
- Long turnaround to raise accounts.
- Lack of systems integration
- Slow reaction to incidents within the hospital
- Poor stock management for instance drug management

As part of the ECDoH ICT innovation, the HMS2 electronic medical record system will be implemented as part of the e-Health suite of products. The system is in-house developed and has gone through the NDoH review process and has been certified for HPRS integration. New modules develop would automatically become the property of the government, who would own the source code with full control to further develop, enhance and or customise such solutions. The licencing cost such as free software licencing modules would remain the same, irrespective if deployed to 1 or 1000 health facilities. Saving on commercial software and licencing can bring about significant savings and such savings can then be used in ICT infrastructure, implementation and ICT resources for development, enablement, and the sustainability of such solutions. In the 2021/22 financial year, the department is investing an amount of R96 million to enhance e-Health solutions.

Financial Management

Budget decisions

Budget decisions in the department continue to be largely impacted by the increasing burden of diseases; the increasing demand for services and the growing uninsured population that are dependent on public health services. The Department continues to operate within a fragile space bedded within intractable service pressures on a daily basis with severe resource limitations. This fragility is fuelled by the escalating burden of disease, including the multi - morbidity from chronic diseases, mental illness and others. While the pace and scale of progress has been constrained primarily through reduced budgets and the magnitude of medico legal claims brought against the Department, the need to ensure uninterrupted service provision continues.

Notwithstanding, the department continues to assess amongst others, its policy priorities, service delivery models, areas of collaboration in order to improve efficiencies and minimise costs where applicable in order to do more with less in the midst of this weak economic outlook.

REVIEW OF THE CURRENT FINANCIAL YEAR (2020/21)
COVID-19 Pandemic

On 24 June 2020, the Minister of Finance tabled an Adjustments Budget for 2020/21, which set out government's initial economic and fiscal response to COVID-19. Therefore, based on the National Supplementary Budget, the Provincial Special Adjustment Budget sought to modify the 2020/21 current baseline allocations in order to reprioritise funds towards the provincial response to COVID-19. Thus, the Provincial Special Adjustments Budget catered for reprioritisation of funds as well as the allocation of additional funds, which enabled departments to spend on COVID-19.

An amount of R746 169 000 was reduced from the department's equitable share budget in response to the COVID-19 pandemic. An additional R2 514 000 000 was allocated to the vote. R481.076 million was allocated to the new COVID-19 component within the HIV, TB, Malaria and Community Outreach grant.to complement spending for the purchase of personal protective equipment and ventilators, hiring of additional staff, including Cuban medical personnel. R44.551 million was allocated from the Provincial Disaster Relief Grant. These funds were utilised to purchase Personal Protective Equipment (PPE). R307.100 million was allocated in terms of Section 25 of the PFMA. R1.681 billion was allocated as additional funding to deal with the COVID-19 pandemic.

2020/21 Second Adjustment Budget Allocations

Herein, the department's budget was adjusted downwards by R688.940 million, resulting in a total adjusted appropriation of R27.446 billion. The 2nd 2020/21 EPRE wage freeze of R1,017 billion cushioned by R742,820 million resulted in a net reduction of Equitable Share COE of R274,803 million with a further resulting pressure on the baseline after the supplementary additional cut of R449 897 000, creating a devastating effect on the department's operations.

The department sought approval from PT for the appointment of key prioritised posts in the Department (with a projected in year 31 March 2021 cost of up to R59,90 million and projected 2021/22 carry through cost of up to R402,4 million) to inter alia mitigate the significant increase in the burden of disease arising from SARS-Cov-2, strengthened management and leadership of prioritized institutions, necessary prioritized capacitation of supply chain management units and the capacitation of the medico legal.

OUTLOOK FOR THE COMING FINANCIAL YEAR (2021/22)

National adjustments result in baseline reductions of R2.486 billion in 2021/22, R3.357 billion in 2022/23 and R2.790 billion in 2023/24. The department will continue to relook the service delivery platform so that it is able to deliver within the available resources.

Medico legal claims / State Attorney

The department has been spending an ever-increasing proportion of its allocated annual budget on the settlement of medico legal claims brought against it. These payments are upfront settlements, largely to meet future medical needs of cerebral palsy (CP) claimants and are incurred at the cost of funds otherwise meant for delivering healthcare services to the people of the Eastern Cape. The medico legal claims payments are uninsured, unbudgeted and unfunded. The department does not budget for these claims primarily because Provincial Treasury is concerned that should the department budget for these claims, this will lead to more litigation against the department.

The amounts paid for medico-legal claims are not included as part of the appropriated budgets. Accordingly, funds have to be sourced from other service delivery budget lines/cash flows in order to pay these claims. This has a detrimental effect on the ability of the ECDoH to deliver healthcare to the public and payment obligations in terms of its supply chains are materially delayed.

Transfers and Subsidies in the 2019/20 and 2020/21 account for higher percentages than in the MTEF period. The department is not permitted to budget for these by Provincial Treasury, whose preferred approach is to apply the robustness and consequence management of the provisions of Section 34 (1) (a) of the PFMA wherein unauthorised expenditure does not become a charge against the Revenue Fund except when the Provincial Legislature approves as a direct charge against the Provincial Revenue Fund. Section 34 (2) of the PFMA states that in the event that the Provincial Legislature does not approve the additional amount of the overspending, then the amount becomes a charge against the funds allocated for the next or future years for the relevant vote.

Due to the threat that the challenge of medico legal claims poses on the provincial financial stability, it has been elevated to a provincial intervention. The provincial Executive Council has established a Specialised Litigation Unit (SLU) within the Office of the Premier (OTP) which is tasked with the active defence of the medico legal claims. Provincial Treasury (PT) has been tasked with the investigation of suspected cases of medico legal claims as well as looking at the modalities for funding medico legal claim settlements.

A Memorandum of Agreement for the management of medico-legal litigation has been entered into in December 2020 by and between the Eastern Cape Office of the Premier and the Eastern Cape Department of Health and the Eastern Cape Provincial Treasury. In terms of this, the parties have sought to formalize their relationship, by stipulating terms and conditions, rights and obligations, as well as duties and responsibilities that will regulate their conduct during the operation of the SLU, existence of this agreement and thereafter.

The preamble of the agreement is that the provincial government is beset by the high level of medico-legal claims and/or medical negligence litigation which has the effect of eroding the provincial government's budget. In assessing the root cause of the problem, the provincial government realised that the panacea to some of the problems that persistently trouble the health system in the Eastern Cape Province is amongst others, the enhancement of capacity in the departments that are intimately involved in and/or responsible for the managing of medico-legal claims and/or medical negligence litigation;

The Department had previously developed its medico legal strategy implementation plan (MLSIP), which was a short term, medium term and long-term action plan to reduce the financial impact of the contingent liabilities of the Department and improve the quality of care of patients. The medico legal strategy comprises interventions, including packages to prevent cerebral palsy, electronic patient records management systems, promotion of early intervention, targeted district hospital to provide full packages of services, capacity for medical legal defence, rationalization of contingent liability records, amendments to the legislative frameworks, anti-fraud and corruption activities and reporting.

In addition, the Health Action Plan (HAP) of the National Department of Health dealt with the 2017 Health 10x10 resolution that a joint health action plan be developed to address challenges existing within the sector including increasing medico legal claims and improving quality of healthcare.

Establishment of a Medico-Legal Investigation Unit Part of the PFMA S18-2-G Interventions - this includes inter alia medico-legal claims, budget management, ICT, payroll verification, SCM efficiencies, infrastructure and the management of accruals and payables. These interventions seek to have an impact on the cash position of the Department of Health, the benefits of which will accrue over the medium to long-term. The intervention will have an impact to turn around Health's finances, but there is an immediate budget pressure in the department which will not be solved immediately through the intervention. Provision has been made for disbursed expenses of the MIU located in the Provincial Treasury via inter-departmental claims.

COVID-19 Management and ECCOVAC-19 - COVID 19 Vaccination Project

The Department has allocated the additional national adjustment COVID-19 response funding amounting to R1.039 billion in 2021/22 (plus HIV Aids) to assist to cover the costs associated with responding to the pandemic.

One intervention to prevent ongoing Covid-19 transmission and reduce mortality and morbidity is effective vaccination. The World Health Organisation (WHO) approved the first vaccine in November 2020, with further vaccine approvals subsequently. South Africa has secured vaccines for rollout in the initial phases in our country. In time, additional vaccines will become available.

The National Department of Health has appointed a Ministerial Advisory Committee (MAC) on Covid-19 Vaccines which consists of experts in the field. The MAC has worked with the National Department to develop a strategy to ensure equitable access to vaccines. The strategy includes the various purchasing mechanisms, funding implications, local manufacturing opportunities and identifying priority groups for vaccination. The NDOH will procure the vaccines with the provinces procuring the ancillary supplies. A national rollout committee will oversee the rollout in both the public and private sector.

DEPARTMENTAL PRIORITIES / adjustments further provide for: -

e-Health Project Implementation

An amount of R200.6 million is allocated to the E-health project to be executed over three (3) years from 2021/2022 to 2023/2024 for the implementation of the E-Health project to 28 highly litigated healthcare facilities. The solution also makes provision for the stabilisation and replacement of dilapidated server infrastructure. The E-HEALTH systems project for the Eastern Cape Department of Health aims to support the strategic objectives of the Department through the use of information communication technologies to promote, support and strengthen healthcare in the Province of the Eastern Cape.

The Department is at a turning point where its enterprise architecture is now in place and aligned to the National Department of Health E-HEALTH strategy. This has set in motion the development and implementation of various E-HEALTH initiatives across all levels of care that will seamlessly interface with the National Department of Health E-HEALTH systems and strategy to enable systems interoperability. The E-HEALTH systems project is aimed at assisting the Eastern Cape Department of Health to health care reform with better and timelier health information that can assist health care facilities to improve the quality of patient care and services rendered to our communities.

7. MTEF budgets

Table 14: Summary of payments and estimates by programme.

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2020/21
R thousand	2017/18	2018/19	2019/20		2020/21		2021/22	2022/23	2023/24	
1. Administration	589 458	694 832	600 813	720 803	687 418	655 476	791 566	724 901	750 329	20,8
2. District Health Services	11 342 496	12 779 800	13 640 040	13 676 205	14 146 639	15 224 347	14 245 892	13 365 504	13 624 995	(6,4)
3. Emergency Medical Services	1 279 087	1 273 093	1 277 761	1 431 884	1 340 520	1 335 394	1 304 848	1 299 392	1 323 625	(2,3)
4. Provincial Hospital Services	3 488 361	3 835 551	4 026 399	3 557 063	3 537 325	3 976 146	3 339 400	3 266 786	3 366 843	(16,0)
5. Central Hospital Services	3 471 073	3 749 152	4 329 290	4 618 025	4 785 653	4 829 547	4 372 654	4 355 280	4 453 642	(9,5)
6. Health Sciences And Training	727 692	776 535	728 562	906 026	863 891	818 221	928 658	912 781	913 911	13,5
7. Health Care Support Services	99 998	110 060	101 329	130 869	188 856	169 241	173 245	127 845	116 489	2,4
8. Health Facilities Management	1 274 514	1 253 296	1 496 307	1 349 703	1 896 076	1 792 052	1 274 325	1 287 515	1 319 655	(28,9)
Total payments and estimates	**22 272 679**	**24 472 319**	**26 200 501**	**26 390 578**	**27 446 377**	**28 800 424**	**26 430 588**	**25 340 004**	**25 869 489**	**(8,2)**

Table 15: Summary of provincial payments and estimates by economic classification.

R thousand	Outcome 2017/18	2018/19	2019/20	Main appropriation	Adjusted appropriation 2020/21	Revised estimate	Medium-term estimates 2021/22	2022/23	2023/24	% change from 2020/21
Current payments	**20 347 078**	**22 121 145**	**23 829 297**	**24 568 223**	**24 984 899**	**25 634 125**	**24 673 066**	**23 694 552**	**24 258 589**	**(3,7)**
Compensation of employees	14 558 949	15 980 940	17 154 718	18 348 000	17 584 489	18 404 755	17 116 280	17 098 125	17 654 108	(7,0)
Goods and services	5 784 042	6 110 829	6 650 052	6 220 223	7 400 410	7 228 781	7 556 786	6 596 427	6 604 481	4,5
Interest and rent on land	4 087	29 376	24 527	–	–	589	–	–	–	(100,0)
Transfers and subsidies to:	**689 345**	**1 051 664**	**957 621**	**235 546**	**265 529**	**1 100 089**	**308 056**	**337 902**	**352 769**	**(72,0)**
Provinces and municipalities	313	3 091	–	–	–	–	–	–	–	
Departmental agencies and accounts	11 013	11 856	12 263	13 058	13 058	13 058	10 649	18 844	19 673	(18,4)
Non-profit institutions	7 278	17 566	9 060	8 495	8 495	8 495	-4 336	15 010	15 670	(151,0)
Households	670 741	1 019 151	936 298	213 993	243 976	1 078 536	301 743	304 048	317 426	(72,0)
Payments for capital assets	**1 236 256**	**1 287 172**	**1 413 583**	**1 586 809**	**2 195 949**	**2 066 210**	**1 449 466**	**1 307 550**	**1 258 131**	**(29,8)**
Buildings and other fixed structures	637 152	912 450	1 060 483	935 918	1 385 479	1 330 189	619 937	669 598	653 487	(53,4)
Machinery and equipment	599 104	374 722	353 100	650 891	810 470	736 021	829 529	637 952	604 644	12,7
Software and other intangible assets	–	–	–	–	–	–	–	–	–	
Payments for financial assets	**–**	**12 338**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**22 272 679**	**24 472 319**	**26 200 501**	**26 390 578**	**27 446 377**	**28 800 424**	**26 430 588**	**25 340 004**	**25 869 489**	**(8,2)**

Table 14 and 15 above show the summary of payments and estimates per programme and economic classification. The total payments grew from R22.272 billion in 2017/18 to a revised estimate of R28.800 billion in 2020/21. In 2021/22, the budget is declining by 8.2 per cent from R28.800 billion to R26.430 billion when compared to the 2020/21 revised estimate due to national and provincial adjustments.

Compensation of employees shows a decrease of 7 per cent from R18.404 billion to R17.116 billion when compared to the 2020/21 revised estimate as a result of 2020 wage freeze reductions and overall fiscal consolidation reductions.

Goods and services show a positive growth of 4.5 per cent from R7.228 billion to R7.556 billion when compared to the 2020/21 revised estimate due to the additional funding allocated for COVID-19 Health Sector Support.

Transfers and subsidies show a negative growth of 72 per cent from R1.100 billion to R308.056 million when compared to the 2020/21 revised estimate due high revised estimate as result of payment of medico legal claims.

Payments for capital assets show a negative growth of 29.8 per cent from R2.066 billion to R1.449 billion when compared to the 2020/21 revised estimate due to overall fiscal consolidation reductions.



PART C

MEASURING OUR PERFORMANCE



PART C – MEASURING OUR PERFORMANCE (PROVINCIAL DOH APP PER BUDGET PROGRAMME)

1. PROGRAMME: HEALTH ADMINISTRATION AND MANAGEMENT

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

1.1 SUB-PROGRAMME: Health Administration - Office of the MEC

Sub - programme purpose

To provide political and strategic direction to the Department by focusing on transformation and change management.

IMPACT STATEMENTS

Impact	Long, healthy and quality life for the people of the Eastern Cape

Table 16: Outcomes, Outputs and Output indicators for the next MTEF for the Office of the MEC

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
9. Leadership and governance in the health sector enhanced to improve quality of care	Statutory document submitted	9.1.2 Number of statutory documents tabled at Legislature	6 statutory documents	8 statutory documents	8 statutory documents	5 statutory documents	8 statutory documents	-	1	2	5	7 statutory documents	7 statutory documents

1.2 SUB-PROGRAMME: HEALTH MANAGEMENT

SUB-PROGRAMME PURPOSE

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

The management component under the Head of Departments' supervision is comprised of four branches with their sub-components (branches) as listed below:

Finance Branch

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

Corporate Services Branch

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

Hospital and Clinical Support Management Branch

- Hospital Services
- Clinical Support Services
- Emergency Medical Services and Forensic Services
- Quality Care Assurance Services

District Health Services Management Branch

-
- District Health Support
- Communicable Diseases
- Health Programmes

Table 17: Outcomes, Outputs and Output indicators for the next MTEF for Health Management

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
7. Improve financial management	Audit opinion of provincial DOH achieved	7.1.1 Audit opinion	Unqualified	Unqualified	Qualified	Unqualified	Unqualified	-	Unqualified	-	-	Unqualified	Unqualified
	Improved access to essential medicines, vaccines and medical products through better management of supply chain accruals reduced	7.1.2 Approved Annual Procurement Plan	New Indicator	New Indicator	New Indicator	1st Draft submitted to Provincial Treasury	Approved Annual Procurement Plan	-	1st draft	2nd draft	Approved Annual Procurement Plan	Approved Annual Procurement Plan	Approved Annual Procurement Plan
	Increased revenue collection	7.1.3 Amount Revenue generated (R)	R165.5mil	R165.5mil	242 mil	125 mil	284 mil	65 mil	72 mil	72 mil	75 mil	297 mil	311 mil
6. Quality of health services improved	Compliance to Occupational health and safety regulations	6.3.8 Percentage of Health facilities compliant with Occupational Health and Safety	New Indicator	New Indicator	New Indicator	19.2%	28.6%	21.4%	23.8%	26.2%	28.6%	31.1%	33.5%
		Numerator				165	249	186	207	228	249	270	291
		Denominator				858	868	868	868	868	868	868	868
	Security incidents reported	6.3.9 Number of security incidents reported	New Indicator	New Indicator	New Indicator	2	8	2	2	2	2	8	8

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
	Approved costed. HRH Strategy to create share vision to realise. NHI	6.4.1 Holistic Human Resources for Health (HRH) strategy approved	New Indicator	New Indicator	New Indicator	-	Approved HRH Strategy	-	-	-	Approved HRH Strategy	-	-
		6.4.3 Vacancy rate	New Indicator	New Indicator	New indicator	12.4 %	12%	-	-	-	12%	10%	10%
		Numerator				6 211	5 977				5 977	4 981	4 981
		Denominator				49 810	49 810				49 810	49 810	49 810
8. Reduced causes of medical legal claims in facilities by 80%	Causes of Medico. legal claims reduced	8.1.1 % Reduction of medico Legal claims	New Indicator	New Indicator	New Indicator	10%	10%	10%	10%	10%	10%	10%	10%
11. Robust and effective health information systems to automate business processes and improve evidence-based decision making	Improved connectivity in health facilities	11.1.1 Percentage of Hospitals with broadband access	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Numerator	89	89	89	89	89	89	89	89	89	89	89
		Denominator	89	89	89	89	89	89	89	89	89	89	89
		11.1.2 Percentage of fixed PHC facilities with broadband access	71%	55	56%	97.5%	100%	100%	100%	100%	100%	100%	100%
		Numerator	551	428	428	752	775	775	775	775	775	775	775
		Denominator	772	772	768	771	775	775	775	775	775	775	775

Explanation of planned performance over the medium-term period

Audit improvement: The department developed an audit improvement plan(AIP) which outlines the strategies to be undertaken in order to achieve the desired audit outcome of unqualified audit. The qualifications emanate mainly from the unauthorised expenditure due to the challenges of medico legal contingency liability.

Human Resource Management: Annually, the department develops the Annual Recruitment Plan (ARP) based on the prioritised critical, new and replacement posts during the financial year. The current vacancy rate is 12.48% (norm is 10%), with 6108 posts that are vacant and unfunded. The departmental has implemented interventions to curb COE expenditure. The department sought approval from Provincial Treasury for the appointment of key prioritised posts in the department to inter alia mitigate the significant increase in the burden of disease arising from SARS-Cov-2 and to strengthen management and leadership of prioritized institutions. Due to the financial pressure the department's Annual Recruitment Plan is limited to the posts as approved by Provincial Treasury.

Medico legal

Digitisation: The Department of Health is in the process of aligning its enterprise architecture to the National Department eHealth strategy. This will set in motion the development and implementation of various eHealth initiatives across all levels of care that will seamlessly interface with the National Department of Health eHealth systems and strategy to enable systems interoperability. eHealth should give the department qualitative and timeous health information to assist health care facilities in improving quality patient care. It should as well enable health care access to the most remote of areas of our province through tele-medicine, and collaboration with specialists. Information communication technology plays a vital role as an eHealth enabler.

Poor ICT infrastructure and old ICT equipment in health facilities, is the primary focus for ICT strategy to avoid downtime and not to dynamically drive ICT solutions within the eHealth spectrum. 87% of hospitals within the ECDoH has very limited to zero penetration of ICT networks and computer infrastructure Provision has been made for the implementation of the E-Health project for the ECDoH over three (3) years to 28 highly litigated healthcare facilities. HMS2 Electronic medical record system key features included patient registration that is integrated to the National HPRS system, billing, and revenue management. A total of 532 of health facilities will be connected in the first phase of the project which is currently in progress over the MTEF. The department has strengthened the strategic alliance with SITA, leveraging on site prioritisation and timing together with SITA .

Revenue generation

The department is focusing on increasing revenue collection through various revenue streams, e.g. building the linkage with medical aids to improve collection. Digitisation of patient administration and payment systems will assist to increase revenue collection. Collaboration with hospital boards in fund-raising initiatives should be enhanced. The other revenue streams will be explored e.g.

- Reviving of the feasible Private Public Partnership arrangements
- Implement the findings of the UFH revenue study.
- Enhance billing capabilities in health facilities and emergency medical services (road and air ambulance) and increase the number of available Psycho-Legal evaluation beds.
- Renting out / leasing High Value Medical Equipment in non-peak hours
- Designated service provider status with medical schemes

1.3 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

Table 18: Summary of payments and estimates by sub programme: Programme 1: Administration.

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2020/21
R thousand	2017/18	2018/19	2019/20		2020/21		2021/22	2022/23	2023/24	
1. Office Of The Mec	6 056	9 262	7 800	9 536	10 370	11 447	8 259	8 644	8 808	(27.9)
2. Management	583 402	685 570	593 013	711 267	677 048	644 029	783 307	716 257	741 521	21.6
Total payments and estimates	**589 458**	**694 832**	**600 813**	**720 803**	**687 418**	**655 476**	**791 566**	**724 901**	**750 329**	**20.8**

Table 19: Summary of payments and estimates by economic classification: P1 – Administration

R thousand	Outcome 2017/18	Outcome 2018/19	Outcome 2019/20	Main appropriation 2020/21	Adjusted appropriation 2020/21	Revised estimate 2020/21	Medium-term estimates 2021/22	Medium-term estimates 2022/23	Medium-term estimates 2023/24	% change from 2020/21
Current payments	**580 128**	**681 305**	**590 647**	**712 215**	**675 036**	**643 986**	**765 006**	**697 291**	**722 168**	**18.8**
Compensation of employees	390 869	414 236	426 063	507 736	427 416	429 791	464 830	424 285	455 580	8.2
Goods and services	188 964	266 664	164 084	204 479	247 620	213 606	300 176	273 006	266 588	40.5
Interest and rent on land	295	405	500	–	–	589	–	–	–	(100.0)
Transfers and subsidies to:	**3 226**	**4 183**	**3 979**	**1 797**	**3 687**	**3 774**	**1 896**	**1 985**	**2 072**	**(49.8)**
Provinces and municipalities	–	–	–	–	–	–	–	–	–	
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–	
Higher education institutions	–	–	–	–	–	–	–	–	–	
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–	
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–	
Non-profit institutions	–	–	–	–	–	–	–	–	–	
Households	3 226	4 183	3 979	1 797	3 687	3 774	1 896	1 985	2 072	(49.8)
Payments for capital assets	**6 104**	**9 344**	**6 187**	**6 791**	**8 695**	**7 716**	**24 664**	**25 625**	**26 089**	**219.6**
Buildings and other fixed structures	–	–	–	–	–	–	–	–	–	
Machinery and equipment	6 104	9 344	6 187	6 791	8 695	7 716	24 664	25 625	26 089	219.6
Heritage Assets	–	–	–	–	–	–	–	–	–	
Specialised military assets	–	–	–	–	–	–	–	–	–	
Biological assets	–	–	–	–	–	–	–	–	–	
Land and sub-soil assets	–	–	–	–	–	–	–	–	–	
Software and other intangible assets	–	–	–	–	–	–	–	–	–	
Payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**589 458**	**694 832**	**600 813**	**720 803**	**687 418**	**655 476**	**791 566**	**724 901**	**750 329**	**20.8**

Tables 18 and 19 above show the summary of payments and estimates from 2017/18 to 2020/21 and over the 2021 MTEF period per sub-programme and economic classification. The programme's total expenditure increased from R589.458 million in 2017/18 to a revised estimate of R655.476 million in 2020/21. In 2021/22, the budget increases by 20.8 per cent from R655.476 million to R791.566 million when compared to the 2020/21 revised estimate.

Compensation of employees and goods and services, which make up current payments, are the major cost drivers of the programme. Compensation of employees shows a positive growth of 8.2 per cent from R429.791 million to R464.830 million when compared to the 2020/21 revised estimate due provision of critical vacant funded posts and pay progression.

Goods and services show a positive growth 40.5 per cent from R213.606 million to R300.176 million when compared to the 2020/21 revised estimate due to provision ICT infrastructure replacement project.

Transfers and subsidies show a negative growth of 49.8 per cent from R3.774 million to R1.896 million when compared to the 2020/21 revised estimate due to reduction in the payment of leave gratuities.

Payments for capital assets show a positive growth of 219.6 per cent from R7.716 million to R24.6644 million when compared to the 2020/21 revised estimate due to payment of ICT accounts in relation to maintenance and replacement of computer equipment, SITA data lines, desktops and computers, network for BAS, LOGIS and PERSAL.

1.4 Key Risks

The table below outlines the key risks.

Table 20: Key Risks and mitigating factors

Outcome	Risk	Mitigating factors
• Leadership and governance in the health sector enhanced to improve quality of care Improve financial management • Reduced causes of medical legal claims in facilities by 80% • Robust and effective health information systems to automate business processes and improve evidence based decision making	• Non-payment of Creditors within 30 days • Budget cuts due to shrinking economy and increase in exchange rate for medicines and medico legal claims (not able to budget for) • Inadequate management of revenue • Covid-19 abuse of deviation processes • Inadequate provision of ICT (Information communication technology) services to support service delivery • Perpetration of fraudulent and corrupt activities • Delays in recruitment and inadequate retention of staff	• Monitor and strengthen implementation of Supplier Payment Plan. • Strengthen support visits and training. • Effective implementation and regular reporting on the audit improvement strategy • Effective implementation and regular reporting on the audit improvement plan • Provincial and Decentralised Cost Containment Committee Structures Implementation of the resolutions of the Cost containment meetings • Allocation of resources as far as the budget allows, strengthen fees collection value chain, training and monitoring. • Follow competitive bidding processes • Maintain approval threshold • Filling of vacant funded posts • Monitoring compliance with the Policies, Procedures and SOPs • Influence the prioritisation of the connectivity of Health Institutions with OTP • Continued Improvement of Consequence Management • Enforce compliance with the Policies, Procedures and SOPs • Implementation of the resolutions of the meetings • Conduct continuous staff training • Software to validate patient income levels • HR Delegations register monitored monthly • HR Delegations register monitored monthly • Recruitment time reduced to 3 months • HR Management Information System (HR MIS) management in place • Annual Intake Plan and Annual Intake Plan fully functional and updated annually • Implementation of interventions to address staff attitude • Maintain lower vacancy rate • Strengthening deadline compliance for all reports and plans • Staff are replaced within three months • Registrar Program remains operational • 105 medical students sent to Cuba • The Special Employee Relations Training Unit is fully functional • PILIR management outsourced to Metropolitan and SOMA • Alignment of PERSAL to the organogram
	Transition from the old to the new organogram	• Conduct consultations with the relevant stakeholders • Full implementation of migration plan and its terms of reference- Ensure correct implementation of the organogram • Approval of Micro Organogram
	Lack of 100% Occupational Health and safety compliance with statutory structures (H&S Reps and H&S Committees	• Appointment of statutory structures (16.2 appointments, Safety raps, fire marshal and first aiders) • Ensure compliance with employee wellness framework and reporting tool • Programme marketing • Ensure training and capacitation • Ensure compliance with OHS policies and SOP's • Develop OHS correction plan
	Increased litigation	• Appointment of paralegal secretaries for deployment at districts and the targeted highly litigated facilities • Contracting of a medico legal expert firm to defend the cases in court

Outcome	Risk	Mitigating factors
		• Contracting of the SIU to investigate elements of fraud and corruption relating to theft of files • Strengthen the quality of reports (Adverse events reports) • Implementation of meeting resolutions
	Inadequate contract management	• Filling of vacant funded posts • Communicating renewal of expiring contracts • Implementation of the resolutions of the meetings • Enforce compliance with the Policies, Procedures and SOPs • All contracts must have SLAs • Continuous monitoring and reporting on the existing contracts • Ensure proper management of contractual disputes • Maintain updated contracts and dispute registers



PROGRAMME 2: DISTRICT HEALTH SERVICES (DHS)

PROGRAMME PURPOSE

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

PROGRAMME DESCRIPTION

The District Health Services (DHS) programme is responsible for the management of health services in the six (6) districts and two (2) metropolitans of the Province. The services offered are mainly preventive and minor curative, maternal, child and women's health and nutrition, HIV and AIDS, STI and TB (HAST), prevention and control of chronic diseases, public health / other community-based services such as waste management and coroner services. These are offered through the following service delivery platforms: community Health Clinics, Community Health Centres (CHCs) and District Hospitals

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

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

2.1 SUB – PROGRAMME: DISTRICT MANAGEMENT

SUB-PROGRAMME PURPOSE

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

Table 21: Outcomes, Outputs and Output indicators for the next MTEF for District Management

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
9. Leadership and governance in the health sector enhanced to improve quality of care	Districts Quality Improvement: Monitoring and Response Forums established	9.1. 1 Number of Districts with Quality Improvement; Monitoring and Response Forums formalized and convened quarterly	New Indicator	New Indicator	New Indicator	8	8	8	8	8	8	8	8
6. Quality of health services improved	Supervision of fixed PHC facilities.	6.4.2 % of Fixed PHC Facilities Supervised.	New Indicator	New Indicator	New Indicator	97.8%	65%	65%	65%	65%	65%	70%	70%
		Numerator				754	503	503	503	503	503	542	542
		Denominator				771	775	775	775	775	775	775	775

2.2 SUB-PROGRAMME: CLINICS

Sub- Programme purpose

The sub-programme manages the provision of preventive, promotive, curative and rehabilitative care, including the implementation of priority health programmes through accessible fixed clinics, outreach services (reengineering of PHC services) and mobile services in 8 districts.

Table 22: Outcomes, Outputs and Output indicators for the next MTEF for Clinics

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
6. Quality of health services improved	PHC facilities that qualify as Ideal clinics increased	6.2.1 Ideal clinic status obtained rate	New Indicator	11%	9.1%	11 %	10.9%	-	-	-	10.9%	13.6%	16.3%
		Numerator		80	66	80	80	-	-	-	80	99	119
		Denominator		727	727	730	734	-	-	-	734	734	734
10. Community engagement improved	Clinic committees for all public health facilities established and trained	10.1.1 Percentage of Clinics facilities with functional Clinic committees	New Indicator	New Indicator	New Indicator	12.3%	30%	-	-	-	30%	41%	48%
		Numerator				90	220	-	-	-	220	300	352
		Denominator				730	734	-	-	-	734	734	734
6. Quality of health services improved	Patient experience of care in fixed public health facilities improved	6.1.1 Patient experience of care satisfaction rate	New Indicator	New Indicator	New Indicator	87.2%	90%	-	90%	-	-	90%	90%
		Numerator				563 594	593 654		593 654			593 654	593 654
		Denominator				646 682	659 616		659 616			659 616	659

2.3 SUB – PROGRAMME: COMMUNITY HEALTH CENTERS (CHCS)

Sub – Programme purpose

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

Table 23: Outcomes, Outputs and Output Indicators for the next MTEF for CHCs

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
6. Quality of health services improved	PHC facilities that qualify as Ideal CHC increased	6.2.2 Ideal CHC status obtained rate	New Indicator	9.8%	12%	15%	20%	-	-	-	20%	24%	37%
		Numerator		4	5	6	8				8	10	15
		Denominator		41	41	41	41				41	41	41
10. Community engagement improved	CHC committees for all public health facilities established and trained	10.1.2 Percentage of CHC facilities with functional CHC committees	New Indicator	New Indicator	New Indicator	39%	44%	-	-	-	44%	49%	49%
		Numerator				16	18				18	20	20
		Denominator				41	41				41	41	41
6. Quality of health services improved	Patient experience of care in public health facilities improved	6.1.2 Patient experience of care satisfaction rate	New Indicator	New Indicator	New Indicator	84%	85%	-	85%	-	-	85%	90%
		Numerator				58 876	60 957		60 957			60 957	64 543
		Denominator				70 308	71 714		71 714			71 714	71 714

Explanation of Planned Performance over the Medium-Term Period:

Strengthen Governance, Leadership & Management

Review and monitor implementation of health governance structure policy guidelines. Reconstitution of District Health Council for the health districts and provincial health council to ensure oversight on health planning, implementation, and monitoring. Review PHC facility supervision policy guidelines and align to the Ideal clinic/CHC and Office of Health Standards compliance regulations. Strengthen coherence in planning, implementation, and monitoring of health services through participation in District Development Model.

Improve Quality Of Care

Facilitate establishment and monitoring of district quality improvement teams to enhance progressive achievement on Ideal status for clinic/CHCs'. Provide budget for the ICRM, NHI initiative. Develop a program to capacitate and empower PHC facility managers on operations management and integrated clinical service management. Improve continuity of care through monitoring of the implementation of referral policy to ensure seamless health service delivery platform.

2.4 SUB-PROGRAMME: COMMUNITY BASED SERVICES – DISEASE PREVENTION AND CONTROL (NON-COMMUNICABLE DISEASES)

Sub – Programme purpose

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

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

Table 24: Outcomes, Outputs and 0utput indicators for the next MTEF for Non communicable diseases

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performanc e	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
4. Morbidity and Premature mortality due to Non-Communicable diseases reduced	Clients initiated on treatment and controlled	4.2.1 Hypertension new client 18 years and older detection rate	New Indicator	New Indicator	New Indicator	1.18%	2%	1.2%	1.5%	1.7%	2%	3%	3.5%
		Numerator				52 379	88 361	53 016	66 270	75 106	88 361	132 542	154 632
		Denominator				4 418 057	4 418 057	4 418 057	4 418 057	4 418 057	4 418 057	4 418 057	4 418 057
		4.3.1 Diabetes new client 18 years and older detection rate	New Indicator	New Indicator	New Indicator	2%	3%	2.1%	2.5%	2.8 %	3%	4%	4,5%
		Numerator				72 174	132 542	92 779	110 451	123 706	132 542	176 722	198 812
		Denominator				4 418 057	4 418 057	4 418 057	4 418 057	4 418 057	4 418 057	4 418 057	4 418 057
	Prevention and early detection of mental illness	4.4.1 Mental disorders treatment rate new	New Indicator	New Indicator	New Indicator	0.06%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%
		Numerator				6 162	28 817	7 204	7 204	7 205	7 204	28 817	28 817
		Denominator				9 605 728	9 60 5 728	2 401 432	2 401 432	2 401 432	2 401 432	9 605 728	9 605 728
	Refractive errors corrected	4.5.1 Cataract surgery rate	718/ 1 000 000	633/ 1 000 000	457/1 000 000	151 / 1 000 000	450/1 000 000	120/ 1 000 000	250/ 1 000 000	380/ 1 000 000	450/1 000 000	450/1 000 000	450/1 000 000
		Numerator	4 527	4 112	2 971	1 004	2 990	798	1 662	2 525	2 990	2 990	2 990
		Denominator	6 307 194	6 494 701	6 494 701	6 646 193	6 646 193	6 646 193	6 646 193	6 646 193	6 646 193	6 646 193	6 646 193
6. Quality of health services improved	Outreach campaigns conducted	6.4.3 Number of Districts Conducted outreach campaigns (Thuma Mina).	New Indicator	New Indicator	New Indicator	0	8	2	4	6	8	8	8

Explanation of Planned Performance over the Medium-Term Period:

Non communicable diseases have increased in the country as a result of changing lifestyles (reduced physical activity and increasing consumption of foods high in salt and sugar). Both diabetes and hypertension contribute directly to the development of cardio- and cerebrovascular diseases which are becoming increasingly major causes of death in the Province. Planned interventions to manage this challenge include changing individual behaviour towards better health, screening and early detection, those detected must be initiated on treatment and retained in care. Universal health coverage will be significantly facilitated where health promotion and prevention of illness is able to reduce the numbers of people needing health interventions, and where good quality and person-centred care is provided within an integrated, effective and efficiently functioning health care system. The Province is finalising the development of provincial cancer strategy. The strategy prioritises increasing access to oncology services to cover the Eastern part of the Province.

2.5 SUB-PROGRAMME: PUBLIC HEALTH / OTHER COMMUNITY BASED SERVICES

Sub- programme purpose

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

Table 25: Outcomes, Outputs and Outputs indicators for the next MTEF for Other community base services

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
6. Quality of health services improved	Hospitals comply with health care risk waste norms and standards	6.4.4 Percentage of hospitals complying with health care risk waste norms and standards	New Indicator	New Indicator	New Indicator	54%	65%	65%	65%	65%	65%	70%	70%
		Numerator				48	58	58	58	58	58	62	62
		Denominator				89	89	89	89	89	89	89	89
3. Morbidity and Premature mortality due to Communicable reduced	Prevention and early detection of malaria cases managed	3.4.1 Malaria cases reported	New Indicator	New Indicator	New Indicator	0	0	-	-	-	0	0	0
	Social mobilisation and community engagement Screening of clients Testing of the clients who meet the testing criteria	3.5.3 Covid-19 positivity rate	New indicator	New indicator	New indicator	27%	<20%	<20%	<20%	<20%	<20%	-	-
		Numerator				81 328	195 948	48 987	48 987	48 987	48 987		
		Denominator				301 338	979 739	244 934	244 935	244 935	244 935		
		3.5.4 Covid-19 incidence rate (per 100k)	New indicator	New indicator	New indicator	1 211 per 100k	< 200 per 100 000	< 50 per 100 000	< 50 per 100 000	< 50 per 100 000	< 50 per 100 000	-	-
		Numerator				81 328	13 427	3 356	3 357	3 357	3 357		

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
		Denominator				6 713 457	6 713 457	6 713 457	6 713 457	6 713 457	6 713 457		
		3.5.5. Case Fatality Rate for covid-19	New indicator	New indicator	New indicator	2%	<5 per 100 000	-	-	-	<5 per 100 000	-	-
		N**umerator**			11316	1 647	4				4		
		Denominator				81 328	81 328				81 328		
		3.5.6 Number of people vaccinated	New indicator	New indicator	New indicator	New indicator	3 874 626	968 656	968 657	968 657	968 656		

Explanation of Planned Performance over the Medium-Term Period:

The Department is working hard in curbing the spread of Corona Virus disease. The number of newly reported SARS-Cov-2 cases, active cases and deaths have significantly decreased after the second wave of COVID 19. The department will implement the multi-pronged Covid-19 resurgence plan aimed at curbing the spread of the Covid-19 virus whilst also mitigating against future resurgences, until population herd immunity is achieved through the vaccination program. There is a need to ensure that the currently active cases are isolated, and their contacts are quarantined to minimize the possibility of a resurgence of SARS-Cov-2. Promotion of Non-Pharmaceutical interventions e.g. handwashing, mask wearing, and social distancing is key in curbing the spread of Covid 19

2.6 SUB-PROGRAMME: HIV & AIDS, STI & TB (HAST) CONTROL

Sub – programme purpose

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

Table 26: Outcomes, Outputs and Output indicators for the next MTEF for HAST

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
3. Morbidity and Premature mortality due to Communicable diseases	HIV new cases identified and initiated	3.1.1 HIV test done – sum	1 726 702	1 851 552	2 086 072	1 087 836	1 740 870	435 217	435 218	435 217	435 218	1 740 870	1 740 870
		3.1.2 HIV positive 15-24 years (excl. ANC) rate	New Indicator	New Indicator	New Indicator	2,8%	2 ,9%	2,9%	2,9%	2,9%	2,9%	2,9%	2,9%
		Numerator				9 307	38 365	9 591	9 591	9 592	9 591	38 365	38 365
		Denominator				327 647	1 322 957	330 739	320 739	330 740	330 739	1 322957	1 322957
		3.2.1 ART client naïve start ART during month – sum	New Indicator	New Indicator	New Indicator	37 455	69 314	17 328	17 328	17 329	17 329	50 000	50 000
	People living with HIV retained on care	3.2.2 ART adult [1]remain in care rate	New Indicator	New Indicator	New Indicator	38%	45%	40%	42%	43%	45%	48%	48.4%
		Numerator				518 005	652 664	569 474	597 204	624 935	652 664	735 512	774 718
		Denominator				1 375 785	1 462 655	1 410 669	1 427 992	1 445 327	1 462 655	1 531 969	1 601 283
		3.2.3 ART child remain in care rate	New Indicator	New Indicator	New Indicator	25%	37%	34%	35%	36%	37%	39%	38%
		Numerator				17 425	27 195	23 729	24 884	26 038	27 195	30 627	31 967
		Denominator				68 397	73 801	70 274	71 449	72 625	73 801	78 502	83 204
	Access to condoms	3.2.4 Male condoms distributed	61 256 400	73 672 416	78 817 157	41 302 109	78 400 000	19 600 000	19 600 000	19 600 000	19 600 000	79 968 000	81 567 360
	Male circumcision performed	3.2.5 Medical male circumcision – sum	60 835	47 345	10 722	1 278	11 443	2 677	2 458	2 423	3 885	12 199	12 199
		3.2.6 Traditional male circumcision – sum	New Indicator	New Indicator	New Indicator	10 741	17 931	-	7 110	-	10 821	22 517	22 517

[1] Please note that the final business plan has been used in TROA indicators and submitted to NDoH. The final feedback or report from NDoH will be received by the end of March after we have submitted the 2021/22 APP. The report may have revised targets on TROA that may affect ECDoH 2021/22 APP. The department may have to amend those indicators before the end of first quarter.

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
	People viral load undetected	3.2.7 ART Adult – viral load suppressed rate	New Indicator	New Indicator	New Indicator	88%	90%	90%	90%	90%	90%	90%	90%
		Numerator				20 415	587 398	512 527	537 484	562 442	587 398	595 765	627522
		Denominator				23 198	652 664	569 474	597 204	624 935	652 664	661 550	661 550
		3.2.8 ART Child – viral load suppressed rate	New Indicator	New Indicator	New Indicator	61.5%	90%	90%	90%	90%	90%	90%	90%
		Numerator				375	24 476	21 356	22 396	23 434	24 476	24 476	19 534
		Denominator				611	27 195	23 729	24 884	26 038	27 195	27 195	21 704
	TB/HIV co-infected clients identified and initiated	3.2.9 TB/HIV co-infected client on ART rate	97%	94.5%	74.7%	93.2%	90%	90%	90%	90%	90%	90%	90%
		Numerator	17991	16990	11 668	8 893	14 555	3 638	3 638	3 639	3 639	15 282	15 282
		Denominator	18488	17980	15 616	9 528	16 172	4 043	4 043	4 043	4 043	16 980	16 980
	TB Positive clients initiated and cured	3.3.1 TB investigation done 5 years and older rate	New Indicator	New Indicator	New Indicator	89.4%	90%	90%	90%	90%	90%	90%	90%
		Numerator				154 775	328 094	82 023	82 024	82 024	82 023	34 4499	34 4499
		Denominator				172 979	364 549	91 137	91 137	91 138	91 137	38 2776	38 2776
		3.3.2 DS – TB treatment start 5 years and older rate	109%	101%	98.3%	90.8%	90%	90%	90%	90%	90%	90%	90%
		Numerator	29 956	33 179	31 392	16 527	29 321	7 330	7 330	7 330	7 331	36 129	36 129
		Denominator	27 473	32 864	31 940	18 196	32 579	8 145	8 145	8 145	8 144	40 143	40 143
		3.3.3 TB XDR treatment start rate	New Indicator	New Indicator	New Indicator	100%	90%	90%	90%	90%	90%	92%	92%
		Numerator				77	243	60	61	61	61	253	253
		Denominator				77	271	67	68	68	68	275	275
		3.3.4 All DS -TB client treatment success rate	New Indicator	New Indicator	New Indicator	76.5%	77%	77%	77%	77%	77%	85%	85%
		Numerator				22 597	23 200	5 800	5 800	5 800	5 800	27 446	27 446
		Denominator				29 539	30 129	7 532	7 533	7 532	7 532	32 289	32 289
		3.3.5 TB Rifampicin Resistant/MDR/pre – XDR treatment success rate	New Indicator	New Indicator	New Indicator	63.8%	65%	65%	65%	65%	65%	70%	70%

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
		Numerator				626	943	235	236	236	236	1 050	1 050
		Denominator				981	1 451	362	363	363	363	1 500	1 500
	Lost clients tracked and re-initiated	3.3.6 All DS – TB client lost to follow – up rate	New Indicator	New Indicator	New Indicator	15.2%	10%	10%	10%	10%	10%	9%	8%
		Numerator				4 490	3 013	753	753	753	754	2 906	2 583
		Denominator				29 539	30 129	7 532	7 532	7 532	7 533	32 289	32 289

2.6.1 Explanation of Planned Performance over the Medium-Term Period

Planned interventions for the TB management will focus on finding the missing TB persons. These include people who do not know that they have TB and those that have been tested and not on treatment In finding the missing TB persons, the department will optimize TB screening in health facilities, conduct effective contact screening of TB Index patients, enhance TB detection in vulnerable groups which are HIV positive and pregnant women, continue to improve diagnostic yield by implementing the use of GeneXpert Ultra as well as the use of Lateral Flow Lipoarabinomannan. Finally, close monitoring of the implementation of integrated TB HIV Information system to improve record and data management in the districts and health facilities.

In line with the 90-90-90 target strategies, the planned intervention for HIV/AIDS will focus on HIV testing, find people living with HIV who are not yet confirmed to be living with HIV, ensure those tested positive are initiated on ARV treatment as early as possible through implementation of the same day ART initiation strategy. Those who are initiated on ART are kept on treatment, adhering to a point of not being able to detect the HIV virus in the blood, a state referred to as viral suppression. Viral suppressed patients suggest that patient will be able to live a longer life, thus contributing to increased life expectancy of the people in the Eastern Cape Province. HIV Outcome indicators chosen are in line with the National Strategic Plan and 90-90-90 national targeting strategy that works towards achieving the NDP goal of achieving zero new HIV infection by 2030

2.7 MATERNAL, CHILD AND WOMEN'S HEALTH AND NUTRITION (MCWH&N)

Sub – programme purpose

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

Table 27: Outcomes, Outputs and Output indicators for the next MTEF for MCWH&N

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
1. Maternal, Neonatal, Infant and Child Mortality reduced	Family planning improved	1.1.1 Couple year protection rate	49%	53.7%	57%	30.3%	65%	65%	65%	65%	65%	66%	67%
		Numerator	916 626	1 020 122	1 101 342	591 540	1 233 581	1 233 581	1 233 581	1 233 581	1 233 581	1 252 559	1 271 537
		Denominator	1 796 910	1 897 817	1 931 211	1 952 556	1 897 817	1 897 817	1 897 817	1 897 817	1 897 817	1 897 817	1 897 817
	Early booking for Antenatal clients visit increased	1.1.2 Antenatal 1st visit before 20 weeks rate	65%	61.7%	63.7%	62.8%	65%	65%	65%	65%	65%	67%	68%
		Numerator	70 962	75 710	81 995	57 466	83 621	20 905	20 905	20 906	20 905	86 194	87 481
		Denominator	109 447	122 773	128 648	91 523	128 648	32 162	32 162	32 162	32 162	128 648	128 648
		1.1.3 Antenatal client start on ART rate	86.6%	93.4%	95.3%	88.1%	96%	96%	96%	96%	96%	97%	97%
		Numerator	12 985	12 171	10 536	6 430	10 606	2 651	2 652	2 652	2 651	10 717	10 717
		Denominator	14 997	13 025	11 048	7 110	11 048	2 762	2 762	2 762	2 762	11 048	11 048
	Teenage pregnancy reduced	1.1.4 Delivery in 10 – 19 years in facility rate	15.4%	16.4%	16.7%	17.4%	15%	15%	15%	15%	15%	14%	11%
		Numerator	15474	17167	17 882	13 704	16 059	4 014	4 015	4 015	4 015	14 989	11 777
		Denominator	100759	104827	107 065	78 482	107 065	26 766	26 766	26 767	26 766	107 065	107 065
	Maternal mortality reduced	1.1.5 Maternal mortality in facility ratio	128/100 00	106/100 000	108/100 000	147.9/100 000	120/100 000	-	-	-	120/100 000	110/100 000	100/100 000
		Numerator	138	118	123	127	136				136	125	113
		Denominator	107 595	111 229	113 688	85 854	113 688				113 688	113 688	113 688
	Low birth weight reduced	1.2.1 Live birth under 2500g in facility rate	New Indicator	New Indicator	New Indicator	13.2%	14%	14%	14%	14%	14%	13%	12%
		Numerator				10 697	11309	2827	2827	2828	2827	10 501	9 694
		Denominator				80 780	80 780	20 195	20 195	20 195	20 195	80 780	80 780

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
	Postnatal care coverage increased	1.2.2 Mother postnatal visit within 6 days rate	63%	67.1%	69%	71.2%	73%	73%	73%	73%	73%	75%	78%
		Numerator		70 331	73 886	55 844	76 524	19 131	19 131	19 131	19 131	81 765	81 765
		Denominator		104 827	107 065	78 482	104 827	26 206	26 207	26 207	26 207	104 827	104 827
	Mother to child transmission eliminated	1.3.1 Infant 1st PCR test positive at birth rate	New indicator	New indicator	New indicator	0.5 %	0.4%	0.4%	0.4%	0.4%	0.4%	0.3%	0.2%
		Numerator				122	97	24	24	25	24	72	48
		Denominator				24 207	24 207	6 051	6 052	6 052	6 052	24 207	24 207
		1.3.2 Infant PCR test positive around 10 weeks rate	1.2%	1.0%	0.9%	0.9%	<0.5%	<0.5%	<0.5%	<0.5%	<0.5%	<0.5%	<0.5%
		Numerator	244	218	187	140	109	27	27	28	27	109	109
		Denominator	20 084	21 343	21 748	15 700	21 748	5 437	5 437	5 437	5 437	21 748	21 748
	Child Immunisation Coverage increased	1.3.3 Immunisation under 1year coverage	69%	71.9%	76%	50.5%	80%	80%	80%	80%	80%	80%	80%
		Numerator	111 191	117 114	123 677	81 572	130 210	130 210	130 210	130 210	130 210	130 210	130 210
		Denominator	162 370	162 773	162 762	161 497	162 762	162 762	162 762	162 762	162 762	162 762	162 762
		1.3.4. Measles 2nd dose coverage	66%	64.9%	73.6%	48.2%	80%	80%	80%	80%	80%	80%	80%
		Numerator	109 211	107 475	120 683	78 363	131 051	131 051	131 051	131 051	131 051	131 051	131 051
		Denominator	166 530	165 446	163 814	162 542	163 814	163 814	163 814	163 814	163 814	163 814	163 814
	Child mortality reduced	1.3.5 Death under 5 years against live birth rate	New indicator	New indicator	New indicator	1.8%	<2%	<2%	<2%	<2%	<2%	<2%	<2%
		Numerator				1 438	1 616	404	404	404	404	1 616	1 616
		Denominator				80 780	80 780	20195	20195	20195	20195	80 780	80 780
		1.3.6 Neonatal death in facility rate	14/1000	12.5/1000	12.3/1000	14.5/1 000	10/1000	10/1000	10/1000	10/1000	10/1000	10/1000	10/1000
		Numerator	1 390	1 311	1 312	1 055	1 046	261	262	262	261	1 046	1 046
		Denominator	100 803	104 655	107 079	80 780	104 655	26 164	26 164	26 164	26 164	104 655	104 655
	Micro and macro nutrient malnutrition reduced	1.3.7 Vitamin A dose 12-59-months coverage	53%	54.9%	62.5%	61%	64%	64%	64%	64%	64%	64%	64%
		Numerator		740 339	772 904	399 113	791 378	791 378	791 378	791 378	791 378	791 378	791 378
		Denominator		1 347 170	1 236 528	658 633	1 236 528	1 236 528	1 236 528	1 236 528	1 236 528	1 236 528	1 236 528
		1.3.8 School learner underweight rate	New Indicator	New Indicator	New Indicator	0.28%	7%	7%	7%	7%	7%	6%	6%
		Numerator				60	100	25	25	25	25	90	90
		Denominator				20 513	1 400	350	350	350	350	1 400	1 400

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
		1.3.9 Child under 5 years diarrhoea case fatality rate	3.6%	3.0%	2.8%	3.7%	2.7%	2.7%	2.7%	2.7%	2.7%	2.6%	2.5%
		Numerator		127	159	74	151	28	28	28	2 8	109	104
		Denominator		4 196	5598	2000	5598	1 049	1 049	1 049	1 049	4 196	4 196
		1.3.10 Child under 5 years pneumonia case fatality rate	3.7%	3.2%	3.4%	3.9%	3%	3%	3%	3%	3%	2.8%	2.6%
		Numerator		147	139	71	127	31	32	32	32	127	118
		Denominator		4 564	4 053	1 803	4 564	1 141	1 141	1 141	1 141	4 564	4 564
		1.3.11 Child under 5 years severe acute malnutrition case fatality rate	12%	8.9%	9.9%	8.4%	8%	8%	8%	8%	8%	7%	7%
		Numerator		131	149	41	117	29	29	29	29	102	102
		Denominator		1 464	1 498	487	1 464	366	366	366	366	1 464	1 464
2. Stunting among children reduced	Food supplementation for children increased	2.1.1 Child under 5 years food nutritional supplementation coverage	New Indicator	New Indicator	New Indicator	41.1%	>10%	>10%	>10%	>10%	>10%	>10%	>10%
		Numerator				2 768	82 013	82 013	82 013	82 013	82 013	82 013	82 013
		Denominator				820 136	820 136	820 136	820 136	820 136	820 136	820 136	820 136
4. Morbidity and Premature mortality due to Non-Communicable diseases reduced	Obesity in children managed	4.1.1 School learner overweight rate	New Indicator	New Indicator	New Indicator	0.5%	9%	9%	9%	9%	9%	8.5%	8.5%
		Numerator				172	130	32	33	33	32	120	120
		Denominator				20 513	1 400	350	350	350	350	1 400	1

Explanation of Planned Performance over the Medium-Term Period:

Maternal deaths in facilities have decreased over the past five years but districts with referral hospitals still experience challenges, Deaths happening in the institutions (or in communities) that could have been avoided must become an unacceptable occurrence and their prevention a top priority. Currently over 50% of audited maternal and child institutional deaths have one or more modifiable factors. Monitoring numbers of deaths as the key outcome measure will require the identification and elimination of these avoidable deaths.

Improving access to family planning is key in curbing unwanted pregnancies and risks associated with teenage pregnancies. All pregnant women must access quality antenatal care services and those that are HIV positive must have access to antiretroviral therapy to reduce mother to child transmission. The Province has clustered district hospitals to conduct safe caesarean section to assist with resource sharing, reduction of distances travelled by inter facility obstetric ambulances thus reducing the mortalities. Furthermore, the following interventions are planned for the next five years; Improving and maintaining effective clinical skills levels, through structured skills training and mentoring and proper placement and retention of competent clinical staff, that must be linked to strong clinical accountability and governance, through the District Clinical Specialist Teams as well as the entire clinical management and staff complement.

The province is planning to increase access to neonatal units in so doing reduce overcrowding in the existing units and also strengthen outreach services by neonatologists and neonatal nurses. Primary level and community-based services are intended to impact directly on the demand side of patient care-seeking behaviour in terms of educating mothers or caregivers to make use of preventive and curative services to improve health. There are also important elements of influencing the adoption of healthy practices or behaviours (nutrition in pregnancy, hygiene, handwashing, breastfeeding and infant feeding) and avoiding negative ones (herbal medicines to induce labour, early weaning). There critical partners (for example SASSA, Department of education, Department of social development and NGOs) will provide concrete support to at-risk families when they are involved.

Some districts within the province are experiencing problem of malnutrition. A multi sectoral approach is engaged on led by the Department of social development and other stakeholders to address the underlying causes of food insecurity and poverty

2.8 SUB-PROGRAMME: CORONER SERVICES

Sub-Programme Purpose

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

Table 28: Outcomes, Outputs and Output indicators for the next MTEF for Coroner Services

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
6. Quality of health services improved	All post mortem cases finalised	6.4.5 Percentage of post – mortem performed within 72 hours	94%	95%	96%	98.1%	96%	96%	96%	96%	96%	96%	96%
		Numerator		10 159	9 483	3 092	10 246	10 246	10 246	10 246	10 246	10 246	10 246
		Denominator		10 673	9 860	3 152	10 673	10 673	10 673	10 673	10 673	10 673	10 673

Explanation of Planned Performance over the Medium-Term Period

Coroner services will improve capacity of the staff through recruitment of Forensic Pathologists and training of medical officers and Forensic Pathology Officers. Expansion of forensic pathology service sites across the Province (new dissecting facility at Ngcobo, opening of holding facilities at Dutywa, Port Alfred, Thafalofefe, Molteno) with procurement of disaster truck per region, additional body collecting vehicles and Installation of Lodox Machines

Infrastructure improvements include redesigning and reconstruction of frontline offices at all dissecting facilities, construction of visitor's holding/waiting rooms and counselling facilities and installation of technological and innovative features to control body movement and prevent body loss. The forensic pathology suites need to increase security and install maximum-security features . Forensic officers deal with major trauma and provision of trauma debriefing services and counsel is a priority.

The challenge of unclaimed and unidentified bodies Promotion of cooperative interaction between stakeholder on management of unclaimed and unidentified bodies as well as to facilitate paupers burial process.

2.9 SUB PROGRAMME: DISTRICT HOSPITALS

Sub-Programme Purpose

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

Table 29: Outcomes, Outputs and Output indicators for the next MTEF for District Hospital

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
6. Quality of health services improved	Hospitals that qualify as Ideal hospitals increased	6.2.3 Ideal Hospital status obtained rate	New Indicator	New Indicator	New Indicator	31%	40%	-	-	-	40%	49%	49%
		Numerator				20	26				26	32	32
		Denominator				65	65				65	65	65
		6.1.3 Patient experience of care satisfaction rate	New Indicator	New Indicator	New Indicator	81.4%	63%	-	63%	-	-	65%	65%
		Numerator				81389	64 257		64 257			66 297	66 297
		Denominator				99 996	101 996		101 996			101 996	101 996
	Patient Safety Improved	6.3.1 Severity assessment code 1 incident reported within 24 hours rate	New Indicator	New Indicator	New Indicator	51.4%	61%	61%	61%	61%	61%	65%	65%
		Numerator				36	44	11	11	11	11	48	48
		Denominator				70	72	18	18	18	18	74	74
10. Community engagement improved	Hospital boards for all public health facilities established and trained	10.2.1 Percentage of Hospitals with functional hospital boards	New Indicator	New Indicator	New Indicator	1.5%	49%	49%	49%	49%	49%	49%	49%
		Numerator				1	32	32	32	32	32	32	32
		Denominator				65	65	65	65	65	65	65	65
6. Quality of health services improved	Hospital efficiencies improved	6.7.1 Average Length of Stay	4.9 days	4.7 days	4.6 days	4.3 days	4.5 days	4.5 days	4.5 days	4.5 days	4.5 days	4.5 days	4.5 days
		6.7.6 Inpatient Bed Utilisation Rates	55%	55%	54.5%	41.6%	60%	60%	60%	60%	60%	62%	62%
		Numerator	1 211 494	1 218 528	1 201 911	691 272	1 327 942	331 985	331 986	331 986	331 985	1 372 208	1 372 208
		Denominator	2 213 238	2 221 268	2 207 032	1 660 497	2 213 238	553 309	553 310	553 310	553 309	2 213 238	2 213 238
		6.7.11 Expenditure per PDE	R2,528	R2,680.2	R3,168.16	R5,898.60	R3,191	R3,191	R3,191	R3,191	R3,191	R3,191	R3,191

Explanation of Planned Performance over the Medium – Term Period

The department is in the process of implementing service delivery optimisation with special focus to the district hospitals . Currently the province has a high number of hospitals with poor efficiencies and thinly spread resources with direct referral into the expensive higher-level facilities . Long distance travelled to seek appropriate services in an environment of insufficient Emergency Medical response with shortages of qualified life support expertise in transit increasing the possibility of poor outcomes and resultant litigations. Low performance due to this thin spreading with resultant low Bed Utilisation rate and Caesarean section rate within low population serviced areas again perpetuating inefficiencies

2.10 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

Table 30: Summary of payments and estimates: P2 – District Health Services

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2020/21
R thousand	2017/18	2018/19	2019/20		2020/21		2021/22	2022/23	2023/24	
1. District Management	881 476	973 747	1 012 920	996 670	1 115 838	1 257 469	1 466 403	931 347	957 656	16.6
2. Community Health Clinics	2 420 417	2 636 946	2 862 890	2 562 791	2 446 557	2 871 315	2 450 891	2 449 345	2 512 438	(14.6)
3. Community Health Centres	948 991	1 135 530	1 254 401	1 374 293	1 254 451	1 259 946	1 294 525	1 261 676	1 300 980	2.7
4. Community Based Services	524 720	569 552	562 012	685 004	623 143	491 704	574 143	540 912	551 641	16.8
5. Other Community Services	81 360	65 016	72 687	67 360	66 638	66 372	82 278	68 599	70 438	24.0
6. Hiv/Aids	2 045 769	2 089 536	2 398 092	2 667 462	3 157 298	3 305 300	3 062 783	3 093 381	3 026 917	(7.3)
7. Nutrition	24 872	32 333	27 281	39 546	53 230	43 366	39 779	40 535	40 067	(8.3)
8. Coroner Services	100 885	109 401	117 315	117 665	112 050	126 518	108 847	108 248	110 984	(14.0)
9. District Hospitals	4 314 006	5 167 739	5 332 442	5 165 413	5 317 434	5 802 357	5 166 243	4 871 461	5 053 874	(11.0)
Total payments and estimates	**11 342 496**	**12 779 800**	**13 640 040**	**13 676 205**	**14 146 639**	**15 224 347**	**14 245 892**	**13 365 504**	**13 624 995**	**(6.4)**

Table 31: Summary of payments and estimates by economic classification: P2 – District Health Services

R thousand	Outcome 2017/18	2018/19	2019/20	Main appropriation	Adjusted appropriation 2020/21	Revised estimate	Medium-term estimates 2021/22	2022/23	2023/24	% change from 2020/21
Current payments	**11 038 627**	**12 098 714**	**13 082 349**	**13 432 794**	**13 884 433**	**14 602 508**	**14 049 030**	**13 168 575**	**13 431 991**	**(3.8)**
Compensation of employees	7 809 396	8 579 777	9 328 322	9 902 952	9 693 772	10 061 996	9 441 488	9 300 792	9 673 621	(6.2)
Goods and services	3 227 910	3 513 624	3 745 787	3 529 842	4 190 661	4 540 512	4 607 542	3 867 783	3 758 370	1.5
Interest and rent on land	1 321	5 313	8 240	–	–	–	–	–	–	
Transfers and subsidies to:	**182 610**	**568 015**	**462 964**	**56 989**	**78 882**	**459 120**	**47 725**	**68 575**	**71 592**	**(89.6)**
Provinces and municipalities	313	3 091	–	–	–	–	–	–	–	
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–	
Higher education institutions	–	–	–	–	–	–	–	–	–	
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–	
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–	
Non-profit institutions	7 278	17 566	9 060	8 495	8 495	8 495	-4 336	15 010	15 670	(151.0)
Households	175 019	547 358	453 904	48 494	70 387	450 625	52 061	53 565	55 922	(88.4)
Payments for capital assets	**121 259**	**100 733**	**94 727**	**186 422**	**183 324**	**162 719**	**149 137**	**128 354**	**121 412**	**(8.3)**
Buildings and other fixed structures	–	–	–	–	–	–	900	–	–	
Machinery and equipment	121 259	100 733	94 727	186 422	183 324	162 719	148 237	128 354	121 412	(8.9)
Heritage Assets	–	–	–	–	–	–	–	–	–	
Specialised military assets	–	–	–	–	–	–	–	–	–	
Biological assets	–	–	–	–	–	–	–	–	–	
Land and sub-soil assets	–	–	–	–	–	–	–	–	–	
Software and other intangible assets	–	–	–	–	–	–	–	–	–	
Payments for financial assets	**–**	**12 338**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**11 342 496**	**12 779 800**	**13 640 040**	**13 676 205**	**14 146 639**	**15 224 347**	**14 245 892**	**13 365 504**	**13 624 995**	**(6.4)**

Tables 30 and 31 above show the summary of payments and estimates for District Health Services per sub-programme and economic classification. The programme's total expenditure increased from R11.342 billion in 2017/18 to a revised estimate of R15.224 billion in 2020/21. In 2021/22, the budget decreases by 6.4 per cent from R15.224 billion to R14.245 billion when compared to the 2020/21 revised estimate.

Compensation of employees and goods and services, which make up current payments, are the major cost drivers of the programme. Compensation of employees shows a negative growth of 6.2 per cent from R10.061 billion to R9.441 billion when compared to the 2020/21 revised estimate due to a high revised estimate as a result of a 2020/21 special additional allocation to deal with the COVID-19 pandemic and subsequent medium-term baseline reductions as a result of wage freeze reductions and fiscal consolidation. Goods and services shows a positive growth 1.5

per cent from R4.540 billion to R4.607 billion when compared to the 2020/21 revised estimate due reprioritisation efforts for cost containment measures and implementation of national fiscal consolidation which resulted in baseline reductions.

Transfers and subsidies show a negative growth of 89.6 per cent from R459.120 million to R47.725 million when compared to the 2020/21 revised estimate due to high revised estimates in 2020/21 as a result of payment of medico legal claims.

Payments for capital assets show a negative growth of 8.3 per cent from R162.719 million to R149.137 million when compared to the 2020/21 revised estimate due to high revised estimates in the current year as a result of once off COVID-19 additional funding on infrastructure.

2.11 KEY RISKS

The table below outlines the key risks.

Table 32: Key Risks and mitigating factors

Outcome	Risk	Mitigating factors
• Quality of health services improved. • Community engagement improved. • Morbidity and Premature mortality due to Non-Communicable diseases reduced. • Maternal, Neonatal, Infant and Child Mortality reduced • Stunting among children reduced	• High mortality of Health Personnel due to Covid 19 • Frontline and Workforce high exposure to COVID-19 • Adverse effect of Covid 19 on the mental and physical wellbeing of staff • Inadequate Testing / Covid-19 Screening • Non adherence to the phased vaccination roll out • Inadequate supply of oxygen for Covid 19 patients	• Filing of funded Strategic posts • Strengthened Infection Prevention and Control • Ongoing PPE stock control and procurement in place controlled by Business Continuity Team • Improved IPC initiatives- Ensure implementation of annual recruitment plan • Conduct Monitoring support visits quarterly • Improved communication of available psychosocial support services (Virtual and Physical) • Procure more testing consumables and kits • More patients to be tested in line with the testing strategy. • Communication guidelines on phased vaccination roll out • Inadequate supply of oxygen for Covid 19 patients





PROGRAMME 3

EMERGENCY MEDICAL SERVICES (EMS)



PROGRAMME 3: EMERGENCY MEDICAL SERVICES (EMS)

3.1 PROGRAMME PURPOSE

To render quality and efficient prehospital emergency services, inter-hospital transfer and planned patient transport services. Based on the current structure, Emergency Medical Services has two sub-programs.

Programme 3.1: Emergency Medical Transport: The sub-program is solely for emergency incidents (prehospital care and interhospital transfer) and has components that underpin its functionality:

- Communication Services: Call taking and dispatching of emergency calls.
- Road ambulances and aeromedical services: modes of patient transport to definitive care
- Specialised services: Medical rescue and disaster management

Programme 3.2: Planned Patient Transport: The sub-program deals with non-emergency transport of booked outpatients to referral centre and patients referred to step-down facilities.

- This includes all EDHOH outpatient referral pathways: inter-district, intra-district and inter-provincial referrals.
- Pre booking is essential to map out drop off and pick up points for outpatients.

SUB-PROGRAMME: EMERGENCY MEDICAL TRANSPORT

Sub-Programme Priorities

- Increase number of licenced ambulances and bases in accordance with EMS regulations (Ideal EMS status)
- Rollout of computer aided dispatch system and monitoring of call escalation rate
- Establishment of governance structures within EMS (EMS board and district ITU)
- Management development programs for all levels of management within EMS
- Establish multi sectoral committee for disaster management.
- Full implementation of record management systems

SUB-PROGRAMME: PLANNED PATIENT TRANSPORT

Sub-Programme Priorities

- Rollout of electronic booking system, integrated with hospital booking and referral system
- Deployment or appointment of dedicated planned patient transport staff

Table 33: Outcomes, Outputs and Output indicators for the next MTEF for EMS

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
6. Quality of health services improved	EMS P1 rural and urban response time	6.5.1 EMS P1 urban response under 30 minutes rate	New indicator	New Indicator	New Indicator	45.1%	50%	50%	50%	50%	50%	70%	70%
		Numerator				6 628	20 136	5 034	5 034	5 034	5 034	28 190	28 190
		Denominator				14 685	40 272	10 068	10 068	10 068	10 068	40272	40272
		6.5.2 EMS P1 rural response under 60 minutes rate	New indicator	New Indicator	New Indicator	63.2%	65%	65%	65%	65%	65%	80%	80%
		Numerator				18 178	26 176	6 544	6 544	6 544	6 544	32 218	32 218
		Denominator				28 776	40 272	10 068	10 068	10 068	10 068	40272	40272
	Efficient transfer of patients between facilities	6.5.3 EMS Inter facility transfer rate	30%	33.3%	35%	25%	35%	35%	35%	35%	35%	30%	25%
		Numerator		154 911	168 060	116 450	163 031	40 758	40 758	40 758	40 757	139 741	116 451
		Denominator		465804	478 198	465 804	465 805	116 451	116 451	116 452	116 451	465 805	465 805
	Functional PTVs availability	6.5.4 Number of Patients transported on the PTV services	New Indicator	New Indicator	New Indicator	5 259	10 000	2 500	2 500	2 500	2 500	11 250	12 500

Explanation of planned performance over the Medium-Term period

Improving response times for priority 1 calls in both rural and urban district has a directly contribution to the provincial goal of improving quality of health. The ability of the emergency medical service crew to reach a scene within the 30 to 60 minutes can prevent the development of medical complication and reduced quality of life in certain instances. The priority 1 calls are mainly those of maternal and neonatal services, and some of the cardiac related incidences. The ability to respond to these incidents by qualified personnel, in appropriately equipped vehicles will ensure that the quality of health care provided to the community and residents is of the highest standard.

The programme will continue to prioritize improving response times in the community for priority 1 emergency calls. This will be achieved through the following interventions:

- Rationalize the location of EMS stations closer to health facilities and communities serviced
- Establishing dedicated inter-facility transport attached to the 28 most litigated health facilities for the transfer of maternal and other priority cases
- Rollout of the electronic call taking and vehicle dispatch system
- Integrating the EMS component into the district health to allow for share corporate services such as finance, human resource management and supply chain systems.
- Compliance with EMS regulations in terms of the state of the EMS bases, skills of personnel and infrastructure.
- Increase the number of paramedics with priority given to the rural districts.

The availability of appropriately conFigureured vehicles is important in the delivery of quality emergency medical services. The department of transport is responsible for all EMS vehicle under a service level agreement between the department of health and the department of transport. The department of health is leasing the vehicles from the department of health. The department will work closely with the department of transport to ensure speedy repairs and maintenance of emergency medical service vehicles. The department will also work to ensure that there is efficient management of EMS fleet to ensure that all vehicles are repaired on time and the quality of work is monitored.

Outputs, indicators and targets contribute towards the achievement of the P-MTSF as well as addressing challenges and opportunities that have been identified in the updated situational analysis.

3.2 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

Table 34: Summary of payments and estimates: P3 – Emergency Medical Services

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2020/21
R thousand	2017/18	2018/19	2019/20		2020/21		2021/22	2022/23	2023/24	
1. Emergency Transport	1 041 871	1 031 914	1 034 403	1 310 911	1 219 857	1 089 259	1 194 110	1 188 592	1 212 244	9.6
2. Planned Patient Transport	237 216	241 179	243 358	120 973	120 663	246 135	110 738	110 800	111 381	(55.0)
Total payments and estimates	**1 279 087**	**1 273 093**	**1 277 761**	**1 431 884**	**1 340 520**	**1 335 394**	**1 304 848**	**1 299 392**	**1 323 625**	**(2.3)**

Table 35: Summary of payments and estimates by economic classification: P3 – Emergency Medical Services

R thousand	Outcome 2017/18	Outcome 2018/19	Outcome 2019/20	Main appropriation 2020/21	Adjusted appropriation 2020/21	Revised estimate 2020/21	Medium-term estimates 2021/22	Medium-term estimates 2022/23	Medium-term estimates 2023/24	% change from 2020/21
Current payments	**1 115 425**	**1 171 266**	**1 174 650**	**1 281 279**	**1 189 915**	**1 198 901**	**1 173 936**	**1 167 492**	**1 199 444**	**(2.1)**
Compensation of employees	933 626	971 943	913 266	984 595	902 231	1 002 541	877 529	878 545	914 455	(12.5)
Goods and services	181 799	199 323	261 384	296 684	287 684	196 360	296 407	288 947	284 989	51.0
Interest and rent on land	–	–	–	–	–	–	–	–	–	
Transfers and subsidies to:	**2 100**	**3 778**	**3 128**	**3 594**	**3 594**	**3 387**	**3 792**	**3 970**	**4 145**	**12.0**
Provinces and municipalities	–	–	–	–	–	–	–	–	–	
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–	
Higher education institutions	–	–	–	–	–	–	–	–	–	
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–	
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–	
Non-profit institutions	–	–	–	–	–	–	–	–	–	
Households	2 100	3 778	3 128	3 594	3 594	3 387	3 792	3 970	4 145	12.0
Payments for capital assets	**161 562**	**98 049**	**99 983**	**147 011**	**147 011**	**133 106**	**127 120**	**127 930**	**120 036**	**(4.5)**
Buildings and other fixed structures	–	–	–	–	–	–	–	–	–	
Machinery and equipment	161 562	98 049	99 983	147 011	147 011	133 106	127 120	127 930	120 036	(4.5)
Heritage Assets	–	–	–	–	–	–	–	–	–	
Specialised military assets	–	–	–	–	–	–	–	–	–	
Biological assets	–	–	–	–	–	–	–	–	–	
Land and sub-soil assets	–	–	–	–	–	–	–	–	–	
Software and other intangible assets	–	–	–	–	–	–	–	–	–	
Payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**1 279 087**	**1 273 093**	**1 277 761**	**1 431 884**	**1 340 520**	**1 335 394**	**1 304 848**	**1 299 392**	**1 323 625**	**(2.3)**

Tables 34 and 35 above show the summary of payments and estimates for Emergency Medical Services per sub-programme and economic classification. The programme's total expenditure increased from R1.279 billion in 2017/18 to a revised estimate of R1.335 billion in 2020/21. In 2021/22, the budget decreased by 2.3 per cent from R1.335 billion to R1.303 billion when compared to the 2020/21 revised estimate.

Compensation of employees shows a negative growth of 12.5 per cent from R1.002 billion to R877.529 million when compared to the 2020/21 revised estimate due to the high revised estimate as a result of the once off backlog overtime payments made in that year.

Goods and services show a positive growth 51.0 per cent from R196.360 million to R296.407 million when compared to the 2020/21 revised estimate due to the reprioritisation of funds to fleet management from finance lease under payments of capital assets.

Transfers and subsidies show a positive growth of 12 per cent from R3.387 million to R3.792 million when compared to the 2020/21 revised estimate due to provision for payment of leave gratuities. Payments for capital assets show a negative growth of 4.5 per cent from R133.106 million to R127.120 million when compared to the 2020/21 revised estimate due to reprioritisation of funds to fleet management from finance lease under payments of capital assets to alleviate current pressures under goods and services.

3.3 KEY RISKS

The table below outlines the key risks.

Table 36: Key Risks and mitigating factors

Outcome	Risk	Mitigating factors
• Quality of health services improved	• Inadequate EMS Services • Inadequate EMS response to Covid 19 patients (Transportation to Quarantine, Isolation and Hospitalisation facilities)	• Filling of funded Strategic posts • Introduction and training of personnel • Ensure the implementation of the electronic call taking bad dispatch system • Increase the number of functional vehicles suitable for the terrain • Integrated Quarterly Management and human capital (supervision, labour relations, development) • Establish a formal memorandum of understanding between DOH/EMS and provincial SAPS • Integration of EMS corporate service functions into District Management • Continuous training of EMS personnel • Additional dedicated fleet for Covid 19 patients



PROGRAMME 4

PROVINCIAL HOSPITAL SERVICES

PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES (REGIONAL AND SPECIALISED)

4.1 PROGRAMME PURPOSE

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

Sub-Programme 4.1

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

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

Sub-Programme 4.2

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

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

Sub-Programme 4.3

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

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

Table 37: Outcomes, Outputs and Output indicators for the next MTEF for Regional Hospital

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2022/23
								Q1	Q2	Q3	Q4		
6. Quality of health services improved	Hospitals that qualify as Ideal hospitals increased	6.2.4 Ideal Hospital status obtained rate	New Indicator	New Indicator	New Indicator	20%	40%	-	-	-	40%	40%	40%
		Numerator				1	2				2	2	2
		Denominator				5	5				5	5	5
	Patient satisfaction surveys conducted	6.1.4 Patient experience of care satisfaction rate	New Indicator	New Indicator	New Indicator	69.8%	60%	-	60%	-	-	63%	65%
		Numerator				25 019	21 655		21 655			22 738	23 460
		Denominator				35 384	36 092		36 092			36 092	36 092
	Patient Safety Incident (PSI) case closure rate	6.3.2 Severity assessment code1 incident reported within 24 hours rate	New Indicator	New Indicator	New Indicator	94.2%	80%	80%	80%	80%	80%	80%	80%
		Numerator				146	128	32	32	32	32	129	129
		Denominator				155	160	40	40	40	40	161	161
10. Community engagement improved	Hospitals with functional hospital boards established	10.2.2 Percentage of Hospitals with functional hospital boards	New Indicator	New Indicator	New Indicator	100%	100%	100%	100%	100%	100%	100%	100%
		Numerator				5	5	5	5	5	5	5	5
		Denominator				5	5	5	5	5	5	5	5
6. Quality of health services improved	Efficiency indicators improved	6.7.2 Average length of stay	5.8 days	5.8 days	5.8 days	5.6 days	5.5 days	5.5 days	5.5 days	5.5 days	5.5 days	5.5 days	5.5 days
		6.7.7 Inpatient bed utilisation rates	68%	71.3%	73%	60%	75%	75%	75%	75%	75%	75%	75%
		Numerator	528 803	405 654	557 674	345 157	581 371	581 371	581 371	581 371	581 371	581 371	581 371
		Denominator	775 162	569 158	769 261	575 851	775 162	775 162	775 162	775 162	775 162	775 162	775 162
		6.7.12 Expenditure per PDE	R3,349	R3,445	R3,759	R5,359.5	R3,500	R3,500	R3,500	R3,500	R3,500	R3,500	R3,500

4.2 SUB – PROGRAMME: SPECIALISED TB HOSPITALS

Table 38: Outcomes, Outputs and Output indicators for the next MTEF for Specialised TB Hospital

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2022/23
								Q1	Q2	Q3	Q4		
6. Quality of health services improved	Hospitals that qualify as Ideal hospitals increased	6.2.5 Ideal Hospital status obtained rate	New Indicator	New Indicator	New Indicator	20%	30%	-	-	-	30%	30%	40%
		Numerator				2	3				3	3	4
		Denominator				10	10				10	10	10
	Percentage of patients satisfied with their experience of care in public health facilities	6.1.5 Patient experience of care satisfaction rate	New Indicator	New Indicator	New Indicator	85%	60%	-	60%	-	-	63%	65%
		Numerator				5 563	4 004		4 004			4 205	4 338
		Denominator				6 543	6 674		6 674			6 674	6 674
	Patient Safety Incident (PSI) case closure rate	6.3.3 Severity assessment code 1 incident reported within 24 hours rate	New Indicator	New Indicator	New Indicator	100%	80%	80%	80%	80%	80%	80%	80%
		Numerator				2	4	4	4	4	4	4	4
		Denominator				2	5	5	5	5	5	5	5
10. Community engagement improved	Hospitals with functional hospital boards established	10.2.3 Percentage of Hospitals with functional hospital boards	New Indicator	New Indicator	New Indicator	20%	100%	100%	100%	100%	100%	100%	100%
		Numerator				2	10	10	10	10	10	10	10
		Denominator				10	10	10	10	10	10	10	10
Quality of health services improved	Hospital efficiencies improved	6.7.3 Average length of stay	77 days	7.3 days	80 days	44 days	60 days	60 days	60 days	60 days	60 days	60 days	60 days
		6.7.8 Inpatient bed utilisation rates	50%	45.6%	60%	24.7%	60%	60%	60%	60%	60%	60%	60%
		Numerator	262 129	177 526	313 678	86 395	246 365	246 365	246 365	246 365	246 365	246 365	246 365
		Denominator	522 798	389 345	522 798	349 343	410 609	410 609	410 609	410 609	410 609	410 609	410 609
		6.7.13 Expenditure per PDE	R1,626	R 1,722	R1,758	R3,747.4	R1,800	R1,800	R1,800	R1,800	R1,800	R1,800	R1,800

4.3 SUB – PROGRAMME: SPECIALISED PSYCHIATRIC HOSPITALS

Sub- Programme Priorities

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

Table 39: Outcomes, Outputs and Output indicators for the next MTEF for Specialised Psychiatric Hospitals

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2022/23
								Q1	Q2	Q3	Q4		
6. Quality of health services improved	Hospitals that qualify as Ideal hospitals increased	6.2.6 Ideal Hospital status obtained rate	New Indicator	New Indicator	New Indicator	33%	33 %	-	-	-	33%	33%	66%
		Numerator				1	1				1	1	2
		Denominator				3	3				3	3	3
	Patients satisfied with experience of care in public health facilities	6.1.6 Patient experience of care satisfaction rate	New Indicator	New Indicator	New Indicator	81%	81%	-	81%	-	-	81%	81%
		Numerator				3 897	3 897		3 897			3 897	3 897
		Denominator				4 813	4 813		4 813			4 813	4 813
	Patient Safety Incident (PSI) case closure rate	6.3.4 Severity assessment code 1 incident reported within 24 hours rate	New Indicator	New Indicator	New Indicator	100%	80%	80%	80%	80%	80%	80%	80%
		Numerator				2	4	4	4	4	4	4	4
		Denominator				2	5	5	5	5	5	5	5
10 Community engagement improved	Hospitals with functional hospital boards established	10.2.4 Percentage of Hospitals with functional hospital boards	New Indicator	New Indicator	New Indicator	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%	66.6%
		Numerator				2	2	2	2	2	2	2	2
		Denominator				3	3	3	3	3	3	3	3
4. Morbidity and Premature mortality due to Non-Communicable diseases reduced	Functional mental health review boards	4.4.2 District specialist mental health teams established	New Indicator	New Indicator	New Indicator	5	5	-	-	-	5	6	8

4.5 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

Table 40: Summary of payments and estimates: Programme 4 – Provincial Hospital Services

R thousand	Outcome 2017/18	Outcome 2018/19	Outcome 2019/20	Main appropriation 2020/21	Adjusted appropriation 2020/21	Revised estimate 2020/21	Medium-term estimates 2021/22	Medium-term estimates 2022/23	Medium-term estimates 2023/24	% change from 2020/21
1. General (Regional) Hospitals	2 685 261	2 954 759	3 152 971	2 543 333	2 529 297	3 041 499	2 368 889	2 310 596	2 385 003	(22.1)
2. Tb Hospitals	303 673	349 112	310 434	437 825	412 576	382 352	416 222	420 781	434 550	8.9
3. Psychiatric Mental Hospitals	499 427	531 680	562 994	575 905	595 452	552 295	554 289	535 409	547 290	0.4
Total payments and estimates	**3 488 361**	**3 835 551**	**4 026 399**	**3 557 063**	**3 537 325**	**3 976 146**	**3 339 400**	**3 266 786**	**3 366 843**	**(16.0)**

Table 41: Summary of payments and estimates by economic classification: P4 – Provincial Hospital Services

R thousand	Outcome 2017/18	Outcome 2018/19	Outcome 2019/20	Main appropriation 2020/21	Adjusted appropriation 2020/21	Revised estimate 2020/21	Medium-term estimates 2021/22	Medium-term estimates 2022/23	Medium-term estimates 2023/24	% change from 2020/21
Current payments	**3 209 342**	**3 536 052**	**3 726 914**	**3 530 051**	**3 513 133**	**3 639 181**	**3 312 450**	**3 239 103**	**3 339 333**	**(9.0)**
Compensation of employees	2 511 845	2 762 095	2 844 562	2 801 646	2 651 465	2 908 564	2 608 131	2 562 633	2 667 377	(10.3)
Goods and services	695 326	770 873	869 098	728 405	861 668	730 617	704 319	676 470	671 956	(3.6)
Interest and rent on land	2 171	3 084	13 254	–	–	–	–	–	–	
Transfers and subsidies to:	**266 501**	**275 990**	**286 900**	**13 141**	**13 141**	**326 262**	**13 864**	**14 515**	**15 154**	**(95.8)**
Provinces and municipalities	–	–	–	–	–	–	–	–	–	
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–	
Higher education institutions	–	–	–	–	–	–	–	–	–	
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–	
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–	
Non-profit institutions	–	–	–	–	–	–	–	–	–	
Households	266 501	275 990	286 900	13 141	13 141	326 262	13 864	14 515	15 154	(95.8)
Payments for capital assets	**12 518**	**23 509**	**12 585**	**13 871**	**11 051**	**10 703**	**13 086**	**13 168**	**12 356**	**22.3**
Buildings and other fixed structures	–	486	–	–	–	–	–	–	–	
Machinery and equipment	12 518	23 023	12 585	13 871	11 051	10 703	13 086	13 168	12 356	22.3
Heritage Assets	–	–	–	–	–	–	–	–	–	
Specialised military assets	–	–	–	–	–	–	–	–	–	
Biological assets	–	–	–	–	–	–	–	–	–	
Land and sub-soil assets	–	–	–	–	–	–	–	–	–	
Software and other intangible assets	–	–	–	–	–	–	–	–	–	
Payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**3 488 361**	**3 835 551**	**4 026 399**	**3 557 063**	**3 537 325**	**3 976 146**	**3 339 400**	**3 266 786**	**3 366 843**	**(16.0)**

Tables 40 and 41 above shows the summary of payments and estimates for Provincial Hospital Services per sub-programme and economic classification. The programme's total expenditure decreased from R3.488 billion in 2017/18 to a revised estimate of R3.976 billion in 2020/21. In 2021/22, the budget decreases by 16.0 per cent from R3.976 billion to R3.339 billion when compared to the 2020/21 revised estimate.

Compensation of employees shows a negative growth of 10.3 per cent from R2.908 billion to R2.608 billion when compared to the 2020/21 revised estimate due to 2020 wage freeze reductions and fiscal consolidation reductions.

Goods and services show a negative growth of 3.6 per cent from R730.617 million to R704.319 million when compared to the 2020/21 revised estimate due to baseline reductions and fiscal consolidation reductions.

Transfers and subsidies show a negative growth of 95.8 per cent from R326.262 million to R13.864 million when compared to the 2020/21 *revised estimate due* to a high revised estimate as a result of payment of Medico Legal Claims.

Payments for capital assets show a positive growth of 22.3 per cent from R10.703 million to R13.086 million when compared to the 2020/21 revised estimate, due to reprioritisation to fund procurement of medical equipment in Regional Hospitals.

4.6 KEY RISKS

The table below outlines the key risks.

Table 42: Key Risks and mitigating factors

Outcome	Risk	Mitigating factors
• Quality of health services improved • Community engagement improved	• Non adherence to policies and guidelines on referrals and services between Primary, Secondary and Tertiary Services	• Ensure timeous filling of critical and replacement posts • Enforcement of Policies, Procedures and SOPs • Implementation of the meeting resolutions • Strengthen the quality of reports • Procurement of appropriate healthcare technology as per APP



PROGRAMME 5

CENTRAL & TERTIARY HOSPITALS

PROGRAMME 5: CENTRAL & TERTIARY HOSPITALS

5.1 SUB-PROGRAMME PURPOSE FOR CENTRAL HOSPITALS

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

SUB-PROGRAMMES

Central Hospital: Nelson Mandela Academic Hospital

Table 43: Outcomes, Outputs and Output indicators for the next MTEF for Central Hospital

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2022/23
								Q1	Q2	Q3	Q4		
6. Quality of health services improved	Hospitals that qualify as Ideal Hospitals increased	6.2.7 Ideal Hospital status obtained rate	New Indicator	New Indicator	New Indicator	100%	100%	-	-	-	100%	100%	100%
		Numerator				1	1				1	1	1
		Denominator				1	1				1	1	1
	Percentage of patients satisfied with their experience of care in public health facilities	6.1.7 Patient experience of care satisfaction rate	New Indicator	New Indicator	New Indicator	73%	60%	-	60%	-	-	63%	65%
		Numerator				74	62		62			65	67
		Denominator				101	103		103			103	103
	Patient Safety improved	6.3.5 Severity assessment code 1 incident reported within 24 hours rate	New Indicator	New Indicator	New Indicator	33.3%	78%	78%	78%	78%	78%	78%	78%
		Numerator				5	14	14	14	14	14	14	14
		Denominator				15	18	18	18	18	18	18	18
10 Community engagement improved	Percentage of Hospitals with functional hospital boards	10.2.5 Percentage of Hospitals with functional hospital boards	New Indicator	New Indicator	New Indicator	100%	100%	100%	100%	100%	100%	100%	100%
		Numerator				1	1	1	1	1	1	1	1
		Denominator				1	1	1	1	1	1	1	1
6. Quality of health services improved	Hospital efficiencies improved	6.7.4 Average length of stay	*9 days*	*8.9days*	*8days*	*8days*	*8days*	*8days*	*8days*	*8days*	*8days*	*8days*	*8days*
		6.7.9 Inpatient bed utilisation rates	*79%*	*83%*	*82.4%*	*64%*	*83%*	*83%*	*83%*	*83%*	*83%*	*84%*	*84%*
		Numerator	218 522	172 723	228 129	132 111	229 661	229 661	229 661	229 661	229 661	232 428	232 428
		Denominator	274 145	207 525	276 700	207 525	276 700	276 700	276 700	276 700	276 700	276 700	276 700
		6.7.14 Expenditure per PDE	R 3,472	R4,147	R4,677	R7,749.37	R4,953	R4,953	R4,953	R4,953	R4,953	R4,953	R4,953

5.2 SUB-PROGRAMME PURPOSE FOR TERTIARY HOSPITAL SERVICES

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

Sub-Programmes

Tertiary Hospitals

- Livingstone Hospital
- Frere Hospital

Table 44: Outcomes, Outputs and Output indicators for the next MTEF for Tertiary Hospitals

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	21/22	2021/22 Quarterly Targets				2022/23	2022/23
								Q1	Q2	Q3	Q4		
6. Quality of health services improved	Hospitals that qualify as Ideal hospitals increased	6.2.8 Ideal Hospital status obtained rate	New Indicator	New Indicator	New Indicator	50%	50%	-	-	-	50%	50%	50%
		Numerator				1	1				1	1	1
		Denominator				2	2				2	2	2
	Percentage of patients satisfied with their experience of care in public health facilities	6.1.8 Patient experience of care satisfaction rate	New Indicator	New Indicator	New Indicator	72.7%	80%	-	80%	-	-	82%	82%
		Numerator				9 396	10 540		10 540			10 804	10 804
		Denominator				12 917	13 175		13 175			13 175	13 175
	Patient Safety Incident (PSI) case closure rate	6.3.6 Severity assessment code 1 incident reported within 24 hours rate	New Indicator	New Indicator	New Indicator	100%	80%	80%	80%	80%	80%	80%	80%
		Numerator				87	72	72	72	72	72	72	72
		Denominator				87	90	90	90	90	90	90	90
10. Community engagement improved	Percentage of Hospitals with functional hospital boards	10.2.6 Percentage of Hospitals with functional hospital boards	New Indicator	New Indicator	New Indicator	100%	100%	100%	100%	100%	100%	100%	100%
		Numerator				2	2	2	2	2	2	2	2
		Denominator				2	2	2	2	2	2	2	2
6. Quality of health services improved	Hospital efficiencies improved	6.7.5 Average length of stay	6 days	4.8 days	5.6 days	9 days	6 days	6 days	6 days	6 days	6 days	6 days	6 days
		6.7.10 Inpatient bed utilisation rates	75%	77.3%	76%	60%	75%	75%	75%	75%	75%	75%	75%
		Numerator	725 699	367235	488 259	286 361	455 143	455 143	455 143	455 143	455 143	455 143	455 143
		Denominator	967 599	481579	642 105	481 579	606 858	606 858	606 858	606 858	606 858	606 858	606 858
		6.7.15 Expenditure per PDE	R3,303	R3 ,733	R3,700	R4,454.20	R3,878	R3,878	R3,878	R3,878	R3,878	R3,878	R3,878

5.3 SUB-PROGRAMME PURPOSE FOR SPECIALISED TERTIARY HOSPITAL

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

Sub-Programmes

Specialised Tertiary Hospitals
- Fort England (specialised psychiatric Hospital)

Table 45: Outcomes, Outputs and Output indicators for the next MTEF for Specialised Tertiary Hospital

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2022/23
								Q1	Q2	Q3	Q4		
6. Quality of health services improved	Hospitals that qualify as Ideal hospitals increased	6.2.9 Ideal Hospitals status obtained rate	New Indicator	New Indicator	New Indicator	100%	100%	-	-	-	100%	100%	100%
		Numerator				1	1				1	1	1
		Denominator				1	1				1	1	1
	Percentage of patients satisfied with their experience of care in public health facilities	6.1.9 Patient experience of care satisfaction rate	New Indicator	New Indicator	New Indicator	80%	80%	-	80%	-	-	80%	80%
		Numerator				1 406	1 314		1 314			1 314	1 314
		Denominator				1 610	1 642		1 642			1 642	1 642
	Patient Safety Incident (PSI) case closure rate	6.3.7 Severity assessment code 1 incident reported within 24 hours rate	New Indicator	New Indicator	New Indicator	100%	80%	80%	80%	80%	80%	80%	80%
		Numerator				1	4	4	4	4	4	4	4
		Denominator				1	5	5	5	5	5	5	5
10. Community engagement improved	Percentage of Hospitals with functional hospital boards	10.2.7 Percentage of Hospitals with functional hospital boards	New Indicator	New Indicator	New Indicator	100%	100%	100%	100%	100 %	100%	100%	100%
		Numerator				1	1	1	1	1	1	1	1
		Denominator				1	1	1	1	1	1	1	1

Explanation of planned performance over the Medium-Term period

The vacant and critical leadership positions of seven hospital Chief Executive Officers at regional and tertiary hospitals pose a threat to leadership and governance. We are moving with speed to address this vacuum and the related acting appointments to improve hospital services and for better health outcomes. Governance and leadership will be improved through the appointments and filling of these vacant posts including Clinical governance management heads at regional, central, tertiary and specialised tertiary hospitals.

Furthermore, Community engagements will be improved with the establishment of all hospital boards in line with the revised guidelines for the next 3 years according to the hospital board policy.

5.6 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

Table 46: Summary of payments and estimates: P5 – Central Hospital Services

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2020/21
R thousand	2017/18	2018/19	2019/20		2020/21		2021/22	2022/23	2023/24	
1. Central Hospital Services	1 084 905	1 249 007	1 350 353	1 441 847	1 211 895	1 583 463	1 405 900	1 298 699	1 319 919	(11.2)
2. Provincial Tertiary Services	2 386 168	2 500 145	2 978 937	3 176 178	3 573 758	3 246 084	2 966 754	3 056 581	3 133 723	(8.6)
Total payments and estimates	**3 471 073**	**3 749 152**	**4 329 290**	**4 618 025**	**4 785 653**	**4 829 547**	**4 372 654**	**4 355 280**	**4 453 642**	**(9.5)**

Table 47: Summary of payments and estimates by economic classification: P5 – Central Hospital Services

R thousand	Outcome 2017/18	Outcome 2018/19	Outcome 2019/20	Main appropriation 2020/21	Adjusted appropriation 2020/21	Revised estimate 2020/21	Medium-term estimates 2021/22	Medium-term estimates 2022/23	Medium-term estimates 2023/24	% change from 2020/21
Current payments	**3 331 701**	**3 606 700**	**4 150 526**	**4 460 643**	**4 603 514**	**4 516 567**	**4 166 130**	**4 241 222**	**4 291 583**	**(7.8)**
Compensation of employees	2 375 151	2 643 838	3 005 961	3 402 113	3 200 416	3 318 827	3 012 884	3 214 318	3 238 582	(9.2)
Goods and services	956 250	962 592	1 142 641	1 058 530	1 403 098	1 197 740	1 153 246	1 026 904	1 053 001	(3.7)
Interest and rent on land	300	270	1 924	–	–	–	–	–	–	
Transfers and subsidies to:	**81 281**	**40 901**	**107 343**	**29 596**	**29 596**	**172 746**	**29 596**	**32 692**	**34 130**	**(82.9)**
Provinces and municipalities	–	–	–	–	–	–	–	–	–	
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–	
Higher education institutions	–	–	–	–	–	–	–	–	–	
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–	
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–	
Non-profit institutions	–	–	–	–	–	–	–	–	–	
Households	81 281	40 901	107 343	29 596	29 596	172 746	29 596	32 692	34 130	(82.9)
Payments for capital assets	**58 091**	**101 551**	**71 421**	**127 786**	**152 543**	**140 234**	**176 928**	**81 366**	**127 929**	**26.2**
Buildings and other fixed structures	–	152	–	–	4 466	4 466	–	–	–	(100.0)
Machinery and equipment	58 091	101 399	71 421	127 786	148 077	135 768	176 928	81 366	127 929	30.3
Heritage Assets	–	–	–	–	–	–	–	–	–	
Specialised military assets	–	–	–	–	–	–	–	–	–	
Biological assets	–	–	–	–	–	–	–	–	–	
Land and sub-soil assets	–	–	–	–	–	–	–	–	–	
Software and other intangible assets	–	–	–	–	–	–	–	–	–	
Payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**3 471 073**	**3 749 152**	**4 329 290**	**4 618 025**	**4 785 653**	**4 829 547**	**4 372 654**	**4 355 280**	**4 453 642**	**(9.5)**

Tables 46 and 47 above show the summary of payments and estimates for Central Hospital Services per sub-programme and economic classification. The programme's total expenditure increased from R3.471 billion in 2017/18 to a revised estimate of R4.829 billion in 2020/21. In 2021/22, the budget decreases by 9.5 per cent from R4.829 billion to R4.372 billion when compared to the 2020/21 revised estimate.

Compensation of employees shows a negative growth of 9.2 per cent from R3.318 billion to R3.012 billion when compared to the 2020/21 revised estimate due to budget cuts as a result of 2020 wage freeze reductions and overall fiscal consolidation reductions.

Goods and services show a negative growth 3.7 per cent from R1.197 million to R1.015 billion when compared to the 2020/21 revised estimate due reprioritisation and overall fiscal consolidation reductions.

Transfers and subsidies show a negative growth of 82.9 per cent from R172.746 million to R29.596 million budgets on households due to a high revised estimate as a result of payment of Medico Legal Claims.

Payments for capital assets show a positive growth of 26.2 per cent from R140.234 million to R90.238 million when compared to the 2020/21 revised estimate due reprioritisation to fund procurement of medical equipment in Provincial Tertiary Hospitals.

5.7 KEY RISKS

The table below outlines the key risks.

Table 48: Key Risks and mitigating factors

Outcome	Risk	Mitigating factors
• Quality of health services improved. • Community engagement improved.	• Non -adherence to policies and guidelines on referrals and services between Primary, Secondary and Tertiary Services	• Ensure timeous filling of critical and replacement posts. • Enforcement of Policies, Procedures and SOPs • Implementation of the meeting resolutions • Strengthen the quality of reports. • Procurement of appropriate healthcare technology as per APP



PROGRAMME 6

HEALTH SCIENCES AND TRAINING (HST)

PROGRAMME 6: HEALTH SCIENCES AND TRAINING (HST)

6.1 PROGRAMME PURPOSE

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

Table 49: Outcomes, Outputs and Output indicators for the next MTEF for Health Science and Training

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/221 Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
6. Quality of health services improved	Qualified and competent staff	6.4.6 Number of registrars trained	New Indicator	New Indicator	New Indicator	20	20	-	-	-	20	30	30
		6.4.7 Number of nurses trained on post basic courses	New Indicator	New Indicator	New Indicator	195	195	-	-	-	195	195	195
		6.4.8 Number of EMS Practitioners enrolled in Emergency care degree	New Indicator	New Indicator	New indicator	7	16	-	-	-	16	16	16

Explanation of planned performance over the Medium-Term period

The programme is planning to implement a range of capacity development programmes for existing workforce such NQF aligned Skills Development programmes, bursaries for existing workforce in order obtain qualifications and specialist clinical skills, and also youth development programmes in order to create a pool of qualified individuals with which the department can recruit from by implementing learnership, internships, traineeships programmes and bursaries for unemployed youth. The department is trying to get accreditation with American Heart Association to be able to enrol 70 life supporter trainer of trainers that will train other members of departmental staff . 900 EMS staff members will be trained on infection prevention and control. The EMS college is in partnership with Nelson Mandela University towards accreditation to train one-year certificate and 2-year diploma in Emergency Medical Care

6.2 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

Table 50: Summary of payments and estimates: P6 – Health Sciences and Training

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2020/21
R thousand	2017/18	2018/19	2019/20		2020/21		2021/22	2022/23	2023/24	
1. Nursing Training Colleges	276 980	288 232	274 293	358 144	328 384	285 569	320 614	318 241	329 676	12.3
2. Ems Training College	13 873	10 939	10 441	16 795	16 109	15 982	14 996	15 109	14 991	(6.2)
3. Bursaries	141 117	147 216	81 139	121 632	127 632	121 512	203 439	202 379	211 008	67.4
4. Other Training	295 722	330 148	362 689	409 455	391 766	395 158	389 609	377 052	358 236	(1.4)
Total payments and estimates	**727 692**	**776 535**	**728 562**	**906 026**	**863 891**	**818 221**	**928 658**	**912 781**	**913 911**	**13.5**

Table 51: Summary of payments and estimates by economic classification: P6 – Health Sciences and Training

R thousand	Outcome 2017/18	Outcome 2018/19	Outcome 2019/20	Main appropriation 2020/21	Adjusted appropriation 2020/21	Revised estimate 2020/21	Medium-term estimates 2021/22	Medium-term estimates 2022/23	Medium-term estimates 2023/24	% change from 2020/21
Current payments	**562 753**	**611 253**	**625 048**	**753 616**	**705 914**	**662 244**	**700 426**	**679 028**	**671 731**	**5.8**
Compensation of employees	468 511	519 800	544 030	637 207	605 241	598 056	601 397	590 707	582 510	0.6
Goods and services	94 242	91 453	81 018	116 409	100 673	64 188	99 029	88 321	89 221	54.3
Interest and rent on land	–	–	–	–	–	–	–	–	–	
Transfers and subsidies to:	**153 526**	**158 770**	**93 233**	**130 429**	**136 429**	**134 770**	**211 183**	**216 165**	**225 676**	**56.7**
Provinces and municipalities	–	–	–	–	–	–	–	–	–	
Departmental agencies and accounts	11 013	11 856	12 263	13 058	13 058	13 058	10 649	18 844	19 673	(18.4)
Higher education institutions	–	–	–	–	–	–	–	–	–	
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–	
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–	
Non-profit institutions	–	–	–	–	–	–	–	–	–	
Households	142 513	146 914	80 970	117 371	123 371	121 712	200 534	197 321	206 003	64.8
Payments for capital assets	**11 413**	**6 512**	**10 281**	**21 981**	**21 548**	**21 207**	**17 049**	**17 588**	**16 504**	**(19.6)**
Buildings and other fixed structures	–	–	–	–	–	–	–	–	–	
Machinery and equipment	11 413	6 512	10 281	21 981	21 548	21 207	17 049	17 588	16 504	(19.6)
Heritage Assets	–	–	–	–	–	–	–	–	–	
Specialised military assets	–	–	–	–	–	–	–	–	–	
Biological assets	–	–	–	–	–	–	–	–	–	
Land and sub-soil assets	–	–	–	–	–	–	–	–	–	
Software and other intangible assets	–	–	–	–	–	–	–	–	–	
Payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**727 692**	**776 535**	**728 562**	**906 026**	**863 891**	**818 221**	**928 658**	**912 781**	**913 911**	**13.5**

Tables 50 and 51 above show the summary of payments and estimates for Health Sciences and Training per sub-programme and economic classification. The programme's total expenditure increased from R727.692 million in 2017/18 to a revised estimate of R818.221 million in 2020/21. In 2021/22, the budget increases by 13.5 per cent from R818.221 million to R928.658 billion when compared to the 2020/21 revised estimate.

Compensation of employees shows a minimal positive growth of 0.6 per cent from R598.056 million to R601.397 million when compared to the 2020/21 revised estimate due to budget cuts as a result of 2020 wage freeze.

Goods and services show a positive growth 54.3 per cent from R64.188 million to R99.029 million when compared to the 2020/21 revised estimate due to a low revised estimate as a result of non-payment of training skills levy that were impacted by the COVID-19 pandemic.

Transfers and subsidies show a positive growth of 56.7 per cent from R134.770 million to R211.183 million when compared to the 2020/21 revised estimate due reprioritisation of funds to cater for Cuban Program.

Payments for capital assets show a negative growth of 19.6 per cent from R21.207 million to R17.049 million when compared to the 2020/21 revised estimate due to fiscal consolidation reductions.

6.3 KEY RISKS

The table below outlines the key risks.

Table 52: Key Risks and mitigating factors

Outcome	Risk	Mitigating factors
Quality of health services improved	• Inadequate number of registrars trained • Inadequate number of nurses trained on Post Basic Courses	• Ensure timeous filling of critical and replacement posts • Enforcement of Policies, Procedures and SOPs • Implementation of the meeting resolutions • Strengthen the quality of reports • Create, implement and maintain a clear training plan for registrars and nurses • Have an SLA and good working relationship with institutions of higher learning



PROGRAMME 7

HEALTH CARE SUPPORT SERVICES (HCSS)

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES (HCSS)

7.1 PROGRAMME PURPOSE

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

Transversal Health Services consists of:

- The orthotic & prosthetic (O&P) services sub-programme, which has three existing O&P centers. The centers 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 centers.

Pharmaceutical Services is responsible for

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

Strategies to reach the targets over the three-year period

- Resource mobilization to strengthen the management of the Cerebral Palsy (CP) cases as part of the medico legal mitigation strategy.
- Establishment of centers of excellence for the management of Cerebral Palsy.
- Develop the capacity of the rehabilitation health professionals on such skills as wheelchair seating
- Strengthen rehabilitation services at District Hospitals and Primary Health Care facilities.
- Establish partnerships with private and not-for-profit organizations to support the achievement of rehabilitation programme results.
- Outreach services for the Medical Orthotist and Prosthetist (MOP) to improve access to Prostheses and orthoses for people with disabilities to maintain their dignity.
- Introduce efficiencies in the blood products and laboratory service utilization
- Strengthen the functioning of the provincial pharmaceutical and therapeutics committee to promote rational use of medicine and pharmaceutical products.
- Expand the CCMDD programme to reach more clients in more wards around the province.
- Promoting compliance to relevant legislation e.g. South African Pharmacy Council, Office of Health Standards Compliance,
- Strengthen and promote efficiency in the medicines supply chain management

Table 53: Outcomes, Outputs and Output indicators for the next MTEF for Health care support

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
6. Quality of health services improved	Availability of assistive devices in primary health care	6.4.9 Wheelchair issued adult 19 years and older rate	New Indicator	New Indicator	New Indicator	44.86%	30 %	5%	15%	20%	30%	50%	50%
		Numerator				987	750	125	375	500	750	1 250	1 250
		Denominator				2 200	2 500	2500	2500	2500	2500	2 500	2 500
		6.4.10 Wheelchair issued child 0-18 years rate	New Indicator	New Indicator	New Indicator	67%	70%	10%	30%	50%	70%	80%	80%
		Numerator				201	210	30	90	150	210	400	400
		Denominator				300	300	300	300	300	300	500	500
		6.4.11 Hearing aid issued adult 19 years and older rate	New Indicator	New Indicator	New Indicator	29.16%	35%	5%	15%	25%	35%	40%	50%
		Numerator				729	420	60	180	300	420	480	600
		Denominator				2500	1 200	1 200	1 200	1 200	1 200	1 200	1 200
		6.4.12 Hearing aid issued child 0-18 years rate	New Indicator	New Indicator	New Indicator	10,88%	35%	5%	15%	25%	35%	40%	50%
		Numerator				98	175	25	75	125	175	280	350
		Denominator				900	500	500	500	500	500	700	700
3. Morbidity and Premature mortality due to Communicable diseases reduced	Monitor the NHLS	3.5.9 Percentage COVID 19 tests with turnaround time (<48hours)	New Indicator	New Indicator	New Indicator	42%	80%	80%	80%	80%	80%	-	-
		Numerator				102 739	199 610	49 901	49 903	49 903	49 903		
		Denominator				244 619	249 511	62 377	62 378	62 378	62 378		
	Facilities supported by centrally procuring the Personal Protective Equipment; Monitor facilities to prevent stock-outs. Stock visibility system utilised to monitor stock levels in facilities Protocols on rational use of PPE developed.	3.5.10 Percentage Personal Protective Equipment availability in facilities	New Indicator	New Indicator	New Indicator	90%	90%	90%	90%	90%	90%		

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
6. Quality of health services improved	Availability of medicine in depos and facilities	6.4.13 Percentage Order fulfilment for essential drugs at depot	84%	75.5%	73,1%	76.5%	80%	80%	80%	80%	80%	85%	90%
		Numerator		472 310	90 475	104 607	550 624	137 656	165 187	137 656	110 125	643 542	715 467
		Denominator		625 709	123 735	136 695	688 280	172 070	206 484	172 070	137 656	757 108	794 963
		6.4.14 Percentage of availability of essential medicine at facilities.	New Indicator	New Indicator	New Indicator	91.3%	80%	80%	80%	80%	80%	85%	90%
		Numerator				73	64	64	64	64	64	64	64
		Denominator				80	80	80	80	80	80	80	80
		6.4.15 Number of active patients on CCMDD	New Indicator	New Indicator	New Indicator	258 613	312 500	262 500	281 250	300 000	312 500	375 000	450 000

Explanation of planned performance over the medium-term period

The programme is very important in improving quality of health services through reducing the risk of severe adverse events. Treatment and rehabilitation which are central to this programme are important to the achievement of health outcomes.

The department endeavours to improve quality health care through the provision of effective rehabilitative services and the rational use of medicines.

Provision of assistive devices is one of the services which seek to contribute to improved quality of life for people living with disabilities. The availability of assistive devices and adequately skilled personnel are essential inputs to the quality of care provided to people living with disabilities. The Eastern Cape province has seen an increase in demand for assistive devices due to high cases of trauma and injury in the province. The programme supplies assistive devices, orthotic and prosthetic devices to people who have been clinically assessed by qualified rehabilitation professionals and orthopaedic specialist in the hospitals. Physiotherapy, occupation health, speech therapy and audiology services are provided to eligible clients by the multi-disciplinary team of registered professionals at various levels of care

Due to the current financial position of the department, the targets have been revised down for both hearing aids and wheelchairs. The department will continue to mobilise resources through partnership with non-governmental organizations to supply assistive devices to more clients. The department also intends to establish a wheelchair maintenance service which will increase the lifespan of wheelchairs issued by the department. This service will focus on minor repairs of wheelchairs which in the past required replacement of the wheelchair.

The department will also strengthen the operation and functioning of the three orthotic and prosthetic centres for better service delivery to the rest of the province.

The availability and rational use of medicines remains a key input of the programme to achieving quality health care targets. The achievement of health outcomes rests on the department's ability to efficiently procure, warehouse, distribute and dispense quality assured medicines for the management of common health conditions. The correct prescribing and dispensing of medicines is important in reducing adverse events coursed by medication errors. The current fiscal space forces the department to look at efficiencies in the procurement and supply chain management of essential medicines to the clinics and hospitals around the province. The focus in this financial year would be to establish a formulary which will standardise the type of medicines to be provided to the public, guided by the level of care and the services provided at each institutions. Monitoring of stock levels using the SVS system will be strengthened to ensure adequate stock levels are maintained and excess stock is redistributed before it expires.

7.2 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

Table 54: Summary of payments and estimates: P7 – Health Care Support Services

R thousand	Outcome 2017/18	Outcome 2018/19	Outcome 2019/20	Main appropriation 2020/21	Adjusted appropriation 2020/21	Revised estimate 2020/21	Medium-term estimates 2021/22	Medium-term estimates 2022/23	Medium-term estimates 2023/24	% change from 2020/21
1. Orthotic & Prosthetic Services	36 270	39 316	36 740	56 062	117 899	99 956	108 757	54 021	49 631	8.8
2. Medicine Trading Account	63 728	70 744	64 589	74 807	70 957	69 285	64 488	73 824	66 858	(6.9)
Total payments and estimates	**99 998**	**110 060**	**101 329**	**130 869**	**188 856**	**169 241**	**173 245**	**127 845**	**116 489**	**2.4**

Table 55: Summary of payments and estimates by economic classification: P7 – Health Care Support Services

R thousand	Outcome 2017/18	Outcome 2018/19	Outcome 2019/20	Main appropriation 2020/21	Adjusted appropriation 2020/21	Revised estimate 2020/21	Medium-term estimates 2021/22	Medium-term estimates 2022/23	Medium-term estimates 2023/24	% change from 2020/21
Current payments	**99 397**	**109 832**	**100 819**	**130 287**	**180 990**	**161 597**	**172 653**	**127 502**	**116 166**	**6.8**
Compensation of employees	52 707	60 148	64 231	73 344	66 580	64 800	67 394	80 996	70 229	4.0
Goods and services	46 690	49 684	36 588	56 943	114 410	96 797	105 259	46 506	45 937	8.7
Interest and rent on land	–	–	–	–	–	–	–	–	–	
Transfers and subsidies to:	**34**	**16**	**68**	**–**	**200**	**30**	**–**	**–**	**–**	**(100.0)**
Provinces and municipalities	–	–	–	–	–	–	–	–	–	
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–	
Higher education institutions	–	–	–	–	–	–	–	–	–	
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–	
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–	
Non-profit institutions	–	–	–	–	–	–	–	–	–	
Households	34	16	68	–	200	30	–	–	–	(100.0)
Payments for capital assets	**567**	**212**	**442**	**582**	**7 666**	**7 614**	**592**	**343**	**323**	**(92.2)**
Buildings and other fixed structures	–	–	–	–	–	–	–	–	–	
Machinery and equipment	567	212	442	582	7 666	7 614	592	343	323	(92.2)
Heritage Assets	–	–	–	–	–	–	–	–	–	
Specialised military assets	–	–	–	–	–	–	–	–	–	
Biological assets	–	–	–	–	–	–	–	–	–	
Land and sub-soil assets	–	–	–	–	–	–	–	–	–	
Software and other intangible assets	–	–	–	–	–	–	–	–	–	
Payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**99 998**	**110 060**	**101 329**	**130 869**	**188 856**	**169 241**	**173 245**	**127 845**	**116 489**	**2.4**

Tables 54 and 55 above show a summary of payments and estimates for Health Care Support Services per sub-programme and economic classification. The programme's total expenditure increased from R99.998 million in 2017/18 to a revised estimate of R169.241 million in 2020/21. In 2021/22, the budget decreased by 32.2 per cent from R166.970 million to R113.132 million when compared to the 2020/21 revised estimate.

Compensation of employees shows a positive growth of 4.0 per cent from R64.800 million to R67.394 million when compared to the 2020/21 revised estimate due to provision for filling of critical funded vacant posts.

Goods and services show a negative growth 8.7 per cent from R96.797 million to R105.259 million when compared to the 2020/21 revised estimate due the reprioritisation of funds towards core items.

Payments for capital assets show a negative growth of 92.2 per cent from R7.614 million to R592 000 when compared to the 2020/21 revised estimate due to fiscal consolidation reductions.

7.3 KEY RISKS

The table below outlines the key risks.

Table 56: Key Risks and mitigating factors

Outcome	Risk	Mitigating factors
Quality of health services improved	• Interrupted inventory supply and availability (medicine and medical supplies) • Inadequate Inventory Management • Inadequate vaccination site readiness • Inadequate number of wheelchairs issued • Inadequate number of hearing aids issued	• Capacity building and Staff development • Recruitment of pharmaceutical posts at Depots and Institutions. • Roll out Remote Demander Module for electronic medicines and consumables ordering. • Continual Medicine Supply Chain Management training • Monitor Contract Management of Medicine suppliers • Establish a provincial contract for certain essential medicines and supplies that are not on national contract • Expansion of Direct Delivery to hospitals • Strengthen of HR components at clinics and hospitals • Continue employment of pharmacy assistants • Continue Roll Out of RX Solution to all hospitals and support full functionality • Enforcement of Policies, Procedures and SOPs • Implementation of the meeting resolutions • Strengthen the quality of reports • Ensure adequate procurement of wheel chairs and hearing aids as per APP





PROGRAMME 8

HEALTH FACILITIES MANAGEMENT (HFM)



PROGRAMME 8: HEALTH FACILITIES MANAGEMENT (HFM)

8.1 PROGRAMME PURPOSE

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

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

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

Table 57: Outcomes, Outputs and Output indicators for the next MTEF for Health facilities management

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2017/18	2018/19	2019/20	2020/21	2021/22	2021/22 Quarterly Targets				2022/23	2023/24
								Q1	Q2	Q3	Q4		
6. Quality of health services improved	Health facilities with major refurbishment or rebuild	6.6.1 Number of planned health facilities with major refurbishment	4	18	1	2	3	-	-	-	3	4	4
		6.6.2 Number of Health facilities with minor refurbishment	17	30	38	30	15	-	2	2	11	14	14
	Health facilities with major refurbishment or rebuild or repurposed for COVID management. Increase the capacity for isolation, high care, and Intensive care beds in existing hospitals. Increase isolation, high care capacity in field hospitals.	6.6.3 Number of Major renovations or upgrades completed at facilities	New Indicator	New Indicator	New Indicator	2	4	-	-	1	3	4	5
		6.6.4 Number of Minor renovations or upgrades completed at facilities	New Indicator	New Indicator	New Indicator	30	4	-	1	1	2	4	4
		6.6.5 Number of additional High Care bed spaces and beds at existing hospitals	New Indicator	New Indicator	New Indicator	375	150	-	30	50	70	-	-
		6.6.6 Number of additional isolation beds at existing hospitals	New Indicator	New Indicator	New Indicator	750	500	35	100	150	215	-	-
		6.6.7 Number of Regional and Tertiary Hospitals fitted with additional oxygen points at beds	New Indicator	New Indicator	New Indicator	2	9	2	2	2	3	9	10
		6.6.8 Number of District Hospitals fitted with additional oxygen points at beds	New Indicator	New Indicator	New Indicator	9	30	5	10	8	7	35	30

Explanation of planned performance over the medium-term period

The strategic approach for the planning, delivery and management of ***infrastructure projects*** is guided by the concept of the Infrastructure Delivery Management System (IDMS), the chosen government wide system for infrastructure delivery.

In order to establish a common approach to infrastructure delivery across all organs of state, the National Treasury adopted the Standard for Infrastructure Procurement and Delivery Management (SIPDM). In order to give effect to the SIPDM the following guidelines were issued:

- Treasury Instructions Notes No. 4 of 2015/16 in terms of Public Finance Management Act (PFMA); and
- Circular 77 for Model Supply Chain Management (SCM) policy for infrastructure procurement and delivery management.

The National Treasury, in consultation with relevant stakeholders, conducted the SIPDM review, which resulted in the Framework for Infrastructure Delivery and Procurement Management (FIDPM). The FIDPM prescribes minimum requirement for effective governance of infrastructure delivery and procurement management.

The Framework prescribes minimum requirements for the implementation of the IDMS through the:

- Infrastructure Delivery Management processes consisting of portfolio, programme, projects,
- operations and maintenance of infrastructure; and
- Infrastructure Procurement Gates.

This Framework specifies the allocation of clear responsibilities for performing activities and making decisions at control points, stages and procurement gates.
This Framework promotes the concept 'value for money' by organs of state throughout all the Infrastructure Delivery Management and Infrastructure Procurement Management processes and activities to promote optimal use of resources to achieve the intended outcomes. The stages are as follow:

STAGE 1 – INITIATION

This Initiation report for the project known as ***Name of facility/scope*** defines project objectives, needs, acceptance criteria, organization's priorities and aspirations, procurement strategies, and which sets out the basis for the development of the Concept Report.

Planning for the Proposed Projects under the Infrastructure programme focuses primarily on the Packaging" of projects, i.e. the identification of a "package" or scope to be implemented in one single contract.

The identification of a "package" or scope in one single contract is informed and guided by Need & priorities as determined by the U-Amp (User Asset Management Plan), IAMP (Infrastructure Asset Management Plan) and Strategic priorities of the Department as depicted in the IPMP Infrastructure Programme Management Plan) and B5 project list.

The ***Name of facility/scope***, forms part of the list of identified facilities strategically prioritized for construction as a single standalone project.

STAGE 2 – CONCEPT

The Concept Stage represents an opportunity for the development of different design concepts to satisfy the project requirements, as developed during Stage 1. It also presents, through the testing of alternative approaches, an opportunity to select a conceptual approach. The ultimate objective of this stage is to determine whether the project is viable to proceed, with respect to available budget, technical solutions, timeframe, and other information that may be required.

The Concept Report should as a minimum, provide the following information:

a) Document the initial design criteria, cost plan, design options and the selection of the preferred design option, or the methods and procedures required to maintain the condition of infrastructure for the project.
b) Establish the detailed brief, scope, scale, form and cost plan for the project, including, where necessary, the obtaining of site studies and construction and specialist advice.
c) Provide an indicative schedule for documentation and construction or maintenance services, associated with the project.
d) Include a site development plan, or other suitable schematic layouts of the works.
e) Describe the statutory permissions, funding approvals and utility approvals required to proceed with the works associated with the project.
f) Include a baseline risk assessment for the project, and a health and safety plan, which is a requirement of the Construction Regulations, issued in terms of the Occupational Health and Safety Act.
g) Contain a risk report linked to the need for further surveys, tests, other investigations and consents and approvals, if any, during subsequent stages and identified health, safety and environmental risk.

STAGE 3 – DESIGN DEVELOPMENT

The Design Development Report shall as necessary:
a) Develop in detail the approved concept to finalize the design and definition criteria.
b) Establish the detailed form, character, function and costings.
c) Define all components in terms of overall size, typical detail, performance and outline specification.
d) Describe how infrastructure or elements or components thereof are to function, how they are to be safely constructed, how they are to be maintained and how they are to be commissioned.
e) Confirm that the project scope can be completed within the budget or propose a revision to the budget.

STAGE 4 – DESIGN DOCUMENTATION

Design documentation provides the:
a) production information that details, performance definition, specification, sizing and positioning of all systems and components that would enable construction;
b) manufacture, fabrication and construction information for specific components of the work informed by the production information.

STAGE 5 – WORKS

The following is required for completion of the Works Stage:
a) Completion of the works is certified in accordance with the provisions of the contract; or
b) The goods and associated services are certified as being delivered in accordance with the provisions of the contract.

STAGE 6 – HANDOVER

The following activities shall be undertaken during the handover stage:
a) Finalize and assemble record information which accurately reflects the infrastructure that is acquired, rehabilitated, refurbished or maintained;
b) Hand over the works and record information to the user organization and if necessary, train end user staff in the operation of the works.

STAGE 7 – CLOSE OUT

The Close-Out Stage commences when the end user accepts liability for the works. It is complete when:

a) Record information is archived.

b) Defects certificates and certificates of final completion are issued in terms of the contract.

8.2 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

Table 58: Summary of payments and estimates: P8 – Health Facilities Management

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2020/21
R thousand	2017/18	2018/19	2019/20		2020/21		2021/22	2022/23	2023/24	
1. Community Health Facilities	155 394	106 070	300 782	301 505	219 782	202 231	356 228	550 170	456 364	76.1
2. Emergency Medical Rescue Services	281	136	–	–	–	–	–	–	–	
3. District Hospital Services	752 511	661 090	626 499	659 926	792 104	810 303	471 223	412 259	500 587	(41.8)
4. Provincial Hospital Services	289 282	412 773	528 898	341 231	608 442	549 012	411 950	302 748	346 202	(25.0)
5. Other Facilities	77 046	73 227	40 128	47 041	275 748	230 506	34 924	22 338	16 502	(84.8)
Total payments and estimates	**1 274 514**	**1 253 296**	**1 496 307**	**1 349 703**	**1 896 076**	**1 792 052**	**1 274 325**	**1 287 515**	**1 319 655**	**(28.9)**

Table 59: Summary of payments and estimates by economic classification: P8 – Health Facilities Management

R thousand	Outcome 2017/18	Outcome 2018/19	Outcome 2019/20	Main appropriation 2020/21	Adjusted appropriation 2020/21	Revised estimate 2020/21	Medium-term estimates 2021/22	Medium-term estimates 2022/23	Medium-term estimates 2023/24	% change from 2020/21
Current payments	**409 705**	**306 023**	**378 344**	**267 338**	**231 965**	**209 141**	**333 435**	**374 339**	**486 173**	**59.4**
Compensation of employees	16 844	29 103	28 283	38 407	37 369	20 180	42 627	45 849	51 754	111.2
Goods and services	392 861	256 616	349 452	228 931	194 596	188 961	290 808	328 490	434 419	53.9
Interest and rent on land	–	20 304	609	–	–	–	–	–	–	
Transfers and subsidies to:	**67**	**11**	**6**	**–**	**–**	**–**	**–**	**–**	**–**	
Provinces and municipalities	–	–	–	–	–	–	–	–	–	
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–	
Higher education institutions	–	–	–	–	–	–	–	–	–	
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–	
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–	
Non-profit institutions	–	–	–	–	–	–	–	–	–	
Households	67	11	6	–	–	–	–	–	–	
Payments for capital assets	**864 742**	**947 262**	**1 117 957**	**1 082 365**	**1 664 111**	**1 582 911**	**940 890**	**913 176**	**833 482**	**(40.6)**
Buildings and other fixed structures	637 152	911 812	1 060 483	935 918	1 381 013	1 325 723	619 037	669 598	653 487	(53.3)
Machinery and equipment	227 590	35 450	57 474	146 447	283 098	257 188	321 853	243 578	179 995	25.1
Heritage Assets	–	–	–	–	–	–	–	–	–	
Specialised military assets	–	–	–	–	–	–	–	–	–	
Biological assets	–	–	–	–	–	–	–	–	–	
Land and sub-soil assets	–	–	–	–	–	–	–	–	–	
Software and other intangible assets	–	–	–	–	–	–	–	–	–	
Payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**1 274 514**	**1 253 296**	**1 496 307**	**1 349 703**	**1 896 076**	**1 792 052**	**1 274 325**	**1 287 515**	**1 319 655**	**(28.9)**

Tables 58 and 59 above show the summary of payments and estimates for Health Facilities Management per sub-programme and economic classification. The programme's total expenditure decreased from R1.274 billion in 2017/18 to a revised estimate of R1.792 billion in 2020/21. In 2021/22, the budget decreases by 28.9 per cent from R1.792 billion to R1.274 billion when compared to the 2020/21 revised estimate.

Compensation of employees shows a positive growth of 111.2 per cent from R20.218 million to R42.627 million when compared to the 2020/21 revised estimate in order to improve capacitation within the programme.
Goods and services show a positive growth 53.3 per cent from R188.961 million to R290.808 million when compared to the 2020/21 revised estimate due the reprioritisation of maintenance of infrastructure and machinery and equipment.

Payments for capital assets show a negative growth of 40.6 per cent from R1.582 million to R940.890 million when compared to the 2020/21 revised estimate due to the additional funding on Health Revitalisation Facilities Grant.

-

8.3 KEY RISKS

The table below outlines the key risks.

Table 60: Key Risks and mitigating factors

Outcome	Risk	Mitigating factors
Quality of health services improved	• Unsuitable infrastructure • Insufficient hospital space/ beds to cater for Covid-19 admissions	• Improve human resource capacitation within the unit in the build environment profession • Strengthen and monitor compliance to the terms of the SLA • Enforce compliance with the Policies, Procedures and SOPs • Implementation of the resolutions of the meetings • Strengthen the quality of reports • Establish more isolation sites to cater for Covid-19 infected patients

9. INFRASTRUCTURE PROJECTS

INFRASTRUCTURE PAYMENTS

Table 61: Departmental infrastructure payments

R thousand	Outcome 2017/18	2018/19	2019/20	Main appropriation	Adjusted appropriation 2020/21	Revised estimate	Medium-term estimates 2021/22	2022/23	2023/24	% change from 2020/21
Existing infrastructure assets	**980 099**	**813 132**	**829 483**	**814 219**	**814 219**	**1 064 394**	**798 879**	**771 557**	**908 405**	**(24.9)**
Maintenance and repairs	457 918	301 246	353 692	348 796	348 796	303 781	405 207	455 445	551 273	33.4
Upgrades and additions	378 129	209 819	89 588	136 907	136 907	140 257	105 829	105 508	112 592	(24.5)
Refurbishment and rehabilitation	144 052	302 067	386 203	328 516	328 516	620 356	287 843	210 604	244 540	(53.6)
New infrastructure assets	**294 415**	**438 855**	**586 617**	**470 495**	**470 495**	**491 111**	**225 366**	**353 487**	**296 356**	**(54.1)**
Infrastructure transfers	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Current	–	–	–	–	–	–	–	–	–	
Capital	–	–	–	–	–	–	–	–	–	
Infrastructure payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Infrastructure leases	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Non infrastructure	**–**	**73 651**	**153 576**	**282 182**	**282 182**	**411 833**	**457 641**	**386 872**	**340 279**	**11.1**
Total department infrastructure	**1 274 514**	**1 325 638**	**1 569 676**	**1 566 896**	**1 566 896**	**1 967 338**	**1 481 886**	**1 511 916**	**1 545 040**	**(24.7)**

Table 61 above shows summary of infrastructure expenditure per category from 2017/18 to 2021 MTEF. Infrastructure spending shows an increase from R1.274 billion in 2017/18 to a revised estimate of R1.967 billion in 2020/21. Overall, the budget shows a negative growth of 24.7 per cent. The bulk of the budget is in the existing infrastructure for maintenance and repairs.

10. CONDITIONAL GRANTS

10.1 HEALTH PROFESSIONS TRAINING AND DEVELOPMENT GRANT

Table 62: Health professions training and development grant

Name conditional grant	Purpose of the grant	Performance indicators	National Indicator targets for 2020/21	Provincial Indicator targets for 21/22
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.	1 Provincial Consolidated business plans and 4 Facility Business Plans	Approved business plan submitted
		Number of site visits.	Number facility site visits after 28 February 2020	• 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.	1 Annual performance reports Number of quarterly reports will be confirmed after 28 February 2021	4 quarterly reports & 1 annual report submitted

10.2 COMPREHENSIVE HIV/AIDS GRANT

Table 63: Comprehensive HIV/AIDS grant

Name conditional grant	Purpose of the grant	Performance indicators	Provincial Indicator targets for 2021/22
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.	ART adult [2]remain in care rate	45% (652 664/1 462 655)
		ART child remain in care rate	37%(27 195/73 801)
		Infant PCR test positive around 10 weeks rate	<0.5%(109/21 748)
		TB/HIV co-infected client on ART rate	90% (14 555/16 172)
		ART client naïve start ART during month – sum	69 314
		HIV tests done	1 740 870
		Medical Male Circumcisions total	11 443

10.3 NATIONAL TERTIARY SERVICES GRANT

Table 64: National Tertiary Services grant

Name conditional grant	Purpose of the grant	Performance indicators	National Indicator targets for 202/21	Provincial Indicator targets for 2021/22
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.	• 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)	• 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
	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 financial year

10.4 HEALTH FACILITY REVITALISATION GRANT

Table 65: Health facility revitalisation grant

[2] Please note that the final business plan has been used in TROA indicators and submitted to NDoH. The final feedback or report from NDoH will be received by the end of March after we have submitted the 2021/22 APP. The report may have revised targets on TROA that may affect ECDoH 2021/22 APP. The department will have to amend those indicators before the first quarter.

Name conditional grant	Purpose of the grant	Performance indicators	National Indicator targets for 2019/20	Provincial Indicator targets for 2020/21
Health Facility Revitalization 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 Revitalization Grant and National Health Grant	Availability of approved Annual Implementation Plans (AIP) for all projects funded from National Health grant and Health Facility Revitalization Grant	• A signed and approved AIP 2018/19 submitted to NDOH.
		Monitoring number of projects receive. Funding from Health Facility Revitalization Grant and National Health Grant	Monitor implementation of all conditional grant funded projects	• 59 Projects funded by HFRG to be implemented on 2018/19 B4. • Monthly Infrastructure Reporting Model (IRM) and Quarterly Progress Report is submitted to NDOH, NT and PT.

11. PUBLIC ENTITIES

The department of Health does not have any Public Entities.

12. PUBLIC-PRIVATE PARTNERSHIPS (PPPS)

Table 66: Public-private partnerships

Name of PPPs	Purpose	Outputs	Date of Termination	Measures to ensure smooth transfer of responsibilities
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	27 June 2023 20-year period	Management of contract by the department assisted by national and provincial Treasury
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	7 May 2022- 15-year period	Management of contract by the department assisted by national and provincial Treasury

APP TIDS FOR PROVINCIAL DOH

N:B POPULATION BASED INDICATORS ARE NOT DIVIDED BY 4 WHEN IT COMES TO QUARTERLY TARGETS

Table 67: Technical Indicator Data Set

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
PROGRAMME 1: HEALTH ADMINISTRATION & MANAGEMENT											
9.1.2 Number of statutory documents tabled at Legislature	Statutory documents submitted and tabled at the Provincial Legislature	Copies of the documents	Not applicable	None	Unavailability of statutory documents	Not applicable	Not applicable	Cumulative year end	Quarterly	Higher	Office of the MEC
7.1.1 Audit opinion	Improvement of Audit opinion for Provincial Department of Health for financial performance	Documented Evidence: Annual Report Auditor General's Report	Not applicable Categorical	N/A	N/A	N/A	Not applicable	Categorical	Annual	Higher	Chief Financial Officer
7.1.2 Approved Annual Procurement Plan	List of projects according to capital budget	Final approved procurement plan	Not applicable	None	None	Not applicable	Not applicable	Categorical	Annual	Higher	Manager: Supply Chain Management
7.1.3 Amount Revenue generated ®	Amount of revenue to be collected by districts	Financial management system	Amount of revenue collected	None	Client affordability	Not applicable	All districts	Non-cumulative	Quarterly	Higher	Manager: Financial Management
6.3.8 Percentage of Health facilities compliant with Occupational health and safety	Facilities that are compliant to occupational health and safety	Ideal facility tool	Number of facilities compliant with occupational health and safety	Total number of health facilities	Not applicable	Not applicable	All districts	%	Quarterly	Higher	Corporate services manager
6.3.9 Number of security incidents reported	All security incidents recorded and reported	Security incident register or logbook	Number of security incidents reported	Not applicable	All security incidents reported	Not applicable	All Districts	Cumulative to date	Quarterly	Higher	Corporate services manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
6.4.1 Holistic Human Resources for Health (HRH) strategy approved	Approved HRH strategy for Health	HRH strategy	HRH strategy approved	Not applicable	Strategy developed and approved	Not applicable	Not applicable	Categorical	Annual	Higher	HRM manager
6.4.3 Vacancy rate	Reduction of vacant funded posts	PERSAL	Number of vacant funded posts	Total number of posts funded	Dependent on availability of budget for recruitment	Not applicable	All districts	Non-Cumulative	Annual	Lower	HRM manager
8.1.1 % Reduction of medico Legal claims	Reduction of medico legal claims for all backlog cases that were on the case register as at 31 March 2020	Medico-legal case management system	Number of medico legal claims resolved	Number of medico legal claims for all backlog cases that were on the case register as at 31 March 2020	Accuracy dependent of reporting of data into the system	Not Applicable	All Districts	Non-cumulative	Quarterly	Lower	Finance Manager
11.1.1 Percentage of Hospitals with broadband access	Ensure the Hospitals have access to broadband	Networks reports that confirm availability of broadband or Network rollout report for sites that are not yet live	Total Number of hospitals with minimum 2 Mbps connectivity	Total Number of Hospitals	Depending on Provincial broadband	Not applicable	Districts	Cumulative to date	Quarterly	Higher	ICT Directorate / Chief Directorate
11.1.2 Percentage of fixed PHC facilities with broadband access	Ensure that all fixed PHC facilities have access to broadband	Networks reports that confirm availability of broadband. Or Network rollout report for sites that are not yet live	Total Number of fixed PHC facilities with minimum 1Mbps connectivity	Total Number of fixed PHC Facilities	Depending on Provincial broadband	Not applicable	Districts	Cumulative to date	Quarterly	Higher	ICT Directorate / Chief Directorate

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
DISTRICT HEALTH SERVICES (DHS)											
SUB PROGRAMME 2.1: DISTRICT DEVELOPMENT											
9.1.1 Number of Districts with Quality Improvement; monitoring and Response Forums formalized and convened quarterly	Establishment of Quality Improvement; monitoring and Response Forums in Districts	Reports Attendance register	Not applicable	Not applicable	Not applicable	Not applicable	Districts	Number	Quarterly	Higher	DHS Manager
6.4.2 % of Fixed PHC Facilities Supervised.	All facilities supervised according to supervision manual	Reports	Number of PHC facilities supervised	Total number of PHC facilities	Not applicable	Not applicable	Districts	Cumulative to date	Quarterly	Higher	DHS Manager
SUB PROGRAMME 2.2: CLINICS											
6.2.1 Ideal Clinic status obtained rate	Health facilities that obtained Ideal status (bronze, silver, gold) as a proportion of fixed PHC clinics and CHCs and or CDC and or Hospitals	ICS	Fixed PHC clinics have obtained Ideal status	Fixed PHC clinics	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	%	Annual	Higher	Quality Assurance Manager
10.1.1 Percentage of Clinics facilities with functional Clinic committees	Improve quality of services at PHC facilities conducting regular meetings with functional Clinic committees	Attendance Registers of meetings of Clinic committees	Number of clinics with functional clinic committees	Number of PHC Facilities	Attendance Registers are accurately kept	Not Applicable	All Districts	%	Annual	Higher	District Health Services Manager
6.1.1 Patient experience of care satisfaction rate	Total number of satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	Patient Surveys	Patient Experience of Care survey satisfied responses	Patient Experience of Care survey total responses	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	%	Annual	Higher	Quality Assurance Manager
SUB PROGRAMME 2.3: CHC'S											

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
6.2.2 Ideal CHC status obtained rate	Health facilities that obtained Ideal status (bronze, silver, gold) as a proportion of fixed PHC clinics and CHCs and or CDC and or Hospitals	ICS	Number of CHCs that have obtained Ideal status	Total number of CHCs facilities	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	%	Annual	Higher	Quality Assurance Manager
10.1.2 Percentage of CHC facilities with functional CHC committee	Improve quality of services at PHC facilities conducting regular meetings with functional CHC committees	Attendance Registers of meetings of CHC committees	Number of functional CHC committees	Number of CHC Facilities	Attendance Registers are accurately kept	Not Applicable	All Districts	%	Annual	Higher	District Health Services Manager
6.1.2 Patient experience of care satisfaction rate	Total number of Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	Patient Surveys	Patient Experience of Care survey satisfied responses	Patient Experience of Care survey total responses	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	%	Annual	Higher	Quality Assurance Manager
SUB-PROGRAMME 2.4: COMMUNITY BASED SERVICES: DISEASE PREVENTION AND CONTROL (DPC)											
4.2.1 Hypertension new client 18 years and older detection rate	Client-18 and older newly diagnosed with hypertension at facility. Diagnosis made according to hypertension treatment guidelines.	DHIS. patient files	Hypertension client 18 years and older new	Population 18 years and older	Not Applicable	Not Applicable	All Districts	%	Quarterly	Higher	Communicable Diseases
4.3.1 Diabetes new client 18 years and older detection rate	Client 18 years and older newly diagnosed with diabetes at facility. Diagnosis made according to diabetes treatment guidelines. count only once when client (18 - 44 years and older) to diagnosed with	DHIS. patient files	Diabetes client18 years and older new	Population 18 years and older	Not Applicable	Not Applicable	All Districts	Number	Quarterly	Higher	Communicable Diseases

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
	diabetes. Newly diagnosed clients with a fasting blood glucose of >/ = 7 mmol / l or random blood glucose > /= 11 mmol/l										
4.4.1 Mental disorders treatment rate new	Clients screen for the first time for mental disorders (depression, anxiety, dementia, psychosis, mania, suicide, developmental disorders, behavioural disorders and substance use) as a proportion of total PHC headcount	PHC Comprehensive Tick Register, DHIS	PHC client treated for mental disorders - new	PHC headcount - total	Accuracy dependent on quality of data submitted by health facilities	None	All Districts	%	Quarterly	Higher	Communicable Diseases
4.5.1 Cataract surgery rate	Clients who had cataract surgery per 1 million uninsured populations. The population will be divided by 12 in the formula to make provision for annualisation	Facility registers, patient registers	Cataract surgery total	Uninsured population	Accuracy dependent on quality of data from health facilities	None	Districts	Rate per 1 Million	Quarterly	Higher.	Hospital Services Manager
6.4.3 Number of Districts Conducted outreach campaigns (Thuma Mina).	Community Outreach services Conducted (Thuma Mina Campaign)	Reports Attendance register	Not applicable	Not applicable	Not applicable	Not applicable	Districts	Number	Quarterly	Higher	DHS Manager
SUB-PROGRAMME 2.5: PUBLIC HEALTH / OTHER COMMUNITY SERVICES											
6.4.4 Percentage of hospitals complying with health care risk	This measure hospitals that dispose waste in line with SANS 10248 regulation as a	Waste disposal management	Number of Hospitals that dispose waste in line with SANS 10248	Number of Hospitals during same time period.	None	None	Districts	%	quarterly	Higher	Manager health programmes

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
waste norms and standards	proportion of the total health facilities		regulation at a given reporting period								
3.4.1 Malaria cases reported	Malaria deaths reported as a result from primary malaria diagnosis at the time of death	Malaria Information System Midnight census	Malaria case reported	None	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Number	Annual	Lower	Environmental Health- Malaria Program
3.5.3 Covid-19 positivity rate	Number of confirmed positive cases against the total tests done	COVID 19 reports ;Lab trek NICD report	Number of confirmed covid-19 cases - Total	Number of Covid-19 tests conducted	N/A	N/A	All districts	%	Quarterly	Lower	Health programmes manager
3.5.4 Covid-19 incidence rate (per 100k)	New COVID 19 positive test results per 100 000 population	COVID epidemiologic report NICD report	Number of confirmed covid-19 cases - Total	Total population/ 100 000	N/A	N/A	All Districts	per 100k	Quarterly	Lower	Health programmes manager
3.5.5 Case Fatality Rate for covid-19	Number of deaths in positive Covid 19 <5 years	Facility registers NICD report	Number of deaths in positive Covid 19 cases < 5 years	Separations Covid 19 cases < 5 years (sum of deaths, discharges and transfer out)	N/A	N/A	All districts	%	Quarterly	Lower	Health programmes manager
3.5.6 Number of people vaccinated	Total number of people received Covid 19	Electronic Vaccination Data system	Number of people vaccinated against COVID 19	N/A	N/A	N/A	All District	Cumulative to date	Quarterly	Higher	Health programmes manager
SUB-PROGRAMME 2.6 : HIV & AIDS, STI & TB (HAST) CONTROL											
3.1.1 HIV test done - sum	Total number of HIV Tests done in all age groups	PHC Comprehensive Tick Register; HTS Register (HIV Testing Services) or HCT module in TIER.Net	SUM ([Antenatal client HIV 1st test]) +SUM ([Antenatal client HIV re-test]) + SUM ([HIV test **19-59 months**]) + SUM ([HIV test 5-14 years]) + SUM ([HIV test **15 - 24** years and older + 25 – 49 years + HIV test 50 years and older (excl. ANC)])	Nil	Dependent on the accuracy of facility register	Not applicable	Districts	%	Quarterly	Higher	HIV/AIDS Programme Manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
3.1.2 HIV positive 15-24 years (excl. ANC) rate	Adolescents and youth 15 to 24 years who tested HIV positive as a proportion of children who were tested for HIV in this age group	PHC Comprehensive Tick Register; HTS Register (HIV Testing Services) or HCT module in TIER.Net	HIV positive 15-24 years (excl ANC) rate	HIV test 15-24 years (excl ANC)	Dependent on the accuracy of facility register	Not applicable	Districts	%	Quarterly	Higher	HIV/AIDS Programme Manager
3.2.1 ART client naïve start ART during month – sum	All child and Adult who started live long ART as naïve clients during the month	ACR register Tier.net,	ART client naïve start ART during month – sum	None	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	Number	Quarterly	Higher	HIV/AIDS Programme Manager
3.2.2 ART adult [3]remain in care rate	Total adults remaining on ART (Adult TROA) at the end of the reporting month are the sum of the following: -Any adult that has a current regimen in the column designating the month you are reporting on. -Any adult client that has a star without a circle (someone who is not yet considered loss to follow-up (LTF) in the column designating the month you are reporting on. Clients remaining on ART equals [naïve	ART Register; Tiered System; DHIS	ART adult remain in care - total	ART adult start minus cumulative transfer out	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Higher	HIV/AIDS Programme Manager

[3] Please note that the process of finalising the APP and Business plan are not necessarily linked, the Final APP submission from Provincial Legislature dates are within second to third week of March and the Final Business plan is received from National Department of Health only late March /early April after submission of the APP. The Business plan may have change of targets especially TROA indicators.

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
	(including PEP and PMTCT) + Experienced (Exp) + Transfer in (TFI) + Restart] minus [Died (RIP) + loss to follow-up (LTF) + Transfer out (TFO)]										
3.2.3 ART child remain in care rate	Total children under 15 years remaining on ART (Child TROA) at the end of the reporting month are the sum of the following: -Any child under 15 years that has a current regimen in the column designating the month you are reporting on. -Any child under 15 years that has a star without a circle (someone who is not yet considered lost to follow-up (LTF) in the column designating the month you are reporting on. Clients remaining on ART equals [naive (including PEP and PMTCT) + Experienced (Exp) + Transfer in (TFI) + Restart] minus [Died (RIP) + lost to follow-	ART Register; Tiered System. DHIS	ART child remain in care - total	ART child start minus cumulative transfer out	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Higher	HIV/AIDS Programme Manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
	up (LTF) + Transfer out (TFO)]										
3.2.4 Male condoms distributed	Male condoms distributed from a primary distribution site to health facilities or points in the community (e.g. campaigns, non-traditional outlets, etc.).	Bin/ Stock card	Male condoms distributed	Male population 15 years and older (Male 15-44 years + Male 45 years and older)	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	Number	Quarterly	Higher	HIV/AIDS Programme Manager
3.2.5 Medical male circumcision - sum	Medical male circumcisions performed - sum	MMC register	SUM ([Medical male circumcision 10-14 years])+([Medical male circumcision 15 years and older]) + male circumcision performed by medical professional in traditional sector	None	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	Number	Quarterly	Higher	HIV/AIDS Programme Manager
3.2.6 Traditional male circumcision - sum	Traditional male circumcisions performed	TMC register	SUM TMC circumcision performed by Traditional practitioner in a traditional setting	Not applicable	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	Number	Quarterly	Higher	HIV/AIDS Programme Manager
3.2.7 ART Adult - viral load suppressed rate	Adults with suppressed viral load (VLS) of under 400 per millilitre (cps/Ml) at interval after ART started. An undetectable viral load is any result less than 400 copies / mL	Art clinical record	ART adult viral load under 400	ART adult viral load done	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Higher	HIV/AIDS Programme Manager
3.2.8 ART Child - viral load suppressed rate	Child with suppressed viral load (VLS) of under 400 per millilitre (cps/Ml) at interval after ART started. An	Art clinical record	ART child viral load under 400	ART child viral load done	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Higher	HIV/AIDS Programme Manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
	undetectable viral load is any result less than 400 copies / mL										
3.2.9 TB/HIV co-infected client on ART rate	TB/HIV co infected client on ART as a proportion of all HIV positive TB clients.	PHC Comprehensive Tick Register; Art clinical record Register (HIV Testing	DS TB client HIV positive on ART	DS TB client HIV positive	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Higher	HIV/AIDS Programme Manager
3.3.1 TB investigation done 5 years and older rate	TB investigation done 5 years and older as a symptomatic clients who tested positive as a proportion of TB symptomatic clients 5 years and older	THIS	TB investigation done 5 years and older	TB symptomatic client 5 years and older	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Higher	TB Programme Manager
3.3.2 DS - TB treatment start 5 years and older rate	DS TB treatment started as a proportion of those where confirmed DS TB in the 5 years and older age group	THIS	DS - TB treatment start 5 years and older rate	DS TB confirmed 5 years and older	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Higher	TB Programme Manager
3.3.3 TB XDR treatment start rate	TB XDR confirmed clients started on treatment as a proportion of TB XDR confirmed clients	DR TB register	TB XDR client confirmed start on treatment	TB XDR confirmed client	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Higher	TB Programme Manager
3.3.4 All DS -TB client treatment success rate	All TB clients who started drug susceptible tuberculosis (DS TB) treatment 12 ago and who have successfully completed treatment	TB register THIS	All TB client successfully completed treatment	All DSTB patients in treatment outcome cohort	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Higher	TB Programme Manager
3.3.5 TB Rifampicin Resistant/MDR/	TB Rifampicin Resistant (RR), multiple drug resistant (MDR) and	TB register THIS	TB Rifampicin Resistant/MDR/ pre -	TB Rifampicin Resistant/MDR/	Accuracy dependent on quality of data	Not application	All Districts	%	Quarterly	Higher	TB Programme Manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
pre - XDR treatment success rate	pre extensive drug resistance (pre-XDR) clients successfully completed treatment. Client who were cured and those who completed treatment. Cure patients are those who received treatment for recommended period of time (short: 9 months or long: 18 months) , remained clinically stable, achieved TB culture conversion and had at least three negative culture results after TB culture conversion. Those who successfully completed treatment are similar to the cured clients expect that they do not have three negative TB culture after culture conversion.		XDR successfully completed treatment	pre – XDR start on treatment	submitted by health facilities						
3.3.6 All DS - TB client lost to follow - up rate	All TB clients who started DS TB treatment 12 months ago but were lost to follow up during TB treatment. This is a subset for all TB clients' treatment outcome cohort. Lost	TB register THIS	All DS TB client lost to follow up	All DS TB patients in treatment outcome cohort	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Lower	TB Programme Manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
	to follow up is defined as interruption of treatment for period of two consecutive months or longer at any time during the treatment period.										
SUB-PROGRAMME 2.7: MATERNAL, CHILD AND WOMEN'S HEALTH AND NUTRITION (MCWH&N)											
1.1.1 Couple year protection rate	Women protected against pregnancy by using modern contraceptive methods, including sterilisations, as proportion of female population 15-49 year. Couple year protection are the total of (Oral pill cycles / 15) + (Medroxyprogesterone injection / 4) + (Norethisterone enanthate injection / 6) + (IUCD x 4.5) + (Sub dermal implant x 2.5) + Male condoms distributed / 120) + (Female condoms distributed / 120) + (Male sterilisation x 10) + (Female sterilisation x 10).	PHC Comprehensive Tick Register	(SUM ([Oral pill cycle]) / 15) + (SUM ([Medroxyprogesterone injection]) / 4) + (SUM ([Norethisterone enanthate injection]) / 6) + (SUM ([IUCD inserted]) * 4.5) + (SUM([Male condoms distributed]) / 120) + (SUM([Sterilisation - male]) * 10) + (SUM([Sterilisation - female]) * 10) + (SUM([Female condoms distributed]) / 120) + (SUM([Sub-dermal implant inserted]) * 2.5)	(SUM {[Female 15-44 years]} + SUM {[Female 45-49 years]}) /12	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Higher	MCW&H Programme Manager
1.1.2 Antenatal 1st visit before 20 weeks rate	Women who have a first visit before they are 20 weeks into their	PHC Comprehensive Tick Register,	Antenatal 1st visit before 20 weeks	Antenatal 1st visit total	Accuracy dependent on quality of data	Not application	All Districts	%	Quarterly	Higher	MCW&H Programme Manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
	pregnancy as proportion of all antenatal 1st visits	Tick register OPD		([Antenatal 1st visit 20 weeks or later]) + SUM ([Antenatal 1st visit before 20 weeks]	submitted by health facilities						
1.1.3 Antenatal client start on ART rate	Antenatal clients who started on ART as a proportion of the total number of antenatal clients who are HIV positive and not previously on ART	ART clinical record	Antenatal start on ART	Antenatal known HIV positive but NOT on ART at 1st visit	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Higher	MCW&H Programme Manager
1.1.4 Delivery in 10 - 19 years in facility rate	Deliveries to women under the age of 20 years as proportion of total deliveries in health facilities	Midnight census, Inpatient sick neonatal admission register, birth register, Peads register	Delivery 10-19 years in facility	Delivery in facility - total	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Lower	MCW&H Programme Manager
1.1.5 Maternal Mortality in facility ratio	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 100,000 live births in facility	Tick register, admission register, birth register	Maternal death in facility	Live births known to facility	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	Per 100 000	Annual	Lower	MCW&H Programme Manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
1.2.1 Live birth under 2500g in facility rate	Infant born alive in health facility who weighs less than 2500g	Delivery register	Live birth under 2500g in facility	Live birth in facility	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Lower	MCW&H Programme Manager
1.2.2 Mother postnatal visit within 6 days rate	Postnatal visits by a mother within 6 days of delivery. The visit can be at PHC facility or postnatal home visit by facility staff and include mother who were hospitalised within 6 days. The purpose of the visit if for postnatal check-up.	PHC comprehensive tick register Postnatal register, Maternity register, OPD register	Mother postnatal visit within 6 days after delivery	Delivery in facility - total	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Higher	MCW&H Programme Manager
1.3.1 Infant 1st PCR test positive at birth rate	Infants tested PCR positive for the first time at birth as proportion of infants PCR tested at birth	PHC comprehensive tick register, HCT module in Tier.net, Pead's ward register	Infant 1st PCR test positive at birth	Infant 1st PCR test at birth	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Lower	MCW&H Programme Manager
1.3.2 Infant PCR test positive around 10 weeks rate	Infants born to HIV positive women with PCR positive results around 10 weeks	PHC comprehensive tick register, HCT module in Tier.net, Peads ward register	Infant PCR test positive around 10 weeks	Infant PCR test around 10 weeks	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Lower	MCW&H Programme Manager
1.3.3 Immunisation under 1year coverage	A child who have completed his or her primary course of immunisation before the age of 1 year	PHC comprehensive tick register,	Immunised fully under 1 year new	Population under 1 year	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Higher	MCW&H Programme Manager
1.3.4. Measles 2nd dose coverage	Measles vaccine 2nd dose given to a child at 12 months after birth.	PHC comprehensive tick register	Measles 2nd dose	Target population 1 year	Accuracy dependent on quality of data	Not application	All Districts	%	Quarterly	Higher	MCW&H Programme Manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
	The cut of age is under 33 months				submitted by health facilities						
1.3.5 Death under 5 years against live birth rate	Children 29 days to 11 months who died during their stay in the facility as a proportion of all live births	PHC comprehensive tick register, OPD tick register	Death in facility 29 days - 11 months	Live birth in facility	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Lower	MCW&H Programme Manager
1.3.6 Neonatal death in facility rate	Infants 0-28 days who died during their stay in the facility per 1000 live births in facility	PHC comprehensive tick register, OPD tick register	Neonatal deaths (under 28 days) in facility	Live birth in facility	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	Per1K	Quarterly	Lower	MCW&H Programme Manager
1.3.7 Vitamin A dose 12-59 months coverage	Children 12-59 months who received Vitamin A 200,000 units, every six months as a proportion of population 12-59 months (The denominator is multiplied by 2 because each child should receive supplementation twice a year)	PHC comprehensive tick register, OPD tick register	Vitamin A dose 12-59 months (Vitamin A dose 15-59 months + COS vitamin A dose 12 to 59 months)	Target population 12 – 59 months *2 (Female 1 year + Female 02-04 years + Male 1 year + Male 02-04 years) * 2	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Higher	MCW&H Programme Manager
1.3.8 School learner underweight rate	Learner with weight diagnosed below the -2 SD line but above the -3 SD line for the first time	Tick register school health	School learner underweight	School leaners screened - sum	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	lower	MCW&H Programme Manager
1.3.9 Child under 5 years diarrhoea case fatality rate	A child under 5 years who died in a health facility where diarrhoea was documented as the main cause of death (count only the	Peads register	Diarrhoea death under 5 years	Diarrhoea separation under 5 years	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Lower	MCW&H Programme Manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
	main diagnosis). Where applicable these deaths must also be counted under SAM and MAM deaths										
1.3.10 Child under 5 years pneumonia case fatality rate	A child under 5 years who died in a health facility where pneumonia was documented as the main cause of death	Peads register	Pneumonia death under 5 years	Pneumonia separation under 5 years	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Lower	MCW&H Programme Manager
1.3.11 Child under 5 years severe acute malnutrition case fatality rate	Death in child under 5 years with severe acute malnutrition (SAM)	Peads register	Severe acute malnutrition inpatient under 5 years	Total nutritional assessments under 5 years in facility	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Lower	MCW&H Programme Manager
2.1.1 Child under 5 years food nutritional supplementation coverage	Children under 5 newly started on food nutritional supplementation as proportion of population under 5 years	PHC comprehensive tick register, OPD register	Child under 5 years food nutritional supplementation new	Population under 5 years	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Higher	MCW&H Programme Manager
4.1.1 School learner overweight rate	A learner with weight recoded above the + 2 SD line for the first time	Tick register school health	School learner overweight	School learner screened - sum	Accuracy dependent on quality of data submitted by health facilities	Not application	All Districts	%	Quarterly	Lower	MCW&H Programme Manager
SUB-PROGRAMME 2.8: CORONER SERVICES											
6.4.5 Percentage of post – mortem performed within 72 hours	Measures number of post-mortems performed by Forensic Pathologists within a period of 3 days of receiving the body from the SAPS as a	Death register	Number of cold bodies with post-mortem performed within 72 hrs. of receipt of body	Total number of cold bodies received from SAPS (expressed as percentage)	Not applicable	Not application	All Districts	%	Quarterly	Higher	Hospital services Programme Manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
	percentage of the total number of bodies received										
SUB – PROGRAMME 2.9: DISTRICT HOSPITALS											
6.2.3 Ideal hospital status obtained rate	Health facilities that obtained Ideal status (bronze, silver, gold) as a proportion of fixed PHC clinics and CHCs and or CDC and or Hospitals	ICS	Health facilities have obtained Ideal status	Number of hospitals	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	%	Annual	Higher	Hospital Manager
6.1.3 Patient experience of care satisfaction rate	Total number of Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	Patient Surveys	Patient Experience of Care survey satisfied responses	Patient Experience of Care survey total responses	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	%	Annual	Higher	Quality Assurance Manager
6.3.1 Severity assessment code 1 incident reported within 24 hours rate	Severity assessment code (SAC) one incident in the reporting month reported within 24 hours after occurrence of the incident. This allows for speedy follow up and intervention after the incident.	Patient safety incident register	Severity assessment code 1 incidents reported within 24 hours	Severity assessment code 1 incident reported	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	%	Quarterly	Higher	Hospital Manager
10.2.1 Percentage of Hospitals with functional hospital boards	Improve quality of services at Hospitals conducting regular meetings with functional Hospital Boards	Attendance Registers of meetings of hospital boards	Number of functional Hospital Boards	Number of Hospitals	Attendance Registers are accurately kept	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager
6.7.1 Average Length of Stay	The average number of client days an admitted client spends in	Tick register	Inpatient days + 1/2 Day patients	Inpatient separations	Accuracy dependent on quality of data	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
	hospital before separation. Inpatient separation is the total of Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all specialities				submitted by health facilities						
6.7.6 Inpatient Bed Utilisation Rates	Inpatient bed days used as proportion of inpatient beds approved - total days (inpatient beds x days in period) available. Include all specialities	Tick register	Inpatient days + 1/2 Day patients	Inpatient beds approved - total bed days available	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager
6.7.11 Expenditure per PDE	Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD headcount total) * 0.33333333	BAS report	Expenditure - total	Patient Day Equivalent - Total	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager
PROGRAMME 3: EMERGENCY MEDICAL SERVICES											
6.5.1 EMS P1 urban response under 30 minutes rate	P1 responses in an urban area where the response time was under 30 minutes	EMS province specific data collection tool.	EMS P1 urban response under 30 minutes	EMS P1 urban response	Accuracy dependent on quality of data from reporting EMS station	Not applicable	All districts	%	Quarterly	Higher	EMS Manager
6.5.2 EMS P1 rural response under 60 minutes rate	P1 responses in an rural area where the response time was under 60 minutes	EMS province specific data collection tool.	EMS P1 response rural under 60 minutes	EMS P1 rural response	Accuracy dependent on quality of data from reporting EMS station	Not applicable	All districts	%	Quarterly	Higher	EMS Manager
6.5.3 EMS Inter facility transfer rate	Inter-facility (from one inpatient facility to another facility) transfers as proportion	EMS province specific data collection tool	SUM ([EMS inter-facility transfer])	SUM([EMS clients total])	Accuracy dependent on the reliability of data	Not applicable	All districts	Number	Quarterly	Lower	EMS Manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
	of total EMS patients transported				recorded on the Efficiency Report at EMS stations and emergency headcount reported from hospitals.						
6.5.4 Number of Patients transported on the PTV services	Patients transported on the PTV referred to the next level of care	Logbook EMS province specific data collection tool.	Number of Patients transported on the PTV services	Not applicable	Not applicable	Not applicable	All districts	Number	Quarterly	Lower	EMS Manager
SUB-PROGRAMME 4.1: REGIONAL HOSPITALS											
6.2.4 Ideal hospital status obtained rate	Health facilities that obtained Ideal status (bronze, silver, gold) as a proportion of Hospitals	IHS	Health facilities have obtained Ideal status	Number of Regional hospitals	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	%	Annual	Higher	Quality Assurance Manager
6.1.4 Patient experience of care satisfaction rate	Total number of Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	Patient Surveys	Patient Experience of Care survey satisfied responses	Patient Experience of Care survey total responses	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	%	Annual	Higher	Quality Assurance Manager
6.3.2 Severity assessment code 1 incident reported within 24 hours rate	Severity assessment code (SAC) one incident in the reporting month reported within 24 hours after occurrence of the incident. This allows for speedy follow up and intervention after the incident.	Patient safety incident register	Severity assessment code 1 incidents reported within 24 hours	Severity assessment code 1 incident reported	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	%	Quarterly	Higher	Hospital Manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
10.2.2 Percentage of Hospitals with functional hospital boards	Improve quality of services at Hospitals conducting regular meetings with functional Hospital Boards	Attendance Registers of meetings of hospital boards	Number of functional Hospital Boards	Number of Hospitals	Attendance Registers are accurately kept	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager
6.7.2 Average length of stay	The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all specialities	Tick register	Inpatient days + 1/2 Day patients	Inpatient separations	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager
6.7.7 Inpatient bed utilisation rates	Inpatient bed days used as proportion of inpatient beds approved - total days (inpatient beds x days in period) available. Include all specialities	Tick register	Inpatient days + 1/2 Day patients	Inpatient beds approved - total bed days available	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager
6.7.12 Expenditure per PDE	Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD headcount total) * 0.33333333	BAS report	Expenditure - total	Patient Day Equivalent - Total	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager
SUB-PROGRAMME 4.2: SPECIALISED TB HOSPITALS											
6.2.5 Ideal hospital status obtained rate	Health facilities that obtained Ideal status (bronze, silver, gold) as a proportion of TB Hospitals	IHS	Health facilities have obtained Ideal status	Number of hospitals	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	%	Annual	Higher	Quality Assurance Manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
6.1.5 Patient experience of care satisfaction rate	Total number of Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	Patient Surveys	Patient Experience of Care survey satisfied responses	Patient Experience of Care survey total responses	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	%	Annual	Higher	Quality Assurance Manager
6.3.3 Severity assessment code 1 incident reported within 24 hours rate	Severity assessment code (SAC) one incident in the reporting month reported within 24 hours after occurrence of the incident. This allows for speedy follow up and intervention after the incident.	Patient safety incident register	Severity assessment code 1 incidents reported within 24 hours	Severity assessment code 1 incident reported	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	%	Quarterly	Higher	Hospital Manager
10.2.3 Percentage of Hospitals with functional hospital boards	Improve quality of services at Hospitals conducting regular meetings with functional Hospital Boards	Attendance Registers of meetings of hospital boards	Number of functional Hospital Boards	Number of Hospitals	Attendance Registers are accurately kept	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager
6.7.3 Average length of stay	The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all specialities	Tick register	Inpatient days + 1/2 Day patients	Inpatient separations	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager
6.7.8 Inpatient bed utilisation rates	Inpatient bed days used as proportion of inpatient beds approved - total days	Tick register	Inpatient days + 1/2 Day patients	Inpatient beds approve - total bed days available	Accuracy dependent on quality of data	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
	(inpatient beds x days in period) available. Include all specialities				submitted by health facilities						
6.7.13 Expenditure per PDE	Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD headcount total) * 0.33333333	BAS report	Expenditure - total	Patient Day Equivalent - Total	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager
SUB-PROGRAMME 4.3: SPECIALISED PSYCHIATRIC HOSPITALS											
6.2.6 Ideal hospital status obtained rate	Health facilities that obtained Ideal status (bronze, silver, gold) as a proportion of Psychiatric Hospitals	IHS	Health facilities have obtained Ideal status	Number of hospitals	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	%	Annual	Higher	Quality Assurance Manager
6.1.6 Patient experience of care satisfaction rate	Total number of Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	Patient Surveys	Patient Experience of Care survey satisfied responses	Patient Experience of Care survey total responses	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	%	Annual	Higher	Quality Assurance Manager
6.3.4 Severity assessment code 1 incident reported within 24 hours rate	Severity assessment code (SAC) one incident in the reporting month reported within 24 hours after occurrence of the incident. This allows for speedy follow up and intervention after the incident.	Patient safety incident register	Severity assessment code 1 incidents reported within 24 hours	Severity assessment code 1 incident reported	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	%	Quarterly	Higher	Hospital Manager
10.2.4 Percentage of Hospitals with	Improve quality of services at Hospitals conducting regular	Attendance Registers of	Number of functional Hospital Boards	Number of Hospitals	Attendance Registers are	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
functional hospital boards	meetings with functional Hospital Boards	meetings of hospital boards			accurately kept						
4.4.2 District specialist mental health teams established	All districts establish mental health teams	Attendance registers	Number of districts with mental health teams	Not applicable	Not applicable	Not Applicable	All Districts	Number	Annual	Higher	Hospital manager
SUB-PROGRAMME 5.1: CENTRAL HOSPITALS											
6.2.7 Ideal hospital status obtained rate	Health facilities that obtained Ideal status (bronze, silver, gold) as a proportion of Central Hospitals	ICS	Health facilities have obtained Ideal status	Number of hospitals	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	%	Annual	Higher	Hospital Manager
6.1.7 Patient experience of care satisfaction rate	Total number of Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	Patient Surveys	Patient Experience of Care survey satisfied responses	Patient Experience of Care survey total responses	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	%	Annual	Higher	Quality Assurance Manager
6.3.5 Severity assessment code 1 incident reported within 24 hours rate	Severity assessment code (SAC) one incident in the reporting month reported within 24 hours after occurrence of the incident. This allows for speedy follow up and intervention after the incident.	Patient safety incident register	Severity assessment code 1 incidents reported within 24 hours	Severity assessment code 1 incident reported	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	%	Quarterly	Higher	Hospital Manager
10.2.5 Percentage of Hospitals with functional hospital boards	Improve quality of services at Hospitals conducting regular meetings with functional Hospital Boards	Attendance Registers of meetings of hospital boards	Number of functional Hospital Boards	Number of Hospitals	Attendance Registers are accurately kept	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
6.7.4 Average length of stay	The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all specialities	Tick register	Inpatient days + 1/2 Day patients	Inpatient separations	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager
6.7.9 Inpatient bed utilisation rates	Inpatient bed days used as proportion of inpatient beds approved - total days (inpatient beds x days in period) available. Include all specialities	Tick register	Inpatient days + 1/2 Day patients	Inpatient beds approved - total bed days available	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager
6.7.14 Expenditure per PDE	Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD headcount total) * 0.33333333	BAS report	Expenditure - total	Patient Day Equivalent - Total	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager
SUB-PROGRAMME 5.2: TERTIARY HOSPITALS											
6.2.8 Ideal hospital status obtained rate	Health facilities that obtained Ideal status (bronze, silver, gold) as a proportion of Tertiary Hospitals	ICS	Health facilities have obtained Ideal status	Number of hospitals	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	%	Annual	Higher	Quality Assurance Manager
6.1.8 Patient experience of care satisfaction rate	Total number of Satisfied responses as a proportion of all responses from Patient	Patient Surveys	Patient Experience of Care survey satisfied responses	Patient Experience of Care survey total responses	Accuracy dependent on quality of data	Not Applicable	All Districts	%	Annual	Higher	Quality Assurance Manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
	Experience of Care survey questionnaires				submitted by health facilities						
6.3.6 Severity assessment code 1 incident reported within 24 hours rate	Severity assessment code (SAC) one incident in the reporting month reported within 24 hours after occurrence of the incident. This allows for speedy follow up and intervention after the incident.	Patient safety incident register	Severity assessment code 1 incidents reported within 24 hours	Severity assessment code 1 incident reported	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	%	Quarterly	Higher	Hospital Manager
10.2.6 Percentage of Hospitals with functional hospital boards	Improve quality of services at Hospitals conducting regular meetings with functional Hospital Boards	Attendance Registers of meetings of hospital boards	Number of functional Hospital Boards	Number of Hospitals	Attendance Registers are accurately kept	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager
6.7.5 Average length of stay	The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all specialities	Tick register	Inpatient days + 1/2 Day patients	Inpatient separations	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager
6.7.10 Inpatient bed utilisation rates	Inpatient bed days used as proportion of inpatient beds approved - total days (inpatient beds x days in period) available. Include all specialities	Tick register	Inpatient days + 1/2 Day patients	Inpatient beds approved - total bed days available	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
6.7.15 Expenditure per PDE	Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD headcount total) * 0.33333333	BAS report	Expenditure - total	Patient Day Equivalent - Total	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager
SUB-PROGRAMME 5.3: SPECIALISED TERTIARY HOSPITAL											
6.2.9 Ideal hospital status obtained rate	Health facilities that obtained Ideal status (bronze, silver, gold) as a proportion of specialised tertiary hospitals	ICS	Health facilities have obtained Ideal status	Number of hospitals	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	%	Annual	Higher	Quality Assurance Manager
6.1.9 Patient experience of care satisfaction rate	Total number of Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	Patient Surveys	Patient Experience of Care survey satisfied responses	Patient Experience of Care survey total responses	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	%	Annual	Higher	Quality Assurance Manager
6.3.7 Severity assessment code 1 incident reported within 24 hours rate	Severity assessment code (SAC) one incident in the reporting month reported within 24 hours after occurrence of the incident. This allows for speedy follow up and intervention after the incident.	Patient safety incident register	Severity assessment code 1 incidents reported within 24 hours	Severity assessment code 1 incident reported	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	%	Quarterly	Higher	Hospital Manager
10.2.7 Percentage of Hospitals with functional hospital boards	Improve quality of services at Hospitals conducting regular meetings with	Attendance Registers of meetings of hospital boards	Number of functional Hospital Boards	Number of Hospitals	Attendance Registers are accurately kept	Not Applicable	All Districts	%	Quarterly	Higher	Hospital manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
	functional Hospital Boards										
PERFORMANCE INDICATORS FOR HEALTH SCIENCES AND TRAINING											
6.4.6 Number of registrars trained	Doctors trained for specialisation	Attendance Registers	Number of registrars trained	Not applicable	Dependant on practitioners not dropping out the study course	Not Applicable	All Districts	Number	Annual	Higher	Human Resources Development Programme Manager
6.4.7 Number of nurses trained on post basic courses	Nurses trained on post basic course to improve service delivery	Attendance Registers	Number of registrars trained	Not applicable	Dependant on practitioners not dropping out the study course	Not Applicable	All Districts	Number	Annual	Higher	Human Resources Development Programme Manager
6.4.8 Number of EMS practitioners enrolled in emergency care degree	Emergency care practitioners enrolled in the emergency care degree to upgrade skills	Bursary database report	Number of EMS practitioners enrolled in emergency care degree	N/A	Dependant on practitioners not dropping out the study course	Not applicable	All district	Number Cumulative year -end	Annually	Higher	Programme Manager – Health Science and training
PERFORMANCE INDICATORS FOR HEALTH CARE AND SUPPORT											
6.4.9 Wheelchair issued adult 19 year and older rate	Wheelchairs issued to adults 19 years and older	PHC comprehensive tick register, Tick register OPD,	Wheelchairs issued to adults 19 years and older	Wheelchairs required 19 years and older	Depending on assessment and specialised need	Not applicable	All districts	%	Quarterly	Higher	Clinical support manager
6.4.10 Wheelchair issued child 0-18 years rate	Wheelchairs issued to children 0 -18 years	PHC comprehensive tick register, Tick register OPD,	Wheelchairs issued children 0 - 18 years	Wheelchairs required by children 0 - 18 years	Depending on assessment and specialised need	Not applicable	All districts	%	Quarterly	Higher	Clinical support manager
6.4.11 Hearing aid issued adult 19 year and older rate	Hearing aid issued to adults 19 years and older	PHC comprehensive tick register, Tick register OPD,	Hearing aid issued to adults 19 years and older	Hearing aid required by adults19 years and older	Depending on assessment and specialised need	Not applicable	All districts	%	Quarterly	Higher	Clinical support manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
6.4.12 Hearing aid issued child 0-18 years rate	Hearing aid issued to children 0 - 18 years	PHC comprehensive tick register, Tick register OPD,	Hearing aid issued to children 0 - 18 years	Hearing aid required by children 0 - 18 years	Depending on assessment and specialised need	Not applicable	All districts	%	Quarterly	Higher	Clinical support manager
3.5.9 Percentage COVID 19 tests with turnaround time (<48hours)	Time taken to get results from the Laboratory after the COVID 19 specimens have been taken	Lab trek	Number of Covid-19 tests with results < 48 hours	Number of Covid-19 tests conducted	Laboratory has a capacity to test al COVID 19 specimens	N/A	All districts	%	Quarterly	Higher	Clinical support services programme manager
3.5.10 Percentage Personal Protective Equipment availability in facilities	Availability of personal protective equipment for health workers working with 19 management	Stock visibility system	Number of PPE available per facility	Total number of PPE available in the essential list	Availability of PPE from the manufacturers	N/A	All districts	%	Quarterly	Higher	Clinical support services Manager
6.4.13 Percentage Order fulfilment for essential drugs at depot	Drug orders fulfilled completely	MEDSAS	Number of order fulfilled completely	Number of orders received x 100	Poor maintenance of stock levels by the depot	Not applicable	All districts	%	Quarterly	Higher	Clinical support manager
6.4.14 Percentage of availability of essential medicine at facilities.	Mange number of essential medicine on stock	MEDSAS	Number of essential medicines out of stock	Total number of essential medicines	Poor maintenance of essential medicines stock levels at the depot	Not applicable	All districts	%	Quarterly	Higher	Clinical support manager
6.4.15 Number of active patients on CCMDD	CCMDD clients who opted to collect their patient medicine parcels from CCMDD contracted external pick up points	CCMDD register	CCMDD Client collecting medicine parcel from contracted external pick up points (PUP)	Not applicable	Poor maintenance of essential medicines stock levels at the depot	Not applicable	All districts	Number	Quarterly	Higher	Clinical support manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
PROGRAMME 8: HEALTH FACILITIES MANAGEMENT											
6.6.1 Number of planned health facilities with major refurbishment	Number of existing health facilities where Capital, Scheduled Maintenance, (Management Contract projects only) have been completed (excluding new and replacement facilities).	Practical Completion Certificate Capital infrastructure project list, Scheduled Maintenance project list, and Contract projects).	Total number of health facilities with completed refurbishment	Total number of health facilities on the 10 year infrastructure plan that needed major refurbishment	Accuracy dependent on reliability of information captured on project lists.	Not applicable	All districts	Number	Annual	Higher	Manager Health facilities
6.6.2 Number of Health facilities with minor refurbishment	Number of existing health facilities where Professional Day-to-day Maintenance projects (Management Contract projects only) have been completed (excluding new and replacement facilities).	Job card / invoice, Professional Day-to-day Maintenance project list (only Management Contract projects).	Number of health facilities that have undergone minor refurbishment	Not applicable	Accuracy dependent on reliability of information captured on project lists.	Not applicable	All districts	Number	Quarterly	Higher	Manager Health facilities
6.6.3 Number of Major renovations or upgrades completed at facilities	Number of existing health facilities where Capital, Scheduled Maintenance, (Management Contract projects only) have been completed (excluding new and replacement facilities).	Practical Completion Certificate Capital infrastructure project list, Scheduled Maintenance project list, and Contract projects).	Number of health facilities that have undergone major upgrades	Not applicable	Accuracy dependent on reliability of information captured on project lists.	Not applicable	OR Tambo, Alfred Nzo, Chris Hani, Amathole	Number Non-cumulative	Bi Annual	Higher	Manager Health facilities
6.6.4 Number of Minor renovations or	Number of existing health facilities where Professional Day-to-	Job card / invoice,	Number of health facilities that have	Not applicable	Accuracy dependent on reliability of	Not applicable	O R Tambo, Alfred Nzo, BCM, NMB	Number & Non-cumulative	Quarterly	Higher	Manager Health facilities

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
upgrades completed at facilities	day Maintenance projects (Management Contract projects only) have been completed (excluding new and replacement facilities).	Professional Day-to-day Maintenance project list (only Management Contract projects).	undergone minor upgrades		information captured on project lists.						
6.6.5 Number of additional High Care bed spaces and beds at existing hospitals	A count of high care bed spaces created in the existing hospitals	Capital infrastructure project list, Scheduled Maintenance project list, and Contract projects).	Number of additional High Care bed spaces and beds at existing hospitals	Not applicable	Accuracy dependent on reliability of information captured on project lists.	N/A	All districts	Non-cumulative	Quarterly	Higher	Manager Health facilities
6.6.6 Number of additional Isolation beds at existing hospitals	A count of additional isolation bed spaces created in the existing hospitals	Capital infrastructure project list, Scheduled Maintenance project list, and Contract projects).	Number of additional Isolation bed spaces and beds at existing hospitals	Not applicable	Accuracy dependent on reliability of information captured on project lists.	N/A	All Districts	Non-cumulative	Quarterly	Higher	Manager Health facilities
6.6.7 Number of Regional and Tertiary Hospitals fitted with additional oxygen points at beds.	Number of facilities (regional and tertiary hospitals that have been fitted with additional oxygen points for COVID 19	Job card / invoice, Professional Day-to-day Maintenance project list (only Management Contract projects).	Number of Regional and Tertiary Hospitals fitted with additional oxygen points at beds	Not applicable	Accuracy dependent on reliability of information captured on project lists.	Not applicable	BCM, Chris Hani, Nelson Mandela , OR Tambo,	Non-cumulative	Quarterly	Higher	Manager Health facilities
6.6.8 Number of District Hospitals fitted	Number of facilities (district hospitals) that are fitted with	Job card / invoice,	Number of health facilities that have	Not applicable	Accuracy dependent on reliability of	Not applicable	All Districts	Non-cumulative	Quarterly	Higher	Manager Health facilities

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or non-cumulative	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator							
with additional oxygen points at beds.	additional oxygen points	Professional Day-to-day Maintenance project list (only Management Contract projects).	undergone minor refurbishment		information captured on project lists.						

CONCLUSION

This is the final 2021/22 Annual Performance Plan of the Department, which stands as a proposal to accelerate service delivery towards the achievement of its vision and mission as set out in the 2020/21 – 2024/25 Strategic Plan of the Department. The department is committed to supporting districts, sub-districts, and the facilities to achieve outcomes through implementation of outputs and agreed targets.