



Province of the
EASTERN CAPE
HEALTH

ANNUAL REPORT

2010/11



United in achieving quality health care for all



Ikamva eliqagambileyo!

PART A



GENERAL INFORMATION

PART A

GENERAL INFORMATION

SUBMISSION OF THE ANNUAL REPORT TO THE EXECUTIVE AUTHORITY

I have the honour of submitting the Annual Report of the Department of Health for the period 1 April 2010 to 31 March 2011 in compliance with Section 40 (1) (d) of the Public Financial Management Act



Dr S M Pillay
Accounting Officer: Department of Health
31 August 2011

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I. GENERAL INFORMATION

VISION, MISSION AND VALUES

Vision

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

Mission

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

Values

The Department's activities are anchored on the following values:

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

ORGANISATIONAL STRUCTURE

The organisational structure of the department (high-level structure) is attached hereto. This structure reflects the office of the MEC, the Superintendent General, and each of the four clusters i.e. Clinical Services, Finance, Corporate Services, and Corporate Strategy and Organisational Performance. In addition, there is a Chief Directorate: Risk Assurance and Internal Audit.

However, countless challenges with the organogram have been encountered (e.g. the structure has been found to be misaligned in that the Head Office is bloated, some operational areas are at Head Office and not where services are located, there are blurred reporting lines for certain key services, etc.); thus the structure does not conform to a decentralised service delivery platform. The steps taken include the ongoing re-alignment of the organisational structure based on the Revitalisation of Primary Health Care. This will ensure the empowerment of districts.

LEGISLATIVE AND OTHER MANDATES

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

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

- Labour Relations Act (Act No. 66 of 1995)
- Local Government: Municipal Demarcation Act, 27 of 1998
- Local Government: Municipal Systems Act, 32 of 2000
- Medical Schemes Act, 131 of 1997
- Medicines and Related Substances Act (Act No. 101 of 1965, as amended)
- Medicines and Related Substances Control Amendment Act, 90 of 1997
- Mental Health Care Act (Act No. 17 of 2002)
- National Health Act (Act No. 61 of 2003)
- National Health Laboratories Services Act (Act No. 37 of 2000)
- Non-Profit Organisations Act, 71 of 1977
- Nuclear Energy Act, 46 of 1999
- Nursing Act (Act No. 33 of 2005)
- Occupational Health and Safety Act (Act No. 85 of 1993)
- Pharmacy Act (Act No. 53 of 1974, as amended)
- Preferential Procurement Policy Framework Act (Act No. 5 of 2000)
- Prevention and Treatment of Drug Dependency Act, 20 of 1992
- Promotion of Access to Information Act, 2 of 2000
- Promotion of Administrative Justice Act, 3 of 2000
- Promotion of Equality and Prevention of Unfair Discrimination Act, 4 of 2000
- Protected Disclosures Act, 26 of 2000
- Public Finance Management Act (Act No. 1 of 1999, as amended) and the Treasury Regulations
- Public Service Act (Act No. 103 of 1994) and the Public Service Regulations
- Road Accident Fund Act, 56 of 1996
- Sexual Offences Act, 23 of 1957
- Skills Development Act (Act No. 97 of 1998)
- Skills Development Levies Act, 9 of 1999
- South African Medical Research Council Act, 58 of 1991
- South African Police Services Act, 68 of 1978
- State Information Technology Agency Act, 88 of 1998
- Sterilisation Act, 44 of 1998
- The Constitution of the Republic of South Africa (Act No. 108 of 1996)
- Traditional Health Practitioners Act (Act No. 35 of 2004)
- Tobacco Products Control Act, 83 of 1993

FORWARD BY MEC FOR HEALTH



The 2010/11 Annual Performance Report of the Department reflects the process of implementing the ten health priorities that were identified for major improvement in the health care system.

Equally important, this report is also prepared against the background of the accelerating the implementation of the Millennium Development Goals which is to:

- a) reduce by 2/3 the under-five mortality rate by 2014
- b) reduce by $\frac{3}{4}$ the maternal mortality rate by 2014
- c) halting and reversing the spread of HIV and AIDS and TB by 2014.

The progress and achievements regarding the above matters are provided in the document in Programme Two (02) of this Annual Report.

At the centre of the provision of health care, the Department did indicated that it will also implement a number of campaigns to promote healthy lifestyles with concerted effort to build a strong primary health care foundation through social compact and mobilisation of communities as part of accelerating the implementation of the millennium development goals.

Although progress and challenges for 2010/11 are reflected in the performance report of the different programmes, it is also important to report and highlight certain progress made by the Department which includes among other things the following:-

- a) The Provincialization of Primary Health Care Facilities with the exception of the two Metropolitan Municipalities was finalised accordingly.
- b) The number of Community Health Centres rendering 24hour services has been increased from 27 in the previous financial year to 31 in an attempt to improve access to primary health care services to all the citizens of the Eastern Cape Province.
- c) In addition, the number of CHCs providing MOU and Trauma has been increased to 30 MOU'S and 29 Trauma units respectively.
- d) The Department established 21 new health posts, which make a total of 103 health posts province wide. Fourteen of these were established in Ukhahlamba, 18 in OR Tambo, 20 Amathole, 20 Chris Hani, 8 Cacadu and 23 Alfred Nzo districts.
- e) A total of 1,055, 755 clients were tested through HCT campaign. Although this output is less than the target of 1,6million set for 2010/11, it is significantly higher (55%) than the number of clients (471 484 clients) tested through VCT programme during 2009/10 financial year.
- f) There has been a significant reduction in number of new TB cases reported during the year 2010. The incidence of TB seems to have peaked in 2008 and declined thereafter. A 27% decrease from 983 per 100 000 in 2008 to 722 per 100 000 in 2010 has been observed. The declining trend is observed across all seven districts. This has been achieved through concerted efforts and strategies that include the Intensified Case Finding intervention which includes tracing and screening of contacts for the smear positive patients and drug resistant patients.
- g) A total of 136 midwives and doctors were trained on ESMOE and anaesthesia which aimed at improving their competency in prevention and management of complicated deliveries. Target group for capacity building on anaesthesia were doctors, especially those working in district hospitals. About 76 health professionals of those trained on ESMOE were also trained of IUCD and cervical cancer screening, and 16 of them were trained on the insertion of IUCD. Incorporation of pap smear collection and insertion of IUCD in OSMOE trainings has resulted in the increase of cervical cancer screening to 36.1% in 2010/11 financial year.
- h) In Port Elizabeth for the 2010 World Cup, a state of the art call-taking facility with Customer Relations Monitoring (CRM) and automated call-taking and recording was piloted. This system will be duplicated for the entire province and will be located at the Departmental integrated Call Centre in East London.
- i) 213 new bursaries were awarded during 2010/11 financial year for different categories of

health professionals. A revised bursary recruitment and contracting process has been phased in which aligns the Department's efforts closely to the goals of the Social Compact. As of February 2011, bursars are now contracted to return to the sub-districts from which they were recruited.

- j) Construction of four new clinics namely Thabalesoba, Ntafufu, Ntsitho and Qiba clinics was completed. Two clinics Mangoameleng and the 5th Avenue Walmer were successfully upgraded. The Accident and Emergency (A&E) Centre at Livingstone hospital was completed just on time for the 2010 FIFA World Cup and was handed over at the beginning of June 2010. Construction of Oncology unit and accommodation at Livingstone and Cecilia Makiwane hospitals respectively, is underway and progressing well.

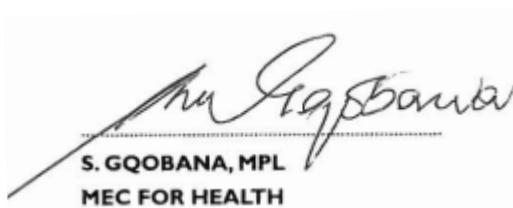
The above progress has not distracted the department in understanding and appreciating the serious challenges that the Department experienced during the 2010/11 period. These challenges are clearly documented in the different Programmes of this report and the department and the executive management has been instructed to deal and manage all the challenges that we experienced.

It is without doubt that the provision of health services to our communities will continue to be strengthened as this is a constitutional responsibility and the priority of the ruling party in government.

As we report to the citizenry of the Eastern Cape Province, and to other stakeholders, there is a mammoth task ahead for all of us to appreciate the strides the department is making including the challenges that we are facing so that we do not rest on our laurels, but continue to provide the best health care services with the minimal resources we have.

I therefore wish to take this opportunity to thank all the health professionals, the leadership of our health facilities and programmes, executive management of the Department for their commitment in providing health services to our communities.

Furthermore, the advice and positive critique that we received and appreciated from the EXCO of the Province and the Provincial Legislature during the 2010/11 financial year will always be welcomed and utilized to improve our systems so as to strengthen the provision of health services in the Province.



S. GQOBANA, MPL
MEC FOR HEALTH

ACCOUNTING OFFICER'S OVERVIEW



During the year under review the Department went through an exciting but also full of challenges period. We were called upon to implement the new Term of Government Program of Action and new policies following national elections in mid 2009. Health services were prioritized for

intense focus and the new Ten Point Plan called on the Department to develop the new Program that was based on the Revitalization of Primary Health Care - "back to basics".

There was a change of political heads, MEC Mr. P. Masualle was deployed to the Department of Provincial Planning and Finance in November 2011 and MEC Mr. M. Gqobana joined the department on the 1st December 2011

POLICY CHANGES

The provincialization of 19 of the 26 municipalities that provided PHC services on behalf of the department has been completed, with the remaining targeted for completion in the new financial year. This was done in line with the function shift between provincial and local government as stipulated by the National Health Act, 2003 in order to address the fragmentation within the management of PHC services. The two Metropolitan Municipalities (Nelson Mandela Bay and the new Buffalo City Metropolitan) were still negotiating retention of these PHC services.

The President's announcement on 1st December 2009 was followed by the Department launched the HIV Counselling & Testing (HCT) Campaign in all our districts. In the reporting period, the department has seen 478 079 people (and 405 606 people were tested) and 13% tested positive. The department is also implementing the new ART guidelines, namely, providing ARV treatment to special groups with CD4 count of 350 or less, HIV positive multi-resistant TB patient and children

Government introduced the outcome-based delivery and monitoring system that will ensure that performance is focused on identified critical areas. The MEC for Eastern Cape Department of Health has

signed the Negotiated Service Delivery Agreement with the National Minister of Health committing the department to contribute towards identified Four Outputs and one Outcome in the health sector. The department will also work closely with other partners in the delivery of health services

The un-intended policy consequences of the Occupation Specific Dispensation continue to impact negatively on the management of the compensation of employees in the Department. Although this matter is a national prerogative, the Department is engaging with it, both at the Bargaining Chamber, the Cabinet Budget Committee and with the Provincial Treasury

A new collective agreement, the PHSDSBC Resolution No. 2 of 2010 came into effect, introducing an Occupation Specific Dispensation (OSD) for Therapeutic, Diagnostics and Allied Health Professionals. The OSD introduces higher remuneration packages and career paths for these professionals with an impact on compensation for employees (COE).

The Office of the Premier is spearheading province-wide communication on the Public Service Transformation Strategy to ensure implementation of this strategy by all departments. This seeks to transform Public Service.

FINANCIAL MANAGEMENT

During the year under review the department was allocated an adjusted budget of R13.8 billion. At the end of the financial year 95.89% of the budget had been spent resulting in an overall under expenditure of R569.1 million, which translates to 4.11% of the budget. The under spending is primarily as a result of delays in the procurement of infrastructure projects and machinery and equipment.

The non - transfer of the fifth instalment of R100 million of the infrastructure grant to provinces for the 2010/11 financial year due to the Province on 04 February 2011, which amount was stopped by National Treasury in accordance with section 17 of the 2010 Division of Revenue Act contributed to the under expenditure.

The department has applied for the Conditional Grants funds totalling R489.7 million appropriated but not spent in the 2010/11 financial year to be rolled over to the 2011 / 2012 financial year. The request for roll over is supported by commitments where goods and services had been delivered or rendered and therefore funds were committed and the department is either awaiting submission of invoices by suppliers or invoices had been received but will be paid in the next financial year.

The financial affairs of the Department must be placed in the context of the significant financial pressures faced by the Eastern Cape Department of Health as a result of underfunding which manifest in accruals and carry through costs in the structure of the Department's budget for 2010/11.

Notably, the achievements of the department for 2010/11 were largely curbed by the substantial over-expenditure incurred in prior years (2008/09 and 2009/10), which resulted primarily from insufficient funding for the carry through costs of the Occupational Specific Dispensation (OSD) for nurses, the payment of HROPT and the impact of accruals from previous years.

In an effort to address the underfunded occupation specific dispensation and unbudgeted / unfunded HROPT mandate carry through costs, the budget for compensation of employees was increased by R2 billion or 29.3% from the R6.4 billion allocation in 2009/10 to R8.3 billion in 2010/11. This has meant that the proportion of the budget allocated to COE has increased from 54% in 2009/10 to 63% in 2010/11.

This increase has been at the expense of other critical allocations such as goods and services and buildings and fixed structures which have seen their allocations reduced to make up for shortfalls in this area.

HIGHLIGHTS OF ACHIEVEMENTS

The Department contributed immensely to the country's success in hosting 2010 FIFA World Cup. Working closely with other provincial sister departments, the Department provided services from disease surveillance, Emergency Medical Services, and the provision of the world class Accident & Trauma Centre in Port Elizabeth. Areas around official FIFA World Cup venues also had our facilities put on full alert and readiness for any calamity that may have happened.

The experience and institutional memory and most of these facilities will form part of the FIFA World Cup legacy and will continue to provide better services to the community members. There were no adverse events or reported incidents and both National Department of Health and FIFA were satisfied with the standard and quality of our services.

The Department has embarked on a project to strengthen PHC services and prioritized three sub-districts in the province for implementation in the next three years. The program focused on Social Compact and community mobilization, and it took place in Uitenhage (Nelson Mandela Metro), Intsika Yethu (Chris Hani District), and King Sabata Dalindyebo (O R Tambo District)

As part of the transformation the Department initiated the Revenue Generation project in identified hospitals to increase attraction of specialist clinicians and create teaching platform. Part of the project was negotiating policy changes with Provincial Treasury for retention some of the generated income. The finalisation and appreciation of the policy and strategy to retain revenue generated by the Department is of critical importance in finding additional sources of revenue.

In the reporting year, the prevalence of diabetes and hypertension increased by 2.4% and 9.9% respectively. This is evidence that non-communicable diseases are increasingly becoming a challenge we need to address.

Notably, we have showed slight improvement in the maternal deaths with decrease from 269 (2009) to 229 (2010). A lot of investment was made with the training of a total of 303 health professionals (doctors and midwives) on various programs including ESMOE, BANC, and IUCD insertions. The Department has moved 36 ambulances that have been designated to service obstetric and neonatal services from bases and placed them at the health facilities'

We have recorded reduction in the new TB cases from 983 in the previous year to 722 per 100 000 in the reporting year. All of this can be attributed to Intensified Case Finding and other strategies.

CHALLENGES

Firstly, the national three weeks 2010 general public service strike that took place in August and September; strike compromised effective service

delivery especially essential services like health. The department, one of the hardest hit departments, is however appreciative to certain members of our staff who exercised their professional and ethical responsibility by staying put and continuing to provide services despite intimidation and other threats. This group of our staff and some community members who also came and assisted ensured that risk to loss of life and threat to patient safety were minimized.

Estimated total man-hours of 6 769hrs was lost to the strike, which was rife with intimidation and complete shut-down of health services in certain areas.

The second challenge relates to severe budgetary constraints with a threat of not only over-expenditure but also not delivering adequate services in our

facilities. Details of over-expenditure and deferment of non-critical work is explained in the programmes. The department continues to work closely with the National Department of Health and Provincial Treasury to find solutions to this challenge.



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DR S PILLAY

SUPERINTENDENT-GENERAL

31 August 2011

PART B



**INFORMATION ON
PREDETERMINED OBJECTIVES**

2. 1.INFORMATION ON PRE-DETERMINED OBJECTIVES

2.1 OVERALL PERFORMANCE

2.1.1 VOTED FUNDS

Main Appropriation R'000	Adjusted Appropriation R'000	Actual Amount Spent R'000	(Over)/Under Expenditure R'000
133,408,72	13,842,348	13,272,823	569,525
Responsible Minister/ MEC	MEC for Health, Province of the Eastern Cape		
Administering Dept	Department of Health		
Accounting Officer	Superintendent General, Department of Health, Province of the Eastern Cape		

2.1.2 AIM OF VOTE

The main aim of the Department of Health is to develop and implement a sustainable, co-ordinated, integrated and comprehensive health system based on the primary health care (PHC) approach, which encompasses promotive, curative, rehabilitative, supportive and palliative care. This is guided by the principles of accessibility, equity, community participation, appropriate technology, inter-governmental and inter-sectoral cooperation.

The department provides health services primarily to the uninsured population of the province, who comprise approximately 89% of the province's total population of approximately 6,7 million people (2010 mid-year estimates), and amounting amounts to 5,963m million uninsured people.

The department provides the following four categories of health services:

Primary health care services - This category focuses on the prevention of illness and the provision of basic curative health services. These services include immunisation, health promotion, HIV and AIDS prevention and treatment, nutrition, maternal, child and women's health (MCWH), communicable disease control, environmental health, oral and dental health, rehabilitation and disability, occupational health and chronic diseases, mental health and prevention and treatment of tuberculosis (TB).

Hospital services - District, general and provincial hospitals cater for those patients who require admission to hospital for treatment at the general practitioner level, and at the specialist level, respectively.

Tuberculosis hospitals, psychiatric/mental hospitals and sub-acute, step-down and chronic medical hospitals provide hospitalisation for patients suffering from tuberculosis, mental illnesses and those patients requiring long-term nursing care. Tertiary hospitals provide facilities and expertise needed for sophisticated medical procedures.

Forensic pathology services - The aim is to render forensic pathology and medico – legal services.

Emergency medical services - The aim of this category is to provide emergency care and transport for victims of trauma, road traffic accidents, and emergency medical and obstetric conditions. Planned patient transport is provided for inter-hospital transfer, while indigent patients are transported between clinics and hospitals.

Other

- Delivery of support services to ensure efficient health services.
- The overall management and administration of the delivery of public health care within the province.
- The development of organisational structures that enable effective quality service delivery.
- The regulation of private health care.

2.1.3 SUMMARY OF PROGRAMMES

The activities of the Department are carried out through eight programmes, of which five are directly linked to its core function. These are briefly described below.

Programme 1: Health Administration

This programme is composed of two sub-programmes namely, the Office of the MEC and Management. The objectives of these sub-programmes are detailed below:

Office of the MEC

The objective of this sub-programme is to provide political and strategic direction to the department by focusing on transformation and change management. It assists the MEC to:

- Give political and strategic direction to the Department through an efficiently and effectively managed office;
- Liaise between the offices of the Political Head and Head of Department in particular, and branches in general, on major policy and administration matters;
- Circulate cabinet resolutions to the HOD for implementation by the department ensuring that the MEC attends departmental strategic sessions and other functions of the Department; and
- Respond to parliamentary questions and ensure that resolutions of the legislature are implemented.

Management

This sub-programme is responsible for the management of human, financial, information and infrastructure resources. It is made up of the Office of the Superintendent General and the policy, strategic planning, co-ordination and regulatory functions of the head office located in the different clusters i.e. Clinical, Corporate and Financial Services as well as the Corporate Strategy & Organisational Performance (CS&OP).

Programme 2: District Health Services

The objective of the District Health Services (DHS) is to ensure delivery of PHC services through the implementation of the district health system. This programme consists of nine sub-programmes outlined below:

- District Management manages the effectiveness and functionality of 7 districts

and municipalities within the social needs cluster, especially in the Integrated Sustainable Rural Development Plan (ISRDP), URP nodes and the identified the 12 poorest municipalities; coordination of health services, referrals, supervision, evaluation and reporting as per provincial and national policies & requirements.

- The Community Clinics sub-programme manages the provision of preventive and curative care and priority health programme implementation through accessible clinics and mobile services in 24 sub-districts.
- The Community Health Centres (CHC) sub-programme renders 24 hour health services, maternal health at midwifery units and the provision of trauma services, as well as the integration of community-based mental health services within the down referral system.
- The Community-Based Services sub-programme manages the implementation of the community-based health services framework. This includes implementation of prevention strategies at the community level, promoting healthy lifestyles through health education and support, as well as strengthening of traditional health services.
- The Other Community Services sub-programme manages the devolution of Mental Health Services (MHS) to the municipalities and implements Environmental and Port Health policies and strategies to control the spread of diseases. Through this sub-programme, oral health services are provided at a community level (including schools and old age homes) and the prevention of substance, drug, and alcohol abuse is promoted to reduce unnatural deaths. In addition, geriatric services are provided for support and rehabilitation.
- The HIV & AIDS sub-programme renders PHC services in respect of the prevention of HIV and AIDS infections through campaigns, continuous care, management and treatment (CCMT) as well as strengthening and increasing access to the antiretroviral treatment (ART) programme.
- TB management and Control is responsible for the implementation of strategies and interventions to reduce TB incidence.
- The Integrated Nutrition sub-programme renders nutrition services as a poverty alleviation programme through the provision of nutrition supplements including

Vitamin A, Iodine and Zinc aimed at specific target groups (children, pregnant mothers, & the aged) to address malnutrition; the provision of formula feeds to health facilities; the establishment of food gardens at clinics, CHCs & hospitals and assisting communities to start community gardens in collaboration with the Department of Agriculture to fight poverty.

- Maternal, Child and Women's Health (MCWH) sub-programme

Through this sub-programme, the department implements strategies and policies to reduce maternal and child mortality and morbidity.

- The District Hospitals sub-programme is to provide a comprehensive and quality district hospital service to the people of the Eastern Cape Province.

Programme 3: Emergency Medical Services

The purpose of this programme is to render an equitable, efficient, effective, professional and sustainable emergency medical service. The programme comprises two sub-programmes with the following objectives:

- To render emergency medical and rescue services including both road and air ambulance services, patient operations and communications.
- To render planned patient transport including local outpatient transport (within the boundaries of a given town or local area) and inter-city/town outpatient transport (into referral centres).

Programme 4: Provincial Hospital Services

The objective of this programme is to provide cost-effective, good quality, effective and efficient secondary hospital services as well as academic outreach & in-reach support to lower level health facilities to strengthen District Health Services. The programme has three sub-programmes with the following objectives:

- General (Regional) Hospitals: Rendering of hospital services at general specialist level and providing a platform for research and the training of health workers.
- TB Hospitals: To convert current tuberculosis hospitals into strategically-placed centres of excellence in which a

small percentage of patients may undergo hospitalisation under conditions that allow for isolation during the intensive phase of treatment, as well as the application of the standard multi-drug resistant (MDR) protocols.

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

Programme 5: Central Hospital Services – Provincial Tertiary Services

The purpose of this programme is to provide cost effective, good quality, effective and efficient tertiary hospital services as well as academic outreach & in-reach support to lower level hospitals to strengthen the DHS.

Programme 6: Health Science and Training

The objective of this programme is to provide training, development and academic support to all health professionals and employees in the Province. The Programme consists of five sub-programmes and these are:

- Nursing Training Colleges: Training of nurses at undergraduate level and post-basic level.
- EMS Training College: Training of rescue and ambulance personnel.
- Bursaries: Provision of bursaries for health science training programmes at undergraduate and postgraduate levels.
- Other Training: Provision of PHC-related training for personnel provided by the regions.
- Skills Development: Provision of interventions for all occupational categories in the department.

Programme 7: Health Care and Support Services

The programme deals with Orthotic and Prosthetic (O&P) services and houses Clinical Support Management. The latter is composed of Laboratory, Radiography and Rehabilitation services. Whilst the management of clinical support falls under programme 7, the budget for this function resides with hospital services.

- Orthotic and Prosthetic Services render specialised, assistive clinical device services including prescription, manufacturing and distribution of orthoses, prostheses, hearing and walking aids;
- Medicine Trading Account (Pharmaceuticals Depot Management) renders specialist cross-functional pharmaceutical, supply chain, financial, risk and human resources management (HRM) to strengthen service delivery in the two pharmaceutical depots.

Programme 8: Health Facilities Management

The purpose of the Health Facilities Management is to improve access to health care services through the provision of new health facilities, upgrading and revitalization, as well as maintenance of existing facilities including the provision of appropriate healthcare equipment. The programme consists of three sub-programmes:

- Health Facilities Planning - this encompasses planning, design, construction of new and replacement facilities.
- Health Facilities Maintenance - this includes general maintenance of buildings and servicing of building equipment & mechanical plants.
- Hospital Revitalization Programme – this is responsible for revitalization of health facilities through infrastructural development, health technology management, quality assurance and organizational development.

2.1.4 KEY STRATEGIC OBJECTIVE ACHIEVEMENTS

Although programme performance and the achievements are presented and discussed in section 2.2 of this annual report for each programme individually, the following are significant achievements that are worth mentioning:

Objective:

To achieve 100% implementation and institutionalisation of financial management

strategy, systems and platform to support service delivery of the organization.

Revenue Generation

The department is currently in the process of initiating income generating projects in identified hospitals to increase its attraction and retention of revenue, as well as increasing its nucleus of health facilities towards readiness for the implementation of the National Health Insurance Policy, which will have a positive effect on its operations in future financial periods. The Departmental Revenue collected amounted to R85.97 million, which exceeded the targeted amount by approximately R11.0 million.

Objective:

To develop the DHS by strengthening the district health service platform based on a regionalised service delivery model and PHC approach.

Provincialisation of Municipal PHC services

The provincialisation of 19 of the 26 municipalities that provided PHC services on behalf of the department has been completed, with the remaining 7 targeted for completion in the new financial year. This was done in line with the function shift between provincial and local government as stipulated by the National Health Act, 2003 in order to address the fragmentation within the management of PHC services.

Provincialisation of Provincially-Aided Hospitals (PAHs)

Administration in 18 Provincially-Aided Hospitals (PAHs) was officially taken over by the Department of Health. Signing of the Transfer Agreements by all relevant stakeholders and absorption of employees in terms of Section 197 of the Labour Relations Act was done successfully for 18 hospitals.

Provision of 24 hour Service in CHCs

Despite the province being faced with challenges in terms of human resources and infrastructure, the number of CHCs rendering 24 hour services has increased from 27 in the previous financial year to 31 in an attempt to improve access to PHC services for all the citizens of the Eastern Cape Province. In addition, the number of CHCs providing MOU

and Trauma has been increased to 30 and 29 respectively; 75% of CHCs are rendering 60% of the PHC package.

Establishment of Health Posts

Through the implementation of the social compact (one of the five DOH priorities) the Department has seen the involvement of communities in health issues and has managed to establish 21 new health posts, which make a total of 103 health posts province wide. Fourteen of these were established in Joe Gqabi, 18 in OR Tambo, 20 in Amathole, 20 in Chris Hani, 8 in Cacadu and 23 in Alfred Nzo districts. Community members with the assistance of the DOH select local residents who have been trained by the DOH on home-based care to run these health posts. The primary function of the health post is to educate on disease prevention and health promoting strategies. Health posts also provide accommodation or venues for support group meetings. Health posts are used as a strong support to PHC facilities and assist by performing activities at the community level. Whilst these refer to clinics, in turn they are used to do follow-up on PHC clients.

Objective:

To improve and strengthen maternal and child health services.

Establishment of Child Friendly Villages

With the implementation of Revitalisation of Primary Health Care (RPHC), one of the ECDOH priorities is the provincial focus on disease prevention strategies at a community level. This has resulted in the rolling out of Child Focus Villages (CFV), an initiative that is meant to strengthen the child health programs in order to reduce child mortality. Thirteen CFVs were established in five districts including Chris Hani, Cacadu, Joe Gqabi, Amathole and OR Tambo. Door to door campaigns were conducted by the DOH in collaboration with the local municipalities, traditional leaders and the Department of Social Development. Children at risk (those not immunized, poor nutritional status, orphaned and vulnerable children (OVCs)) were identified, assessed and referred for assistance.

Baby-Friendly Hospital Initiative

Efforts to reduce child mortality and improve child survival also include the accreditation of

four hospitals as baby friendly with the EC province having a total of 38 baby-friendly hospitals during the financial year 2010/11.

Implementation of the NCCEMD Recommendations

Reduction in maternal mortality ratio from 202 to 188 per 100 000 live births was observed by the end of the year under review. In order to improve the skill and competency in both prevention and management of obstetric complications and reduce maternal and neonatal deaths, a total of 303 health professionals (doctors and midwives) were trained on various programs including:

- Essential Steps in the Management of Obstetric Emergency (ESMOE) and anaesthesia
- Basic Antenatal Care services (BANC)
- Contraception with more focus on emergency contraceptive and intrauterine cervical device (IUCD)

A total of 136 midwives and doctors were trained on ESMOE and anaesthesia which aimed at improving their competency in prevention and management of complicated deliveries. The target group for capacity building on anaesthesia were doctors, especially those working in district hospitals. About 76 of the health professionals trained on ESMOE were also trained on IUCD insertion and cervical cancer screening, and 16 were trained on the insertion of IUCD. The incorporation of pap smear collection and insertion of IUCD in ESMOE trainings has resulted in the increase of cervical cancer screening to 36.1% in 2010/11 financial year. Approximately 76 midwives were trained on BANC.

In addition, the NCCEMD recommended the availability of emergency blood in all health facilities that perform caesarean sections. Fifty four district hospitals including all district hospitals that perform caesarean sections now have emergency blood services.

Emergency Medical Services

In order to improve response times and curtail maternal and neonatal deaths from obstetric emergencies, the EMS vehicles are being de-provincialised from the Medical Emergency Transport and Rescue Organization (METROs) bases to be stationed at health facilities for easy

accessibility to the communities at the time of need. A total of 36 ambulances have been designated to service Obstetric and Neonatal emergencies at 32 identified health facilities with Obstetric Maternal Units (MOU) as well as three busy hospitals namely Port Elizabeth Health Complex, East London Health Complex and Mthatha Health Complex to enhance inter-hospital transfers of emergency cases.

Objective:

To combat and reduce diseases of lifestyle and mental condition

Oral health

Approximately 315 tooth fissure sealant applications were performed on children between the ages of six and 12 years to prevent tooth decay.

Operation Smile

Madzikane kaZulu Memorial Hospital was used as a provincial centre for screening of 55 clients and for operating on 21 patients with cleft lips and palates by Operation Smile, which is an independent international organization. Operation Smile also trained 48 health professionals on Basic Life Skills from All Saints, St. Barnabas and Madzikane kaZulu Memorial Hospitals.

Prevention of blindness

A total of 5,787 cataract operations were performed translating to a provincial cataract operation rate of 866 per 100 000 population. For clients with irreversible blindness, low vision service is rendered in only one of the seven planned sub-districts namely Nelson Mandela Metro. A three year contract was signed between the Department and International Centre for Eye-care Education (ICEE) for provision of spectacles and mentoring of optometry services. This will also support in training of nurses on eye screening at all levels of care.

Prevention and management of chronic diseases

To reduce morbidity and mortality due to diseases of lifestyle, or non-communicable disease (NCD), including hypertension, diabetes, asthma and cancer, a long-term care model is being implemented in nine sub-districts. A total of 50 nurses had been trained on the long-term care model and diabetes strategies. All priority

sub-districts were supplied with basic equipment. In addition, 65 officials comprising of nurses, physiotherapists and NCD managers were trained from six priority districts on stroke management. In an effort to establish stroke units, three hospitals (Butterworth, Madzikane kaZulu and Settlers Hospitals) allocated cubicles in the medical ward which are used as stroke units. A plan of expanding this initiative to other district hospitals has been put in place for the next financial year.

Child and Youth Psychiatry Services

In order to assist the families and carers for children and youth with mental health challenges, the department has established nine Child and Youth Psychiatry services in nine sub-districts. This has been done in collaboration with officials from the Social Development and Education departments who formed part of the intersectoral teams consisting of mental health nurses, social workers, teachers, psychologists and psychiatrists. Against the target of 10, the department managed to implement the service in nine sub-districts. These sub-districts include Lukanji, Buffalo City, Matatiel, Mzimvubu, Makana, Kouga, Senqu, Nelson Mandela Metro and Inxuba Yethemba.

Objective:

To combat and reduce HIV & AIDS

HIV Counselling and Testing

Against a target of 1,6 million, a total of 1,055,755 clients were tested (66% of the target) through the HCT campaign. Although this output is less than the target set for 2010/11, it is significantly (55%) higher than the number of clients (471,484 clients) tested through the VCT programme during the 2009/10 financial year. This is believed to be a minimum performance estimate as clients tested during outreach campaigns and those from private companies were not included in reporting. There are also 97 non-medical sites which provide HIV testing services within the province. High transmission area sites targeting truck drivers and commercial sex workers have been increased from 40 to 50 during the financial year under review.

PMTCT

Whilst there are data collection and recording challenges experienced by the PMTCT programme, the success of this programme is

nonetheless, best demonstrated over the years by the consistent decline in the proportion of babies testing positive on PCR at six weeks. Baby PCR positivity ratio at six weeks has dropped from 9.9% in 2009/10 to 6.8% in the year under review.

Approximately 80.4% of clients with CD4 counts of less than 350 were put on highly active antiretroviral therapy (HAART). Positive outcomes have also been achieved through the PMTCT program.

Comprehensive Care and Management of Treatment

There has been an increase in the number of facilities providing antiretroviral treatment from 85 in 2009/10 to 580 in 2010/11 in order to cater for the HCT output and demand. Whilst some of these facilities were found to be competent to render the ART service, infrastructural and human resource issues remain a challenge. The increase in the number of facilities providing the ART service resulted in a 49% increase in the number of clients registered on the ART programme from 102,186 in 2009/10 to 152,357 in 2010/11. In order to increase the capacity and meet the ART demand, to equip and man the added facilities on the nurse-led treatment approach, the department trained 852 professional nurses on Nurse Initiated Management of Anti-Retroviral Therapy (NIMART).

Objective:

To implement HIV& AIDS and TB interventions in order to combat and reduce disease impact on communities

TB incidence

There has been a significant reduction in the number of new TB cases reported during the year 2010. The incidence of TB seems to have peaked in 2008 and declined thereafter. A 27% decrease from 983 per 100,000 in 2008 to 722 per 100,000 in 2009 has been observed. The declining trend is observed across all seven districts. This has been achieved through concerted efforts and strategies that include the intensified case finding intervention that involves tracing and screening contacts of smear positive patients and drug resistant patients.

TB cure rate

The TB programme has for the first time achieved and exceeded the set target of 65% cure rate; the EC Province achieved a cure rate of 66% during the year under review. Five districts achieved a 70% cure rate or above with Chris Hani having the highest result at 76.2%. Greater efforts are needed in Amathole and Alfred Nzo Districts where low cure rates of 52.5% and 56% respectively were achieved. It should be noted however, that despite these two districts having the lowest rate relative to other districts and the set target, over the years they have been showing a steady increasing trend in their cure rates as well.

Objectives:

To provide a reliable and efficient EMS service for the Eastern Cape communities

To develop effective EMS systems that will support health care delivery service

Ambulances

The department has, through innovation in procuring an additional 100 own stock ambulances and robust management of said contract, managed to raise the number of ambulances from a pittance of 84 at the worst of times to 341 currently which translates to just 50% of the norm. The average rostered ambulances throughout the financial year under review was 169 or 2.8 per 100,000 uninsured population. Judicious application of the limited resources at the disposal of the Department will ensure further closing of this gap in a progressive fashion. All new vehicles were fitted with tracking devices allowing management to track the position of vehicles and the speed at which they are being driven.

EMS call-taking and recording system

In Port Elizabeth in preparation for the 2010 World Cup, a state of the art call-taking facility with Customer Relations Monitoring (CRM) and automated call-taking and recording was piloted and will be duplicated. For the entire province the system is located at the Departmental Shared Contact Centre and the DOH plan is to have this fully operational in the new financial year. This system will ensure accuracy of EMS service delivery statistics which are currently in a poor state.

EMS bases

The EC province has 79 bases throughout the province. In the last three to four years the department has built two EMS bases; the recent opening of Mount Ayliff base which is still under construction, is an upgrade from the park homes that they were using previously. This can be viewed as the ECDOH continued attempt to improve the services and working conditions for the EMS staff in the department.

Objectives:

- To develop and ensure implementation of the secondary health care services to achieve 85% functionality.
- To strengthen secondary and tertiary academic support services by implementing outreach & in-reach programmes for an effective referral system.
- To strengthen and facilitate the institutional capacity to deliver secondary and tertiary psychiatric services.

Frontier Hospital

The new domain of Radiology was established at Frontier Hospital and resulting in the hospital having a total of eight functional domains. The establishment of the radiology department has afforded the communities serviced by the hospital access to ultrasound and mammography services. The hospital procured and installed X-Ray equipment, a CT scanner and Fluoroscopy through the hospital revitalization programme.

St. Elizabeth Hospital

St. Elizabeth Hospital is also on the hospital revitalization programme. One of the current projects addresses the shortage of staff accommodation, which is a major challenge and is critical for staff retention. The construction of accommodation for health professionals is almost complete and the contractor has indicated readiness for final inspection and practical completion. In addition, UNICEF has donated a structure that is utilized for the 24 hrs/7 days Thuthuzela programme. Finally, 8 doctors were employed at St. Elizabeth during the financial year, approximately 62% increase from a total number of 13 to 21 doctors.

East London Hospital Complex

In order to strengthen the District Health Services and therefore implement the referral policy effectively, the East London Hospital

Complex intensified its outreach programme to support the maternal and child health programme. By the end of the financial year, the complex had a total of 22 outreach sites. Training was conducted for the doctors from health facilities that feed into the complex. In addition, with the appointment of the Family Medicine specialist, the complex has re-established Family Medicine at both Frere and Cecilia Makiwane Hospital.

The new Oncology unit is operational and has started seeing patients however, the construction of the oncology wards was suspended and will resume in the new financial year.

Cecilia Makiwane Hospital is on the revitalization programme. On completion of the revitalization project, this hospital will be able to comprehensively offer sustainable level 1 and 2 services to the adjacent communities.

The appointment of a radiologist has been a challenge for a number of years and in this financial year the complex has been able to appoint one. Academic: Two senior clinicians were appointed as Associate Professors by the Walter Sisulu University; the complex has now four associate professors in total.

Mthatha Hospital Complex

The Mthatha Hospital Complex has established a dental laboratory for manufacturing of dentures that will serve the eastern region of the Province. Plans for the construction of a 50-bedded Burn unit at the Nelson Mandela Academic Hospital were completed and are awaiting approval by the ECDOH.

Mammography and fluoroscope machines were procured for the Radiography Department. Two registrars passed the specialist examinations in surgery in 2010/11. New appointments during the financial year under review included two principal specialists, a dermatologist, a forensic pathologist and a chief specialist, an ENT surgeon. Five doctors were appointed as associate professors at Walter Sisulu University.

Port Elizabeth Hospital Complex

The first successful stem-cell transplant for the EC was done at the Port Elizabeth Hospital Complex, as well as a surgical innovation in general surgery pertaining to gall bladder



surgery utilizing a single port through the navel. This innovation will result in a shorter hospital stay for patients with gall bladder disease. The Burns high-care ward at Dora Nginza Hospital was established with 14 beds.

The Accident and Emergency (A&E) Unit at Livingstone Hospital was completed just in time for the 2010 FIFA World Cup. A dedicated Acute Surgical Unit established within the Accident and Emergency Unit is the first of its kind in the country. In this unit, trauma patients do not have to be booked with general surgery, but rather are operated on before admission resulting in improved outcomes.

The Maternity Obstetric Unit established at Dora Nginza Hospital has resulted in improved services in the area and a reduction in perinatal deaths. The extension of the neonatal ward at Dora Nginza Hospital in conjunction with the latest equipment and facilities was made possible with the assistance of donors such as Fuchs Family Foundation, Vodacom, and Nestle. The Isolation/Infectious Diseases Unit that was under construction at Livingstone Hospital is complete and the complex also established a 20-bed step-down ward at Dora Nginza Hospital for all patients that require the service. Finally, refurbishment of M1 and M2 of the Malan Building at PE Provincial Hospital is in progress to turn them in to cutting-edge wards on par with the most modern private sector standards and with the latest equipment and facilities in preparation for the implementation of a revenue generation project.

A fully fledged Thuthuzela Centre for sexual assault victims was established with the National Prosecuting Authority at Dora Nginza Hospital; the NPA appointed three staff members for this centre: the site coordinator, a case manager and the victim assistance officer.

The first phase of Tele-Radiology was completed; the next phase is expected to

commence in the new financial year. Digital Radiology was consolidated for Livingstone. Dora Nginza and PE Provincial Hospitals are partially established with computerized Radiography. Full implementation will reduce X-ray printing costs by R2,5m per annum and improve the management of patient records. The hospital also procured a mammography unit for Livingstone Hospital, a fluoroscopy screening unit for the PE Provincial Hospital and two general X-Ray Units for Dora Nginza and Livingstone hospitals.

In an effort to reduce the high TB defaulter rate in the NMM Metro, Dora Nginza Hospital established the first EC TB focal point in a provincial hospital in collaboration with the Nelson Mandela Bay District. Since there is no district hospital in the Metro, Dora Nginza Hospital has a high patient load of TB cases. The TB focal point manages the clinical pathway of TB patients in terms of patient records and referral to and from the PHC facilities and traces TB defaulters.

2.1.5 OVERVIEW OF SERVICE DELIVERY ENVIRONMENT FOR 2010/11

Demographic information

The Eastern Cape Province is spread over an area of 169,952 km² and constitutes 13.9% of the total SA land area. The mid-year population in 2010 was approximately 6,656,037 million (Table A1). The largest proportions of the population are concentrated in Amathole and OR Tambo Districts with 27.1% and 26.3% of the total population respectively. Ukhahlamba District has the smallest population constituting 5.1%. Approximately 65% percent of the population is younger than 30 years. One third of the population is children of which a third is under five years (Figure 1). About 88% of the EC population is serviced by the public health sector as medical aid coverage in this province is only 12%.

Table A1: EC population distributed by health districts, 2010

District	Total population	% of total	% Urban	% Rural	Females	Males
A Nzo DM	406 722	6.1	2.0	98.0	207 563	199 159
Amathole DM	1 803 187	27.1	39.0	61.0	941 920	861 267
C Hani DM	780 974	11.7	39.0	61.0	406 396	374 578
Cacadu DM	438 024	6.6	27.2	72.8	230 275	207 749
N Mandela MM	1 139 037	17.1	97.9	2.1	597 997	541 040
OR Tambo DM	1 748 630	26.3	8.9	91.1	899 694	848 936
Joe Gqabi DM	339 463	5.1	37.9	62.1	176 151	163 312
Province	6 656 037	100.0	30	70	3 459 996	3 196 041

Source: Statssa mid-year estimates, 2010

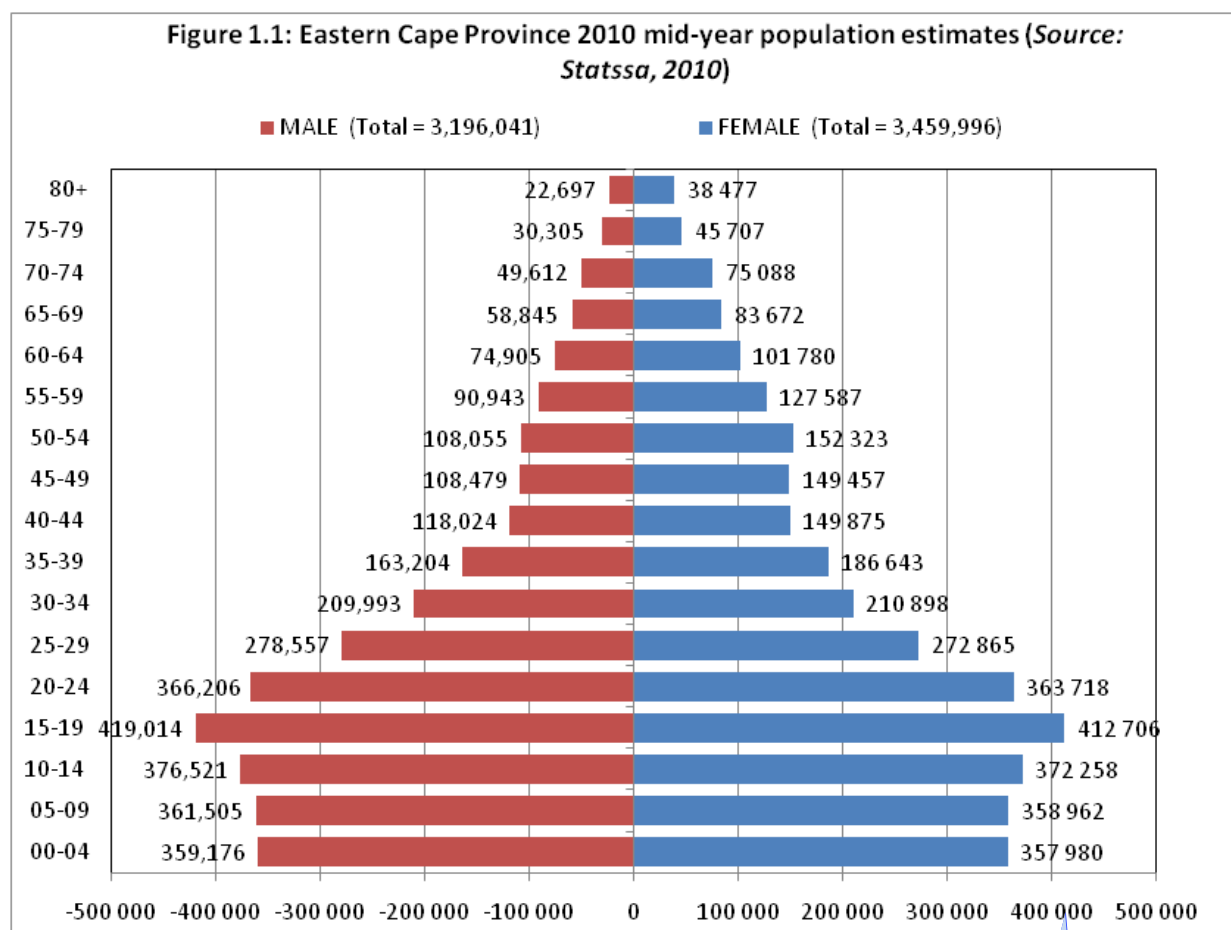
The key developmental indicators for the province that influence the health status and outcomes in the province are shown in Table A2 below.

Table A2: Key developmental indicators in the Eastern Cape Province

Indicator	Year	Eastern Cape	SA
Demographic indicators			
Population density (people per km2)	2009	39.1	40.4
Average household size	2007	4.1	3.8
% public sector dependant population	2007	92.9	--
% of households for which the usual place of consultation is a public facility	2010	79.7	--
Total fertility rate (No. of children per woman)	2006-2011	2.8	2.4
Total live births (facility-based data)	2009/10	116 022	--
Life expectancy at birth (females)	2006-2011	55.5	57.2
Life expectancy at birth (males)	2006-2011	50.3	53.5
% disabled population	2010	12.4	--

Indicator	Year	Eastern Cape	SA
Socio-economic indicators			
% Households classified as poor (monthly expenditure <R2500)	2010	79.3	-
% of persons with medical aid coverage	2010	12.1	-
% household with informal housing	2007	7.4	14.4
% households using electricity for cooking	2007	45.3	66.4
% of households using wood/coal for cooking	2010	20.9	-
% households with access to piped water	2007	70.8	88.7
% of households with no water supply infrastructure	2010	26	-
% population 20 years and older with no schooling	2010	8.5	10.4
% of households with access to a functioning basic sanitation facility	2010	61.1	-
% households with no toilets	2010	16.3	8.3

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



Overview of Departmental Performance

During the year under review the department was allocated an adjusted budget of R13.8 billion, at the end of the financial year 95.89% of the budget had been spent resulting in an overall under expenditure of R569.1 million, which translates to 4.11% of the budget. The under spending is primarily as a result of delays in the procurement of infrastructure projects and machinery and equipment.

The non - transfer of the fifth instalment of R100 million of the infrastructure grant to provinces for the 2010/11 financial year due to the Province on 04 February 2011, which amount was stopped by National Treasury in accordance with section 17 of the 2010 Division of Revenue Act contributed to the under expenditure.

The department has applied for the Conditional Grants funds totalling R489.7 million appropriated but not spent in the 2010/11 financial year to be rolled over to the 2011 / 2012 financial year. The request for roll over is supported by commitments where goods and services had been delivered or rendered and therefore funds were committed and the department is either awaiting submission of invoices by suppliers or invoices had been received but will be paid in the next financial year.

After adjusting for the rollovers application above, a net amount of R79.9 million in equitable share had not been spent as the department ran out of cash.

The financial affairs of the Department must be placed in the context of the significant financial pressures faced by the Eastern Cape Department of Health as a result of underfunding which manifest in accruals and carry through costs in the structure of the Department's budget for 2010/11.

Notably, the achievements of the department for 2010/11 were largely curbed by the substantial over-expenditure incurred in prior years (2008/09 and 2009/10), which resulted primarily from insufficient funding for the carry through costs of the

Occupational Specific Dispensation (OSD) for nurses, the payment of HROPT and the impact of accruals from previous years.

Resulting from the above pressures, the expenditure of the department in 2010/11 exceeded its budget by approximately R1.1 billion when including accruals. This shortfall will be funded from the 2011/12 budget, as a first claim against the budget.

In an effort to address the underfunded occupation specific dispensation and unbudgeted / unfunded HROPT mandate carry through costs, the budget for compensation of employees was increased by R2 billion or 29.3% from the R6.4 billion allocation in 2009/10 to R8.3 billion in 2010/11. This has meant that the proportion of the budget allocated to COE has increased from 54% in 2009/10 to 63% in 2010/11.

This increase has been at the expense of other critical allocations such as goods and services and buildings and fixed structures which have seen their allocations reduced to make up for shortfalls in this area.

One of the main focuses of the Department is to revitalize and strengthen PHC service delivery and to implement an effective and well-structured referral system. Whilst significant achievements have been made in a number of service delivery areas as summarized in section 2.1.4 above, there has been a slight drop in service volumes during the year under review. This reduction is mainly as a result of the civil servants' strike that took place in August 2010. The key outputs affected were mainly the PHC headcount in PHC facilities and consequently the average number of client visits to PHC facilities per year decreased from 2.8 in the previous financial year to 2.7. In hospitals, whilst separations decreased, the OPD headcount increased significantly as the emergency staff that was operational was mainly used for PHC purposes. Unfortunately, many clients could not be attended to during that time. Table A3 below summarises the key indicators that reflect service volumes rendered directly to the public.

Table A3: Key Provincial Service Volumes, 2005/06 – 2010/11

Indicator	2005/06 (actual)	2006/07 (actual)	2007/08 (actual)	2008/09 (actual)	2009/10 (actual)	2010/11 (actual)
PHC headcount in PHC	16 268 199	16 557 208	16 410 459	17 671 355	18 623 987	17 662 518
OPD Headcount - Total	1 204 082	1 097 243	1 233 644	1 762 685	2 107 032	2 428 947
Deliveries in facility	115 246	118 694	121 324	119 924	116 456	114 103
Live births in facility	111 457	116 911	117 280	119 287	123 104	116 022
Hospital separations	445 106	443 907	354 486	476 771	525 605	513 849
PDE in district hospital	1 686 752	1 643 811	1 818 830	1 944 192	1 997 931	1 891 467
PDE in provincial hospital	1 264 200	1 183 686	1 339 968	1 379 638	1 330 792	1 427 361
BUR (% - District hospitals)	55	63.9	66.9	69.5	71	65.5
BUR (% Provincial Hospitals)	73.3	75	73.3	75.1	73.7	75.8

Key services rendered by the department

The Eastern Cape Department of Health in terms of its constitution provides health care services to the people of the province. The Department is structured in 8 programmes. The core services are delivered through the four programmes, namely:

- District Health Services Programme 2
- Emergency Medical Services Programme 3
- Provincial Hospital Services Programme 4
- Central Hospital Services Programme 5

The remaining programmes offer the necessary support in the rendering of health care. Table A4 shows the key services rendered by the Department.

Table A4: Services rendered by the Department:

Service rendered	Service Outputs
Primary Health Care Services through the implementation of the District Health Services	Primary health care services are provided at 884 facilities and these include mobile & satellite clinics, fixed clinics and community health centres (CHCs). A total PHC headcount of 17 662 518 was recorded in 2010/11 translating to a provincial average of 2.7 visits per person per year. Children under the age of five comprised 17.4% of the total with PHC utilization rate in children under five being on average 4.3 visits per child per year. PHC headcount decreased by five percent from the 18.6 million total headcount reported in the 2009/10 financial year. This is attributable to a significant decrease in headcount during the month of August 2010 due to the civil servants' strike. The percentage of fixed PHC facilities supported by a doctor at least once a week is at 32.4%, whilst the percentage of CHCs with a resident doctor is 59.9%. The Department is experiencing a shortage of doctors with a high vacancy rate for this professional category. Whilst this may be a national challenge, the rural nature of the province in particular contributes towards more challenges in recruitment and retention. Shortage of doctors at the PHC level drives PHC clients to seek services at higher health care levels, rendering referral policies ineffective. The provincial strategy to revitalize PHC has been adopted to address this challenge and will see to more doctors allocated at the PHC level. A total of 114 103 deliveries were performed of which 10.5% occurred in women under the age of 18 years.
Emergency medical and rescue services to all the parties of the Province	There has generally been a decrease in reported calls compared to previous years. A total of 290 007 calls and 318 677 total emergency head count as well as a total of 288 054 emergency trips were made. The majority of calls received were Priority 3 response calls comprising 48.9% of the total number of calls showing an increase compared to the previous years. Priority 1 response calls remain fewer than the other categories. In addition to the Metro ambulances, 1 648 patients were transported by private ambulance and 13 303 by private vehicles. 14 333 patients could not be located probably due to infrastructural challenges and 6 864 patients refused the service. A total of 4 617 hoax calls pose a problem considering limited resources and an inadequate number of ambulances.
The provision of hospital and specialized services in collaboration with Health Science Faculties of various higher institutions of learning within the Province	OPD head count – 1 293 643 PDE – 1 633 564 Separations – 219 231 BUR – 75.8% Caesarean section rate: 44.6% ALOS – 5.3 days The major challenge with contributing to the high OPD headcount is self-referral of patients to higher level institutions. In addition, some hospital complexes do not have a level 1 hospital in their vicinity (e.g East London Health Complex (levels 2 & 3)) and therefore have to service level 1 clients as well. To address this challenge, a level 1 hospital has to be instituted. In addition, revitalization of PHC, which is one of the ECDOH priorities is designed to strengthen the functionality of PHC and address referral pathways so that patients can be treated at appropriate levels of care. Whilst caesarean section is primarily a function to be performed at level 1 health facilities, many district hospitals are not performing this function and simply refer their patients to provincial hospitals hence the output of this indicator is high. Outreach and in-reach that is conducted by the provincial hospitals is meant to address these challenges.

Service rendered	Service Outputs
Specialised services, such as clinical orthotic and prosthetic services	A total of 15 218 clients were assessed for prescription of assistive devices. The following assistive devices were supplied to clients during the year under review: • Wheelchairs = 2 122 • Walking aids = 14 806 • Orthoses = 8 906 • Prostheses = 3 068 • Hearing aid = 981 The annual target for hearing aids of 1 600 was not met because of the limited number of booths available as well as the shortage of audiologists in the province. Devices that achieved the target for the year were mainly off the shelf devices. Since wheelchairs are made according to patient specifications, there tends to be a delay in production hence the target of 3 150 was not met.
Training of all health professionals employed by the ECDoH	During the year under review, the department had 182 bursars in the system. The Eastern Cape province was the first province in the country to start the three-year clinical associate programme and is again the first province to place these students. All the other provinces are learning lessons from the province. At the end of December 2010, 23 clinical associate students graduated. A total of 396 Enrolled Nursing Assistants (ENAs) graduated. These are being oriented on the PHC elementary module as ENA primary health practitioners (NAPHP) which will form the backbone of the community-based PHC strategy to promote the prevention of diseases. A total of 279 professional nurses are under training and 324 four-year diploma nurses graduated. One hundred and seventeen midwives underwent training during the year under review. Training outputs are further discussed in detail under programme 6 of this report.
New health facilities and revitalization of dilapidated facilities	Sub-programme: Community Health Facilities • Completed 4 out of 17 new clinics Ntsitho, Qiba, Thabalesoba and Ntafufu • Upgraded 2 out of 4 dilapidated clinicsangoameleng and 5hAvenue Walmer • Construction of Sada CHC at final stage • Construction of Dutywa CHC at final stage • Planning of Letitia Bam and Maluti CHC at design stage • Bought equipment for Qolombane, KTC and Nxothwe clinics Sub-programme: District Hospitals • Construction of Madwaleni spital water project completed • Provision of accommodation for nurses at Victoria spital completed • Civil works at Victoria Hospital at final stages • Construction of Casualty/OPD at Victoria completed • Construction of Uitenhage spital 3d4hand 5hoors completed • Five health facilities provided with gensets • Construction of Midlands Casualty Sub-programme: Provincial Hospital • Construction of Accident and Emergency Centre at Livingstone completed • Construction of phase I Oncology at Frere Hospital completed • Construction of accommodation for nurses at Cecilia Makiwane Hospital in progress • Medical equipment procured for Livingstone Accident and Emergency Centre

Service rendered	Service Outputs
	Sub-programme: EMS - Construction of Mt. Ayliff EMS Base complete. Sub-programme: Forensic Pathology - Construction of forensic pathology unit at Graff Reinet in progress Sub-programme: Hospital Revitalization - Construction of EMS Base at Dr. Malizo Mpehle in progress - Construction of Mortuary at Frontier Hospital in progress - Construction of Mortuary at St. Elizabeth at final completion phase - Construction of helipad at Madzikane KaZulu at planning phase - Provision of accommodation at St. Patricks is at final completion phase

Health facilities development and maintenance, planning and construction of new clinics and hospitals, rehabilitation of existing hospitals and clinics and replacement and maintenance of capital equipment

Sources of funding covered in this report are the Infrastructure Grant to Provinces (IGP), the Equitable Share as well as the Hospital Revitalization Programme.

This part of the report entails the evaluation of progress on infrastructure funding utilized by the department for delivering Health Infrastructure Development during the 2010/2011 financial year.

Table A5 below shows sources of funding covered in the report i.e. the Infrastructure Grant to Provinces (IGP), the Equitable Share as well as the Hospital Revitalization Programme.

Table A5: Sources of funding for infrastructure development in the ECDOH

Source of funding	2010/11 Allocations	Adjusted appropriation	YTD Expenditure
Hospital Revitalization	360,660	439,535	168,853
IGP	331,782	356,165	278,811
Equitable Share	780,861	659,023	422,592
Total	1,473,303	1,454,723	870,256

Table A6 below provides a detailed account of progress on infrastructure per category of funding utilized by the department for delivering Health Infrastructure Development during the 2010/2011 financial year.

Table A6: Expenditure by type of facility

Programme Name	Original Budget R'000	Adjusted Budget R'000	YTD Expenditure R'000
Programme 8: Health Facilities Dev			
8.1 Community Health Facilities	180,326	341,340	70,830
8.2 Emergency Medical Rescue Services	30,400	26,146	14,965
8.3 District Hospital Services	490,870	349,704	355,165
8.4 Provincial Hospital services	710,932	717,638	427,606
8.6 Other Facilities	60,775	19,895	1,690
Total	1,473,303	1,454,723	870,256

Table A7 below provides an account per project stage of funding utilised for delivering Health Infrastructure Development during the financial year 2010/11

Table A7: Frequency distribution and financial performance of infrastructure projects by stage in project cycle

Stage in Project Cycle	Number of Projects	Total committed for this financial year (R'000)	Actual expenditure to date for this financial year	Percentage expenditure at end of Q4	Value of Under Expenditure per stage in the project cycle (R'000)
Identified	105	72 967	12 009	16.5%	(-60 958)
Feasibility	61	26 979	9 588	35.5%	(-17 391)
Design	43	163 640	59 859	36.6%	(-103 781)
Tender	24	169 362	52 954	31.3%	(-116 408)
Construction started	29	100 228	72 332	72.2%	(-27 896)
Construction 25%	20	70 619	30 483	43.2%	(-40 136)
Construction 50%	38	205 301	153 144	74.6%	(-52 157)
Construction 75%	64	537 283	431 851	80.4%	(-105 433)
Retention	146	121 231	72 393	59.7%	(-48 838)
Handed-Over	1	46	-	-	(-46)
Cancelled	96	20 435	3 143	15.4%	(-17 292)
Total	627	1 488 091	897 756	60.3%	(-590 335)

Table A8: Expenditure by type of Infrastructure Projects

Type of Infrastructure	Number of Projects	Funding Classification	Total available for this financial year (R'000)	Actual expenditure to date for this financial year (R'000)	Percentage Expenditure at end of Q4 (%)	R Value Over or Under Expenditure at end of Q4
Additions	9	Capital	-	1,895	-	(-1,895)
Disposal	0	Capital	-	-	-	-
Maintenance - Periodic	54	Current	230,102	165,029	71.7	65,073
Maintenance - Recurrent	73	Current	75,385	44,162	58.6	31,223
New	154	Capital	321,614	207,324	64.5	114,290
Rehabilitation	93	Capital	324,035	247,243	76.3	76,792
Renovations	97	Capital	78,146	13,401	17.1	64,745
Replacement	54	Capital	54,452	46,446	85.3	8,006
Upgrading	93	Capital	404,358	172,256	42.6	232,102
Total	627		1,488,091	897,756	60.3	590,335

Problems encountered during service delivery

Financial Management and Capacity

The Eastern Cape Department of Health continues to grapple with the implementation of basic fundamental principles of financial accounting. Financial management is performed by officials who lack the necessary technical training and proficiency. Lack of capacity in terms of skills, competence, and numbers qualified to perform financial management functions has contributed to the negative opinions obtained by the department in the past years.

The persistent negative audit outcomes over the past years have necessitated the department to implement a number of interventions targeted towards improving financial management and audit outcomes. The plan has been developed with the primary focus of improving financial management in an attempt to respond to the weaknesses in controls and the control environment as well as improve overall financial management in the department. The issue of weak controls has been raised and reported by both the internal audit unit and the Auditor-General. In putting together a turnaround strategy various sources of information have been used, including the audit report,

internal audit reports, National Treasury's financial management capability maturity model and key activity controls as advocated by the Auditor-General.

Further focus will be on the reengineering of budget processes to be transparent, ensuring effective and efficient allocation of scarce financial resources, managing and controlling expenditure against the budget, ensuring spending within the budget, as well as monitoring. Also, to review that conditional grants spending is in line with DORA requirements and section 40 projections.

The department has also adopted the Supply Chain Management Turnaround Plan developed by the Multi-Agency Working Group (MAWG). The MAWG was formally established in October 2009 under the political leadership of the Minister of Finance (MoF). The MAWG is mandated to review the entire state procurement system and to provide a set of priorities and proposals with appropriate action plans to deliver a rapid improvement in the state procurement system.

The fundamental success of this turnaround plan hinges on the change in the finance organogram, which will require additional skilled, competent and capable staff to be recruited and placed at the various sub



districts, employing finance personnel at the institutions where transactions are initiated. It is imperative that finance officials are employed for the optimal functioning of the hospital to effectively support clinical services. Secondly the availability of infrastructure such as network connectivity and computers will be key to the achievement of the desired outcomes. There will be added costs to process, including adequate funding of the finance organogram, costs of infrastructure and other costs associated with restructuring of the finance cluster.

The intervention takes cognisance of the need to build capacity within the department to maintain and improve financial management systems and processes over a period of time. Accordingly, a developmental programme will be put in place along with the implementation of the project plan. Policies and standard operating procedures will be consolidated and tools developed to empower staff at the sub-districts and institutions to perform their work to facilitate compliance.

Recruitment and retention of critical staff

The rural nature of the province makes it difficult to attract and retain health professionals despite the introduction of the OSD, Rural Allowance, etc. As a result, the department has a vacancy ratio of about 56% of critical posts (doctors, nurses, pharmacists, etc) affecting rural areas especially, despite dedicated efforts to eradicate the problem. Apart from the unattractiveness of the province and its rural areas, the department has a serious problem of underfunding of its organogram.

Steps taken to address the problem include:

- Targeted recruitment of foreign qualified professionals. In 2010/11, a total of 104 doctors were appointed for placement in rural hospitals.
- The department is re-opening nursing schools under the Lilitha Nursing College. This will assist with increasing the pool of nurses.

- The department has appointed 23 clinical associates. This cadre is a first of its kind in the country and they work as a middle health worker to compliment doctors – whilst working under the supervision of doctors.
- The department has, through its implementation of the social compact, introduced a cadre of Community Health Workers who go directly to households and implement a community-based health programme.

Supply Chain Management limitations

The biggest challenge that SCM is being confronted with is the lack of proper financial and supply chain management systems to generate orders and to procure goods and services. The Department is utilising a paper-based system that can be manipulated and will ultimately result in a loss of finances to the Department. Appropriately qualified personnel in strategic positions and functions also pose a challenge. The Department has put in place a turn-around plan that is meant to address all aspects of supply chain management together with a multi-agency working group from the National Treasury.

EMS challenges to service delivery

Internal factors: Poor professional conduct and staff shortages in all the EMS centres is impacting negatively on the availability of ambulances to communities. To address this, the Department is registering the EMS staff with the HPCSA and will be employing a total of 150 new staff that will be stationed at district hospitals

External factors: The terrain that EMS employees must contend with when responding to calls in the rural areas creates delays as the majority of roads in the Eastern Cape are dirt roads and are not well maintained.

Table A9: Explanations and reasons for additions to or virements between the main appropriation allocations:

PROGRAMMES	TOTAL VIREMENTS	REASON FOR THE VIREMENT
EHW: ADMINISTRATION		
COMPENSATION OF EMPLOYEES	-39,392,311	This programme under spent its COE budget as a result
EHW: DISTRICT HEALTH SERVICES		
COMPENSATION OF EMPLOYEES	106,459,080	OSD, HRPOT and the provincialisation of PHC and provincially-aided hospitals led to this programme overshooting its COE allocation. In order to defray or mitigate this over expenditure, Virements from programmes 1, 3, 4, 6 and 8 were done.
GOODS AND SERVICES	10,695,765	The pressure on goods and services, particularly in medical supplies, led this programme to overspend its goods and services allocation. The virement to mitigate this situation was done from Programme 4's under expenditure.
EHW: EMERGENCY MEDICAL SERVICE		
GOODS AND SERVICES	-2,928,959	This programme under spent its goods and services as a result of Treasury restricting payments to conditional grants only. This amount was given to programme 2 for COE.
EHW: PROVINCIAL HOSPITAL SERVICES		
GOODS AND SERVICES	-12,957,752	As this programme is funded from the equitable share, Treasury's decision to restrict payments to conditional grants only resulted in this under expenditure. This under spent amount was moved to Programme 2's COE and goods and services.
EHW: HEALTH SCIENCE & TRAINING		
GOODS AND SERVICES	-12,722,068	This underspend was from the equitable share portion of the funding of this programme. The payment of conditional grant expenditure only, led to this underspend which was used in Programme 2 under COE.
EHW: HEALTH FACILITIES DEV & MAINT		
GOODS AND SERVICES	-49,153,755	As this programme is funded from both equitable share and conditional grants, Treasury's decision to restrict payments to conditional grants only, resulted in this under expenditure under equitable share. This under spent amount was moved to Programme 2's COE.
TOTAL	0	

Rollovers from the previous financial year:

In the 2009/10 financial year, the Department applied for the rollover of Conditional Grant Funding totalling R299,530; this was received in the 2010 / 2011 adjustment estimates of provincial expenditure:

TABLE A10: Grants managed by the Department

NAME OF GRANT	Roll Overs from 2009/10
	R'000
National Tertiary Services Grant	75,094
Health Professionals and Development Grant	46,754
Hospital Revitalisation Grant	78,875
Comprehensive HIV/AIDS Grant	67,187
Forensic Pathology Grant	7,237
Infrastructure grant to provinces	4,383
	299,530

A description of any significant developments, external to the department, that may have impacted either on the demand for the department's services or on the department's ability to deliver those services.

The unintended policy consequences of the Occupation Specific Dispensation continues to impact negatively on the management of the compensation of employees in the Department. Although this matter is a national prerogative, the Department is engaging with it at the Bargaining Chamber, the Cabinet Budget Committee and with the Provincial Treasury.

Notably, the achievements of the department for 2010/11 were largely curbed by the substantial over-expenditure incurred in 2008/09 and 2009/10, which resulted primarily from the insufficient provision of funding for the carry through costs of the Occupational Specific Dispensation (OSD) for nurses, the payment of HROPT and the impact of accruals from previous years. Resulting from these pressures, the expenditure of the department in 2010/11 exceeded its budget, on an accrual basis, by approximately R910.00 million. This shortfall has been funded from the 2011/12 budget, as a first claim against this budget, in the form of increased accruals.

In an effort to address the underfunded occupation-specific dispensation and unbudgeted / unfunded

HROPT mandate carry through costs, the budget for compensation of employees was increased by R2.0 billion or 31.7% from the R6.27 billion allocation in 2009/10 to R8.26 billion in 2010/11. Consequently, the proportion of the budget that went to COE has increased from 54% in 2009/10 to 60% in 2010/11. This increase has been at the expense of other critical allocations such as goods and services and buildings and fixed structures, which have seen their allocations reduced to make up for shortfalls in this area.

The department has incurred over-expenditure of R128.47 million this financial year on its compensation of employees costs, which is mainly attributed to the increase in COE costs arising primarily from the absence of funding and/or shortfalls in the funding of the Human Resource Operating Project Team (HROPT), and Occupation Specific Dispensation (OSD).

The introduction of the Negotiated Service Delivery Agreement, as a strategy to facilitate the improvement of healthcare services remained a challenge in terms of the planned targets which were not budgeted for. This matter will be addressed in the next financial year.

The national, three week, 2010 general public service strike that took place in August and September, strike compromised effective service delivery especially

essential services like health. The department, one of the hardest hit departments, is however, appreciative to certain members of our staff who exercised their professional and ethical responsibility by staying put and continuing to provide services despite intimidation and other threats. This group of our staff and some community members who also came and assisted ensured that risk to loss of life and threat to patient safety were minimized.

The department must also highlight significant achievements with regard to the 12 outcomes announced by the Department of Performance Monitoring and Evaluation. This is only applicable to departments that directly contribute to the achievement of one or more of the 12 outcomes. A department that does not directly contribute to any of the 12 outcomes must indicate its own outcome(s).

Government introduced the outcome-based delivery and monitoring system that will ensure that performance is focused on identified critical areas. Our MEC has signed the Negotiated Service Delivery Agreement with the National Minister of Health committing the Eastern Cape Department of Health to contribute towards the health sector outcome and its four outputs. The department will also work closely with other partners in the delivery of health services.

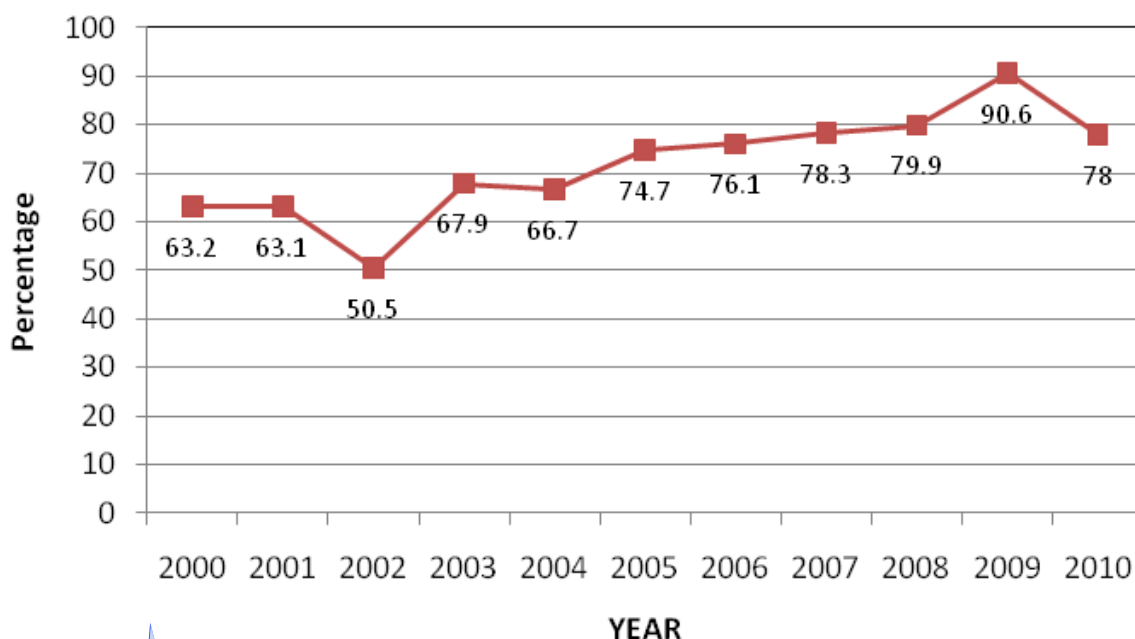
NSDA OUTCOME 2: A LONG AND HEALTHY LIFE FOR ALL SOUTH AFRICANS

Output 1: Increase Life Expectancy

Immunisation coverage

- The Department has over the years, significantly increased the immunisation rate in children under the age of one year from 63.2% in 2000 to 90.6% in 2009 (figure 1.2); however, there was a decrease during the year under review to 78% due to shortages of vaccines in the depots. The Department is engaging with the supplier in order to increase supplies to match the provincial demand.
- The coverage of newly introduced vaccines is increasing; rotavirus 2nd dose coverage has increased in the year under review from 35.2% in 2009/10 to 40.7% and PCV3 coverage from 38.5% to 41.9%. Strengthening the Reach Every District (RED) strategy and ensuring vaccine stock availability at all times is crucial.
- Over the past 10 years the PHC client load due to diabetes mellitus and hypertension has doubled. During the 2010/11 financial year, 2.4% and 9.9% of the total PHC facility client load were attributed to diabetes mellitus and hypertension diseases respectively.

Figure 1.2: Immunisation coverage of children under one year, 2000 - 2010



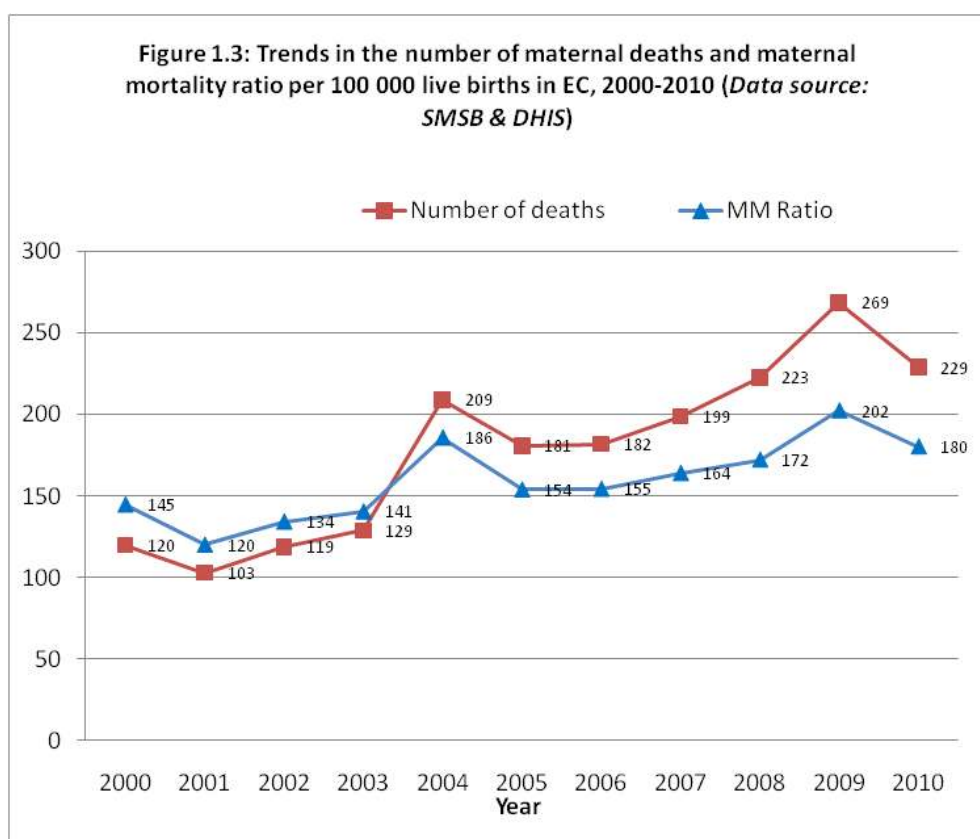
Output 2: Decreasing Maternal and Child mortality

Maternal deaths

The number of women dying due to pregnancy-related conditions (maternal deaths) had been increasing over the years; however, a 15% decrease was observed in the number of maternal deaths that were reported during 2010. A total of 229 maternal deaths were reported against 269 in 2009; this translates into a facility-based maternal mortality ratio of 188 per 100,000 live births (Figure 1.3). Mitigation measures include the implementation of the recommendations from the confidential enquiry into maternal deaths through implementing a maternal health project, "Saving Mothers, Saving Babies". The project focuses on

interventions to reduce mortality of pregnant mothers and newborn babies. Other initiatives include the establishment and implementation of halfway stations to accommodate women from remote, rural areas closer to health facilities when they get to term and the implementation of NCCEMD recommendations.

In order to improve the skill and competency in both prevention and management of obstetric complications and reduce maternal and neonatal deaths, a total of 303 health professionals (doctors and midwives) were trained on various programmes including the Essential Steps in the Management of Obstetric Emergency (ESMOE) and anaesthesia, Basic Antenatal Care services (BANC) and contraception with emphasis on emergency contraceptive and the intrauterine cervical device (IUCD).

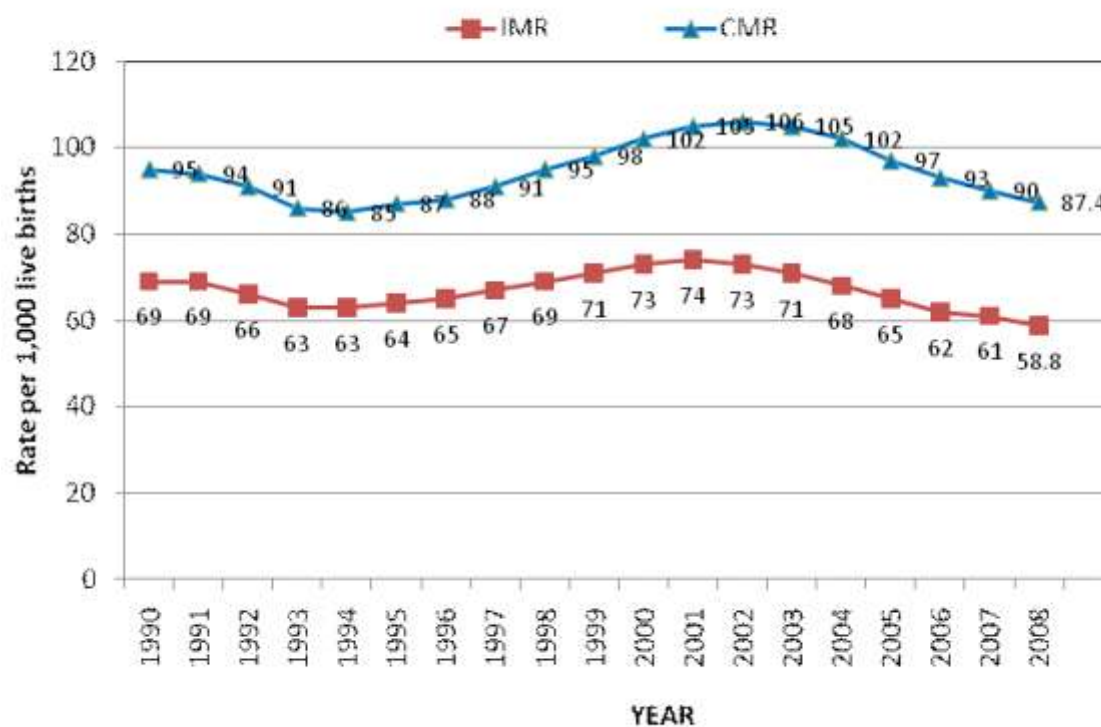


In addition, to improve response times and curtail maternal and neonatal deaths from obstetric emergencies, the EMS vehicles are being de-provincialised from the Medical Emergency Transport and Rescue Organizations (METROs) bases to be stationed at health facilities for easy accessibility to the communities in the time of need. In total, 36 ambulances have been designated to service obstetric and neonatal emergencies at 32 identified health facilities with Obstetric Maternal Units (MOU) as well as three busy hospitals namely PEHC, ELHC and MHC to enhance inter-hospital transfer of emergency cases.

Infant and child mortality

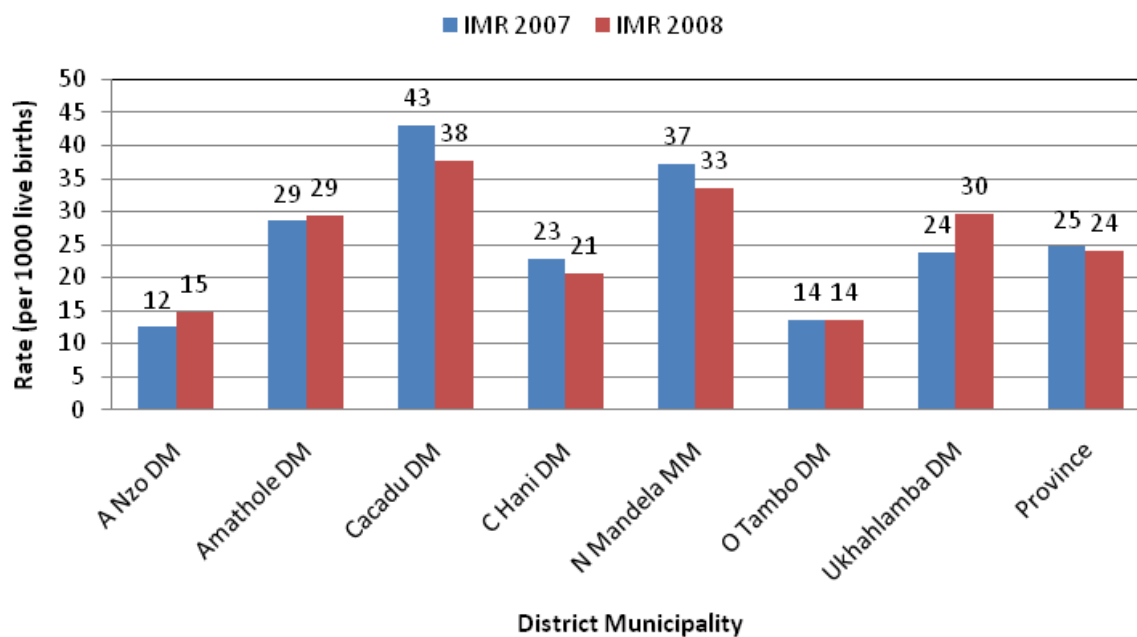
Figure 1.4 depicts the modelled and projected infant & child mortality rates per 1000 live births in the Eastern Cape Province. The Demographic Health Survey (DHS) showed an increase in infant mortality rate from 61.2 per 1000 live births in 1998 to 68.3 per 1000 live births in 2003 against a projected 71 per 1000 in the same year. Whilst infant mortality rate is lower, a similar pattern and trend was projected for the child mortality rate.

Figure 1.4: Infant and Child Mortality Rate in the Eastern Cape Province, 1990-2008



(Source: MRC report, 2002)

Figure 1.5: Probability of dying within the first year of life in the EC province (Statssa, 2010)

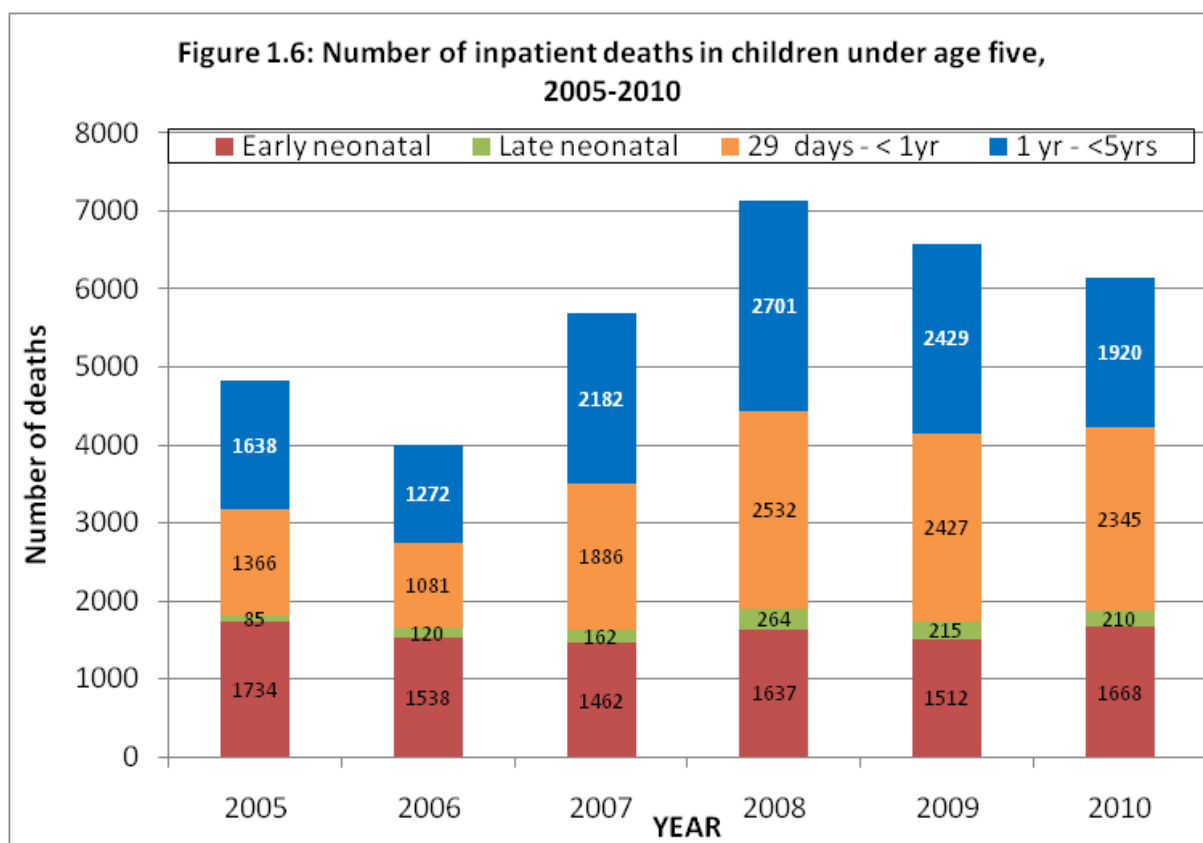


Against these projections, figure 1.5 shows infant mortality rate based on death certificates for the years 2007 and 2008 (StatsSA 2009 & 2010). Approximately 24 infants for every 1000 live births die within the first year of life. This outcome did not differ significantly from the 25 infant deaths per 1000 live births reported in the previous year. However, a 25% increase in IMR was observed at Joe Gqabi and Alfred Nzo districts whilst a decrease was observed in Cacadu, Chris Hani and NMMM.

There has been a constant trend on perinatal mortality

rate (PMR) over the years and during the year under review the perinatal mortality rate was 36.6 per 1000 total births with stillbirths having a greater contribution to this rate.

Whilst HIV infection poses a challenge, the success of the PMTCT programme is best demonstrated over the years by the consistent decline in the proportion of babies testing positive on PCR at six weeks. Baby PCR positivity rate has dropped from 9.9% in 2009/10 to 6.8% during the year under review.

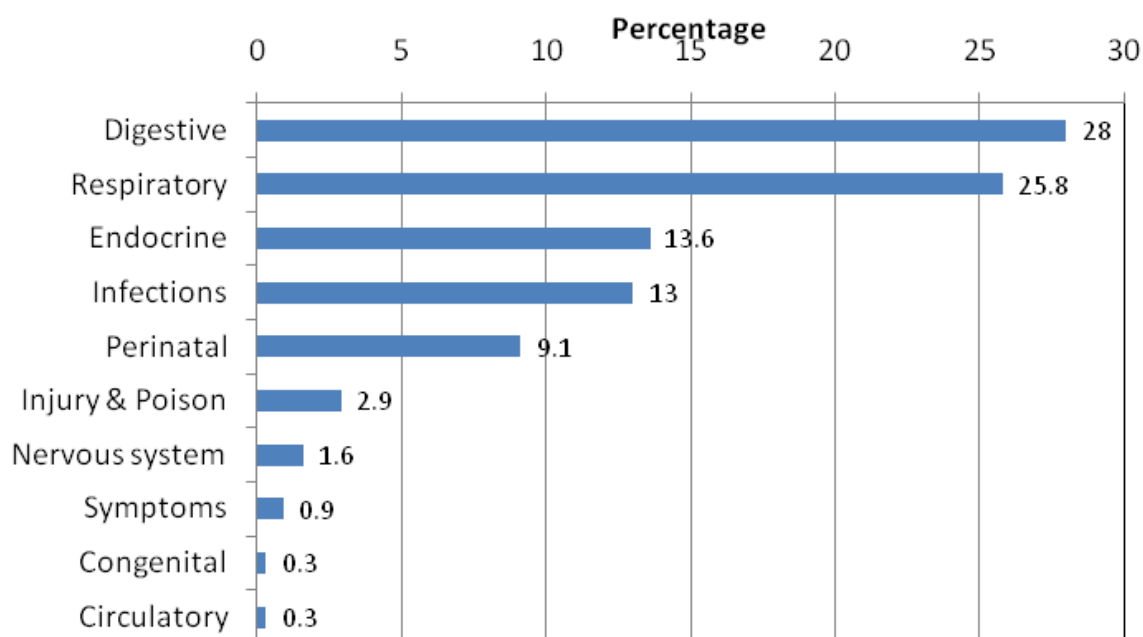


Under-five mortality

Figure 1.6 shows inpatient deaths in EC health facilities of children under the age of five from 2005/06 to 2010/11 by age categories. A total of 6 143 against 6 583 deaths in the previous year was reported. Just above two-thirds of the total deaths were in children under the age of one year and deaths in children one year and older accounted for the other third. The percentage contribution of deaths in children 29 days to less than one year is also showing an increasing trend from 27% in 2006 to 38.2% in 2010/11, a 41% increase over a five year period.

The mortality study conducted in EC hospitals on children under the age of five commissioned by the ECDOH showed digestive and respiratory causes to be the leading cause of death in this age category. In addition, injury & poison, congenital and circulatory conditions were in the top 10 causes of death (figure 1.7).

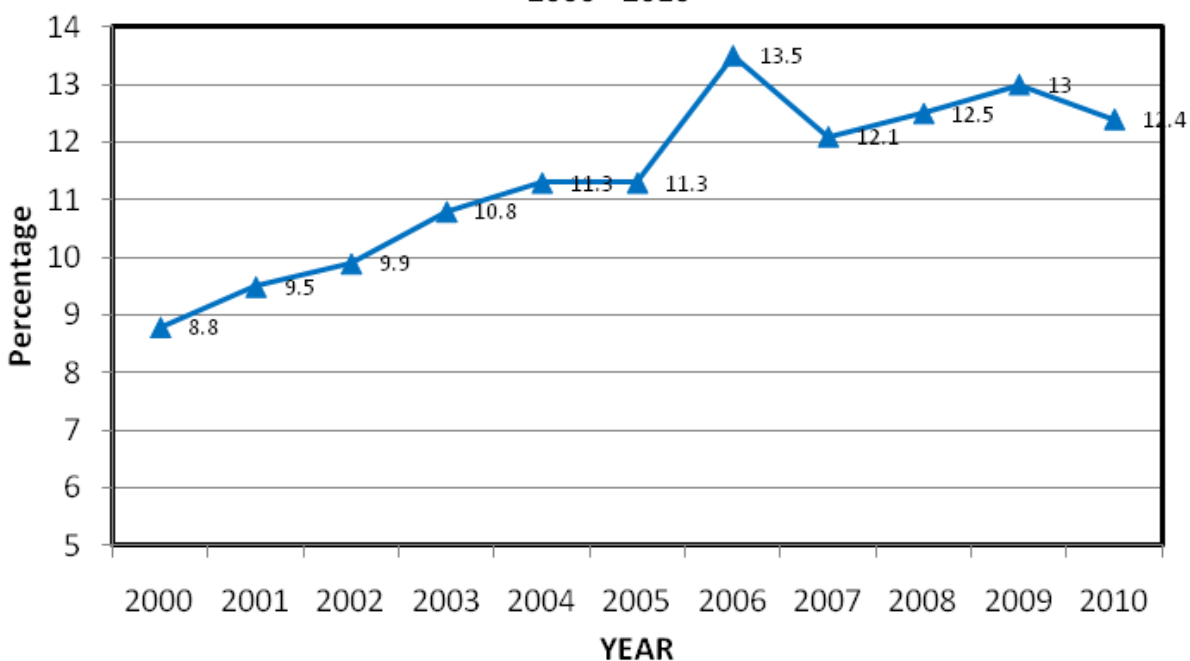
Figure 1.7: Percentage frequency distribution of causes of death in U5s in the EC hospitals, 2006-2008 (source: ECDOH report, 2010)



Low birth weight is also one of the significant determinants of neonatal mortality and this has been increasing over the 10-year period from 8.8% in 2000 to 12.4% in 2010/11 (figure 1.8). To reduce child mortality, the Department is engaging in a number of

initiatives and interventions including IMCI both at the facility and community levels as well as the introduction of rotavirus and pneumococcal vaccine to prevent diarrhea and pneumonia respectively.

Figure 1.8: Trends in low birth weight in the EC province, 2000 - 2010



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

Tuberculosis

There has been a significant reduction in the number of new TB cases reported during the year 2010. The incidence of TB seems to have peaked in 2008 and declined thereafter (see figure 1.9 & 1.10). A 27% decrease from 983 per 100 000 in 2008 to 722 per 100 000 in 2010 has been observed. The declining trend is observed across all seven districts. This

reduction has been achieved through concerted efforts and strategies that include the Intensified Case Finding intervention involving the tracing and screening of contacts of smear positive patients and drug resistant patients.

The TB programme has for the first time achieved and exceeded the set target for the TB cure of 65%; the latest cure rate in the EC Province achieved during the year under review is 66% (figure 11). Five districts achieved 70% cure rate and above with Chris Hani having the highest rate of 76.2%.

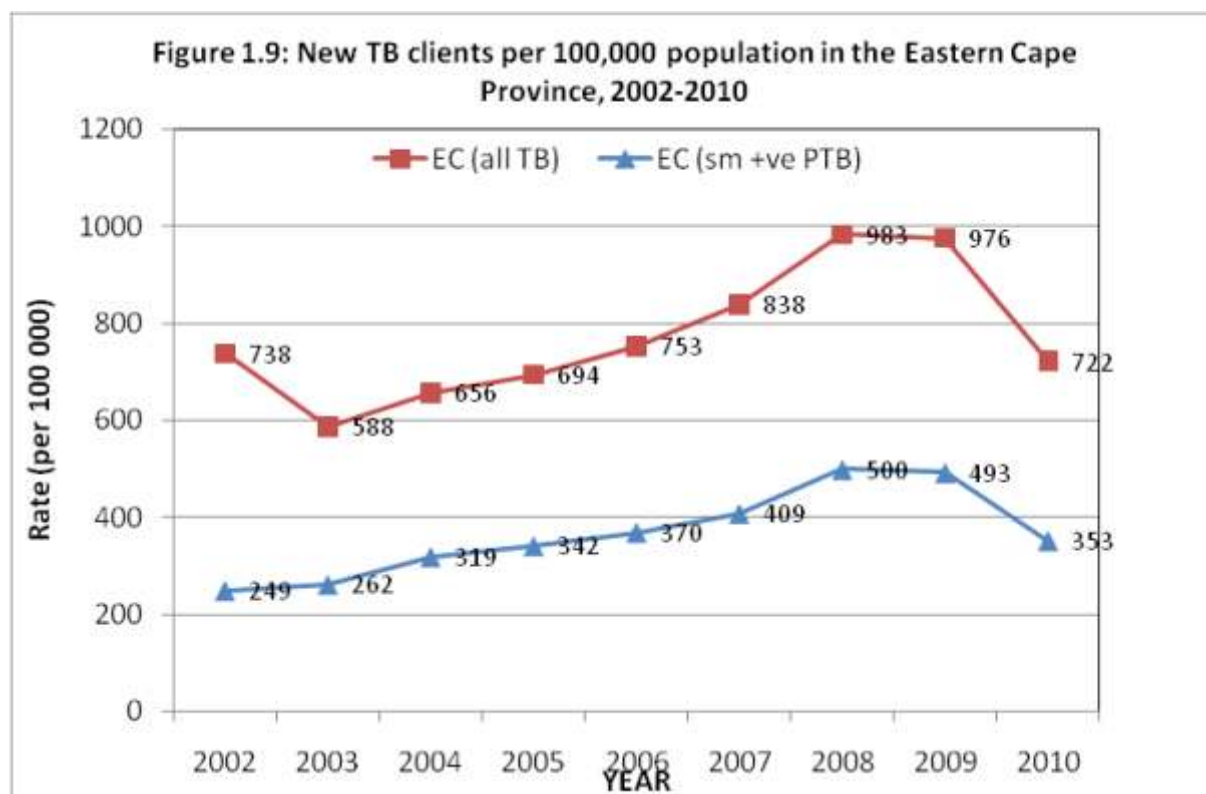
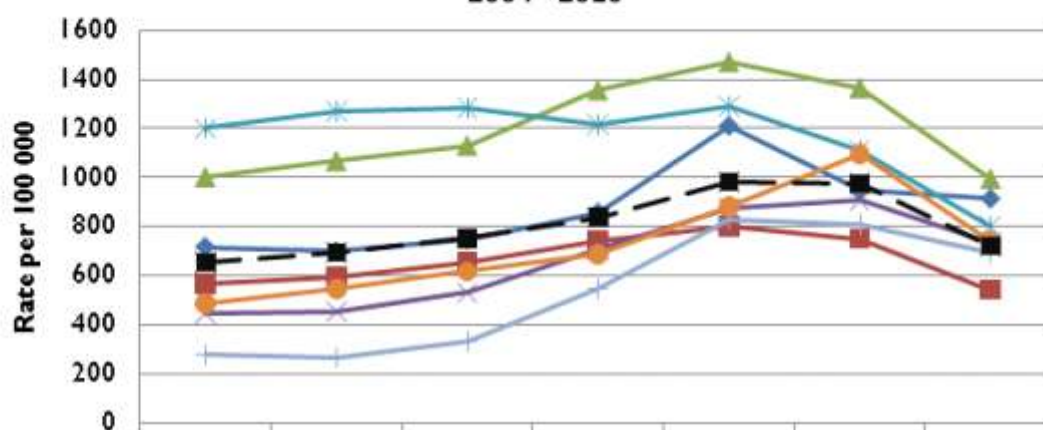
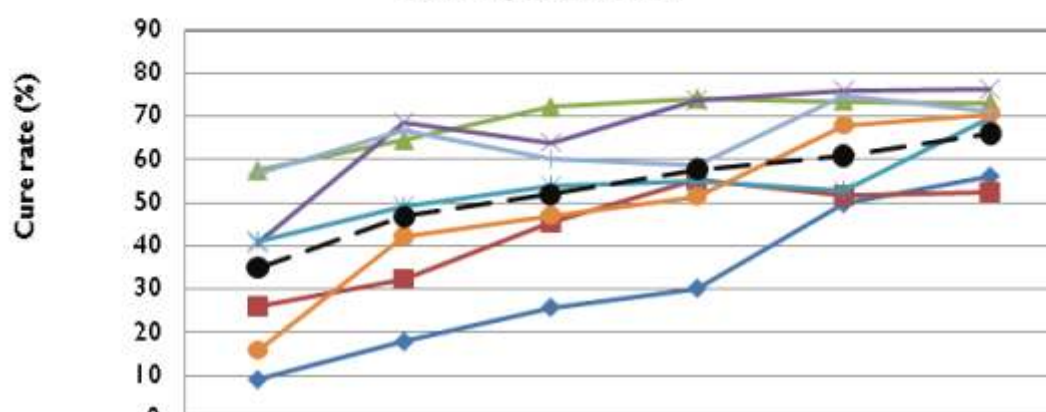


Figure 1.10: Incidence of TB in the EC Province by Health District, 2004 - 2010



	2004	2005	2006	2007	2008	2009	2010
A Nzo	718	699	746	858	1211	951	914
Amathole	570	595	655	740	801	752	544
Cacadu	1003	1068	1130	1354	1470	1363	995
C Hani	446	456	532	707	874	907	736
NMMM	1201	1269	1282	1216	1290	1112	801
OR Tambo	490	547	619	689	882	1095	740
Ukhahlamba	279	268	336	546	830	810	696
Province	656	694	753	838	983	976	722

Figure 1.11: TB Cure Rate in the Eastern Cape Province by Health Districts, 2004 - 2009



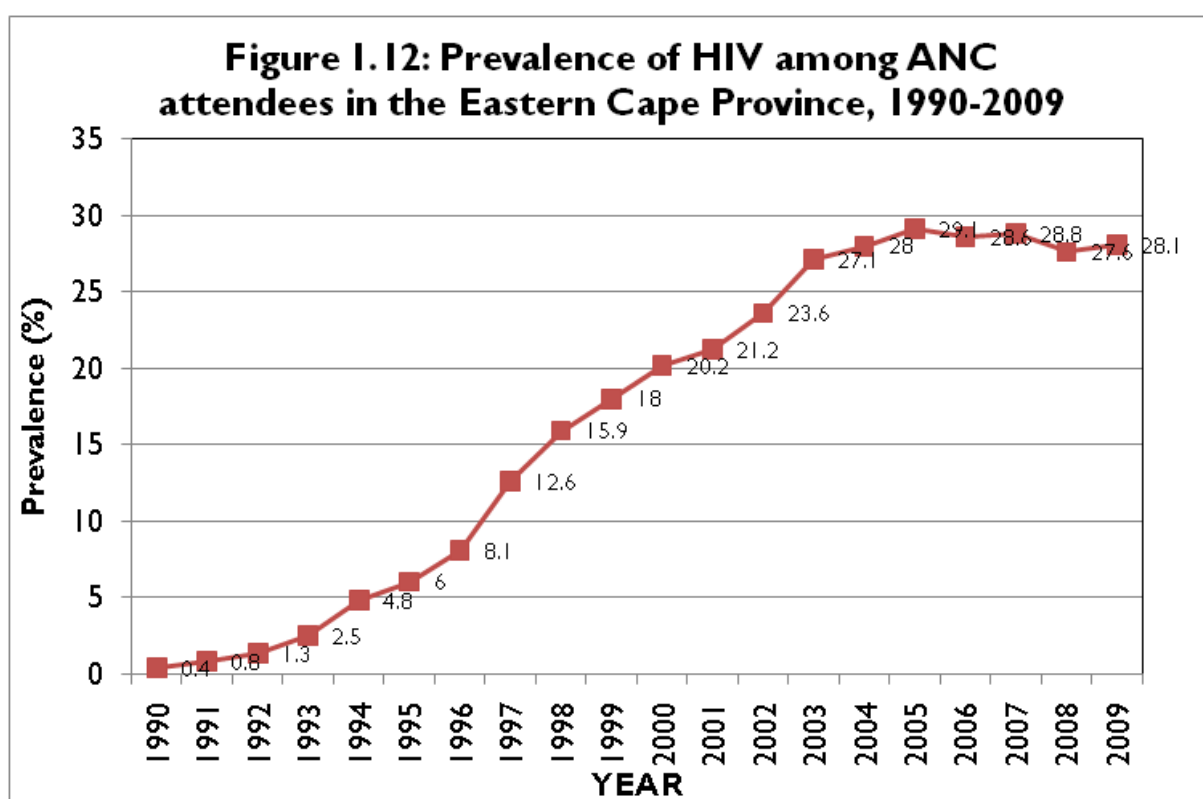
	2004	2005	2006	2007	2008	2009
A Nzo	9.0	17.8	25.7	30.1	49.7	56
Amathole	26.1	32.4	45.4	55.3	51.7	52.5
Cacadu	57.6	64.5	72.1	74	73.5	73.1
C Hani	40.8	68.7	64	73.7	75.9	76.2
NMMM	41.2	49.1	53.8	55.1	52.8	69.6
OR Tambo	15.9	42.1	47.1	51.5	68	70.6
Ukhahlamba	57.0	66.9	60.2	58.8	74.7	71
Province	34.9	46.8	52	57.7	60.9	66

HIV Prevalence

The percentage of pregnant women infected with HIV in Eastern Cape Province has been increasing over the years and reached a peak at 29.1% in 2006 (Figure 1.12). The prevalence trend has reached a plateau with the latest prevalence of 28.1%. NMM Metro had the highest prevalence at 30.7% followed by the OR Tambo District with 29.8% (see Table A11).

Table A11: HIV prevalence (%) among antenatal care attendees in the Eastern Cape, 2006 – 2009

District	2006		2007		2008		2009	
	% Prev	CI (95%)	% Prev	CI (95%)	% Prev	CI (95%)	% Prev	CI (95%)
Alfred Nzo	25.1	(20.3-29.9)	24.9	(20.7- 29.1)	29.9	(23.6- 36.7)	23.7	(16.3 - 33.0)
OR Tambo	29.7	(25.8-33.5)	30.3	(26.5- 34.1)	29.6	(26.9- 32.5)	29.8	(27.1 - 32.6)
NMM	31.95	(26.3-37.6)	28.96	(22.4-35.5)	29.1	(25.9- 32.4)	30.7	(24.0 – 38.4)
Chris Hani	27.1	(22.6-31.6)	30.2	(26.1 - 34.4)	27	(23.3 - 31.1)	27.1	(23.1 - 31.4)
Amathole	28.7	(26.0-31.4)	29.2	(26.6- 32.1)	26.5	(24.0- 29.2)	27.2	(24.5 - 30.2)
Cacadu	22.8	(17.8-27.7)	20.1	(14.7 -25.5)	23.8	(19.0- 29.3)	24.3	(16.4 – 34.5)
Ukhahlamba	29.9	(22.58-33.3)	29.5	(24.1- 34.1)	21.9	(16.6- 28.0)	23.8	(16.0 - 33.2)
EC Province	28.6	(26.9-30.4)	28.8	(26.9- 30.8)	27.6	(26.2-29.0)	28.1	(26.1 – 30.1)



Output 4: Strengthening Health System Effectiveness

The Six Priority Areas are incorporated into the National Core Standards and have been identified by the National Department of Health as areas where patients feel that services are far from what they expect in the service delivery environment. It is expected that following implementation, patient satisfaction will be improved. The priority areas include attitudes, cleanliness of facilities, waiting times, safety of patients, shortage of medicines, and infection prevention and control. Forty-nine health facilities were monitored on the implementation of the six priorities.

2.1.6 Overview of Organizational Environment for 2010/11

The Department of Health operates through eight health programmes whose activities are spread within three main branches, i.e. Clinical, Corporate Services and Financial Services branches. The core business of

the Department is driven through Programme 2 (District Health Services) and Programme 4 (Provincial Hospital Services) with the remainder of the programmes offering the relevant support.

Table A12 below shows the number and type of health facilities from which the core business of the Department is provided. In addition to district and provincial hospitals, there are specialized hospitals which consist of four mental hospitals, four mental health units that are operating within hospitals and one orthopaedic hospital at Mthatha. As of 31 March 2011, health services in the Eastern Cape were provided in 883 fixed health facilities depicted in Table A12 below whilst PHC services were provided at 884 facilities including mobile & satellite clinics, fixed clinics and community health centres (CHCs).

Eighteen Provincially-Aided Hospitals were provincialized under the DOH provincial administration and this increased the number of district hospitals from 48 in 2009/10 to 66 in 2010/11.

Table A12: Distribution of EC Health Facilities by Health District

District	District	Tertiary	Regional	Specialized	CHC's	Clinics
Alfred Nzo	3	-	-	2	1	60
Amathole	15	2	-	5	11	219
Chris Hani	14	-	1	1	7	147
Cacadu	10	-	-	5	1	81
N Mandela MM	1	3	-	3	9	55
OR Tambo	12	3	1	3	11	141
Joe Gqabi	11	-	-	-	0	45
Grand Total	66	8	2	19	40	748

Health Personnel

During the 2010/11 financial year, the EC population was served by a total of 39 657 provincial health workers with 6 572 (14.8%) being contract appointees. Overall, the DOH had a vacancy rate of 55.8% which varied significantly amongst the various categories of health professionals. Table A13 shows the number of

health workers per 100 000 uninsured population in the Province which is significantly lower than the WHO recommendations. The major challenge that is still experienced in the organizational milieu is a difficulty in the recruitment of clinicians. This occurs against the backdrop of rising MDR and XDR tuberculosis, chronic diseases and HIV and AIDS.

Table A13: Number of health personnel per 100 000 population in the EC, 2010

Category of Health Personnel	Number	Number per 100 000 (All population)	Number per 100 000 (Uninsured population)
Number of medical officers	1193	17.9	20.4
Number of medical specialists	171	2.6	2.9
Number of dentists (including specialists)	93	1.4	1.6
Number of professional nurses	8996	135.2	153.6
Number of student nurses (annually)	1422	21.4	24.3
Number of pharmacists	297	4.5	5.1
Number of physiotherapists	108	1.6	1.8
Number of occupational therapists	91	1.4	1.6
Number of psychologists	54	0.8	0.9
Number of radiographers	391	5.9	6.7
Number of emergency medical staff	1977	29.7	33.8
Number of nutritionists	23	0.3	0.4
Number of dieticians	67	1.0	1.1
Number of community care-givers	6748	101.4	115.2

% of persons with medical aid coverage = 12.1%

Significant developments internal to the Department of Health

There was a change of political heads in the ECDOH when MEC Mr. P. Masualle was deployed to the Department of Planning and Treasury in November 2011 and MEC Mr. M. Gqobana joined the DOH on the 1st December 2011.

Flowing from the policy changes which government introduced around the fight against HIV&AIDS as well the President's announcement on 1st December 2009, the Department launched the HIV Counselling & Testing (HCT) Campaign in all our districts. In the reporting period, the department has seen 478 079 people and tested 405 606 with 13% testing positive through this campaign. The department is also implementing the new ART guidelines, providing ARV treatment to special groups with CD4 count of 350 or less, HIV positive multi-drug resistant TB patients and children.

The Department contributed immensely to the country's success in hosting the 2010 FIFA World Cup.

Working closely with other provincial sister departments, the Department provided services from disease surveillance, Emergency Medical Services, and the provision of the world class Accident & Trauma Centre in Port Elizabeth. Areas around official FIFA World Cup venues also had facilities put on full alert and readiness for any calamity that may have occurred. The experience and institutional memory will form part of the FIFA World Cup legacy and will contribute to better services for our community members. There were no adverse events or reported incidents and both the National Department of Health and FIFA were satisfied with the standard and quality of our services.

Government introduced the outcome-based delivery and monitoring system that will ensure that performance is focused on identified critical areas. Our MEC has signed the Negotiated Service Delivery Agreement with the National Minister of Health committing the Eastern Cape Department of Health to contribute towards Four Outputs and one Outcome identified for the health sector. Our department will also work closely with other partners in the delivery of health services.

Despite these successes, the department was confronted by two main challenges in the province. Firstly, the national, three-week, 2010, general public service strike that took place in August and September, compromised effective service delivery especially essential services like health. An estimated total of 29460 man-hours was lost to the strike, which was rife with intimidation and caused a complete shut-down of health services in certain areas, however 5080 (equivalent to 9,231 960,50m) man hours were recovered. The Department was one of the hardest hit departments during the strike. The second challenge related to severe budgetary constraints with a threat of not only over-expenditure but also of not delivering adequate services in our facilities. Details of over-expenditure and deferment of non-critical work is explained in the programmes. The department continues to work closely with the National Department of Health and Provincial Treasury to find solutions to this challenge.

A new collective agreement, the PHSDSBC Resolution No. 2 of 2010 came into effect, introducing an Occupation Specific Dispensation (OSD) for Therapeutic, Diagnostics and Allied Health Professionals. The OSD introduced higher remuneration packages and career paths for these professionals with an impact on the compensation for employees (COE). In addition, the provincialisation of 19 of the 26 municipalities that provided PHC services on behalf of the department has been completed, with the remaining seven targeted for completion in the new financial year. This was completed in line with the function shift between provincial and local government as stipulated by the National Health Act, 2003 in order to address the fragmentation within the management of PHC services. Eighteen (18) former Provincially-Aided Hospitals were also taken-over by the department during the financial year. These two processes impact the Department through an increase in the COE budget and organogram/structures in terms of the widening span of control for management of people and other resources at the provincial level.

The Chief Financial Officer was suspended in October 2010 and an acting CFO was appointed; key management positions that are vacant include the positions of Chief Financial Officer, Chief Operations Officer and Deputy Director General: Clinical Services, General Managers: Financial Management, Supply Chain Management, Integrated Human Resources Management and Infrastructure Development and Management.

The HROPT independent audit was concluded by Grant Thornton. The audit found that more than 99%

of promotions effected were incorrect and recommended that all monies paid as a result, be reversed and or recovered. During March 2011, the department reversed all HROPT promotions effected during 2009 on the strength of both the EXCO resolution and the Grant Thornton audit findings. However, affected employees obtained an interim injunction which ordered the department to reverse all demotions pending the return date on May 30th 2011.

The seven districts have completed District Health Expenditure Reviews (DHERs) that informed the development of District Health Plans for each district. The latter has been aligned to the Annual Performance Plan of the department to facilitate integrated planning at provincial and district levels. Participation of districts and sub-districts in the municipal Integrated Development Plans as well as other inter-governmental structures has improved cooperation between the provincial and local spheres of government.

The department has embarked on a project to strengthen PHC services and prioritised three sub-districts in the province for implementation over the next three to five years, i.e. Uitenhage (Nelson Mandela Metro), Intsika Yethu (Chris Hani) and King Sabata Dalindyebo (OR Tambo). The intent of this project is to strengthen all areas of PHC services, including upgrading certain Community Health Centres to community health hospitals, whilst ensuring that clinics are equipped to provide the full package of services thereby increasing communities' access to PHC services. This strengthening is coupled with the implementation of a social compact, which is aimed at increasing communities' participation in health services.

Despite the province being faced with challenges in terms of human resources and infrastructure, the number of CHCs rendering 24hour services has increased from 27 in the previous financial year to 31 in an attempt to improve access to PHC services for all citizens of the Eastern Cape Province. In addition, the number of CHCs providing MOU and Trauma has been increased to 30 and 29 respectively; 75% of CHCs are rendering 60% of the PHC package.

Fraud Prevention Policies

An approved Fraud Prevention Policy is in place. The Policy encompasses a Fraud Prevention Plan, Fraud Policy Statement, Fraud Response Plan and a Whistle Blowing Policy.

The Audit Committee oversees and monitors implementation of the Fraud Prevention Strategy.

The department encourages its stakeholders to report matters of fraud to the Provincial fraud hotline and the call centre/ hotline of the department, which act as whistle-blower mechanisms available to all employees of the department, patients and the public at large to report fraudulent and unethical behaviour of any nature (including unethical medical behaviour). These channels ensure the anonymity of all information received and the protection of the employees reporting these incidents.

The department's Fraud Prevention Policy outlines a "zero tolerance" approach towards fraud and corruption. Accordingly all identified matters that have a criminal element are reported to the South African Police Services and any other appropriate law enforcement agency.

The fraud hotline is but one of the mechanisms available to employees, suppliers, patients and the public to report incidents of fraud and corruption.

The status of investigation activities during the year was as follows:

Internal and External parties can contact the departments' forensic unit by telephone, email or request a meeting. The specialised forensic investigations department resides within the Internal Audit Unit, and reports directly to Chief Audit Executive.

All incidents reported on the fraud hotline are logged onto a case register and are investigated. Regular feedback is sent to the Office of the Director General at the Eastern Cape Office of the Premier. The status with regards to attending to reported cases is also reported on to the Audit Committee at its regular meetings.

The department has registered some successes on forensic matters. These have come either in the nature of recoveries, registering a criminal matter with the SAPS for further follow up or effecting dismissals on all individuals implicated in illegal activities.

These actions have helped to ensure that the Specialised Forensic Unit acts as a deterrent to would fraudsters.

Phase	Total
Reports submitted and cases closed	46
Investigations completed.Awaiting confirmation of debt	2
Investigations completed.Awaiting outcome of disciplinary	8
Under investigation	40
Reporting Phase	11
Cases being investigated by other units within ECDOH	17
Preliminary Investigation	5
Handed over to SAPS	1
	130

Ensuring that all reported irregularities are followed up and investigated is a challenge to the department, given its current financial position. However, the department is actively seeking inter-governmental support on this matter, and is also seeking ways to recover monies on investigations performed.

2.1.7 KEY POLICY CHANGES

The following key policy changes were introduced during the reporting period:

Outcomes Approach Policy

Following the release of the Policy Document (Green Paper), government soon introduced the Outcomes Approach Policy changes. The Ruling Party transformed its Five Manifesto Priorities into the Ten Strategic Priorities in the Medium Term Strategic Framework (MTSF). The government translated the MTSF priorities into the much focused on 12 outcomes to ensure an effective and strategically focused service delivery. The health sector has one outcome: A long and healthy life for all South Africans, and four outputs.

The President has signed Performance Agreements with all the Cabinet Ministers. This will ensure that the ministers are held accountable to deliver on specific, focused and well defined outcomes. The ministers are then expected to sign Negotiated Service Delivery Agreements (NSDA) with all the stakeholders that will play a greater part in the delivery of the determined outputs and outcome. The Minister of Health has signed his NSDA with all his provincial counterparts. As part of the changes this year the APP had to incorporate NSDA objectives, indicators and targets.

Revenue Generation

The department is currently in the process of initiating income generating projects in identified hospitals to increase its attraction and retention of revenue, as well as increasing its nucleus of health facilities in readiness for the implementation of the National Health Insurance Policy, which will have a positive effect on operations in future financial periods.

Public Service Transformation Strategy (PSTS)

The Office of the Premier (OTP) is spearheading the province-wide communication of the PSTS and ensuring the implementation of this strategy throughout the province. The purpose of the strategy is to ensure ongoing transformation of the culture of the provincial public service for the effective and efficient delivery of services to the people of the province. The PSTS has the following pillars

- Transforming the Organizational Culture
- Transforming Human Capital and Talent Management Practices
- Transforming Service Delivery Improvement Culture
- Effective use of Communication as a Key Lever for Change
- Instilling a Culture of Good Corporate Governance

Departments are expected to drive the implementation of the pillars throughout all the levels of the organization.

Primary Health Care Policy Changes

The Department commenced with the implementation of the Provincialisation of PHC in line with the consolidation of the one single authority principle in terms of health service delivery. Already 21 out of 26 municipalities in the province have been provincialized. The two metropolitan municipalities (including the recently established Buffalo City Metro) are negotiating for retention of these services. The impact of this policy implementation means that the department must ensure that there are no duplications of services in certain areas.

The department has also developed and is implementing the Revitalization of PHC (RPHC) in five sites. This involves “going back to basics” in the provision of the PHC services, Community Health Worker driven services, the centrality of home and family as the core element, and the social compact including the critical role to be played by the communities. The targeted sites are not considered as pilots but rather the springboard from which best practices will be rolled out to other sub-districts.

The HIV Counseling & Testing (HCT) campaign was launched in May 2010 in OR Tambo District followed by launches in other districts. The policy change and the campaign follows the December 2009 President's Call. This means that the department, working closely with the Eastern Cape AIDS Council, had to mobilize all civil formations and other stakeholders for greater penetration of the program in order to achieve the 2 million target of people tested for HIV.

The finalisation and appreciation of the policy and strategy to retain revenue generated by the

Department is of critical importance in finding additional sources of revenue.

The sub-optimal supervision of Primary Health Care facilities has remained a critical and strategic issue to be resolved by the Department as the 100% target to supervise all primary health facilities was not achieved.

The data policy has to be revisited to ensure that the data generated, captured and recorded within the EMS Programme conforms to the standards and norms of this policy.

The introduction of the Negotiated Service Delivery Agreement, as a strategy to facilitate the improvement of health care services remained a challenge in terms of the planned targets which were not budgeted for. This matter will be addressed in the next financial year.

2.1.8 DEPARTMENTAL REVENUE, EXPENDITURE AND OTHER SPECIFIC TOPICS

Collection of departmental revenue

The Department exceeded its collection target for the year, primarily due to the improvement in billing of Medical Aid and Motor Vehicle Accident patients. In addition, there has been an increase in medical aid patients arising from the introduction of GEMS. The department further improved controls on collection of rental revenue.

As reported above, the department is currently in the process of initiating income generating projects in identified hospitals to increase its attraction and retention of revenue.

Sources of Revenue and Collections During the Year Under Review

Table A14: Departmental Revenue, 2010/11

	2007/08	2008/09	2009/10	2010/11	2010/11	% Deviation From Target
	R'000	R'000	R'000	R'000	R'000	
Sales of goods and services product by the department	63,658	79,844	73,592	70,599	81,024	15%
Financial transactions	6136	10,258	6224	4068	4949	22%
TOTAL DEPARTMENTAL RECEIPTS	69,794	90,102	79,816	74,667	85,973	15%

2.1.9 DEPARTMENTAL EXPENDITURE

The table below shows the variance between actual and planned expenditure per programme and per economic classification.

Table A15: Departmental Expenditure 2010/11

Programme Name	Prog. No.	Compensation of Employees	Goods & Services Interest and Rent on Land & Financial Transactions in Assets & Liabilities	Transfers and Subsidies	Purch / Constr Capital Assets	Total 31st March Actual Expend.	Final savings / Over expend.
		R'000	R'000	R'000	R'000	R'000	R'000
Health Administration	1	319,947	197,657	703	3,774	522,081	12,018
District Health Services	2	4,404,925	1,761,616	427,941	12,541	6,607,023	-117,524
Emergency Medical Services	3	313,855	213,774	125	9,159	536,913	40,861
Provincial Hospital Services	4	2,865,735	569,489	13,595	32,369	3,481,188	15,197
Central Hospital Services	5	110,499	418,933		65,022	594,454	37,777
Health Science & Training	6	340,360	132,007	111,748	10,018	594,133	19,086
Health Care & Support Services	7	29,568	36,141	0	1,285	66,994	26,578
Health Facilities Dev. & Maintenance	8	5,860	260,591	14	603,577	870,042	535,527
Total incl Statutory		8,390,748	3,590,208	554,126	737,746	13,272,828	569,520
Statutory Appropriation included in Prg 1 above: R1,484							

Reason for the (over) /under expenditure for Programmes with significant variances

The detail of the reasons for (over)/under-expenditure for Programmes with significant variances is given in the Accounting Officer's Report.

Programme 1: Under-expenditure of R12.018 million

The under-expenditure on Goods and Services and Capital Assets was caused by insufficient cash flow available towards year end, arising from a restricted cash flow for the Vote as well as only conditional grants being allowed to be paid.

Programme 2: District Health Services – Over-expenditure of R117.524 million

The programme overspent its budget for compensation of employees by R68.747 million, caused mainly by the carry through costs related to HROPT, partially-funded mandates of Occupation Specific Dispensation payments for doctors and therapeutics and the carry through costs related thereto, the higher than normal increase in the ICS and the provincialisation of PHC services and provincially-aided hospitals.

The over-expenditure on Compensation of Employees is expected to remain a challenge as the carry through

costs of HROPT and OSD mandates that resulted in the over expenditure in the current year have not been adequately compensated by new funding. The over expenditure, by R83.541 million, on Goods and Services was caused primarily through sustained, increased Pharmaceutical and Surgical Sundries expenditures, a result of the ever increasing burden of disease within the Province.

Transfers and Subsidies under-spent by R17.310 million in total. This under-expenditure relates to municipal transfers outstanding at year end for municipalities that rejected provincialisation; as well as households that could not be paid due to payments being restricted to conditional grants only.

The Department has submitted an application for rollover of conditional grant funding of R66.813 million to the Provincial Treasury in respect of the Comprehensive HIV/AIDS, Forensic Pathology and Expanded Public Works Programme Conditional Grants.

Programme 3: Emergency Medical Services – Under-expenditure of R40.861 million

The under-expenditure on Payments for Capital Assets of R46.399 million arose from orders made for the outright purchase of new customized ambulances which were received in March 2011 but could not be paid for due to payments being restricted to conditional grants.

The programme over spent its budget for compensation of employees by a net amount of R8.581 million, caused mainly by carry-through costs related to the unfunded/partially-funded mandates of Occupation Specific Dispensation payments, wherein the respective policy decisions were not aligned with the budget allocations.

Programme 4: Provincial Hospital Services – Under-expenditure of R15.197 million

The programme overspent its budget for compensation of employees by R14.498 million, caused by the carry through costs related to HROPT, partially-funded mandates for OSD for doctors and therapeutics as well as the higher than normal increases in ICS.

The under-expenditure on Goods and Services of R12.770 million and Machinery and Equipment of R15.624 million relate to payments being restricted to conditional grants only at financial year end.

Programme 5: Provincial Tertiary Service – Under-expenditure of R37.777 million

The Department under spent in total by R37.777 million, mainly in respect of Goods and Services (R 22.652 million) and Payments for Capital Assets (R15.637 million). An application for a rollover of funds for R37.407 million has been submitted to Provincial Treasury.

Programme 6: Health Sciences & Training – Under-expenditure of R19.086 million

The budget for compensation of employees was overspent by R41.607 million, caused mainly by the January intake of newly qualified doctors, nurses and registrars. The Department has submitted an application for a rollover of conditional grant funding of R36.730 million to Provincial Treasury in respect of the Health Professions Training and Development Grant, made up of R10.576 million for Goods and Services, R6.977 million for transfers to universities and R19.175 million for Payments for Capital Assets.

Programme 7: Health Care Support Services – under-expenditure of R26.578 million

Compensation of Employees was underspent by R3.320 million, Goods and Services by R17.563 million and Payment for Capital Assets by R5.165 million. Delays in procurement processes as well as the restriction of payments to conditional grants impacted on the under-expenditure.

Programme 8: Health Facilities Development and Maintenance – Under-expenditure of R535.527 million

Challenges in the procurement processes of the Department, including the uncertainty that resulted with the issuing of ECSM Circular 9 of 2010/11 resulted in the under-expenditure that took place in this programme.

The Department has submitted an application for the rollover of conditional grant funding to Provincial Treasury in respect of R272.182 million for the Hospital Revitalisation Conditional Grant and R76.519 million for the Infrastructure Grant to Provinces. The bulk of these rollovers relate to Buildings and other fixed structures and Machinery and Equipment.

2.1.10 TRANSFER PAYMENTS

The details of transfer payments that the department has made to municipalities, departmental agencies and accounts, universities and technikons as well as households are given in Annexures IB, IC, ID and IH respectively in the Annual Financial Statements.

The provincialisation of 19 of the 26 municipalities that provided PHC services on behalf of the department has been completed, with the remaining seven targeted for completion in the new financial year. This was done in line with the function shift between provincial and local government as stipulated by the National Health Act, 2003 in order to address the fragmentation within the management of PHC services. Eighteen formerly Provincially-Aided Hospitals were also taken-over by the department during the financial year.

2.1.1 CONDITIONAL GRANTS AND EARMARKED FUNDS

The Department spent R2.020 billion of its allocated funding of R2.504 billion - a net underspend of R484.937 million in its conditional grants.

Table A16: Conditional Grants Received by the Department, 2010/11

NAME OF GRANT	GRANT ALLOCATION						
	Division of Revenue Act/Prov.	Roll Overs from 2009/10	DORA Adj	Other Adj	Total Available	Amount received by Dept	Amount spent by Dept
	R'000	R'000	R'000	R'000	R'000	R'000	R'000
National Tertiary Services Grant	557,137	75,094	0	0	632,231	594,453	594,454
Health Professionals and Development Grant	160,444	46,754	0	0	207,198	182,319	182,320
Hospital Revitalisation Grant	360,660	78,875	0	0	439,535	168,853	168,610
Comprehensive HIV/AIDS Grant	690,940	67,187		1,000	759,127	700,215	700,216
Forensic Pathology Grant	69,345	7,237	0	0	76,582	62,826	63,070
Infrastructure grant to provinces	331,782	4,383	0	0	356,165	256,165	278,691
EPWP Incentive	33,659	0	0	0	33,659	6,012	6,012
	2,203,967	299,530	0	1,000	2,504,497	1,970,843	2,019,560

The Department has made application for Conditional Grant Funds totalling R489.65 million appropriated but not spent in the 2010/11 financial year, to be rolled over to the 2011/12 financial year. There are three primary reasons for having applied for the rollover of the conditional grants including;

- awaiting the submission of invoices from suppliers;
- the implications of the procurement delays of the KwaZulu-Natal High Court judgment in Sizabonke Civils t/a Pilcon Projects v Zululand

District Municipality & Others, Case No. 10878/2009, which dealt with the conflict that exists between the Preferential Procurement Policy Framework Act, 5 of 2000, and the Preferential Procurement Regulations, 2001;

- the non- transfer of the fifth installment of R100,00 million of the infrastructure grant to provinces for the 2010/11 financial year, due on 04 February 2011. This amount was stopped by National Treasury in accordance with section 17 of the 2010 Division of Revenue Act.

Table A17: The application for rollovers and surrender of unspent funds

	Rollovers
Health Professions Training and Development Grant	24,878,000
National Tertiary Services Grant	37,777,000
Comprehensive HIV/Aids (Health) Grant	58,911,000
Forensic Pathology Services Grant	13,512,000
Hospital Revitalisation Grant	270,925,000
Infrastructure Grant to Provinces	77,474,000
EPWP Incentive	1,370,000
	484,847,000

Reconciled as follows:	
Goods and Services	81,564,000
Universities & Technikons	6,977,000
Buildings & Other Fix Structures	331,089,000
Machinery and Equipment	65,217,000

According to the records of the Department, the roll over amount of R489.65 million resided with Provincial Treasury, as these were not requisitioned by the Department – [after adjusting for the amounts of R100 million for Infrastructure Grant to Provinces and R48.7 million for Hospital Revitalisation Grant - stopped in terms of section 17 of DORA.]

2.1.12 CAPITAL INVESTMENT, MAINTENANCE AND ASSET MANAGEMENT PLAN

Section 3: Acquisition Plan

The department is currently facing a large demand for new facilities (new clinics, community health hospitals, and all hospitals (new and upgrades)).

“After an intense examination of the demographic Characteristics of the Eastern Cape Population, the Burden of Disease, the Health Facilities Definitions, Norms and Standards, the Provincial Growth and Development Strategies. Furthermore, the intensive internal and external consultation and Communication about the Service Transformation Plan, particularly the shape and size of the Provincial Health Facilities and other health services, the Eastern Cape Department of Health Resolved that in terms of the Shape and Size, and health services, the following should be considered and budgeted accordingly for the next ten years:”

Table A18: Health facility projections

	CURRENT STATE	FUTURE STATE
District Hospitals	66	29
Provincially-aided Hospitals	18	0
Community Health Centres	32	96
Fixed Clinics	750	550
Satellite Clinics	31	178
Mobile Clinics	160	87
Health Posts	0	165
TB Hospitals	11	13
Psychiatric Hospitals	4	5
Orthopaedic Hospital	1	1
Level 2 & 3 tertiary hospitals in 3 complexes	8	3
Regional Hospitals	2	3
EMS Metro Bases	5	7
EMS Satellite Bases	73	141
Orthotic and Prosthetic Centres	3	3
Medical Depots	2	1 or 2
Forensic Pathology Mortuaries	-	15
Forensic Pathology Holding Facilities	-	40

Current and future requirements from STP - At the moment these figures are being reviewed by the department.

Constraints in budget have not allowed the Department to provide new facilities (determined by planning norms and standards) or to adequately maintain existing facilities. The current backlog for infrastructure and maintenance was estimated at approximately R19,169 billion. This amount will be escalated significantly for each year that the backlogs are not addressed.

The Table A19 below is an illustration of the number of anticipated health facilities in the province with indicative figures to address the backlogs per type of facility:-

Table A19: Estimate of cost to address facilities backlog

	No. of Projects	Total ESTIMATE Required
New	159	R 4 182 186 047
CHC's	59	R 2 960 000 000
Clinics	100	R 1 222 186 047
Upgrade	95	R 14 986 771 000
Accommodation	1	R 500 000 000
Hospitals	92	R 13 746 771 000
LSA Offices	1	R 40 000 000
Medical Equipment	1	R 700 000 000
Grand Total	254	R 19 168 957 047

The table below illustrates the number of projects prioritised for development for the MTEF period:

Table A20: Number of projects for development in MTEF period

	Number of Projects		
	2011/12	2012/13	2013/14
1. New and replacement assets	105	35	30
Community Health Facilities	72	12	12
District Hospital Services	10	6	6
EMS	5	-	-
Other facilities	2	2	2
Provincial Hospital services	16	15	10
2.Total upgrades and additions	65	32	29
Community Health Facilities	6	3	6
District Hospital Services	35	20	13
EMS	1	-	-
Other facilities	1	-	1
Provincial Hospital services	22	9	9

	Number of Projects		
	2011/12	2012/13	2013/14
3. Rehabilitations, renovations and refurbishments	71	30	1
Community Health Facilities	32	2	-
District Hospital Services	34	24	1
Provincial Hospital services	5	4	-
4. Maintenance and Repairs	205	204	201
Community Health Facilities	51	51	51
District Hospital Services	98	97	95
Other facilities	7	7	7
Provincial Hospital services	49	49	48
Mortuary	3	-	-
Mortuary	3	-	-
Grand Total	449	301	261

From the above table it is clear that the number of new and upgrade projects decreases substantially over the MTEF period whilst maintenance and repairs has remained constant over the years. The table A21 below illustrates investment on capital assets per facility type.

Table A21: Investment on capital assets by facility type

	Budget Allocations		
	2011/12	2012/13	2013/14
1. New and replacement assets	R 303 116 965	R 199 352 145	R 176 853 624
Community Health Facilities	R 73 703 188	R 81 770 934	R 90 196 506
District Hospital Services	R 31 833 155	R 36 106 066	R 35 656 812
EMS	R 10 466 184	-	-
Other facilities	R 10 308 227	R 13 000 000	R 12 000 000
Provincial Hospital services	R 176 806 210	R 68 475 145	R 39 000 306
2. Total upgrades and additions	R 511 577 030	R 630 140 917	R 703 973 376
Community Health Facilities	R 334 564	R 26 061 537	R 28 695 000
District Hospital Services	R 151 117 902	R 255 490 125	R 292 100 581
EMS	R 565 892	-	-
Other facilities	R 0	-	R 6 850 851
Provincial Hospital services	R 359 558 673	R 348 589 255	R 376 326 944
3. Rehabilitations, renovations and	R 85 183 793	R 68 679 193	R 33 900 000
Community Health Facilities	R 16 894 112	R 8 100 000	-
District Hospital Services	R 61 366 922	R 55 379 193	R 33 900 000
Provincial Hospital services	R 6 922 759	R 5 200 000	-
4. Maintenance and Repairs	R 238 613 149	R 267 509 645	R 299 880 000
Community Health Facilities	R 41 538 708	R 47 212 500	R 52 632 500
District Hospital Services	R 134 363 660	R 129 830 000	R 152 405 000
Other facilities	R 3 450 367	R 4 390 000	R 5 390 000
Provincial Hospital services	R 59 260 414	R 86 077 145	R 89 452 500
Mortuary	R 14 000 000	-	-
Mortuary	R 14 000 000	-	-
Grand Total	R 1 152 490 937	R 1 165 681 900	R 1 214 607 000

From the above table it is clear that the value of the new and upgrade projects decreases substantially over the MTEF period which is in line with the strategic objectives of the department taking the financial deficits into account.

Refurbishment Plan

In terms of the Uamp, the priorities for refurbishment are determined based on functional performance and utilization of the facilities available to the department. The department as required for in template 3 above is busy doing its best to assess the condition and functional performance of all its facilities as prescribed.

The department has information from condition assessments on clinics and CHCs on the capital required to refurbish all the facilities to an acceptable level – which have been included.

Note: On all the hospitals that require major capital injection (approximately R15 billion) we have linked the refurbishment requirements with the new and upgrades because for efficiency reasons, the scope of work for the hospitals will in practice combine them.

	Required Refurbishment Amount (Capital)
CHC's	R 24 396 649
Clinic	R 190 675 833
Grand Total	R 215 072 482

The refurbishment programmes main objective is to get all facilities to a condition rating of 4 or 5 as defined in the table below

Table A22: Descriptions of condition ratings for facilities

Condition	Condition	Action	Description
5.	Very good	Planned preventative maintenance	The component or building is either new or has recently been maintained. Does not exhibit any signs of deterioration.
4.	Good	Condition-based maintenance	The component or building exhibits superficial wear and tear; minor defects, minor signs of deterioration to surface finishes and requires maintenance/servicing. It can be re-instated with routine scheduled or unscheduled maintenance/servicing.
3.	Fair	Repairs required	Significant sections or component require repair, usually by a specialist. The component or building has been subjected to abnormal use or abuse, and its poor state of repair is beginning to affect surrounding elements. Backlog maintenance work exists.
2.	Bad	Rehabilitation required	Substantial sections or component have deteriorated badly, suffered structural damage or require renovations. There is a serious risk of imminent failure. The state of repair has a substantial impact on surrounding elements or creates a potential health or safety risk.
1.	Very bad	Replacement required	The component or building has failed, is not operational or deteriorated to the extent that does not justify repairs, but should rather be replaced. The condition of the element actively contributes to the degradation of surrounding elements or creates a safety, health or life risk.

Constraints within the department have not allowed it to adequately maintain its existing facilities. In terms of the desired level of service, it is the Department's obligation to ensure equality across the province. In this regard, affordability and sustainability are the desired guiding principles.

The following key activities are performed:

Repairs

Repairs includes building defects, machinery and equipment components etc.. These are in many cases done by the Department in-house. In addition, the Department transfers funds to institutions for day to day maintenance and grounds maintenance. In some

cases the repairs may be of a specialist nature and need to be done by a service provider. Generally all repairs will require departmental approval before implementation. It is a challenge to design SCM and procurement processes to streamline the appointment of service providers to support these activities especially as the department has not done a condition assessment audit of its equipment and buildings.

Rehabilitation and Refurbishment

The aim of the department is that all equipment and facilities function at a “condition rating” of 4 or 5. The

actions to get the equipment or facility to this level may be classified as rehabilitation or refurbishment. The department often encounters building and or equipment defects that will require large scale rehabilitation and refurbishment.

Replacement

In many instances the building defects, machinery and equipment components etc. are so outdated or irreparable that they need to be replaced. In most cases these need to be done by a specialist service provider or a project must be created and funded.

The following table contains projects that are currently in progress and to be completed in the next MTEF period.

Table A 23: Projects in progress or planned for completion in next MTEF period

HEALTH PROJECT CLASSIFICATION	2011/12	2012/13	2013/14
Clinics & Comm Health Centres	25	2	5
District Hospitals	8	-	1
Provincial Hospitals	-	4	1
EMS Bases	3	-	-
Mortuaries	2	1	-
Accommodation	-	3	1
Facilities Revitalized (HRP)	1	1	1
Maintenance – Health Facilities			-
Building Repairs	11 hospitals 34 clinics	12 clinics	-
Water and Sanitation Plants upgrades	8	7	1

The ECDOH has no plans to down-grade or close down any of the current facilities.

Table A24: Current maintenance backlog

Projects	No. of Institutions	Major Maintenance CME	Minor day to day Maintenance Transfers to institutions	Backlogs
Clinics and CHCs	800	46	200	600
Hospitals	100	11	32	70

Asset management plan

The department has acquired approximately R110m worth of assets in the year under review. Assets that needed to be disposed of were identified and were submitted to the Board of Survey for approval of disposal. An amount of R165,000 was generated from proceeds of sale. Loss of about R1m was reported from various health facilities including Head Office.

Table A25:

Number of capital assets	% Good & Fair	% Bad Condition
266,000	80%	20%

PROGRAMME I



ADMINISTRATION

PROGRAMME I: HEALTH ADMINISTRATION

Purpose

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

Strategic Objective

To facilitate the provision of strategic leadership and creation of social compact to improve health outcomes.

1.1 SUB-PROGRAMME: OFFICE OF THE MEC

Programme Priorities

- Give political and strategic direction to the Department through an efficiently and effectively managed office.
- Liaise between the offices of the Political Head, Head of Department and branches in general on major policy and administration matters.
- Ensure that the MEC attends Departmental strategic sessions and other functions of the Department.
- Respond to parliamentary questions and ensure that resolutions of the legislature are implemented.

Service delivery achievements:

- The MEC tabled the Department's half year oversight report 2010/11 and the 2011/12 Policy and Budget Speech at the Legislature.
- The MEC has been conducting outreach sessions and addressing and/or participating in various activities and events province wide including:
 - Visits to a number of health facilities in order to understand issues and challenges facing health officials at coalface; and meetings with hospital management and officials in various hospitals including St Barnabas, Madzikane KaZulu, Nelson Mandela Academic and Frere to mention a few.
 - The MEC officially opened five clinics; namely Qiba, Ntafufu, Xume, Ngqwarha and Qolombana.
 - The Department, in partnership with the Office of the Premier (OTP), officially launched and introduced Innovation and Knowledge Management (IKM) to health facilities (hospitals and clinics) in the Districts; Provincial champions were also elected (see Shared Contact Centre).
 - The MEC presided over the allocation and transfer of 100 new ambulances to five Metros.

Table 1.1: MEC - Performance against Provincial Targets from 2010/11- 2012/13 Annual Performance Plan for the Office of the MEC

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
To facilitate the provision of strategic leadership and the creation of social compact to improve health outcomes.	% Compliance with the provincial legislature requirements (policy and budget speech and statutory planning documents).	2008/09 Policy and Budget Speech was tabled at the legislature.	2009/10 Policy and Budget Speech was tabled at the legislature.	2010/11 Policy and Budget Speech was tabled at the legislature.	2010/11 Policy and Budget Speech was tabled at the legislature in April	Target achieved
		2009/10-2011/12 APP tabled at the legislature.	2010/11-2012/13 APP tabled at the legislature.	Statutory planning documents tabled at the legislature.	2011/12-2013/14 APP was tabled at the legislature in April	Target achieved
		100%	100%	100% compliance with all the reports, resolutions and instructions of the legislature	100%	Target achieved
	Number of sessions of governance structures hosted and interacted with the Honourable MEC.	9 Sessions: 7 Hospital Boards, 2 Clinic Committees, 2 Provincial Consultative Forums	12 Sessions: 7 Hospital Boards, 3 Clinic Committees, 2 Provincial Consultative Forums	22 Sessions in total: 7 Hospital Boards, 7 Clinic Committees, 2 Provincial Consultative Forums 6 PHC Meetings	7 Sessions: 4 Hospital Boards, 1 Clinic Committee, 1 Provincial Consultative Forum 1 PHC Meeting	Only 1 PHC meeting convened - due to challenges with availability of some external PHC members. The recess which had to happen because of the local government elections also contributed to the low number of sessions.

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	Number of MEC outreach sessions to all districts, health facilities and health agencies.	4 sessions in 7 districts	7	7	7	Target achieved

1.2 SUB-PROGRAMME: OFFICE OF THE SUPERINTENDENT GENERAL

Purpose

The Office of the Superintendent-General (OSG) covers the strategic management, compliance and cooperative governance matters.

The Superintendent-General (SG) provides strategic leadership towards the achievement of the DOH mandate, and provides executive support to the MEC in the implementation of provincial and national health policy and legislation. The SG is supported by five senior managers; one who provides strategic management support to him, and four who manage the sub-directorates:- Senior Management Service [SMS Unit], Intergovernmental Relations [IGR Unit], Special Programmes Unit, and Office Management Support Unit.

Programme Priorities

- To provide organized, capacitated and efficient strategic and office management support to facilitate the administrative leadership role of the Superintendent-General.
- To provide high-level support to the Superintendent-General in the performance of his accountability to the Executing Authority/MEC, provincial and national legislative structures, governance structures (e.g. Social Needs Cluster and Cabinet Committee for Social Needs), and statutory bodies (e.g. Public Service Commission, Human Rights Commission, etc).
- To intensify compliance of senior management personnel [levels 13 - 16] with their financial declarations.
- To provide a standardized advocacy strategy - in line with national legislative, policy and analysis frameworks - to promote the socio-economic interests of designated groups such as children, elderly, youth and people with disabilities.
- To provide monitoring and project management technical support to departmental turnaround plans, within Clinical, Infrastructure, Finance, Integrated Human Resources Management Services and Corporate Strategy and Organisational Performance – Compliance Management Tool.

Service delivery achievements:

- In line with Executive Council/Cabinet Resolutions, implementation commenced on: Revitalisation of PHC, Revenue Generation Project, Pharmaceutical Depots Turnaround Strategy, Finance Turnaround Strategy, HIV Counselling & Testing Campaign and an audit of Human Resources Operations Project Team (HROPT) payments. Two of these have been project managed and progress is as follows:
- Revitalisation of PHC (RPHC):
Project implementation plans were completed.
- Pharmacy PPP: The legal review has been done.
- In line with the National Health Council resolutions, most preparations for provincialisation of PHC have been completed. The Department commenced the implementation of the Better Health Outcomes Project in the targeted districts; O.R. Tambo, Amathole, Cacadu, Joe Gqabi and Alfred Nzo. Implementation of the HCT Campaign, revitalisation of PHC, and the District Health Model also commenced.
- In line with visits to the service delivery 'coal face', the Superintendent-General visited four health facilities (Port Elizabeth Hospital Complex, Nelson Mandela Academic Hospital, Elizabeth Donkin Hospital, and ELHC [Frere Hospital]) and five district hospitals (Nompumelelo, SS Gida, Bhisho, Fort Grey and Uitenhage Hospitals).
- A rapid qualitative survey was undertaken to assess information dissemination to women and their knowledge about public health services available to women. A mobilization plan was completed based on the outcome of the survey.
- Outreach sessions were held at Cacadu District Office, Rosedale Clinic in Nelson Mandela Metro.
- The Special Programmes Unit completed eight outreach visits to Joe Gqabi, OR Tambo, Alfred Nzo and Nelson Mandela Metro which sensitized managers and promoted:
- health service delivery targeting youth,

- women's health [including young women] and cervical cancer screening,
- women's groups and women's access to public health services at the local level, and
- improving and increasing access to public health services by people with disabilities.
- ***Increasing access to public health facilities by people with disability:*** Disability disclosure forms were distributed to health personnel in the seven districts for verification of their disability status where applicable, so as to facilitate their access to job opportunities in the Department. In addition, three health facilities in the Alfred Nzo District were assessed for accessibility by people with disabilities; Mntwana, Mpoza and Rhode Clinics. A policy document on increasing access to public health services and employment opportunities for people with disabilities was also completed incorporating input from all districts. District outreach sessions were held to explain the revised departmental Disability Management Policy, and to obtain additional input from middle managers involved in disability management and accessibility
- District outreach and planned information sessions on accessing health services by women and youth were completed.
- The Department through the OSG facilitated and implemented the Cuban and Tunisian agreements, SA-Canada development cooperation through a delegation to Canada, the Eastern Cape Department of Health and Walter Sisulu University (WSU) cooperation as well as the renewal of the SA-India Agreement.
- **Ten projects in the ECDOH receiving official development assistance include:**
 - Equipment and consumables in support of the TB programme,
 - Computers, a server and software for Health Information Systems (HIS),
 - Programme to support Vaccine Development for HIV & AIDS,
 - Provision of an economist to Strategic Planning (through Italian Co-operation),
 - Support to PHC by the European Union,
 - PHC Business Plan development by Anglo American,
 - Construction of a new clinic by Anglo-American,
 - Construction of additional consulting rooms in rural clinics around Canzibe by Transcape,
 - Donation of computers and medical records by Italian government to clinics in OR Tambo, and
 - Donation of a technical assistant for epidemiology by the University of Alberta in Canada.

Table 1.2: Performance Against Provincial Targets from 2010/11 - 2012/13 Annual Performance Plan for the Office of the SG

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
To facilitate the provision of strategic leadership and the creation of social compact to improve health outcomes.	% of the Cabinet Committee on Social Needs, the Budget Committee and the EXCO's resolutions implemented.	100%	100%	100% Implementation of the Cabinet committee resolutions and instructions.	100%	Target achieved
	% of National Health Council's resolutions and recommendations implemented.	100%	100%	100% Implementation of NHC resolutions and recommendations	100%	Target achieved
	% of PHC's resolutions and recommendations implemented.	100%	100%	100% Implementation of the PHC resolutions and recommendation	100%	Only 1 PHC meeting convened - due to challenges with availability of some external PHC members
	% of resolutions and recommendations by the EMC and EMT communicated and implemented accordingly	100%	100%	100% implementation of all the Resolutions by the EMC and EMT	60%	No formal EMT meeting held in Dec '10. No follow up evidence of implementation esp. from HRM and ICT.
	Number of outreach sessions to all districts, health facilities and health agencies led by the SG for Health.	7	7	10	12 outreach sessions	Target achieved

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	% of the resolutions taken by IGR structures in the province that were implemented.	100%	100%	100% of resolutions taken by IGR structures in the province were implemented.	100%	Target achieved
	% of the existing and new international agreements facilitated and implemented	Not measured	100%	100% implementation of all existing and new international agreements	100%	Target achieved
	Number of projects / programmes receiving official development assistance.	4	4	4 projects / programmes.	10	Target achieved
	Number of sessions held with women's groups and health facilities to mobilize women to access health services at the health centres.	Not measured	1 session held in 1 district.	1 session in each districts (total=7)	7 sessions, 1 in each district.	Target achieved
	Number of sessions held to profile and institutionalize the DPSA-Gender Framework.	Not measured	Not measured	1 session in each districts total=7	2 sessions, 1 in each of 2 districts.	SPU funds reduced in quarter 3

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	Number of sessions hosted to profile accessibility of family planning services to young people including the sensitization of health.	Not measured	1	1 session in each districts (7)	7 sessions, 1 in each district.	Target achieved
	An approved and institutionalized departmental disability policy.	Ongoing consultation sessions held with districts.	3 Consultative stakeholder sessions held in two districts for input consolidation	Approved Departmental disability policy	Draft Disability Policy not yet approved but has been institutionalized	Consultative sessions held with staff and stakeholders in 5 of 7 districts for final inputs. All districts agreed that an implementation strategy should be drafted for the final Disability Policy.
	Number of institutions assessed for accessibility by people with disabilities.	Not measured	2	2 institutions	3	Target achieved
To provide project management support to the SG for his priority projects.	% of key projects that have been project managed according to the Project Charter.	Not Measured	Scope of work and number of projects determined	100% of 3 projects:	100% (3 projects: RPHC, Pharmacy PPP and revenue generation)	Target achieved

1.3 CORPORATE STRATEGY AND ORGANISATIONAL PERFORMANCE CLUSTER

Purpose

1. To facilitate the development and execution of integrated strategic plans of the ECDOH.
2. To act as a coordinating centre for the DOH, in order to monitor, evaluate and report on the progress made by health programmes with respect to service delivery and the health status of the Eastern Cape population.
3. To assist in the control of communicable and non-communicable diseases by providing information for planning, decision making and policy formulation through disease surveillance and research activities.

Strategic Objective

To facilitate 100% achievement of an effective and compliant planning and monitoring system, including research and development.

Programme Description

The Corporate Strategy and Organizational Performance cluster is made up of three chief directorates:

- Strategy and Organisational Performance (SOP),
- Quality Health Care Assurance Systems (QHCAS), and
- Risk Assurance Management Systems (RAMS).

1.3.1 STRATEGY AND ORGANISATIONAL PERFORMANCE (SOP) CHIEF DIRECTORATE

The SOP chief directorate is composed of three directorates:

- Strategic Planning, Research and Policies Directorate,
- Monitoring, Reporting and Evaluation, and
- Epidemiological Research and Surveillance Management Directorate

Programme Priorities

- Development of the 3 year Annual Performance Plan (APP) – 2011/2011-2013/14.
- Strengthen communication of the Strategic Imperatives and the APP to all employees of the ECDOH.
- Facilitate capacity development and training on strategic planning, including facilitation of the strategic planning processes.
- Facilitate capacity development and training in monitoring and evaluation.

- Monitor, evaluate and report organizational performance to identify challenges and gaps for service delivery improvement.
- Strengthen and increase research capacity and use of research findings to inform planning.
- Improve collaboration with other relevant research institutions in order to further enhance epidemiological research.
- Provide information on health priority problems.

Service delivery achievements:

- The Research Unit appointed a provincial research committee and successfully co-ordinated the 2009 Antenatal HIV & Syphilis Survey.
- The Department complied in submitting the statutory compliance documents to relevant authorities in line with the PFMA. These included the 2011/12-2013/14 Annual Performance Plan, 2009/10 Annual Report, 2010/11 Oversight Report and four Performance Quarterly Reporting System (PQRS) reports. In addition, ad hoc reports requested through the office of the Superintendent General including the Programme of Action (POA), Millenium Development Goals (MDGs) and National General Council (NGC) reports were compiled and submitted.
- Five health districts were supported with the development of District Health Plans (DHPs) (OR Tambo, Alfred Nzo, Cacadu, NMMM and Amathole). Support to health programmes with regards to monitoring and evaluation activities is offered on a regular basis; a minimum of 36 contact sessions were held with various health programmes.
- In order to improve and enhance planning in the Department, a Provincial Planning Framework was developed to regulate the process of developing and implementing the Statutory Planning.
- The Integrated Strategic Planning Unit facilitated 19 health institutions in developing their own three year Strategic Plans. These plans were intended to assist the service delivery agencies of the Department, to map out the targets to be implemented in the 2010/11 financial year.

- 
- Two policies were developed: the Policy Development Framework, which is meant to assist other Units in the Department with developing and implementing their line function policies; and the Policy Framework to regulate governance structures in the Department.

Challenges limiting service delivery

- Budget constraints limit provision of planning and M&E support to the districts. There are limited forums in which performance information is discussed amongst programme

managers, senior & executive management and between programmes. Quarterly performance review sessions both at district and Head Office need to be conducted.

- Planning, monitoring, reporting and evaluation need to be institutionalized at all levels of the organization and physical support in this regard is required. Budget constraints and staff shortages impact negatively on achieving planned and expected deliverables from these directorates.

Table 1.3: SOP - Performance Against Provincial Targets from 2010/11 - 2012/13 Annual Performance Plan

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
To establish, strengthen and implement systems for effective planning, monitoring and evaluation processes including research and development.	Statutory planning documents developed and tabled at the Legislature.	2008/09-2010/11 APP, Service Delivery Improvement Plan (SDIP), Developed and Tabled	2009/10-2014/15 New Strategic Plan; 2009/10-2012/13; SDIP Developed.	2009/10-2014/15 New Strategic Plan; 2009/10-2012/13; SDIP Developed and Tabled.	The final 2011/12 - 2013/14 APP was submitted on 22 March 2011 at Legislature and Provincial Treasury	Target achieved
	Planning framework to regulate strategic planning processes developed and institutionalised.	New Strategy	Draft planning framework became available.	Approved planning framework and institutionalised.	Planning framework has not been finalized yet.	The planning framework had been presented to Head Office Managers for inputs and Extended Senior Management adopted it.
	Number of sessions hosted to communicate the strategic objectives, imperatives and service delivery improvement programme of the Department.	4 session were held in: OR Tambo Joe Gqabi Alfred Nzo and Chris Hani.	3 sessions were held for CAC, NMM, AMT officers and 1 for head office personnel.	2 session per District	1 session was held at head office.	The district sessions were postponed due to budget constraints.
	Number of health institutions and health agencies assisted with the development of their three year strategic plans.	17 District hospitals, 22 CHCs, and 8 Specialized hospitals have a draft strategic plan	Second drafts of the 3 year strategic plans were developed for 22 District Hospitals, 13 Specialized hospitals and 30 Community Health centers	1 Regional Hospital; 22 district hospitals 30 CHC'S	12 CHC, 1 Regional Hospitals and 5 district hospitals' strategic plan documents were consolidated and finalized.	The target was not achieved because there was no budget to host sessions to finalize these documents

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	Number of policies developed, analyzed and institutionalized.	67 policies and guidelines have been collated, bound into three booklets and distributed to all hospitals in all Districts.	3 policies were developed and were awaiting approval (Reporting Policy, Clinic Committee Policy and Remuneration of Governance Structure). 4 Policies were analyzed: Boarding and Lodging, Disability in the Work Place, Events Management and Marketing Policy.	2 Policies developed and institutionalized 3 policies analyzed.	2 draft policies were developed and are awaiting approval. 1 policy was analyzed.	3 Draft policies are awaiting approval; • Oral Health Policy, • Policy Development Framework, and • Institutionalisation of Government Structures. 1 policy was analysed • Visual and Corporate Identity Policy.
	Number of quarterly organizational performance review sessions hosted both at head office and in the districts.	1 session for head office 4 Sessions per district	1 session for head office 2 Sessions per district	4 sessions for head office. 4 Sessions per district	1 session for head office.	Performance reviews were not conducted as there was no budget to host the sessions at head office or in the districts.
	Number of statutory compliance reports compiled and submitted.	• 4 Treasury PQR reports 1 half yr oversight report 1 Annual Report	• 4 Treasury PQR reports 1 half yr oversight report 1 Annual Report	• 4 Treasury PQR reports 1 half yr oversight report 1 Annual Report	• 4 Treasury PQR reports 2010/11 1 half yr oversight report 2010/11 • 2009/10 Annual Report: • 4 ad hoc reports: POA, MDGs and ANC NGC resolutions reports	Target achieved

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	Number of sub-programmes /agencies and districts supported on monitoring and evaluation activities.	Not Measured	Not Measured	36	41	Target achieved. This was mainly M&E contact sessions with health programmes at Head Office; 5 Districts were supported during DHP development.
	% of disease outbreaks investigated within 24 hours of detection.	85%	83.00%	95%	95%	Target achieved
	Acute Flaccid Paralysis (AFP) case detection rate per 100,000 population <15yrs. (Number of cases in brackets)	1.7 (38 cases detected)	2 (44 cases detected)	2 (48 cases expected)	2.3 (51 cases detected)	Output within target range
	Number of HIV & Syphilis surveys conducted and reports produced.	1	1	1	1	Target achieved
	% of research proposals reviewed and approved.	100% (21/21)	89% (17/19)	100%	92% (46/50)	Four research proposals were not approved and were sent back to the authors to provide outstanding information.

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	Number of research seminars / conferences conducted.	0	1	1	0	There were no funds to perform this activity.
	Number of commissioned research proposals in terms of the Ten Point Plan for Health.	Not measured	Not measured	1	1 (The Child Mortality Survey was commissioned)	Target achieved

1.3.2 CHIEF DIRECTORATE: QUALITY HEALTH CARE ASSURANCE SYSTEMS

Purpose

The chief directorate coordinates and capacitates the institutions in the implementation of norms and standards in order to ensure the delivery of quality services for the citizens of the Eastern Cape.

Programme Priorities

- Strengthen implementation of core standards.
- Strengthen complaint identification and resolution systems.
- Improve service delivery units by ensuring implementation of Batho Pele initiatives.
- Improve reporting on clinical adverse events, submission of reports with recommendation and identification of problem areas for improvement.
- Development of QIPs to close the gaps on service standards.

Service delivery achievements:

- 49 facilities were supported and monitored on their implementation of core standards.
- 49 facilities monitored on six priorities of National DOH.
- 49 facilities supported in the development of QIPs to close the gaps in service standards.
- 81.8% of complaints were resolved within 30 days.
- 11 facilities were supported and monitored on compliance with Complaints Policy.
- 7 facilities were supported and monitored in implementation of peer reviews.

Table 1.4: Performance Against Provincial Targets from 2010/11 - 2012/13 Annual Performance Plan

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
To facilitate 60% of facilities in the implementation of quality & patient safety programs; including adverse events and national core norms & standards.	Number of facilities supported and monitored on the implementation of core standards.	7 Districts	7 Districts	49	49	Target achieved
	Number of facilities monitored on National Six priorities.	Not measured	Not measured	49	49	Target achieved
	Number of facilities supported in the development of QIPs to close the gaps in service standards.	Not measured	Not measured	49	49	Target achieved
	Number of health facilities supported and monitored on compliance with complaints policies.	29 hospitals	10 district hospitals, 9 clinics, 6 CHCs, 2 hospital complexes, and 1 regional hospital were monitored.	49 facilities	11	Support was done telephonically since there was no budget to visit facilities.
	Percentage of complaints, in all facilities, resolved within 30 days.	62.5% (1409/2255)	85% (3491/4124)	60%	81.8% (3642/4453)	Target achieved
	Number of health facilities supported and monitored on implementation of customer care polices/strategies.	Draft policy in place	The policy was approved and institutionalized.	49 facilities	11	Support visits could not be done due to budget constraints.

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	Number of health facilities supported and monitored in the implementation of peer reviews.	Draft policy in place	The policy was approved and institutionalized.	49 facilities	7	Visits could not be done due to unavailability of funds.
	Number of health facilities monitored on conducting PSS and produced reports.	Not measured	Not measured	49 facilities	33	Visits could not be done due to unavailability of funds.
	Number of facilities supported and monitored in the implementation of National Flagship Programs.	Not measured	7 Districts	49 facilities	47	Output is within target range.
	Number of Province wide PSS conducted.	Not measured	0	1	0	Survey not done due to unavailability of budget.
	Number of provincial clinical audits conducted on priority conditions.	0	1	1	1	Target achieved
	Number of health facilities audited on the clinical audit process.	0	40	45	47	Output within the target range.

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	Adverse events management policy in place.	Concept documents developed.	Policy Guidelines not yet approved.	Policy rolled out in all 7 districts.	Policy rolled out in 7 districts.	Target achieved
	Number of public hospitals reporting on adverse events.	0	10	32 hospitals	65	All hospitals report adverse events
	Number of facilities monitored on the implementation of QIPs for infection prevention and cleanliness.	33	56	26 hospitals monitored on the implementation.	6	Officer resigned
	Number of clinics surveyed on the implementation of IPC guidelines.	33	56	26	2	Officer resigned
	Develop IPC standard operation procedures for EMS and Forensic Pathology Services.	Not measured	Not measured	SOPs developed for EMS and FPS	SOPs not developed	Officer resigned

I.4 OFFICE OF THE CHIEF FINANCIAL OFFICER: FINANCE CLUSTER

Purpose

Directing, managing and providing policy guidance and oversight of Departmental financial management personnel, activities and operations of Financial Accounting, Management Accounting, Supply Chain Management and Internal Financial Control including the phased change from cash based accounting to accrual accounting.

Strategic Objectives

- To achieve 100% implementation and institutionalization of financial management strategies, systems and platforms to support service delivery of the organization.
- To provide 100% effective financial management in order to achieve full accountability and a clean audit.
- To facilitate 100% implementation of supply chain policies and procedures in order to promote transparency, effectiveness, efficiency and economy of the Department's supply chain management.

Programme Priorities

- To ensure that the Department obtains unqualified audit reports from the Auditor-General by 2010/11, through implementation of the Financial Management Turnaround Plan.
- Restructure financial management in line with the revitalization of PHC.
- To improve revenue collection in order to finance health programmes.
- To implement cost centre accounting in pilot sites of the department.
- Approval of the Financial Management Capability Model Strategy.

Service delivery achievements:

Financial Management Turn Around Plan

The plan has been developed in the current financial year. The main focuses are; improving

financial management, re-engineering budget processes to be transparent, ensuring effective and efficient allocation of financial resources, managing and controlling expenditure against budget, ensuring that spending is within budget, and monitoring that Conditional Grants spending is in line with DORA requirements. It is a living document and will be reviewed and revised whenever there are new developments.

The intervention takes cognisance of the need to build capacity within the provincial DOH to maintain and improve the internal control systems over time. It is an attempt to respond to the issues raised by the Auditor-General and Internal Audit Unit. and the plan incorporates information from other sources, such as the National Treasury's Financial Management Capability Maturity Model and Key Activity Controls as advocated by the Auditor-General, and focuses on financial management and integrated budget planning.

The Supply Chain Management Turnaround Plan has been developed by the Multi-Agency Working Group (MAWG). The MAWG is mandated to review the entire state procurement system and to provide a set of priorities and proposals with appropriate action plans to deliver rapid improvement in the system.

Revenue collection

As per the annual financial statements, the Departmental revenue collected amounted to R85.97 million, which exceeded the appropriated amount by approximately R11.0 million.

The Department is currently dealing with the initiation of revenue generation and retention initiatives, intended to leverage additional income through its facilities.

Pilot on Cost Centre Accounting

The cost centre accounting project was piloted at the East London Hospital Complex and further rolled out to the other complexes and regional hospitals including the Mthatha and Port Elizabeth Hospital Complexes, St. Elizabeth and Frontier Hospitals as well as Head Office.



This data is currently being transferred to a central server as to allow access to users, all of whom will be supported and trained on how to use the new system during the 2011/2012 financial year.

Financial Management Capability Model Strategy

The Department has adopted the Financial Management Capability Model, which is a framework for strengthening financial management through many small evolutionary steps.

The model illustrates the stages through which the Department can evolve as it defines,

implements, measures, controls, and improves its financial management processes. These steps have been organized into five progressive "capability levels". Each level represents a well-defined stage toward developing a mature financial management regime.

Key challenges & recommendations to address

The availability of infrastructure such as network connectivity and computers will be key to achieving the desired outcomes of the turnaround plan, as will the availability of financial resources to fund additional personnel within the finance organogram.

Table 1.5: CFO - Performance Against Provincial Targets from 2010/11 - 2012/13 Annual Performance Plan

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
To facilitate 90% appropriate financial resource analysis, allocation and control management to support the service delivery imperatives of the Department.	Amount of revenue collected	90,102m	79,816m	74,013m	85,973m	The over collection is due to timing differences between when money is expected and when it is actually received.
	Number of sites implementing cost centre accounting	1	3	2	2	(Head Office and St.Elizabeth) Hospital. Implementation completed only training of officials is outstanding.
To achieve 100% implementation and institutionalization of financial management strategies, systems and platforms to support the service delivery of the organization.	Develop, approve and Institutionalize the Financial Management Capability Model Strategy.	New strategy	New strategy	Approval and institutionalization of Financial Management Capability Model	Development of Financial Management Policies and Service Standards were completed and are awaiting Accounting Officer Approval	Target partially approved
	% of Quality AFS Prepared and Submitted on the required schedule.	100% of Quality AFS was prepared and submitted on the required schedule.	100% of Quality AFS was prepared and submitted on the required schedule.	100% of Quality AFS prepared and submitted on the required schedule.	80% complete on AFS and the audit for the year's end.	Submitted AFS, as required per PFMA, on 31 January 2011 to the Provincial Treasury.

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
To facilitate a 100% of supply chain management policy and procedures implementation in order to promote transparency, effectiveness, efficiency and economy of the department's supply chain management.	Number of procurement plans implemented as planned.	7 programme procurement plans implemented.	7 programme procurement plans implemented.	7 programme procurement plans implemented.	7 programme procurement plans implemented.	Target achieved
	% of tenders awarded to BBBEEE entities.	Not measured	50%	40%	70% (139 Contracts awarded to BBBEEE out of a total of 198 contracts awarded).	The increase is due to the increased number of contracts awarded to women owned entities.
	Number of districts and health facilities implementing contract performance reviews and monitoring.	Head Office Contract Register established.	3 Districts	7 Districts 3 hospitals complexes 2 regional hospitals	7 Districts 3 hospitals	Target achieved
	Approved Automated Asset Management Register.	Not measured	Not measured	Automated Asset Management Register developed, approved and institutionalised.	Automated Asset Management Register not developed. Asset register is maintained on excel spreadsheet.	Due to budget and Treasury moratorium a decision was made that only LOGIS will be used for asset management. LOGIS is currently being implemented but the process is very slow due to capacity limitations. However asset registers are maintained on excel spreadsheet.

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	% of health facilities, health agencies and health administrative units compliant with inventory / stock management guide and policies.	70%	80%	90%	92%	The remaining 8% are institutions who have not submitted their stock reports, therefore it is difficult to verify compliance.

1.5 INTEGRATED HUMAN RESOURCE MANAGEMENT CLUSTER

Purpose

The sub-cluster, IHRM supports human resource planning, management systems development and capacity building throughout the Eastern Cape provincial Department of Health for effective and efficient health service delivery.

Strategic Objectives

To ensure 100% effective human resource planning, development and management.

Programme Priorities

- To review and re-organize the human resource functions and processes in the department to maximize service impact.
- Correct all employee records, both manual and electronic, and maintain accuracy consistently in line with National Minimum Information Requirements.
- Optimize the utilization of human resources to help improve planning, budgeting and management of compensation for employees.
- Improve recruitment and retention of human resources.
- Step-up effective internal controls to manage human resources related risks and achieve compliance.
- Embark on an extensive organizational development and change management program as part of the transformation.
- Re-engineer systems to efficiently manage paper-based documents.
- To manage the behavior and safety risks of employees by providing employee wellness services.
- To promote positive employment relations through fair employment practices.

Service delivery achievements:

Staff recruitment and retention:

The department has embarked on a massive recruitment drive whereby a total of 5,601 new employees were recruited; some of these were transfers from Provincially-Aided Hospitals

(PAHs) and Municipal clinics through the provincialisation process. The DOH strategy focuses mainly on recruiting health professionals to drive the core business therefore 1,956 health professionals were recruited at a cost of R127 million.

Alignment of organizational structures

As part of the Human Resource Plan, a recruitment plan was prepared as an implementation tool for the filling of critical posts in the department. Whilst assisting the various institutions to fill posts, a plan for the year was prepared in line with priorities of institutions and available resources. As part of the strategy to attract and retain health professionals, OSD was introduced for the Medical Cluster (which includes Doctors, Pharmacists and Emergency Medical Service staff) and the Allied Health Professionals. To implement the OSD, all organisational structures (Health facilities and Head Office) which reflect the above categories had to be aligned and approved in terms of the DPSA implementation guidelines and the terms of the OSD. The DOH has started a process to review and realign organisational structures. During the year under review, 15,472 employees in the medical cluster and allied health categories received OSD amounting to R270,824,927.

Project HR Connect

The National Department of Public Service and Administration embarked on a project to standardise the post-job title structure in the public service. The aim of this project was to enable government to conduct a skills audit involving all employees in government; the ECDOH participated in the project in May 2010. HR Connect survey forms were distributed to all employees to gather information on each employees' qualifications and experience. The surveys have been returned to the Department of Public Service and Administration for capturing and analyses. The ECDOH archived copies of these surveys in employee HR files. District managers have been instructed to commence updating employee information on the PERSAL system. It is envisaged that this project will be completed by 30 November 2011.

Establishment of district employment equity committees

Section 16 of the Employment Equity Act (55 of 1998) stipulates that Employment Equity Committees should be established in all districts to ensure proper consultation and to drive implementation and monitoring of the Employment Equity Plans in districts and complexes. Employment Equity Committees were established for the 3 complexes, 2 regional hospitals and 7 district offices.

Employment Relations

A joint task team consisting of representatives from the DOH and unions worked together to resolve grievances relating to OSD and HROPT. This has improved employment relations.

The department successfully completed 34 SASSA and RDP housing fraud cases in line with the relevant DPSA directive during the year under review. These are cases that were investigated by the Special Investigation Unit (SIU) at national level and brought to the province through the Office of the Premier.

Ninety percent of dispute cases have been won by the Department as there was outsourced assistance arranged by the SG and Legal Unit.

Key challenges limiting service delivery

- Budget constraints towards payments of human resource backlogs, allowances and benefits including recruitment of general personnel other than health professionals.
- ICT and Office Infrastructure – this has a direct bearing on recruitment and retention of staff.
- Late payments of newly appointed staff where relevant documentation for the appointment was not forthcoming; including but not limited to supporting documents from the officials that were appointed. This scenario happens especially when human resource management has not been involved from the inception of the recruitment process.
- Top management offices are flooded with HR challenges due to unavailability of finances and lack of proper communication between officials and complainants.

Table (IHRM) 1.6: Performance Against Provincial Targets from 2010/11 - 2012/13 Annual Performance Plan

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
To ensure effective management of HR Planning and Organisational Development.	Approved HR Plan of the Organisation.	Approval of HR Plan by MEC	Implementation of HR Plan	Review and revise the HR plan in line with the new health priorities and outcomes.	The HR Plan has not been finalized	The HR Plan has not been finalized due to the parallel process of restructuring and realignment of the departmental structure based on a new model. This will be finalized in the next financial year.
	% of Employees with information updated on PERSAL (NMIR).	50%	60%	70% of 41 000 Employees information updated on PERSAL	79% of employee information has been updated	Most information came through the HR connect project which forced institutions to speed up the updating exercise.
	Number of health professionals recruited.	1429	511	600	1 956	Many of these professionals were recruited late in the year. The majority were in the lower levels such that a larger number could be appointed.
	Number of Employment Wellness Promotion sessions or programmes offered to employees.	14	40	60	109	The capacity to render services has increased with the appointment of new staff

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	Number of employee cases managed including IOD cases.	287 EAP case 819 IOD Case	213EAP case 931 IOD Cases	350 EAP case 950 IOD Cases	1687 EAP cases 2235 IOD Cases	The capacity to render services has increased with the appointment of new staff.
	Number of disciplinary investigation cases finalized within 30 days.	180	180	200	356 (which is 61% of total cases)	Cases reflected as finalised range from written warning to dismissal.
	Number of grievances finalized.	7	30	30	99	These were mainly HROPT and OSD grievances which were dealt with in clusters.
	Number of disputes finalised.	175	200	200	107	Cases are attended to by the Bargaining Council and during the Public Service Strike all cases were frozen.
	Number of sessions hosted to profile and institutionalise the Occupational Safety and Health Policy.	New Strategy	20	11	0	These were not hosted because of the limited budget.
	Number of PHC Facilities audited for OHS.	New Strategy	5	85	20	Unable to meet target because of budget limitations.

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	Number of District Hospitals with complete occupational acquired TB assessments.	New Strategy	New Strategy	10	3	Unable to meet target because of budget limitations.
	Number of institutions implementing Medical Surveillance Protocols in adherence with OSH.	New Strategy	New Strategy	10	0	The protocol has not been finalized due to budget constraints so it was not possible to implement.

1.6 CORPORATE SERVICE MANAGEMENT CLUSTER

Purpose

To plan, direct and monitor all corporate service operations at Head Office, including Corporate Service Centres.

Strategic Objectives

- To facilitate 80% development and implementation of corporate systems and ICT platforms.
- To facilitate 100% implementation of a communication plan in order to communicate, engage and manage internal and external stakeholders effectively.

Programme Priorities

- To communicate the strategic imperatives of the Department to internal and external stakeholders using communication channels.
- Resolve of complaints, queries and claims by the Department in order to project a positive image of the Department.
- Develop, approve and implement Corporate Services policies in order to streamline the support given to the other directorates of the Eastern Cape Department of Health.
- Improve cooperation with the state attorney in finalization of legal cases.

Service delivery achievements:

Communications

Both internal and external stakeholders are informed about ECDOH activities through the DOH website, intranet, publications and health (HLT) communications page. The policies of the department, the profile of the EC public health facilities including clinics and hospitals, and the tender documents are posted and can be found on the website as well as on the intranet. Communications makes use of radio, television and print media as well. The Communications Unit is responsible for the branding of venues. Furthermore, it designs and provides artwork

for the statutory compliance documents such as the annual & half year oversight reports, Policy Speeches, Notices, Annual Performance Plans, and Service Delivery Improvement Plan.

Shared Contact Centre

Shared Contact Centre Services methodology for implementation is a major strategic achievement that ensured customer centricity in the entire ECDOH through consolidating management of handling customer queries and complaints into a “one-stop shop”. The following service queries are integrated to ensure efficiency in costs, skills and scope management through the Shared Services Model:

- All clinical health related queries from various facilities and health promotion related issues as required by clients on line.
- EMS frontline calls for ambulance requests – 70% of them are handled by Shared Contact with 100% resolution.
- Salaries and integrated human resource queries are integrated in the Centre with their transversal systems.
- Payment management of supplier and tender queries are fully integrated with Contact Centre Customer Relationship Management (CRM).
- The Centre is responsible for handling and managing all health facilities' first line support on IT queries and requests of which 100% are resolved monthly.

The above frontline operations processes flow within the Department's Shared Contact Centre. They are traced and tracked through a functional systematic data management processes tool, CRM and Contact Centre Management (CCM), customized to meet the reporting needs of ECDOH. This links up to all health facilities and units in the province through the government network. This has allowed the unit to meet the requirements of reporting with credible evidence for the above achievement.

The large scale of architecture at the Contact Centre CRM opens for any integration to accommodate other future needs of the department.

Most of the queries that came through the contact centre were category one in terms of the Contact Centre resolution architecture. All of these were resolved within 72 hours of receiving the query which is a major achievement. This was possible because of track and trace systems installed in the shared contact centre. The Quality Assessment Unit within the Centre, responsible for call monitoring and staff adherence to service levels, makes it possible to reach a target of 100% of cases resolved.

The shared contact centre system (Inbound and Outbound operating systems, Mitel telephone system used by centre, Ms CRM system with its knowledge base servers) are tools used to harvest knowledge from both internal and external customers, through Information and Knowledge Management (IKM) practices. The Centre has thus far managed to achieve the following:

- The DOH is the leading department in the EC province in mainstreaming and institutionalizing IKM to the coalface of health service delivery. In collaboration with the Office of the Premier which funded the workshops, each of the seven health districts in the province produced comprehensive reports for effective planning of improved service delivery turnaround plans
- The Centre has successfully implemented Shared Services methodology within the Department through provision of shared departmental venues for meetings and conferences in order to reduce costs and minimize the booking of accommodation elsewhere.

Security

Security Services Directorate planned to have long-term security contracts (24-36 months) in all health districts in order to ensure security stability and compliance with Control of Access to Public Premises & Vehicles Act 53 of 1985, Minimum Physical Security Standards and Private Security Industry Regulatory Authority (PSIRA).

The actual plan for 2010/11 was to ensure compliance (safety of personnel, information, assets, patients and visitors) in 40% (347) of facilities. As part of intensifying security measures/controls in the department, the Security Services Directorate has successfully managed to facilitate provision of Physical Security Services in 746 health facilities i.e. (hospitals, CHCs, clinics, forensic pathology, depots, Lilitha Nursing College and EMS centres).

A 2-year contract for the provision of security services was awarded at Cacadu Health District. As part of cost-cutting measures the Security Services Directorate also planned to integrate physical guarding with electronic security systems that would immensely reduce the budget. The directorate has coordinated installation of the electronic security systems for proper access control measures (i.e. Biometric System in the Office of the Member Executive Council as well as the Integrated Security System at Dukumbana building). They have also facilitated the awarding of the Surveillance Systems (CCTV) tender for maximizing security measures in Fort England, as it is one of the specialized Psychiatric hospitals.

The directorate managed to screen 21 Service Providers. Additionally, 112 short listed candidates, 64 members of the Senior Management and 88 other officials have submitted Z204 forms, all have been forwarded to the State Security Agency for vetting and SSD is awaiting security clearances. Twenty three Information Security Learning sessions have been conducted in seven health districts including head office to create Information Security Awareness.

Key challenges limiting service delivery

- The excessive litigation workload with limited personnel and resources.
- Budgetary constraints in respect of the whole Department, thus leading to non-payment of obligations resulting in excessive litigation and non-compliance with court orders.

Table (CSM) 1.7: Performance Against Provincial Targets from 2010/11- 2012/13 Annual Performance Plan for Corporate Service Management

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
To facilitate 80% development and implementation of corporate systems and platforms to support the service delivery imperatives of the Department.	Number of communication tools developed and	6 Health Link Newsletter	4 Health Link	12 Health Link Newsletter in 4 Languages	5	
	Number of communications tools developed and implemented to communicate the strategic imperatives of the Department externally.	Bi-monthly publications were introduced. One Advertorial placed in journals and magazines.	Publications were produced 4 times.	6 Impilo Publications in 4 languages. 6 Advertorials placed in journals and magazines.	42 Bi-Monthly publications. 15 advertorials	Target achieved
	Number of health facilities & institutions with appropriate and correct road signage installed.	Not Measured	Not Measured	50	31	.
	Number of external billboards profiling health service outcomes of the department.	Not Measured	2	4	2	
	% of Complaints resolved by Contact Centre within 72hrs.	67%	71%	90%	91%	Target achieved

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	Number of Call Centre reports presented to the DMT, Head Office Clusters, and EMC.	Not Measured	12	12	10 reports presented	Output within range
	Approved and implemented events management policy and strategy of the department.	Draft Manual Available	Draft events management policy and manual are available	Approval of the policy and Institutionalization and Rollout of the Policy and Strategy.	Policy not yet approved	Rollout of the policy therefore not done
	Number of strategic events facilitated and hosted.	96 Strategic Events successfully hosted	101 Strategic events successfully hosted	40 Strategic events to be hosted.	26	Target not achieved due to unavailability of budget
	Corporate Legal Services Policy developed	Not in place	Not in place	Legal service policy developed and approved	First draft of legal service policy has been developed and submitted for approval.	Policy is awaiting approval
	Number of new claims received	269	236	240 new claims	320 new claims opened	No control over incoming claims against Department hence the actual output was higher than planned.
	% of claims finalized - total	Not measured	1.1% (9/783)	5%	5% (53/1054)	Court orders and other matters are paid once the case is finalized in terms of the court order.

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	% of invoices paid out of the total received	Not Measured	123 invoices received, 123 invoice paid out 100%	80%	48% (46/95)	Budgetary constraints
	Percentage of health facilities, agencies, and administrative buildings complying with minimum information/ physical security standards.	Not Measured	Not Measured	40% (347)	40%	40% - 347 Health Institutions i.e. 15 District hospitals, 20 CHCs, 3 TB hospitals, 309 Clinics
	Number of SMS and other officials vetted	Not Measured	6 employees have been successfully vetted	8	8	Still waiting for security clearances (results) from state security agency.
	Number of shortlisted service providers screened	Not Measured	8 service providers have been successfully screened.	20	20	Target achieved

1.7 INFORMATION MANAGEMENT CLUSTER

PURPOSE:

To plan, direct and monitor all information, communication and technology (ICT) services for the department and other related projects.

To develop the departmental IT Services and Information Systems unit strategies and provide departmental ICT support to the functional areas.

Strategic Objectives

- To facilitate 80% development and implementation of corporate systems and ICT platforms.

Programme Priorities

- Implement Virtual Private Network (VPN - connectivity).
- Assist in the implementation of LOGIS.
- Implement the leasing contract to procure computers.
- To have a functional Health Information System, prioritizing Master Patient Index capability.
- Implementation of the Anti-Retroviral Treatment (ART) Registration system.
- Implementation of the Electronic Register System (ERS).
- Access to DHIS reporting tool through web-based solution.
- Access to information through business intelligence solution.
- Improvement of Data Quality through measuring of Data Quality Indices (DQI).

Key Programme Achievements

Web-based Reporting Tools

Information Management System has successfully implemented DHIS-WEB service which provides effective reporting based on DHIS data. This web-based application is designed to allow users to access and view the DHIS data that gets collected by all reporting organizational units.

Orientation of some senior managers and training of middle managers and information managers from head office and district offices have been done. This tool has now been adopted nationally as a best practice to be implemented by all provinces and Eastern Cape Province has been highly commended for this innovation. The tool has also been published via the Communications Unit for ease of access by all users. It is based on intranet and internet technologies. Currently the department is on a testing phase of DHIS web version two (2) to improve functionality. There are predefined indicators including those of PMTCT, HOD, Child Health, and performance quarterly reporting system (PQRS).

Improving DHIS data quality

The Eastern Cape has started to implement and report on the data quality index (DQI) which measures the data timelines, completeness, validity and submission rate by the health facilities. The DQI is based on the South African Statistical Quality Assurance Framework (SASQAF) developed by the Statssa (2009). It is meant to address four of the eight quality dimensions in the SASQAF and will be expanded as the target on the four that is currently being implemented is achieved. The department has prioritized those indicators that it feels are critical to produce credible data to address immediate needs for example, report writing. The DQI has been adopted as part of the district health management information systems policy (DHMIS) to be implemented nationwide soon. In the EC, currently there are two districts that are implementing and reporting on this indicator, NMMM and Alfred Nzo. The National and Eastern Cape Department of Health are jointly working on a plan to fulfill the national reporting objective, which was adopted as a national requirement.

Quality Health Care Assurance Core Standards Module

The information management directorate has been pivotal in the successful implementation of the DHIS core standards module, information software designed to assist with reporting on the implementation of the quality health care assurance national core standards in health facilities. This tool measures quality

rather than quantity in the service delivery platform and complements the quantitative DHIS modules. A combined analysis of both the qualitative and the quantitative modules will to some extent provide a reasonable picture of the status of health care in the province. The tool is fully functional and as of the end of the financial year under review, there were 155 facilities that had conducted baseline self-assessment for future comparison. These baselines have been captured on this system.

Electronic Patient Register

The electronic patient register (EPR) solution was built as a template to replace the manual register process at institutions. The development phase of this project is now completed. The next phase is the connectivity project, whereby leased computers and the Virtual Private Network (VPN) will be distributed to targeted institutions; it is expected to commence during the second quarter of the new financial year. The VPN will act as a platform for the EPR and will establish an independent connectivity model, bring efficiency, and cost savings to the operations.

The leasing project

The department successfully implemented the leasing project, which forms part of the departmental computer acquisition strategy. The leasing model being implemented aims to

alleviate the departmental budget pressure and leverages on getting more computers distributed throughout the province on a lease basis which includes their maintenance. A three year service level agreement (SLA) and a Master Rental Agreement was signed with the supplier and the distribution of computers will commence early in the new financial year (2011/12).

Business Intelligence

It is envisaged that there is a need to make provision for the Business Intelligence capability to reflect on the departmental score card. This project aims to develop a template and create a prototype for the core and support functions scorecards. Phase one (Clinical Scorecard Template) is finished and will be deployed after the Microsoft licensing is completed during the first quarter of 2011/2012. Other scorecards could not be finished due to budgetary limitation.

Key challenges limiting service delivery

- The lack of funding impacts the entire program as no development and/or upgrades can be performed and vacancies cannot be filled.
- Frequent power failures interrupt the DHIS web system.
- Noncompliance of other districts in implementing the DQI.

Table (HIM) 1.8: Performance Against Provincial Targets from 2010/11 - 2012/13 Annual Performance Plan

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
To facilitate 80% development and implementation of ICT systems and platforms to support the service delivery imperatives of the Department.	Number of facilities where electronic patient registers (EPR) were piloted.	Reconciliation of the projects, infrastructure, and position of the activities.	EPR user requirement (URS) and business process analysis done.	Electronic patient register developed and piloted in 5 health facilities.	0	Electronic registers developed but not piloted due to non-availability of network infrastructure.
	Patient Management System (PMS) developed and implemented in 130 facilities.	Not measured	Not measured	Procure PMS software, identify user requirements URS and develop the system.	Procurement process for a PAAB, a government owned system, is underway.	Currently awaiting proposals for implementation on the defined scope for rollout. The proposals should have been received to commence the vendor contracting process; the delay has been in defining the scope and specification of the PAAB.
	Web-based DHIS reporting tool developed and accessible.	Not measured	Development of the DHIS web-based reporting tool was done.	DHIS web-based reporting tool accessible to all managers especially those at Head Office	DHIS web-based reporting tool is accessible to all users and is used for generating reports	Target achieved
	Business Intelligence (BI) solution procured and deployed by March 2013	Not measured	BI Procurement , URS and business process analysis done	Development of BI according to URS.	BI Solution was not procured	Development of the functional specification and definition of automated KPI's for the BI has been completed at developer's license.

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	Number of districts with Data Quality Index of 95%	Not measured	Baseline on Data Quality Indices (DQI) of all 7 Districts done.	Implementation of Data Quality Indices (DQI) by all 7 Districts.	1	DQI implemented at NMMM. Other district could not implement due to budget constraints
	Number of institutions upgraded with reliable connectivity and access to voice and data communication systems.	A total of 7 new institutions were cabled.	A total of 4 institutions had been provided with new connectivity.	26 institutions to be cabled.	16 sites were cabled.	The other 10 were not cabled, due to budget constraints.
		A total number of 9 institutions had been upgraded with reliable connectivity.	A total number of 8 institutions had been upgraded with reliable connectivity.	28 institutions to be upgraded with reliable connectivity.	18 sites were upgraded.	The other 10 were not upgraded, due to budget constraints.
		New strategy	Twenty-eight (28) institutions to utilize cost-effective, modern & reliable telephone systems.	19 Institutions to utilize cost effective modern and reliable telephone systems.	2 institutions.	Due to the financial constraints funding was not available to upgrade any telephone system.
	Number of Institutions utilizing active directory and participating in the enterprise licensing model	New strategy	Institutions connected to the government network enrolled in the enterprise licensing model, and utilized the active directory.	61 institutions	All ECDOH institutions are now participating in the licensing agreement. None are participating in the active directory.	None are participating in the active directory; due to budget constraints this could not be implemented.

PROGRAMME 2



DISTRICT HEALTH SERVICES

PROGRAMME 2: DISTRICT HEALTH SERVICES

Purpose

To strengthen the district health system and build capacity throughout the districts for effective and efficient delivery of quality Primary Health Care (PHC) and Level I hospital services to the citizens of Eastern Cape Province (ECP).

Strategic Objectives

- To develop district health systems by strengthening the district health service platform based on a regionalised service delivery model and PHC approach.
- To strengthen and build capacity for the effective implementation of the priorities of the health programmes in order to improve health outcomes.

Programme Description

This programme provides integrated PHC in an equitable, accessible and affordable manner for the citizens of the Eastern Cape and is composed of the following sub-programmes:

- District Management;
- Community Clinics
- Community Health Centres (CHC);
- Community Based Services (CBS);
- Other Community Services;
- Maternal Child and Women's Health services (MCWH);
- Integrated Nutrition Programme (INP)
- Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) and Tuberculosis (TB) programmes and
- District hospitals services.

Programme Objectives

- To strengthen the district health service
- To strengthen governance structures for effective participation by civil society
- To strengthen functionality of PHC facilities through monitoring and supervision
- To implement and monitor the Integrated Sustainable Rural Development Plan (ISRDP) and Urban Renewal Program (URP) in line with

the National Monitoring and Evaluation (NM&E) Framework

- To strengthen and build capacity for the effective implementation of priority health programmes HIV/AIDS and TB, MCWH and INP in order to improve health outcomes, including health promotion and healthy lifestyles

Program Priorities

- To facilitate the provision of Strategic Leadership and the creation of a Social Compact for better Health by strengthening governance structures for increased participation in health issues.
- To increase access to the comprehensive PHC Service Package.
- To implement quality improvement plans in 35 district hospitals including the National Minimum Core Standards applicable to all health facilities.
- To combat and reduce the impact of TB and HIV/AIDS with a special focus on preventing the emergence of drug resistant strains.
- To improve and strengthen the mother and child health services within the ECP.
- To improve the management of Substance Abuse and early detection and management of people with chronic conditions at community-based level through social mobilisation of communities and further promoting healthy lifestyles.
- To facilitate effective management and adherence of ports of entry in the Province in order to ensure compliance with International Health Regulations (IHR).
- To ensure compliance of District Hospitals to the Mental Health Care Act No 17 of 2002.

2.1 District Management

The seven districts have completed District Health Expenditure Reviews (DHERs) that informed the development of District Health Plans (DHP) for each district. The latter has been aligned to the Annual Performance Plan of the department to facilitate integrated planning at provincial and district levels. Participation of districts and sub-districts in the municipal Integrated Development Plans as well as other inter-governmental structures has improved cooperation between the provincial and local spheres of government.

The department has embarked on a project to strengthen PHC services and has prioritised three sub-districts in the province for implementation over the next three to five years, i.e. Uitenhage (Nelson Mandela Metro), Intsika Yethu (Chris Hani) and King Sabata Dalindyebo (OR Tambo). It is intended, through this project, to strengthen all areas of PHC services, including upgrading certain CHCs to community health hospitals, whilst ensuring that clinics are equipped to provide the full package of services in order to increase communities' access to PHC services. This is coupled with the implementation of a social compact, which is aimed at strengthening communities' participation in health services.

The first phase of provincialisation with 19 of the 26 municipalities that provided PHC services on behalf of the department has been completed, with the remaining seven targeted for completion in the new financial year. This was done in line with the function shift between provincial and local government as stipulated by the National Health Act, 2003 in order to address the fragmentation within the management of PHC services, however the two metros, Nelson Mandela Metro and Buffalo City will apply for the possible assignment of PHC services in the new financial year 2011/12.

2.2 Community Clinics

Clinic committees in four of the seven districts were re-constituted in line with the revised policy. The training of these committees regarding the policy as well as their roles and functions is still in progress. The addition of seven clinics to the existing 60 that have been identified as centres of excellence has enabled the department to further strengthen PHC services. Approximately 715 out of 752 clinics are rendering 60% of the PHC package.

2.3 Community Health Centres

Despite the province being faced with challenges in terms of human resources and infrastructure, the number of CHCs rendering 24-hour services has increased from 27 in the previous financial year to 31 in an attempt to improve access to PHC services to all the citizens of the Eastern Cape Province. In

addition, the number of CHCs providing MOU and Trauma has been increased from 27 to 30 MOU'S and 29 Trauma units. Thirty out of 40 CHCs are rendering 60% of the PHC package.

PHC facility-based services

Primary health care services are provided at 884 facilities and these include mobile & satellite clinics, fixed clinics and community health centres (CHCs).

A total PHC headcount of 17,662,518 was recorded in 2010/11 translating to a provincial average of 2.7 visits per person per year. This is a five percent decrease from the 18.6 million total headcount reported in 2009/10 financial year. Significant decrease in headcount was observed during the month of August due to the civil servants' strike.

The PHC supervision rate is consistent with that reported in 2009/10 at 80.9% in the year under review; availability of transport and poor road infrastructure still pose a challenge to achieving the 100% target. The percentage of fixed PHC facilities supported by a doctor at least once a week is at 33.8%, whilst percentage of CHCs with a resident doctor is 59.9%. The EC Province is experiencing a shortage of doctors with a high vacancy rate for this professional category. Whilst this may be a national challenge, the rural nature of the province in particular contributes to greater challenges in recruitment and retention. The shortage of doctors at the PHC level drives PHC clients to seek services at higher health care levels, rendering the referral policy ineffective. The provincial strategy to revitalize PHC has been adopted to address this challenge and will work towards allocating more doctors at the PHC level.

Due to recent implementation of the new NIDS dataset from October 2010, some indicators that were not collected previously have not stabilized as yet and are still very low. This includes professional nurse workload and the count of PHC facilities with doctors. Education of health care providers about the importance of accurate recording of statistics will improve this indicator.

Challenges limiting service delivery

- Shortage of human resources, especially doctors at PHC level, results in patient influx in hospitals. Closure of municipal clinics at I6H00 also contributes to the influx into hospitals. The Department has identified filling of clinical posts for doctors and nurses as a priority in the core business.
- Poor performance and non-achievement of some of the indicators (ie. doctor workload) is likely to be due to poor recording and

incompleteness of data. The department will be embarking on routine data auditing. In addition, educating health care providers about the importance of evidence-based decision making and use of information is critical including an understanding of the value of accurate recording and reporting.

- The department needs to ensure 100% supervision of PHC at least once a month and therefore provision of subsidized vehicles to clinic supervisors at sub-district levels should be ensured.

Table 1.1: MEC - Performance against Provincial Targets from 2010/11 - 2012/13 Annual Performance Plan for the Office of the MEC

Indicator Type	Type	Actual 2008/09	Actual 2009/10	Actual 2010/11	Provincial Target
Input					
1. Provincial PHC expenditure per uninsured persons	R	511	531	351	250
2. Sub-districts offering 60% PHC package	Number	24	24	24	24
Output					
3. PHC total Headcount	Number	16.8m	18.6m	17,662,518	18m
4. PHC total headcount under 5 years	Number	3,164,870	2,582,748	3,081,144	3m
5. Utilisation rate – PHC	%	2.5	2.8	2.7	2.7
6. Utilization rate - PHC under 5 years	%	4.5	4.8	4.3	4.7
7. Professional Nurse clinical workload (PHC)	%	Not measured	Not measured	12	30
8. Doctor clinical workload (PHC)	%	18.8	24	20.6	30
Quality					
9. Supervision rate	%	90	81.5	80.9	85
10. Fixed PHC facilities supported by a doctor at least once a week	%	Not measured	Not measured	33.8	20
11. Percentage of community Health Centres (CHCs) with a resident doctor	%	Not measured	Not measured	59.9	100
Efficiency					
12. Provincial PHC expenditure per headcount at provincial PHC facilities	R	75	94	119	250

Table 2.2: Performance Against Provincial Targets from 2010/11-2012/2013 Annual Performance Plan for DHS

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
2.1 District Management						
To facilitate the provision of strategic leadership and the creation of social compact for better Health.	Number of districts that developed and submitted District Health Plans (DHP) according to guidelines	7	7	7	7	Target achieved
	Number of districts that completed their District Health Expenditure Reports (DHERs)	7	7	7	7	Target achieved
	Number of districts participating in Integrated Development Plan (IDP) forums	7	7	7	7	Target achieved
	Number of sub-districts participating in IDP sessions	Not measured	Not measured	23	23	Target achieved
2.2 Community Clinics						
Re-constitute clinic committees in PHC facilities	Number of clinics with functional clinic committees	662	750	752	719	2 Districts (Amathole & Cacadu) still in process of re-constituting committees in line with policy

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	Number of clinic committees that underwent training	516	375	Train 563 clinic committees	455	Target not achieved due to challenges with some training logistics
To improve and strengthen the quality of services and functionality of PHC facilities	Number of clinics implementing the Project on Clinics as Centres of Excellence	60	60	Implement Project on Clinics as Centres of Excellence in 67 Clinics (60 existing and 7 new)	67	Target achieved; additional centres of excellence include: Makhapusi, Bongweni, Dundee, KuBengu, Bityi, P.E. Central, Palmietfontein clinic
Increase access to comprehensive Primary Health Services packages	Number of clinics implementing 60% of PHC package	Not measured	Not measured	401	687	Annual target was under estimated, furthermore training of supervisors and operational managers contributed to achievement of 60% implementation of the package.
2.3 Community Health Centres						
To strengthen implementation of PHC package to 60% by the clinics and CHCs	Number of CHCs implementing 24 hour services (MOU & Trauma)	25	27	40	24 Hr service: 31 MOU: 30 Trauma: 29	9 CHCs operate as Day clinics, due to shortage of staff and infrastructural challenges
	Number of CHCs implementing 60% PHC package	Not measured	Not measured	30	30	Target achieved

2.4 COMMUNITY BASED SERVICES

Purpose

Render a community-based health service at non-health facilities in respect of prevention of disease and promotion of health, home-based care, traditional health and school health.

Strategic Objectives

- To promote healthy lifestyles
- To increase and strengthen the functionality of Health Posts within the Province
- To prevent circumcision deaths
- To increase access to Oral Health Services

Programme Description

The sub-programme Community-based Services is comprised of the following components:

- Health Promotion and Healthy Lifestyles Programme
- Traditional Health Services
- EU Partnership for the Delivery of PHC including HIV/AIDS Programme (PDPHCP)

2.4.1 HEALTH PROMOTION AND HEALTHY LIFESTYLES PROGRAMME

Purpose

Enablement, mediation and advocacy for the people of the Eastern Cape in the prevention of illness and promotion of their health.

Programme Priorities

- To establish, implement and sustain health promoting schools, correctional services and businesses
- To promote healthy lifestyle practices in communities including:
 - Physical activity

- Systematic screening of diseases for early diagnosis and treatment
- Implementation of the Tobacco Control Act
- To support PHC Priority Programmes in:
 - Development of a plan for equitable placement of Community Health Workers by district.
 - Development, management and dissemination of health-related Information, Education and Communication (IEC) material

Service delivery achievements:

A total of 189 campaigns on various topics of communicable and non-communicable disease programmes including HIV counseling and testing (HCT), cancer screening, TB, chronic illnesses, Expanded Program on Immunisation (EPI) and issues around cleanliness were conducted in all the 24 sub-districts within the province.

Health Promoting Settings

This approach addresses the context in which people engage in daily activities, and also the needs and capacities of people in each environment in order to make the setting itself more health promoting. The settings included health promoting businesses, schools, hospitals, correctional services, churches and child friendly villages.

Health Promoting Businesses

The Health Promoting Business (HPB) programme facilitates the implementation of the National Tobacco Act of 1993 which aims to reduce tobacco smoke-related outcomes, particularly cancers and respiratory tract infections. Health promotion has targeted shebeens and taverns in order to educate people on the danger of smoking. The programme also creates awareness about proper implementation of the National Tobacco Act; consequently approximately 45 taverns have built shacks to separate smokers from non-smokers in order to reduce passive smoking. Education in these settings provides



information on signs and symptoms of communicable diseases and clients are supplied with condoms to prevent sexual transmitted infection.

Health Promoting Schools

The number of schools in which the concept of health promotion has been introduced and commonly known as “Health Promoting Schools” or HPS has increased to 1065 in the year under review. All programs from various departments were introduced in these schools. Through this initiative there is a collaboration of government departments in addressing scholar challenges. For example, uniforms were bought by the Social Development Department for 41 children in Mbabakazi JSS from Ngcobo sub-district. Outreach health services were also initiated in Mbabakazi JSS and mobile services are rendered fortnightly with the support of a doctor from All Saints Hospital. Furthermore through involvement of Department of Water Affairs and Local Government, schools were provided with clean water and sanitation in order to reduce the prevalence of waterborne diseases.

Child Friendly Villages (CFV)

The implementation of the Revitalisation of Primary Health Care (RPHC), one of the DOH priorities, has raised a provincial focus on disease prevention strategies at the community level. This has resulted in rolling out Child Focus Villages (CFV), an initiative that is meant to strengthen child health programs. Thirteen CFVs were established in five districts including Chris Hani, Cacadu, Joe Gqabi, Amathole and OR Tambo. Door-to-door campaigns were conducted by the DOH in collaboration with the local municipalities and traditional leaders. Through this initiative about 146 at risk children (those not immunized, poor nutritional status and neglected) were identified, assessed and referred for assistance. A total of 62 children-headed families were also identified and these children were referred to the Social Development Department for assistance. Furthermore this initiative focused on the environment within the household which can pose health risks to children under the age of five.

Health Posts

Through the implementation of the social compact (one of the five DOH priorities) the department has seen an increased involvement of communities in health issues and has managed to establish 21 new health posts, which make a total of 103 health posts province-wide. Fourteen of these are in Joe Gqabi, 18 in OR Tambo, 20 Amathole, 20 Chris Hani, 8 Cacadu and 23 Alfred Nzo districts. Community members with the assistance of the DOH selected local residents who have been trained by the DOH on home-based care to run these health posts. The primary function of the health post is to educate on prevention of disease and health promoting strategies. Health posts also provide accommodation or venues for support group meetings. Health posts are used as a strong support to PHC facilities and assist to perform some activities at a community level. These refer to clinics and in turn, are used to do follow-up on PHC clients.

Challenges limiting service delivery

The Health Posts are difficult to sustain as they need funding and stipends for personnel. The initiative has managed to bridge the gap of access to services delivery through provision of health education and follow up of clients to ensure treatment compliance. To sustain this initiative, a clear policy on establishment, funding, involvement of other stakeholders and their role as well as the maintenance of these facilities should be drawn and communicated.

2.4.2 SUB-PROGRAM: TRADITIONAL HEALTH SERVICES

Purpose

To promote and facilitate the implementation of the Traditional Health Practitioner Act and the application of Health Standards in Traditional Circumcision Act in the province.

Strategic Objective

- To facilitate the implementation of mobilisation and advocacy campaigns in order to reduce mortalities and

morbidities as a result of traditional initiation practices.

- To facilitate the 80% institutionalisation of African Traditional Medicine into the provincial health system.

Programme Priorities

- Implementation of the PGDP Priorities within the context of the Social Needs Cluster to reduce mortality and morbidity resulting from traditional circumcision.
- Enhance traditional initiation/circumcision outcomes within the Province through education, health promotion and advocacy campaigns.
- Implement the legislative reforms with special focus on the African Traditional Medicine Policy in the province.
- Develop and implement a Traditional Health Services (THS) Efficacy Strategy.
- Enhance effective governance and accountability within programmes.

Service delivery achievements:

Traditional male circumcision is widely practiced in Eastern Cape and the involvement of all relevant stakeholders which include traditional surgeons, traditional nurses, traditional leaders, traditional healers, medical officers, police, parents, initiates and the communities concerned has resulted in a decrease in the number of circumcision-related deaths from 91 in 2009/10 to 62 in 2010/11. This has been achieved through campaigns which were conducted throughout the province. Although much has been achieved, illegal circumcision schools still pose a major challenge and illegal practices lead to tragic mutilation and deaths. A total of 21 766 initiation schools were reported and 1.7% (370) of them were illegal; 63% (234) of illegal schools were reported from Amathole district. No illegal schools were reported from Nelson Mandela Metro (NMM) or Joe Gqabi.

The total number of initiates was 74 359 and 3.7% (2781) of these were illegally initiated; 10% of illegal circumcisions were reported from OR Tambo District. Through intersectoral collaboration with the South African Police

Service (SAPS), 20 illegal traditional surgeons were arrested. Approximately 658 initiates were admitted to hospital with a case fatality rate of 9.4% (62 deaths) and 23 initiates were amputated. The majority of deaths were reported from OR Tambo District with 61% (38), followed by Chris Hani and Amathole districts with 19% (12) and 10% (6) of the total deaths respectively.

Challenges limiting service delivery

Unqualified traditional surgeons, negligent traditional nurses, less caring parents, and prospective initiates (youths) that are medically unfit for the hardships of the initiation process continue to contribute to tragic outcomes. Poor buy-in and acceptance of government interventions with regards to ritual and the stigma attached to any initiate visiting health institutions are the main problems. In an effort to control illegal and unsafe practices as well as to enhance requirements for compliance with health standards, the department is working closer with the House of Traditional Leaders and SAPS and has established circumcision committees and forums to ensure the safety of initiates during their stay in initiation schools.

2.4.3 EU: PARTNERSHIP FOR THE DELIVERY OF PHC INCLUDING HIV/AIDS PROGRAMME (PDPHCP)

Purpose

To strengthen the delivery of PHC Services (especially those addressing HIV & AIDS) by supporting the development of formal partnerships between Government and Non-Profit Service Organizations (NPOs).

Programme Priorities

1. Strengthen governance and management structures and systems of NPOs.
2. Promote partnerships and public participation by NPOs & Communities.
3. Strengthen oversight over NPO governance structures providing PHC services.

4. Ensure that all funded NPOs comply with requirements of Public Finance Management Act (PFMA) and treasury regulations.
5. Establish and strengthen the delivery of PHC by supporting the development of partnerships between government and NPOs.
6. Ensure establishment, implementation and maintenance of management control systems.
7. Coordinate and manage all stakeholder engagement with funded NPOs.
8. Ensure that implementation of PDPHCP is aligned to the DHP.

Service delivery achievements:

The Partnership for Health Program (PHP) has supported the decentralization of health services in the province by strengthening and supporting the cooperation between the non-profit health providers and government services. It created a formalized partnership for delivery of PHC services, especially those services addressing HIV and AIDS. Gaps and under capacity in the provision of PHC were identified and the government has entered into a partnership with non-governmental and civil society organizations; 42 NGOs have signed the service level agreement (SLA) with the department in order to fulfill the legal obligation guiding the development of partnership arrangements as contained in section 16 of the PFMA.

Capacity Building

A total of 19 provincial and district personnel received training on Foundation for Professional Development (FPD). In addition, a total of 103 NPO staff were trained on management and computer skills; 13 staff were trained on computer skills and 90 on management. Approximately 715 Expanded Public Works Program (EPWP) CHWs from Amathole, Chris Hani and OR Tambo districts were trained on Ancillary Health Care (AHC) levels 1 and 2 of (National Qualification Framework) and Adult-Based Education and Training (ABET). Furthermore, 38 board members were trained on 10 modules which focus on governance, composition of the board, roles and responsibility of board members, committees of boards, understanding the context of health service, health strategy planning and implementation, resource mobilisation and management, risk management, internal control and introduction to project management.

Community-based Health Services

The programme primarily supported the HIV and AIDS programme in two main areas: the HCT campaign and home-based care. A total of 155 967 clients in need of home-based services were reached. Of these clients 62 985 were category 1, 72 144 were category 2 and 20 838 were category 3. Whilst under-reported, 8 173 clients were referred to PHC facilities. To increase the HIV testing rate, 8774 clients were tested at non-medical sites.

Challenges limiting service delivery

- Limited budget has resulted in under achievement of some activities.
- There is gross under-reporting of referrals by NPOs; the programme has to strengthen its monitoring system in order to accurately document its outputs.

Table 2.3: Performance Against Provincial Targets from 2010/11 - 2012/13 Annual Performance Plan for Community-Based Services

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
2.4.1: Health Promotion and Healthy Lifestyles						
To facilitate the promotion and strengthening of Healthy Lifestyles Campaigns in order to prevent diseases.	Number of healthy lifestyle campaigns conducted per subdistrict	37	72	96 (4 campaigns per sub-district)	189	More campaigns were conducted per sub-district in support of MCWH, NCD, HIV and THS. This included social mobilisation conducted in preparation for H1N1, Rift Valley Fever and Cholera outbreak response.
	Number of Health Promoting Settings Implementing Healthy Lifestyles Programmes	527 Phase1:180 Phase2:152 Phase3:195	324 Phase1:84 Phase2:116 Phase3:124	HPS : 96 HPH : 7 CFV : 7 HPB : 75 HPCS : 5 HPC : 10	HPS : 114 HPH : 3 CFV : 13 HPB : 73 HPCS : 21 HPC : 17	Through inter-departmental collaboration with Department of Education, more schools were introduced on health promoting setting concept. The DOH in addition signed a MOU with Correctional Services and the programme has managed to access more correctional services clients

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
To increase and strengthen the functionality of Health Posts within the Province.	Number of new Health Posts established	21	45	35	21	Only 21 new health posts were established due to lack of funds to pay volunteer stipends. Total Health Post in Province = 83
	Number of Community Health Workers placed at new Health Posts.	Not measured	Not measured	148	21	High staff turn-over rate with CHWs leaving the Health Post due to unavailability of funds.
To commission two research studies on health literacy and the impact of health promotion.	Number of research studies conducted	Not measured	Not measured	1	0	Not done due to budgetary constraints
2.4.2 Traditional Health Services						
To strengthen traditional health practices	Number of mobilisation and advocacy campaigns conducted	Not measured	Not measured	600	239	Target not achieved due to unavailability of funds to conduct the campaigns
	Number of traditional health practitioners provided with awareness and knowledge of health standards	86	372	2500	2753	There were 253 newly registered THP which resulted in greater numbers of THPs being in-serviced on health standards

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	Number of provincial colloquiums on African Traditional Medicine	Not measured	Not measured	1	0	Provincial conference on African Traditional Medicine shifted to June 2011 as there was no budget for this activity.
	Number of research studies conducted to assess the reason and impact of traditional circumcision mortalities	Not measured	Not measured	1	0	Activity not done due to financial constraint
	Number of deaths amongst initiates	24	91	0	62	This is due to circumcision performed illegally as well as poor management and poor supervision of initiates by traditional circumcision practitioners and communities.
	Number of initiates with penile mutilation	3	49	0	23	Penile mutilation are the results of illegal circumcision.

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	Number of initiates admitted to hospital	323	713	0	658	Illegal performance of circumcision and poor supervision has resulted in some initiates being admitted in hospital because there are no medical officers specifically appointed for this function; DMO's are seconded from other programmes and they are not always available on call.
	Number of illegal traditional circumcisions performed	Not measured	3366	0	2781	Lack of ownership of the circumcision program at the community level. The practice is largely driven by peers hence no pre-examination or supervision.
2.4.3 EU-PDPHCP						
To maintain and improve effective and efficient running of the provincial and district office.	Number of performance agreements and work plans developed, signed and reviewed	Not measured	15	19	15	General Assistants are still struggling to develop their work plans, hence set target not met

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	Number of personnel trained	Not measured	49	19	19	Target achieved
To strengthen district health system through the implementation of Community Based Health Services.	Number of CHWs trained from EU programme	Not measured	390	714	715	Target achieved
	Number of referrals from NPOs to health facilities	Not measured	42	18 800	8173	There is gross under reporting of referrals by NPOs/CCGs. Attempts being made to ensure that each referral is recorded.
	Number of NPO stakeholder engagement seminars	Not measured	2	2	1	Only one seminar conducted due to financial constraints
	Number of HBC Kits for CHWs procured	Not measured	270	714	500	Funds to procure HBC kits were transferred to the district to take over this activity.
To train funded NPOs on management and computer skills	Number of NPO staff trained on management and computer skills	Not measured	Not measured	118	103	Only 103 trained due to financial challenges, rest will be trained in 2010/11 financial year
To train NPO governance structures on their roles and responsibilities	Number of NPO board members trained	70	12	118	38	Target not achieved due to financial constraints.

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
To implement and institutionalise NPO administrative tools and systems	Number of NPOs implementing quality admin tools	Not measured	Not measured	59	59	Target achieved
To increase access to PHC services through partnerships with NGOs (Extend contracts for current 42 NPOs)	Number of NPOs contracted to deliver PHC	Not measured	Not measured	42	42	Target achieved
	Number of comprehensive HBC clients reached	3 186	94 218	100 800	155 967	An incentive grant was received from treasury for Expanded Public Work Program (EPWP), which resulted in recruitment of 354 additional home base care givers hence increase in number of HBC clients reached.
	Number of clients accessing VCT services from non-medical sites	Not measured	Not measured	10 000	8774	The target of clients accessing VCT was not met because non-medical sites do not have full-time and fixed staff to guarantee continuous provision of this service at all times; the nurses who provide HCT services at these sites are doing this on voluntary basis.

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
To implement and strengthen NPO Supervision and Management Programme through implementation of quality assurance tools	Number of NPOs implementing supervision tools	Not measured	Not measured	42	42	Target achieved
	Number of visits conducted to implement quality assurance tools	Not measured	656	168	218	Some NPOs were visited twice per quarter for follow-up purposes.
To conduct NPO quarterly performance reviews	Number of performance reviews conducted.	Not measured	Not measured	4	4	Target achieved
To conduct NPO assessments & programme evaluation	Number of NPO post-funding assessments done.	Not measured	Not measured	1	0	Could not be done due to financial constraints
To integrate NPO monthly reports into DHIS	Number of NPO reports transmitted into DHIS monthly	36	102	504 (42 x 12)	504	Target achieved

2.5 OTHER COMMUNITY SERVICES

Purpose

To assess, correct, control and prevent factors that can adversely affect health.

Program Description

Other community services sub-programme of the district health services is composed of three components namely:

- Environmental Health Services
- Oral Health Services
- Non-communicable diseases

2.5.1: Environmental Health Services

Purpose

To assess, correct, control and prevent environmental factors that can adversely affect health

Programme Priorities

- Management of Health Care Waste
- Overseeing and management of Port Health Services in all 4 ports of entry in the EC Province
- Management, control and monitoring of hazardous substances licensing
- To monitor Municipal Health Service delivery and outputs

Service delivery achievements:

Environmental Health Services plays a pivotal role in health service delivery and concentrates on preventative and promotive health that is vital for alleviation of current pressures on curative health services. Devolution of Municipal Health Services to districts is in progress and 59 Environmental Health Officers are in a process of being transferred to Amathole District; this process will be finalised in the new financial year.

FIFA World Cup

During World Cup, the Eastern Cape had one Fan Park and six Public Viewing Areas (PVAs).

Teams which included EHPs were set in all these viewing areas in order to monitor food and water quality with the aim of preventing water borne diseases and food poisoning. Teams were also set up at all ports of entry in order to check all visitors arriving from yellow fever endemic areas for their vaccination certificates. Through active surveillance, five citizens from Angola were refused entry at PE airport as they could not produce the yellow fever vaccine certificate. At St. Georges Fan Park, 600 kg of food stuffs was condemned as the food had expired. Only accredited vendors were allowed to sell food stuffs as per the General Requirements for Food Premises (Regulation 918).

Food safety

There are 55 909 registered food handling premises in Eastern Cape and 20% (10 971) of the food handling premises were inspected during the year under review. During inspection the focus was on the structure (cleanliness, availability of proper drainage and ventilation, rodent proofing and pesticide program) and personal protective clothing for workers. Of the food handling premises inspected only 67% (7 349) were compliant. Furthermore a total of 8 067 informal vendors were inspected of which only 54 were compliant (0.7%).

A total of 1071 food samples were sent to the laboratory for bacteriological and chemical analysis to check for pathogens and toxins that may result in food-borne illness in consumers. Of the 766 samples analysed for bacteria, 42% were contaminated and of the 205 analysed for chemicals, 49% (101) were contaminated.

Water and sanitation

Poor sanitation, water and hygiene have serious health implications causing a high incidence of diarrhoeal diseases especially in children under 5 years of age. To improve water supplies and sanitation facilities in schools and communities, routine water sampling is done to check the quality of water and health education is conducted in collaboration with health promotion to promote safe hygiene practices.

Domestic and stream water samples were collected by the water service authority and sent to the laboratory for total coliform and E coli bacteria analysis. Of the 6 644 domestic water

samples collected, 5021 (76%) samples were found to be compliant and out of 148 stream water samples collected, only 24 (16%) were compliant. A total of 1704 schools were inspected in respect to potable water and 1300 (76%) of these were found to be compliant. Reports for these results were sent to local municipalities in respective areas, water purification was done and some households were provided with Jik (chlorine solution).

In terms of sanitation, school toilets were inspected for availability of hand-washing facilities, proper ventilation and cleanliness. About 1741 schools were inspected and 70% (1224) of schools were compliant.

Challenges limiting service delivery

- “Brain drain” of personnel especially in Port Health Services due poor conditions of service
- Poor cooperation of some district municipalities in the devolution of municipal health services

2.5.2 Oral Health Services

Purpose

To coordinate and monitor the implementation of activities aimed at promoting good oral health practices in order to prevent oral disease occurrence throughout the Eastern Cape Province.

Programme Priorities

- To equip dental facilities so as to increase access to basic primary oral health care services
- To promote good oral health hygiene practices in order to reduce dental carries and tooth loss
- To increase oral health awareness amongst school children

Service delivery achievements

The Oral Health Programme provides dental services to children and adults according to criteria that target emergency situations, those

in most need, dental education and oral health promotion services. These services are delivered in dental clinics based in schools, community health centres and hospitals within the province. The services provided include general dentistry such as examinations, fillings, and dentures. There are 28 district hospitals, three hospital complexes and 35 CHCs that render these services in the province. A provision is made for communities in rural areas where mobile dental services are offered, and currently there are 16 of these units in use.

Approximately 315 tooth fissure sealant applications were performed for children between the age of 6 and 12 years to prevent tooth decay. Furthermore about 265 377 tooth extractions and 11 274 restorations were performed, thus translating to a ratio of one restoration performed to every 24 teeth extracted.

Integration of oral health services into health promoting schools

To promote oral health and prevent oral disease occurrence (gum diseases and dental carries) in young people, oral health services were integrated into school health services. Approximately 33 schools have integrated oral health services, this include 6 primary schools (Noxolo, Makaziwe, Ndiveni, Nomandla, Lonesi, Thuta Ndamase) in OR Tambo District ; 9 primary schools (Msundulu, Nyara, Ncera, Sandile, Jojweni, Hebron, Makhazi, Zikhova and Soto) in Buffalo City Sub-district and 18 primary schools (Dambuza, Kuyasa, Mtyobo, Ntaba, Maria Enkuthazweni for Disabled, C.M Vellel, Station Hill, Bongweni, George Dickeson, Good Shepard, St Mary's, Samuel Ntlebi, Makana, Archie Mbolekwa, Grahamstown, Amasango School for Homeless, Fikizolo and Kuyasa for Disabled in Makana sub-district).

During the national campaign 51 schools were visited, about 4220 children were given health education on dental care and 247 teeth were extracted.

Challenges limiting service delivery

- Although there is a large number of schools that were identified and that need to be reached with this service, there is limited

human resource capacity with regards to dentists, dental assistants, oral hygienists and therapists in the province. This has significant implications for the human resource development and training cluster to ensure increased production of this cadre & skill in the Province.

- Limited resources in terms of budget and restoration material pose a challenge to this programme, hence the high restoration to extraction ratio, a scenario that needs to be reversed.
- Poor and/or lack of maintenance of the dental units with very few dental units having received new equipment. The department needs to intervene on this matter before this situation gets out of hand and becomes more costly.

2.5.3 Prevention and Control of Non-Communicable Diseases

Purpose

To prevent and control the occurrence of lifestyle-related diseases in order to increase the life expectancy of the Eastern Cape population.

Strategic Objectives

Combating and reducing non-communicable diseases and mental conditions.

Programme Description

This sub-programme focuses on five components which are conducted at PHC level and these are:

- Mental health services
- Substance abuse
- Chronic diseases
- Eye care services and
- Geriatric services

Programme Priorities

- To implement the national Drug Master Plan to mainstream substance dependency treatment
- To implement chronic disease priority guidelines on diabetes, hypertension and cancer

- To increase access and improve eye care services
- Mainstream programmes for the elderly with other departments

Service delivery achievements:

Child and youth psychiatry services

In order to assist the families and carers of children and youth with mental health challenges, the department has established 9 Child and Youth Psychiatry services in 9 sub-districts. This has been done in collaboration with officials from the Social Development and Education departments who formed part of the teams that consist of mental health nurses, social workers, teachers, psychologists and psychiatrists. Against the target of 10, the department managed to implement the service in 9 sub-districts. These sub-districts include Lukanji, Buffalo City, Matatiele, Mzimvubu, Makana, Kouga, Senqu, Nelson Mandela Metro and Inxuba Yethemba. Mbashe, as one of the priority sub-districts, has not implemented the service as yet due to non-availability of a psychologist, a critical member of the multidisciplinary team. To bridge this gap the department is in the process of establishing outreach services in this particular sub-district.

Management of substance abuse

To improve the management of substance abuse at the community level, the department has approached 3 rehabilitation NGO centers in the province which are Shepherdsfields in Port Elizabeth, Bethany in Cathcart and Thembelitsa in Umthatha. As part of this initiative, Shepherdsfield Rehabilitation Centre has signed a MOU with the department.

A total of 25 doctors from all the seven districts were trained on substance abuse detoxification guidelines that were introduced in 2008. Despite the fact that training was conducted, only 82 clients received detoxification treatment due to a lack of rehabilitation centres post-detoxification to hold these clients. Three health facilities namely Settlers, Dora Nginza and Cala hospitals have however recently started rendering rehabilitation services post-treatment.

Prevention of blindness

A total of 5787 cataract operations were performed and these translate to a provincial cataract operation rate of 866 per 1000 000



population. For clients with irreversible blindness, low vision service is rendered in only one of the seven planned sub-districts namely Nelson Mandela Metro. A three year contract was signed between the department and International Centre for Eye-care Education (ICEE) for the provision of spectacles and mentoring of optometry services. This will also support the training of nurses on eye screening at all levels of care.

Chronic diseases

To reduce morbidity and mortality due to diseases of lifestyle and other non-communicable diseases (NCDs) including hypertension, diabetes, asthma and cancer, a long-term care model is being implemented in 9 sub-districts. A total of 50 nurses have been trained on long-term care model and diabetes strategies. All priority sub-districts were supplied with basic equipment. Furthermore, 65 officials comprising of nurses, physiotherapists and NCD managers were trained from six priority districts on stroke management. In an effort to establish stroke units, three hospitals (Butterworth, Madzikane ka Zulu and Settlers

Hospitals) allocated cubicles in the medical ward which are used as stroke units. A plan of expanding this initiative to other district hospitals has been put in place for the next financial year.

Challenges limiting service delivery

- Shortage of doctors leading to non-reviewal of patients on chronic and mental illness medications.
- A shortage of rehabilitation centres for substance abuse patients, leading to relapse of treated patients.
- To rectify this situation the department needs to seek assistance from other stakeholders and engage more NGOs. A good start has been made as the department has approached SANCA in East London, Thembelitsha in Umthatha and Shepherdsfield in Port Elizabeth.
- The limited number of optometrists in the Province has significant implications for the human resource development and training cluster. Program 7 which is responsible for rehabilitation services will support the program through training of ophthalmologists.

Table 2.4: Performance Against Provincial Targets from 2010/11 - 2012/13 Annual Performance Plan for Other Community Services

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
2.5.1: Environmental Health Services						
Monitor the successful implementation of the Waste Management Act to a number of health facilities within the Province.	% of health facilities segregating waste in line with waste management regulations	Not reported	Not reported	60%	85%	Target achieved
	% of health facilities with waste collected per service level agreement SLA	Not reported	Not reported	100%	100%	Target achieved
To facilitate devolution of municipal health services to district municipalities and metros by transferring 63% of EHPs from DOH to district municipalities	Number of EHPs transferred to the district municipalities	New initiative	New initiative	Transfer of 59 EHPs to Amathole district municipality	Not achieved	Delays in the transfers were due to logistical challenges and the fact that Buffalo City is to become a metro after the local government elections which lead to further delays. Transfers will be finalised in the next financial year.
To strengthen the functionality and	% of Vessels issued with free pratique	Not reported	Not reported	100%	100%	Target achieved

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	Number of international travellers without yellow fever vaccination	Not reported	Not reported	0	5	5 travellers during the World Cup arrive from Angola to watch a game but were refused entry due to unavailability of vaccination certificates
2.5.2: Oral Health Services						
To equip PHC dental and oral health facilities	Number of PHC Dental / Oral Health facilities equipped	3	27	30	0	There has not been any replacement or procurement of new equipment for any facility this financial year due to budget shortages.
To increase number of mobile dental units servicing rural areas in order to increase access to oral health service.	Number of functional Mobile Dental units	13	20	15	16	Target achieved
	Number of schools with integrated Oral Health Services	Not measured	20	15	33 (15 new)	The figure includes 18 schools which were maintained from last financial year.
To retain the rate of restorations to extractions (norm) *7:1*	Dental extraction to restoration ratio	2:6	2:9	7:1	1:23	Target not met due to limited restoration material and skilled personnel hence more extractions than restorations are done.

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
2.5.3 Prevention and Control of Non-Communicable Diseases						
To facilitate the establishment of community-based After Care Services for patients with mental health conditions	Number of established Mental Health Units at community-based level	Not measured	Not measured	1	0	This activity has fallen off due to unavailability of space or structure to render the service
To strengthen child & youth psychiatry services	Number of Sub-districts with established Child & Youth Psychiatry Services	Not measured	Not measured	10	9	This activity needs a multidisciplinary approach and Mbashe sub-district does not have a psychologist which is the most important member of the team.
To facilitate the improvement of management of Substance Abuse at community-based level	Number of Community-based rehabilitation NGOs supported by DOH	Not measured	Not measured	3	1	Target not achieved due to delays in signing of the MOU by the NGOs
	Number of patients on detoxification treatment.	Not measured	Not measured	200	82	Target not met due to challenge around referral place for clients post-detoxification for rehabilitation purposes.

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
To facilitate the eradication of blindness in patients presenting within the Province	Number of cataract operations done	5993	6427	6 500	5787	Currently only one ophthalmologist in Amathole and although we have 3 in Umthatha, only one theatre is available for ophthalmology cases. Screening of patients and referral of client in Chris Hani and Joe Gqabi has improved which should lead to more cataract operations being done at Sawubona Eye Centre at Frontier Hospital.
	Number of sub-districts with optometry services including outreach	Not measured	Not measured	13	6	Limited number of qualified optometrists
	Number of Sub-districts with Low Vision Services for irreversible blindness (N=7)	Not measured	Not measured	2	1	Target not met due to limited budget for procurement of equipment to render the service

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
To facilitate the reduction in morbidity and mortality from targeted non-communicable diseases through implementation of Long Term Care Model	Number of Sub-districts implementing Long Term Care Model (N=21)	Not measured	9	6	9	Target achieved
	Number of stroke units established in district hospitals.	Not measured	Not measured	3	3	Target achieved
	Number of Sub-districts implementing the Active Ageing program	Not measured	15	6	3	Service done in collaboration with Social Development in Kouga, Mbashe and Mzimvubu. These are done in social development service centres. Target not achieved as the activity is driven by Social Development and the department does not have funds to render the service.

2.6 HIV & AIDS and STIs

Purpose

The purpose of this sub-programme is to control the spread of HIV infection and reduce and manage the impact of the disease on those infected and affected in line with the PGDP Goals.

Strategic Objectives

- To combat and reduce the impact of HIV and AIDS
- To achieve a 50% reduction in HIV prevalence in the 15 to 24 age group
- To facilitate 80% achievement of ARV treatment coverage
- To facilitate 95% achievement of the PMTCT coverage

Programme Priorities

- To increase the number of sites providing HCT
- To enhance implementation of dual therapy
- To increase the number of sites competent to provide ART
- To increase the number of clients accessing ART
- To increase high transmission area (HTA) implementing and monitoring sites
- To increase access for clients to Home Based Care
- To educate and increase knowledge of the EC population in order to maintain negative HIV status of millions of people

Service delivery achievements:

Advocacy, mobilisation and communication

HIV prevention is the main key strategy in combating HIV infection. Various advocacy, mobilisation and communication activities were conducted in the year under review. The activities included:

- Candlelight commemoration and HCT launch campaign was conducted in all seven districts and 2,012 clients were tested for HIV; 251 (12.4%) of these clients tested positive.
- HCT road shows

- Live Longer Campaign by Kagiso TV & Communication in partnership with ECDoh where communities were encouraged to be tested in order to know their status.

Management and control of STIs

The incidence of STIs in the province remained consistently below 5% in the last three years. Although the partner notification rate is at 69%, the partner treatment rate remains low at 23.2% which is below the set target of 35%. It should be noted that only those clients seen at public health facilities are reported, and there is under-reporting of the actual number of partners treated.

There has been an increase in the number of condoms distributed compared to 2009/10 financial year. Male condom distribution rate has increased from 12 in 2009/10 to 16 in 2010/11 probably attributable to rigorous HCT campaigns conducted province-wide. Although such an achievement has been noted, condom stock outs have been reported due to a shortage in the condom supply from the National DOH. More efforts have to be directed towards sustaining this rate and ensuring availability of stock at all times.

Post-exposure prophylaxis (PEP)

HIV post-exposure prophylaxis is considered for all survivors of sexual abuse and rape who report the incident. The department is working with SAPS and the Thuthuzela Centres were established to improve service delivery to survivors timeously and moreover, to facilitate conviction of perpetrators. During the year under review, of the 6002 sexual assault cases reported, 74% (4424) received HIV PEP.

Health care providers are at risk of occupational HIV exposure. Of the 625 health care providers who reported needle stick injuries, 82% (510) received HIV PEP.

HIV counselling and testing (HCT)

A total of 1,055,755 clients were tested through the HCT campaign. Although this output is less than the target of 1.6 million set for 2010/11, it is significantly higher (55%) than the number of clients (471,484 clients) tested through the VCT programme during the 2009/10 financial year. This is believed to be an

underestimation of performance as clients tested during outreach campaigns and with private companies have not been included. There are also 97 non-medical sites that provide HIV testing services within the province. High transmission area sites targeting truck drivers and commercial sex workers have been increased from 40 in previous financial year to 50.

- Of the total number of clients tested, 12% (129,061) tested positive for HIV. In line with the population figures in districts, a large proportion (28.6%) of those testing positive were reported from OR Tambo District followed by Amathole District (23.5%). Cacadu District had the lowest proportion at 4.8%.

Prevention of mother to child transmission (PMTCT)

The PMTCT program is implemented in all PHC facilities including mobile services. A total of 128,205 pregnant women were tested for HIV; of these 19.7% (25,214) tested positive. Whilst comparable to the HIV prevalence in the general EC population (18.5%), the facility-based PMTCT prevalence is significantly lower than the latest prevalence of 28.1% reported from the National ANC Sentinel HIV & Syphilis Prevalence Survey of 2009.

Whilst there are data collection and recording challenges within the PMTCT programme, the success of this programme is best demonstrated over the years by the consistent decline in the proportion of babies testing positive on PCR at six weeks. Baby PCR positivity rate has dropped from 9.9% in 2009/10 to 6.8% in the year under review.

Approximately 80.4% of clients with a CD4 count less than 350 were put on highly active antiretroviral therapy (HAART). A positive outcome has been achieved through the PMTCT program.

Comprehensive care, management and treatment (CCMT)

There has been an increase in the number of facilities providing ARV treatment from 85 in 2009/10 to 580 in 2010/11 in order to cater for the HCT programme output and demand. Whilst some of these facilities were found to be competent to render the ART services, infrastructural and human resource issues remain a challenge. The increase in the number of facilities providing ART services resulted in an increase in the number of clients registered in the ART programme from 102,186 in 2009/10 to 152,357 in 2010/11. In order to meet the increasing ART demand, and to equip and staff the added facilities using a nurse-led treatment approach, the department trained 852 professional nurses on Nurse Initiated Management of Antiretroviral Therapy (NIMART).

Home-based care

An increase in the number of clients accessing home-based care through the funded NGOs and CBOs was seen. The HIV/AIDS program funded 17 NGOs in four districts, and 42 NGOs in the other three districts were funded by the EU programme. About 150,044 clients reached through NGOs were funded by the HIV/AIDS program and 95,820 households were visited.

Table 2.5: HIV and AIDS NGO support to districts by source of funding

District	Number of NGOs	Source of funding
Alfred Nzo	4	HIV/AIDS
Amathole	14	EU
Cacadu	2	HIV/AIDS
Chris Hani	16	EU
Nelson Mandela Metro	6	HIV/AIDS
OR Tambo	12	EU
Joe Gqabi	5	HIV/AIDS

Challenges limiting service delivery

- The introduction of the new ART guidelines came with a new drug regimen (tenofvir and truvada) which were not available on the RT71 tender, and this has resulted in ART drug stock outs.
- Patients transferring from the previously accredited sites to the new competent ART sites are not reported as transfers; in addition, the movement of clients to new sites resulted in under-reporting as these were not recorded & reported due to unavailability of registers at the beginning of the implementation period at the new sites. Furthermore, the civil servants' strike had a negative effect on August to September 2010 outputs.
- Outreach data from supporting NGOs is not captured on DHIS, only clients tested in provincial facilities are reflected on DHIS; this is significant because clients seen at private facilities are not reflected in the data.
- Poor data management, especially in hospitals, has resulted in under-reporting.
- Both male and female condom tenders pose condom stock out challenges in the Province and need close monitoring. In addition, the ECDOH still has to secure storage for bulk condom deliveries by suppliers.

Table 2.6: HIV/AIDS and STI - Performance Against National Targets from 2010/11-2012/2013 Annual Performance Plan

Indicator	Type	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between annual target and actual output
Total number of registered Antiretroviral Therapy (ART) clients on treatment	No.	75 919	102 186	150 000	152 357	Increase in number of facilities providing ART resulted in the increase in number of clients accessing this service however, poor recording has resulted in low numbers being reflected on DHIS
Male condom distribution rate	No.	12	12	12	16	Since the introduction of HCT campaign there has been an increase in number of condoms distributed
Antenatal client initiated on AZT during antenatal care	No.	3 693	16 177	28 000	23 489	Under-reporting has contributed to the variance; verification of data is being done through facility visits.
Antenatal client Nevirapine uptake rate	%	74.3%	92.9%	80%	54.6%	Implementation of the new NIDS with old registers still used in some facilities and the issue of definitions in the new and old NIDS affects reporting.

Indicator	Type	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between annual target and actual output
Newborn baby NVP uptake rate	%	65%	99.3%	75%	98.5%	Increase in the number of ART sites and mass awareness campaign has resulted in the improvement of baby NVP uptake.
Newborn baby AZT uptake rate	%	Not measured	Not measured	55%	23.8%	With the new 2010 PMTCT guidelines, AZT is being phased out and no longer given to babies hence there is a drop in this indicator.
Fixed facilities with any ARV drug stock out	%	0%	0%	0%	28%	The amendments to treatment regimens resulted in some newly introduced drugs delayed in arriving resulting in stock outs e.g. Tenofovir.
STI partner treatment rate	%	22.7%	22.4%	35%	23.2%	At times clients do not indicate that their partners were treated for STIs hence low output. In other instances infected partners seek assistance in the private sector so there is no recording in public sector data

Table 2.7: HIV/AIDS and STI - Performance Against Provincial Targets from 2010/11-2012/2013 Annual Performance Plan

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
To combat and reduce the impact of HIV & AIDS.	Number of clients tested for HIV	297 000	471 484	1 600 000	1 055 755	Challenge is under reporting due to the following: • Data from private companies was not included • Data from outreach campaigns was not included
	Number of HIV rapid test kits procured	467 000	531 519	2 560 000	2 822 360	National DOH also supplied the test kit and this will continue until end June 2011
	Male condoms distributed	30 600 000	25 122 192	70m	7 724 883	Condoms were supplied through NDOH tender; as a result the department never received the amount of condoms ordered
	Female condoms distributed	1.7 m	1 207 373	2m	845 919	Condoms were supplied through NDOH tender; as a result the department never received the amount of condoms ordered. Female condom tender was not awarded by National Treasury.

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	Number of patients accessing Home-Based Care	228 714	57 114	150 000	149 684	Output within target range
	Number of functional SDC facilities.	Not measured	Not measured	15 (1 new = Grey Hospital)	15	Target achieved
	Number of pregnant women tested for HIV	130 703	138 735	100 500	128 205	There is a drop in number tested compared to previous years because some pregnant women already know their status. HCT campaign contributed.
	Number of National HIV/AIDS calendar events commemorated	4	3	4	3	Activity not done in 4th quarter due to financial constraints
To achieve 50% reduction in HIV prevalence in 15 to 24 age group.	Number of functional HTA facilities.	27	40	50	50	Target achieved
To facilitate 80% achievement of ARV treatment coverage.	Number of facilities accredited to provide CCMT services	77	85	410	580	According to the latest policy, these are no longer accredited but facilities are being assessed and confirmed competent to provide ART.

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	% of facilities offering PMTCT	100	100	100%	100%	Target achieved
	Number of health care professionals, community care workers and stakeholders trained on HIV and AIDS related issues	Not measured	Not measured	5 525	9 491	Department was supported by PEPFAR funded NGO and Regional Training Centre (RTC), more focus on training for Nurse initiated management of ART(NIMART)
	Number of partners consulted	Not measured	Not measured	136	137	Target achieved
	Number of policy guidelines, flowcharts, training manuals, registers, patient recording materials printed	Not measured	Not measured	8 400	6 000	No printing was done in 4th quarter due to moratorium measures within the department.
	Number of STI standard equipment and sexual assault comfort packs procured	Not measured	Not measured	4 500	0	Tender for sexual assault comfort packs was awarded but service provider could not render the service; however, stock carried over from the previous financial year was used.

2.7: TB CONTROL

Purpose

To control the spread of TB, manage individuals infected with the disease and reduce the impact of the disease in communities.

Strategic Objectives

To implement HIV& AIDS and TB interventions in order to combat and reduce disease impact on communities.

The TB control programme is composed of the following sub programmes:

- TB Management
- TB HIV Sub-programme
- Advocacy, Communication and Social Mobilization (ACSM) Sub-programme
- Inpatient Care

Programme Priorities

- Achieve universal access to high quality diagnosis and patient –centred treatment.
- Reduce the human suffering and socioeconomic burden associated with TB.
- Protect poor and vulnerable populations from TB, TB/HIV, multidrug-resistant and extreme drug-resistant TB.
- Support development of new tools and enable their timely and effective use.
- Conduct surveys to determine the provincial prevalence of XDR-TB
- Ensure availability of key drugs to treat and control XDR-TB.
- Strengthen infection control measures to protect healthcare staff.
- Capacitate health professionals on the use of new drugs, clinical management and adverse events.

Service delivery achievements:

TB case detection

There has been a significant reduction in the number of new TB cases reported during the year 2010. The incidence of TB seems to have peaked in 2008 and declined thereafter. A 27% decrease from 983 per 100,000 in 2008 to 722 per 100,000 in 2010 has been observed. The declining trend is observed across all seven districts. This has been achieved through

concerted efforts and strategies that include the Intensified Case Finding intervention. This intervention involves tracing and screening of contacts for smear positive cases and drug-resistant patients.

TB treatment outcomes

The WHO recommends that any effective TB programme should achieve an 85% cure rate in order to reverse the incidence of TB disease. The TB programme has for the first time achieved and exceeded the set target for the TB cure of 65%; the EC Province achieved a cure rate of 66% in 2010 (Table 2.7). Five districts achieved a 70% cure rate and above with Chris Hani having the highest rate at 76.2%. Greater efforts are needed in Amathole and Alfred Nzo Districts which achieved low cure rates of 52.5% and 56% respectively. It should be noted however, that despite these two districts having the lowest rate relative to other districts and the set target, over the years they have been showing a steady increase in their cure rates (see figure 1.11) Defaulter rate is still high at 7.8% against the target of 5%. Chris Hani District is a good example of the correlation between a low defaulter rate (4.4%) and high cure rate (76.2%) as well as the high sputum conversion rate at two months (75%).

A contributing and favorable factor to the programme's success is a significant reduction in cases that were not evaluated at the end of their treatment regimen; by the end of the year under review this was reported at 0.3%.

Integration of TB with HIV and AIDS

About 81% of TB patients were tested for HIV. There has been a decline in this indicator from the previous year's report. The transition from paper-based data to ETR.net has affected data negatively as recording of this data in TB registers and capturing of this information in ETR.net has been started but at a low pace though it is improving gradually. TB patients are offered HCT at TB diagnosis. Some may refuse HIV testing and health care workers are expected to continuously offer HCT through the TB treatment period such that by the end of TB treatment, 100% of TB patients are expected to know their HIV status.

If the case finding sheet is submitted with clients not yet tested during conversion they are expected to be tested during the outcome



period. This poses a challenge for data management because updating of that data in the ETR.net in most cases is not done.

- All TB hospitals are providing ART. All the TB hospitals have been accredited as ART sites and this has assisted in strengthening integration of HIV into TB services. TB/HIV co-infected patients are treated under one roof rather than being referred to another facility for initiation of ART. More than 50% of TB patients are HIV co-infected.

Community-based interventions

- Introduction of community-based care of MDR/XDR TB services resulted in an increase in the number of patients started on treatment.

Challenges limiting service delivery

- Some doctors diagnose TB patients by chest x-ray which affects the case detection rate.
- TB and co-infected HIV patients who are unable to produce sputum leads to low smear conversion rates.
- High mobility of TB clients results in a high defaulter rate which further affects the cure rate
- Failure of some client to respond to TB treatment indicating a rise in MDR TB
- Drug stock-outs from depot
- Shortage of MDR-TB beds results in a large number of patients (233) on waiting lists especially those served by Fort Grey TB hospital. The programme has started implementing the Community-Based Model for the management of MDR-TB to address the long wait lists.

Table DHS 2.8: Performance Against Provincial Targets from 2010/11 - 2012/13 Annual Performance Plan for TB Control

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
To reduce Mortality and Morbidity due to TB	Percentage of new smear positive TB cases detected	57.6%	57.1%	65% (28 075)	56.8%	Most patients are co-infected and present with smear negative; these are put on treatment by culture positive.
	TB smear conversion rate	58%	68%	61%	54.0%	Many of the clients are unable to produce sputa. Districts are in the process of procuring nebulizers to obtain sputa from dry TB clients.
	TB cure rate	58.50%	60%	65%	66%	Target achieved
	TB defaulter rate	7%	7.10%	5%	7.80%	Target could not be achieved due to high mobility of clients, cross border issues and wrong addresses given by clients.
To achieve 100% integration of TB and HIV/AIDS Program	Percentage of TB patients screened for HIV	78%	70.60%	90%	81%	Data is not updated when some clients test at a later stage of their treatment. In addition, the data has been affected by the transmission from paper-based system to ETR.net.

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	Number of TB hospitals accredited as ART sites	4	5	1	1	Nkqubela TB Hospital
	Percentage of co-infected clients started on CPT (cotrimoxazole prophylaxis therapy)	97%	98%	98%	78.5%	Data is not updated when some clients test at a later stage of their treatment. In addition, the data has been affected by the transmission from the paper-based system to ETR.net.
To facilitate the reduction of MDR and XDR TB incidence by 50% in 2014.	Number of MDR cases	1.30%	2.00%	2% decrease	1 311	The use of the new diagnostic tool (line probe assay) is picking up high numbers of MDR cases. The implementation of MDR-TB community treatment and management is assisting in reducing the number of MDR-TB cases
	Number of XDR cases	0.20%	1.20%	1.1% decrease	289	

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	% of confirmed MDR TB patients started on treatment	96.9%	95.8%	100%	75%	Target could not be achieved due to high mobility of clients, cross border issues and wrong addresses given by clients. Treatment of some clients is initiated elsewhere e.g. by GPs or some are transfers from other provinces. Other clients die before treatment is initiated.
	% of confirmed XDR TB patients started on treatment	100%	82%	100%	patients out of 56)	

2.8 MCWH AND INTEGRATED NUTRITION:

Purpose

To ensure delivery of a comprehensive PHC package for women and children through maternal and child health care service and an integrated nutrition programme in order to reduce infant and maternal morbidity and mortality rate.

Strategic Objectives

- To facilitate the 85% achievement of the Integrated Management of Childhood Illnesses (IMCI) coverage.
- To facilitate the 80% achievement of Vitamin A coverage for 12-59 months old and postpartum coverage.
- To facilitate the achievement of reduction of malnutrition, reduce stunting rate by 5%, underweight by 0.2% and case fatality rate by 12%.
- To facilitate the 95% achievement of immunisation coverage and implementation of the Reach Every District (RED) strategy.
- To facilitate the 95% implementation of the National Committee for the Confidential Enquiries on Maternal Death (NCCEMD).
- To facilitate a 10% reduction in severe maternal and neonatal morbidity.
- To facilitate the reduction of maternal mortality to 36 per 100 000 population.

Program Description

This program is made of two sub-programmes:

- Integrated Nutrition Programme (INP) and
- Maternal Child and Women's Health (MCWH)

2.8.1 Integrated Nutrition Programme

Programme Priorities

- Reduction of morbidity and mortality rates due to severe malnutrition in hospitalized children from 30% to 10%.
- To continue to ensure provision of 100% food supplementation for people living with TB, HIV and AIDS.
- Increasing the number of health facilities with maternity beds awarded a baby-friendly status by 4 every year.
- Routine Vitamin A supplementation of children less than 5yrs presenting at PHC facilities to 100%.
- Incorporation of nutrition activities into the Integrated Food Security and Nutrition projects in Integrated Sustainable Rural Development Nodal Sites through intersectoral collaboration especially at provincial level.
- To conduct crèches outreach services to improve Vitamin A supplementation for 12-59 month old children.
- Contribute to household food security through establishment of clinic and hospital gardens and provision of food parcels.

Service delivery achievements:

Baby friendly hospital initiative

The baby friendly hospital initiative (BFHI) is one of the key strategies to improve child survival. It is implemented in institutions that perform deliveries to promote, protect and support safe infant feeding practices. Formerly accredited facilities are re-assessed every three years. In the year under review five new facilities were assessed for BFHI by the external assessors and four of these facilities passed. The total number of BFHI accredited facilities in the province is 38.

Table 2.9 showing number of facilities accredited as BFHI by districts

Districts	Number of facilities
Alfred Nzo	2
Amathole	14
Cacadu	5
Chris Hani	5
Nelson Mandela Metro	1
OR Tambo	9
Joe Gqabi	2
Province	38

Vitamin A and food supplementation

The vitamin A supplementation programme is implemented to protect immunity, prevent blindness and reduce the risk of children dying from common childhood illnesses. Significant progress has been made since the inception of this programme and the province has now managed to reach a coverage of over 94.5% of infants less than one year of age. Vitamin A supplementation for new mothers has increased significantly from 36.7% in 2009/10 financial year to 78.6% in the year under review due to improvement in reporting of this indicator by hospitals. However, vitamin A supplementation coverage in children 12 to 59 months is very low and in 2010/11 was at 36.6%. This is because mothers often fail to take children of this age group to clinics. To improve on this situation, the programme started outreach services to crèches and in the year under review, 30 crèches per sub-district were reached.

The programme also provided food supplements to 66,030 clients on the ART programme, 75,109 clients living with HIV and 4,994 clients who are on TB treatment.

Nutritional status of children under five years

Routine growth monitoring and promotion is done in health facilities in the province. The road-to-health chart (RTHC) is used as the primary tool to assess the growth of children. Children's growth is evaluated in terms of underweight, severe underweight and those not

gaining weight. The weighing rate for children under five in Eastern Cape is 83.3% and the prevalence of those not gaining weight is 0.8%; 0.4% are underweight. The incidence rate for severe malnutrition is at 5.5 per 1000 children under five years. Out of 2,315 children who were admitted in hospital for severe malnutrition, 498 (21.5%) died. The districts with high severe malnutrition case fatality rates are OR Tambo (28.3%) followed by Joe Gqabi (27%) and Amathole (20.6%). The district with the lowest case fatality rate is Cacadu with 6.3%.

Appropriate interventions for example, provision of food supplementation and establishment of vegetable gardens, have been established in 24 clinics and 10 hospitals. Increasing efforts are made to establish links with community-based services through child friendly villages, as well as other sectors and government departments to manage children who are malnourished. A total of 11,077 malnourished and at risk children were given food supplements. All hospitals with paediatric wards are implementing the national guidelines on the 10 steps in management of severe malnutrition. Growth monitoring and health promotion practices are being improved through continuous training of nurses as well.

Integrated Food Security & Integrated Sustainable Rural Development Plan (ISRDP) Site project

The nutrition programme is establishing clinic and hospital vegetable gardens to benefit local

communities with fresh produce. Vegetable gardens are also established in the community health posts to demonstrate nutritional value of subsistence farming and to assist mothers with malnourished children.

Challenges limiting service delivery

Although there is gradual improvement in Vitamin A supplementation in the age-group 12-59 months there is still a challenge around mothers not bringing their children to facilities. To improve the coverage, several mop up campaigns have been conducted. Furthermore, the INP unit in collaboration with Health Promotion will be embarking on an awareness campaign.

2.8.1 Maternal, Child and Women's Health

Purpose

To ensure implementation of national and provincial MCWH policies related to the delivery of comprehensive PHC services in clinics, community health centres and mobile clinics for women and children so as to improve maternal & child healthcare services and reduce maternal, neonatal, infant and child mortality and morbidity.

Programme Description

The MCWH programme has three (3) key components which are

1. Maternal Health
2. Child Health
 - Expanded Programme on Immunisation (EPI)
 - Integrated Management of Childhood Illnesses (IMCI)
 - School Health Services
 - Child Healthcare Problem Identification Programme (CHPIP)
3. Women's Health
 - Cervical Cancer Screening
 - Choice of Termination of Pregnancy (CTOP)
 - Youth Friendly Services
 - Contraceptive Services

Programme Priorities

- Increase the number of fixed PHC facilities implementing IMCI
- Expansion of Community IMCI implementation to all Urban Renewal Nodes
- Reduction of teenage pregnancy
- Improve access to cervical cancer screening services
- Improve immunisation coverage

Service delivery achievements:

Maternal, child and women's health is a worldwide priority entrenched in the Millennium Development Goals (MDGs) and countries are required to improve maternal and child health services in order to reduce maternal and child mortality and morbidity.

Child Health

To reduce the burden of disease in children under five years, the Eastern Cape focused on two intervention strategies. The strategies included Integrated Management of Childhood Illnesses (IMCI) and the Expanded Programme on Immunisation (EPI).

Integrated Management of Childhood Illnesses (IMCI)

The main objective of IMCI is to reduce mortality and morbidity associated with the major causes of childhood illness which include acute respiratory infections, diarrhoeal diseases, measles, malnutrition and HIV/AIDS. The initial focus is to improve care at first-level health facilities where the majority of children present with one or more of the major causes of illness and death. IMCI has a three pronged approach:

- Improving case management skills of healthcare staff
- Improving overall health systems
- Improving family and community health practices

Since its introduction in Eastern Cape in 1999, a total of 730 PHC facilities are implementing IMCI and 452 of these facilities have 60% of professional nurses trained on IMCI. During the year under review, about 1,389 professional nurses were trained on IMCI case management including nurses from paediatric wards.

Community health workers, traditional health practitioners and traditional leaders from urban and rural nodes were trained in the community component of IMCI. They were trained on signs and symptoms of dehydration, respiratory tract infection, how to monitor the RTHC in order to identify children who have missed their immunisations and or are under weight. Their role is to assist the programme by identifying children with childhood illnesses for early referral to the health facilities. They also assist in the tracing of immunisation defaulters as well as advising mothers on how to prepare oral rehydration solutions when their children are having diarrhoea. The initiative has resulted in good collaboration between health professionals working at the PHC level and traditional health practitioners.

Expanded Programme on Immunisation (EPI)

In 2008, two new vaccines, pneumococcal and rotavirus vaccines which address pneumonia meningitis, bacteraemia and diarrhoea, were introduced for the first time into the EPI programme. The new vaccines were launched and piloted in Joe Gqabi District in 2008.

A steady increase in the percentage of children less than one year fully immunized had been observed in previous years; however, by the end of the financial year under review there has been a decrease from 90.6% in 2009/10 to 82.5%. This has been due to vaccine stock-outs in pharmaceutical depots and facilities, especially for the new vaccines. The most affected district is Alfred Nzo with immunisation coverage of only 50%. Out of the seven districts only Amathole and Chris Hani achieved coverage above 80%. Measles coverage for the year under review is 90.8% which is below the set provincial coverage of 93%; nonetheless, this output is within the national target of 90%.

Despite the stock-out challenges with the vaccines, rotavirus 2nd dose coverage has increased by 4.3% in the year under review from 35.2% in 2009/10 to 39.5% and PCV 3 coverage remained at 38.3%. Considering the fact that the Eastern Cape Province was the first province to introduce these new vaccines, it is evident that the provincial performance in this regard is less than what would be expected and therefore strengthening of Reach Every

District (RED) strategy and ensuring vaccine stock availability at all times is crucial.

Women's health

The strategies to improve women's health include strengthening of ANC, cervical cancer screening, reduction of teenage pregnancy and improvement of access to CTOP for those in need of these services.

Women year protection rate

The provincial target for women year protection is 30% and the Eastern Cape managed to reach the set target in the year under review, with Nelson Mandela Metro having reached 45.3% followed by Cacadu and Joe Gqabi equally achieving 37.5%. Revival of family planning is crucial especially emergency contraceptives and promotion of the intrauterine cervical device as it has been found to be effective with fewer side effects compared to other methods of contraception. There is an increase in the number of clients opting for insertion of an IUD and a total of 1,171 clients have been reached.

Cervical cancer screening

Cervical cancer is one of the few preventable cancers among women. The national cervical cancer screening policy set a target of 70% of women above 30 years attending public health facilities to be screened over a period of 10 years in order to reduce cervical cancer by two-thirds. The Eastern Cape target for 2010/11 was 35% and the provincial average was 37%. Chris Hani District achieved 57.4% followed by Joe Gqabi District (41.2%). OR Tambo District was the lowest with 20.7%.

To improve cervical screening coverage, the MCWH Directorate has approached National Health Laboratory Services (NHLS) to assist in training nurses on how best to collect pap smears and to provide equipment. A total of 179 nurses were trained by NHLS.

Antenatal care services

One of the key priorities for the National Committee for the Confidential Enquiries on Maternal Death (NCCEMD) is community empowerment and involvement on



programmes aimed at improving maternal and neonatal health as well as reproductive health in general. Through active participation of the communities, the province achieved 95.3% ANC coverage which is above the set target of 90%. However, the EC province is challenged with cultural beliefs that result in pregnant women attending ANC late; as a result the ANC visit rate before 20 weeks is 31.3% which is below the set target of 40%. There is a need to embark on awareness campaigns and educate women on the importance and benefits of early booking.

Teenage pregnancy

Delivery rate in facilities for young women under 18 years is steady at 10.4%. Teenage pregnancy rate is high in OR Tambo and Alfred Nzo Districts, with both districts equally at 12.9% followed by Joe Gqabi district at 11.5%. The ECDOH has entered into an agreement with two NGOs, Path Finder and Love Life to strengthen Youth Friendly Services (YFS). The number of PHC facilities accredited as YFS have

increase from 30 in 2008/09 to 55 in 2010/11. Through this initiative, fast lane services for family planning have been put in place whereby youths who are in need of family planning do not wait for a long time and instead are attended to immediately. The ECDOH has started negotiations with the Department of Education to have family planning as part of school health services.

Challenges limiting service delivery

- Vaccine stock-out which can compromise the gains already achieved and is linked to delays in payment by the Department. ECDOH needs to pay pharmaceutical companies on time in order to get all the ordered supplies timeously.
- Equipment: some facilities still use small domestic fridges forcing them to order small quantities of vaccine. This can contribute to outbreaks.
- Poor family planning services result in many teenagers using CTOP as a method of contraception.

Table 2.10: Performance Against Provincial Targets from 2010/11 - 2012/13 Annual Performance Plan for MCWH and INP

Indicator	Type	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between annual target and actual output
Immunisation coverage under 1 year	%	83.4%	90.6%	90%	78%	This is affected by the new vaccine stock out
Vit A coverage under 1 year	%	91%	93.1%	90%	93.3%	Target achieved
Vit A coverage for new mothers	%	41%	50.9%	60%	80.1%	Mop-up campaigns were conducted targeting poor performing sub-districts
Measles coverage under 1 year	%	87%	93.9%	93%	87.8%	Vaccine stock-out in Umthatha depot contributed to under performance
Pneumococcal Vaccine (PCV) 3rd Dose Coverage	%	4.2	38.5%	40%	41.9%	Target achieved
Rotavirus (RV) 2nd Dose Coverage	%	2.8	35.2%	40%	40.7%	Target achieved
Cervical cancer screening coverage	%	2.1	2.8%	35%	36.1%	Target achieved

Table 2.11: Performance Against Provincial Targets from 2010/11-2012/2013 Annual Performance Plan for MCWH and INP

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
2.8.1 Integrated Nutrition Programme						
To facilitate the achievement of reduction of malnutrition by 5% of stunting rate, 0,2% underweight and 12% case fatality rate	% of underweight children	0.5%	0.4%	0.4%	0.4%	Target achieved
	Case fatality rate under 1yr	Not measured	Not measured	15%	9.4%	Target achieved
To facilitate 80% achievement of Vit A coverage for under 5 and postpartum women	% of Vit A coverage 0-5 months	Not measured	Not measured	49%	28.1%	Provision of Vit A to babies 0-5 months is being phased out because research has proven that there is no benefit when compared to those not given
	% of Vit A coverage 6-	29%		90%	93.3%	Target achieved
	% of Vit A coverage 12-59 months	31.3%	36.7%	57%	36.4%	Mother do not bring their babies to clinic especial after first year birthday, they bring them only when they are sick, hence low Vit A coverage in this age group.

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	% of Vit A coverage new mothers	31.3%	36.7%	60%	80.1%	Target achieved
To increase advocacy, literacy and communication to women of child bearing age to improve exclusive breastfeeding to 21%	% of children exclusively breastfed	41%	50.9%	17%	17%	Target achieved
	Number of awareness campaigns on complementary feeding	Not measured	Not measured	4	3	Activity not done in 4th quarter due to unavailability of funds
	% of infants 0-6 months exclusively formula fed given formula	Not measured	Not measured	20%	20%	Target achieved
To improve socio-economic status and dietary consumption through establishing clinic & hospital vegetable gardens, and agric-health coops	Number of clinics and hospitals with vegetables gardens	64	34	5 hospitals 48 clinics	5 hospitals 48 clinics	Target achieved
	Number of campaigns on healthy eating habits conducted	28	58	4	3	Activity not done in 4th quarter due to unavailability of funds
To ensure 95% achievement of supplementary feeding.	Number of HIV positive clients supplemented	Not measured	Not measured	75 000	75 109	Target achieved
	Number of ART clients supplemented	21 446	8 000	80 000	66 030	Target not achieved. There is still a problem of correct reporting but it is improving compared to the past years

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	Number of TB clients supplemented	16 679	8 000	50 000	4 994	This indicator is not collected properly as it was left out in the collecting tool. This has been corrected now
To achieve 100% food service management through assessment of food service unit and 60% rendering dietetic services	Number of clients reached for soup and bread	207 435	361 186	10 177	3 392	The project was stopped end of August 2010.
	% of hospitals qualifying in rendering quality food service	Not measured	Not measured	50%	50%	Target achieved
	% hospitals rendering dietetic services	Not measured	Not measured	30%	30%	Target achieved
2.8.2 Mother, Child, Women and Health Programme						
To ensure 85% IMCI coverage.	Number of facilities implementing IMCI	711	728	600	730	Set target below the already existing number of facilities implementing IMCI
	Number of facilities with 60% of professional nurses trained on IMCI	377	25	50	50	50 new facilities reached 60% IMCI saturation, increasing total number of facilities with 60% saturation to 452.
	Number of sub-districts implementing CIMCI	24	24	24	24	Target achieved

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
To strengthen implementation of CHIPP	Number of additional hospitals implementing CHIPP	50	50	45	17	Shortage of clinicians a challenge, managed to establish paediatric teams only in 17 hospitals. Plan is to train nurses in paediatric wards.
To ensure 95% immunization coverage through implementation of RED strategy	% of fully immunised children	83.40%	90.6%	90%	78%	Target not achieved due to vaccine stock out, especially the new vaccines. Most affected districts are those serviced by Umthatha depot.
	% of under 1 year measles coverage	87%	93.9%	93%	87.8%	Affected by vaccine stock-out, however it is within the national target of 90%
	% of OPV 3 coverage		85.30%	94%	17.3%	OPV 3 no longer given since the introduction of the combination vaccine pentaxim (DTaP-IPV/Hib)
	% of Rotavirus 2nd dose coverage	2.8	35.2%	40%	40.7%	Target achieved
	% of PCV 3rd dose coverage	4.2	38.5%	40%	41.9%	Target achieved

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
To strengthen provision of school health services	Number of sub-districts rendering school health services	24 sub-districts (637 schools)	24 sub-districts (214 schools)	24 sub-districts	24 sub-districts (836 schools)	Number of schools increased when compared to previous year as the service was moved to health promotion in 2009/10.
	Number of sub-districts with staff trained on RED strategy	20	23	24	24	Target achieved
To improve health of women through implementation of reproductive health and cancer screening	% of women year protection rate	26.8%	28.7%	30%	30.3%	Target achieved
	% of women screened for cervical cancer	31%	36%	35%	36.1%	Target achieved
To reduce youth and adolescent morbidity and mortality	Number of facilities newly accredited as youth services.	30	35	55	55	Target achieved
	Number of facilities designated for CTOP	31	19	55	45	Some professionals who have been trained have moved to other area of work and some could not practice due to their religious beliefs
To ensure reduction of maternal and perinatal morbidity and mortality.	% of deliveries in under 18 years	10%	10.5%	<10%	10.5%	Ever since devolution of school health services there have been a decrease in women year protection rate

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	% of women attending ANC services before 20 weeks	28.2%	31.1%	40%	31.7%	Few women attend ANC due to cultural beliefs.
	% ANC coverage	87.3%	93.6%	90%	93.7%	Target achieved
	% health facilities rendering postnatal care services	Not measured	Not measured	100%	100%	Target achieved
	% of facilities implementing BANC	Not measured	Not measured	100%	100%	Target achieved
	Maternal Mortality Ratio (per 100 000 live births)	172	202	158	142	Whilst the outcome is still high, it is both below the set target and the previous 6 years' outcomes and this is encouraging.
	Perinatal Mortality Ratio per 1000 live births	2.4	3.3	10	37	High rate of macerated stillbirths which is indicative of infection and HIV contributed to high perinatal mortality. Furthermore misoprostol drug which is sold over the counter for abortion results in women aborting viable fetuses which is counted as stillbirth.

2.8.2 Saving Mothers Saving Babies Project

Purpose

The project is a turnaround strategy to reduce maternal and perinatal morbidity and mortality through provision of better services to mothers and their infants. The project is designed to raise the level of professionalism among local midwives.

Project Objective

- To build capacity of all personnel working in maternity.
- To establish partnerships with other institutions and stakeholders.
- To support local health clinics through provision of equipment and training of midwives.
- To develop systems to enable all facilities to function using computerized systems.
- To develop staffing norms and implement staff to patient ratios in all maternities to improve maternal and neonatal outcomes.

Programme Priorities

- To develop protocols and train nurses on management of important conditions causing maternal deaths.
- Educate pregnant women on screening and appropriate management of communicable and non-communicable diseases.
- Establish criteria for referrals and referral routes.
- Ensure that emergency transport for pregnant women with complications is readily available at the sites.
- Establish staff and equipment norms for all levels of care concerned with pregnant women and their babies.
- Ensure availability of blood transfusion services in all facilities performing caesarean sections.
- Promote use of contraceptives through education and service provision.
- Ensure correct use of partogram by all facilities conducting deliveries.
- Improve skills on anaesthesia at all levels of care.
- Empower and ensure active participation of women, families and communities in programs aimed at improving maternal and neonatal health as well as reproductive health generally.

Service delivery achievements:

Training of health professionals

In order to improve the skill and competency in both prevention and management of obstetric complications and reduce maternal and neonatal deaths, a total of 303 health professionals (doctors and midwives) within the province were trained on various programs including:

- Essential Steps in the Management of Obstetric Emergency (ESMOE) and anaesthesia
- Basic Antenatal Care services (BANC)
- Contraception with more focus on emergency contraceptive and intrauterine cervical device (IUCD)

A total of 136 midwives and doctors were trained on ESMOE and anaesthesia to improve their competency in prevention and management of complicated deliveries. The target group for capacity building on anaesthesia was doctors, especially those working in district hospitals. About 76 health professionals of those trained on ESMOE were also trained in IUCD insertion and cervical cancer screening, and 16 of them were trained on the insertion of IUCD only. Incorporation of pap smear collection and insertion of IUCDs in ESMOE trainings has resulted in the increase of cervical cancer screening to 36.1% in 2010/11 financial year. Approximately 76 midwives were trained on BANC.

To improve family planning coverage and prevent unwanted pregnancies, a total of 91 professional nurses were trained on contraceptives. Furthermore, clients who have terminated pregnancies were screened for cervical cancer and educated on the use of IUCDs.

Empowerment of women, families, and communities

Twenty eight awareness campaigns were conducted with the involvement and active participation of members of the communities; this has contributed toward early booking which has helped to pick up HIV positive clients and ensure provision of AZT as early as 14 weeks. A significant overall reduction of maternal mortality ratio in the province from 202/100 00 in 2009/10 financial year to 142/

100 000 in the year under review, is a good indication of expected results of empowering women together with their families. Furthermore, active participation and empowerment of women and families has resulted in an increase in the percentage of pregnant women attending ANC before 20 weeks in four of the seven districts namely NMMM, Chris Hani, Cacadu and Joe Gqabi whilst the overall provincial rate has not changed significantly (i.e. 31.7% during the financial year under review compared to 31% in the previous year). Greater effort needs to be focused on OR Tambo, Amathole and Alfred Nzo Districts. The effectiveness of this initiative coupled with other interventions still has to translate into a reduction of perinatal mortality.

Auditing of maternal deaths

The provincial confidential enquiry into maternal death committees have been set to investigate all maternal deaths. The committee gathers information on the main causes of maternal deaths as well as factors related or contributing to these deaths. The results of these enquiries and recommendations made, where these are implemented appropriately, have resulted in the improvement of quality of care in health facilities where deliveries are conducted. Maternal Mortality Ratio (MMR), which is the number of maternal deaths for every 100,000 live births in the Eastern Cape province has decreased from 202 per 100 000 in 2009 to 147 per 100 000 live births in 2010; this figure was last recorded in 2003. In addition, there has been an increase in the number of HIV infected pregnant women who had access to the PMTCT program with 23 489 HIV positive pregnant women initiated on AZT and a Nevirapine uptake rate of 59.8%.

Nevirapine uptake rate among newborn babies is at 98.5%; this coupled with the uptake by HIV positive mothers has resulted in only 6.7% of babies born to these mothers having positive PCR results compared 8.6% in the previous year; the highest prevalence of 8.7% was recorded at Amathole district.

Challenges limiting service delivery

- A lack of transportation for women during labour from home to hospital or from the referral health facility is the main contributory factor to maternal and neonatal deaths.
- Limited budget impacted negatively on the establishment of halfway stations for high risk clients especially those from hard to reach rural areas. Staffing in maternities not in line with the National or World Health Organisation (WHO) guideline and this compromise the quality of care rendered.
- Need to strengthen clinical audit committees in health facilities in order to learn lessons and understand trends and patterns in adverse events occurring in facilities.
- High rate of stillbirths, especially macerated stillbirth which is indicative of HIV. Furthermore selling of misoprostol drug (which is used for abortion) over the counter results in women aborting viable fetuses which is counted as a stillbirth; however, revival of family planning (emergency contraceptive and promotion of IUCD) can help to prevent unwanted pregnancies. AEnsuring access to CTOP to those who opt for it will result in the reduction of perinatal deaths.

Table 2.12: Performance Against Provincial Targets from 2009/10-2011/2012 Annual Performance Plan for SMSB

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
To ensure training for health professionals working in maternity units in anaesthesia & ESMOE	Number of doctors and midwives trained in anaesthesia, ESMOE and BANC	9 (3 health professionals trained in 3 districts)	15 (5 health professionals trained in 3 districts)	210 health professionals	212 health professionals	Target achieved
Ensure availability of VDRL onsite test kits in all districts	Number of sub-districts with VDRL onsite test kits	24 Sub-districts	24 sub-districts	24 sub-districts	24 sub-districts	Target achieved
Establish new halfway stations in rural areas	Number of new halfway stations	Not measured	4	4	1	Only 1 new half way station established in this financial year due to financial constraints
Strengthening of postnatal care services	% of women seen at 6days post delivery	Not measured	Not measured	60%	17%	Under reporting is a challenge as this is a new indicator; health care provider sensitisation on new indicators and improvement is expected in the next financial year.
To ensure availability of blood for transfusion at every institution where caesarean sections are performed	Number of institutions having emergency blood available and blood transfusion committees	50%	100% (52 institutions)	52	52	Target achieved

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
To ensure that contraceptive use be promoted through education and service provision	Number of health professionals trained on contraceptives/ women protection	Not measured	Not measured	60 health professionals to be trained in 4 Districts	91 health professionals trained	Target achieved. Incorporation of IUCD in ESMOE training has resulted in more professional nurses being trained on contraceptive. This has expanded to all the 7 districts.
To empower women, families, and communities at large to be involved & participate actively in projects aiming at improving maternal outcomes	Number of awareness campaigns conducted	Not measured	Not measured	34	28	Campaigns not conducted as planned due to financial constraints

2.9 District Hospitals

Purpose

The purpose of the district hospital sub-programme is to provide comprehensive, integrated and quality district hospital services to the people of the Eastern Cape Province.

Strategic Objectives

- To improve and strengthen the quality of District Hospital Services

Programme Objectives

- To provide comprehensive and quality district hospital services.
- To facilitate the provision of strategic leadership and creation of the social compact for better health by strengthening governance structures.
- To monitor and report on efficiency indicators, and give appropriate support so as to achieve the National targets.
- To implement the hospital improvement plan as a quality issue.

Sub-programme Priorities

- Implementation of the district health package.
- Improve the quality of health services in district hospitals through formulation of policies and protocols.
- Improve the quality of care through implementation of Infection Control, Norms and Standards, Clinical Governance, reviewed Standard Operative Procedures as well as providing the necessary support to the provincial Quality Assurance programme.
- Ensure and facilitate the provision of rationalized health care services within the district hospital clusters; this will include the review of district hospital clusters, and the status quo of provincially-aided hospitals (PAHs) with the aim of provincializing them.
- Enhancing effective governance and accountability within district hospitals.
- Implement relevant hospital improvement plans that will impact on health outcomes (clinical services, & infrastructure modifications).
- To implement an integrated TB/HIV programme including infection control, mechanical ventilation, training and capacity building.

- Facilitate down referral of patients with chronic diseases.
- Strengthening and maintaining security services.
- Ensuring availability of drugs at all times.
- Strengthening the implementation of the Mental Health Care Act [72 hour assessment].

Service delivery achievements:

Readiness for 2010 FIFA World Cup

District hospitals were prepared for medical emergency readiness for the 2010 World Cup. Five hospitals, Cofimvaba, Taylor Bequest [Matatiele], Settlers, Holy Cross and Lady Grey, were prepared to support the Public Viewing Areas [PVA's] so that any emergencies occurring during the World Cup could be dealt with timeously. Other hospitals situated along the routes to the stadium in Port Elizabeth and to the PVAs were also prepared to deal with medical emergencies i.e. Aliwal North, St. Patrick's, Greenville, Madzikane kaZulu, Butterworth, Grey, Nompumelelo, and Port Alfred. Preparations done amongst others were:-

- Ensuring maximum staff complement during the World Cup period.
- All necessary equipment available, fully functional and for medical emergencies.
- All staff were trained on disaster management, including undergoing disaster drills.

Operation Smile

Madzikane kaZulu Memorial Hospital was used as a provincial centre for screening of 55 clients and for operating on 21 patients with cleft lips and palates by Operation Smile, an independent international organization. Operation Smile also trained 48 health professionals on Basic Life Skills from All Saints, St. Barnabas and Madzikane kaZulu Memorial hospitals.

Revival of hospital boards

Hospitals with dysfunctional hospital boards were identified and supported to elect and train new members in line with the new hospital board policy. There were six hospitals including Hewu, Madwaleni, Stutterheim, Madzikane kaZulu, Mt Ayliff and Dr Maliza Mpehle Hospital.

Provincialisation of Provincially-Aided Hospitals (PAHs)

Administration of 12 Provincially-Aided Hospitals (PAHs) was officially taken over by the Department of Health. Signing of the Transfer Agreements by all relevant stakeholders and absorption of employees in terms of Section 197 of the Labour Relations Act was done successfully for the following hospitals: (NB 5 PAH were taken over with effect from 1st of April 2011 namely Sawas, Maritjie Venter, Sterkstroom, Adelaide and Molteno.)

Table 2.13: List of PAHs that were provincialised by district

Amathole	Cacadu	Chris Hani	Joe Gqabi
Komga	Aberdeen	Dordrecht	Jamestown
Stutterheim	Willowmore	Indwe	St Francis
	BJ Vorster		Maclear
	Sunday's Valley		Lady Grey

Quality improvement

Implementation of the six priority areas for improvement of quality of care in the targeted hospitals has been achieved during the period under review. Table 2.13 below shows the 23 hospitals that received new linens for the improvement of services.

Table 2.14 Hospitals that received new linens by district, 2010/11

Amathole	Chris Hani	OR Tambo	Alfred Nzo
Tafalofefe	Cofimvaba	Holy Cross	Madzikane kaZulu
Victoria	All Saints	St Patrick's	Mt Ayliff
Madwaleni	Mjanyana	Isilimela	Taylor Bequest
Grey	Cala	Greenville	
Butterworth	Glen Grey	Canzibe	
Bhisho		Siphetu	
		St Lucy's	
		Nessie Knight	
		Zitulele	



Mental health care

There has been an increase in the number of district hospitals that comply with the Mental Health Act and are rendering 72 hour mental health services, from 21 in the previous year to 24 at the end of the year under review. The referral pathway from the district hospitals is either to tertiary hospitals or Fort England in Grahamstown.

Challenges limiting service delivery

- Lack of equipment and capacity makes it difficult for some district hospitals to implement the full service package e.g.

Equipment for dental services, tracheostomy, X-ray services and tendon repairs.

- Poor monitoring and management of pregnant women leading to more caesarean sections being performed to save the lives of both the mother and the child; however, training in obstetrics and child care is being intensified.
- There are no temporary seclusion rooms for psychotic/ aggressive patients in all the district hospitals. This issue is being attended to with infrastructure.

Table 2.15: Efficiency Indicators for District Hospitals

Indicator	Type	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between annual target and actual output
Efficiency Indicators						
Caesarean section rate	%	11	13.2	12	12.5%	Target achieved
Total separations	No.	246,432	288,278	303,846	294,618	Output within target range
Patient Day Equivalents	No.	1,948,753	1,951,204	3,655,380	1,878,517	There are additional sub-districts that are strengthening PHC services thus resulting in less admissions than targeted e.g. Lukhanji, Nyandeni
Total OPD Headcount	No.	894,020	1,023,848	1,157,994	973,806	There are additional sub-districts that are strengthening PHC services thus resulting in less patients/clients visiting OPD's
Average length of stay (ALOS)	Days	5.8	5.2	4.5	5.0	Output within target range
Bed utilisation rate (BUR - based on usable beds)	%	63	69.3	72	65.5	This reflects success of revitalised PHC services
Expenditure per patient day equivalent (PDE)	R	948	920	1,150	1,128	

Table 2.16: Performance Against Provincial Targets from 2010/11-2012/2013 Annual Performance Plan for District Hospitals

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
To facilitate the provision of strategic leadership and the creation of Social Compact for better health outcomes.	Number of hospitals with trained hospital boards	25	29	39	23	An extension of term of office was approved for 16 hospitals and will re-elect their boards in the next financial year.
	Number of hospitals with board meeting at least once a month	25	29	39	39	Target achieved
To implement quality improvement plans in 35 district hospitals	Number of district hospitals implementing District Hospital Health Package.	25	21	25	25	Target achieved
	Number of district hospitals implementing the prioritised 6 Core Standards	11	21	19	19	Target achieved
	Number of district hospitals implementing Quality Improvement Plans (QIPs)	25	6	19	19	Target achieved
	Number of district hospitals that have fully established & are providing 72 hour mental health care	12	28	28	28	Target achieved

Objective	Performance indicator	Actual Output 2008/09	Actual Output 2009/10	Annual Target 2010/11	Actual Output 2010/11	Explanation of variance between planned annual target and actual output
	Number of Provincially-Aided Hospitals receiving transfer payments on time	18	18	17	7	10 PAHs had been provincialized. The remaining 7 were provincialised at the end of March 2011.
	Number of progress reports provided regarding the utilisation of the transfer payments to PAH	Not measured	Not measured	4 per PAH	4 per PAH (x 17 PAHs)	Target achieved