PART A

1. DEPARTMENT GENERAL INFORMATION

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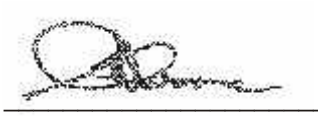
GENERAL INFORMATION

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 2012-31 March 2013 in compliance with section 40(1)(d) of the Public Financial Management Act.



Mr. M.D. Qwase
Acting Accounting Officer: Department of Health
31 August 2013

CONTENTS

PART A: GENERAL INFORMATION

PART B: PERFORMANCE INFORMATION

5. PERFORMANCE INFORMATION BY PROGRAMME

6. SUMMARY OF FINANCIAL INFORMATION

PART C: GOVERNANCE

PART D: HUMAN RESOURCE MANAGEMENT

PART E: FINANCIAL INFORMATION

2. LIST OF ACRONYMS

AEA	Ambulance Emergency Assistance
AIDS	Acquired Immune Deficiency Syndrome
AFCON	Africa Cup of Nations
ALOS	Average Length of Stay
ALS	Advanced Life Support
ANC	Antenatal Care
ANZO	Alfred Nzo District
ART	Antiretroviral Therapy
AY	Annual Year
B Cur	Baccalaureus Curationis
BCM	Buffalo City Metropolitan
BAA	Basic Ambulance Assistant
BAS	Basic Accounting Services
BMI	Body Mass Index
BP	Blood pressure
BUR	Bed Utilisation Rate
C Hani	Chris Hani District
CA	Clinical Associate
CAATS	Computer Assisted Auditing Techniques
CBO	Community-based Organisation
CCA	Critical Care Assistant
CHC	Community Health Centre
CHW	Community Healthcare Worker
CMH	Cecilia Makiwane Hospital
CMR	Child Mortality Rate
CoE	Compensation of Employees
Comm-servs	Community Service
CPD	Continuous Professional Development
CPT	Cotrimoxazole Prophylaxis Therapy
CRM	Customer Relations Monitoring
CS	Caesarean Section
CS&OP	Corporate Strategy & Organisational Performance
CTOP	Choice on Termination of Pregnancy
DCH(SA)	Diploma in Child Health (South Africa)
DDG	Deputy Director General
DHC	District Health Council
DHIS	District Health Information System
DHS	District Health Services
DNH	Dora Nginza Hospital
DM	District Municipality
DOH	Department of Health
DoT	Department of Transport
DPSA	Department of Public Service and Administration
DUT	Durban University of Technology
EC	Eastern Cape
ECDoH	Eastern Cape Department of Health
ECIPA	Eastern Cape independent Practitioner Association
ECP	Emergency Care Practitioner
ECSECC	Eastern Cape Socio Economic Consultative Council
ECT	Emergency Care Technician
EDH	Elizabeth Donken Hospital
EHP	Environmental Health Practitioner
EL	East London
ELCB	Eastern Cape Chamber of Business
EMP	Environmental Management Plan
EMS	Emergency Medical Services
EMRS	Emergency Medical Rescue Services
EN	Enrolled Nurse
ENA	Enrolled Nursing Assistant
ENACHP	Enrolled Nursing Assistants Community Health Practitioners
ESMOE	Essential Steps in the Management of Obstetric Emergency
EU	European Union
EWP	Employee Wellness Programme
FAEC	Fleet Africa Eastern Cape
FEH	Fort England Hospital
FPD	Foundation for Professional Development
FY	Financial Year
GP	General Practitioner
HAST	HIV & AIDS, STI & STB
HB	Hemoglobin
HCBC	Home Community-Based Care
HCT	HIV Counselling & Testing
HFM	Health Facilities Management
HIV	Human Immunodeficiency Virus
HOD	Head of Department
HPCSA	Health Professions Council of South Africa

HPH	Health Promoting Hospital
HPTD	Health Professionals Training and Development
HR	Human Resources
HR Rems	Human Resource Records Management Systems
HR TAP	Human Resources Turn Around Plan
HRM	Human Resource Management
HROPT	Human Resources Operating Project Team
HST	Health Systems Trust
HTA	High Transmission Area
ICAP	International Center for AIDS Care and Treatment Programs
ICASA	Independent Communications Authority of South Africa
ICT	Information Communication Technology
ICU	Intensive Care Unit
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
INH	Isoniazid
INP	Integrated Nutrition Programme
IPT	Isoniazid Prophylaxis Therapy
ISRDP	Integrated Sustainable Rural Development Plan
IT	Information Technology
IYA	Imbumbayama Khosikazi Akomkulu
JICA	Japanese International Development Cooperation Agency
KSD	King Sabata Dalindyebo
KTP	Knowledge Transfer Partnership
LTDOT	Long-Term Domicilliary Oxygen Therapy
M/XDR	Multi/Extreme Drug Resistant
MAWG	Multi-Agency Working Group
MBChB	Bachelor of Medicine and Bachelor of Surgery
MCWH	Maternal Child and Women's Health
MDR-TB	Multi-Drug Resistant Tuberculosis
MEC	Member of Executive Committee
METRO	Meidcal Emergency Transport and Rescue Organization
MHS	Municipal Health Services
MHU	Mental Health Unit
MMC	Male Medical Circumcision
MMR	Maternal Mortality Ratio
MO&P	Medical Orthotics & Prosthetics
MoU	Memorandum of Understanding
MOU	Maternal Obstetric Unit
MTEF	Medium Term Expenditure Framework
NEMA	National Environmental Management Act
NCCEMD	National Committee on Confidential Enquiry into Maternal Deaths
NCD	Non-Communicable Diseases
NDOH	National Department of Health
NGO	Non-governmental Organisation
NHC	National Health Council
NHI	National Health Insurance
NHLS	National Health Laboratory Service
NIDS	National Indicator Data Set
NIMART	Nurse Initiated Management of Antiretroviral Therapy
NMM	Nelson Mandela Metropolitan
NMMB	Nelson Mandela Metro Sub-district B
NMMU	Nelson Mandela Metro University
NPO	Non-Profit Organisations
NSDA	Negotiated Service Delivery Agreement
O&P	Orthotic & Prosthetic
OPD	Outpatient Department
OTP	Office of The Premier
OSG	Office of the Superintendent General
PAH	Provincially-Aided Hospital
PCR	Polymerase Chain Reactive
PCV	Pneumococcal Vaccine
PDE	Patient Day Equivalent
PDP	Public Driver's Permits
PE	Port Elizabeth
PEHC	Port Elizabeth Hospital Complex
PEPH	Port Elizabeth Provincial Hospital
PERSAL	Personnel Salary System
PFMA	Public Finance Management Act
PGDP	Provincial Growth and Development Plan
PHARM. D	Doctor of Pharmacy
PHC	Primary Health Care
PHC	Provincial Health Council

PHS	Port Health Services
PILLIR	Policy on procedure on incapacity leave and ill Health Retirement
PLWHA	People Living with HIV/AIDS
PMDS	Performance Management and Development System
PMR	Perinatal Mortality Rate
PMTCT	Prevention of Mother to Child Transmission
PPT	Planned Patient Transport
PROVHOC	Provincial Health Operations Centre
PHSDSBC	Public Health and Social Development Sectoral Bargaining Council
PSCBC	Public Service Co-ordinating Bargaining Council
PTB	Pulmonary Tuberculosis
RiskCo	Risk Committee
RPHC	Revitalisation of Primary Health Care
RSDP	Rationalised Service Delivery Platform
RTC	Regional Training Centre
RV	Rotavirus Vaccine
SA	South Africa
SAMA	South African Medical Association
SANBS	South Africa National Blood Services
SANCA	South African Cancer Association
SAPS	South African Police Service
SAQA	South African Qualifications Authority
SARS	South Africa Revenue Service
SASO	Senior Auxilliary Service Officers
SCOPA	Standing Committee On Public Accounts
SDF	Skills Development Facilitators
SFH	Society for Family Health
SG	Superintendent General
SITA	State Information Technology Agency
SLA	Service Level Agreement
sm+	Smear Positive
SMME	Small, Medium and Micro Enterprises
SMSB	Saving Mothers Saving Babies
SOP	Standard Operating Procedure
STATS SA	Statistics South Africa
STI	Sexually Transmitted Infection
TB	Tuberculosis
THS	Traditional Health Services
UDIPA	Uitenhage Despatch Independent Practitioner Association
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UPH	Uitenhage Provincial Hospital
URP	Urban Renewal Nodes
VCT	Voluntary Counselling and Testing
VitA	Vitamin A
VPN	Virtual Private Network
WAMTEC	Willem Andries Machiel Technology
WSAs	Water Services Authority
WSU	Walter Sisulu University
XDR-TB	Extremely Drug Resistant Tuberculosis

3. STRATEGIC OVERVIEW

3.1 Vision

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

3.2 Mission

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

3.3 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

3.4 Strategic Outcome Oriented Goals

The primary business of the EC DoH and health care service delivery is based on five strategic outcomes-oriented goals as shown in Table A1 below.

Table A1: Outline of the strategic goals of the ECDoH for the years 2010-2015

STRATEGIC GOAL TITLE	GOAL STATEMENT	EXPECTED OUTCOMES
1. Public Health System	To facilitate a functional quality driven public health system that provides an integrated and seamless package of health services and is responsive to customer needs.	By 2015, the organisation should demonstrate the following outcomes: * Functional district health characterised by well managed and effective clinics, CHCs, district and specialised hospitals, * Each district to have a fully functional EMS METRO Centre. * Fully functional regional and tertiary hospitals.
2.TB and HIV/AIDS	To combat and reduce the impact of TB and HIV/AIDS with a special focus on preventing the emergence of drug – resistant strains.	By 2015, the organisation should demonstrate the following outcomes: * Reduction of HIV prevalence * % coverage of ART * Improved TB cure rate * Reduction of TB Incidence * Arrest rate of progression to MDR/XDR

STRATEGIC GOAL TITLE	GOAL STATEMENT	EXPECTED OUTCOMES
3. Mother and Child Health	To improve and strengthen the mother and child health services.	By 2015, the organisation should demonstrate the following outcomes: * % reduction of maternal morbidity * % reduction of maternal mortality * % reduction of infant mortality * % reduction of <5 child morbidity * Reduce no. of underweight children <5 – nutrition/social needs cluster * Greater awareness of women's sexual and reproductive rights.
4. Non-communicable diseases and mental conditions.	To combat and reduce diseases of lifestyle and mental conditions.	By 2015, the organisation should demonstrate the following outcomes: * Reduction in incidence of mental conditions. * Reduction in re-admissions of mental patients. * Reduction in substance abuse. * Reduce complications in hypertension and diabetes. * Improved health promotion. * Reduce incidence of obesity. * Reduction in morbidity, mortality resulting from circumcision. * Reduction in epilepsy and asthma morbidity. * Reduction in morbidity and mortality of the most common cancers (breast, cervix, prostrate, oesophagus and lung).
5. Institutional capacity	To enhance institutional capacity through effective leadership, governance, accountability and efficient and effective utilization of resources.	By 2015, the organisation should demonstrate the following outcomes * Unqualified audit opinion received from the Auditor General * Effective leadership and audit * Effective planning and monitoring system * Achieve % of norms and standards re ratios fully-fledged and independent Lilitha College of Nursing that is able to produce ready, able and capable nurses to service the health system. * Fully-fledged EMRS College is able to produce ready, able and capable EMRS Practitioners to service the health system.

4. LEGISLATIVE MANDATES

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

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

4.1. Legislation falling under the Minister of Health's portfolio

- Medicines and Related Substances Act, 101 of 1965
  Provides for the registration of medicines and other medicinal products to ensure their safety, quality and efficacy, and also provides for transparency in the pricing of medicines
- Foodstuffs, Cosmetics and Disinfectants Act, 54 of 1972 (As amended)
  Provides for the regulation of foodstuffs, cosmetics and disinfectants, particularly quality standards that must be complied with by manufacturers, as well as the importation and exportation of these items
- Hazardous Substances Act, 15 of 1973
  Provides for the control of hazardous substances, particularly those emitting radiation.
- Occupational Diseases in Mines and Works Act, 78 of 1973
  Provides for medical examinations on persons suspected of having contracted occupational diseases, especially in mines, and for compensation in respect of those diseases
- Pharmacy Act, 53 of 1974 (As amended)
  Provides for the regulation of the pharmacy profession, including community service by pharmacists
- Health Professions Act, 56 of 1974 (As amended)
  Provides for the regulation of health professions, in particular medical practitioners, dentists, psychologists and other related health professions, including community service by these professionals
- Dental Technicians Act, 19 of 1979
  Provides for the regulation of dental technicians and for the establishment of a council to regulate the profession
- Allied Health Professions Act, 63 of 1982 (As amended)
  Provides for the regulation of health practitioners such as chiropractors, homeopaths, etc., and for the establishment of a council to regulate these professions
- Human Tissue Act, 65 of 1983
  Provides for the administration of matters pertaining to human tissue
- National Policy for Health Act, 116 of 1990
  Provides for the determination of national health policy to guide the legislative and operational programmes of the health portfolio
- SA Medical Research Council Act, 58 of 1991
  Provides for the establishment of the South African Medical Research Council and its role in relation to health research
- Academic Health Centres Act, 86 of 1993
  Provides for the establishment, management and operation of academic health centres
- Choice on Termination of Pregnancy Act, 92 of 1996 (As amended)
  Provides a legal framework for the termination of pregnancies based on choice under certain circumstances
- Sterilisation Act, 44 of 1998
  Provides a legal framework for sterilisations, including for persons with mental health challenges
- Medical Schemes Act, 131 of 1998
  Provides for the regulation of the medical schemes industry to ensure consonance with national health objectives
- Tobacco Products Control Amendment Act, 12 of 1999 (As amended)
  Provides for the control of tobacco products, the prohibition of smoking in public places and of the advertisements of tobacco products, as well as the sponsoring of events by the tobacco industry
- National Health Laboratory Service Act, 37 of 2000
  Provides for a statutory body that offers laboratory services to the public health sector

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

- **Mental Health Care Act, 17 of 2002**
  Provides a legal framework for mental health in the Republic and, in particular, the admission and discharge of mental health patients in mental health institutions, with an emphasis on the observation of human rights for mentally ill patients

- **National Health Act, 61 of 2003**
  Provides a framework for a uniform structured health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services.The objects of the Act are to:

  - unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa;

  - o provide for a system of co-operative governance and management of health services within national guidelines, norms and standards, in which each province, municipality and health district must address questions of health policy and delivery of quality health care services;

o establish a health system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognised standards of research and a spirit of enquiry and advocacy which encourage public participation;

o promote a spirit of co-operation and shared responsibility among public and private health professionals, providers and other relevant sectors within the context of national, provincial and district health plans.

- **Nursing Act, of 2005**
  Provides for the regulation of the nursing profession

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

- **Criminal Procedure Act, Act 51 of 1977, Sections 212 4(a) and 212 8(a).**
  Provides for establishing the causes of non-natural deaths

- **Child Care Act, 74 of 1983**
  Provides for the protection of the rights and well-being of children

- **Occupational Health and Safety Act, 85 of 1993**
  Provides for the requirements that employers must comply with in order to create a safe working environment for employees in the workplace

- **Compensation for Occupational Injuries and Diseases Act, 130 of 1993**
  Provides for the compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment and for death resulting from such injuries or diseases

- **The National Roads Traffic Act, 93 of 1996**
  Provides for the testing, analysis and implementation of the applicable law against drunk driving by drivers under the influence of liquor.

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

- **Employment Equity Act, 55 of 1998**
  Provides for the measures that must be put into operation in the workplace in order to eliminate discriminatory practices as well as to promote affirmative action.

- **State Information Technology Act, 88 of 1998**
  Provides for the creation and administration of an institution responsible for the state's information technology systems

- **Skills Development Act, 97of 1998**
  Provides for the measures that employers are required to take to improve the levels of the skills of employees in their workplaces.

- **Public Finance Management Act, 1 of 1999**
  Provides for the administration of state funds by functionaries, their responsibilities and incidental matters

- **Promotion of Access to Information Act, 2 of 2000**
  Amplifies the constitutional provision pertaining to accessing information under the control of various bodies

- **Promotion of Administrative Justice Act, 3 of 2000**
  Amplifies the Constitutional provisions pertaining to administrative law by codifying it.

- **Promotion of Equality and the Prevention of Unfair Discrimination Act, 4 of 2000**
  Provides for the further amplification of the Constitutional principles of equality and the elimination of unfair discriminatory practices.

- **The Division of Revenue Act, 7 of 2003**
  Provides for the manner in which revenue generated may be disbursed.

- **Broad-based Black Economic Empowerment Act, 53 of 2003**
  Provides for the promotion of black economic empowerment in the manner which the state awards contracts for services to be rendered, and such incidental matters as they relate to such law.

5. ORGANISATIONAL STRUCTURE

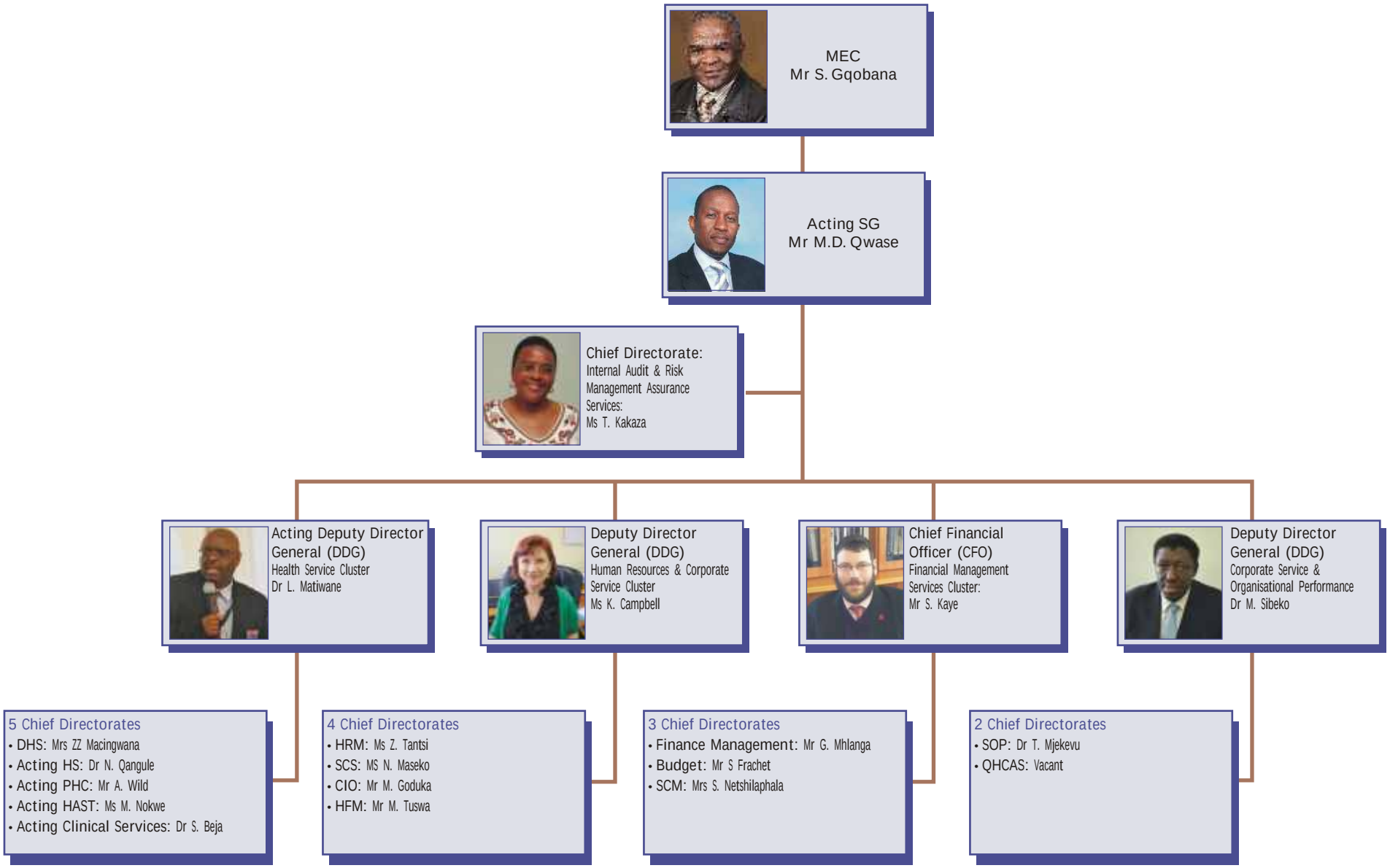
The organisational structure of the department (high-level structure) is attached hereto. This structure reflects the Office of the MEC, the Superintendent General, and each of the four clusters namely, Clinical Services, Finance, Corporate Services and Corporate Strategy & Organisational Performance.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

Countless challenges within the organogram have been encountered - the structure has been found to be misaligned in that the head office is bloated and some operational areas are at head office rather than being where services are delivered, while there is continuation of blurred reporting lines for certain key services, etc. Consequently, the structure does not conform to a decentralised service delivery platform. To remedy this situation, an on-going re-alignment of the organisation structure is applied based on the Revitalisation of Primary Health Care to address these challenges. This realignment will ensure the empowerment of the districts.

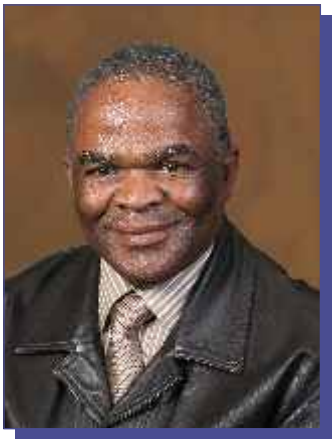
6. ENTITIES REPORTING TO THE MEC

There are no trading or public entities under the control of the Eastern Cape Department of Health.

Organogram of the Eastern Cape Department of Health



MEC'S STATEMENT



The 2012/13 Annual Report marks the fourth year of the current Term of Government. On tabling this report we need to also reflect back on our achievements against the strategic objectives we set for ourselves. It is our innate responsibility to report and account on the work that has been successfully executed to meet the policy shifts in an attempt to fast-track service delivery. It is however, important to state that government and the Eastern Cape Department of Health in particular, are operating during harsh and challenging economic times since the economic meltdown. Financial resources and budgets have been shrinking against expanding service delivery demands and the burden of diseases.

Achievements in relation to policy directives and strategic outcome

The government approach in focusing on specific outcomes and outputs has provided a clear line of sight on critical health systems and clinical outcomes. Since 2009/10 when this was introduced, we demonstrated a sustained improvement in our clinical outcomes.

The life expectancy in the province has increased from 55.5 to 59.3 in females and from 50.3 to 53.7 in males during the periods 2006/11 and 2011/16 respectively. Part of this achievement may be attributable to the December 2009 President's Statement and HIV&AIDS Policy shift to expand access to these services for our people. Already, 790 health facilities were providing ARV services during the reporting period and this has increased the total number of patients from 188 544 in 2011 to 237 830 in 2012/13. The transmission of the HIV virus from mother to babies has decreased from 8% in 2009 to 3% at present thereby saving thousands of lives of babies. The department has achieved a consistent decrease in new TB patients from 976 to 851 per 100 000 in 2009 and 2012 respectively and an increase in TB cure rate from 66% to 68.,9% during the same period.

In the area of reproductive health we have demonstrated similar consistent and positive trends with maternal mortality rate reduction from 202 to 152 per 100 000 in the period 2009 to 2012. These results are based on our sustained program that focused on maternal waiting homes, training on ESMOE and decentralised ambulances stationed at delivery units. The Infant Mortality Rate has equally been reduced from 60,1 to 45,4 per 1000 live births in the period from 2006 to 2012 respectively.

The National Health Insurance (NHI) strategic intervention remains a critical policy imperative in the overall transformation of our healthcare. The National Health Council (NHC) took a resolution that 10 district pilot sites will be established and O R Tambo Health District was chosen in the province. In the reporting period R11.5million was allocated towards the NHI Conditional Grant.

The first year of performance has mainly focused on communication with critical stakeholders including municipalities, community and governance structures, academic and provider structures and individuals like GPs.

Challenges for the financial year under review

The Department finds itself in a contracting fiscal environment compounded by the results of the 2011 census. This means that the department has to become more efficient and effective with its limited resources whilst still delivering quality health care services to all. The department is currently addressing the human resource accrual back log as well as the strengthening of the financial and supply chain management functions at the head office, districts, sub-districts and institutions. These are the critical foundational support services for the department to move forward on a progressive trajectory.

The medium to long term goals of the department

The country and the current government have focused on the National Development Plan 2030 to improve the lives of every citizen in the country. The Eastern Cape Department of Health will develop its strategic priorities to be aligned with broad objectives of NDP. Specific focus will be on social determinants of health

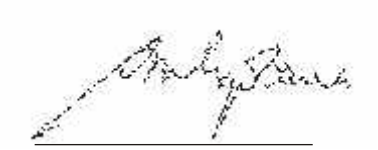
through close collaboration with specific government agencies and non-governmental organizations; continue on our work on building health system and RPHC; and continue to build on the past achievement in the HIV&AIDS and TB program using the NSP, and maternal and child health services.

Acknowledgements /Appreciation

I would like to acknowledge the great support and leadership direction from the National Department of Health through the National Health Council, and technical support from the Office of the Premier and Provincial Treasury. We are also greatly appreciative of good collaboration we have had with municipalities in carrying our responsibilities, the sister social services departments through our Social Transformation Cluster work and various Development Partners. Lastly, we need to salute the Eastern Cape Province communities who showed appreciation of our services and when we came short of expectations were still displaying patience.

Conclusion

In conclusion, while we enjoyed the successes we have had in the past four years in carrying the strategic priorities and commitment of the current government, we still understand the bigger task – transformation of the lives of the people in the province. We will continue to focus on this bigger goal and move forward using the NDP as our basis of our program to achieve our main objective.



Honorable S Gqobana
MEC for Health
31 August 2013

ACCOUNTING OFFICER'S OVERVIEW

This Annual Report for 2012/13 outlines the key achievements of the Eastern Cape Department of Health for this reporting period as well as challenges and constraints that were experienced. In line with the set Government Program in the current term of government and the health sector program in particular, the department set its targeted interventions to meet its international, national and provincial responsibilities and improve the health status of the people in the province. This was achieved through the implementation of the MDG imperatives and the Negotiated Service Delivery Agreement (NSDA) with its national vision, "A long and healthy life for all South Africans". The department, in terms of its constitutional mandate and PFMA provisions, also continued to respond and meet the reporting obligations to the oversight bodies and other executive agencies.

Reducing Burden of Disease

Critical and important milestones were attained in the area of improving maternal and child health services. All these interventions and achievements meaningfully contributed in the reduction of maternal and child mortality rates, and made some strides towards achieving the MDGs obligations. The interventions among many include the provision of waiting homes for near term of pregnancy mothers, decentralized and dedicated ambulances that were stationed in the hospitals and delivery units, and ESMOE training of our maternity clinical staff. Measures to prevent infant deaths include increase in immunisation coverage through the roll-out of Reach Every District strategy, campaigns and the school health teams outreach programs. Infant mortality rate in the EC province was projected to decrease from 60.1 to 45.4 per 1000 live births and Under 5 from 86.2 to 63.4 per 1000 live births.

Over the past four years the department has substantially increased its capability to provide ARV program to all who need this service including pregnant mothers, TB patients and the general population. The latest statistics shows the percentage of pregnant women tested for HIV and testing positive (HIV prevalence) to be at 29.3%, and prevention of mother to child transmission (PMTCT) resulted in significant decrease in HIV infected babies tested around six weeks of birth, from 8% in 2009/10 to 3% in 2012. There were 49 286 new clients put on ART programme increasing the number from 188 544 in 2011 to a total of 237 830 clients on the ART programme by end of the year under review. HIV and TB co-infected clients are prioritised on the FDC drug.

The ART uptake for TB patients co-infected with HIV, initiated on ART has improved during the 2012/13, however the department has to ensure that 80% of TB patients co-infected are initiated on ART , by the end of 2013/14 financial year. The CPT uptake for all the TB patients co-infected with HIV remains above 80% which is quite commendable.

Revitalization of PHC

The department has rolled out the Revitalization of PHC model through establishment of ward-based and school health teams. The number of sub-districts participating in this approach increased from three in 2011/12 to five in 2012/13. What is encouraging and that translates to be the strength of this approach over and above bringing the health services to the EC communities, is the strengthening of the inter-sectoral and inter-governmental collaboration that is displayed by the various stakeholders. The maternal child and women's health together with the integrated nutrition programmes of the DOH have joined forces and established teams with the Department of Agriculture and the Social Development in the implementation of the anti-poverty alleviation strategy. The DOH has joined forces, and is enjoying co-operation and sharing scarce resources with the Department of Education in implementing the School Health programme. In addressing the emerging burden of non-communicable diseases, the Department of Agricultue and Department of Sports Arts Recreation & Culture are collaborating in health promotion to tackle healthy life style issues. In recognizing health as a societal matter, various community-based organisations and NGOs are participating in enhancing the PHC model including Imbumba Yamakhosikazi Akomkhulu that are playing a pivotal role in the fight against TB and HIV infections.

National Health Insurance

The department implemented the NHI Pilot in the O R Tambo Health District with establishment of the Facility Improvement Teams that provided critical support to our health facilities in the districts. Good progress has been made in improving the infrastructure, health systems and quality standards performance. The department engaged General Practitioners with the intention to contract them to provide medical services in our clinics, and already 12 have shown interest and willingness to come on board.

Human Resources for Health

The HR Directorate has set out with a Human Resource Turnaround Strategy to improve the quality of services it provides to the Department. This includes improving management of the PERSAL salary system through conducting employee verification exercise which will be commencing in the 2013/14 financial year. We have taken a streamlined approach to recruitment and have Annual Recruitment Plans in place. Our recruitment turnaround times have been reduced and we have set in motion an Annual Intake Committee to ensure that the department is well prepared for all new staff members coming on board. This encompasses payment of staff benefits on time and to ensure that the working environment is prepared in terms of tools of trade.

Despite the structural budget deficit and escalating employment costs, we have continued to invest and displayed our commitment in improving services by providing resources to the health priority programmes, supply chain reform as well as strengthening leadership and management of the health establishment. Critical skills including 173 medical and pharmacy interns, 288 EMS interns, 1448 community service professionals as well as 789 post community-service professionals were recruited and retained.

The department is in the final stages of completing the revision of its organogram so that it meets the standardized profile of the National Department of Health directive. Recognising and embracing the government national development plan (NDP) in promoting health and coupled with the difficulty in attracting and retaining core clinical staff in our rural and remote areas, during the year under review, the Department awarded 1485 bursaries of which 145 were students studying Medicine in Cuba. The Department is planning to award a further 100 bursaries to the students from the Eastern Cape to join the Cuban medical programme from September 2013 in order to increase doctor capacity in these areas. Through the DOH HPTD grant we are supporting the Walter Sisulu University (WSU) to establish a course to train Orthotic and Prothestic students hence the Department has seen the last EC DOH bursars trained and graduating from Tanzania during 2012/13 FY. The Department will continue to implement the social compact approach and principles with the communities in identifying and selecting the deserving bursars from their communities that will ultimately serve the very communities after graduation.

The department will undertake a capability and best practice development in HR, ensure improved integrity of all HR related data and implement readiness for an end-to-end HR process integration and future Enterprise Planning Software (ERP) implementation initiative (based on the Department of Public Service Administration (DPSA) and Integrated Financial Management System (IFMS) frameworks and directives). The departmental HR Plan will be reviewed and aligned to the DPSA Framework and to the departmental Strategy. The plan will identify priorities, challenges and weaknesses in strategic areas of human resources and put in place an action plan to address potential HR risks.

Governance and Leadership

In order to strengthen the organisational leadership and the executive management, the Department has appointed Chief Executive Officers (CEOs) to 65% of our tertiary, specialised and regional hospitals. In the new financial year the Department will prioritise the appointment of CEOs to remaining provincial hospitals and the district hospitals.

Strengthening Information Technology

We have improved connectivity by 90% in the OR Tambo district health facilities in preparation of the NHI implementation. The Department has upgraded connectivity to 14 Hubs for the Supply Chain Management Reform project. We have implemented Rx Solution in 7 sites in OR Tambo district hospitals and LSA offices. This system is targeted to improve the stock management for pharmaceuticals and also assists with dispensing to patients in hospitals. The Demander Codes have been created for OR Tambo although we are still building and strengthening capacity to prepack stock for intended facilities from the depot level. ICT unit is continuously upgrading the telephone systems (PABX) to stabilise telephonic capacity. The unit is putting together a comprehensive Integrated Enterprise Voice Communications System, to deal with fixed infrastructure challenges, lack of network reception and cable theft problem.

Eliminating Infrastructure Backlog

The focus of the Department has shifted from building new health facilities and is now firmly on maintaining the existing ones. Renovations and Repairs of PHC facilities are receiving priority. To this extent, general maintenance work in Hospitals such as Cala, Elliot, Cloete Joubert, Tafalofefe, Nelson Mandela Academic hospital, Komani, Fort Beaufort hospitals is on –going. Furthermore, 222 clinics covering the entire Province were repaired and renovated. Approximately, 112 of these will be completed during the first quarter of the 2013/14 financial year.

The implementation of this programme is viewed as having created opportunities for jobs as 28 locally based black contractors which were supported by 32 sub-contractors were employed to renovate and repair the health facilities. It is estimated that this programme created about 1 800 work opportunities and to have cost the department around R240 million. Capacitating the programme with human resources have seen the full utilisation of the HFM budget. This

approach will henceforth form the basis of infrastructure investment in the Health space.

The department will focus on eradicating its' extensive health infrastructure backlogs. Infrastructure Delivery Management System (IDMS) will be implemented to ensure effective and efficient planning and delivery of infrastructure in the health sector. The department will intensify its participation in the Centralised Project Management Unit (CPMU) that is hosted by the Department of Roads and Public Works. The objective of this unit is to provide technical leadership on the planning and implementation of infrastructure projects in the province. The Infrastructure Procurement Project will also be implemented in the coming year to enhance procurement and improve expenditure and the delivery of infrastructure facilities in the sector. All categories of health infrastructure will be constructed, maintained, rehabilitated and repaired during the MTEF period. The National Department of Health is currently developing a Project Management Information System (PMIS) which is designed to enable the department to manage the infrastructure implementation programme in a more effective and efficient manner. The department will be enhancing its infrastructure capacity by the employment of infrastructure specialists in the coming year.
Equitable Share allocation for infrastructure will largely be used for general repairs and maintenance of all facilities in the province with particular focus on electro-mechanical areas and clinics. Procurement and maintenance of medical equipment will be procured through this funding source.

The Hospital Revitalisation Grant will be used to fund the revitalisation of 5 five hospitals in the province and these are: Cecelia Makiwane, Frontier, St Elizabeth, Madweleni and St Patricks. The focus is on building upgrades, procurement of medical equipment for commission purposes, organisational development and quality of care.

The Health Infrastructure Grant will be used for general maintenance of district and provincial hospitals.

Strengthening Financial Management (Monitoring & Evaluation)

Over the past three years the department implemented interventions that were designed to improve the financial outcome of the department. This entailed improving accounting practices and control environment, introducing Generally Recognised Accounting Practices (GRAP) best practices, ensuring integrity of financial data and implementing systems and controls. The result was the turnaround of the audit opinion from disclaimer to qualified opinion, which needs to be enhanced in the 2013/14 financial year. The challenge that still faces the department in the area of financial management is the lack of skilled, proficient and competent personnel. The appointment and retention of skilled financial management personnel is a prerequisite for the improved financial management in the department. The department will collaborate with the PCMT to ensure that critical financial management posts are filled in the coming financial year.

Supply Chain Management Initiatives

The department is participating as a pilot site for the implementation of MAWG, formed by the Minister of Finance, to review the state procurement system and develop broad level mechanisms to optimise its functioning. The department has prioritised the implementation of the SCM Reform Project. The objective of the project is to provide a set of priorities and proposals with appropriate action plans to deliver a rapid improvement in the departments' procurement system. It is anticipated that this intervention will lead to an improved functioning of the department which will in turn enhance the capacity of the department to provide better quality health service.

The three main objectives of this project are: to make SCM activities visible and controllable by management, to strengthen SCM capabilities and to provide sufficient human resources for the SCM function. It is expected that the implementation of the project will enable the department to turn around its negative SCM audit outcomes into unqualified opinions in the future. R15 million was allocated in 2012/13 while an additional R72 million is allocated for the 2013/14 financial year. The department will ensure the rigorous implementation of the project not only to enhance audit outcomes but also significantly improve the service delivery performance of the department.

Conclusion

In conclusion, the future plans of the Department of Health are based on driving the health program that resonates with the vision of the National Development Plan, with focus on social determinants of health in addition to the current focus on the NSDA. The department has established various projects in O R Tambo NHI Pilot District, and these will now be scaled up through the whole district. In addition to the current strengthening of financial management, the department will roll-out the SCM Turnaround Program. The department has full understanding of its responsibilities and obligations and will continue to commit itself to drive its mandate through its limited resources. It is building capacity to work smart, provide efficient and effective programs and realize more value.

Mr M D Qwase
Accounting Officer for Health
31 August 2013

PART B

PERFORMANCE INFORMATION

1A. STATEMENT OF RESPONSIBILITY FOR PERFORMANCE INFORMATION

Statement of Responsibility for Performance Information for the year ended 31 March 2013

The Accounting Officer is responsible for the preparation of the department's performance information and for the judgements made in this information.

The Accounting Officer is responsible for establishing, and implementing a system of internal control designed to provide reasonable assurance as to the integrity and reliability of performance information.

In my opinion, the performance information fairly reflects the performance information of the department for the financial year ended 31 March 2013.

Mr. M.D. Qwase
Acting Accounting Officer: Department of Health
31 August 2013

2. AUDITOR GENERAL'S REPORT: PREDETERMINED OBJECTIVES

The AGSA performed the necessary audit procedures on the performance information to provide reasonable assurance in the form of an audit conclusion. The audit conclusion on the performance against predetermined objectives is included in the report to management, with material findings being reported under the Predetermined Objectives heading in the Report on other legal and regulatory requirements section of the auditor's report.

Refer to page 356 of the Report of the Auditor General, published as Part E: Financial Information.

3. OVERVIEW OF DEPARTMENTAL PERFORMANCE

3.1. Service Delivery Environment

In order to assist users of the annual report to gain an understanding of the challenges, successes and other factors that might impact on the department's performance, it is necessary to provide the users with an overview of the context within which the department operated and sought to implement its Strategic Plan and its Annual Performance Plan.

Demographic information

The Eastern Cape Province is spread over an area of 169,952 km2 and constitutes 13.9% of the total SA land base. The mid-year population in 2012 was approximately 6 671 956 million (Table B1) constituting 12.6% of the SA population. The largest proportions of the population are concentrated at OR Tambo district and Nelson Mandela Bay Metropolitan Municipality with 20.4% and 17.4% of the total population respectively. Joe Gqabi District has the smallest population constituting 5% of the total EC population.

Approximately 65% percent of the population is younger than 30 years. About one third (31.7%) of the population is children; one third of these children (11% of total population) is under the age of five years (Figure 1). Six percent of the total population is 65 years and older.

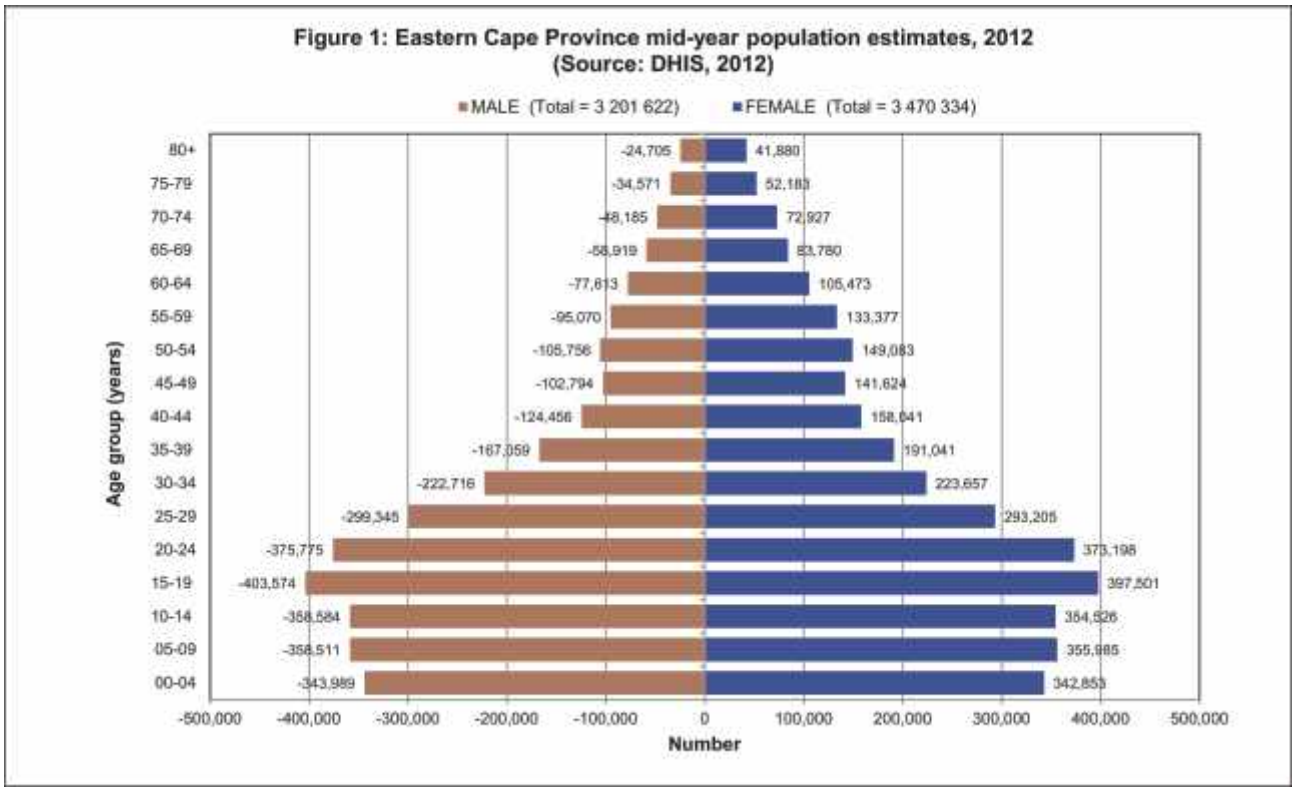
The latest statistics shows that 89% of the EC population is serviced by the public health sector, as medical aid coverage in the province is only 11%.

Table B1: EC population distributed by health districts, 2012

District	Total population	% Total EC population	Females	Males	% Urban population	% Rural population
A Nzo DM	806 466	12.1%	415003	391462	2	98
Amathole DM	995 607	14.9%	527439	468168	39	61
Buffalo City Municipal	801 238	12.0%	412057	389181	70	30
C Hani DM	769 810	11.5%	400906	368904	39	61
Cacadu DM	445 217	6.7%	234235	210982	27.2	72.8
Joe Gqabi DM	334 994	5.0%	173894	161100	2.1	97.9
N Mandela Bay MM	1 160 171	17.4%	609543	550628	91.1	8.9
OR Tambo DM	1 358 453	20.4%	697257	661197	37.9	62.1
Province	6 671 956	100.0%	3470334	3201622	30	70

Source: DHIS mid-year estimates, 2011; Source for % Urban & Rural population – Statssa cs 2007

Data source: Statssa General Household Survey, 2011



Developmental indicators influencing the health status

The key developmental indicators for the Province that influence health status and outcomes are shown in Table B. 2 below. The largest population of the Province (89%) depends on the public health sector as only 11% of the EC population was covered by Medical Aid. There has been a significant increase in the life expectancy, on average by 4% from that recorded in 2006-2011. Overall, the health improving indicators which include access to piped water and mode of cooking amongst others, showed a significant improvement by the year 2011. The general household survey, as shown in 2011 (Statssa 2013) showed that population with no schooling dropped to 7.4% and this tallies well with the observed reduction in total fertility rate in the province. Whilst these gains and their influence on the provincial health status are worth noting, areas of concern however, still exist. These include access to appropriate toilet facilities by about one fifth of the household in the province as well as use of rivers, dams and/or stagnant water sources by a number of households in most rural parts of the province (ECSECC, 2012).

Table B2: Key developmental indicators in the Eastern Cape Province

Indicator	Year	Eastern Cape
Demographic indicators		
Population density (people per km2)	2011	39/km2
Average household size (ECSECC, 2012)	2011	3.9 pers/hh
% public sector dependant population	2011	88.9
% of households for which the usual place of consultation is a public facility	2010	79.7
Total fertility rate (No. of children per woman)	2011-2016	2.72
Life expectancy at birth (females)	2011-2016	59.3
Life expectancy at birth (males)	2011-2016	53.7
% disabled population	2011	6.1
Socio-economic indicators		
% Main source of household income - Grant	2011	37.9
% Main source of household income - Salary	2011	42.5
% of persons with medical aid coverage	2011	11.1
% of households with informal housing	2011	6.5
% households connected to the mains electricity supply	2011	74.7
% households using electricity from mains for cooking	2011	59.8
% of households using wood for cooking	2011	19.3
% of households using paraffin for cooking	2011	16.7
% of households with access to piped water	2011	74.8
% of households with no water supply infrastructure	2010	26
% of population 20 years and older with no formal education (ECSECC, 2012)	2011	11
% of households with no toilet facility or using a bucket toilet	2011	17

**Data sources: General Household Survey 2011 - Statssa 2013, ECSECC 2012*

Services rendered by the department:

The Eastern Cape Department of Health, in terms of its mandate, provides health care services to the people of the province. The Department operates through eight programmes.

Programme 1: Administration

This programme comprises 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.

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 namely Clinical, Corporate and Financial Services

Programme 2: District Health Services

The main objective of this programme is to ensure delivery of Primary Health Care Services through the implementation of the District Health System. This Programme has nine sub-programmes with the following objectives:

- District Management manages the effectiveness and functionality of seven districts and municipalities within the social needs cluster, especially in ISRDP, URP nodes and the identified twelve poorest municipalities. It also manages the co-ordination of health services, referrals, supervision, evaluation and reporting mechanisms as per Provincial and National policies

- The Community Health Clinics sup-programme manages the provision of preventive and curative care and priority health programme implementation through accessible clinics and mobile services in twenty four sub-districts.

- The Community Health Centres sub-programme renders a 24 hours heathhealth 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.

- The Other Community Services sub-programme manages the devolution of MHS to the municipalities and implements a 'port health' strategy to control the spread of communicable diseases through ports of entry in the Eastern Cape Province; provides oral health services at a community level (including schools and old age homes); strengthens the traditional health services through health education campaigns for role players; prevention of substance, drug, and alcohol abuse to reduce unnatural deaths and geriatric services as a supportive and rehabilitation service.

- The HIV/AIDS sub-programme renders primary health care services in respect of the prevention of HIV and AIDS infections through campaigns, continuous care, management and treatment (CCMT) and strengthening the accreditation process of ART sites for accessibility.

- The Nutrition sub-programme sub-programme renders nutrition services as a poverty alleviation program, providing nutrition supplements including inter alia Vitamin A, Iodine, Zinc aimed at specific target groups (children, pregnant mothers, & the aged) to address malnutrition. This ensures provision of formula feeds for health facilities; establishment of food gardens at clinics, CHCs and hospital gardens as well as assisting communities to start community gardens in consultation with the Department of Agriculture to fight poverty.

- The Coroner Services sub-programme renders forensic pathology services in order to establish the circumstances and causes surrounding un-natural deaths.

- 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 services including ambulance services, special operations, communications and air ambulance services.

- To render planned patient transport including local outpatient transport (with 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. 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 which 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

The purpose of this programme is to provide cost effective, good quality effective and efficient tertiary hospital Services.

Programme 6: Health Sciences 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 has five sub-programmes with the following aims:

- 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, as well as the provision of
- Skills development interventions for all occupational categories in the department.

Programme 7:Health Care Support Services

This Programme deals with Orthotic and Prosthetic services and in addition houses Clinical Support Management. The latter is composed of Laboratory services, Radiography services and Rehabilitation services. All the clinical support services are budgeted for under programmes dealing with hospital services; i.e. Programmes 2 (District Health Services), 4 (Provincial Health Services) and 5 (Central Hospital Services).

- Orthotic and Prosthetic Services: Renders specialised clinical orthotic and prosthetic services
- Medicine Trading Account(Pharmaceuticals Depot Management): Renders specialist cross functional Pharmaceutical, Supply Chain, Financial, Risk and Human Resources Management to strengthen service delivery in the two pharmaceutical depots.

Programme 8: Health Facilities Management

This programme aims at improving access to Health care services by providing new health facilities, upgrading and maintaining existing facilities. The objectives of the three sub-programmes of this programme are as follows:

- Community Health Facilities: Focuses on the construction of new clinics and Community Health Centres (CHC) and the upgrading of existing clinics and CHCs.
- Emergency Medical Rescue Services: Focuses on improving Emergency Medical Rescue Services infrastructure.
- District Hospital Services: Focuses on the upgrading of District Hospitals
- Provincial Hospital Services: Focuses on the upgrading of Provincial Hospitals.

Indicators reflecting service platform

Human Resource

The implementation of the PERSAL clean-up as per DPSA directive in June 2012 saw to the reduction of the organizational vacancy rate from 47.6% in 2011/12 to 15.8% in 2012/13. A total of 31 704 unfunded posts were abolished (see figure 2) leaving a total of 46 803 approved posts on establishment (also see Part D of the annual report). Positions for dieticians, nutritionists and medical practitioners remain the most challenging to fill in particularly in the rural areas. To address this challenge, in 2012/13, the department awarded 595 (40.1%), 519 (34.9%) and 6 (0.4%) of total bursaries of provincial DOH respectively towards training of professional nurses, doctors and dieticians (also see page 188 under Programme 6).

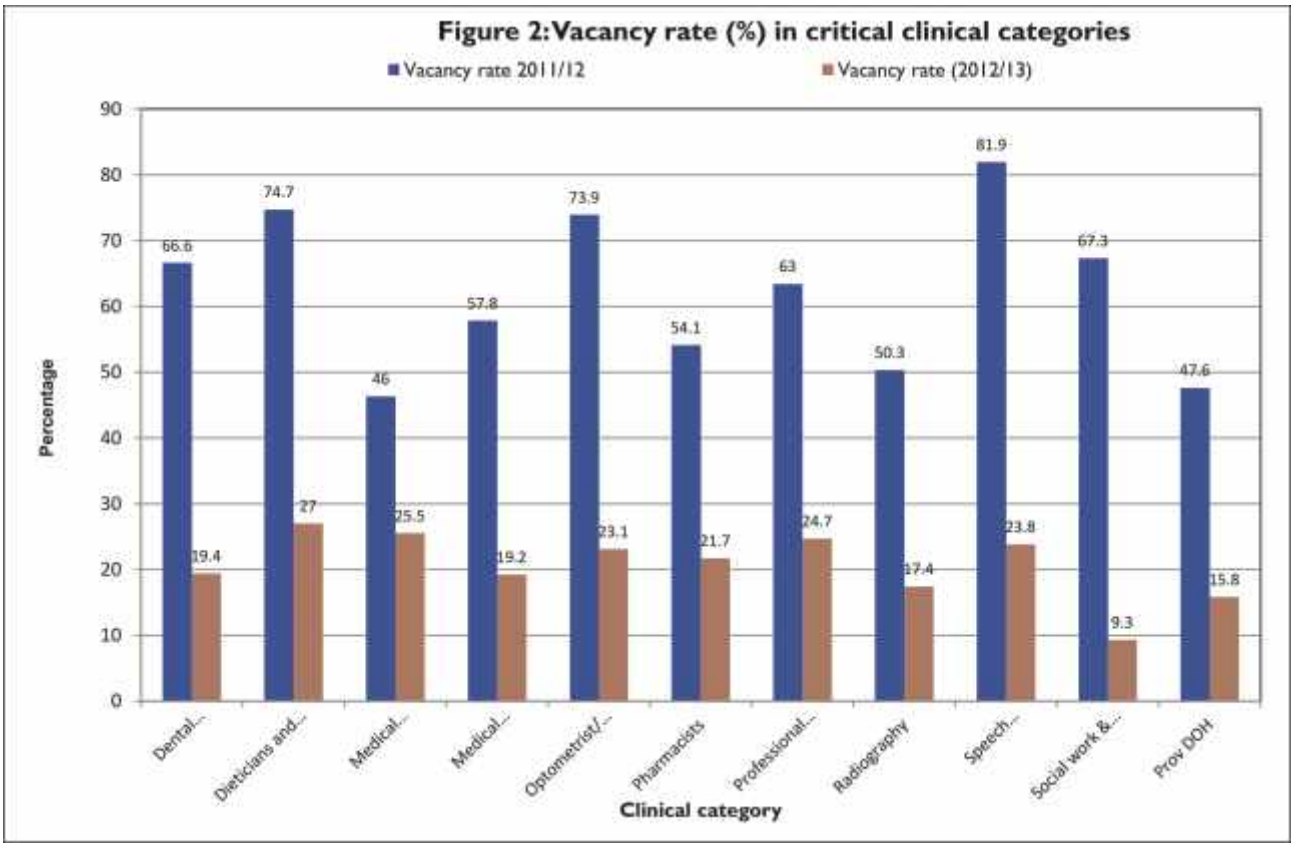


Table B3: Employment by critical occupation, 31 March 2013

Clinical category	Approved posts on establishment	No/100 000 uninsured persons	Posts filled	No/100 000 uninsured persons
Dental practitioners	134	2.3	108	1.8
Dieticians and Nutritionists	148	2.5	108	1.8
Medical practitioners	1 684	28.3	1 255	21.1
Medical specialists	208	3.5	168	2.8
Optometrist/ optician	13	0.2	10	0.2
Pharmacists	471	7.9	369	6.2
Professional nurses	12 699	213.3	9 567	160.7
Radiography	430	7.2	355	6.0
Speech therapy and audiology	63	1.1	48	0.8
Social work & related professionals	129	2.2	117	2.0

Service delivery outputs

Table B4: Key provincial service volumes (actual), 2008/09 – 2012/13

Indicator	2008/09	2009/10	2010/11	2011/12	2012/13
PHC headcount - Total	17 671 355	18 623 987	17 662 518	18 268 477	17 740 496
PHC headcount <5 yrs	3 158 099	2 582 748	3 081 144	3 187 832	3 002 054
OPD Headcount - Total (all hospitals)	1 762 685	2 107 032	2 428 947	2 623 667	2 592 650
Deliveries in facility	119 924	116 456	114 103	118 064	116 299
Total births in facility	121 957	125 883	124 346	121 421	118 615
Hospital separations - Total	476 771	525 605	513 849	[2]528 862	503 444
PDE in district hospitals	1 944 192	1 997 931	1 891 467	1 926 914	1 888 480
PDE in provincial hospitals	1 379 638	1 330 792	1 427 361	1 856 388	1 499 697
PDE in specialized TB hospitals	-	414 369	357 257	311 162	344 814
PDE in specialized Psych hospitals	-	412 262	422 343	454 954	383 211
BUR (% - District hospitals)	69.5%	71%	65.5%	64.7%	62.2%
BUR (% Provincial Hospitals[3])	75.1%	73.7%	75.8%	77.3%	75.5%
BUR (%) in specialized TB hospitals	-	-	-	79.7%	59.7%
BUR (%) in specialized Psych hospitals					86.5%

[2] Separations include those from specialised hospitals.
[3] These are 2 regional hospitals and 3 hospital complexes.

Table B5: Key services delivered and indicators during the year under review with comparative figures.

KEY SERVICE DELIVERED	2008/09	2009/10	2010/11	2011/12	2012/13
Total antenatal clinic visits	458,081[1]	465,225	456,193	464,377	455, 862
Total deliveries	120,593	117,213	120,746	128,194	128,194
PHC case seen by a doctor	345,972	402,535	200,698	502,356	484 824
HIV tests conducted (excluding tests in Antenatal Clinics)	344,505	575,792	1,019,792	1,089,282	1,089,282
Male condom distributed	22,761,216	25,200,487	30,404,275	31,494,278	33,601,670
Female condom distributed	733,856	1,277,257	1,206,009	861,126	738,698
Total PHC head count	26,386,635	18,607,861	17,679,064	18,268,852	17,740,496
Psychiatric illness visits	323,347	341,997	342,289	282,157	145,455
New STIs treated	197,512	205,099	205,391	195,603	198,086
Women screened for cervical cancer	4,586	16,845	47,879	49,663	53,245
Vitamin A supplement supplied to mother	83,685	84,614	92,126	103,287	86,164
Vitamin A supplement supplied to child	541,236	594,597	572,877	642,595	609,896
Immunization: Hep B doses	282,5115	276,4705	294,813	243,992	243,317
Measles doses	222,7406	257,3526	292,804	233,825	219,413
OPV doses	309,5917	322,3367	260,212	136,966	120,851
Emergency total headcount	178,085	209,169	394,080	501,174	486 213
Assistive devices issued (Wheel chairs, hearing aids, orthoses & prostheses)	4,878	2,152	3,122	3,196	2,746

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

NSDA OUTPUTS

1. INCREASING LIFE EXPECTANCY

In the EC Province the life expectancy at birth has increased from 55.5 in females in the years 2006/11 to 59.3 in 2011/16. Among males there has been a three year increase from 50.3 in year 2006/11 to 53.7 in the year 2011/16. In the province, diabetes mellitus and hypertension are the 7th and the 10th leading causes of deaths respectively (Statssa 2013). The two disease mortality profile corresponds with the 2004 EC hospitals' admission profile reported by Buso (et al) in 2006. In all eight districts of the EC province diabetes mellitus is in the top 10 leading causes of death. In the NMBM and the BCM, it is the 2nd and the 4th leading cause of death respectively. During 2012/13, one in every 1000 clients older than the age of five years who visits the PHC facilities was put for the first time on diabetes treatment (diabetes detection rate). Hypertension is the 10th leading cause of death in the EC province with hypertension detection rate of 2 per 1000 clients older than five years visiting PHC facilities newly treated.

Prevention strategy to control increase and for effective management of these diseases include campaigns through integrated health programme approach during which screening of health conditions is done in communities. Through support groups at facility level, health education on life style diseases is provided. An integrated nutrition programme is promoted; healthy lifestyle and good eating habits are promoted through promotion of gardening skills, consumption of fresh produce as well as exercise. A collaborative approach with the Social Development programme sees to promotion of geriatric programme where in particular physical activities are encouraged.

In an effort to improve the quality of life, on average 6 129 cataract operations per year were performed over the past six years (figure 5 below). In 2012/13 a total of 6 426 operations were performed translating to 1094 cataract operations per million uninsured EC population. This success is attributed to the collaboration efforts of the department and the support provided by the partners including the Fred Hallows Foundation. The Department is increasing its efforts to engage more partners whilst also producing its own trained optometrists and ophthalmologists. In 2011 and 2012 the Department awarded eight and three bursaries respectively towards optometry training. In 2012/13, the department absorbed four of its bursar optometrists who were placed at Coega, Barkley East, Malizo Mpehle and St Elizabeth hospitals.

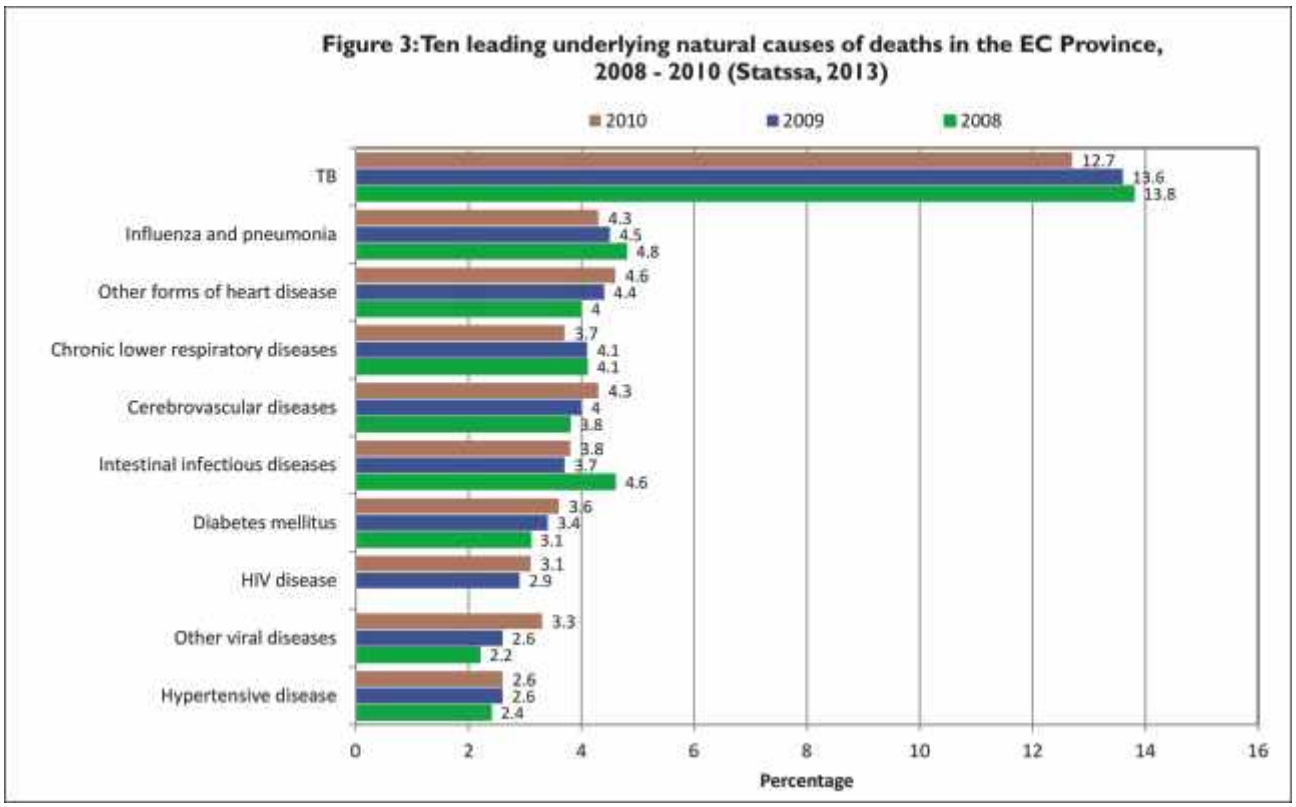


Figure 4: Top 20 leading causes of admissions in EC hospitals, 2004 (Buso et al, 2006)

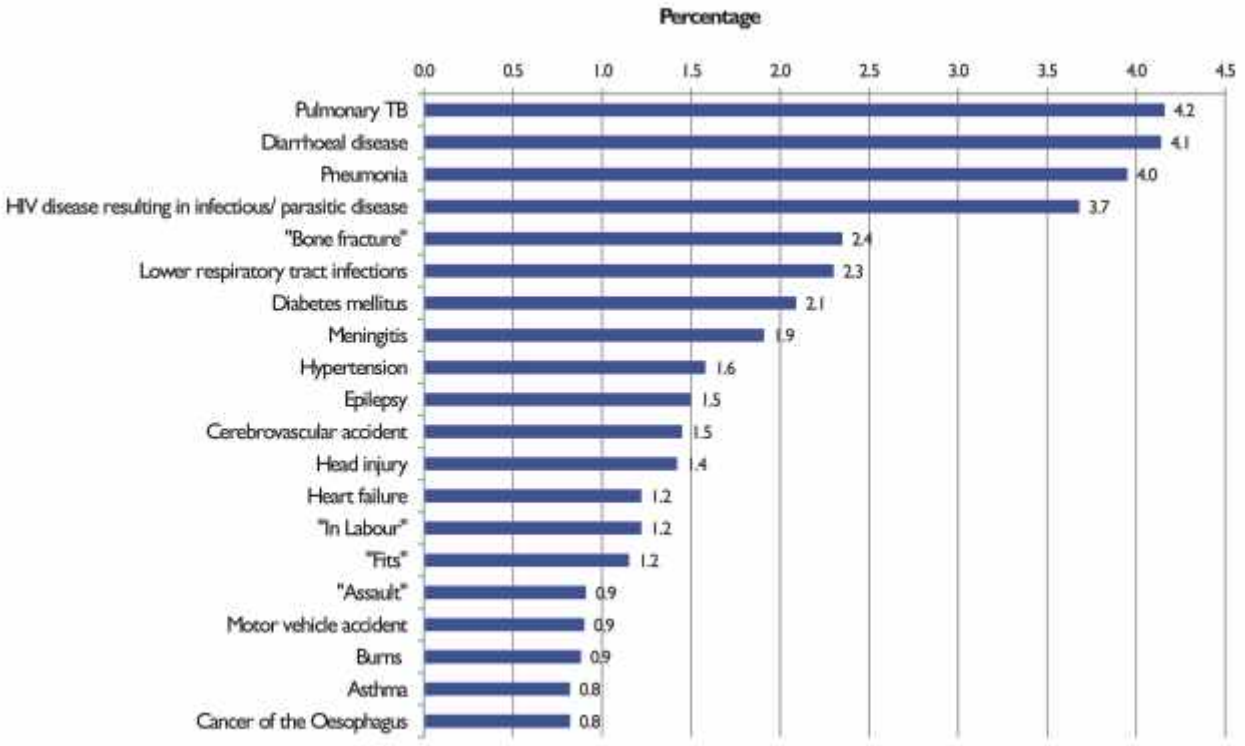
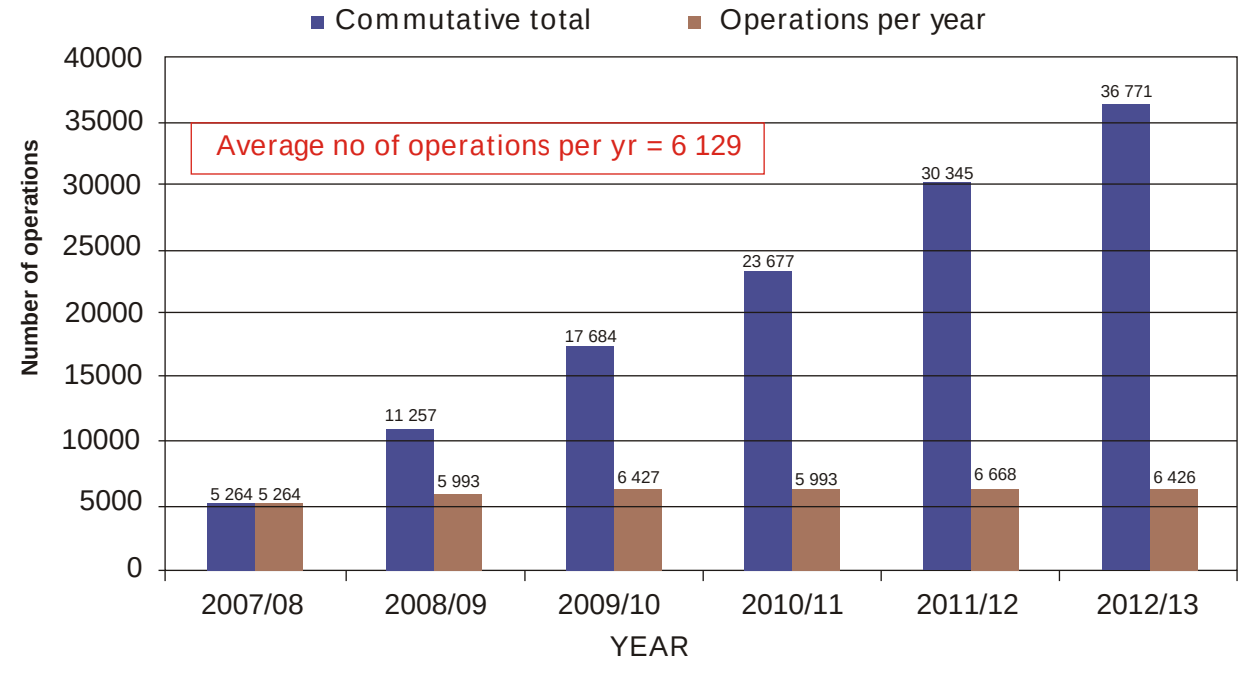


Figure 5: Distribution of catart operations performed by year, 2007-2013 (Baseline = 2007)

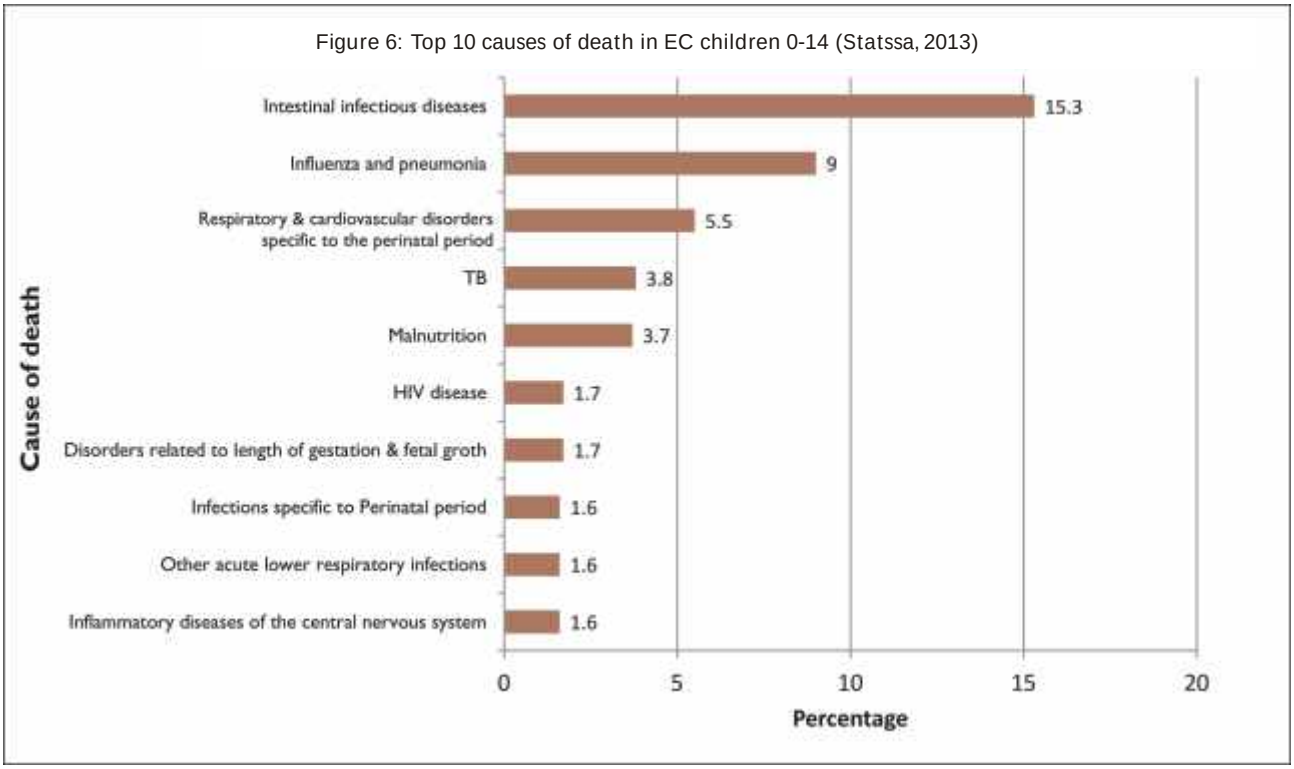


2. DECREASING MATERNAL AND CHILD MORTALITY RATE

Decreasing Infant and Child Mortality

Figure 6 shows the 10 leading causes of deaths among children in EC. The ASSA (2008) infant and under five mortality estimates showed a declining trend from 2006 to 2012 (Figure 7,SAHR 2013). Infant mortality rate in the EC province was projected to decrease from 60.1 to 45.4 per 1000 live births and Under 5 years from 86.2 to 63.4 per 1000 live births. The Statssa data shows a decreasing trend in registered infant deaths (see figure 8). The numbers of deaths in children under 5 years of age are shown in Figure 9 (Statssa 2013). Whilst the infant mortality rate and the number of registered deaths seemed to be decreasing between 2007 and 2010, there are however, some districts that need close monitoring that are showing increasing trend and these include A Nzo, BCM and Joe Gqabi districts (figure 9).

Figure 6: Top 10 causes of death in EC children 0-14 (Statssa, 2013)



Measures to prevent infant deaths are shown in Figure 11 and Tables B6 & B7 below. Immunisation coverage has been increasing over the years. After 2009, programmatic challenges were experienced as a result of vaccine shortages which led to a decrease from 90.6% in 2009 to 82.6% in 2012. The shortage of the Pentaxim vaccine which is administered to children from six weeks of age at both Umtata and PE depots since June 2011 is posing a major challenge on the EPI programme. The Pentaxim vaccine supply has been on and off as it is a newly introduced vaccine and the manufacturing pharmaceutical company Biovac is still rationing the orders for all provinces. The shortage of vehicles following expiry of the Fleet Africa service provider contract in January 2012 has also had an added negative effect on immunisation programme implementation. As a result, outreach services and the distribution of vaccines to facilities were negatively affected.

PCV and Rotavirus vaccine coverage which reduce mortality due to diarrhoea and pneumonia have increased beyond 80% mark (Table B6). On availability of the Pentaxim vaccine, mop-up campaigns are conducted to catch up with the children who could not get these at the time of stock-out.

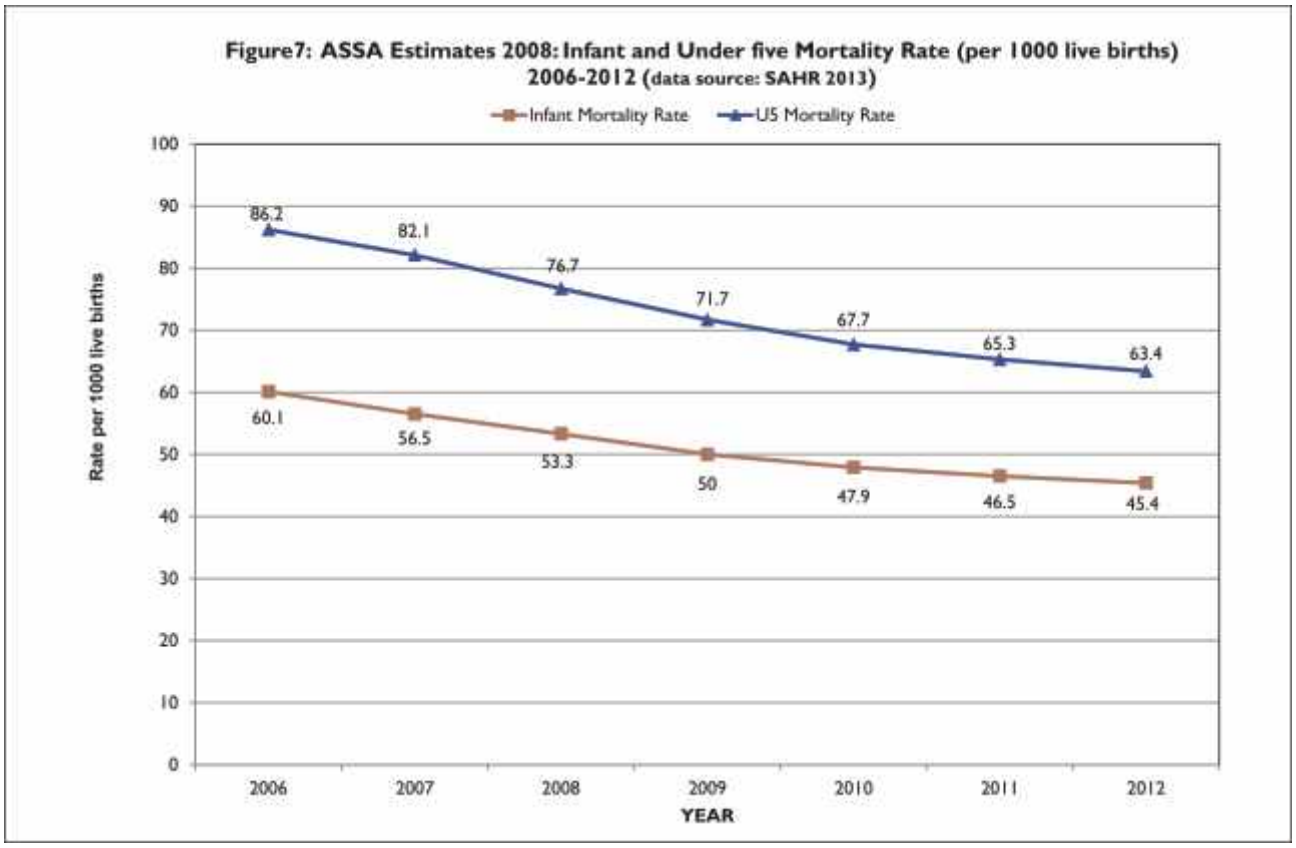


Figure7: ASSA Estimates 2008: Infant and Under five Mortality Rate (per 1000 live births) 2006-2012 (data source: SAHR 2013)
Infant Mortality Rate
U5 Mortality Rate
Rate per 1000 live births
100
90
80
70
60
50
40
30
20
10
0
86.2
82.1
76.7
71.7
67.7
65.3
63.4
60.1
56.5
53.3
50
47.9
46.5
45.4
2006
2007
2008
2009
2010
2011
2012
YEAR

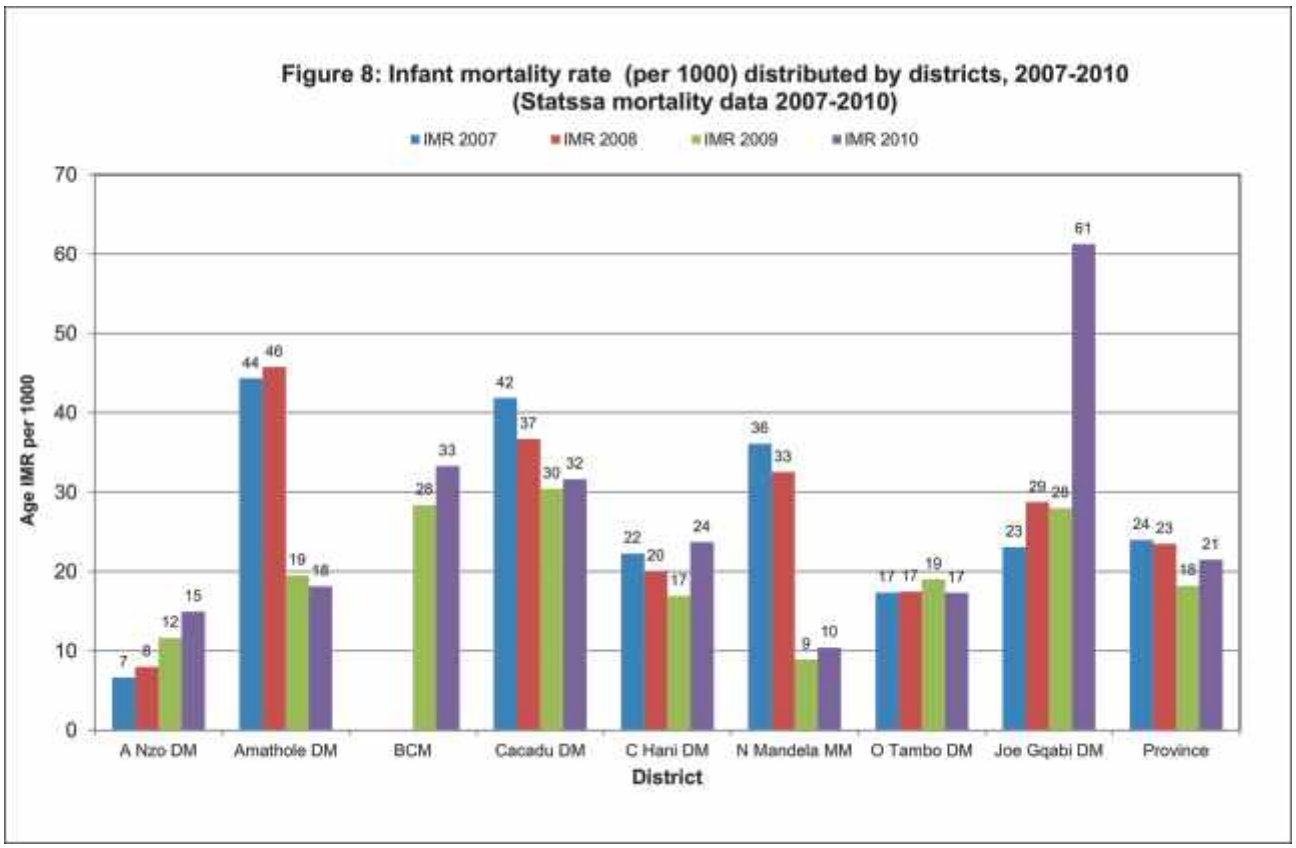


Figure 8: Infant mortality rate (per 1000) distributed by districts, 2007-2010 (Statssa mortality data 2007-2010)
IMR 2007
IMR 2008
IMR 2009
IMR 2010
Age IMR per 1000
70
60
50
40
30
20
10
0
7
8
12
15
44
46
19
18
28
33
42
37
30
32
22
20
17
24
36
33
9
10
17
17
19
17
23
29
28
61
24
23
18
21
A Nzo DM
Amathole DM
BCM
Cacadu DM
C Hani DM
N Mandela MM
O Tambo DM
Joe Gqabi DM
Province
District

Figure 9: Number of registered under five deaths by district, 2008-2010 (Statssa mortality data 2011-2013)

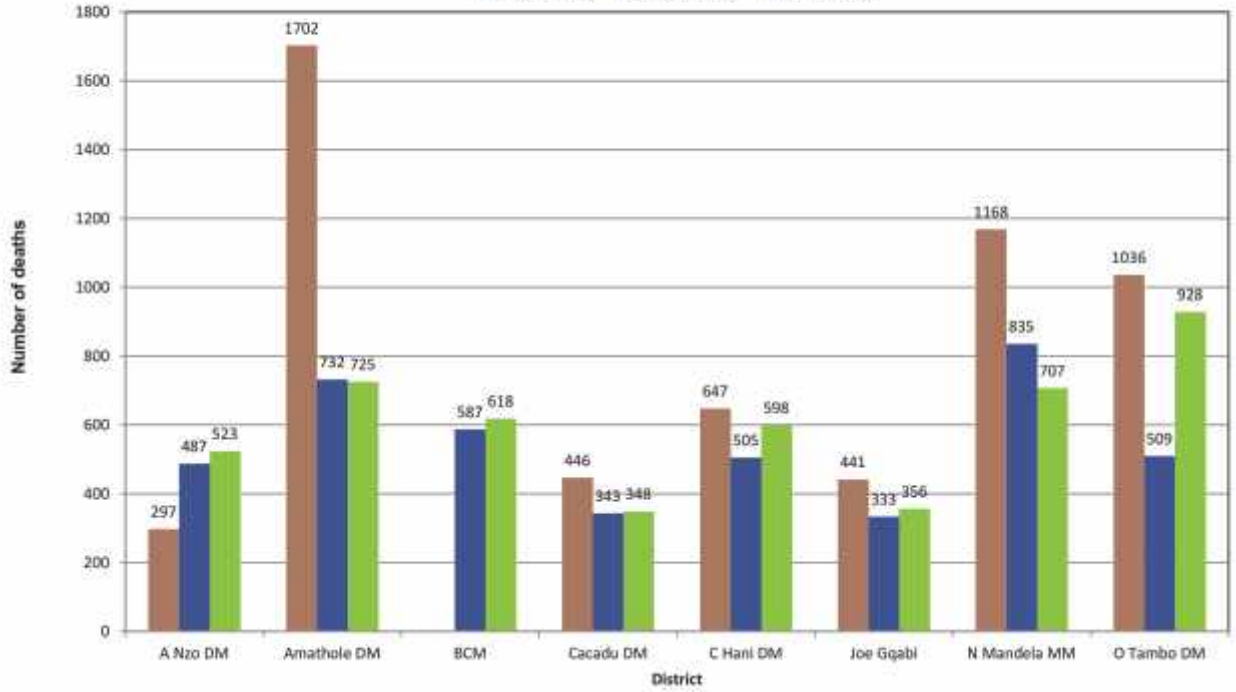
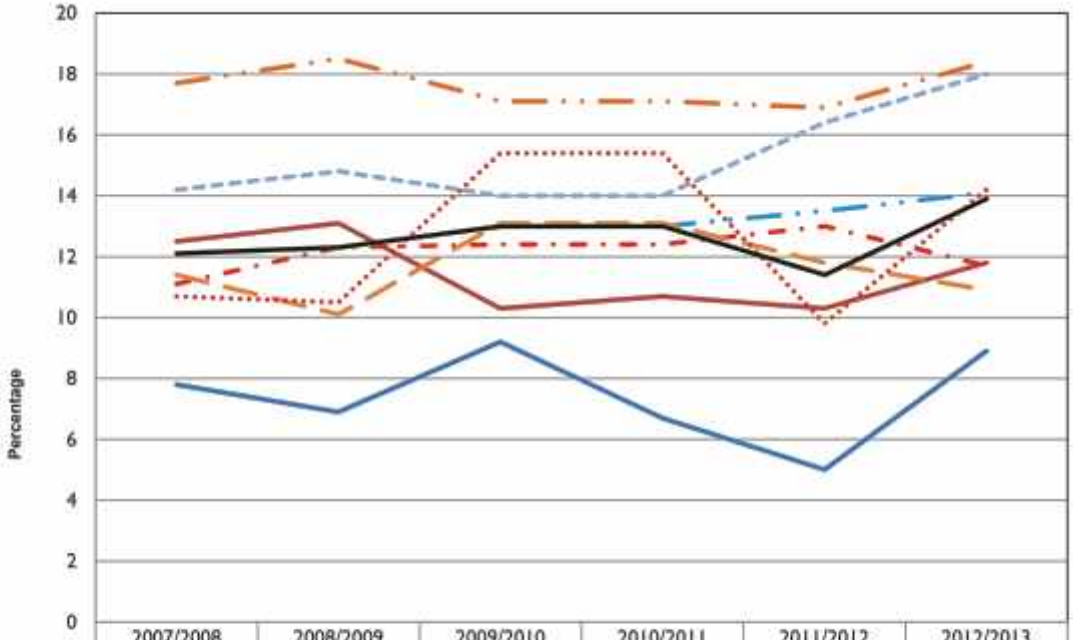


Figure 10: Low birth weight rate in facility distributed by district, 2007-2012



	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013
A.Nzo	7.8	6.9	9.2	6.7	5	8.9
Amathole	12.5	13.1	10.3	10.7	10.3	11.8
BCM				13	13.5	14.1
C.Hani	11.1	12.3	12.4	12.4	13	11.7
Cacadu	17.7	18.5	17.1	17.1	16.9	18.4
Joe Gqabi	11.4	10.1	13.1	13.1	11.8	10.9
NMM	14.2	14.8	14	14	16.4	18
OR Tambo	10.7	10.5	15.4	15.4	9.8	14.2
Province	12.1	12.3	13	13	11.4	13.9

To address child mortality challenges, professional nurses are trained on IMCI. All the nurses previously trained on IMCI are being trained on NIMART in order to initiate children on ARVs. Child mortality reviews are conducted to investigate causes of deaths in order to put appropriate intervention plans.

The Reach Every District (RED) strategy which had initially been implemented in three districts is now being rolled out to all eight districts of the province with the assistance of UNICEF. In order to ensure successful implementation of the RED strategy, managers are trained to reach every child with child health services and on Data Quality Self-Assessment. Further strategies to reduce under-five child mortality include the implementation of school health services and re-vitilisation model of PHC where DOH visits schools and households and provides health services including growth monitoring to under-fives, de-worming and administer Vitamin A to boost nutritional status; Significant increase in Vitamin A coverage in 12-59 months old children is expected with the change in policy and with CHWs now approved to administer Vitamin A at community level (Table B7).

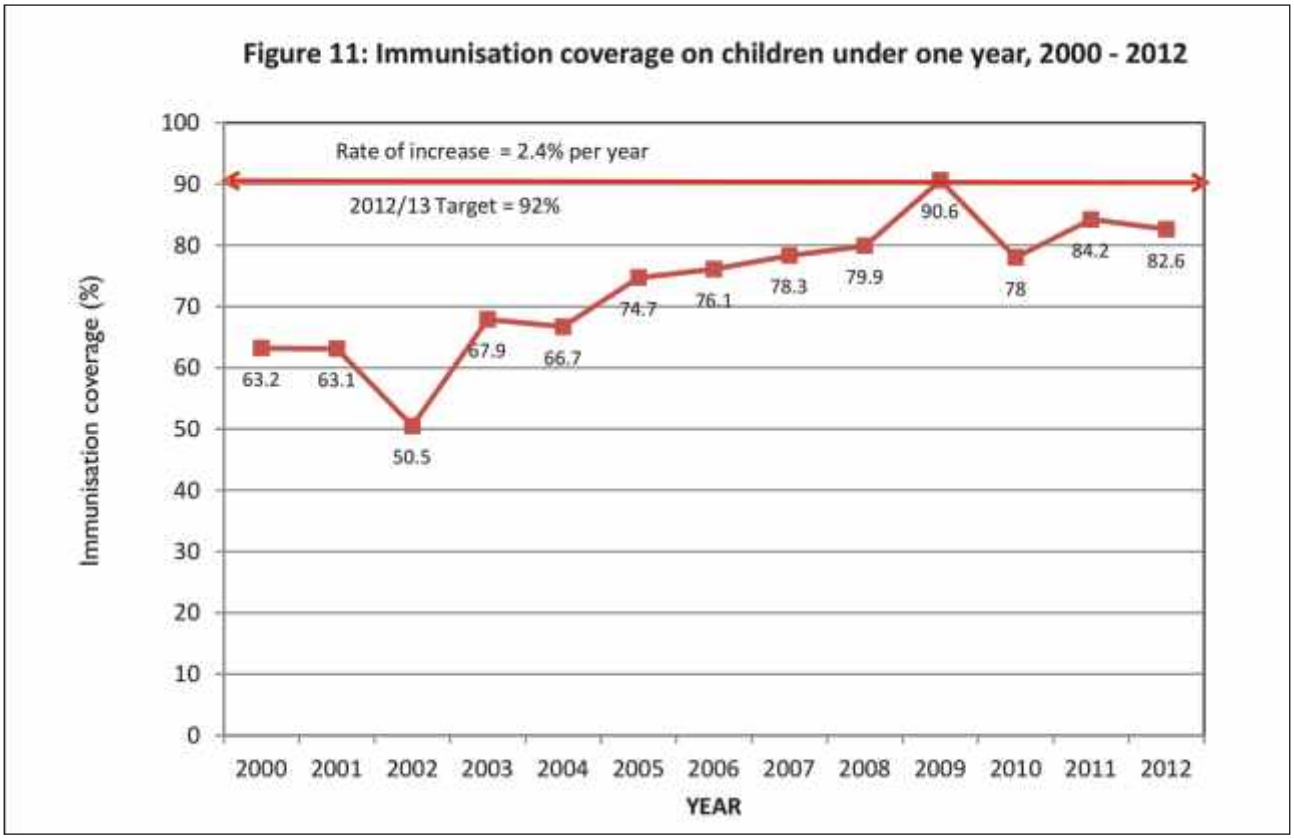


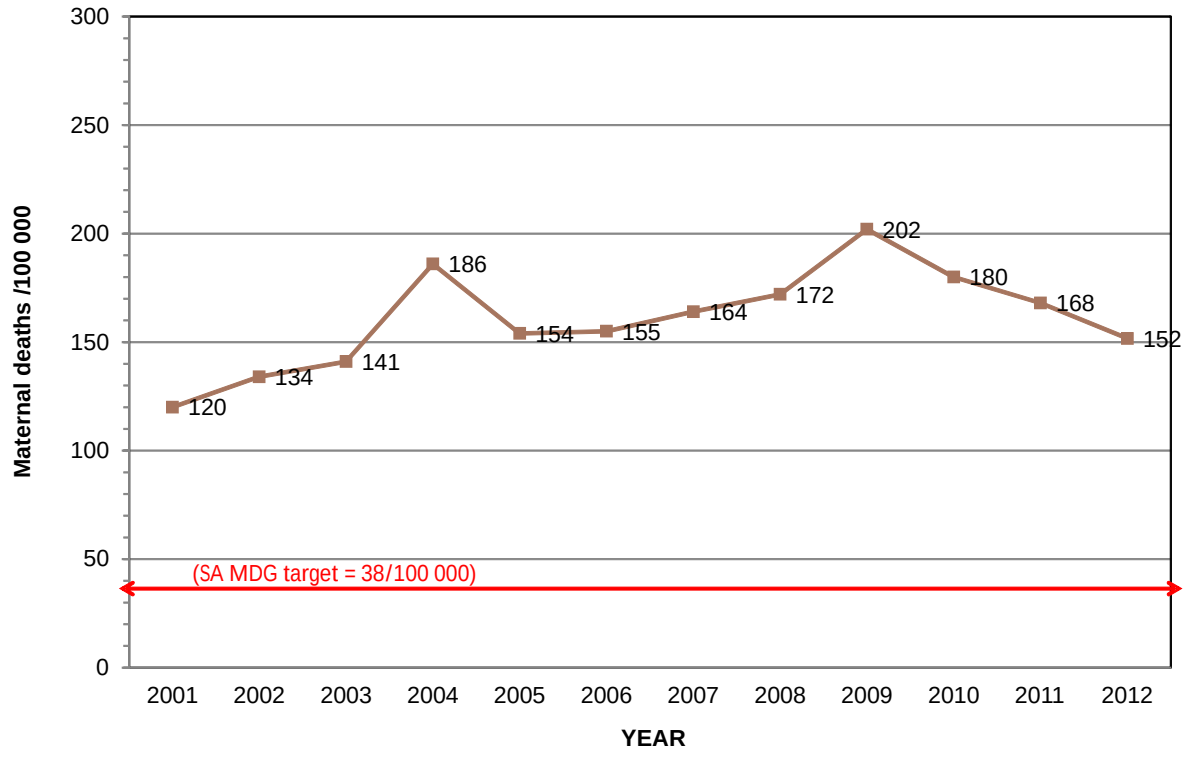
Table B6: Measures to prevent deaths of infants and children under the age of five years

INDICATOR	2009/10	2010/11	2011/12	2012/13
Measles second dose coverage rate (%)	-	76.6	80	75.9
Pneumococcal Conjugate Vaccine (PCV7) third dose coverage (%)	38.5	41.9	80.9	87.7
Rotavirus vaccine (RV) second dose coverage (%)	35.2	40.7	77.6	83.7
Post-natal mother visits within 6 days (%)	56.9	67.1	73	74.4
Post-natal baby visits within 6 days (%)	56.9	70.5	73	76.8
Vitamin A coverage children 12-59 months (%)	36.7	36.4	45.1	43.6
Diarrhoea incidence under 5 years (per 1000)	93	104.2	89.1	79.2
Diarrhoea with dehydration under 5 years (per 1000)	13	13.5	11.9	10.7
Pneumonia incidence under 5 years (per 1000)	56	61.6	58.2	55.7

Decreasing Maternal Mortality

Figure 12 shows after 2009, a declining trend of deaths of women due to pregnancy related causes during pregnancy or within 40 days after delivery. To reduce deaths of pregnant women further, the department is implementing the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA), which is an EU adopted national strategy that was launched in SA in 2012.

Figure 12: Maternal Mortality Ratio (MMR) per 100 000 live births in the EC province 2001 - 2012 (Data source: SMSB, DHIS)



Maternity awaiting homes:

The department is implementing maternity awaiting homes in four district hospitals namely Zithulele, Madwaleni, Taylor Bequest (Mt Fletcher) and Nessie Knight hospitals. These homes are within hospital premises for prompt response at the time of labour. These facilities accommodate women at 38 weeks of pregnancy from remote rural areas with less adequate resources including poor road infrastructure and transport challenges. The department is receiving support from the UNFPA which is building an awaiting home at Tafalofefe hospital. Building plans for an awaiting home at Siphethu hospital had been approved.

Training:

The community obstetrician in the department conducts trainings and train health service providers on ESMOE and Basic Antenatal Care (BANC). Training sessions on insertion of intra-uterine cervical device (IUCD) were conducted. The training of health professional on the new family planning policy is being rolled out in all the EC districts. Youth-friendly clinics are being re-vitalised whilst also training health service providers on youth friendly services. School health services coupled with community-based interventions are implemented to increase awareness about family planning issues. All these strategies will improve the health provider capacity and in addition control teenage pregnancy.

Decentralisation of Emergency Medical Services:

In order to improve response times and facilitate rapid response, the department is implementing a decentralization strategy. Ambulances are being located within reach of communities for ease of access and to shorten response times as opposed to old practice of keeping them at METRO bases from where they were dispatched in response to calls. Similarly, the obstetric emergency ambulances are placed strategically at MOU facilities so that when a patient needs to be transferred for emergency operation there's no waiting and therefore very little time is lost.

Pursuant to the placement of the 36 Obstetric Emergency Units at health facilities closer to the communities they serve during 2011/12 FY, EMS has during August/September 2012 placed an additional 27 ambulances at other designated health facilities to improve the response and turn-around times. The staffing of these units however, remains a challenge. Through this strategy the response base of ambulances was broadened in a given geographical area, especially within the rural context. This had a profound effect on response times with regards to inter-hospital transfers of mother, babies and other emergency patients.

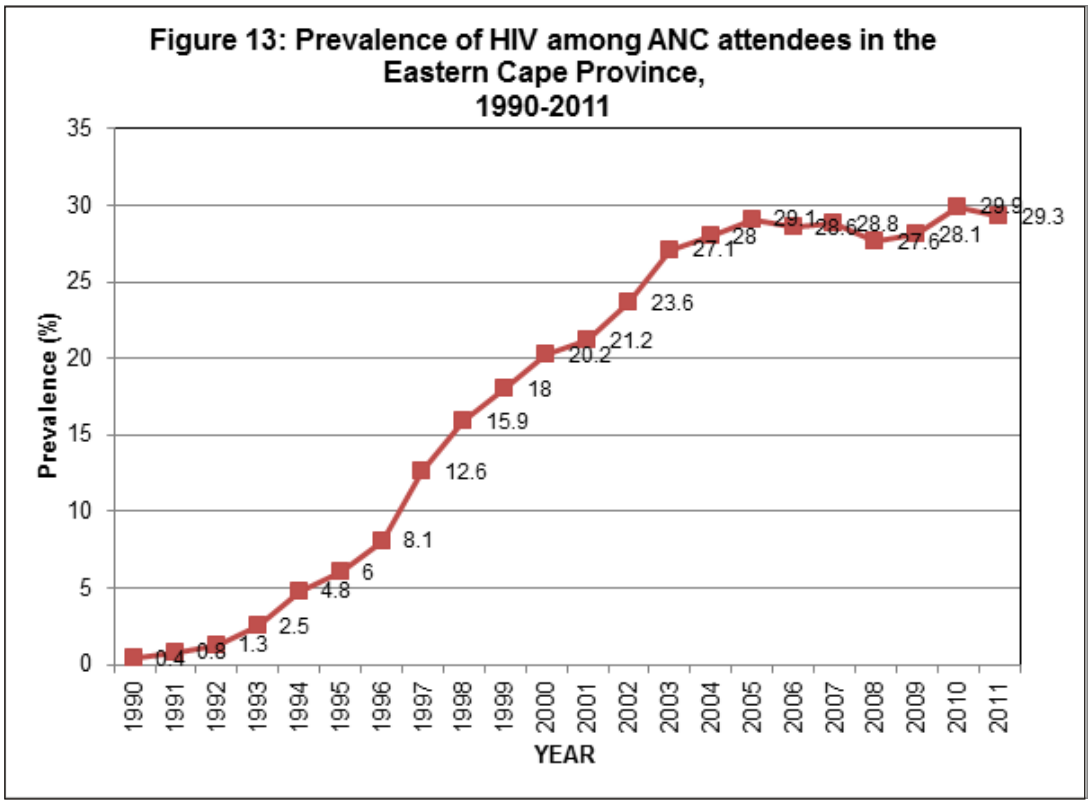
Whilst the EC DOH has achieved a high ANC coverage, the rate of attending ANC before 20 weeks of pregnancy is still very low (Table B7). The department needs to invest in educating the communities regarding the health benefits of early attendance.

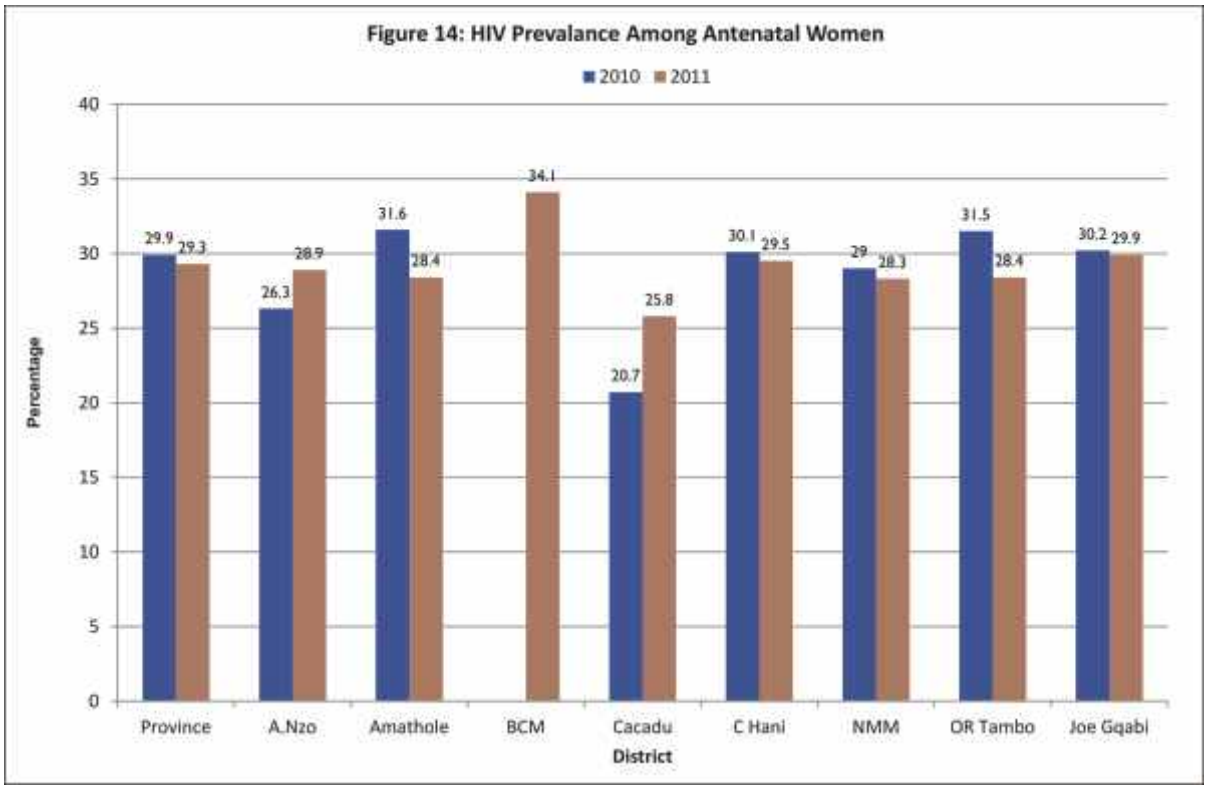
Table B7: Measures to prevent deaths of pregnant mothers

INDICATOR	2009/10	2010/11	2011/12	2012/13
Antenatal care coverage	88.9%	94.6%	99.4%	89.9%
Antenatal visits before 20 weeks rate	31.1%	31.7%	33.6%	39.6%
Delivery rate in facility	76.9%	79.5%	90%	83.7%
Antenatal client HIV first test rate	99.7%	95.9%	94.3%	98.7%
Post-natal mother visits within 6 days	-	32.2%	44.9%	55.6%
Post-natal baby visits within 6 days	-	34.3%	46.1%	58.3%
Couple year protection rate	28.7%	30.3%	31.2%	31.7%

3. Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis

The latest statistics shows the percentage of pregnant women tested for HIV and testing positive (HIV prevalence) to be at 29.3% (figure 13). After plateauing between years 2004 and 2007, the HIV curve on figure 13 shows a slight increase since 2008. The Buffalo City Municipality, Joe Gqabi and Chris Hani district had the highest prevalence of 34.1%, 29.9% and 29.5% respectively. Cacadu recorded the lowest prevalence of 25.8% (Figure 14). The ANC prevalence report (2011) puts the provincial HIV prevalence of adults 15-49 years at 16.02%.





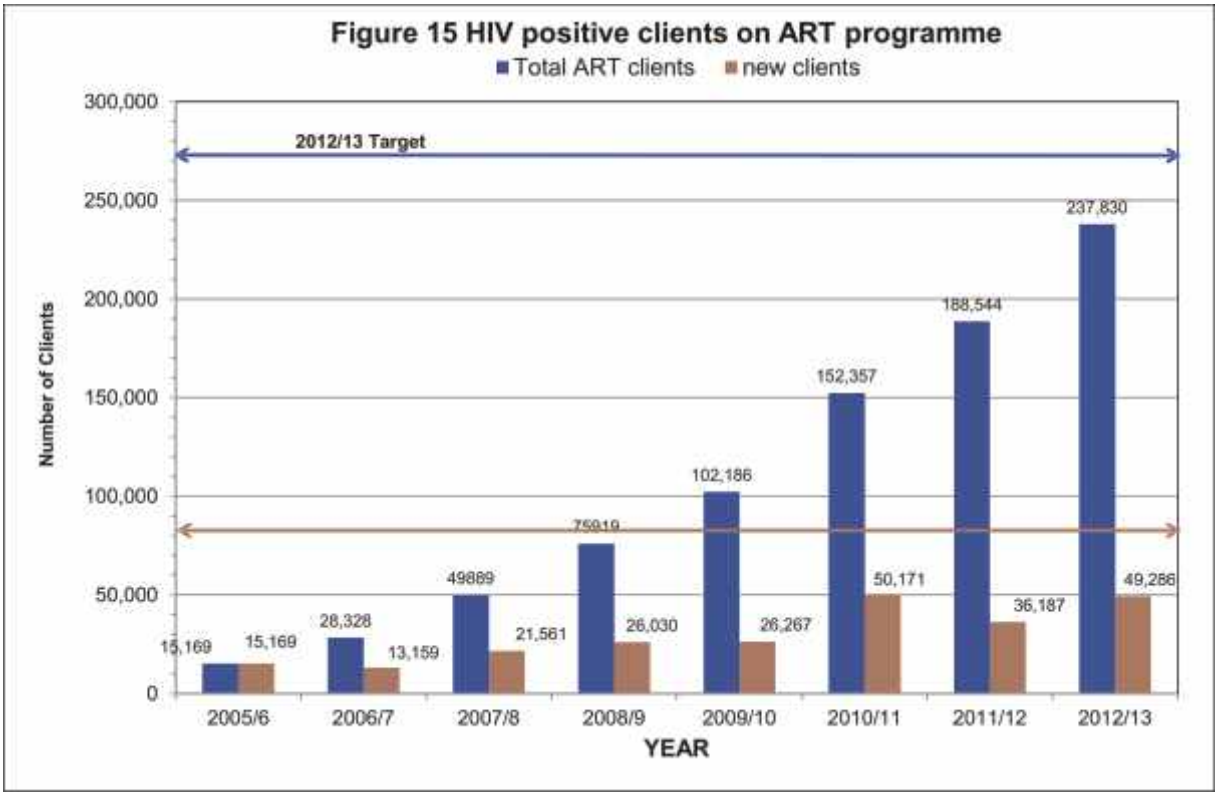
Strategies for HIV prevention and control

Prevention of Mother to child Transmission (PMTCT)

The implementation of the prevention of mother to child transmission (PMTCT) resulted in a significant decrease in HIV infected babies tested around six weeks of birth, from 8% in 2009/10 to 3% in 2012. The programme is targeting zero infections in new born babies by 2015. In order to achieve this target, initiation of ART and fixed dose combination (FDC) drug is prioritised for eligible HIV pregnant mothers. Implementation of prophylaxis in this group is a priority as well.

Nurse Initiated Management of ART (NIMART)

At the end of 2012/13 financial year, there were 790 health facilities that were assessed and considered to be ready to be the access points for ARVs. Mechanism is in place to ensure that at list two nurses per facility are trained in Nurse Initiated Management of ART (NIMART) which led to the observed increase in number of patients put on ART. There were 49 286 new clients put on ART programme, increasing the number from 188 544 in 2011 to a total of 237 830 clients on the programme by end of the financial year under review (see figure 15). HIV and TB co-infected clients are prioritised on the FDC drug as well.



HIV Counselling and Testing (HCT)

Strategies embarked upon in order to upscale HCT during 2012/2013 and that resulted to the realised targets include road shows conducted at all sub-districts to upscale testing during the STI/Condom week in February 2012. The following events were undertaken:

- HCT launch for Men Sector held in Chris Hani district, where 3000 men from the district were tested over one week period;
- The first tertiary institutions' campaign was conducted in February 2012 and 3500 students were tested; subsequently 2000 and 1500 students were tested in July and September 2012 respectively.
- HCT testing was done at an Imbizo meetings;
- In January 2013, data mop-up was done targeting high volume facilities and private companies.
- In February, counselor mentors conducted HCT testing at taxi ranks and
- The HIV programme participated in international Rotary Family Health days in May 2013; during this event 1 286 people were tested for HIV, 86 400 condoms distributed and 3 944 babies were immunized.

Medical Male Circumcision

In the light of the national initiative to embark on Male Medical Circumcision (MMC) as a strategy to prevent HIV infection, the ECDOH has actively rolled out the program in the Eastern Cape during 2012/13. The Eastern Cape, being the province that is practising circumcision as its culture, considered a comprehensive integrated safe circumcision approach that encompasses traditional circumcision. A fully integrated plan, developed in partnership with and led by the House of Traditional Leaders with the DOH playing a supportive role, flagged out the support areas. The DOH support has been resourcing the health promotion and prevention initiatives to curb deaths and manage complications related to circumcision. Consultative outreach and educational programs on safe circumcision practices are driven through an integrated approach by the DOH as well as the relevant stakeholders in the province.

Other significant interventions

In order to meet the programme demands, the HIV and STI program has, through Conditional Grant increased both human and financial resources. The key program focus was to facilitate down referral of ARV patients from hospitals levels to Primary Health Centres in an effort to improve access to ART treatment closer to the communities. In addition, the program is promoting compliance with the treatment by fast-tracking the treatment of pregnant women and TB/HIV co-infected patients and infants; changing and implementing latest policy that increased CD4 eligibility criterion from 200 in 2009 to 350; as well as implementing the Fixed Dose Combination (FDC). The FDC is a newly introduced drug that is improving the clinical management of patients that are on ARVs. The patients are now taking one tablet instead of three tablets a day with the previous regimen. The ART uptake for TB patients co-infected with HIV, initiated on ART has improved during the 2012/13.

However, the department has to ensure that 80% of TB patients co-infected are initiated on ART, by the end of 2013/14 financial year. The Cotrimoxazole prophylaxis therapy (CPT) uptake for all the TB patients co-infected with HIV remains above 80% which is highly commendable.

TB management and Control

A total of 56 480 new TB cases were detected in 2012 translating to an incidence rate of 851 new TB clients per 100 000 population. Of the total TB clients 51 932 were pulmonary TB (PTB). Smear positive TB comprised 54.6% of detected PTB, presenting a provincial incidence of 429 per 100 000 (figure 16). After peaking in 2008, the TB incidence curve in the province is showing a declining trend as a result of dedication and rigour in the implementation of TB interventions.

Whilst there is some decrease observed, Cacadu and NMMM are consistently reporting the highest incidence of TB burden (see figure 17) with Amathole District likely to reflect the challenges that the programme is experiencing in that district. The Department is ensuring that all HIV positive clients are tested by culture. The number of GeneXpert machines has increased from nine in 2011 to 32 in 2012 covering all seven districts. This is a new diagnostic machine that is used to diagnose tuberculosis and detects Rifampicin resistance within two hours, thereby promoting early detection and treatment of clients.

Figure 16: New TB clients per 100,000 population in the Eastern Cape Province, 2002-2011

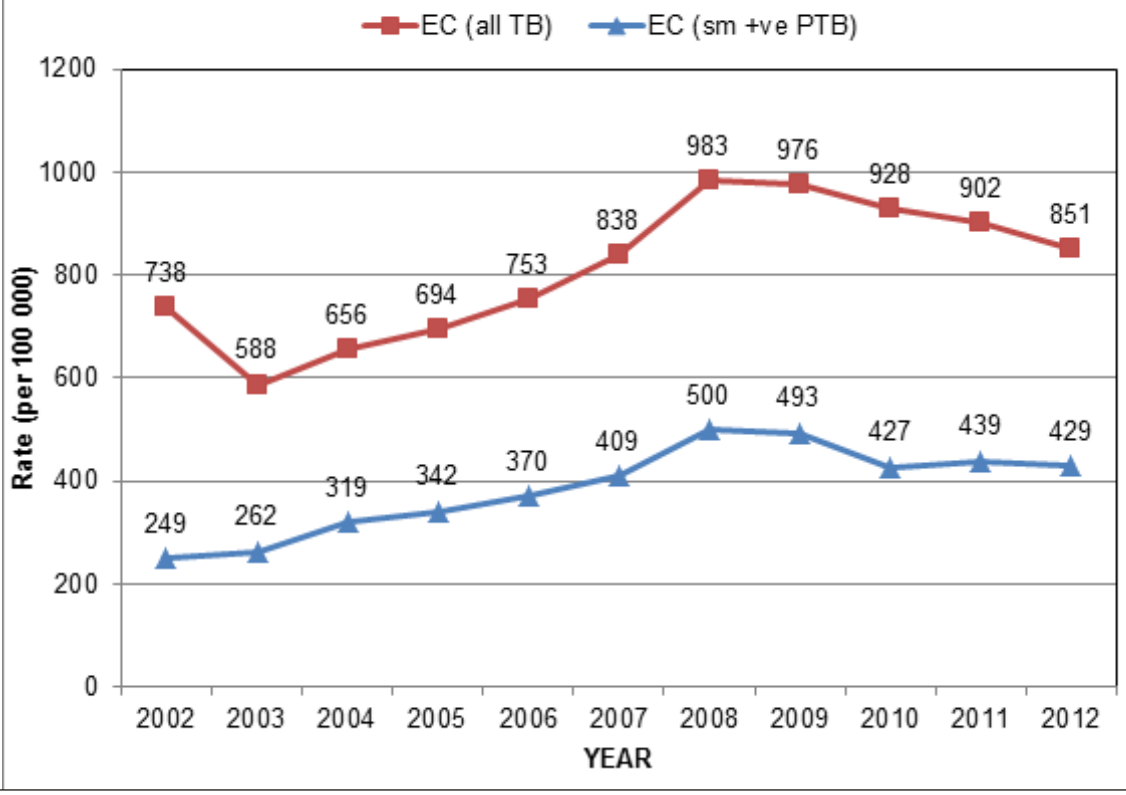
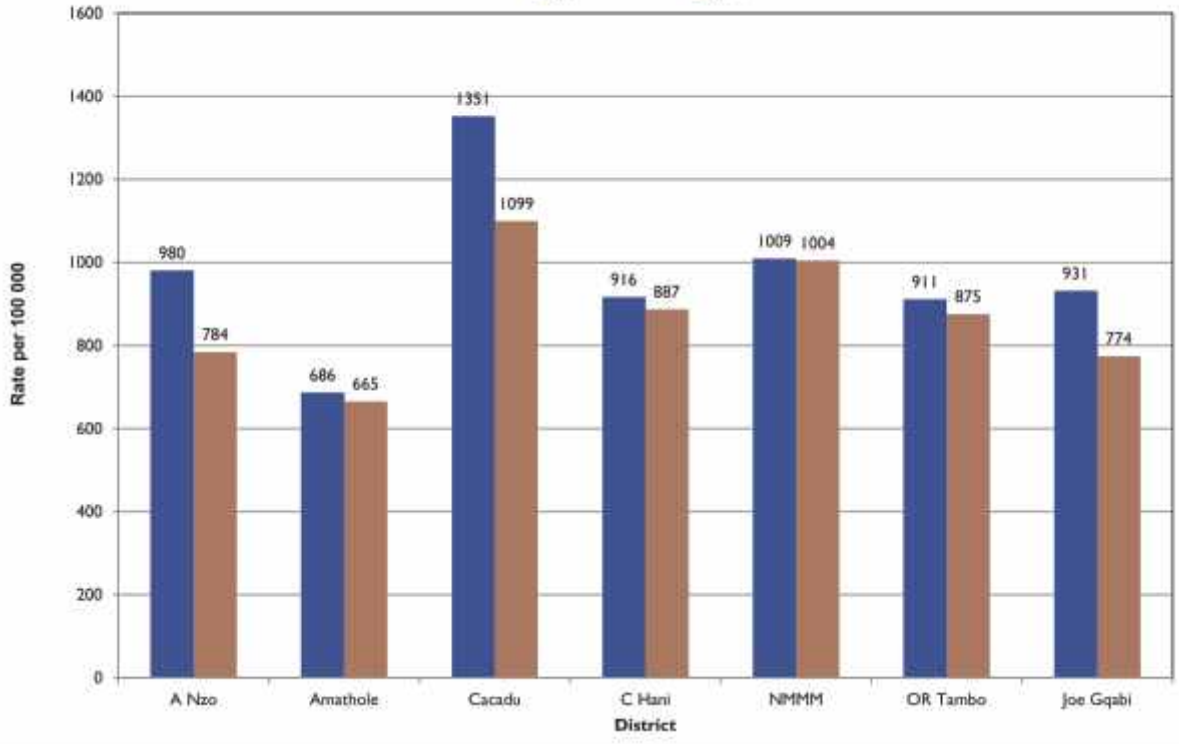


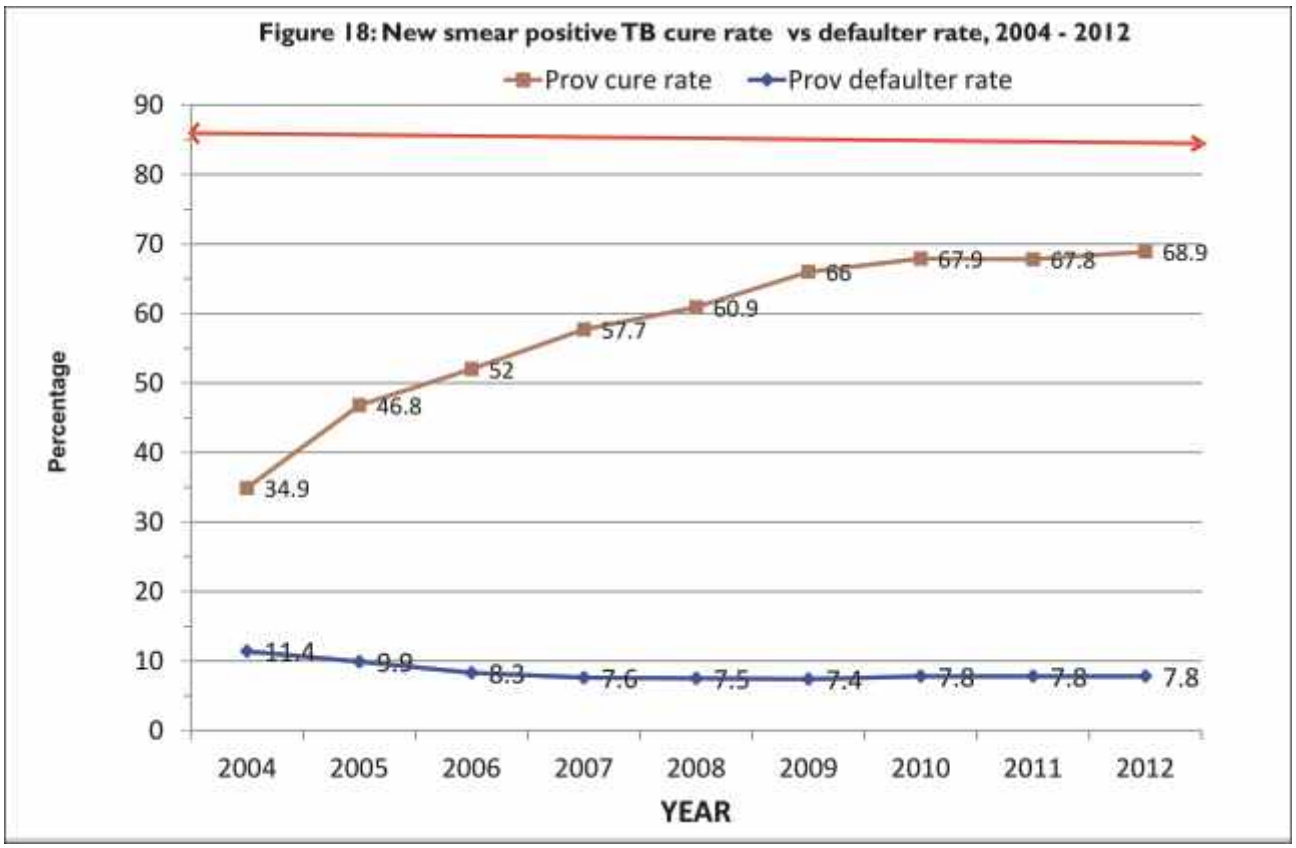
Figure 17: New TB clients per 100 000 distributed by district, 2011 & 2012

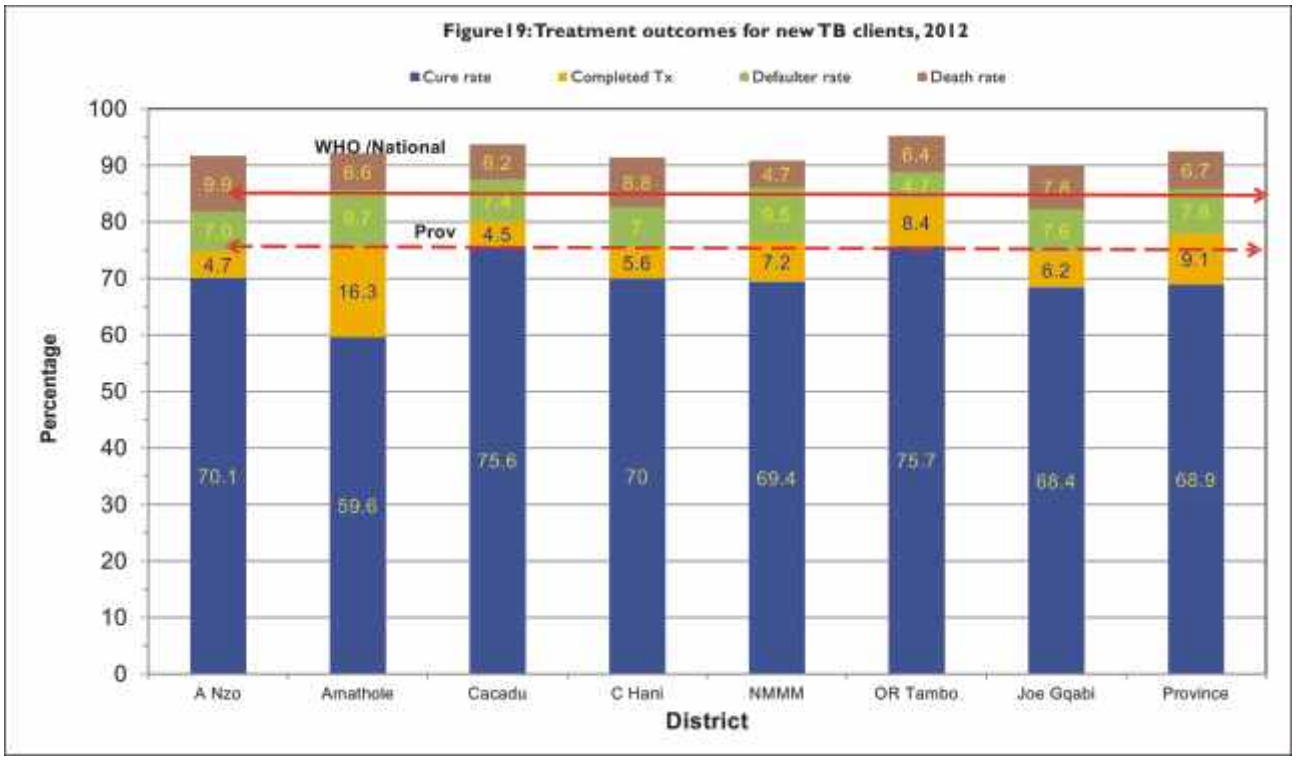


TB Treatment Outcomes

New smear positive PTB cure rate: Against a target of 75%, the TB cure rate increased from 67.8% in 2010 to 68.9% in 2012 (see figure 18). The TB cure rate showed an increasing trend since 2003 in all districts in the EC province. Cacadu and OR Tambo districts were the two districts that met the target (Figure 19). Amathole District had the lowest cure rate of 57%. Despite the fact that both Amathole and Joe Gqabi districts show the lowest cure rates than the other districts, the increasing trend observed in these districts is commendable.

TB defaulter rate: A target of 5% was not met. Treatment defaulter rate was 7.8% consistently for the three consecutive years 2010 to 2012 (figure 18). Defaulter rate was highest at Amathole district and NMMM at 9.7% and 9.5% respectively due to loss to follow-up.These are urban settings and clients migrate back to their places of origin.





TB interventions

In line with the department's RPHC initiatives, the TB programme strengthened its outreach activities by appointing 86 enrolled nurses and hired 22 vehicles to implement the Community-based Model for the management of MDR-TB patients and other PHC programmes. There is no waiting period for admission to hospital as patients are initiated on treatment at home within 48hrs as soon as the MDR-TB gets confirmed. In visiting households, the community-based model affords vigorous follow-up to defaulters, promotes treatment adherence and identify & refer contacts for early management.

The social compact model of the RPHC promotes the advocacy and social mobilisation component of the TB control programme. It also promotes awareness about the TB burden and preventive strategies. The department trained 166 Imbumba Yamakhosikazi Akomkulu (IYA), as part of empowering women on preventative strategies for TB.

Whilst the RPHC aim is to shift focus from curative to preventive strategies the Department has improved infrastructure requirements of the programme by constructing and upgrading TB hospitals including Jose Pearson, Nkqubela and Empilweni to comply with infection control policies and guidelines. Designs included isolation units and improved mechanical ventilation

MDR and XDR-TB

In order to free bed space in multi-drug and extreme drug resistant TB (MDR & XDR TB) hospitals and to fast-track prompt initiation of treatment to confirmed TB MDR clients, the department has de-institutionalised and decentralised MDR TB to Primary health care at community level. The programme thus far has achieved encouraging results; 95% (667) of 703 registered and eligible MDR-TB patients co-infected with HIV were started on ART. Similarly, all 236 XDR patients that were eligible for ART received treatment; this was made possible by institutionalisation of these clients to minimise loss to follow-up.

Integration of TB with HIV and AIDS

This Sub-programme is mainly looking at establishing and strengthening the mechanisms of collaboration and joint management between the HIV programme and TB-control programme for delivering integrated TB and HIV services, preferably at the same time and location. Encouraging results on this program had been achieved with the number of TB/HIV patients started on Cotrimoxazole Prophylaxis Therapy (CPT) in excess of the 20 000 target (21537) whilst those started on ART exceeded 9 000 target (10 811).

FINANCIAL OVERSIGHT REPORT

1. Spending Trends

The table below shows the high level financial performance of the department at the end of the financial year.

Table B8: High Level Financial Performance

Adjusted Budget	Expenditure	Variance	Expenditure as a % of Budget
R'000	R'000	R'000	
15,734,550	15,600,907	133,643	99.2

Table B9: Appropriation per Economic classification

	2012/13							
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000
Current payments								
Compensation of employees	10,228,158	(155,928)	(193,793)	9,878,437	9,825,805	52,632	99.5%	9,182,174
Goods and services	4,243,808	(78,640)	193,793	4,358,961	4,415,869	(56,908)	101.3%	4,044,239
Interest and rent on land	-	-	-	-	4,296	(4,296)		-
Transfers & subsidies								
Provinces & municipalities	8,084	-	-	8,084	7,928	156	98.1%	-
Departmental agencies & accounts	29,436	-	-	29,436	24,428	5,008	83.0%	45,770
Universities & technikons	101,845	-	-	101,845	101,770	75	99.9%	138,649
Households	255,338	8,510	-	263,848	260,360	3,488	98.7%	134,915
Payment for capital assets								
Buildings & other fixed structures	654,810	-	-	654,810	598,417	56,393	91.4%	913,380
Machinery & equipment	211,419	226,058	-	437,477	360,349	77,128	82.4%	351,767
Payment for financial assets	-	-	-	-	17	(17)		88
Total	15,732,898	-	-	15,732,898	15,599,239	133,659	99.2%	14,810,982

2012/13							
Direct charge against the National/ Provincial Revenue Fund	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation
	R'000	R'000	R'000	R'000	R'000	R'000	%
Member of executive committee/parliamentary officers	1,652	-	-	1,652	1,668	(16)	101.0%
Total	1,652	-	-	1,652	1,668	(16)	101.0%

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

On the overall, the Department under-spent its budget allocation by R133,64 million. The under spending emanates primarily from three economic classification categories namely, the current payments - which overspent the budget by a net R8,6 million; the buildings and other fixed structures which exceeded by R56,39 million and the machinery and equipment which went overboard by R77,13 million.

The department has applied for Conditional Grants funds totalling R132,911 million - appropriated but not spent in the 2012/13 financial year, which amount is to be rolled over to the 2013/2014 financial year. The request for roll over is supported by commitments where capital expenditure and 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 decreased spend on COE is attributable mainly to the control measures put in place by the OTP and Provincial Treasury on the filling in of vacant posts.

The under-spending in buildings and other fixed structures was as a result of stop and start of projects such as that of CMH, due to industrial action by employees engaged by contactors as well as certain contractors filing for Business Rescue (Chapter 6 of Companies Act 71 of 2008) and further on granted liquidation. Machinery and equipment was under spent mainly due to challenges with supply chain processes.

Programme 1: Administration - Under expenditure of R0,73 million

The main contributor to this under spend is compensation of employees. The envisaged filling of all vacant executive posts did not take place.

Programme 2: District Health Services - Over expenditure of R52,02 million

This programme over spent its total budget by R52.02 million. This happened despite an underspend in compensation of employees (R3.77 million), departmental agencies and accounts (R4.92 million) and payment for capital assets (R18.98 million).

The over expenditure of R79.22 million on goods and services relates primarily to medical supplies including pharmaceuticals, vaccines and surgical sundries, arising from the increased burden of disease in the province.

In addition, the Department submitted applications for the rollover of conditional grant funds to the Provincial Treasury in respect of the Comprehensive HIV and Aids Grant of R27,0 million and National Health Insurance Grant of R3,41 million.

Programme 3: Emergency Medical Services - Under expenditure of R47,87 million

The under expenditure of R47,00 million on payments for goods and services arose mainly from the non-delivery of 130 ambulances out of an order of 190 by the Department of Transport.

Programme 4: Provincial Hospital Services - Under expenditure of R3,76 million

The main contributor to this under-spend is compensation of employees and is attributable to strict measures imposed by Provincial Treasury with regards to employment and replacement of vacant posts.

Programme 5: Central Hospital Services - Under expenditure of R45,25 million

The under-spend of R45,25 million is primarily represented by an application to the Provincial Treasury for rollover of R3,31 million in goods and services, R40,71 million in machinery and equipment, and R1,56 million in buildings and other fixed structures. This application was in respect of the National Tertiary Services Conditional Grant. It is understood that the roll over applied for may be limited to the amount of under expenditure.

The R3,31 million under-spending in goods and services relates to services rendered by SANBS. The under-spending in machinery and equipment of R40,71 million is attributable to, inter alia, the delays in the delivery of various items of medical equipment such as MRI scanners purchased within the hospital complexes in the Province. The under expenditure in building and other fixed structures relates to fencing at the Fort England Hospital.

Programme 6: Health Sciences & Training - Under expenditure of R59,11 million

The programme has an under-spending of R59,11 million. This Under expenditure occurred mainly in compensation of employees by R32,48 million, goods and services by R21,56 million, transfers to universities and technikons by R2,38 million and machinery and equipment by R2,61 million.

The under-expenditure on COE was due to measures put by the Department, Provincial Treasury and OTP to curb overspending and growing COE pressures.

The under-spend in goods and services is mainly from the Skills Levy, wherein most of its activities stalled.

As the Other Training sub-programme is funded through the Health Professions Training and Development Grant, rollovers amounting to R4,07 million have been applied for from Provincial Treasury.

Programme 7: Health Care Support Services – Under expenditure of R3,00 million

The main contributor to this under-spend is the compensation of employees.

The under expenditure on COE was due to measures put by the Department, Provincial Treasury and OTP to curb overspending and growing COE pressures.

Programme 8: Health Facilities Management – Under expenditure of R25,77 million

Even though the programme had a net under-spend of R25.77 million, goods and services, particularly in relation to contracted maintenance of buildings and machinery and equipment, overran the budgeted amount by R46,50 million. Buildings and other fixed structures under spent by R52,89 million due to stops and starts caused by labour relations issues at CMH while Machinery equipment under spent by R16,18 million due to challenges encountered with supply chain processes.

Since this programme receives funding from conditional grants, rollovers have been applied for. The Department submitted an application for the rollover of conditional grant funding to Provincial Treasury in respect of R45,79 million for Hospital Revitalisation Grant, R4,80 million for the Health Infrastructure Grant and R2,27 million for the Nursing Colleges and Schools Grant.

Virement

The Department implemented, in terms of section 43 (1) of the PFMA and Treasury Regulation 6.3.1, the use of savings of R193,793 million in compensation of employees in the current (2012/2013) financial year to defray over expenditure in goods and services.

Unauthorised expenditure

The department has, for the year under review, incurred unauthorised expenditure amounting to R52,019 million in its vote, due to over spending in goods and services in Programme 2 District Health Services, which overspending was caused primarily through the reimbursement of provincialisation (provincial setting-ups)? of primary health care claims received from various municipalities and metros.

The Unauthorised expenditure as at 31 March 2013 amounts to R1,357,832 billion and is cumulative from the 2009/10 – 2012/13 financial years.

Eastern Cape Finance Act (2013): In terms of the Eastern Cape Finance Act (2013), the Department's unauthorised expenditure totalling R1,286 billion [(2011/12 : R297,6 million), 2010/11: (R116,4 million) and 2009/10 : R871,9 million)] has been condoned with funding.

This act was approved by the Premier of the Province of the Eastern Cape on 28 March 2013, and the funding received by the Department in April 2013.

- Fleet Management Services: Following the expiry of the fleet contract in January 2012, the department entered into an agreement with Government Fleet Management Services (GFMS), a trading entity, of the Department of Transport for the provision of Fleet Services to the Department. The agreement will continue for an indefinite period. The Department may cancel the agreement at any time by giving GFMS 3 months' notice and returning the vehicles to GFMS. In terms of Clause 4.1 of the agreement, ownership of the vehicles will remain vested in GFMS and will not be transferred to the departments at the end of the lease term.

3.1. Service Delivery Improvement Plan

As part of improving the delivery of health services, the department continues to implement the key strategic priorities for quality improvement which are in line with the National Core Standards. These key strategic priorities are listed below and organisational performance progress on these is shown in Table SDIP 1.

These are:

- Revitalisation of Primary Health Care
- Improving the availability of medicines and drugs in all health facilities at all material times.
- Improving the services of the Emergency Medical Services (EMS)

3.2.1 Customers of the Eastern Cape Department of Health.

The list below, though it may not be exhaustive, shows the primary and secondary customers, clients and critical stakeholders of the Department:-

Primary customers of the Department of Health: The patients and the communities who attend public health facilities in the Eastern Cape Province are considered as primary customers of the Department of Health.

Secondary customers: These are clients with whom the Department of Health interacts and include the following:-

- Private Health Organisations;
- Organised labour within the Health Sector;
- Traditional health service providers;
- Health standing committee;
- District Health Councilors;
- Human Rights Commission;Youth Commission;
- Commission for Gender Equality;
- Women groups;
- Designated groups (The youth, elderly, disabled, women and children.);
- Special interest groups;

- Other Government Departments/ work places/ correctional facilities
- Non-Governmental Organizations (NGOs) and
- Community Based Organizations (CBOs);
- Clinic committees and hospital boards;
- Health professionals in the public and private sector;
- Registering Professional bodies Nursing Council,
- Health Professional Council of South Africa,
- Associations for health professionals e.g. South African Medical Association.

The tables below shows the achievements by end of the financial year on the implementation of the service delivery plan.

3.3. Service Delivery Improvement Plan

The department has completed a service delivery improvement plan. The tables below highlight the service delivery plan and the achievements to date.

Table B10: Main services provided and standards

MAIN SERVICES	ACTUAL CUSTOMERS	POTENTIAL CUSTOMERS	STANDARD OF SERVICE	ACTUAL ACHIEVEMENT AGAINST STANDARDS
Delivery of Primary Health Care services through the implementation of the District Health service as delivery mode	Primary customers Communities	Work places Correctional facilities Special interest groups	Clinic for every 10 000 population or within 5km radius; national PHC target of 3.5 visits per person per year	**PHC utilisation rate** The rural nature of the EC province makes it difficult to achieve the set standards; challengesinclude the topography, access roads and the scattered communities. However, the department has a total of 751 PHC facilities serving a total EC population of 6 671 956. To take health services closer to the communities the Department is implementing a community-based revitalisation of PHC model. The aim is to increase the PHC utilisation rate from the current average of 2.7 to the national target of 3.5 visits per person per year. **Ward-based PHC Teams** The Department achieved its target of 5 sub-districts planned to implement the Revitalisation of Primary Health Care (RPHC) program during the first half of the financial year. The RPHC implementing sub-districts are the KSD, Nyandeni, Mbashe, Intsika Yethu and sub-district B of the Nelson Mandela Bay Metro. During the FY under review, there was a total of 325 PHC teams operating in the EC eight health districts. Whilst there is no dedicated budget allocated for the establishment of the PHC teams, the Departmental approach had been to utilise and allocate the existing human resource from the PHC facilities. This was done in order to take the services to the people and thereby anticipating decrease in PHC visits as communities will be utilising more the community-based services. The main responsibilities of these teams are to visit households in the wards, screen for diseases, refer where appropriate and provide health education. **School health services** The EC DOH continues to appoint nurses outside the employment of the DOH on a one year contract basis to join the PHC teams in various sub-districts in order to screen learners at the foundation phase (grade R- 10) and refer where appropriate.

MAIN SERVICES	ACTUAL CUSTOMERS	POTENTIAL CUSTOMERS	STANDARD OF SERVICE	ACTUAL ACHIEVEMENT AGAINST STANDARDS
				During the 2012/13 FY, a total of 101 retired nurses were recruited onto the school health programme. These teams are also used to provide Vitamin A to the 12-59 months aged children (current tendency is for mothers not to continue bringing these kids once they have finished their first year immunization program), and to identify and refer all children who missed or have gaps on their immunization profile. The programme is mainly collaborating with two government Departments namely, Department of Education and Social Development and with other government departments as well though on a lesser scale. The two main Departments are also sharing resources including weighing scales, transport and height measures. The model of the school health programme is based on sharing of resources with the ward-based (RPHC) teams, clinics in the catchment areas, supply from the NGOs and resources from other government departments including DOE. • District Specialist Teams (DST): in strengthening the PHC system, the DSTs are based at the district level and their primary function is to advise and mentor health facility staff at all levels in the district. These teams complement the PHC teams in the RPHC model. DSTs had been appointed for all 7 districts but these are not yet complete. Four districts namely Alfred Nzo, C Hani, OR Tambo and NMM have the full complement of nurses (i.e PHC specialist, advanced midwife, Paediatric nurse and Anaesthetist). Recruitment of doctors for these teams has in the meantime proved to be difficult.

MAIN SERVICES	ACTUAL CUSTOMERS	POTENTIAL CUSTOMERS	STANDARD OF SERVICE	ACTUAL ACHIEVEMENT AGAINST STANDARDS
Provision of the emergency medical service to all the patients of the Province.	Primary customers		• 1 Ambulance rostered per 10 000 population • To achieve this a total of 667 rostered ambulances required to service the entire Province	The Department currently, has a total of 306 ambulances and on average 178 of these are rostered at any point in time. This translates to 0.27 ambulances on a roster per 10 000 population, which is less than one third of the national standard. This results in poor ambulance response times. The Department has two helicopters and one fixed wing for hard-to-reach areas and for airlift emergencies. These are stationed at Port Elizabeth and East London. To address the ambulance fleet shortages, the department entered into an agreement with Government Fleet Management Services (GFMS), a trading entity of the Department of Transport for the provision of Fleet Services to the Department. During the Financial Year under review, the department received 60 replacement ambulances. The agreement will continue for an indefinite period. Ambulances and MOUs: Ambulances are deployed mainly in the rural areas of the Eastern Cape to ensure equity, access and to improve response times. These are all efforts and strategies to reduce maternal deaths and improve pregnancy outcomes. To enhance the EMS programme's Advanced Life Support capability within the province, Paramedics were increased from 12 to 34. Seventeen EMS candidates attended the Paramedic course at the Durban University of Technology during the 2012 academic year. All 17 candidates successfully completed the program and graduated in December 2012. These Paramedics have been redeployed to their districts of origin. There was no student from the Joe Gqabi district.

MAIN SERVICES	ACTUAL CUSTOMERS	POTENTIAL CUSTOMERS	STANDARD OF SERVICE	ACTUAL ACHIEVEMENT AGAINST STANDARDS
The rendering of Specialised Services such as clinical orthotic and prosthetic services.	Primary customers; designated groups (disabled)	Designated groups (elderly)		• A total of 10 854 orthoses were issued to eligible clients exceeding a target of 8000. • 14 615 Walking devices were issued to clients • Against a target of 6000, a total of 3 411 prostheses were supplied to amputees. • Against a target of 2 875, a total of 1 720 wheelchairs were issued • Against a target of 1 475, a total of 977 hearing aids were issued Off-shelf devices such as orthoses are readily available to clients, hence the consistent and good performance was maintained throughout the year. However, challenges are experienced with regards to other assistive devices leading to some targets not being met. This was as a result of delays in service provision by the supplier. The department procures these on national tender resulting into delays by suppliers who fail to deliver on time. To address these challenges and improve service delivery to our communities in future, the following strategies are to be implemented: *ECDoH tender*: On expiry of the national tender the department will be going out on its own tender. *Staffing:* Six Orthotic and Prosthetic students graduated in August 2012 from Tanzania, and presently are in the employ of the ECDoH *Training and Development:* Walter Sisulu University obtained a full accreditation to start offering Orthotics and Prosthetics course in South Africa; new intake is expected during the 2014 academic year

MAIN SERVICES	ACTUAL CUSTOMERS	POTENTIAL CUSTOMERS	STANDARD OF SERVICE	ACTUAL ACHIEVEMENT AGAINST STANDARDS
The provision of training of all health professionals employed by the Eastern Cape Department of Health.	EC DOH employees	EC DOH bursary candidates to be trained in health field; Other government department employees to be trained in health related fields; Interns and learnerships; students for experiential learning		*Bursary Program* • A total of 37 internal candidates were awarded bursaries; two candidates graduated during 2012/13 FY *Training and Development of Medical Registrars* • 16 Registrars completed their programme and are awaiting registration certificates with the HPCSA as specialists doctors *Training of Health Professionals at Rhodes University* • 15 Students were enrolled on the Doctor of Pharmacy (PharmD) programme. • 5 Students graduated in 2012 and are in the process of being absorbed as Clinical Pharmacist Specialists. *Internship and Learnership Program* • In line with the national mandate on Youth development, the EC DOH hosted 655 internships in various disciplines, 264 learnerships and 146 experiential learners. *Young Nurse Educators Development Programme at NMMU* • 20 nurse educators completed the young nurse educators' programme at the NMMU and are now back at the Lilitha Nursing College campuses to improve lecturing standards • 15 Students (4 PHDs & 11 Masters) were enrolled at NMMU during the 2012 academic year • Three clinical laboratory managers completed training and are absorbed at Lilitha Nursing College for continuity. Lilitha Nursing College • Refer to Table 6.6 of Programme 6: Health Sciences and Training Program

MAIN SERVICES	ACTUAL CUSTOMERS	POTENTIAL CUSTOMERS	STANDARD OF SERVICE	ACTUAL ACHIEVEMENT AGAINST STANDARDS
				Establishment of the EMS College Main Campus and Satellite Campuses • A new Advanced Emergency Care (EMC) Degree was established at NMMU; full collaboration and memorandum of understanding between the EMS College and NMMU was drafted and is awaiting approval. • The EMS College's new base in Livingstone hospital is fully refurbished and has received provisional accreditation pending full staff complement in line with the HPCSA accreditation criterion
The provision of new health facilities and revitalizing of the dilapidated facilities	Primary customers; DOH employees	External stakeholders including NGOs, CBO		The Departmental focus has shifted from building of new facilities and is now firmly on maintaining the existing ones. The department took a decision to renovate clinics in all the regions in the Province following the under spending on medical equipment as well as the delays In the awarding of tenders for medium size hospitals by end of September 2012. Renovations and repairs of Primary Health Care facilities received priority. To this extent, general maintenance work in hospitals such as Cala, Elliot, Cloete Joubert, Tafalofefe, Nelson Mandela Academic hospital, Komani, Fort Beaufort hospitals is ongoing. Furthermore, 222 clinics covering the entire Province are being repaired and renovated. By the end of the 4th quarter 127 facilities had reached practical completion. Approximately, 112 of these will be completed during the first quarter of the 2013/14 financial year. Renovated clinics are spread as follows: o 64 in O.R. Tambo o 43 in Amatole o 37 in Cacadu and Nelson Mandela o 27 in Chris Hani o 20 in Joe Gqabi and o 31 in Alfred Nzo Region

MAIN SERVICES	ACTUAL CUSTOMERS	POTENTIAL CUSTOMERS	STANDARD OF SERVICE	ACTUAL ACHIEVEMENT AGAINST STANDARDS
				A total of 28 locally based historically-disadvantaged contractors in respective regions have been used to renovate and repair the afore-mentioned institutions. These were supported by 32 sub-contractors. This programme is estimated to cost the HFM programme around R240 million. It is estimated that this programme has created work opportunities for around 1 800 people. This historic approach will henceforth form the basis of infrastructure investment in the Health space. Construction projects in 16 upgraded hospitals are progressing well; Practical completion at Holy Cross, Cathcart, Canzibe, Fort Beaufort, Mt Ayliff and Isilimela hospitals was achieved during the 4th quarter of the 2012/13.

Table B2: Key developmental indicators in the Eastern Cape Province

TYPE OF ARRANGEMENT	ACTUAL CUSTOMERS	POTENTIAL CUSTOMERS	ACTUAL ACHIEVEMENTS
Governance structures	Hospital boards, Clinic Committees Provincial Health Council, District Health Council (DHC), Sub-district Consultative Forum (SCF), National Health council (NHC), Audit Committee (AC), Portfolio Committee, SCOPA		• Hospital boards and clinic committees were re-constituted, trained and are fully functional in all health facilities in the eight districts • The Department is accountable to the Health Standing Committee and complies with all legislative requirements regarding this committee and the SCOPA. • A Member of Executive Council meets with the Provincial Health Council every quarter. • The District Health Plans at district level is presented to governance structure before these can be approved by the district manager
Social compact with the communities within the RPHC model	Communities		The departmental objectives of recruiting according to a specific HR profile for each sub-district with the aid of local social compact committees were met. The selection of bursary candidates is done at sub-district level through the social compact committees. The department has developed a more stringent social compact bursary contract and directed obligation policy targeting rural district health facilities. The contract is now signed by three (3) parties, i.e. bursary recipient, community member and the department official.
MEC Roadshows	Governance structures at district level	Hospitals and management communities	The MEC visits the hospitals and hold meetings with the hospitals boards

Table B11: Consultation arrangements with customers

TYPE OF ARRANGEMENT	ACTUAL CUSTOMERS	POTENTIAL CUSTOMERS	ACTUAL ACHIEVEMENTS
Governance structures	Hospital boards, Clinic Committees Provincial Health Council, District Health Council (DHC), Sub-district Consultative Forum (SCF), National Health council (NHC), Audit Committee (AC), Portfolio Committee, SCOPA		• Hospital boards and clinic committees were re-constituted, trained and are fully functional in all health facilities in the eight districts • The Department is accountable to the Health Standing Committee and complies with all legislative requirements regarding this committee and the SCOPA. • A Member of Executive Council (MEC) meets with the Provincial Health Council every quarter. • The District Health Plans at district level is presented to governance structure before these can be approved by the district manager
Social compact with the communities within the RPHC model	Communities		The departmental objectives of recruiting according to a specific HR profile for each sub-district with the aid of local social compact committees were met. The selection of bursary candidates is done at sub-district level through the social compact committees. The department has developed a more stringent social compact bursary contract and directed obligation policy targeting rural district health facilities. The contract is now signed by three parties, i.e. bursary recipient, community member and the department official.
MEC Roadshows	Governance structures at district level	Hospitals and management Communities	The MEC visits the hospitals and hold meetings with the hospitals boards

Table B12: Service delivery access strategy, 2012/13

ACCESS STRATEGY	ACTUAL ACHIEVEMENTS
Inadequate budget envelope.	It is historically known that the Department of Health has been under severe financial pressure for over several years. This situation has been caused by inter alia, the magnitude of the current service delivery platform, growth in the burden of disease provincially, top slicing of the budgets, various unfunded and underfunded mandates as well as limitations in the adequate management of cost of employment. The objectives of the department for 2012/13 have accordingly been largely negatively impacted upon. To address most of these challenges, the department has confirmed the centrality of government-driven transformation with financial resources that are directed to the areas in most dire needs in terms of services. The department continues to be deeply involved in extensive turnaround processes. Accordingly, the baseline realignment exercise is currently in progress with various turnaround implementation plans. The impact thereof, is still work-in-progress (with the impact yet to be quantified on the MTEF). The department continues to work closely with the National Department of Health and Provincial Treasury to find solutions to this challenge. The capacity control measures of the Department to fulfil its mandate by way of provision of core health professionals was constrained by several factors. These included the application of austerity measures in order to manage the cost of employment (COE) budget. The authority and functions to appoint were taken away and handed to the Provincial Treasury. This placed severe control measures on the ability of the Department to recruit and replace key health professionals and core support staff. Funding control measures left the department unable to recruit core critical personnel. Besides the moratorium on the appointment and replacement of staff, there proved to be severe control measures in terms of capacity (knowledge, skills and attitudes) at both Head Office and District levels. The combined effect of the above variables resulted in critical staff members not being appointed which had a direct negative impact on healthcare service delivery. The Department overall under-spent its budget allocation by R133,64 million. The under spending emanates primarily from three economic classification categories: current payments, which overspent budget by a net R8,6 million; buildings and other fixed structures by R56,39 million and machinery and equipment by R77,13 million. The department has applied for Conditional Grants funds totaling R132, 911 million which was appropriated but not spent in the 2012/13 financial year but is to be rolled over to the 2013/2014 financial year. The request for roll over is supported by commitments where capital expenditure and goods & services had been delivered or rendered meaning therefore, that the 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.

ACCESS STRATEGY	ACTUAL ACHIEVEMENTS
Critical staff shortages across all categories of employment within the provincial Health sector, especially in rural areas.	The Executive Council endorsed the establishment of the Provincial Coordinating and Monitoring Team (PCMT) as a monitoring and controlling body to ensure that the departments' expenditure stays within the allocated budget. During the year under review, the PCMT endorsed departmental requests for recruitment through its Annual Recruitment Plan and available funding. The Department identified and prioritized 15 vacant & critical management posts that were viewed as key in creating and maintaining stability in the management echelons of department. Owing to the financial constraints of the department, only the top management posts were approved for advertisement i.e. the Chief Financial Officer and two Deputy Director Generals (DDGs) for Human Resources & Corporate Services as well as Clinical Services. As the Department is implementing de-complexing of the tertiary institutions, chief executive officers (CEOs) were appointed for six of the nine tertiary and secondary care health facilities. In the next financial year, the department's focus will be on appointing CEOs for the three remaining provincial hospitals as well as ensuring appointment of CEOs in all district hospitals. The term of office of the EC DOH accounting officer came to an end at the end of December 2012; a new Superintendent General (SG) was appointed to manage the department in an acting capacity whilst the recruitment process for a new incumbent is still underway.
Poor infrastructure and geographic terrain.	The revitalization model of the PHC is one key strategy to bring health services to the people; it utilises mainly the PHC nurses from the clinics in the very communities to visit households and schools in their clinic areas. In addition, the PHC teams have a big contingency of CHWs who are drawn from their own home communities and thereby increasing the chances of being visited by a health worker.
Bad access roads make it difficult for health services providers to reach some areas using ordinary transport or ambulances.	Whilst the EC road infrastructure in some rural communities pose a serious challenge in reaching the patients by ambulance or reaching the community through the health service providers, and in addition to the ward-based PHC teams that are being implemented in all health districts and the CHWs, the DOH establishes health posts within the communities. This is a community volunteered space that is manned by CHWs. Health supplies already packaged are delivered by the clinic staff to the health post where these are collected by the relevant persons from the community. An additional strategy to overcome road infrastructural challenges is the establishment of the half-way houses close to or within the premises of the district hospitals to cater for pregnant women from hard to reach areas that are nearing their term. More resources are required to implement this strategy fully and effectively. Mainly, the EMS vehicles are the ones challenged with the road infrastructural challenges at the most critical times. The EC DOH's latest strategy has been to decentralize the ambulances and place them at hospitals that conduct deliveries which are closest to the communities so as to shorten the driving distance for improvement of response times.

ACCESS STRATEGY	ACTUAL ACHIEVEMENTS
Poor health technology, old and poorly maintained equipment.	*Healthcare Technology* Provincial and District Healthcare Technology Committees (PHTC & DHTC) were established during the FY under review in compliance with the National Health Technology Strategy. The aim of establishing these forums is to provide a platform to discuss provision and proper management of healthcare technology related issues, development of norms and standards as well as the approval of procurement of major equipment. In February 2013, the EC DOH hosted a Healthcare Technology workshop in which relevant delegates including national, Clinical Engineering personnel, Hospital CEOs, Hospital Managers and stakeholders from other provinces participated. Following the institution of the PHTC and DHTC, • A draft essential equipment list for institutions is under development by the national DOH. • A transversal tender to ensure timely and smooth procurement of new medical equipment in the next three years was advertised in November 2012 • Skills development & training: The department planned to award 10 bursaries towards clinical engineering training however, no bursary was awarded in this category as none of the applicants were admitted at relevant institutions of higher learning (see Health Sciences and Training section on page 185). *Provision of Medical Equipment* The Department procured and installed Radiology equipment in three district hospitals namely: Madwaleni, Mt Ayliff and Bambisana hospitals as well as two CHCs i.e Gompo and Port st Johns. Furthermore, new equipment including patient beds, dental equipment, stretcher beds, theatre tables etc. were procured and distributed to health facilities as shown in the Table below. Distribution of health facilities supplied with new equipment by district and type of facility

DISTRICT	HOSPITAL	CHC	CLINIC	Total facilities
Amatole	15	2	16	33
OR Tambo	2	-	25	27
Chris Hani	1	1	11	13
Cacadu	3	-	2	5
Alfred Nzo	-		5	5
Joe Gqabi	-	-	8	8
Total	21	3	67	91

Maintenance of equipment
Tenders for maintenance of medical equipment contracts were advertised in 2012 to be effective in the new financial year. Currently, ad hoc maintenance is implemented at all levels. (also see section 6.8 on page 246)

ACCESS STRATEGY	ACTUAL ACHIEVEMENTS
Inefficient internal process e.g. Supply chain management; poor revenue collection and generation	Strengthening Financial Management (Monitoring & Evaluation) Financial management in the department remains a huge challenge due to lack of qualified, skilled and competent finance personnel mainly at operational level as well as fragmented and non-integrated systems. As a result of lack of integrated systems the department has had to implement a number of compensating manual systems to consolidate financial information from districts and various units including information for the preparation of annual financial statements. The glaring risks of human error associated with use of manual system exist. Over the past 3 years the department implemented interventions that were designed to improve the financial outcome of the department. This entailed improving accounting practices and control environment, introducing Generally Recognised Accounting Practices (GRAP) best practices, ensuring integrity of financial data and implementing systems and controls. The result was the improvement of the audit opinion from nine item qualified opinion to a three item qualified opinion, which needs to be enhanced in the 2013/14 financial year. The challenge that still faces the department in the area of financial management is the lack of skilled, proficient and competent personnel. The appointment and retention of skilled financial management personnel is a prerequisite for an improved financial management in the department. The department will collaborate with the PCMT to ensure that critical financial management posts are filled in the coming financial year. There are specific capacity control measures in the area of revenue collection and generation, including among others, the lack of sufficient automated patient billing systems, insufficient and inexperienced officials in hospital revenue components. Accordingly, the department continues to be challenged in the full implementation of policies. Currently the following areas have been prioritised for implementation: o Addressing HR capacity issues in the revenue units in terms of staff complements o Enhanced training and mentoring of revenue officials at facility level o Enhanced telephonic, Electronic Data Interchange (Medical Aids) and internet connectivity of all facilities o Enhanced monitoring capacity within the head office unit o Extended collection of revenue to include EMS, TB Hospitals and Community Health Centres

ACCESS STRATEGY	ACTUAL ACHIEVEMENTS
	o Ramping up income from applications fees for and inspection fees of private healthcare facilities. o Standardisation of the Revenue Retention Policy MAWG will continue with the intervention to focus on the procurement system of the department. It is anticipated that this intervention will lead to an improved functioning of the department which will in turn, enhance the capacity of the department to provide more and better quality health services. Supply Chain Management Initiatives The Goods and Services budget of the department is the second highest cost driver. The public sector procurement prescripts are based on the principle of "value for money" and the development of the previously disadvantaged communities or households. Given the capacity challenges the department faced in the SCM area, Provincial Planning and Treasury seconded a number of officials to the department to oversee the SCM processes. The Department continued to capacitate its' officials through in-service training and short-term courses to ensure timeous, effective and efficient procurement. It also strengthened its internal procurement structures such as the bids specification, bids evaluation and adjudication committees and also ensured the rigorous application of national and provincial SCM prescripts. In its broad plans to review the state procurement system and develop broad level mechanisms to optimise its functioning, the department participated as a pilot site for the implementation of MAWG, a structure that was formed by the Minister of Finance.. The Department has prioritised the implementation of the SCM Reform Project, the objective of which is to provide a set of priorities and proposals with appropriate action plans to deliver a rapid improvement in the departments' procurement system. It is anticipated that this intervention will lead to an improved functioning of the department which will in turn enhance the capacity of the department to provide better quality health service. The three main objectives of this project are: to make SCM activities visible and controllable by management, to strengthen SCM capabilities and to provide sufficient human resources for the SCM function. The main aspects of the project cover the following: • Strengthening of procurement capabilities and resourcing of the function; • LOGIS Implementation;

ACCESS STRATEGY	ACTUAL ACHIEVEMENTS
	• ICT Infrastructure upgrade; • Provisioning of office accommodation; • Document management; and • Strengthening of asset management capabilities and resourcing of the function. It is expected that the implementation of the project will enable the department to turn around its negative SCM audit outcomes into unqualified opinions in the future. R15 million was allocated in 2012/13 while an additional R72 million is allocated for the 2013/14 financial year. The department will ensure the rigorous implementation of the project not only to enhance audit outcomes but also significantly improve the service delivery performance of the department.

Table B13: Service information tool, 2012/13

TYPES OF INFORMATION TOOL	ACTUAL ACHIEVEMENTS
Facility registers	The implementation of NIDS 2010 in October 2010 had a change of data collection tools in the facilities. This led to the designing of a new register to accommodate the data elements to be reported. These were designed and templates sent to district managers for procurement. All the facilities had to register accommodating NIDS 2010 data element
DHIS	This is a standard desktop system which accommodates or reports on aggregated data. All the hospitals had their DHIS system which, the PHC facilities still lagging behind, thus led to the sub districts to capture their data. Every two years the DHIS data base changes in order to accommodate the NIDS (National Indicator Data Set). DHIS serves as the national reporting tool.it is also used as a data register tool of other systems.
TIER.NET	Tier.net is a national Programme initiated in 2011 aiming at improving reporting of ART services and tracking of clients on the ART. It consists of 3 Tiers; Tier 1 being paper–based; Tier 2 is mandatory computer and Tier 3 is network based computer program. At present 314 and 85 facilities are implementing Tier 1 and 2 respectively. Tier 3 has not yet been implemented. The implementation of this system is preceded by preparation (connectivity and buying of computers), installation as well as training of users. After this initial phase, the following five phases are then implemented: 1) Back capturing 2) Back capturing with live capturing 3) Live capturing and data cleaning in program 4) Data sign off by DIT,PIT 5) Live site able to produce monthly and quarterly reports

Table B14: Complaints mechanism

COMPLAINTS MECHANISM	ACTUAL ACHIEVEMENTS
Complaints are received via a number of sources, namely: the National Department of Health, Office of the MEC; office of the Superintendent General; Departmental Call Centre; Office of the Public Protector, complaints boxes at health facilities and from individuals. These complaints are acknowledged within 72 hours and are investigated within 5 working days The departmental complaints policy classifies complaints into eight categories namely: • Class 1 – Death Related cases • Class 2 – Clinical Care where a serious damaged has occurred • Class 3 – Fraud related cases • Class 4 – Staff attitudes • Class 5 – Hotel or Hospitality, Infrastructure • Class 6 – Leave Gratuity and Pension Benefits • Class 7 – Staff concerns or Grievances • Class 8 – Non Payment of Suppliers The national norm is that complaints are to be resolved within 25 Days of receipt by the Department. In the event that they are not resolved they should not exceed 60 days. This is applicable to all facilities of the ECDOH. The head of a facility is the complaints manager but currently this function is delegated to the Quality Assurance Managers where these are available. The complaints procedure is displayed in each facility and all health facilities are required to submit statistics on a monthly basis to Customer Care Directorate at provincial head office.	Approximately 70% of complaints received were resolved within 25 days. Class 1-3 complaints take longer to resolve. Poor reporting and non-submission of statistics by some facilities remain a challenge. The Department is moving towards establishing electronic complaints database which is believed will resolve some of the challenges that are currently being experienced.

COMPLAINTS MECHANISM	ACTUAL ACHIEVEMENTS
The complaints coming through the EC DOH Shared Contact Centre are captured on a CRM system with database and are categorized according to Clinical, Integrated Human Resource Management and Finance related calls. All these are further categorised according to the resolution rate: • Level 2 complaints – are those complaints resolved within 72 hrs. by the Contact Centre • Level 3 complaints – exceeded 72hrs and within 25 days. These are either sent to the facilities or the Head of Clusters for investigation and resolution. Those that exceeded 25 days become accumulative to the following financial year. These are cases that relate to litigations and some of them are handled by the Departmental Legal Unit.	Level 2: Resolved within 72hrs Clinical - 60% IHRM - 46% Finance - 33.4% Level 3: Resolved within 25 days Clinical - 67% IHRM - 86% Finance - 96% Actual total resolution : 69.1% Clinical - 63.3% IHRM - 76% Finance - 96.4%

3.3. Organisational environment

Human Resource Capabilities

The Executive Council endorsed the establishment of the Provincial Coordinating and Monitoring Team (PCMT) as an expenditure controlling mechanism to ensure that the department stays in line with the available budget. During the year under review, PCMT monitored expenditure on Cost of Employment and endorsed departmental requests for recruitment through the Annual Recruitment Plan and available funding. The Department prioritised about 15 vacant management posts that were viewed as critical in creating and maintaining stability in the management echelons of the department. Owing to the financial constraints of the Department, only the top management posts were approved i.e. Chief Financial Officer, DDG: Human Resources & Corporate Services, and the DDG: Clinical Services. At the end of third quarter of the financial year, the term of Office of the Accounting Officer came to an end and the Superintendent General was appointed to manage the department in an acting capacity with the DDG: Human Resources & Corporate Services assuming duties. The recruitment and selection processes for the Head of Department, Chief Financial Officer and DDG: Clinical Services are at an advanced stage.

Great strides have been taken to capacitate the infrastructure management component in the efforts and commitment of the Department to improve the physical infrastructure and maintenance of our health care facilities. Progress has been made in procuring services of the professionals and workers required for the implementation of the Re-engineering of Primary Health Care as part of the preparation of the National Health Insurance implementation. Whilst recruitment and retention of these district specialist teams still pose challenges for this programme, some efforts are made to employ other strategies to ensure that there is a full cohort for each district. In improving leadership and management of our health establishments Hospital Managers were appointed for the Tertiary and Secondary care health establishments and the focus in the next financial year will be on the District Hospitals.

Industrial Action

During the period under review the Department experienced a number of unprotected industrial action (illegal strikes) sporadically occurring across the province. For some institutions like Mthatha Hospital Complex, Mthatha Pharmaceutical Depot and Emergency Medical Services, a Court Order prohibiting the employees from striking was sought and granted. The causality was mainly unpaid HR backlogs which in some instances were outstanding for a long time.

The Department agreed to pay all verified and qualifying cases. A budget of R191m was set aside to implement the payment. At all times of discussions the unions organised in the Health Sector were consulted. The instability and proposed resolution of the conflict was also dealt with inside the Bargaining Chamber meetings. Payments started in November 2012 to February 2013 when the allocated amount was exhausted. Thirty (38) eight employees were suspended and charged for misconduct for damaging government and intimidation of fellow employees. The Department is implementing a “no work no pay” policy against the strikers. To manage further incidents managers are trained on the procedures to follow on strike management.

Review of Organisational Structure

The department is involved in the realignment of the Organisational structure to review the entire organisational structure with the objective of strengthening operations at district and sub district level as well as to promote primary health care within communities. The project deliverable is therefore a restructured organisation that will promote the delivery of revitalized health services in the department in an effective and affordable manner. The proposed service-delivery model therefore encourages total decentralisation of functions to districts with resultant devolvement of powers. This will free Head Office from operational duties so that it rather focuses on policy development and strategic matters. The exercise will ensure alignment of the structure to National and Departmental priorities. Consultations with all stakeholders have been done and draft organograms for Head Office and all Health Facilities and Districts have been developed with options being discussed with the various managers.

Fleet Management Services

The department entered into an agreement with Government Fleet Management Services (GFMS), a trading entity of the Department of Transport, for the provision of Fleet Services to the Department. The agreement will continue for an indefinite period. The Department may cancel the agreement at any time by giving GFMS 3 months' notice and returning the vehicles to GFMS.

In terms of Clause 4.1 of the Agreement, ownership of the vehicles will remain vested in GFMS and will not be transferred to the departments at the end of the lease term.

3.4. Key policy developments and legislative changes

- The Eastern Cape Finance Act 1 of 2013 was approved by the Premier of the Province of the Eastern Cape on 28 March 2013. In terms of the Eastern Cape Finance Act (2013), the Department's unauthorised expenditure totaling R1,286 billion (2011/12 (R297,6 million), 2010/11, (R116,4 million) and 2009/10 (R871,9 million)) has been condoned with funding.

- Revenue Collection and Retention within the Enhanced Amenities domain:

- In implementing the social compact in the area of human resource development, the Department is using the social committees in the sub-districts to select bursary candidates. The students awarded bursaries sign the contract with the communities, sub-district and the EC DOH; the purpose being to ensure that after graduation, these students will get back to serve their communities.

Table B2: Key developmental indicators in the Eastern Cape Province

STRATEGIC GOAL TITLE	GOAL STATEMENT	EXPECTED OUTCOMES	PROGRESS MADE AT END 2012/13			DEVIATION
			INDICATOR	2010/11	2012/13	
1. Public Health System	To facilitate a functional quality driven public health system that provides an integrated and seamless package of health services and is responsive to customer needs.	By 2015, the organisation should demonstrate the following outcomes: • Functional district health characterised by well managed and effective clinics, CHCs, district and specialised hospitals, • Each district to have a fully functional EMS METRO Centre. • Fully functional regional and tertiary hospitals.	PHC utilisation rate	2.7	2.7	0
			Nurse workload (PHC) (Average number of patients seen)	14.1	31.6	17.5
			BUR (district hospitals)	65.5%	62.2%	-3.3%
			BUR (Regional hospitals)	70.1%	68.4%	-1.7%
			BUR (Tertiary hospitals)	75%	75.5%	0.5%
			Exp/PDE (district hospitals)	R1128	R1688	R560
			Exp/PDE (Regional hospitals)	R1411	R1978	R568
			Exp/PDE (Tertiary hospitals)	R1722	R1831	R109
			Number of districts with EMS METRO centres	5	6	1

STRATEGIC GOAL TITLE	GOAL STATEMENT	EXPECTED OUTCOMES	PROGRESS MADE AT END 2012/13			DEVIATION
			INDICATOR	2010/11	2012/13	
			Number of domains implemented in Tertiary hospitals	Mthatha complex: 30 PE complex: 30 EL Complex: 25	Mthatha-complex: 30 PE complex: 30 EL Complex: 25	Mthatha-complex: -7 PE complex: -7 EL Complex: -12
			Number of domains implemented in Regional hospitals (Only Frontier)	8	8	0
2.TB and HIV/AIDS	To combat and reduce the impact of TB and HIV/AIDS with a special focus on preventing the emergence of drug – resistant strains.	By 2015, the organisation should demonstrate the following outcomes: • Reduction of HIV prevalence • % coverage of ART • Improved TB cure rate • Reduction of TB Incidence • Arrest rate of progression to MDR/XDR	Prevalence of HIV among ANC attendees	28.1% (2009)	29.3% (2011)	1.2%
			Total clients on ART	152 357	237 830	85 473 (56.1%)
			New Smear positive PTB cure rate	66%	68.9%	2.9%
			PTB incidence	722 per 100 000	778 per 100 000	56 per 100 000
			Smear positive PTB incidence	353 per 100 000	425 per 100 000	72 per 100 000
			Number of MDR clients MDR arrest rate	947	1062	115 (12.5%)
			Number of XDR clients XDR arrest rate	242	204	38 (-15.7%)

STRATEGIC GOAL TITLE	GOAL STATEMENT	EXPECTED OUTCOMES	PROGRESS MADE AT END 2012/13			DEVIATION
			INDICATOR	2010/11	2012/13	
3. Mother and Child Health	To improve and strengthen the mother and child health services.	By 2015, the organisation should demonstrate the following outcomes: • % reduction of maternal morbidity • % reduction of maternal mortality • % reduction of infant mortality • % reduction of <5 child morbidity • Reduce no. of underweight children <5 – nutrition/social needs cluster • Greater awareness of women's sexual and reproductive rights	Public Health Facility Maternal Mortality Rate (per 100,000 live births)	142/ 100 000	112/ 100 000	-30/ 100 000
			Facility Infant Mortality (under 1) rate (per 1000)	86/1000	49/ 1000	-37/ 1000
			Facility Child mortality (under 5) rate (per 1000)	63/1000	48/ 1000	-15/ 1000
			Baby tested PCR positive six weeks after birth as a proportion of babies tested at six weeks	7.3%	3%	-4.3%
			Underweight for age rate under 5 years	0.4%	0.3%	-0.1%
			Delivery rate for women under 18 years (%)	10.5%	10.3%	-0.2%
			Couple year protection rate	31.6%	31.7%	0.1%
			Termination of pregnancy rate	0.4%	0.7%	0.3%

STRATEGIC GOAL TITLE	GOAL STATEMENT	EXPECTED OUTCOMES	PROGRESS MADE AT END 2012/13			DEVIATION
			INDICATOR	2010/11	2012/13	
4. Non-communicable diseases and mental conditions.	To combat and reduce diseases of lifestyle and mental conditions.	By 2015, the organisation should demonstrate the following outcomes: • Reduction in incidence of mental conditions. • Reduction in re-admissions of mental patients. • Reduction in substance abuse. • Reduce complications in hypertension and diabetes. • Improved health promotion. • Reduce incidence of obesity. • Reduction in morbidity, mortality resulting from circumcision. • Reduction in epilepsy and asthma morbidity. • Reduction in morbidity and mortality of the most common cancers (breast, cervix, prostrate, oesophagus and lung).	Cervical screening coverage	3.3%	39.4%	36.1%
			Mortality rate in Traditional circumcision	11 deaths	0.2% (74 deaths)	- (63 deaths)
			Asthma under 18 years rate	5%	13.5%	8.5%
			Epilepsy under 18 years rate	5.5%	15.4%	9.9%

STRATEGIC GOAL TITLE	GOAL STATEMENT	EXPECTED OUTCOMES	PROGRESS MADE AT END 2012/13			DEVIATION
			INDICATOR	2010/11	2012/13	
5. Institutional capacity	To enhance institutional capacity through effective leadership, governance, accountability and efficient and effective utilization of resources.	By 2015, the organisation should demonstrate the following outcomes • Unqualified audit opinion received from the Auditor General • Effective leadership and audit • Effective planning and monitoring system • Achieve % of norms and standards re ratios • Fully-fledged and independent Lilitha College of Nursing that is able to produce ready, able and capable nurses to service the health system. • Fully-fledged EMRS College is able to produce ready, able and capable EMRS Practitioners to service the health system.	New intake at Lilitha Nursing College		1758	
			Number of nurses graduating from Lilitha Nursing College		1459	
			Compliance level with MPAT	Not implemented	EC DOH complied at level 1	Two level below target
			% District Hospitals with appointed CEOs		100% (66/66)	
			% Regional Hospitals with appointed CEOs		50% (1/2)	
			% Tertiary Hospitals with appointed CEOs		67% (2/3)	
			% TB Hospitals with appointed CEOs		72.7% (8/11)	
			% Psychiatry Hospitals with appointed CEOs		75% (3/4)	
			% Executive management posts filled	40% (2/5)	40% (2/5)	
			% District Hospitals with appointed CEOs		77.3% (51/66)	

PART B

PROGRAMME 1

HEALTH ADMINISTRATION

PROGRAMME 1: HEALTH ADMINISTRATION AND MANAGEMENT

PROGRAMME PURPOSE

The purpose of the administration programme is to provide political and strategic direction of the Department by focusing on the transformation and change management for better health care outcomes.

The health administration programme comprises of two main components; the executive authority which lies with the Office of the Member for Executive Council (MEC) and the management of the organization which is primarily the function of the office of the Superintendent General (SG).

1.1 Office of the MEC

PURPOSE

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

STRATEGIC OBJECTIVES

5.1 To facilitate the provision of strategic leadership and the creation of social compact to achieve 100% accountability.

PROGRAMME PRIORITIES

- Facilitate the provision of strategic leadership and the creation of a social compact for better health outcomes.
- Give political and strategic direction to the Department through an efficiently and effectively managed office.
- Circulate cabinet resolutions to the HOD for implementation.
- Respond to parliamentary questions and ensure that resolutions of the legislature are implemented.
- Engage all the governance structures of the department, i.e hospital boards, clinic committees, Provincial Health Council and Lilitha Education Nursing Council

Table 1.1: Performance against Strategic Objectives for Health Administration

STRATEGIC OBJECTIVES	Actual Achievement 2011/2012	Planned target 2012/13	Actual achievement 2012/13	Deviation from planned target to Actual Achievement for 2012/2013	Comment on deviations
5.1 To facilitate the provision of strategic leadership and the creation of social compact to achieve 100% accountability	5 Statutory planning and reporting compliance documents submitted to the legislature	Submit 5 statutory planning and reporting compliance documents to the legislature	5 Statutory planning and reporting compliance documents submitted to the legislature	0	Target achieved.
5.2. To facilitate 100% achievement of an effective and compliant planning and monitoring system	Not measured	Department to comply at level 3 with the Management Performance Assessment Tool (MPAT)	EC DOH complied at level 1 with the MPAT	2 levels below target	Under-achievement on this target is attributed to the electronic system flaws. Some of the evidence that was submitted electronically with the completed tool did not go through to the DPME at the Office of the Presidency as these were big files. The EC DOH assessment was therefore based on incomplete
5.3 To provide 100% Financial Management and SCM to achieve full accountability and a clean audit	A qualified audit outcome	A qualified audit outcome with: • Reduced qualifications • Conversion of qualification to emphasis of matter	A qualified audit outcome with: • Qualifications reduced from 9 to 4 • Some qualifications were converted to emphasis of matter	Target achieved	

STRATEGIC OBJECTIVES	Actual Achievement 2011/2012	Planned target 2012/13	Actual achievement 2012/13	Deviation from planned target to Actual Achievement for 2012/2013	Comment on deviations
5.4 To facilitate 80% achievement of developed and implemented corporate systems and ICT platform	Not measured	21 RSDP prioritized hospitals to have Telkom Data Lines/Diginet connectivity	25 RSDP prioritized hospitals with Telkom Data Lines/Diginet connectivity.	4 hospitals	Since the cancellation of the VPN project, the department continued with the connectivity project through the normal process. The process is managed through SITA Wide Area Network (WAN) connectivity SLA.
5.5 To ensure 100% effective HR planning, Development and Management	Organizational vacancy rate was 47.6%	Organization to have vacancy rate of 10%	Vacancy rate of 15.8%	-5.8%	Unfunded posts were abolished.

Table 1.1: Performance against Provincial Targets from 2012/13- 2014/15 Annual Performance Plan for the Office of the MEC

Performance Indicator	Actual achievement 2011/12	Annual Target 2012/13	Actual achievement 2012/13	Deviation from planned target to actual achievement for 2012/13	Comment on deviations
Number of compliance documents tabled at the legislature	3	5 (Policy and. Budget Speech, APP, SDIP, 2011/12 AR, 2012/13 Half Yearly report)	5	0	All statutory documents were tabled at the legislature as required.
Number of NHC meetings attended by the Hon MEC	6	6	5	1	These meetings are chaired by the Minister of Health and are scheduled at the national DOH
Number of Eastern Cape Provincial Health Council (ECPHC) meetings hosted by the Hon MEC	1	4	1	3	Most of the councillors fail to make the dates set for these meetings and subsequently these meetings do not form a quorum.
Number of Lilitha Nursing College Council meetings attended by the Hon MEC	2	2	2	0	All Lilitha Nursing College Executive Council meetings took place as scheduled during the financial year.

1.2 MANAGEMENT

PURPOSE

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

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

1. Finance cluster
- Financial Management Services
- Budget
- Supply Chain Management (SCM)

2. Corporate Strategy and Organisational Performance
- Strategic Planning and Organisational Performance (SOP)
- RAMS and Internal Audit
- Quality Health Care Assurance Systems (QHCAS)

3. Corporate Services
- Information, Communication and Technology (ICT)
- Human Resource Management (HRM)
- Human Resource Development (HRD)
- Corporate Services
- Health Facilities Management

4. Clinical cluster
- District Health Services
- Communicable Diseases
- Primary Health Care Services
- Clinical Support Services

STRATEGIC OBJECTIVES
- To facilitate the provision of strategic leadership and the creation of a social compact to achieve 100% accountability
- To facilitate 100% achievement of an effective and compliant planning and monitoring system
- To provide 100% Financial Management and SCM to achieve full accountability and clean audit
- To facilitate implementation of NHI Readiness in at least one Health District
- To facilitate 80% achievement of developed and implemented corporate systems and ICT platform

Table 1.2: Performance against Provincial Targets from 2012/13- 2014/15 Annual Performance Plan for the Management

Performance Indicator	Actual achievement 2011/12	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual achievement for 2012/13	Comment on deviations
Level of compliance by the department with the Management Performance Assessment Tool (MPAT)	Not measured	Level 3	Level 1	2 levels below target	Under-achievement on this target is attributed to the electronic system flaws. Some of the evidence that was submitted electronically with the completed tool did not go through to the DPME at the Office of the Presidency as these were big files.The EC DOH assessment was therefore based on incomplete submitted evidence.
Number of statutory planning & reporting compliance documents submitted to the Executive Authority	Not measured	4 (APP, SDIP,Annual Report & Oversight Report,	4	0	All statutory compliance documents were submitted in line with the PFMA.
Proportion of invoices paid within 30 days	Not measured	50%	73% (30369/ 41629)	23%	The Department received approval for and (in March 2013) processed virements from COE with a value of R292,3 million in terms of section 43 of the PFMA, as amended. This enabled the Department to have cash flow to continue to pay creditors, in comparison to previous financial years –

Performance Indicator	Actual achievement 2011/12	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual achievement for 2012/13	Comment on deviations
					where there was depletion in equitable share as early as January and February of those years.
Percentage of over expenditure	Not measured	2%	-0.8%	-2.8%	The department spent R15,60 billion (99.2%) of the R15,73 billion adjusted appropriation budget leaving a balance of R133,64 million.This essentially represents the value of conditional grant rollovers funding applied for.
Number of hubs established	Not measured	14	0	0	The team attempted to pilot the MAWG concept in one District office (Amathole).This process was halted when the need arose to redefine the work relationship between MAWG and the Department and also review the concept itself.

Performance Indicator	Actual achievement 2011/12	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual achievement for 2012/13	Comment on deviations
Number of sites with LOGIS system	Not measured	22	8	11	At the end of the financial year, there were 31 LOGIS sites in the ECDOH and eight sites were implemented during the year. In alignment with other SCM Reform initiatives the focus was to ensure implementation of Logis in 14 prioritized sites across the province and this was achieved. The focus is now on provision of on-site support aimed at improving utilization in all these sites. In hindsight the annual target was unrealistic given the available resources.
Amount (rand value) of revenue generated	Not measured	81 394m	114 438m	(33 044m)	The variance is due to timing difference as to when Road Accident Fund (RAF) receipts were expected and received. There were receipts from the RAF in respect of previous financial years, and it is not possible to accurately forecast for receipts from this sector, due to the merit assessment method used to validate claims.

Performance Indicator	Actual achievement 2011/12	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual achievement for 2012/13	Comment on deviations
Number of District Hospitals (prioritised in RSDP) with installed VPN technology.	Not measured	21 RSDP prioritized hospitals to have Telkom Data Lines / Diginet connectivity.	25 RSDP prioritized hospitals with Telkom Data Lines / Diginet connectivity.	4 hospitals	Since the cancellation of the VPN project, the department continued with the connectivity project through the normal process. The process is managed Through SITA Wide Area Network (WAN) connectivity SLA.
Percentage of employment relations cases finalised within 30 days.	Not measured	50%	45.4% (64/141)	4.6%	The turnaround time is influenced by various factors that include the availability of chairpersons for disciplinary cases, the quality of the investigation and delays caused due to post - ponement of the disciplinary hearings. Line managers need to be trained to chair the simple misconduct cases so that employee relations practitioners focus on complex cases.
Percentage of employees whose benefits are paid within 3 months.	Not measured	80%	68%	-12.9%	There was inadequate budget allocated for the employee benefits; the Department requested a go ahead to pay these benefits from the Treasury. In the 2012/13 Adjustments Estimate, an additional allocation of R90 million has been made towards the R111,37 million outstanding.

Performance Indicator	Actual achievement 2011/12	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual achievement for 2012/13	Comment on deviations
Employee wellness utilisation rate.	Not measured	1.5% (724/48288)	4.9% (2360/48288)	3.4% (1636/48288)	Approximately 5% of the EC DOH employees utilize the organization's wellness services.The target was under-estimated as this indicator was not measured before and therefore there was no scientifically established baseline.
Percentage of employees out of adjustment.	Not measured	20% (9658/48288)	20.7% (10000/48288)	0.7% (342/48288)	The planned target of 20% was based on the post establishment prior abolishment of unfunded posts that was done on the 20 June 2012.The reversal of the post levels of most employees who were affected by the HROPT was done only in September 2012 following HROPT court decision. Adjustments done in September 2012 were based on the new post establishment. Of the 9029 employees appointed out of adjustment 790 of them were adjusted as a result of HROPT.

CHANGES TO PLANNED TARGETS

There were no changes made to 2012/13 APP targets in this programme.

LINKING PERFORMANCE WITH BUDGETS

Programme 1: Administration - Under expenditure of R0,73 million. The main contributor to this underspend is compensation of employees. The envisaged filling of all vacant executive posts did not take place.

Programme 1: Health Administration expenditure by sub-programme

SUB- PROGRAMME NAME	2012/2013			2011/2012		
	FINAL APPROPRIATION	ACTUAL EXPENDITURE	(OVER)/UNDER EXPENDITURE	FINAL APPROPRIATION	ACTUAL EXPENDITURE	(OVER)/UNDER EXPENDITURE
	R'000	R'000	R'000	R'000	R'000	R'000
1.1 Office of the MEC	5,734	4,251	1,483	5,502	5,061	441
1.2 Management	528,897	530,812	(1915)	543,908	538,837	5,071
Total	534,631	535,063	(432)	549,410	543,898	5,512

PART B

PROGRAMME 2

DISTRICT HEALTH SERVICES

PROGRAMME 2: DISTRICT HEALTH SERVICES (DHS)

PROGRAMME PURPOSE

To ensure the delivery of Primary Health Care Services through the implementation of the District Health System.

PROGRAMME DESCRIPTION

The District Health Service programme is composed of nine sub-programmes namely:

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

PRIORITIES FOR THE NEXT THREE YEARS

- To facilitate the provision of strategic leadership and the creation of Social Compact for better health by strengthening governance structures for increased participation in health issues.
- To implement the model for the delivery of health services in Eastern Cape based on the Revitalised Primary Health Care (RPHC) approach.
- To increase access to the comprehensive Primary Health Care (PHC) Service Package
- 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 Eastern Cape.
- To improve early detection and management of people with chronic conditions and those abusing substances at the community level through social mobilisation of communities.

2.1-2.3 District Management, Clinics and Community Health Centres

PURPOSE

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

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

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

STRATEGIC OBJECTIVES

1.3 To facilitate implementation of NHI Readiness in at least one health district.

1.4 To ensure revitalisation of Primary Health Care in at least five sub-districts, i.e. Intsika Yethu, Sub-district B (Uitenhage), King Sabata Dalindyebo (KSD), Nyandeni and Mbashe

SUB-PROGRAMME PRIORITIES

- To facilitate the provision of strategic leadership and the creation of Social Compact for better health by strengthening governance structures for increased participation in health issues.
- To review and strengthen the model for the delivery of health services in Eastern Cape based on the Revitalised Primary Health Care (RPHC) approach by March 2013 and
- To increase access to the comprehensive PHC service package and further rationalise health services.

SUB-PROGRAMME ACHIEVEMENTS

Health Governance Structures

- Clinic committees in the five pilot sub-districts are participating in the social compact activities
- District Health Councils are functional in all 7 districts

RE-ENGINEERING OF PHC SERVICES

The department is implementing the revitalisation of PHC services in line with the national policy directive.

Establishment of Ward Based PHC Outreach Teams (WBPHCOTs)

One hundred and eighty four new WBPHCOTs were established against the target of 26 for the year 2012/13. The department rolled out the establishment of these teams to all sub-districts in the province, resulting in a total of 325 teams to date inclusive of the 2011-12 reporting period (see Table 2.1).

Table 2.1: PHC teams established per sub-district

DISTRICT	SUB-DISTRICT	NUMBER OF WARDS	BASELINE NUMBER OF EXISTING TEAMS	TOTAL NO OF NEW TEAMS	Existing teams 2012/13
Alfred Nzo	Maluti	26	0	11	8
	Umzimvubu	76	3	8	11
	TOTAL	102	3	19	19
Amathole	Amahlathi	20	16	8	24
	Buffalo City	76	6	9	15
	Mbashe	31	6	19	25
	Mnquma	31	2	6	8
	Nkonkobe	25	2	2	3
	TOTAL	183	32	44	75

DISTRICT	SUB-DISTRICT	NUMBER OF WARDS	BASELINE NUMBER OF EXISTING TEAMS	TOTAL NO OF NEW TEAMS	Existing teams 2012/13
Cacadu	Camdeboo	21	0	4	4
	Kouga	29	0	3	3
	Makana	24	5	4	9
	TOTAL	74	5	11	16
Chris Hani	Emalahleni	17	7	9	25
	Engcobo	20	4	11	15
	Lukhanji	31	6	29	35
	IntsikaYethu	21	13	11	33
	InxubaYethemba	16	14	6	20
	Sakhisizwe	9	9	0	9
	TOTAL	114	53	66	137
Joe Gqabi	Elundini	17	1	2	3
	Maletswai	11	1	2	3
	Senqu	19	5	3	8
	TOTAL	47	7	7	14
Nelson Mandela	A	26	2	2	4
	B	15	3	5	8
	C	21	0	2	2
	TOTAL	62	5	7	14
O.R.Tambo	KSD	35	9	6	15
	Mhlontlo	26	2	10	12
	Nyandeni	51	6	6	12
	Qaukeni	31	6	5	11
	TOTAL	143	23	27	49
TOTAL		725	128	184	325

District Clinic Specialist Teams (DCSTs)

Eleven specialists were appointed with effect from January 2013. Their orientation and induction commenced at the end of January 2013 with the support of the national department.

Revitalisation Pilot Sites

Revitalization of PHC project was initially implemented in the three sub-districts Intsika Yethu, Sub-district B (Uitenhage) of NMBM and KSD. Two additional sub-districts namely Nyandeni and Mbashe were identified as additional implementation sites during the financial year under review. Core teams were established for each site.

Provincialisation of PHC Services

At the beginning of the financial year under review three of the 18 municipalities in the EC Province namely, Nelson Mandel Bay, Buffalo City and KSD had not transferred their PHC services to the provincial DOH and were still providing health services. By the end of the 2012/13 financial year, these municipal PHC services were transferred to the department. The transfer of both movable and immovable assets to the department has been delayed due to the municipalities' reluctance to sign the relevant documentation.

Facility Improvement Teams (FITs)

In preparation for National Health Insurance, the department established a provincial Facility Improvement Team (FIT) in line with a national policy directive following a national assessment of facilities in O R Tambo district. The aim of the team is to identify challenges that had contributed to poor performance and come up with quick fixes and deal with them immediately. The FIT has to apply a problem solving approach; it has to come up with medium and long term solutions that could be implemented to improve the performance of the facilities.

To date 14 PHC facilities have been assessed and to strengthen implementation in terms of the following:

- Policies and procedures.
- Renovation of infrastructure.
- Reduced waiting times.
- Improved patient safety.
- Drug availability.
- Infection control.

Table 2.1: Performance against Strategic Objectives for Programme 2

Strategic objective	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
To facilitate implementation of NHI Readiness in at least one Health District	New project that started in 2012/13	NHI readiness piloted in OR Tambo district	Preparation for NHI readiness commenced in OR Tambo	None	Focus is on improvement of health systems and infrastructure
To ensure revitalization of Primary Health Care in at least five sub-districts	Piloted in 3 sub-districts	To pilot in 5 sub-districts	5	0	PHC re-engineering is implemented in KSD, Intsika Yethu, Nelson Mandela (B) Nyandeni and Mbashe.
To ensure 60% of our health facilities provide access to Oral Health Services	72%	51%	70% CHCs: 70.7% (29/41) District hospitals: 69.7% (46/66)	19%	The target focused on 25 RSDP prioritized district hospitals and these are all providing oral health services
To facilitate the eradication of blindness to achieve national cataract surgery target	1002 per million	1001 per million	963 per mil (6426/6 671 956)	-38 per million	There has been a reduction in the number of screened patients in the province due to resignations of optometrists. In some facilities ophthalmologists and optometrists posts are unfunded. Transport challenges impact negatively on the outreach programme.

Strategic objective	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
To facilitate 60% of facilities implementing quality and patient safety program.	53.2% (25/47)	38% (25/66)	38% (25/66)	0	Target achieved
To facilitate development of mental health services to achieve 60% service levels	47% (22/47)	36% (24/66)	89% (59/66)	53% (35/66)	The target focused on 24 prioritized RSDP hospitals however, 72 hour service is a component of the district hospitals package and therefore all district hospitals are required to provide this service
To facilitate the 10% reduction of morbidity and mortality from targeted non-communicable diseases and other conditions	Not Measured	0.5%	0.43% (63 550/14 738 442)	-0.07%	The target is not met due to poor reporting of the data element "Diabetes case visit" that is used to calculate this indicator. There was a communication breakdown regarding collection of this data element. After this indicator was discontinued by the NDOH from the national NIDS, the EC DOH decided to continue monitoring this indicator. However, with the introduction of the new NIDS, some EC DOH facilities also discontinued the collection of Diabetes case visit.

Strategic objective	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
	Not Measured	3.6%	1.93% (284 927/14 738442)	-1.67%	The target is not met due to poor reporting of the data element "Hypertension case visit" that is used to calculate this indicator. There was a communication breakdown regarding collection of this data element. After this indicator was discontinued by the NDOH from the national NIDS, the EC DOH decided to continue monitoring this indicator. However, with the introduction of the new NIDS, some EC DOH facilities also discontinued the collection of "Hypertension case visit."
To combat and reduce the impact of HIV & AIDS to achieve 9.5% prevalence in 15-24 year old pregnant women	29.9% (2010)	Achieve < 29.9%	29.3%	0.6%	Target achieved
To reduce TB morbidity and mortality by achieving 85% cure rate	67.9% (15 387/22 765)	75%	68.9% (14 805/21 490)	-6.1%	Target not achieved due to high defaulter and death rates among TB patients. This indicator excludes those clients that complete treatment but could not produce sputum.

Strategic objective	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
To facilitate and ensure 60% provision of an efficient and effective Forensic Pathology Services	84%	95%	73% (6903/9400)	-22%	Staffing: The main challenge contributing to non-achievement of the target is that the Mthatha Region does not have full time doctors to conduct postmortems; all existing doctors are employed on sessional basis. In the East London region staff shortages result in very limited outputs particularly when other staff members are on leave. Only 21% of postmortems were, for example, performed during the 3rd quarter as some staff were on leave with only one operational doctor The situation in Mthatha is further aggravated by the fact that post mortems are conducted in the presence of police investigating officers and these are at times difficult to get within 72 hrs.
3.1 To ensure reduction of child mortality to achieve 26 per 1000 mortality in the under-five children	73/1000	58/1000	49/1000 (1603/32729)	9/1000	Neonatal deaths comprise the largest proportion of these deaths due to maternal related conditions

Strategic objective	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
1.1 To facilitate the reduction of maternal mortality to achieve 36.8 maternal mortality per 100 000	56/1000	80/1000	48/1000 (1415/29674)	32/1000	Community-based component of integrated management of childhood illnesses, training of traditional leaders and early child development center teachers. This is to encourage early booking of pregnant women to reduce early neonatal deaths as well as to integrate early child development centers into school health services
1.2 To ensure efficient and effective hospital services in at least 70% of hospitals	100% (66/66) district hospitals with appointed CEOs	100% (66/66) district hospitals to have CEOs appointed	77.3% (51/66) district hospitals with CEO appointed	0	Target achieved
To facilitate 60% of facilities implementing quality & patient safety program	38% (25/66) district hospitals assessed for compliance with core standards	38% (25/66) district hospitals to be assessed for compliance with core standards	38% (25/66) district hospitals assessed for compliance with core standards	0	Target achieved
To facilitate the development of mental health services to achieve 60% service levels.	33.3% (22/66) District hospitals providing 72 hour mental health services	36% (24/66) District hospitals to provide 72 hour mental health services	89.4% (59/66) District hospitals providing 72 hour mental health services	53% (35/66)	The target focused on 24 prioritized RSDP hospitals. However, 72 hour service is a component of the district hospitals package and therefore all district hospitals are required to provide this service

Table DHS 2.1-3: Performance against Provincial Targets from 2012/13 - 2014/15 Annual Performance Plan for District Management

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Provincial PHC expenditure per uninsured person	R364	R550	R595 (3,494,496,000 / 5 871 321)	R45	Target achieved
PHC total headcount	18 268 477	17.73m	17 740 496	10 496	Output is within acceptable target range
PHC total headcount under 5 years	3 187 832m	3.34m	3 002 054	-337 946	Parents fail to take children above age one to health facilities for routine visits (e.g. vaccines); they only take them to PHC facilities when they are sick. Seasonal changes also impact on headcount in under-five children particularly in rural areas.
Utilization rate – PHC	2.7	2.8	2.7 (17 740 496/ 6 671 956)	-0.1%	Based on the targeted PHC total headcount, of 17.73m a utilization rate in PHC facilities is 2.7 visits and this was achieved.The target of 2.8 was miscalculated
Utilization rate under 5 years - PHC	4.6	4.4	4.4 (3 002 054/ 686 842)	0	PHC utilisation rate in children under the age of 5 is on target

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Percentage of fixed PHC facilities with a monthly supervisory visit	86%	90%	80.8% (613/758)	-9.2%	The target was not achieved due to delays in filling of vacant posts as well as the creation of new posts that resulted in a progressive shortage of clinic supervisors. Districts most affected are Nelson Mandela Bay, Chris Hani and Amathole.
Expenditure per PHC visit	R116	R495	R197 (3,494,496,000/ 17 740 496)	R298	Target setting was incorrect.The target is tantamount to the annual expenditure covering all 2.7 visits
Percentage of complaints of users of PHC Services resolved within 25 days	72.8%	72%	66.3% (4 698/ 7 084)	-5.7%	The complaints that fall under categories 3-8 (mainly general complaints categorized) are usually easy to resolve. Complaints that fall under categories 1 and 2 (i.e. take longer to resolve. At times, clinic committee members are not available to open and attend to complaints on time; this leads to longer time periods to resolve the complaint from the date of receipt

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Number of PHC teams established	19	26	184	158	The department focused on using existing resources from the PHC facilities to establish as many teams as possible in order to increase communities' access to PHC services in line with RPHC, e.g. professional nurses that head the teams are sourced from the health facilities
CHCs/CDCs with a resident doctor rate	41.7%	50%	51.4% (21.6/42)	1.4%	The target has been exceeded due to the department's efforts to strengthen PHC services. Resident doctors were appointed to 22 CHCs. It is anticipated that doctor coverage in the remainder of CHCs will be increased through outreach services from district hospitals as well as the placement of post community service doctors

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

PHC total headcount under 5 years

- Re-engineering of PHC and community-based services.
- School health services: Early Childhood Development Centers are targeted through the School Health Services programme to address this

Percentage of fixed PHC facilities with a monthly supervisory visit

- Departmental will be focusing on transport strategy that will address and give guideline to a number of transport issues including pool vehicles, subsidized vehicles, etc.
- Staff shortages and prioritization of filling of posts is addressed through the departmental recruitment plan.

Percentage of complaints of users of PHC Services resolved within 25 days

The membership on clinic committee is voluntary and therefore the department needs to reinforce and strengthen the functionality of the clinic committees through periodic in-service, so that they appreciate the importance of their role in resolving user complaints.

CHANGES TO PLANNED TARGETS

There were no changes made to the planned targets in this section of the APP.

2.4 COMMUNITY-BASED SERVICES

PURPOSE

The Community-Based Services sub-programme manages the implementation of the Community-Based Health Services Framework. This includes implementation of disease prevention strategies at a community level; promoting healthy lifestyles through health education & support; providing geriatric services as a supportive and rehabilitation service; providing oral health services at a community level (including schools and old age homes); strengthening the prevention of substance, drug, and alcohol abuse to reduce unnatural deaths; as well as strengthening traditional health services (THS).

STRATEGIC OBJECTIVES

1.3 To ensure revitalization of Primary Health Care in at least five sub-districts.
1.4 To ensure 60% of our health facilities provide access to Oral Health Services.
4.1 To facilitate the eradication of blindness to achieve national cataract surgery target.
4.3 To facilitate the 10% reduction of morbidity and mortality from targeted non-communicable diseases and other conditions.

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 health outcomes within the province through education, health promotion and advocacy campaigns.
- To improve early detection and management of people with chronic conditions and those abusing substances at the community level through social mobilisation of communities.
- 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 to and improve eye care services.

ACHIEVEMENTS

Male circumcision

- The total number of male circumcision performed in the province was 52 854. The Male Medical Circumcision (MMC) comprised 8.7% (4 588) of this total and only 13.9% of the national target of 33 102.
- Against a target of 300, the Department reduced the number of circumcised males reporting adverse events to 174.

Oral Health services

- 14 Community service (comm-serves) dentists were deployed in EC health facilities in January 2013;
- Six dentists and a dental technician that were trained through the EC DOH bursary scheme were appointed in permanent posts in the Province
- One mobile dental truck was donated to the OR Tambo district for the NHI pilot project
- To enhance provision of oral health services in schools, 25 potable dental equipment (one for each sub-district) was procured for the school health teams.

Table DHS 2.4.1: Performance against Provincial Targets from 2012/13- 2014/15 Annual Performance Plan for Community-Based Services

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Mortality rate (per 100) in traditional circumcision clients	63 (Number)	0	0.15% (74/48 266)	-0.15%	These deaths occurred in areas that poorly comply with the EC Provincial Circumcision Act no 6 of 2001. Challenges are experienced with illegal circumcisions particularly in Pondoland, where cultural practices lead to late referrals, which in turn lead to complications. These deaths were mainly due to pneumonia, assault, septicaemia and mutilations. The programme is also experiencing transport challenges as a result of the expiry of fleet contract. There is a strong need for close monitoring of this programme and supervision of initiates on the ground during season. As a result of this shortage, officials that are supposed to conduct outreach and visit the circumcision schools are unable to do site visits and supervise on time.

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Number of CHCs providing oral health services	Not Measured	30	29	-1	Intermittent disruptions of service delivery are experienced due to non-appointment of permanent staff and reliance on sessional dentists who terminate their service abruptly
Number of district hospitals providing oral health services	Not Measured	24	46	22	Oral health services form part of the district health package that has to be implemented by all district hospitals.The target was setup focusing on RSDP prioritized district hospitals which all provide this service.

Table DHS 2.4.2: Performance against Provincial Targets from 2012/13- 2014/15 Annual Performance Plan for Disease Prevention and Control

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Malaria case fatality rate	Not Measured	0	0	0	There were no reported deaths due to malaria.
Cholera fatality rate	0	0.5%	0	0	There was no cholera outbreak during the financial year, hence no deaths due to cholera.
Diabetes case load in PHC facility	Not Measured	0.5%	0.43% (63 550/14 738 442)	-0.07%	The target is not met due to poor reporting of the data element "Diabetes case visit" that is used to calculate this indicator. There was a communication breakdown regarding collection of this data element. After this indicator was discontinued by the NDOH from the national NIDS, the EC DOH decided to continue monitoring this indicator. However, with the introduction of the new NIDS, some EC DOH facilities also discontinued the collection of Diabetes case visit.

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Hypertension case load	Not Measured	3.6%	1.93% (284 927/14 738442)	-1.67%	The target is not met due to poor reporting of the data element "Hypertension case visit" that is used to calculate this indicator. There was a communication breakdown regarding collection of this data element. After this indicator was discontinued by the NDOH from the national NIDS, the EC DOH decided to continue monitoring this indicator. However, with the introduction of the new NIDS, some EC DOH facilities also discontinued the collection of Diabetes case visit.
Cataract surgery rate (per million)	1002 per million	1001 per million	963 per mil (6426/6 671 956)	-38 per million	There has been a reduction in the number of screened patients in the province due to resignations of optometrists. In some facilities ophthalmologists and optometrists posts are unfunded. Transport challenges impact negatively on the outreach programme.

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

Mortality rate in traditional circumcision clients

The Eastern Cape Province is taking an integrated approach to address the traditional circumcision challenges. The main stakeholders include the House of Traditional Leaders (HOTL), Department of Health, South African Police Services (SAPS), Department of Education and other stakeholders affected by circumcision. These stakeholders will be developing policy guidelines on the implementation action with clear role clarifications for each stakeholder. Amongst others, the guidelines will focus on establishing the following systems and controls:

- Establishment of the Provincial Steering Committee-chaired by Local government and Traditional Affairs SG-members HOTL, Health GM, HIV/AIDS and other departments.
- Formation of Provincial Task Team consists of HOTL, Health, SAPS, Education and other stakeholders affected by circumcision.
- Establishment of local based Traditional Circumcision Forums to oversee circumcision related issues locally.
- Conduct community Imbizos on initiation before and after initiation season to share challenges and possible solutions with community members on issues affecting circumcision.
- Address transport challenges and securing a significant budget for hiring of vehicles to supervise circumcision schools in order to promote awareness about safe circumcision practices
- Establish systems to monitor initiates in order to reduce morbidity and mortality associated with circumcision.
- Training of traditional surgeons and nurses on health related issues to promote adherence to application of health standards in traditional circumcision.
- Enforce punitive measures for anyone who fail to comply with the legal requirements of this law.

Clinics providing Oral Health Services

- *Appointment of clinical staff:* the departmental strategy is to prioritize filling of vacant clinical posts. It is further looking into strengthening the process of funding the abolished unfunded clinical posts.
- *Addressing transport challenges:* The department is developing a fleet management strategy that will address the transport challenges. The transport Unit is being strengthened with the first step looking into the appointment of a senior manager for this Unit. In addition, the process of awarding staff with subsidized vehicles is being fast-tracked.
- *Implementation of conditions of service for scarce skilled health professional:* the strategy for retention of scarce skilled personnel encompasses the promotion and strengthening of multi-sectoral approaches between the organizational leadership and the clinicians in addressing and prioritizing issues pertaining to budget, subsidized vehicles and accommodation as well as strengthening inter-governmental collaboration.
- *Increasing provincial output of qualified oral hygienists and dental therapists:* The Health Sciences and Training programme of the department is awarding bursaries to address the skills gap in various health disciplines in the province. There is therefore a need to priorities and increase bursary intake of students training to qualify as oral hygienists and dental therapist.

Hypertension and Diabetes case Load in PHC facilities

Both hypertension and Diabetes Case Load indicator targets were not met. These two indicators are used to measure the burden of chronic diseases and are also used to form part of the national indicator data set (NIDS) in the previous three years. They were then discontinued during 2011/12 as a national reporting requirement. The EC Province decided to continue collecting these two indicators as a proxy measure of chronic disease burden. The province appears to have not effectively communicated its intention to continue with the reporting of these data elements. Subsequent to the new NIDS training, some facilities continued collecting these data elements whilst others stopped collecting in line with the national DOH. There is therefore gross under-reporting on these two indicators. As a mitigation strategy, the EC DOH needs to communicate and train health facilities on both the National and Provincial indicator data sets that is guided by the Departmental Monitoring and Evaluation Framework.

Cataract surgery rate

- *Promoting and strengthening collaboration with external health care providers:* The department sourced support of the external stakeholders as a strategy to increase service delivery outputs in this area. During the year under review, the department received the support of the Fred Hallows Foundation which provided two professionals, an optometrist and an optical laboratory technician. In addition, the KZN eye-care coalition will, for a period of three years, be undertaking cataract camps at both St Elizabeth and Butterworth hospitals.

- *Increasing provincial output of qualified ophthalmologists and optometrists:* The Health Sciences and Training programme of the department is awarding bursaries to address the skills gap in various health disciplines in the province. The non-communicable diseases sub-directorate is in constant engagement with this training programme to increase bursary intake of students training to qualify as ophthalmologists and optometrists.

CHANGES TO PLANNED TARGETS

There were no changes made to the planned targets in this section of the Annual Performance Plan.

2.5 OTHER COMMUNITY SERVICES

PURPOSE

The Other Community Services sub-programme manages the devolution of municipal health service (MHS) from the Department of Health to the district municipalities and metros, and implements a Port Health Strategy to control the spread of communicable diseases through ports of entry in the province.

STRATEGIC OBJECTIVES

1.1 To facilitate 60% of facilities implementing quality and patient safety program.
1.3 To ensure revitalization of Primary Health Care in at least five sub-districts.

PROGRAMME PRIORITIES

- To strengthen the functionality and effectiveness of the six ports of entry in the province.
- To implement and monitor compliance with the Hazardous Substances Act.
- To implement and monitor compliance with the Waste management Act.
- To monitor Municipal Health Services delivery and outputs.

ACHIEVEMENTS

1. The Sub-Directorate has devolved the Municipal Health Services (MHS) to two District Municipalities namely and one Metro.
   - Eleven environmental health services were devolved in Joe Gqabi District Municipality in June 2012,
   - 21 EHPs were transferred to Alfred Nzo in September 2012 and
   - 8 EHPs were transferred to Buffalo City Metro in December 2012. These EHPs were transferred with 100% funding of the Compensation of Employees (CoE).

2. The Service Level Agreement for the devolution of MHS has been signed with OR Tambo DM and the actual transfer of staff will occur in 2013-2014 financial year.

3. The department monitors and applies strict controls on Port Health Services: the Port Health Services in Port Elizabeth International airport during the AFCON in January 2012 refused entry to seven passengers from yellow fever endemic areas as they did not comply with the yellow fever vaccination requirements

Table DHS 2.5.1: Performance against Provincial Targets from 2012/13- 2014/15 Annual Performance Plan for Other Community Service

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Percentage of health facilities segregating waste in line with SANS 10248	49.2% (406/ 826)	100% (512/512)	78.5% (402/512)	-21.5%	The contracted service provider delivers a regular supply of disposable plastic bags to the sub-district to further distribute to the health facilities. However, some of the PHC facilities do not get these plastic bags due to the ad hoc delivery by the sub districts. The unit has in addition identified a challenge of ignorance in waste segregation in PHC facilities. In addressing the challenge the unit will be conducting trainings for PHC facilities, addressing all the waste management issues with emphasis on waste segregation.

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

Facilities segregating waste in line with SANS 10248

The major challenges facing the health facilities with regards to non-achievement of this target is due to unavailability of plastic bags for waste segregation and poor compliance by health facilities with waste segregation requirements.

Inconsistencies within the service provider contract (plastic distribution):

The waste management service contract is inconsistent in the area of delivery of plastic bags. In some areas, the service provider delivers directly to health facilities whilst in others the service provider delivers to a central point which further distributes to the health facilities. Best practices show that there is smooth service implementation in those areas which receive plastic bags directly from the service providers. Some transport challenges are experienced in those areas where the service provider delivers at a central point and as a result the facilities that are operating under this approach tend to run out of plastic supply.

Poor compliance with waste segregation requirements:

The Departmental waste management contract includes training of users in waste segregation and waste management in general. Health providers need to be afforded adequate time to attend the training sessions. To ensure proper management of waste in accordance with the six priorities of the core standards particularly infection control and cleanliness, these need to be included as key performance areas in the performance agreements of the health facility managers.

Frequent assessments will be conducted as means to inculcate the culture of segregating waste and proper waste management.

CHANGES TO PLANNED TARGETS

There were no changes made to the planned Annual Performance Plan targets in this section.

2.6 HIV & AIDS, STI & TB CONTROL (HAST)

PURPOSE

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

STRATEGIC OBJECTIVES

- To combat and reduce the impact of HIV & AIDS to achieve 9.5% prevalence in 15-24 year old pregnant women.
- To reduce TB morbidity and mortality by achieving 85% cure rate.

PROGRAMME PRIORITIES

- To increase the HCT uptake in fixed clinics and non-medical sites.
- To enhance implementation of dual therapy.
- To increase access to ART and the number of clients on ART.
- To increase HTA sites.
- To increase patient access to Home Based Care.
- To educate and increase knowledge of the EC population in order to maintain negative HIV status of millions of people.
- To improve TB cure rate and reduce new TB infections.
- To combat and reduce the impact of TB and HIV/AIDS with a special focus on preventing the emergence of drug-resistant strains.
- To prevent mother to child transmission of HIV.

ACHIEVEMENTS

HIV and AIDS Sub-Programme

At the end of 2011/12 there were 188 544 patients accessing ARVs across the province. By the end of the financial year under review, 49 286 new clients were enrolled on the ART programme which totalled up to 237 830 clients enrolled on this programme. This had been achieved as a result of an increase in the number of health facilities implementing the ART programme since the change in policy towards a nurse initiated management of ART (NIMART) approach.

Increased ART coverage is achieved through NIMART mentoring and through ART initiation by more health facilities as the number of new health facilities assessed and ready to initiate ART to eligible patients grew per district to 790 distributed as follows:

- Amathole 209
- Chris Hani 170
- OR Tambo 185
- Cacadu 67
- NMM 53
- Alfred Nzo 44
- Joe Gqabi 62

Prevention of Mother to Child Transmission

The department of health working with the AIDS Council, other sectors and various NGOs has decreased transmission of HIV from mothers to babies (PCR positivity rate) from 4, 4% in 2011 to three in 2012. An additional contributing factor was to improve initiation of ART for pregnant woman However, the department will continuously

ensure that all pregnant women are counselled and tested for HIV and those that are eligible for ART are initiated promptly as this intervention will assist in reducing maternal mortality in the province.

TB Management and Control

The advances in early detection and treatment of TB had been made possible by the introduction and roll out to districts of the GeneXpert machines. GeneXpert is an instrument that is used to conduct rapid diagnosis of tuberculosis and the detection of Rifampicin resistance. It detects the presence of the DNA of Mycobacterium Tuberculosis in the sputum and also identifies any changes in the DNA that may cause Rifampicin resistance. The test is called Xpert MTB/RIF. The rollout of these machines will benefit the TB programme as there will be prompt diagnosis and early initiation of treatment for the patients who are diagnosed as sensitive and drug resistant TB. This will in turn result in a reduction of transmission of the bacilli and the resistant strains.

By the end of 2012/13 financial year, a total of 32 machines were distributed to health facilities in seven EC health districts with the following district allocation:

- Alfred Nzo 5
- Chris Hani 4
- O.R. Tambo 8
- Amathole 8
- NMMM 5
- Cacadu 1
- Joe Gqabi 1

Community-based management for MDR-TB Patients

The implementation of the policy framework on de-institutionalisation and decentralisation of MDR-TB patients has been implemented in the five districts and facilities shown in Table 2:3 below. The department is implementing this programme in partnership with the Italian Cooperation. The implementation of this approach has improved patient access to MDR TB services and has significantly reduced travelling time for clinical follow-up to the two health facilities that only manage MDR namely Fort Grey and Jose Pearson hospitals

Table: 2:3 Decentralized and Centralized sites in the health districts

Districts	Decentralized sites	Satellites
Alfred Ndzo	Khotsong TB hospital	
Amathole	Nkqubela TB hospital	Bisho Hospital
Nelson Mandela	Orsmond TB hospital	Leticia Bam
O.R. Tambo		Sir Henry Elliot Zithulele Hospital Holy Cross Hospital
Cacadu	Marjorie Parish TB hospital	P.Z. Meyer

Collaboration with other health care providers

The Eastern Cape Department of Health is the only province that is currently implementing the Public Private Mix DOTS with the independent practitioners in the Nelson Mandela Metro. This strategy has contributed to the improvement of the TB treatment outcomes for the Nelson Mandela Metro. For example, the cure rate for the Nelson Mandela Metro has increased from 35% in 2007 to 71.2% in 2011. Lessons learnt have been shared in national platforms. The programme will be rolled out to other districts within the province.

Table DHS 2.6.1: Performance against Provincial Targets from 2012/13- 2014/15 Annual Performance Plan for HIV & AIDS, STIs & TB

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Total number of patients (children and adults) on ART	188 544 (38 544 new)	270 000 (82 000 new)	237 830 (49 286)	-32 170	• After provincialisation of municipal clinics, patients were moved from original ART sites to alternative newly provincialized clinic ART sites and these were lost in the system as they are not appearing at both the new and old sites. • Between April and May 2012 there was a nationwide shortage of Tenofovir 300mg which is one of the drugs used by patients on 1st line regimen. This affected the number of new clients initiated on ART
Male condom distribution rate (per male population 15 yrs. and older)	14.8	16	15.7 (33 601 670/ 2 140 538)	-0.3	During quarter 1, the province experienced a shortage of condoms. This was due to challenges with Supply Chain Management processes. In previous years, condoms were procured through the National Department of Health tender.

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
					During 2012/ 13 financial year, the National Department of Health decentralized the condom funds to the provinces but awarded the tender to a supplier which was to be used by all provinces.
New smear positive PTB defaulter rate	7.8%	6%	7.8% (1676 / 21 490)	-1.8%	Defaulter rate is highest at NMMM and Amathole districts hence the high defaulter rate of 9.7% and 9.5% respectively for each of these two districts. The urban nature of these two districts poses a challenge due to migration patterns of TB clients, moving between rural homes and the cities seeking jobs.
PTB two months smear conversion rate	65.9%	73%	63.5% (13 899/21881)	-9.5%	Amathole is the only district with conversion rate below 60% (57.9%) with a significant proportion of patients (22.2%) with no laboratory results recorded on the TB registers until reporting time and some smear results are collected late, this translates to low achievement. Some districts for example Alfred Nzo have high transfer rate of 4% and high death rate of 6.8%.

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Percentage of HIV-TB Co-infected patients placed on ART	37.9%	90%	65.3% (17 261/26453)	-24.7%	The low percentage of HIV & TB co-infected patients placed on ART programme reflects the data challenges facing this programme. The ETR.net system error is affecting this indicator; HIV positive patients that were on ART prior TB treatment are not captured by the system as continuing on ART. Whilst there is a strong drive to integrate TB and HIV services, data collection tools for TB and HIV are still separate. ART initiated patients are recorded on ART register only and are not transferred to the TB register.
Percentage of HIV+ patients started on Isoniazid (INH) Prophylaxis	48% (41 631/87 481)	70%	39.1% (42 681/109 054)	-30.9%	There was no standardized register to record patients initiated on INH Prophylaxis Therapy (IPT) in facilities; hence gross under-reporting on IPT uptake.

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
% of TB/HIV co-infected patients started on Cotrimoxazole	81,1% (19 679/24 236)	90%	87% (23 021/26 453)	-3%	NMMM, O R Tambo and Amatole Districts are the only districts that did not achieved the target of 90%. The Health Professionals are not restarting Cotrimoxazole Prophylaxis Therapy (CPT) for patients who are on ART before they contract TB.
% of TB cases tested for HIV	80,5% (44 332/55 003)	95%	85.5% (48 292/ 56 480)	-9.5%	HIV testing is voluntary; some patients prefer completing TB treatment before knowing their HIV status. In addition, poor recording of the HIV status of clients may contribute to non-achievement of the target.
% of M(X)DR-TB co-infected patients started on ART	65,1% (9497/14571)	100%	MDR:595/623 (95.5%) XDR:118/119 (99%)	-4.5% -1%	One MDR patient died whilst 27 were on preparation phase in line with MDR treatment guidelines. One XDR patient died before commencing treatment

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
HCT Testing rate	88.1%	90%	96% (966 172/ 1006 130)	6%	There has been some improvement in data recording and management. Advocacy, Communication, Social Mobilization and marketing strategies that have been implemented by the department of health in partnership with the Provincial AIDS Council and Partners have increased the awareness about HCT, amongst community members.
New smear positive PTB cure rate	67.9% (15 387/22 765)	75%	68.9% (14 805/21 490)	-6.1%	Target not achieved due to high defaulter and death rates among TB patients. This indicator excludes those clients that complete treatment but could not produce sputum.

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

Patients (children and adults) on ART

The tender for procurement and distribution of Tenofovir 300mg is awarded by the national DOH. During the 1st quarter of the FY, Sonke Pharmaceuticals was the major supplier for the HIV drugs Tenofovir having been awarded 70% of the tender.

The shortage of Tenofovir reduced the rate of initiation of new patients on ART. This drug was supposed to be used to initiate new patients. To address the challenge, the National Department of Health (NDOH) has since awarded the contract for the provision of Tenofovir to three other companies with a split of 33% given to two companies and the third given 34%, in order to reduce the risk of a majority of suppliers running out of stock.

Male condom distribution

After the decentralization of condom funds by the national DOH to the provinces for the first time in 2012/13, the NDOH awarded a tender to a supplier that was to be used by all the Provinces. The Eastern Cape Department of Health was compelled to first follow proper Supply Chain Management processes and register the national supplier on the EC DOH database for suppliers before it could procure the condoms. The supplier was successfully registered in May 2012.

The shortage of Condoms however, continued throughout the year as the manufacturers could not cope with the number of orders that were placed by different provinces in the whole country.

New smear positive PTB defaulter rate

Outreach teams were first introduced in OR Tambo and were operational since the beginning of 2011 hence the defaulter rate of 5% in this district. The outreach teams were then rolled out to other districts towards end of 2011.The outreach teams in conjunction with the NGOs have been tasked to trace patients that are lost to follow up especially in Sub-district C of Nelson Mandela Metro. However, the outreach teams' optimal and effective functionality is hampered by transport shortages especially at Sub-district level. In addition, the province is in the process of employing a district HAST coordinator.

Whilst the Department still has to come up and put a viable transport strategy in place, the Department has engaged the Department of Transport (DoT) in an effort to address the transport challenges at hand which hinder the implementation of outreach and HCT programmes. There were seven sedan vehicles that were allocated for the outreach programme with effect from the February 2013. To alleviate the transport shortage temporarily whilst waiting for the transport strategy to be put in place, 64 vehicles were hired for the outreach teams that render all the PHC programmes including non-communicable diseases, at community and household levels.

PTB two months smear conversion rate

To address the issue of poor recording and reporting of laboratory results, the provincial department of health, working with the TB coordinators from the sub-districts and partners, continuously conduct data verification workshops in Amathole district. Data audits are done quarterly when there are support visits in the clinics. However, there is a plan that was developed by Amathole district team with the partners that seeks to improve the TB treatment outcomes in this district. There are currently NGOs including Red Cross and Siyanqoba that are working on educating communities around Amathole on the importance of seeking medical care, when the individual has shown signs of TB. This will help in reducing the high death rate at two months. Quarterly performance reviews are done to monitor the progress and the challenges related to the implementation of the plan.

HIV and TB co-infected patients placed on ART

This indicator is affected mainly by the information system (ETR.net) error, as well as the data collection and recording tools. The TB and HIV registered are not synchronised and as a result, there is always under-reporting as the two systems are not talking to each other. The ETR.net system is designed and developed by the national DOH and the

provinces implement the system. In response to this challenge, the national DOH has designed and developed a 3 TIER.net system which interfaces with the ETR.net system and the full implementation of TIER 2 and 3 of this system will address this challenge. However, the provincial DOH connectivity becomes key to the implementation of this system.

Percentage of HIV+ patients started on Isoniazid (INH) Prophylaxis

Non-achievement of this target is attributable to the unavailability of registers to record accurately patients initiated on INH prophylaxis. The department in conjunction with its partners has since designed and printed 4000 IPT registers which were distributed to the facilities in January 2013. The IPT registers will enhance management of clients by ensuring that all the patients are recorded, are accurately reported and can be properly followed up.

TB &HIV co-infected patients started on Cotrimoxazole

The districts that have achieved 90% have improved the recording of data related to patients that have TB and co-infected with HIV at facility level. The best practices are shared with the other districts including those with moderate outputs including Amathole, O.R.Tambo and Nelson Mandela. Partners supporting TB/HIV that are working in these districts are mentoring the nurses at the clinics so as to improve data management related to TB patients co-infected with HIV.

TB cases tested for HIV

The programme is currently conducting Data Verification workshops in the Sub-districts, so as to improve recording of data. Training in data management is done to nurses as a form of in-service education as this also helps in improving data management.

All the TB patients are encouraged to test for HIV; this is done through Provider Initiated Counseling and testing (PICT), which means that all the patients that enter the health facility including TB patients, must be offered HIV, Counseling and testing by health professionals.

MDR/XDR/TB & HIV co-infected patients started on ART

The introduction of the GeneXpert is going to assist tremendously in reducing the number of patients dying before they are started on treatment. This is because the turn-around time for culture results takes at least 48 hours to five days at most instead of the six weeks in the past before the introduction of the GeneXpert. This improved early diagnosis of patients and prompt initiation of treatment to patients with the Rifamopicin resistant results.

New smear positive PTB cure rate

Exclusion of clients that are unable to produce sputum at the end of the treatment period contributes to low cure rates as these are not tested. To address this exclusion, this indicator has been redefined to "Treatment Success Rate" nationally to include all clients who completed their treatment but fail to be tested as a result of being unproductive (not being able to produce sputum for testing). During the financial year under reporting for example, should these have been included; the target would have been achieved and exceeded at 78%. The indicator Treatment Success rate has been included in the 2013/14 financial year planning documents. Vigorous and effective interventions are however, still required to address both defaulter rate and deaths of patients whilst on treatment.

CHANGES TO PLANNED TARGETS

Indicator	Original APP target 2012/13	Revised target 2012/13	Reasons for changing target
Total number of patients (children and adults) on ART	215 000 (65 000 new)	270 000 (82 000 new)	Misalignment of information; 215 000 (65 000) was the 2011/12 target

2.7 MATERNAL, CHILD AND WOMEN'S HEALTH & NUTRITION

PURPOSE

To ensure implementation of national and provincial Maternal Child and Women's Health (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 and health care services; and to reduce neonatal, infant and child mortality and morbidity.

STRATEGIC OBJECTIVES

3.1 To ensure reduction of child mortality to achieve 26 per 1000 mortality in under-five children.

3.2 To facilitate the reduction of maternal mortality to achieve 36.8 per 100 000 live births.

PROGRAMME PRIORITIES

- Reduction of morbidity and mortality rates due to severe malnutrition in hospitalized children from 30% to 10%.
- Increasing the number of health facilities with maternity beds awarded a baby-friendly status by four annually.
- Routine Vitamin A supplementation of children less than 5 years 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.
- 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 immunization coverage.

SUB-PROGRAMME ACHIEVEMENTS

School Health Services

- By the end of September 2012 the department has renewed the contracts of 56 retired nurses that form part of the school health teams (PHC teams). These were contracted to implement the school health services in various sub-districts and to screen learners at the foundation phase (grade R- 3). An additional 45 retired nurses had been contracted to join these teams, bringing the total to 101. A total of 64 school health teams have now been established.
- The EC DOH continues to appoint nurses outside the employment of the DOH on one year contract to join the PHC teams in various sub-districts to screen learners at the foundation phase (grade R- 10).
- During the 2012/13 FY, a total of 101 retired nurses were recruited onto the school health programme. These contracts will be reviewed towards the end of March 2013.
- In March 2013, review of the existing 101 contracts was done and 150 new contracts were recommended based on integrated PHC and MCWH budgets. Seventy-five of the 101 contracts in 2012/13 were re-appointed; the other 75 candidates are awaiting approval. These teams are also used to provide Vitamin A immunization coverage for 12-59 months aged children (current tendency is for mothers not to continue bringing these kids once they have finished their first year traditional immunization program.

- The programme is mainly collaborating with two government Departments i.e. Department of Education and Social Development and all other government departments on a lesser scale. The DOE has allocated a special dedicated coordinator to work with the Department of Health; the two Departments are also sharing resources e.g. scales, transport and height measures.
- The model of the school health programme is based on sharing of resources with the ward-based (RPHC) teams, clinics in the catchment areas, supply from the NGOs and resources from other government departments including the DOE.
- NGOs: In 2012, ICAP donated 101 toolkits
- UNICEF donated one double cab which was allocated to the Alfred Nzo district.
- The national DOH donated 3 vehicles towards the school health activities and these were allocated at OR Tambo district;
- The DOE supplied weighing scales, studiometers and audiometers for the teams.
- As per the school health programme recommendations, the DOE is procuring and ensuring the availability of first aid kits in schools.
- in May 2012, the Regional Training Centre (RTC) of the Walter Sisulu University (WSU) together with the national DOH trained two master trainers per sub-district to cascade down training in the Province. Training is now cascaded down to all the sub-districts by the master trainers with the assistance of the provincial office. The department has trained 70 health providers and educators.

Child's Health

The Reach Every District (RED) strategy which had initially been implemented in three districts is now being rolled out to all eight districts of the province with the assistance of UNICEF. In order to ensure successful implementation of the RED strategy, managers are trained to reach every child with child health services and on Data Quality Self-Assessment.

PCV and Rotavirus vaccine coverage have improved beyond 80%. The aim here is to reduce mortality due to diarrhoea and pneumonia. To address child mortality, professional nurses are trained on IMCI. All the nurses previously trained on IMCI are being trained on NIMART in order to initiate children on ARVs. Child mortality reviews are conducted to investigate causes of deaths and to identify what could be addressed.

Integrated Nutrition Project

- MCWH and Integrated Nutrition programme is forming part of the provincial anti-poverty strategy team with other government departments to address poverty in the province. Poverty stricken families eligible for assistance are identified through outreach teams, Health Promoters and CHW as well as other community health services from other government departments. Sixteen wards in 13 local Municipalities had been identified (see Table 2.7.1below).

- DOH visits these homes and provides health services including growth monitoring to under-five year-olds, de-worming and administering Vitamin A to boost nutritional status; immunizations, create Health Posts, community gardens in early child development centers and crèches in the wards that are declared anti-poverty sites (see Table 2.7.1 below)

Table 2.7.1: Identified Anti-Poverty Strategy Sites by District

DISTRICT	LOCAL MUNICIPALITY	WARD	VILLAGE
Alfred Nzo	Mbizana Umzimvubu	16 14	KwaNgutyana Mandileni
OR Tambo	Mhlontlo Port St Johns	21 10	Maladini Village Bolani Village
Amathole	Mnquma Amahlathi	25 4	Nkanga Village Goshen Village
Chris Hani	Ngcobo Ntsika Yethu	13 22	Silindini & Qebe Kwa-Hala
Joe Gqabi	Elundini	6	Upper Sinxako & Siqhungqwini
Cacadu	Ikhwezi Baviaans	3 4	Klipplaat Rietbron
Buffalo City Metro	Metro	34 32 37	Dimbaza Tsholomnqa Masingatha
Nelson Mandela Metro	Metro	4 13	Walmer Helenvale

Table DHS 2.7.2: Performance against Provincial Targets from 2012/13- 2013/14 Annual Performance Plan for Maternal Child and Women's Health & Nutrition

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Immunisation coverage under 1 year	84.2%	90%	82.6% (107 257/129 778)	-7.4%	The availability of vaccines has improved significantly in the current financial year; challenges however, exists with regards to: • Data quality as some sub-districts have rates in excess of 100% and • Interpretation of the data element fully immunized less than one year. This requires in-service training of service providers in PHC facilities. In addition, this needs to be coupled with provision of standard-ised data collection tools including training in data audits.
Vitamin A coverage – 12-59 months	45.1%	77%	43.5% (484 178/1114 118)	-33.5%	The main challenge with this indicator is that parents fail to bring their children to PHC facilities once they are above one year old and are not sick. With the implementation of the PHC teams and the PHC re-engineering strategy whereby Vit. A in this age group is administered by community health workers

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
					With the implementation of the PHC teams and the PHC re-engineering strategy whereby Vit. A in this age group is administered by community health workers at pre-schools, it is believed that Vit. A coverage will improve.
Measles 1st dose under 1 year coverage	95.2%	90%	93.2% (120 891/129 778)	3.2%	During the current financial year, the availability of vaccines in the EC health facilities has improved significantly compared to the previous year. Measles, pneumococcal and rotavirus vaccine coverage have exceeded the set targets. The pneumococcal vaccine that prevents pneumonia in children was upgraded from preventing seven to 13 strains. Following this upgrade, the department has been driving catch-up campaigns to immunize children from six weeks up to age 2 hence the good performance shown on these indicators. Data quality however, still remains a challenge as some sub-districts have rates in excess of 100%
Pneumococcal (PCV) 3rd Dose Coverage	80.9%	80%	87.7% (113 884/129 783	7.7%	
Rota Virus (RV) 2nd Dose Coverage	77.6%	80%	83.7% (108 675/129 783)	3.7%	

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Baby tested PCR positive six weeks after birth as a proportion of babies tested at six weeks	3.9%	7%	3% (772/25 682)	4%	The target for 2012/13 FY for this indicator was set at 7% based on 2011/12 target that was used as estimated actual output. However, the actual annual output for the previous year was 3.9% hence this big variance. In addition, the target was exceeded as a result of the support that the programme receives from the PEPFAR funded NGOs. The Regional Training Centre (RTC) strengthened the programme capacity by training the Community Care givers.
Cervical cancer screening coverage	37.9%	50%	39.4% (53 245/135 306)	-10.6%	The poor skill amongst health service providers to take adequate cervical smears is the major challenge affecting this indicator. The ECDoH employed a community obstetrician who, during the first quarter of the current financial year and with the assistance of UNFPA, trained nurses on the correct method of taking adequate pap smears.

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Antenatal visits before 20 weeks rate	33.6%	60%	39.6% (53 248/134 224)	-20.4%	Some of the reasons that hinder achievement of the target on this indicator include: - Inadequate history taking by health workers leads to late diagnosis of pregnancy. - Client related challenges resulting in clients presenting at health facilities late (beyond 20
Couple year protection rate	29.8%	45%	31.7% (518 816/1636 643)	-13.3%	This indicator is affected by the manner in which some contraceptives are dispensed. In maximizing women protection, women are given contraceptive supply for 3 months and at times the recording is done only for one visit and does not take into consideration the number of months that correspond to the issued supply hence the target is never reached.

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Public Health Facility Maternal Mortality rate	115/100 000	35/100 000	112/100 000 (119/106 259)	77/100 000	Thus far there is an improvement in this indicator output compared to the previous year; however the target of 35 per 100 000 is the national MDG target to be achieved by 2015 and therefore is set too high for 2012.The five causes of maternal deaths are: Non-pregnancy related infections – mainly resulting from AIDS Complications of hypertension Obstetric haemorrhage Pregnancy-related sepsis Pre-existing maternal disease
Delivery rate for women under 18 years	10.6%	10%	10.3% (12 034/116 299)	0.3%	The programme is on target however, educating communities, home visits and referrals from community-based RPHC activities including school health service will increase awareness and further reduce teenage pregnancy. This will be coupled with a strong drive to strengthen family planning.

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Facility Infant mortality (under 1) rate	73/1000	58/1000	49/1000 (1603/32 729)	9/1000	Deaths observed in these age groups are due to HIV and AIDs related infections, malnutrition and pneumonia. Neonatal deaths comprise the largest proportion of these deaths due to maternal related conditions. Community-based component of integrated management of childhood illnesses, training of traditional leaders and early child development center teachers.This is to encourage early booking of pregnant women to reduce early neonatal deaths as well as to integrate early child development centers into school health services.
Facility Child mortality (under 5) rate	56/1000	80/1000	48/1000 (1415/ 29 674)	32/1000	

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

- *Immunization Coverage*

The strategies to address immunisation coverage include conducting catch-up campaigns over and above routine national immunisation campaigns. During the first quarter of the new financial yea, a national immunisation campaigns will be conducted to increase immunisation coverage in the province and this will be followed with catch-up campaigns should a need be identified.

Children who have missed some of their immunisations will be tracked through community-based services including home visits by the RPHC teams, CHWs, health promoters and school health services in crèches and early child development centres.

Since 2012, to address low Vitamin A coverage the department is implementing the new policy that allows the CHWs to administer Vitamin A in communities and early-child development centres to circumvent the truancy of mothers who fail to bring children to PHC facilities for this service.

The department will be developing and/or revising data collection tools and conducting on-site training in order to capture those immunisations that were administered at community level.

- *Cervical cancer screening coverage*

The department employed a provincial community obstetrician who trains the health service providers at PHC level and enhance their skills to take proper and adequate cervical smears. In addition, the advanced midwives employed as part of the District Specialist Teams will be giving technical assistance in this area.

- *Antenatal visits before 20 weeks rate*

The CHWs in conjunction with the health promoters will be educating communities on the importance of early booking and early interventions. They will strengthen referral pathways for those pregnant women identified through communities-based services and through house visits.

- *Couple year protection rate*

The training of health professional on the new family planning policy is being rolled out in all the EC districts. Youth-friendly clinics are being re-vitalised whilst also training health service providers on youth friendly services. School health services coupled with community-based interventions are implemented to increase awareness about family planning issues. All these strategies will improve the health provider capacity and in addition control teenage pregnancy.

- *Public Health Facility Maternal Mortality*

The department has re-deployed its ambulance service and ambulances are based at facilities that conduct deliveries and closer to the communities for early intervention. The department further needs proper integration with other government departments; in this regard the Department of Public Works for planning of road infrastructure as this is one of the major hindrances during delivery time.

Assessment of the availability and use of referral policy is the obstetric units will be done and the implementation of the referral policy will be closely monitored.

A further strategy is that of establishing maternity half-way houses in proximity to the delivery points in order to house pregnant women that are closer to term from remote rural areas with road infrastructure challenges.

CHANGES TO PLANNED TARGETS

Indicator	Original APP target 2012/13	Revised target 2012/13	Reason changing target
Vitamin A coverage – 12-59 months	67%	77%	Printing error; annual target read from a wrong column 2011/12 rather than 12/13
Pneumococcal (PCV) 3rd Dose Coverage	90%	80%	Printing error; annual target read from a wrong column 2011/12 rather than 2012/13
Rota Virus (RV) 2nd Dose Coverage	90%	80%	Printing error; annual target read from a wrong column 2011/12 rather than 2012/13
Cervical cancer screening coverage	60%	50%	Printing error; annual target read from a wrong column 2011/12 rather than 2012/13

2.8 CORONER SERVICES

PURPOSE

To strengthen the capacity and functionality of Forensic Pathology Institutions within the Province and facilitate access to clinical forensic medical services at all material times. The Coroner Services sub-programme renders forensic pathology services in order to establish the circumstances and causes surrounding un-natural deaths.

STRATEGIC OBJECTIVES

1.8 To facilitate and ensure 60% provision of an efficient and effective Forensic Pathology Services

PROGRAMME PRIORITIES

The rendering of an efficient and effective service by:

- Collecting bodies from crime scenes within 1hr in urban and 3hrs in rural areas.
- Conducting postmortems within 72 hrs.
- Generating an accurate postmortem report that will assist the justice system.

SUB-PROGRAMME ACHIEVEMENTS

- The sub-programme has developed the provincial forensic policies in line with the national policies for all mortuaries. The policy communicates and guides the national standards that Forensic Pathology should be adhering to and complying with.

- Approval of Forensic Pathology Officers' overtime contract. According to policy the forensic pathology service is a 24 hour service, but the EC province has not complied with this requirement as yet. The organogram still has to be approved. In the interim the Departmental strategy to address this is to allow stand-by and overtime allocations until such time that the programme complies with the 24 hours service requirement.

Table DHS 2.8: Performance against Provincial Targets from 2012/13- 2013/14 Annual Performance Plan for Coroner Services

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Percentage of post-mortem performed within 72hrs	84%	95%	73% (6903/9400)	-22%	• Staffing:The main challenge contributing to non-achievement of the target is that the Mthatha Region does not have full time doctors to conduct postmortems; all existing doctors are employed on sessional basis. • In the East London region staff shortages result in very limited outputs particularly when other staff members are on leave. Only 21% of postmortems were for example performed during the 3rd quarter as some staff were on leave with only one operational doctor • The situation in Mthatha is further aggravated by the fact that post mortems are conducted in the presence of police investigating officers and these are at times difficult to get within 72 hrs.

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

Shortage of vehicles:

The EC DOH has not received any new forensic pathology fleet since the handover from the SAPS in 2006. This led to the depletion of the current fleet as it is rundown and old. To address this, the sub-programme has received approval to procure and convert 10 additional body collecting vehicles and the delivery of four of these converted vehicles is expected by end of May 2013.

Shortage of forensic specialists in the country generally limits recruitment and employment in this field:

The Forensic Pathology will be engaging the Human Resource Development programme to consider in its planning increasing training of doctors on this scarce skill. In the short to medium term however, the department will be exploring ways to attract and retain the available specialists. The national DOH is developing a training programme for the forensic officers and in the interim, the EC DOH has requested specialist in this field to develop an in-service training program to train forensic officers.

CHANGES TO PLANNED TARGETS

There were no changes made to the original planned targets in this sub-programme

2.9: DISTRICT HOSPITALS

PURPOSE

The District Hospitals sub-programme facilitates the implementation of the district hospital package. 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.

STRATEGIC OBJECTIVES

1.1 To facilitate 60% of facilities implementing quality & patient safety program.
1.5 To ensure efficient and effective hospital services in at least 70% of hospitals.
4.2 To facilitate the development of mental health services to achieve 60% service levels.

SUB-PROGRAMME PRIORITIES

- Implementation of the district hospital package.
- Improve the quality of health services in the district hospitals through policy and protocol formulation, mentoring and supporting the provincial Quality Assurance programme.
- Ensure and facilitate the provision of rationalized health care services within the District Hospital.
- Enhancing effective governance and accountability within the district hospitals.
- Implement relevant hospital improvement plans that will impact on the health outcomes (clinical services, hotel services & infrastructure).
- TB/HIV integration: Infection Control, Mechanical Ventilation, Training and Capacity Building.
- Facilitate down-referral of patients suffering from chronic diseases.
- Improvement of quality of care: Infection Control, Norms and Standards, Clinical Governance, Reviewed Standard Operative Procedures.
- Strengthening and maintenance of security services.
- Disaster management.
- Improvement of drug availability.
- Strengthening the implementation of the Mental Health Care Act [72 hour assessment].

ACHIEVEMENTS

- Comprehensive security solutions, CCTVs were installed in 4 district hospitals namely: Cradock, St Barnabas, Empilisweni and Nompumelelo to enhance safety and security for both patients and staff.
- Of the 17 provincialized hospitals, 7 hospitals including Komga, Dordrecht, Willowmore, Jamestown, Maclear, Indwe and Stutterheim signed the agreements for provincialisation of hospital movable and immovable assets:
- Approval of governance structures: The executive Authority approved hospital boards for 10 district hospitals in the Cacadu district and also 10 district hospitals at Amathole district. These hospitals are:
    - Cacadu District: Port Alfred, Settlers, Midlands, Andries Vosloo, Aberdeen, Humansdorp, SAWAS, Sundays Valley, Willowmore and B.J. Vorster.
    - Amathole District: Bisho, Nompumelelo, New Haven, Cathcart, Tafalofefe, Madwaleni, Bedford, Victoria, Grey and Nompumelelo.

In total 209 hospital board members were trained on Hospital Board Policy resulting in 2012.

- 43 Patients were screened of whom 33 were operated on at Madzikane kaZulu Hospital to reconstruct their cleft lips and cleft palates by Operation Smile. This is an International Non-Profit Organization of medical volunteers performing free reconstruction surgery to adults and children with facial deformities especially cleft lips and palates,
- 50 Park-homes were approved to improve accommodation for health professionals and so far 33 have been erected in 15 district hospitals

Table DHS 2.9.1: Performance against Provincial Targets from 2012/13- 2013/14 Annual Performance Plan for District Hospitals

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Caesarean Section rate	16.2%	15.5%	18.4% (10 825/ 58 749)	2.9%	The caesarean section rate has exceeded its target. This excess is likely due to the following factors: • Hospitals that have private doctors and medical aid patients tend to perform high number of caesarean sections e.g. Uitenhage hospital • Small, rural district hospitals that lack qualified staff to perform the caesarean sections refer to bigger district hospitals that have the necessary competencies. • The absorption of post-community service doctors in district hospitals has assisted in reducing referrals to higher levels of care, thus increasing this indicator.

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Separations - Total	295 864	361 260	280 788 C	-80 472	• The target setting follows the trends from previous years whilst the actual output depends on disease burden, patient-health seeking behaviours and visits as well as the rate at which patients get cured. There are hospitals with the average length of stay that is in excess of the target of 4.9% that range from 7 – 17 days. These mainly admit clients with chronic diseases for example TB patients that take long to be discharged. • Improvement in management of patients at PHC level as a result of RPHC and doctor outreach from the district hospitals will in addition see a reduction in this indicator. The decline may also be attributed to the reduction in the number of patient transfers out to higher levels of care especially maternity patients. The absorption of Post Community Service doctors has made it possible for more patients to be provided the necessary care at this level and only refer really critical patients.

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Patient Day Equivalents – Total	1 926 914	2 016 394	1 888 480	-127 914	The target has not been met and the following factors are likely to be contributing: • Decrease in inpatients due to improvement in the management of patients at PHC level mainly contributes to the reduction in PDE. • Implementation of an effective referral system between the PHC facilities and the district hospitals will ensure further reduction in PDE. • The decline is due to the reduction in the number of patient transfers out to higher levels of care especially maternity patients.
OPD Headcount - Total	1 145 320	1 024 984	1 176 371	151 387 (14.8%)	• Communities in proximity of the district hospitals will continue to use the closest health facilities, which in this case are the district hospitals. • Some communities are still doctor-centric

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Average Length of Stay	5 days	4.9 days	5.0 days (1401652/ 280788)	0.09 days	This indicator is within the norm; however facilities should direct their effort towards separation of acute and chronic patients when reporting by having step-down wards for convalescing patients to prevent mixing them with acute patients.
Bed Utilisation Rate	64.7%	72%	62.2% (1 401 652/ 2 251 424)	-9.8%	The target of 72% for bed utilization rate in district hospitals has not been met. 34.8% of the district hospitals have BUR less than 60% however, bed utilization rate in hospitals holding chronic patients remain high. The department's strategy to strengthen PHC Services has led to increased levels of community awareness towards health issues and morbidity is reduced whilst complications of their conditions are prevented. This has led to fewer admissions.

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Expenditure per day equivalent (PDE-Rand)	R2 590	R1,270	R1688 (3 187 247 000/ 1 888 480)	R418	Expenditures were high due to accruals that were paid during the first & second quarters. Also the PDE Costs have gone up in relation to escalation of goods & services costs generally
Percentage of complaints of users of District Hospital Services resolved within 25 Days	79.2%	75%	85.8% (4408/5139)	10.8%	The majority of complaints that were received fell in categories 3-8 and were easy to resolve hence the target was exceeded. The contribution of the governance structures that have been recently trained also added value.
Percentage of District Hospitals with monthly Maternal Mortality and Morbidity meetings.	53% (34/66)	96% (63/66)	83.3% (55/66)	-12.7%	Five of the 66 district hospitals i.e. Mjanyana, St Lucy's, Grey, St Francis and New Haven do not have functional maternity units as yet, and therefore, are not performing deliveries hence they do not conduct these meetings. The correct denominator to be used in calculating this indicator is 61 since only 61 of 66 district hospitals are conducting deliveries; this would result in an output of 90.2%

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
					The other six hospitals have not been consistent in holding these monthly meetings due to medical doctors resigning and hospitals faced with a challenge of recruiting doctors especially in the rural areas.
Number of District Hospitals assessed for compliance against the 6 priorities of the core standards.	25	25	25	0	Target achieved
Number of District Hospitals providing 72 hour Mental Health Services	22	24	59	35	The target focused on 24 prioritized RSDP hospitals however, 72 hour service is a component of the district hospitals package and therefore all district hospitals are required to provide this service

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

At New Haven Hospital patients admitted have chronic conditions that warrant them to stay in hospital for 365 days per year and leave the hospital on death. The Department is currently having discussions with the Department of Social Development to take over management of this hospital as the patients receive only palliative care.

Umlamli Hospital, Mjanyana and St Francis Hospitals have wards that admit chronic patients with T.B. and therefore their stay in hospital is much longer than other patients. The Department has plans to rationalize services and it is hoped that this challenge will be addressed.

In other district hospitals, monitoring of referral policy and implementation of District Hospital package will be intensified so that these hospitals provide acute services only and refer patients for further management to higher levels and discharge those that need to be referred back to PHC for follow ups. As PHC continues to be strengthened, there will be no need to keep patients longer than it is needed to do so in hospital.

- *Utilisation of Usable Beds*

  The Bed Utilisation Rate in some district hospitals is above the national norm of 72.0%. The strategy to continue and intensify implementation of Re-engineering of Primary Health Care, through placement of Ward Based Teams, will ensure early identification of clients who need care before they complicate and refer them to PHC for management. This will reduce the number of in-patients hospitalized due to complications. After discharge, follow up care will also be managed at home therefore early discharge of patients that do not need hospitalization can take place.

  The Department is continuing to recruit more medical personnel so that patients can be seen and discharged home early. Intensifying implementation of Rationalized Service Delivery Platform, through provision of adequate and sufficient resources (Human, equipment, capacity building etc.) will assist in keeping the BUR within the normal range.

- *Monthly Maternal Mortality and Morbidity meetings*

  There is inconsistency in holding monthly maternal and morbidity meetings by some district hospitals. It is envisaged that with the current drive to recruit more doctors and other health professionals and retaining the qualifying EC DoH provincial bursars, there will be a desirable turn-around on how the hospitals function.

  Through implementation of the Rationalised Service Delivery Platform it is hoped that, the prioritised hospitals will be able to do outreach into smaller hospitals and Community Health Centers and participate in these meetings and share information on issues of mutual interestas well as participate in decision making that will have impact on service delivery.

  The introduction of the District Specialist Teams is hoped to monitor and coordinate district maternal programmes, which will surely impact on hospital activities including maternal and morbidity meetings.

CHANGES TO PLANNED TARGETS

There were no changes made to the planned targets of the Annual Performance Plan targets in this section.

LINKING PERFORMANCE WITH BUDGETS

Programme 2: District Health Services - Over expenditure of R52,02 million

This programme over spent its total budget by R52,02 million. This happened despite an underspending in compensation of employees (R3,77 million), departmental agencies and accounts (R4,92 million) and payment for capital assets (R18,98 million).

The over expenditure on goods and services of R79,22 million relates primarily to medical supplies including pharmaceuticals, vaccines and surgical sundries, arising from the increased burden of disease in the province.

In addition, the Department submitted applications for the rollover of conditional grant funds to the Provincial Treasury in respect of the Comprehensive HIV and Aids Grant of R27,0 million and National Health Insurance Grant of R3,41 million.

Table 2.10: District Health Services expenditure by sub-programme

SUB- PROGRAMME NAME	2012/2013			2011/2012		
	FINAL APPROPRIATION	ACTUAL EXPENDITURE	(OVER)/UNDER EXPENDITURE	FINAL APPROPRIATION	ACTUAL EXPENDITURE	(OVER)/UNDER EXPENDITURE
	R'000	R'000	R'000	R'000	R'000	R'000
District Management	564,361	564,948	(587)	580,682	605,756	(25,074)
Community Health Clinics	1,659,468	1,727,461	(67,993)	1,336,839	1,398,865	(62,026)
Community Health Centres	767,128	769,231	(2,103)	613,970	731,255	(117,285)
Community Based Services	422,316	432,991	(10,675)	398,247	398,642	(395)
Other Community Services	111,700	116,298	(4,598)	103,241	88,711	14,530
HIV/AIDS	1,074,770	1,032,872	41,898	940,663	923,969	16,694
Nutrition	62,509	61,949	560	58,425	56,516	1,909
Coroner Serivces	73,168	74,935	(1,767)	87,045	85,045	2,000
District Hospitals	3,166,191	3,172,944	(6,753)	2,865,647	2,996,507	(130,860)
TOTAL	7,901,611	7,953,629	(52,018)	6,984,759	7,285,266	(300,507)

PART B

PROGRAMME 3

EMERGENCY MEDICAL SERVICES

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

PURPOSE

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

The programme comprises of two sub-programmes with the following objectives:

- Emergency Medical and Rescue services render emergency medical and rescue services including road and air ambulance services, patient operations and communications.
- Planned Patient Transport renders planned patient transport service including local outpatient transport (within the boundaries of a given town or local area) and inter-city/ town outpatient transport (into referral centres).

STRATEGIC OBJECTIVES

1.6 To build a functional and effective Emergency Medical Services to achieve 60% of National Standards.

PROGRAMME PRIORITIES

- To regulate effective and efficient patient transport services within the province.
- Placement of emergency services vehicles at strategic locations to improve response times.

PROGRAM ACHIEVEMENTS

Decentralisation of Emergency Medical Services

In order to improve response times and facilitate rapid response, the department is implementing a decentralization strategy. Ambulances are being located within reach of communities for ease of access and shortening response times as opposed to old practice of keeping them at METRO bases from where they were dispatched in response to calls. Similarly, the obstetric emergency ambulances are placed strategically at MOU facilities so that when a patient needs to be transferred for emergency operation there's no waiting and hence little time lost

Pursuant to the placement of the 36 Obstetric emergency units at health facilities closer to the communities they serve during 2011/12 FY, EMS has placed an additional 27 ambulances at other designated health facilities to improve response and turnaround times during August/September 2012. Staffing of these units however, remains a challenge. Through this strategy the response base of ambulances was broadened in a given geographical area, especially within the rural context. This had a profound effect on response times with regards to inter-hospital transfers of mother, babies and other emergencies.

EMS Human Resource Management

There is currently an audit being done with regards to registration of staff with the Health Professions Council of South Africa (HPCSA) as well as validity of their Professional Driver's Permits (PDP). As opposed to the 2011/12 financial year, there has been a marked increase in the annual renewals of practicing licenses of emergency care personnel. In cases where personnel is not registered, not having a valid PDP, or both, these cases have been referred for disciplinary action and/or incapacity procedures being instituted where applicable.

Seventeen candidates attended the Paramedic course held at the Durban University of Technology during 2012 academic year. All 17 candidates successfully completed the program and graduated in December 2012. These Paramedics have been distributed to their districts of origin, except Joe Gqabi (there were no students from this district). This will greatly enhance the programme's Advanced Life Support capability within the province from 12 Paramedics to 34.

EMS Call Centres

Forty-eight call-takers were employed on a contract basis to staff the Call Centre in East London. This increased the capacity for call-taking from 12 to 60 call-takers.

Improving EMS Data Quality

The poor quality of EMS data in the province is as a result of the manual and weak data collection, recording and processing systems. The department has commenced a strategy to address these inaccuracies.

The human capacity at the control-room in the East London Health Contact and Shared Centre was increased and currently stands at 60 call-takers to ensure that all calls are captured and data exported to the district office. Consequently, data quality on EMS operations at Amathole District has improved and the District has managed to record more accurate data since April 2012 using the DHIS model which in-turn is fed by the electronic call taking system. In the interim, to address data quality issues in the districts that do not have the computerized system as yet, the department is:

- improving EMS reporting tools (i.e registers)
- conducting weekly data evaluation to improve data integrity
- performing monthly data verification processes
- Recurrent training of all DHIS information Officers

Table EMS 3.1: Performance against Strategic Objectives for Emergency Medical Services

Strategic Objectives	Baseline 2011/2012 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to Actual Annual Achievement for 2012/2013	Comment on deviations
1.6 To build a functional and effective Emergency Medical Services to achieve 60% of National Standards.	On average 175 ambulances were rostered at any point in time, translating to 0.3 ambulances rostered per 10 000 population (30% of national target of 1 ambulance per 10 000 population)	On average 240 ambulances to be rostered at any point in time to translate to 0.36 ambulances rostered per 10 000 population (36% of national target of 1 ambulance per 10 000 population)	On average 178 ambulances were rostered at any point in time translating to 0.27 ambulances rostered per 10 000 population (27% of national target of 1 ambulance per 10 000 population)	62 Ambulances translating to 0.09 ambulances rostered per 10 000 population (27% of national target of 1 ambulance per 10 000 population)	The failure to reach the target is attributable to many factors amongst which was the contractual obligation to return about 91 ambulance on expiry of the Fleet Africa Contract – thus significantly depleting available pool of ambulances. This unfortunately could not be matched by rapid replacement due to the transitional teething problems experienced by the Department of Transport during the early transitional phase of the takeover.

Table EMS 3.2: Performance against Provincial Targets from 2012/13- 2013/14 Annual Performance Plan for Emergency Medical Services

Performance Indicator	Baseline 2011/2012 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to Actual Annual Achievement for 2012/2013	Comment on deviations
Rostered Ambulances (per 10000 population)	0.3 175/6 000 000	0.36 (240/6671 956)	0.27 (178/6671 956)	0.09	The failure to reach the target is attributable to many factors amongst which was the contractual obligation to return about 91 ambulance on expiry of the Fleet Africa Contract – thus significantly depleting available pool of ambulances.This unfortunately could not be matched by rapid replacement due to the transitional teething problems experienced by the Department of Transport during the early transitional phase of the takeover.

Performance Indicator	Baseline 2011/2012 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to Actual Annual Achievement for 2012/2013	Comment on deviations
Percentage of P1 calls with a response of time <15 minutes in an urban area	59.4%	65%	81.9% (1173/1433)	16.9%	Following contractual obligation to return ambulances after expiry of fleet contract, the department was left with relatively few ambulances than before, a state that affected response times negatively. Response times that are herein reported significantly overestimate the true response times as a result of the poor quality of data.
Percentage of P1 calls with a response time of <40 minutes in a rural area	81.0%	60%	65.5% (8145/12 436)	5.5%	
Percentage of all calls with a response time within 60 minutes	41.2%	75%	72.2% (126 340/ 174 902)	-2.8%	

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

- To improve DOH call-taking and dispatching ability, the Computerized Call-taking and dispatching system (CRM) will be rolled out to the Mthatha EMS base.
- To improve data capturing and reporting, DHIS staff will undergo development in the field of information management, followed by monthly quality checks on the authenticity of data collected.
- The organogram for all Call Centres will be finalized and vacant posts filled to increase the number of rostered ambulances for rapid response.
- All ambulances will be fitted with a satellite tracking system which will be linked to the Call Centre. In addition most of the other EMS vehicles will also be fitted with such devices.
- The Department will continue to implement the EMS staff development programme and agreement with the Durban University of Technology. An intake of 18 Paramedics will be sent for training being the 3rd year intake of the agreement between these two institutions.

CHANGES TO PLANNED TARGETS

There were no changes made on planned targets in this section of the Annual Performance Plan

LINKING PERFORMANCE WITH BUDGETS

Programme 3: Emergency Medical Services - Under expenditure of R47,87 million

The under expenditure of R47,00 million on payments for goods and services arose mainly from the non - delivery of 130 ambulances out of an order of 190 by the Department of Transport.

Table 3.3: Emergency Medical Services expenditure

SUB- PROGRAMME NAME	2012/2013			2011/2012		
	FINAL APPROPRIATION	ACTUAL EXPENDITURE	(OVER)/UNDER EXPENDITURE	FINAL APPROPRIATION	ACTUAL EXPENDITURE	(OVER)/UNDER EXPENDITURE
	R'000	R'000	R'000	R'000	R'000	R'000
Emergency Medical Services	651,577	603,708	47,869	639,155	633,797	5,358
Planned Patient Transport	15,817	15,817	-	10,829	10,791	38
Total	667,394	619,525	47,869	649,984	644,588	5,396

PART B

PROGRAMME 4

PROVINCIAL HOSPITAL SERVICES

PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES

PURPOSE

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

SUB-PROGRAMMES

- 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.

STRATEGIC OBJECTIVES

- To strengthen capacity to deliver Secondary and Tertiary Services to achieve tertiary 1 level
- To facilitate 60% of facilities implementing quality & patient safety program
- To facilitate the reduction of maternal mortalityto achieve 36.8 maternal mortality per 100 000
- To ensure efficient and effective hospital services in at least 70% of hospitals
- To reduce TB morbidity and mortality by achieving 85% cure rate
- To facilitate the development of mental health services to achieve 60% service levels

PRIORITIES FOR THE NEXT THREE YEARS

- To strengthen the capacity and functionality of Regional Hospitals within the Province.
- To strengthen the child health and contributing towards the achievement of MDGs
- To improve clinical management of M(X)DR-TB in TB hospitals
- To strengthen decentralization and de-institutionalization of MDR-TB management
- To strengthen the capacity and functionality of Psychiatric Hospitals within the Province in order to improve outcomes for clients through the use of effective treatments and rehabilitation programmes
- To implement the National Core Standards and in particular the focus on the 6 Ministerial priority areas.

Programme achievements

Hospital	Achievements
Frontier Hospital	• Functional Intensive Care Unit continues to reduce the number of referrals to Frere and Cecilia Makiwane hospitals. Patients receive prompt care thus reducing preventable and unnecessary morbidity and mortality. • High quality Radiology Services have enabled clinicians from various disciplines to reach appropriate diagnosis thus reducing the unnecessary, costly and long patient stay in hospital.
St Elizabeth hospital	*Staff employment:* 9 doctors (6 of which are comm serves), pharmacists (2), radiographers (2) and a community service Occupational Therapist. *Equipment:* A new digital X-ray machine was installed.
TB hospitals	• Nkqubela TB hospital completed construction of a 64 bedded mechanically ventilated unit which is going to admit MDR-TB patients. • All the 11 TB hospitals have health and Safety officers; this will promote close monitoring of employees and ensures that the pre-medical screening and periodic medical screening is done for the employees especially nurses and doctors.
Psychiatric hospitals	Access to mental health care was improved in OR Tambo district by increasing the number of beds from 10 to 20 at the Flagstaff Mental Health Unit. *Staff employment:* • Fort England Hospital appointed a Chief Executive Officer who is a clinician. • A specialist child psychiatrist was appointed at Mthatha Mental Health Unit. • Clinical psychologists were appointed at East London mental health unit and at Tower hospital. • The mental health service programme is training a cadre of specialists; 4 have completed their training. Four other Registrars will write their final examinations in March 2014.

Table PHS 4.1: Performance against Strategic Objectives for Provincial Hospital Services

Strategic objective	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
1.7 To strengthen capacity to deliver Secondary and Tertiary Services to achieve tertiary 1 level development	8 Service domains provided in Regional hospitals	Provide a minimum of 8 domains in regional hospitals	8 Service domains provided in Regional hospitals	0	Target achieved
1.1 To facilitate 60% of facilities implementing quality & patient safety program	100% (17/17) provincial hospitals assessed for compliance with core standards	Assess 100% (17/17) of provincial hospitals for compliance with core standards	100% (17/17) provincial hospitals assessed for compliance with core standards	0	Target achieved
3.2 To facilitate the reduction of maternal mortalityto achieve 36.8 maternal mortality per 100 000	Public health facility maternal mortality rate reported at 115/100 000	Achieve 35/100 000 public health maternal mortality arte	Public health facility maternal mortality rate reported at 112/100 000	77/100 000	The five causes of maternal deaths are: Non-pregnancy related infections – mainly resulting from AIDS Complications of hypertension Obstetric haemorrhage Pregnancy-related sepsis Pre-existing maternal disease and inappropriate referral system
To ensure efficient and effective hospital services in at least 70% of hospitals	100% (2/2) of Regional hospitals had appointed CEOs	Appoint CEOs in 100% (2/2) of Regional hospitals	50% (1/2) Regional hospitals had appointed CEOs	50%	CEO from St Elizabeth hospital resigned in October 2012

Strategic objective	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
	100% (11/11) of TB hospitals had appointed CEOs	Appoint CEOs in 100% (11/11) of TB hospitals	72.7% (8/11) TB hospitals had appointed CEOs	27.3% (3/11)	Deviation is due to death, resignation and re-deployment
	100% (4/4) of psychiatric hospitals had appointed CEOs	Appoint CEOs in 100% (4/4) of psychiatric hospitals	75% (3/4) of psychiatric hospitals had appointed CEOs	25%	CEO from Elizabeth Donkin Hospital was transferred to Livingstone hospital
	67.2% utilization of usable beds achieved in Regional hospitals	Achieve 75% utilization of usable beds in Regional hospitals	68.4% utilization of usable beds achieved in Regional hospitals	-6.6%	Shortage of staff (nurses and doctors) contributes towards non-achievement of this target.
	Utilization of usable beds in TB hospitals not measured	Achieve 75% utilization of usable beds in TB hospitals	59.7% (343 894/ 575 746) utilization of usable beds achieved in TB hospitals	-15.3%	The bed utilization rate in TB hospitals is reduced because: • Patients are down referred to PHC facilities for continuation of treatment. • The PHC outreach teams are giving injections to patients who require injections and are clinically stable. • Decentralization of MDR/XDR TB patient management policy is fully implemented in O.R.Tambo, Nelson Mandela, Amathole and Alfred Ndzo districts with periodic reviews booked for patients

Strategic objective	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
	Utilization of usable beds in Psychiatric hospitals not measured	Achieve 95% utilization of usable beds in Psychiatric hospitals	86.5% (380 622/439 949) utilization of usable beds achieved in Psychiatric hospitals	-8.5%	Once the patients are in a satisfactory state, they are discharged to free bed space and are followed up through the outreach programme in PHC facilities
To reduce TB morbidity and mortality by achieving 85% cure rate	TB cure rate: 67.9% (15 387/22 765)	75%	TB cure rate: 68.9% (14 805/21 490)	-6.1%	Target not achieved due to high defaulter and death rates among TB patients. This indicator excludes those clients that complete treatment but could not produce sputum.
4.2 To facilitate the development of mental health services to achieve 60% service levels	86% (6/7 components) of mental health package implemented in EC mental health facilities	Implement 86% (6/7) components of mental health package	86% (6/7 components) of mental health package implemented in EC mental health facilities	0	Target achieved

Table PHS 4.2: Performance against Provincial Targets from 2012/13- 2013/14 Annual Performance Plan for Provincial Hospital Services

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for	Comment on deviations
To strengthen capacity to deliver Secondary and Tertiary Services to achieve tertiary 1 level development.	Caesarean section rate	32.4%	32%	32.9% (3 171/9 624)	0.9%	Target Achieved
	Separations - Total	31 514	35 655	31 488	-4 167	St Elizabeth is the hospital that contributes mostly to non-achievement of this target. Few day patients are reported and it has a longer average length of stay of 5.7 days that is in excess of the 4.8 days target. This is mainly due to rural nature of this region. Difficulties are experienced in recruiting the specialists. There are 20 doctors' posts filled against 110 on organogram.

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for	Comment on deviations
	Patient Day Equivalents – Total	193 720	240 555	206 848	-33 707	One or more of the following reasons could have contributed to target being not achieved i.e. • Poor reporting of day patients at St Elizabeth hospital • Shortage of doctors
	OPD Headcounts – Total	136 187	170 000	166 443	-3 557	Self referrals patients
	Average length of stay (days)	4.6	4.8	4.6 (145 714/ 31 488)	0.2	The target was achieved although St Elizabeth hospital did not meet the target. This is mainly due to rural nature of this region. Difficulties are experienced in recruiting the specialists.There are 20 doctors' posts filled against 110 on organogram.
	Bed utilisation rate	67.2%	75%	68.4% (145 714/ 212 982)	-6.6%	Shortage of staff (nurses and doctors) contributes towards non-achievement of this target.

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for	Comment on deviations
	Expenditure per patient day equivalent (PDE) (Rand)	R1748	R1838	R1978 (409112346/ 206 848)	R140	This may be due to accruals
	Percentage of complaints of users of Regional Hospital Services resolved within 25 days	79.2%	80%	88.6% (93/105)	8.6%	Complaints resolution depends on the nature of complaints; some categories take longer to resolve as these need to be investigated.
	Percentage of Regional Hospitals with monthly Maternal Mortality and Morbidity Meetings	100% (2)	100% (2/2)	100% (2/2)	0	Both Regional hospitals conduct maternal mortality and morbidity meetings.
To facilitate the reduction of maternal mortalityto achieve 36.8 maternal mortality per 100 000	Perinatal mortality rate in regional hospitals	41.9/1000	30/1000	43.3/1000 (421/9 732)	13.3 /1000	Disease burden of maternal related conditions including infection with HIV and AIDS, hypertension in pregnancy and others are mainly responsible for this outcome. Also inability to recruit a paediatrician for St Elizabeth Hospital.
To facilitate 60% of facilities implementing quality & patient safety program	Number of Regional Hospitals assessed for compliance with the Core Standards	2	2	2	0	Assessment was conducted by HST following self-assessments by institutions.

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for	Comment on deviations
To reduce TB morbidity and mortality by achieving 85% cure rate	Separations – Total in TB Hospitals	Not Measured	2 354	3 236	882	The likely reasons for exceeding the target are that: • This indicator is reported for the 1st time; because of this there were no previous outputs to estimate a more accurate target. The set target could have been underestimated. • Patients are down referred to PHC facilities for continuation of treatment. • Decentralization of MDR/XDR TB patient management policy is fully implemented in O.R.Tambo, Nelson Mandela, Amathole and Alfred Ndzo districts.

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for	Comment on deviations
	Patient Day Equivalents – Total in TB Hospitals	Not Measured	292 623	344 814	52 191	This indicator is reported for the 1st time this; because of this there were no previous outputs to estimate a more accurate target. The set target could have been underestimated. Whilst the TB control programme is promoting a community-based management approach with clients having to be treated at home, the majority of TB clients are co-infected with HIV. Many present at PHC services late and very sick. These are then referred to TB hospitals for hospitalized treatment.

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for	Comment on deviations
	OPD Headcounts – Total in TB Hospitals	Not Measured	2000	2761	761	These are patients that had been discharged from the MDR/XDR hospitals to continue with their treatment at home. They are booked appointments in these hospitals for review. Since the treatment of MDR/XDR patients takes long about 24 to 36 months. After discharge these patients have to return monthly for clinical reviews, thus the OPD headcount increases in line with the separations.
	Average length of stay in TB Hospitals excluding MDR/XDR-TB hospitals	Not Measured	60 days	90.3 days (232 220/ 2572)	30.3 days	The policy requires patients to be admitted for two months in the TB hospital during which they complete their injections and are expected to convert to negative sputum. However, • Many TB & HIV co-infected patients failto convert at 2 months and take longer about 3 months hence the target was exceeded

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for	Comment on deviations
						• Because the dedicated MDR/XDR TB hospitals are full, some ordinary TB hospitals have opened isolation wards where MDR/XDR patients are held. Therefore mix of ordinary TB with MDR/XDR patients increases the ALOS. For example, Orsmond and Winterberg TB hospitals are supposed to hospitalise ordinary TB patients but have ALOS days of 209 and 119 days respectively due to TB patient mix.

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for	Comment on deviations
	Average length of stay in TB Hospitals for MDR and XDR – TB (J Pearson & fort Grey)	Not measured	160 days	168 days (111 674 / 664)	8 days	This indicator is meant to measure the effectiveness of Decentralization of MDR/XDR TB patient management policy. This policy is fully implemented in O.R. Tambo, Nelson Mandela, Amathole and Alfred Ndzo districts and yet to be implemented in the other 4 districts of the province hence the target has been exceeded.

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for	Comment on deviations
	Bed utilisation rate in TB Hospitals	Not Measured	75%	59.7% (343 894/ 575 746)	-15.3%	The bed utilization rate in TB hospitals is reduced because: • Patients are down referred to PHC facilities for continuation of treatment. • The PHC outreach teams are giving injections to patients who require injections and are clinically stable. • Decentralization of MDR/XDR TB patient management policy is fully implemented in O.R.Tambo, Nelson Mandela, Amathole and Alfred Ndzo districts with periodic reviews booked for patients
	Expenditure per patient day equivalent (PDE) (Rand) in TB Hospitals	Not Measured	R1592	R958 (330163600/344 814)	R634	Staff shortages in TB Hospitals

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for	Comment on deviations
	Percentage of complaints of users of TB Hospital Services resolved within 25 days	Not Measured	80%	55.6% (10/18)	-24.4%	Complaints resolution depends on the nature of complaints; some categories take longer to resolve as these need to be investigated. The situation is exacerbated by the lack of quality assurance coordinators in TB hospitals whose function is to investigate and redress the complaints. The affected hospitals with unresolved complaints include Margery Parks, Majorie Parrish, PZ Meyer and Temba TB hospitals
	Number of TB Hospitals with monthly Mortality and Morbidity Meetings	Not Measured	4	8	4	All the TB hospitals are encouraged to conduct morbidity and mortality meetings in preparation for the monthly provincial TB M&E meetings as this will improve the clinical management of TB patients resulting in good TB treatment outcomes.

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for	Comment on deviations
	Number of TB Hospitals conducting clinical audits	11	11	8	-3	The Clinical Audit policy requires that clinical audits be chaired or directed by a medical doctor. 3 TB hospitals namely Margery Parkes, Temba and Winterberg hospitals did not have full time appointed medical doctors during the 2012/13 FY, hence clinical audits were not conducted.
	Number of TB Hospitals assessed for compliance with the core standards	New indicator	11	11	0	All TB hospitals were assessed for compliance with national core standards by the Health Systems Trust. The provincial DOH is conducting verification of facility self-assessments and by end of the year, 4 facilities were verified.
To facilitate the development of mental health services to achieve 60% service levels	Average length of stay - Acute	Not Measured	30 days	41.5 days	11.5 days	Due to lack of community based psychiatric facilities, patients have to be hospitalized until they are in a satisfactory state

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for	Comment on deviations
	Average length of stay – Chronic	Not Measured	170 days	117 days	53 days	This output excludes Tower hospital as this skews the ALOS.
	Bed utilization rate (based on usable beds)	Not Measured	95%	86.5% (380 622/439 949)	-8.5%	Once the patients are in a satisfactory state, they are discharged to free bed space and are followed up through the outreach programme in PHC facilities
	Expenditure per patient day equivalent (PDE)	Not Measured	R1272	R1321 (506214329 /383 210)	-49	The target was achieved
	Percentage of complaints of users of Mental Hospital Services resolved within 25 days	Not Measured	85%	94.4% (68/72)	9.4%	Most of the complaints received fall into categories 3-8 and take relatively shorter period to resolve
	Percentage of Mental Hospital with monthly Mortality and Morbidity Meetings	Not Measured	100% (4/4)	100% (4/4)	0	The target was achieved

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for	Comment on deviations
	Number of Mental Hospitalsconducting clinical audits	3	4	4	0	Clinical audit is a policy compliance issue and all facilities have established multi-disciplinary teams that conduct these audits
	Number of Mental Hospital Services assessed for compliance with the core standards	New indicator	3	4	0	These assessments are conducted by the managers from the Mental Health directorate every quarter

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

Regional hospitals

- The major challenge that affects the efficiency indicators in Regional hospitals is the difficulty to recruit doctors and specialists for St Elizabeth hospital. The departmental recruitment plan prioritises recruitment and placement of specialists and doctors in health facilities. Whilst grappling with all these efforts, the Mthatha Complex is conducting outreach to St Elizabeth to assist and reduce patients transferred out to the complex.

- The implementation of the social mobilisation approach allows the selection of bursars by the communities in the sub-districts. The bursars sign a contract with the EC DOH to serve the department after graduating.

- Allocation of community-service doctors be focused and biased towards these hospitals

Perinatal mortality

The saving mothers saving babies (SMSB) project is a strategy to reduce perinatal mortality in the province, however, resources (in terms of budget and human resource capacity) will be disbursed in support of the project to ensure its effectiveness.

The SMSB project is supported by decentralisation of ambulances and these are located at hospitals for rapid response on obstetric emergency.

TB hospitals

- In line with the Decentralisation and the Deinstitutionalisation policy framework, that encourages MDR-TB patients to be managed in the community, the number of TB beds will be reduced, resulting in low bed occupancy. However, the reduction of TB beds has to be approved by the Executing Authority. Only, very sick patients will be admitted to the hospitals, as patients managed in the community will be followed up by Outreach teams.

- Clinical audits: To improve the output for the Clinical Audits, hospitals that have sessional doctors will delegate professionals to conduct clinical audits.

Psychiatric hospitals

Average Length of Stay in Psychiatric Hospitals

Tower Hospital is used as a psycho-social referral health facility for the province. The majority of patients at Tower hospital are referrals from the other three psychiatric hospitals. Many patients in this hospital are destitute and as a result ALOS for this hospital at end of 2012/13 FY was 2099 (approximately 6 years). The Department of Social Development had been engaged on this matter. A memo defining patient service requirements relevant to each of the two Departments was drafted and submitted to Intergovernmental Relations to facilitate the process.

Utilisation of usable beds in Psychiatric hospitals

- Establishing Community Residential Homes is a strategy that is in line with the Mental Health Care Act of 2002. The focus of this strategy is to see patients' rehabilitation integrated within their communities and closer home. The Department has started a process for establishment of these community-based mental health rehabilitation services with the tender process having commenced.

- Sourcing service provider to provide mental health services: Since the transfer of Umzimkhulu mental hospital to KwaZulu Natal, there had been no dedicated designated psychiatric hospital to cater for the Eastern Regional of the Province. Efforts of building a new hospital in this region have met challenges. In addition to establishing community residential homes, the plan is to regularise the tender that is currently provided by Life Esidimeni.

- Mental Health Service Plan is about to be finalised which promotes integration of mental health in General Health System; this includes the establishment of mental health beds in all district hospitals and access of specialized medication in all levels of care through a down referral system. In line with this plan and to address the challenge of shortage of beds, an executive decision has been taken to relocate Elizabeth Donkin hospital to Dora Nginza Hospital.

CHANGES TO PLANNED TARGETS

Indicator	Original target 2012/13	Revised target 2012/13	Reasons for changingtarget
Patient Day Equivalents – Total	258 621	292 623	The correct APP target for the 2012/13 financial year was 292 623.This was transferred incorrectly to the operational plan.
Bed utilisation rate in TB hospitals	70%	75%	The correct APP target of 75% was transferred incorrectly to the operational plan.

LINKING PERFORMANCE WITH BUDGETS

Programme 4: Provincial Hospital Services - Under expenditure of R3,76 million

The main contributor to this underspend is compensation of employees and is attributable to strict measures imposed by Provincial Treasury with regards to employment and replacement of vacant posts.

Programme 4.3: Provincial Hospital Services expenditure by sub-programme

SUB- PROGRAMME NAME	2012/2013			2011/2012		
	FINAL APPROPRIATION	ACTUAL EXPENDITURE	(OVER)/UNDER EXPENDITURE	FINAL APPROPRIATION	ACTUAL EXPENDITURE	(OVER)/UNDER EXPENDITURE
	R'000	R'000	R'000	R'000	R'000	R'000
General (Regional) Hospitals	3,145,544	3,141,797	3,747	3,027,385	3,039,179	(11,794)
TB Hospitals	330,475	330,235	240	341,363	329,467	11,896
Psychiatric Mental Hospitals	506,939	506,984	(45)	495,263	491,608	3,655
Total	3,982,958	3,979,016	3,942	3,864,011	3,860,254	3,757

PART B

PROGRAMME 5

PROVINCIAL TERTIARY HOSPITAL SERVICES

PROGRAMME 5: PROVINCIAL TERTIARY HOSPITAL SERVICES

5.1 PROGRAMME PURPOSE

- To strengthen and continuously develop the Modern Tertiary Services and an academic and research platform to adequate levels so as to be responsive to the demands of specialist service needs of the community of the Eastern Cape Province.

5.2 Strategic Objectives

- To strengthen capacity to deliver Secondary and Tertiary Services to achieve tertiary 1 level
- To facilitate 60% of facilities implementing quality & patient safety program
- To facilitate the reduction of maternal mortality to achieve 36.8 maternal mortality per 100 000
- To ensure efficient and effective hospital services in at least 70% of hospitals

PRIORITIES FOR THE NEXT THREE YEARS

- To implement the National Minimum Core Standards.
- To ensure monitoring of efficiency indicators to be in line with National norms to achieve quality Healthcare for all.
- To create a climate that enables and encourages innovation within the Health services to ensure sustained delivery of quality services.

ACHIEVEMENTS

East London Hospital Complex (ELHC)

- Change management initiatives were implemented, encompassing training of 201 officials.
- Appointments: 54 clinicians, 19 allied health officers, 6 at pharmacy, 34 non-clinical employees, and 5 transfers-in.
- Finalized implementation of Digital Radiology at Frere hospital

Mthatha Hospital Complex (MHC)

- The hospital complex is providing academic and service support through outreach to neighbouring district hospitals and CHcs. The Surgery and O&G departments conducted outreach to St Barnabas, DrMalizoMpehle and St Elizabeth Hospitals. The Radiology Department conducted outreach to All Saints Hospital and four CHCs.
- Appointments: Placement and subsequent appointment of the CEO for Nelson Mandela Academic Hospital; 3 Medical Specialists i.e Physician, Plastic Surgeon and Neurosurgeon were appointed.
- The hospital procured 10 renal dialysis machines

Port Elizabeth Hospital Complex

- Quality improvement: 193 staff members were trained on National Core Standards & Ministerial Priorities, complaints management, Batho Pele principles, patients' rights charter and customer care. Waiting times have been improved; the average waiting time is 40 minutes.
- Infection prevention & control strengthened: 264 staff members were trained on basic infection control principles & highly infectious diseases; additional hand-washing dispensers have been installed and pedal bins purchased.
- To improve the quality of services and influx of lower levels of care patients: in-reach & outreach was conducted by the head of O&G and midwives to the catchment areas. Outreach was also conducted by Ophthalmology department.
- Appointments: 82 Clinical/ health professionals were appointed.

Table THS 5.1: Performance against Strategic Objectives for Tertiary Hospitals

Strategic objective	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
1.7 To strengthen capacity to deliver Secondary and Tertiary Services to achieve tertiary 1 level development	2 EC hospital complexes implementing 30 domains; one health complex implemented 25 domains out of the expected 47 in the tertiary services package.	Each of the 3 EC Health Complexes to implement 30 Tertiary services domains	2 EC hospital complexes implementing 30 domains; one health complex implemented 25 domains out of the expected 47 in the tertiary services package.	5 domains less in Mthatha Health complex	Mthatha Health Complex awaiting the NDOH process of categorization of hospitals There is a challenge of recruiting specialists for Mthatha Health Complex
1.1 To facilitate 60% of facilities implementing quality & patient safety program	100% (3/3) hospital complexes assessed for compliance with core standards	Assessed 100% (3/3) hospital complexes for compliance with core standards	100% (3/3) hospital complexes assessed for compliance with core standards	0	Target achieved
3.2 To facilitate the reduction of maternal mortalityto achieve 36.8 maternal mortality per 100 000	Public health facility maternal mortality rate reported at 115/100 000	Achieve 35/100 000 public health maternal mortality arte	Public health facility maternal mortality rate reported at 112/100 000	77/100 000	The five causes of maternal deaths are: Non-pregnancy related infections – mainly resulting from AIDS Complications of hypertension Obstetric haemorrhage Pregnancy-related sepsis Pre-existing maternal disease

Strategic objective	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
To ensure efficient and effective hospital services in at least 70% of hospitals	67% (2/3) Tertiary hospitals with CEOs appointed	100% (3/3) Tertiary hospitals to have CEOs appointed	67% (2/3) Tertiary hospitals with CEO appointed	33% (1)	Mthatha Health Complex awaiting the NDOH process of categorization of hospitals

Table THS 5.2: Performance against Provincial Targets from 2012/13- 2013/14 Annual Performance Plan for Provincial Tertiary Hospital Services

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
To strengthen capacity to deliver Secondary and Tertiary Services to achieve tertiary 1 level development.	Caesarean section rate	47.7%	50%	48.5% (12 575/25 911)	1.5%	These are referral hospitals that receive complicated patients or patients from district hospitals that do not have capacity to perform caesarean sections
	Separations - Total	192 414	227 492	185 166	-42 326	The hospitals have treated more patients than planned due to the availability of specialists and the introduction of new services
	Patient Day Equivalents	1 528 532	1 664 653	1 499 698	-164 955	A reduction in OPD and emergency total headcount as a result of following referral system to appropriate levels of care will result in reduced PDE in these facilities

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
	OPD Total Headcounts	1 220 038	861 005	1 225 655	364 650	• These are referral hospitals with patients referred from lower levels of care • Self-referrals from communities in close proximity to these hospitals e.g Cecilia Makiwane, Frere and Dora Nginza hospitals increases the OPD headcount • OPD visits after hours, during weekends and holidays also contribute a significant proportion as many of the low level of care health facilities in their vicinity are usually closed • Setting of target could have been under-estimated

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
	Average length of stay	5.5	5.5 Days	5.6 days (1 030 023/ 185166)	0.1 days	Whilst all the other tertiary hospitals ALOS is within target, the overall provincial ALOS for these hospitals is skewed and is influenced by the ALOS at Livingstone hospital which is 9.6 days. This is as a result of admissions in orthopaedic, spinal and high care wards that keep patients longer
	Bed utilisation rate (based on usable beds)	78.8%	75%	75.5% (1 030 023/ 1 363 379)	0.5%	Livingstone and NMH with BUR of 87.3% and 79.2% respectively are specialized tertiary services referral hospitals and therefore their BUR is usually nearly up to capacity, which is expected. The high BUR at Frere and Dora Nginza hospitals (80.5% and 78.4% respectively) is multifold:

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
						• There are no district hospitals in their population catchment areas and therefore these hospitals also provide the district hospital services over and above the specialized services • Due to rationalization of services, these hospitals provide specific tertiary services and are therefore referral hospitals in their regions as well as for the specialized tertiary services they provide. All these hospitals experience a significant proportion of self-referral patients that may otherwise be admitted in lower levels of care hospitals

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
	Expenditure per patient day equivalent (PDE) (Rand)	R1 758	R 2 660	R1831 (27454270555 /1499698)	-R67	Deviation within acceptable range
	Percentage of complaints of users of Tertiary Hospitals Services resolved within 25 days	81.4%	80%	70.6% (274 /388)	-9.4%	Complaints resolution depends on the nature of complaints. Whilst the bigger proportion of complaints is resolved within the expected time period; some categories take longer to resolve as their investigations take longer. Legal processes for example in cases of litigation drag the resolution process of complaints to over a year in some instances.
	Percentage of Tertiary Hospitals with monthly Maternal Mortality and Morbidity Meetings	100% (3)	100% (3)	100% (3)	0	Target achieved
	Number of oncology patients treated	Not Measured	17 850	32 736	14 886	Linear accelerator was installed in Livingstone hospital

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
	Number of hematology patients treated	Not Measured	4 225	7 466	3 241	The unit is now fully operational and this has improved access to the communities in the province. As the need was not actually known the target was an under-estimation
To facilitate the reduction of maternal mortalityand achieve 36.8 maternal mortality per 1000 live births	Perinatal mortality rate in tertiary hospitals (expressed per 1000 live births)	59.4/1000	30/1000 live births	83 /1000 live births (2 237/27 001)	53/1000 live births	Main contributory factors are: Premature deliveries and disease burden e.g. infectious and chronic conditions as well as referral problems
To facilitate 60% of facilities implementing quality & patient safety program	Number of Tertiary Hospitals assessed for compliance with the core standards	3	3	3	0	Target met

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

Tertiary hospitals:

- The major challenge that affects the efficiency indicators in Regional hospitals is the difficulty to recruit doctors and specialists for St Elizabeth hospital. The departmental recruitment plan prioritises recruitment and placement of specialists and doctors in health facilities. Whilst grappling with all these efforts, the Mthatha Complex is conducting outreach to St Elizabeth to assist and reduce patients transferred out to the complex.

- The implementation of the social mobilisation approach allows the selection of bursars by the communities in the sub-districts.The bursars sign a contract with the EC DOH to serve the department after graduating.

- Allocation of community-service doctors need to focus and be biased more in these hospitals

Perinatal mortality

The saving mothers saving babies (SMSB) project is a strategy to reduce perinatal mortality in the province, however, resources (in terms of budget and human resource capacity) need to be disbursed in support of the project to ensure its effectiveness.

The SMSB project is supported by decentralisation of ambulances and these are located at hospitals for rapid response on obstetric emergency.

CHANGES TO PLANNED TARGETS

Indicator	Original target 2012/13	Revised target 2012/13	Reasons for changing target
Patient Day Equivalent	1 626 653	1 664 653	Target transferred to the OP were mistakenly read from the 2011/12 column of the APP
OPD Total Headcount	861 863	861 005	Target transferred to the OP were mistakenly read from the 2013/14 column of the APP

LINKING PERFORMANCE WITH BUDGETS

Programme 5: Central Hospital Services - Under expenditure of R45,25 million

The under spend of R45,25 million is primarily represented by an application for rollover of R3,31 million in goods and services, R40,71 million in machinery and equipment and R1,56 million in buildings and other fixed structures to the Provincial Treasury in respect of the National Tertiary Services Conditional Grant. It is understood that the roll over applied for may be limited to the amount of under expenditure.

The R3,31 million under-spending in goods and services relates to services rendered by SANBS.The under-spending in machinery & equipment of R40,71 million is attributable to inter alia the delays in the delivery of various items of medical equipment, such as MRI scanners, purchased within the hospital complexes in the Province. The under expenditure in building and other fixed structures relates to fencing in Fort England Hospital

Table THS 5.3: Provincial Tertiary Hospital Services expenditure

SUB- PROGRAMME NAME	2012/2013			2011/2012		
	FINAL APPROPRIATION	ACTUAL EXPENDITURE	(OVER)/UNDER EXPENDITURE	FINAL APPROPRIATION	ACTUAL EXPENDITURE	(OVER)/UNDER EXPENDITURE
	R'000	R'000	R'000	R'000	R'000	R'000
Provincial Tertiary Services	702,419	657,170	45,249	647,104	627,075	20,029
Total	702,419	657,170	45,249	647,104	627,075	20,029

PART B

PROGRAMME 6

HEALTH SCIENCE AND TRAINING

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

PURPOSE

The objective of this Programme is to provide training, development and academic support to all Health professionals and employees in the Province. The Programme has five sub-programmes with the following aims:

- 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 interventions for all occupational categories in the department.

STRATEGIC OBJECTIVES

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

PRIORITIES FOR THE NEXT THREE YEARS

- In-service learning for primary services (clinical, human resources and finance) by providing effective knowledge to practice programmes, short learning programmes and related skills development interventions
- Facilitate the implementation of the learnership and internship (workplace experience) programmes.
- Implement a comprehensive management development and leadership programme.
- Strengthen core skills development systems for improved organizational impact.
- Implement career management strategies that underpin recruitment and retention of critical and scarce employees or skills.

PROGRAMME ACHIEVEMENTS

Table 6.1: Achievements from the Health Sciences Training and Development, 2012/13

SUB-PROGRAMME	ACHIEVEMENT/S
HPTD Grant	*Training of Medical Doctors in the Republic of Cuba* • 145 students were registered in the Cuban Medical Program. • 17 Doctors who graduated in December 2012 from this programme had been absorbed by the ECDOH as senior medical officers. 24 Doctors are on internship programme an additional 2 doctors are on community service programme
	Orthotic and Prosthetic (O&P) programme • Six O&P students graduated in August 2012 from Tanzania, and are presently in the employ of the EC DOH. • Walter Sisulu University obtained a full accreditation to start offering Orthotics and Prosthetics course in South Africa. New intake is expected during the 2014 academic year.
	Training of Health Professionals at Rhodes University • 15 Students were enrolled on the Doctor of Pharmacy (PharmD) programme. • 5 Students graduated in 2012 and are in the process of being absorbed as Clinical Pharmacist Specialists.

SUB-PROGRAMME	ACHIEVEMENT/S
	Training and Development of Medical Registrars • 16 Registrars completed their programme and are awaiting registration certificates with the HPCSA as specialists.
	Young Nurse Educators Development Programme at NMMU • 20 Nurse Educators completed the Young Nurse Educators' Programme at the NMMU and are now back at the Lilitha Nursing College campuses to improve lecturing standards. • 15 Students (4 PhDs & 11 Masters) were enrolled at NMMU during the 2012 academic year. • Three clinical laboratory managers completed training and are all absorbed at Lilitha Nursing College for continuity. • Simulation Laboratories in all Lilitha Nursing College main campuses are fully established and functional.
	E-Learning Services at Lilitha Nursing College An E-learning platform had been established at the College mainly to integrate the nursing education curriculum with information and communication technology, implement a Student Information Management System and integrate these with a comprehensive learning and management system.This will enable students to view learning material online, view assignments and test marks, access journals and books online, submit tests and assignments and receive online tuition off line. • Moodle database had been constructed and is now live on the ECDOH website. • Full installation of the Student Management System (viz VIDLO) and configuration has been completed. • 9 x Computer Laboratories have been commissioned (one in each district) and are fully functional as well as campuses connected via internet. • 4 x Video Conferencing centers established and fully functional.
	Establishment of the EMS College Main Campus and Satellite Campuses • A new Advanced Emergency Care (EMC) Degree was established at NMMU. Full collaboration and Memorandum of Understanding (MoU) between the EMS College and NMMU was drafted and is awaiting approval. • The EMS College new base in Livingstone hospital is fully refurbished and has received provisional accreditation pending full staff complement in line with the HPCSA accreditation criterion.
	High School Learners' Support Programme The Education and Health departments have forged ties to sensitize learners about various health fields that are awarded bursaries by the ECDOH through career exhibitions at a sub-district level and a shadowing experience in health institutions.
	Development of a Comprehensive Health Sciences Faculty at NMMU • NMMU established a B.Sc. Dietetics programme with the first intake of 16 students having enrolled in January 2013. • A pharmacy assistant programme was established with first intake of 70 students enrolled in January 2013. • A short course for ultra-sonographers was established for health professionals and is expected to be implemented in 2013.

SUB-PROGRAMME	ACHIEVEMENT/S
Lilitha Nursing College	• A total of 1 459 students graduated from the College by the end of the 2012 academic year. These consisted of 368 Enrolled Nursing Assistants (ENAs), 403 Enrolled Nurses (ENs), 578 Basic Nursing diploma and 110 Post Basic Nursing diplomas. • Four satellite campuses re-opened in 2012; these are fully functional and had a total year intake of 180 students which is 10.6% of the total college intake. • The college generated 80% (R16m) of the R 20 million target set for the financial year 2012/13
Bursary Program	• The Department awarded a total of 1 485 bursaries during the 2012 academic year; 23.4% (348) of these were new bursars. • Approximately 20% (286) of the total bursars completed their academic studies in December 2012.
EMS College	• 60 Basic Life Support (BLS) practitioners graduated • 24 Rescue practitioners graduated

Bursary program

During the financial year under review, the ECDoH had a total of 1485 bursars on the programme. These were recruited as a result of the social compact bursary contract, there were 348 newly awarded bursars comprising 23.4% of the total bursars. Table 6.2.1 shows the distribution of bursars by field of study. Internal bursars and equity considerations in bursary allocation is shown in Table 6.2.2 and 6.2.3.

Table 6.2.1: Bursary holders by field of study, 2012/13

FIELD OF STUDY	FINANCIAL YEAR 2011/12		FINANCIAL YEAR 2012/13	
	TOTAL BURSARS	% OF TOTAL	TOTAL BURSARS	% OF TOTAL
B Cur	570	34.2	595	40.1
MBChB	535	32.1	519	34.9
Pharmacy	72	4.3	96	6.5
*Clinical Associate	79	4.7	76	5.1
Radiography	0	0.0	39	2.6
Physiotherapy	25	1.5	28	1.9
Occupation Therapy	17	1.0	15	1.0
Dentistry	15	0.9	22	1.5
Speech & Hearing	10	0.6	11	0.7
Optometry	8	0.5	3	0.2
Paramedics	6	0.4	2	0.1
Dietetics	4	0.2	6	0.4

FIELD OF STUDY	FINANCIAL YEAR 2011/12		FINANCIAL YEAR 2012/13	
	TOTAL BURSARS	% OF TOTAL	TOTAL BURSARS	% OF TOTAL
Clinical Psychology	3	0.2	4	0.3
Audiology	3	0.2	6	0.4
Bio Medical	2	0.1	4	0.3
Other – Food Science	1	0.1	1	0.1
Dental Therapy	1	0.1	0	0.0
Dental Technology	0	0.0	0	0.0
Environmental Health	0	0.0	0	0.0
Oral Hygiene	0	0.0	3	0.2
Micro-Biology	0	0.0	3	0.2
EMC	0	0.0	9	0.6
*Orthotic and prosthetic	8	0.5	6	0.4
*Internal Bursaries	306	18.4	37	2.5
TOTAL	1665	100.0	1485	100.0

*Fields of study excluded amongst bursars in 2011/12 report

Table 6.2.2: DoH Employee graduates by level of study (Internal bursars), 2012/13

LEVEL OF STUDY	NUMBER REGISTERED	NUMBER OF GRADUATES
PhD	1	1
Masters	1	1
Honours	3	0
BTech	5	0
Degree	17	2
Diploma	10	1
Certificates	0	0
Total	37	5

Table6.2.3: Equity considerations in bursary allocation 2012/13

CRITERION	TOTAL NO	NO. GRADUATING IN 2012/13
External candidates	1448	286
Internal candidates	37	2
TOTAL	1485	288
Cuban program	142	0
Failure	0	0
Drop-out	0	0
Bursary holders (Rural origin)	1130	198
Bursary holders (women)	978	97
Bursary holders (African)	1001	214

Learnership and Internship programme

This program was created in compliance with the national government priority areas linked to youth development and provisioning of training opportunities for the unemployed graduates and youth to get experience on the job. The department submitted the expression of interest to HWSETA to fund identified Learnerships and Internships for the year 2012/13. Students with Matriculation certificates are enrolled in a learnership programme for a period not exceeding 12 or 18 months in order to acquire a qualification.

For the past 5 years, the ECDOH did not have any Budget allocation for Learnership, Internship and Experiential Training from the equitable shares budget. As a result, the Training and Development section of the Human Resource Development (HRD) took initiative to set aside an amount of R10,1mil to fund the Learnership and Internship programme. A total of 1065 Learnerships, Internship and Experiential Training were funded by the EC DOH during the 2012/13 financial year (see Table 6.3).

Table 6.3: Enrollment on Learnership and Internship programme 2012/13

CATEGORY	PROGRAMME	NUMBER	COMMENTS
Internship Programme	Basic Ambulance Assistance	288	These were recruited and placed in all EMRS metros during January 2012 to address the skills gap on Basic Ambulance Assistance. The group continued with the programme which is coming to an end in December 2012.
	Port Elizabeth Hospital Complex Admin (Finance, HR and Supply Chain)	18	These were recruited by the PE Hospital Complex and were placed for a 12 months period commencing July 2011 to July 2012.

CATEGORY	PROGRAMME	NUMBER	COMMENTS
	Admin Support Interns from National (Finance, HR, Information Management Systems, Information Technology)	47	These were recruited by the National Department of Health, were placed in the department for a period of 12 months commencing in June 2012 to May 2013.
	Data Capturers	302	They were recruited in November 2010 for a learnership programme. On expiry, their contracts were extended to December 2012.
Total		655	
Learnership Programme	EMRS Call Centre Learners	64	They were recruited and placed in the EMRS Call Centre during January 2012. The learnership programme ends in December 2012.
	Nursing Learnership	200	These were HWSETA funded learnership
Total		264	
Experiential Learners	Admin Support Experiential Learners	63	They were from tertiary institutions in the province and were placed in the department in July 2011 as per their academic needs with different Periods of exposure. 18 of these learners graduated and exited the programme. However, 45 learners are still continuing with their practical experiences.
	NYDA Experiential Learners	83	These were undergoing a Call Centre Learnership and were placed in the Department of Health for a period of three months from September to December 2012.
Total		146	

Lilitha Nursing College

1.1 Expansion of the College

The re-engineering of the primary health care system requires more nursing categories, specifically the mid-level health workers at PHC facilities. The opening of closed colleges will provide undoubted support through the provision of more nurses in all categories focusing on the development of the District Health System through the following three processes: (Midlands, Andre Vosloo, Dora Nginza, Settlers, Dr Malizo Mpehle, MadzikanekaZulu, Fort Beaufort Provincial, Elizabeth Donkin and Cecelia Makiwane Hospitals):

- Multidisciplinary team approach of clinically competent professionals in which nurses play a critical role.
- Effective implementation of national school-based PHC system led by nurses.
- Community ward-based multi-disciplinary health teams with nurses playing a critical role.

Guided by the government's vision as contained in the Negotiated Service Delivery Agreement (NSDA) as well as the four strategic outputs therein, the college must increase its production by more than 50% for the government to meet the targets as outlined in the said agreement.

A lack of progress in addressing the quadruple burden of disease and the Millennium Development Goals, in particular the reduction of maternal and child mortality, HIV/AIDS and TB, also demands an increased number of nursing professionals at all levels, with emphasis on education and training of registered midwives. Utilisation of the Social Compact model in selecting the prospective nursing student commenced during this FY.

1.2 Implementation of the Education and Training of Nurses and Midwives Act 4 of 2003:

The re-engineering of nursing education and training in the country as per the Nursing Compact and Nursing Strategy requires the development and implementation of a comprehensive, well-designed nursing education policy that will translate into an implementable legislation. The demands for the implementation of the new nursing qualifications by the nursing colleges in June 2013 require a clear and well-structured legislative framework that provides for a sustainable, financially viable institution, capable of addressing, amongst other things, the student status, funding models and academic norms and standards. Policy documents on higher education have been developed for the college and affiliated to the consortium of universities (Nelson Mandela Metropolitan, Walter Sisulu and Fort Hare) in the province. Review of the current Provincial Act to meet nursing education and training demands in the province is imminent. The college has partnered with Fred Hollows Foundation in offering the Ophthalmic Nursing Science Post Basic programme in Queenstown.

1.3 Enrolment at Lilitha College:

The recruitment and selection of health science students including nursing students is guided by the implementation of the Social Compact in the EC Province. The Expanded Learning Platform focuses on expanding post-basic nursing qualifications, specifically Advanced Midwifery and Neonatal Care, Operating Theatre, Child Nursing Science, Clinical Health Assessment, Treatment and Care, Orthopaedic Nursing Science, Critical Nursing Science and Ophthalmic Nursing Science in the health facilities in the province. The key to the approach is advancement of nursing skills and knowledge for Professional Nurses of the province. Satellite campuses of the Lilitha College of Nursing offer the full Enrolled Nursing Assistant and Enrolled Nurse programmes including post-registration programmes and accommodate undergraduate and post-basic Professional Nurse rotations under guidance of suitable preceptors including advanced midwives. (See Table 6.4.1)

Table: 6.4.1 Enrolment at Lilitha Nursing College distributed by study course and year level

Category	1st year (Planned intake)	1st year (Actual intake)	2nd year	3rd year	4th year	Total
PN	550	559	521	570	371	2 021
Bridging	77	55	168	Nil	Nil	223
Post basic	120	104	Nil	Nil	Nil	104
Midwifery	117	110	Nil	Nil	Nil	110
EN	600	290	248	Nil	Nil	538
ENA	600	640	Nil	Nil	Nil	640
Other	Nil	Nil	Nil	Nil	Nil	Nil
Total	2064	1758	937	570	371	3 636

The Mthatha campus performance of 75% still affected by non-availability of nurses' residence as this was condemned to be uninhabitable and has since been vacated and closed while awaiting renovations. Nonetheless, performance has improved greatly. In the meantime, nursing students are finding their own accommodation in the nearby areas, though this is negatively affecting their performance. Also East London's performance dropped tremendously due to the regular movement of students between Cecilia Makiwane residence and the Border training centre where academic activities are currently conducted. (Table 6.4.2) Consequently, the movement affected the campus' performance grossly.

On completion of training, graduates are allocated to various provincial health districts as community service practitioners as they have signed contracts with the ECDoH through the college to serve the department for the equivalent number of years that the student has been funded for.

Table 6.4.2: Number of graduates produced (all categories combined) and overall pass rate at Lilitha Nursing College distributed by year of study

CAMPUS	YEAR 1	YEAR 2	YEAR 3	YEAR 4	TOTAL	OVERALL PASS RATE
East London	42/113	42/69	131/182	88/88	303/452	63%
Mthatha	102/147	101/163	93/103	59/61	355/474	75%
Port Elizabeth	90/107	60/82	89/112	56/64	295/365	81%
Queenstown	90/118	80/126	90/109	83/87	343/440	78%
Lusikisiki	61/74	54/81	45/64	71/71	231/290	80%
TOTAL NO	385/559	337/521	448/570	357/371	1 527/2021	75%

2. EMS College

The EMS College is in the process of being accredited to offer the Emergency Care Technician (ECT) course. A major constraint in this process is recruiting appropriately qualified staff needed as part of the College staff establishment given the moratorium on appointments. Compounding this constraint further is the on-going reliance of the College on paramedics seconded from Emergency Medical and Rescue Services (Programme 3) to support learning programmes.

This aside, the College was assessed by the Forum of Emergency Care Colleges (a forum of college principals from the public sector) and found to be materially ready to finalise the accreditation process provided the necessary staff can be appointed.

In February 2012, the Department finalised an agreement with Nelson Mandela Metropolitan University paving the way for them to establish an emergency care degree programme for registration as Emergency Care Practitioners at the Health Professions Council of South Africa. Part of this agreement will see NMMU and the College work closely together to promote the quality of teaching and learning at the College as well as the practical exposure of university students.

The College continues with refresher, continuous development and short course programmes. As part of expanding the learning platform, the College plans to open a campus in East London followed by Mthatha. Funding from the Health Professions Training and Development Grant was made available for this project in 2012/13.

Table 6.5: Performance on Strategic Objectives for the Health Sciences and Training Programme

Strategic objective	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
5.5 To ensure 100% Effective HR planning, Development and Management	3 526 total student enrollment at Lilitha Nursing College	3 868 total number of students enrolled at Lilitha Nursing College	3 636 total number of students enrolled at Lilitha Nursing College	232	This is due to staff shortages
	1272 Bursaries awarded Internal, Cubans, O&Ps	1340	1 485	145	National mandate was to recruit additional students on Cuban programme
	Learnerships	64	264	200	The department received HWSETA Discretionary for nursing learnership
	Internships	302	655	353	47 Admin Support Interns deployed by NDOH 288 EMS funded interns 18 interns funded through skills levy
	Experiential learning	10	156	146	• 83 NYDA-ECDC-DTI funded experiential learners were hosted by the department in the workplace. • 63 experiential learners are from the tertiary institutions in the province.

Table 6.6: Performance against Provincial Targets from 2012/13- 2014/15 Annual Performance Plan for the Health Sciences and Training

<table>
<tr><th>Performance Indicator</th><th>Baseline (Actual output 2011/12)</th><th>Annual Target 2012/13</th><th>Actual Annual achievement 2012/13</th><th>Deviation from planned target to actual annual achievement for</th><th>Comment on deviations</th></tr>
<tr><td>Intake of nurse students</td><td>1165</td><td>1508</td><td>1 758</td><td>250</td><td>The difference is due to the additional re-opened satellite campuses which had their first intake in 2012.
<table>
<tr><th>Campus</th><th>Intake</th></tr>
<tr><td>Elizabeth Donkin</td><td>40</td></tr>
<tr><td>Fort Beaufort Provincial</td><td>20</td></tr>
<tr><td>Cala</td><td>40</td></tr>
<tr><td>CMH site</td><td>80</td></tr>
<tr><td>Study leavers from clinical institutions</td><td>70</td></tr>
<tr><td>Total</td><td>250</td></tr>
</table></td></tr>
<tr><td>Students with bursaries from the</td><td>1272</td><td>1340</td><td>1485</td><td>145</td><td>National mandate was to recruit additional students on Cuban programme</td></tr>
<tr><td>Basic nurse students graduating</td><td>1067</td><td>1398</td><td>1408</td><td>10</td><td>Variance caused by students that joined the group as they carry modules from previous programme to complete the course</td></tr>
</table>

Performance Indicator	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Number of Post-basic nurses graduateda	70	200	110	-90	1. The accredited education and training institution is faced with a challenge of limited capacity. 2. The majority of the Post Basic programmes are housed at the East London Campus. Both the Mthatha and Queenstown Campuses offer two of the seven academic programmes with Port Elizabeth offering one. 3. Attraction and retention of specialist academic staff to the college campuses also poses a challenge as majority prefers clinical services due to OSD allowances which is not considered in the academic platform. This limits the number of students to be registered as ratios are very low 4. Recruitment of applicants for the programmes also depends on the number of professional nurses granted study leave by the health institutions

Performance Indicator	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Number of one year midwifery course nurses graduated	70	200	101	-99	The programme is dependent on availability of Professional Nurses who have passed Diploma in General Nursing and numbers are limited as focus of clinical services is on capacitating basic nurses.
Number of Clinical Associate students trained	79	60	76	16	Since some sub-districts did not manage to award all their allocated bursaries due to limited number of qualifying students, their funds were diverted to the clinical associate program
Number of Registrars in training	115	130	96	-34	Some of the registrars dropped out of the program
Number of clinical Technicians trained	0	10	0	-10	The department's earmarked candidates could not be admitted into institutions of higher learning.

Performance Indicator	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Number of emergency care technicians undergoing training	0	30	0	-30	The EMS college has an organogram but the person to post matching is not completed and vacant posts have not yet been filled especially for lecturers and management of the college.
Number of intermediate life support practitioners graduated	46	68	19	-49	The EMS college has an organogram but the person to post matching is not completed and vacant posts have not yet been filled especially for lecturers and management of the college.
Number of rescue practitioners graduated	72	60	42	-18	Target not achieved due to shortage of staff. Rescue training requires at least 2 lectures. Currently the College has only one lecturer employed and thus far the college relies on Emergency Medical Services to second rescue practitioners to assist with the course facilitation.

TABLE 6.7: STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

INDICATOR	CHALLENGES	STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE
Nursing Training College:		
Number of Post-basic nurses graduated	• Simulation laboratories have got a shortage of medical equipment. • Only two campuses (East London and Mthatha) are accredited to offer nurse specialist courses which results in the inadequate production of nurse specialists by the college. • College does not have an internal quality assurance unit to coordinate quality assurance provisions and systems within the college. • College has 49.9% vacancy rate for Nursing Educators and an absence of researchers in the nursing fraternity. • Most campuses have no proper structures like classrooms, offices, laboratories, libraries and student accommodation. • OSD not considered in academic platform • Enrollment on course depends on number of professional nurses granted study leave	• The department has signed a Service Level Agreement with Nelson Mandela Metropolitan University with these key outcomes and outputs: • Training and housing of new Nurse Educators in a full-time formal programme at NMMU for one academic year. • Masters Training (two academic years) and PhD training (four academic years). • Low fidelity Clinical Laboratory at PE campus and related training. • Student Academic Support programme (Quality of assessment). • The college has been put under the revitalization programme and has budgeted for renovations and minor maintenance of the existing campuses. New buildings are planned and construction at Cecilia Makiwane Hospital is ongoing. • Application has been made to South African Nursing Council (SANC) to roll out to the entire college institutions.
Bursary programme		
Students with bursaries from the province	The majority of learners have limited knowledge about other health related fields as they do not apply for them, e.g. Radiography, Emergency Care Services and Paramedics which are very critical in the department.	• Career Exhibitions to the districts to market other health related fields will be done through the social compact Program. • Local universities will also be invited to market their programmes and inform learners about admissions' requirements at their respective universities
	Limited pool of qualifying matriculants as a result of limited number students studying pure mathematics at school	Through intergovernmental relations, the DOH to engage the EC Department of Education

INDICATOR	CHALLENGES	STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE
	Candidates earmarked for bursaries from the sub-districts are not admitted into tertiary institutions for targeted study fields due to their final year results that do not make the required entry points and/ or due to late application	The department need to consider taking an initiative of negotiating for a number of guaranteed seats withrelevant universities for critical bursary health fields
EMS Training College		
• Number of emergency care technicians undergoing training • Number of intermediate life support practitioners graduated • Number of rescue practitioners graduated	• College has an organogram but the person to post matching is not completed and vacant posts have not yet been filled especially for lecturers and management of the college. • There is only one college, situated in Port Elizabeth, which means there is a limited number of students that can be enrolled, and therefore targets for EMS practitioners for the province are not being met.	• Person matching request has been submitted to Persal Management for rectification and is currently being attended to. • A plan to open a new Main Campus at East London is abreast and a memo motivating for approval to advertise critical vacant posts has been submitted for approval of the SG. • The department needs to encourage the current Intermediate Life Support staff to improve their qualification to Advanced Life Support in order to increase the pool of fulltime lecturers at the EMS College. • Two of the existing lecturers are on training at the Cape.Peninsula University of Technology (CPUT). • In the interim, the department should seek an agreement with DUT CCA to second graduated EMS practitioners to the college to facilitate short course (ILS course) and CPD activities as a short-term measure until the staff establishment is accomplished
HPTD Grant		
Number of Registrars in training	Registrars drop out of the program	Department to develop and implement a policy that will address amongst others issues of: • contractual obligations • robust selection criteria • Those breaching contractual obligation will be charged

CHANGES TO PLANNED TARGETS

There were no changes made to the original planned targets

LINKING PERFORMANCE WITH BUDGETS

Programme 6: Health Sciences & Training - Under expenditure of R59,11 million

The programme has an under spending of R5911 million. Under expenditure occurred mainly in compensation of employees by R32,48 million, goods and services by R21,56 million, transfers to universities and technikons by R2,38 million and machinery and equipment by R2,61 million.

The under expenditure on COE was due to measures put by the Department, Provincial Treasury and OTP to curb overspending and growing COE pressures.

The under-spend in goods and services is mainly from the Skills Levy wherein most of its activities stalled.

As the Other Training Sub-programme is funded through the Health Professions Training and Development Grant, rollovers amounting to R4,07 million were applied for from Provincial Treasury.

Programme 6.8: Health Sciences & Training expenditure by sub-programmes

SUB- PROGRAMME NAME	2012/2013			2011/2012		
	FINAL APPROPRIATION	ACTUAL EXPENDITURE	(OVER)/UNDER EXPENDITURE	FINAL APPROPRIATION	ACTUAL EXPENDITURE	(OVER)/UNDER EXPENDITURE
	R'000	R'000	R'000	R'000	R'000	R'000
Nursing Training Colleges	291,313	290,229	1,084	299,755	296,131	3,624
EMS Training College	5,219	4,435	784	4,978	2,650	2,328
Bursaries	87,095	86,866	229	73,693	71,060	2,633
Other Training	255,006	198,434	56,572	249,296	235,983	13,313
Total	638,633	579,964	58,669	627,722	605,824	21,898

PART B

PROGRAMME 7

HEALTH CARE SUPPORT SERVICES

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

PURPOSE

To render quality, effective and efficient Transversal Health (orthotic & prosthetic, rehabilitation, laboratory, social work services in hospitals and radiological services) and Pharmaceutical services to the communities of the Eastern Cape.

The health care support service branch consists of two sub-programme namely:

i) Transversal Health Services

- *Orthotic & Prosthetic (O&P) services:* There are three existing O&P centers that are at different levels of staffing and different level of functionality in terms of equipment and infrastructure. These centers provide assistive devices (wheel chairs, hearing aids, orthoses, prostheses etc.) to eligible clients and are situated in the three hospital complexes namely P.E Provincial Hospital, Frere Hospital (East London), and Bedford Orthopaedic Hospital (Mthatha). The number of prescriptions received from medical professionals and that of referrals especially from the outreach programme determine the need for the service.

- *Rehabilitation, Laboratory, Social Work and Radiological services* are rendered at all hospitals and/or community health centers.

ii) Pharmaceutical Services

PROGRAMME OBJECTIVES

1.9 To improve clinical support and rehabilitation services to achieve 60% of the demand.
1.10 To ensure 95% availability of essential drugs in all health facilities.

PRIORITIES FOR THE NEXT THREE YEARS

- To strengthen systems to ensure uninterrupted availability of essential medicines in health facilities at all levels.
- To ensure availability of essential drugs from the Depots to all levels of care.
- To ensure the availability of emergency blood transfusion services at all health institutions conducting Emergency Caesarean Sections.
- To improve systems for the provision of assistive devices and Rehabilitation equipment to persons with disabilities.

Rehabilitation

Rehabilitation is a goal-oriented and time-limited process aimed at enabling an impaired person to reach an optimum mental, physical and/or social functional level thus providing him/her with tools that will change his/her life. The outreach clinics for rehabilitation services have been instrumental to improve access to rehabilitation services for the disadvantaged people with disabilities especially those in the rural areas. This service is provided by the rehabilitation health professionals namely: Occupational Therapy, Physiotherapy, Speech & Audiology and Orthotic and Prosthetic services. This service has stopped in most rural areas due to lack of transport. However, consultation with district services is in progress to address this hindrance.

The Department has been sending students to Tanzania to study for the BSc in Medical Orthotics and Prosthetics (MOP) since 2004. The last six medical Orthotics and Prosthetic students (who were studying with Tumani University) have graduated for a BSc. in MOP with Tumani University in Tanzania. This will add more staff for O&P services as the department will employ these graduates. Currently, the department is working closely with Walter Sisulu University to offer the O&P course locally.

Laboratory and Emergency Blood Services

The National Health Laboratory Services (NHLS) is a Public Entity established by an act of parliament, Act No. 37 of 2000. It was created to establish a non-fragmented and centrally coordinated laboratory service in South Africa for the purpose of providing accessible, equitable and cost efficient laboratory services to the public health sector in support of the health system. NHLS is one of the major cost drivers in the Department. In an attempt to mitigate this situation, the department is negotiating a capitation arrangement with NHLS whereby an agreed capped and fixed amount would be payable monthly for rendering the service other than the current fee for service which result in high expenditure on this item.

www.Disa, a web based electronic system designed to facilitate the availability of laboratory test results to clinicians through a computer or cell phone, has been installed and is fully functional at the PE complex. Clinicians are able to access laboratory results from their work space. Installation in the other two hospital complexes is in progress.

Pharmaceutical Services

During the year under review the provincial pharmaceutical depots fared extremely well regarding the consistent delivering according to expectations, in so far as tracer drugs are concerned. A combination of factors were responsible for this performance, namely, the conscious and proactively keeping of communication channels alive with demanders, the active and consistent tracking of orders as well as pro-active substitution of pack sizes when the occasion demanded. As a result the tracer drug basket items were at all material times available.

Hiccups are still being experienced in relation to meeting the requirement of ensuring availability of essential medicines, surgical supplies and vaccines. This is primarily attributed to systemic and capacity deficiencies in the system. However, these challenges are progressively being addressed beginning with the filling of essential and critical posts.

Table 7.1: Performance on Strategic Objectives for Programme 7

Strategic objective	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
1.1 To improve clinical support and rehabilitation services to achieve 60% of the demand	15 280 assistive devices were issues to eligible clients	55% (18 350/33 164) of eligible applicants to be issued with assistive devices	51.1% (16 962/33 164) of eligible applicants received assistive devices	-3.9%	Challenges include delays by suppliers, lack of transport for outreach and to deliver assistive devices as well as challenges to trace clients
1.10 To ensure 95% availability of essential drugs at all health facilities	70%	80%	68.8% (310318/451339)	-11.2%	The initial lead-time for National contracts of 90 days is still having an impact on stock that is available, as it is taking longer for the stock to be available from the supplier. During the last quarter of the year, 4 national DOH surgical contracts ended with no replacement contracts available to purchase from; this had a huge impact on stock availability as the province purchases under the national contract

Strategic objective	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
	64.8%	85%	98% (392/4)	13%	The delivery routes in the Mthatha area had been reduced from 11 to 8, which ensure more frequent deliveries to demanders.

Table: 7.2: Performance against Provincial Targets from 2012/13- 2014/15 Annual Performance Plan for Health Care Support Services

Performance Indicator	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Number of District Hospitals (Prioritised in RSDP) with 24 hour emergency blood services	49 of 66 district hospitals	26	26	0	Target achieved
Percentage of applicants supplied with wheelchairs	1714 (Number)	35% (2875/8214)	20.9% (1720/8214)	-14.1%	The target set could not be achieved on account of a combination of challenges; primary among this being inability by suppliers at the beginning of the year to timeously deliver optimally on the orders. Another contributing factor related to the Fleet Africa contract expiry when vehicles were depleted and this negatively impacted on efficient delivery of materials. There were also challenges related to the tracing of recipient clients. The challenge with the procurement of wheelchairs is that the service providers have an upper hand which needs to be addressed by the

Performance Indicator	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
					National department. On expiry of the contract, the Province will have its own tender as the National tender is failing to deliver on time.To address the challenge of tracing the clients, the department will review data collection tools in order to get more precise patient information; we will improve our method of data collection to create better sites and also utilize the PHC and CHW to track clients.
Percentage of clients supplied with hearing aids	1093 (Number)	50% (1475/ 2950)	33.1% (977/2950)	-16.9%	Hearing aids are procured through a national tender; the supplier delayed delivery and only delivered during the second quarter of the financial year. An additional challenge is that of tracking the clients to come to service provision sites for their fittings.

Performance Indicator	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Percentage of applicants supplied with prostheses	3270 (Number)	50% (6000 / 12000)	28.4% (3411/12000)	-21.6%	• The target set could not be achieved on account of a combination of challenges primary among this being inability by suppliers at the beginning of the year to timeously deliver optimally on the orders. • Shortage of vehicles impacted negatively on efficient delivery of prostheses to the clients. • There were also challenges related to the tracing of recipient clients.
Percentage of applicants supplied with orthoses	Number= 9203	80% (8000/10000)	108.5% (10 854/10000)	28.5%	Most of these are off shelf items that are readily available and are supplied immediately on demand.

Performance Indicator	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Percentage of immediate order fulfilment of essential drugs at the depot.	70%	80%	68.75 (310318/451339)	-11.25%	The target was not reached on account of capacity challenges particularly with respect to Mthatha Depot which is grossly under resourced. Other factors that influenced performance included the National Transportation strike during October 2012 ; industrial action at Nelson Mandela Hospital Complex and Mthatha Depot
Tracer drug stock out rate at the Depots	<3%	<5% (101/101)	<2,04% (8.16/4)	> 2.96%	Performance beyond expectation is on account of • Active communication between the Depots and Demanders as regards Tracer Drugs • Consistency in actively tracking orders with Suppliers • Proactive pack size substitution

Performance Indicator	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Percentage supplies to depots received within contract lead time.	88.7%	85%	87.6% (350.46/4)	2.6%	Improved management of contracts whereby more than one supplier was contracted for delivering the same items helped a lot As well as actively following up on orders by the Depots from suppliers
Percentage facilities receiving their issued order supplies from depots within 5 days	64.8%	85%	97.93% (391.72/4)	12.9%	Improved management of the logistics arrangements and of deliveries arrangements and schedule of deliveries particularly for routes served by the Mthatha Depot

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

Assistive devices

The wheelchairs and the hearing aids are procured based on a national tender. On expiry of the national contract, the EC DOH has decided to go on its own tender in order to address the service provider delays that are currently experienced with the national tender. In addition, the penalty clause will be invoked if the service providers do not deliver within the agreed time-frames.

Prostheses materials are procured on a provincial tender. To address the shortage of materials for prostheses, the department will closely monitor the service provider compliance with the service contract and the contract lead time. The penalty clause will be invoked should the service providers fail to deliver within the agreed time-frames.

Order fulfilment of essential drugs at the depot

The pharmaceutical depots' organogram had been approved, critical posts were identified and advertised. Currently the recruitment process is underway

CHANGES TO PLANNED TARGETS

Indicator	Operational Plan target 2012/13	Revised Operational Plan target 2012/13	Reason for change
Percentage of order fulfilment of essential drugs at the depot	85%	80%	The operational plan target was changed to match the APP target for the same year. The target on the operational plan section of the planning document was different from that of the APP as it was mistakenly copied from a wrong year column of the APP into the 2012/13 operational plan.

LINKING PERFORMANCE WITH BUDGETS

Programme 7: Health Care Support Services – Under expenditure of R3,00 million

The main contributor to this underspending is the compensation of employees.

The under expenditure on COE was due to measures put by the Department, Provincial Treasury and OTP to curb overspending and growing COE pressures.

Programme 7.4: Health Care Support Services Expenditure by sub-programme

SUB- PROGRAMME NAME	2012/2013			2011/2012		
	FINAL APPROPRIATION	ACTUAL EXPENDITURE	(OVER)/UNDER EXPENDITURE	FINAL APPROPRIATION	ACTUAL EXPENDITURE	(OVER)/UNDER EXPENDITURE
	R'000	R'000	R'000	R'000	R'000	R'000
Orthotic and Prosthetic Services	33,493	32,108	1,385	34,204	31,684	2,520
Medicine Trading Account	53,819	52,201	1,618	55,808	47,063	8,745
Total	87,312	84,309	3,003	90,012	78,747	11,265

PART B

PROGRAMME 8

HEALTH FACILITIES MANAGEMENT

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

PURPOSE

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

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

STRATEGIC OBJECTIVES

- To facilitate building, upgrading and maintenance of health facilities to support service delivery
- To ensure provision and maintenance of equipment for facilities

PROGRAMME PRIORITIES:

- To facilitate and provide infrastructural support in terms of the construction of new buildings and the upgrading of the existing structures for health services delivery, as well as other organisational building requirements.
- To facilitate general maintenance in all sphere of the organization
- To facilitate the provision of essential equipment in health facilities
- To ensure the implementation of PGDP requirements by engaging SMME contractors in health facilities management projects
- To promote skills development in general maintenance
- To maintain the fixed assets at health facilities according to industry regulations

ACHIEVEMENTS:

- The Livingstone Oncology Services Unit has been completed at a cost of R70 million;
- In respect of Frere Oncology and support medical services, completion is expected before the end of the 3rd quarter in 2013 financial year. The work involved in this project is in respect of:
    - New medical wards
    - Building of adult ICU and High Care
    - Building of the Paediatrics ICU and High Care
    - Building of the Oncology Unit
    - Building of the Neurosurgery Unit
    - Building of Chemotherapy and Maxilo-Facial Unit

This project is costing the department R167 million.

- 300 Student Units in Cecilia Makiwane Hospital are now occupied and are functioning well. This costed the department approximately R110 million;
- Unlike the previous financial years, during the year under review, the infrastructure services in the areas below received full organizational support and attention:

a) Laundry and kitchen equipment,
b) Auto claves,
c) Air Conditioners and Ventilators,
d) Boilers and team water pipes
e) Fire extinguishers and
f) Medical Gas vacuum pumps
g) Uninterrupted Power Supply and light electrical works
h) Installation of new generators sets and maintenance

The renovations and repairs of Primary Health Care facilities are receiving priority. The focus has shifted from new facilities and is now firmly on maintaining the existing ones. To this extent, general maintenance work in hospitals such as Cala, Elliot, Cloete Joubert, Tafalofefe, Nelson Mandela Academic hospital, Komani, Fort Beaufort hospitals is ongoing. Furthermore, 222 clinics covering the entire Province are being repaired and renovated. Approximately 112 of these will be completed during the first quarter of the 2013/14 financial year. From a geographical location the clinics are spread as follows:

- 64 in O.R. Tambo
- 43 in Amatole
- 37 in Cacadu and Nelson Mandela
- 27 in Chris Hani
- 20 in Joe Gqabi and
- 31 in Alfred Nzo Region

A total of 28 locally based historically disadvantaged contractors in respective regions have been used to renovate and repair the afore-mentioned institutions. These were supported by 32 sub- contractors. This programme is estimated to cost the Health Facilities Management programme around R240 million. It is estimated that this programme has created work opportunities for about 1 800 persons. This approach will henceforth form the basis of infrastructure investment in the health space.

On the *skills capacitation* point of view. First the organogram of the Infrastructure Unit in the Head office has been revised with more technical skilled personnel added. Critical positions in areas of planning, delivery and medical equipment management have now been filled.

From the project implementation side of things, 53 young unemployed people have been in two construction sites (namely, Frere and Cecelia Makiwane). This placement is purely for learning purposes. This programme will now henceforth be implemented in other projects in various parts of the Province.

Nursing Colleges Satellite Campuses are now part of the provincial infrastructure portfolio. In the current financial year, extensive building repair works including the provision of learning structures is being undertaken in five satellite campuses institutions. These are the Andre Vosloo, Port Elizabeth, East London, , All Saints and Queenstown hospitals.

Temporary accommodation – the department is currently busy installing 52 temporary accommodation structures in various facilities in the Province. Of these are 33 two bed room units and 19 single bed units.

Notwithstanding the continuous labour problems, the Department encountered tremendous loss of working hours in two of its *Mega Projects,* namely Cecilia Makiwane and St Patrick's hospitals. However, the department is still on track to complete these two projects within the 2014/15 period. At the time of completion these projects would have costed the department a combined value of R1.4 billion.

Remarkable progress is being made in Cecilia Makiwane Hospital though. To date. a fully functional laundry has been constructed. A new mortuary is now functioning. Completion of the main hospital is expected on the 01 December 2014 at a cost of R935 million. Approximately 1 600 work opportunities have been created in Cecelia Makiwane to date.

In the case of St Patricks Hospital 356 work opportunities have been created. The project scope in this hospital involves construction of the following areas and is costing the department R347 million. The project will be completed in October 2014.

- Construction of the OPD/Casualty
- X-Ray Block
- New Surgical wards (male and female)
- New maternity unit
- Accommodation units for health professionals
- Bulk stores, plant rooms
- TB and communicable disease wards
- Recreational halls and walkways

A multi-million Rand development of Madwaleni hospital has started with the construction of the Gateway Clinic that will cost the department R28.5 million. The contractor for the Gateway Clinic occupied site on the 06th March 2013 and is expected to complete the programme in the first quarter of 2014.

Four hospitals have received X-Ray equipment. Amongst these are Madwaleni, Gombo, Bambisana and Mount Ayliff.

Upgrade of St Elizabeth hospital: –: Focus is on the construction of the main hospital complex and towards the finishing of the Resource Centre. This is a 4 year programme and is estimated to cost the department R740 million. To date, a replacement contractor for the finishing of the Resource Centre has been appointed. Detailed designs are near completion for the hospital complex and an advertisement for a contractor is expected to be out during the course of the second quarter of 2013.

Upgrade of Mjanyana hospital: –A consortium of technical professionals was appointed in October 2012 to assist with the design and planning of this hospital. To date a project brief document and a master plan were produced and signed off. A contractor is expected to assume construction on site before the end of June 2013.

Upgrade of Khotsong hospital: -This is a TB hospital in Matatiele. In terms of the project brief and a master plan that have been approved, this will be a 120 bed hospital. In view of the fact that this facility is currently in use, construction will be done in a phased approach. A contractor was appointed for phase one and is expected to assume site before the end of May 2013.

Upgrade of Nessie Knight hospital: –As with the Mjanyana hospital, a consortium of technical professionals was appointed during the course of the 3rd quarter of 2012. To date a master plan and a project briefs have been developed and signed off for a 100 bed hospital. Similar with Khotsong Hospital, this hospital will be done in a phased approach with a contractor expected to start on site before the end of June 2013.

Upgrade of Isiphethu hospital: –Detailed designs and tender documents have been compiled for construction of 100 bed district hospital. The contractor is expected to assume site during the course of the 2nd quarter in 2013.

Upgrade of Madwaleni hospital: –A contractor for the construction of a gateway clinic was appointed and occupied site on the 06th March 2013. Detailed designs of the main hospital are progressing well and are anticipated to be completed before end of the send quarter of 2013. In terms of the programme and budget availability, the contractor is expected to assume site before the end of the last quarter of the 2013/14 financial year.

Upgrade of Komani hospital upgrade: – Upgrading of this hospital is progressing well and is expected to be completed before 30 September 2013.

Upgrade of Frontier Casualty/ OPD and Paediatrics Unit: – The department has concluded a procurement process of finding a replacement. To this extent, a replacement contractor has already occupied site. This project is estimated to cost the department R281 million over the next three financial years.

Temporary accommodation structures: – 51 Accommodation units (17 x 1 bedroom unit and 33x2 bedrooms units) were provided to various hospitals throughout the Province. Three contractors (Manza Bantu, Cool Maintenance and Kwicksapce) were appointed to provide this service.

Relocation of Elizabeth Donkin hospital to Dora Nginza hospital: -The department has finalized the brief document for this relocation and forwarded a copy to the National Health Department for review purposes. This project is being implemented over a 4 phased approach. Phase one is in respect of refurbishing the existing buildings at Elizabeth Donkin Hospital. A contractor occupied site in February 2013 and is expected to finish before the end of June 2013. Phase two is in respect of construction a pharmacy and pediatrics wellness centre. Phase three is in respect of enabling works for the construction of mental health unit and the construction of the mental unit itself and phase four is in respect of upgrading Dora Nginza hospital.

Table 8.1: Repairs & Maintenance of EC Clinics

Phase 1 Contractors' Expenditure

SUPPLY CHAIN NUMBER	CLUSTER/AREA NAME	NUMBER OF CLINICS	STATUS OF THE PROJECT
CDC/676/12 B (ii)	MBHASHE	9	All have reached practical completion
CDC/676/12 D (i)	CHRIS HANI A	6	All have reached works completion
CDC/676/12 E (i)	CHRIS HANI B	3	All have reached works completion
CDC/676/12 C (i)	ALFRED NZO A	15	All have reached works completion
CDC/676/12 A (i)	NKONKOBE	10	All have reached practical completion
CDC/676/12 G (ii)	TSOLO	5	All have reached practical completion
CDC/676/12 G (i)	LIBODE	6	All have reached practical completion
CDC/676/12 H (i)	JOE GQABI A	13	All have reached works completion
CDC/676/12 G (iii)	MTHATHA A	7	All have reached practical completion
CDC/676/12 G (iv)	LUSIKISIKI	5	All have reached practical completion
TOTAL		79	

PHASE 2 CONTRACTORS' EXPENDITURE

SUPPLY CHAIN NUMBER	CLUSTER/AREA NAME	NUMBER OF CLINICS	STATUS OF THE PROJECT
CDC/676/12 H (ii)	JOE GQABI B	7	All have reached practical completion
CDC/676/12 D (ii)	CHRIS HANI C	8	All have reached practical completion
CDC/676/12 E (i)	CHRIS HANI D	10	All have reached practical completion
CDC/676/12 D (iii)	CACADU REGION A	13	All have reached practical completion
CDC/676/12 A (vi)	PORT ELIZABETH-GRAAFREINET	10	All have reached practical completion
SUB-TOTAL		48	
TOTAL		127	

Table 8.2: Performance on Strategic Objectives for Health Facilities Management

STRATEGIC OBJECTIVES	Actual Achievement 2011/2012	Planned Target 2012/13	Actual Achievement 2012/13	Deviation from planned target to Actual Achievement for 2012/2013	Comment on deviation
1.11. To facilitate building, upgrading and maintenance of health facilities to support service delivery	Building of 11 PHC facilities completed	20 PHC facilities upgraded and/or renovated	115	95	Owing to under spending in the medical equipment area as well as the awarding of tenders for medium size hospitals by end of September 2012, the department took a decision to renovate clinics in all the regions in Province.
	13 Hospitals under upgrade programme	17 Hospitals under upgrade programme	16 Hospitals under upgrade programme	-1	Deviation is due to a contractor that was liquidated.
	8 Other Health institutions under upgrade (e.g. EMS bases, mortuary, office accommodation)	8	8	0	Target achieved
To ensure provision and maintenance of equipment for facilities	Maintenance provided in 106 health facilities	Provide maintenance in 20 health facilities	Maintenance provided in 114 health facilities	94	Four Facilities Management Contractors have been appointed to deal with all electro- mechanical services (except medical equipment) items in hospitals.

Table: 8.3: Performance against Provincial Targets from 2012/13- 2014/15 Annual Performance Plan for Health Facilities Management

Objective	Performance Indicator	Actual Annual achievement 2011/12	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
To facilitate building, upgrading and maintenance of health facilities to support service delivery	Number of Clinics under renovation	6	14	110	96	Owing to under spending in the medical equipment area as well as the awarding of tenders for medium size hospitals by end of September 2013, the department took a decision to renovate clinics in all the regions in Province. However, there are delays by the Contractor
	Number of Clinics under upgrading programme	1	4	3	-1	Delays by the Contractor
	Number of Community Health Centres under upgrading programme	2	2	2	0	Nontyatyambo and Ngonyama CHCs achieved practical completion stages; the contractor has taken occupation of site for Upgrading of Cala CHC only in November 2012 .Practical Completion is expected before the end of September 2014.

Objective	Performance Indicator	Actual Annual achievement 2011/12	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
	Number of district hospitals under upgrading programme	5	10	9	-1	Delays by the Contractor Practical completion of Holy Cross, Cathcart, Canzibe, Fort Beaufort, Mt. Ayliff, and Isilimela has been achieved. In respect of Komani, Elliot, Cloete Joubert and Tafalofefe works are progressing well and are expected to be completed during the course of 2013/14 financial year.
	Number of secondary (regional) and tertiary hospitals under upgrading programme	3 in progress	2	2	0	Practical completion of Livingstone Oncology was supposed to have been achieved by the contractor in March 2013. This however, was not the case as snags were not completed on time. The contract has been put to terms to rectify all the buildings errors before the end of May 2013.

Objective	Performance Indicator	Actual Annual achievement 2011/12	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
						At Frere hospital works are progressing well. Sections of the building have been completed and are now in use by the hospital.The entire project will reach practical completion before the end of the 2013/14financial year.
	Number of hospitals under revitalization programme	1 awarded	5	5	0	These are: • Cecilia Makiwane Hospital • Frontier Hospital • Madwaleni Hospital & Gateway clinic • St Elizabeth's Hospital Health Resource Centre • St Patrick's hospital

Objective	Performance Indicator	Actual Annual achievement 2011/12	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
1.12. To ensure provision and maintenance of equipment for facilities	Number of water and sanitation plants upgraded	4	4	2	2	Practical completion has been reached at Canzibe and Greenville hospitals. As for Tafalofefe a contractor pulled out of site as it was facing liquidation. In respect of Emplisweni, and Mlamli contractors were only appointed in April 2013.
	Number of facilities provided with engineering services	Not reported	20	114	94	Four Facilities Management Contractors have been appointed to deal with all electro-mechanical services

CHANGES TO PLANNED TARGETS

There were no changes made on planned targets in this section of the Annual Performance Plan.

LINKING PERFORMANCE WITH BUDGETS

Programme 8: Health Facilities Management – Under expenditure of R25,77 million

Even though the programme had a net underspend of R25,77 million, goods and services, particularly in relation to contracted maintenance of buildings and machinery and equipment, overran the budgeted amount by R46,50 million. Buildings and other fixed structures underspent by R52,89 million due to stops and starts caused by labour relations issues at CMH. Machinery and equipment underspent by R16, 18 million due to challenges with supply chain processes.

Since this programme receives funding from conditional grants, roll overs have been applied for. The Department submitted an application for the rollover of conditional grant funding to Provincial Treasury in respect of R45,79 million for Hospital Revitalisation Grant, R4,80 million for the Health Infrastructure Grant and R2,27 million for the Nursing Colleges and Schools Grant

Programme 8.4: Health Facilities Management Expenditure

SUB- PROGRAMME NAME	2012/2013			2011/2012		
	FINAL APPROPRIATION	ACTUAL EXPENDITURE	(OVER)/UNDER EXPENDITURE	FINAL APPROPRIATION	ACTUAL EXPENDITURE	(OVER)/UNDER EXPENDITURE
	R'000	R'000	R'000	R'000	R'000	R'000
Community Health Facilities	157,594	151,774	5,820	154,274	103,446	50,828
Emergency Medical Rescue Services	1,019	1,122	(103)	16,594	12,807	3,787
District Hospital Services	530,106	529,753	353	411,131	371,824	39,307
Provincial Hospital Services	511,263	481,202	30,061	782,958	734,526	48,432
Other Facilities	17,958	28,317	(10,359)	33,023	22,441	10,582
Total	1,217,940	1,192,168	25,772	1,397,980	1,245,044	152,936