Province of the
EASTERN CAPE
HEALTH

STRATEGIC PLAN

2025/26

2029/30

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Abbreviation and Acronyms

AIDC-EC	Automotive Industry Development Centre – Eastern Cape
ART	Antiretroviral Therapy
BANC	Basic Ante Natal Care
CCMDD	Central Chronic Medicine Dispensing and Distribution
CDC	Coega Development Corporation
CFO	Chief Financial Officer
CIDB	Construction Industry Development Board
CSSD	Central Sterile Supply Department
CHCs	Community Health Centres
COGTA	Co-orporate Governance and Traditional Affairs
CQI	Continuous Quality Improvement
DCSTs	District Clinical Specialist Teams and General Practitioner
DDG	Deputy Director General
DHIS	District Health Information System
DHIMS	District Health Information Management System
DHS	District Health Services
DHA	Department of Home Affairs
DM	District Municipality
DME	Department of Monitoring & Evaluation
DMT	District Management Team
DoE	Department of Education
DoCS	Department of Correctional Services
DoH	Department of Health
DoT	Department of Transport
DSD	Department of Social Development
DPWI	Department of Public Works Infrastructure
DOA	Department of Agriculture
DSRAC	Department of Sports, Recreation Arts and Culture
DWS	Department of Water and Sanitation
ECDC	Eastern Cape Development Corporation
ECDoH	Eastern Cape Department of Health
ECAC	Eastern Cape AIDS Council
ECRDA	Eastern Cape Rural Development Agency
ECSECC	Eastern Cape Socio-Economic Consultative Council
ECPACC	Eastern Cape Provincial Art & Culture Council
ECLB	Eastern Cape Liquor Board
ELIDZ	East London Industrial Development Zone
ECGB	East London Gambling Board
EMS	Emergency Medical Services
ESMOE	Essential Steps in the Management of Obstetric Emergency
GIAMA	Government Immovable Asset Management Act
GP	General Practitioner
HST	Health Sciences and training
HAST	HIV & AIDS, STI and TB control
HCSS	Health Care Support Services
HFM	Health Facilities Management
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMS2	Health Management System 2
HPRS	Health Patient Registration System
HPTD	Health Professionals Training and Development (Grant)
HRM	Human Resource Management
HRD	Human Resource Development
HRH	Human Resources for Health
ICRM	Ideal Clinic Realisation and Maintenance

ICT	Information and Communications Technology
IDMS	Infrastructure Delivery Management System
IDIP	Infrastructure Delivery Improvement Programme
IMCI	Integrated Management of Childhood Diseases
IMR	Infant mortality rate
ISHP	Integrated School Health Programme
LEDIS	Local Economic Development Implementation Strategy
MDGs	Millennium Developmental Goals
MEC	Member of the Executive Council
METROs	Medical Emergency Transport and Rescue Organizations
MTDP	Medium Term Development Plan
PMTDP	Provincial Medium Term Development Plan
MTEF	Medium Term Expenditure Framework
NCDs	Non-Communicable Diseases
NDoH	National Department of Health
NDP	National Development Plan
NHA	National Health Act
NHI	National Health Insurance
NHLS	National Health Laboratory Services
NTSG	National Tertiary Services Grant
O&P	Orthotic and Prosthetic
OHH	Outreach Households
OPD	Outpatient Department
OTP	Office of the Premier
PAJA	Promotion of Administration Justice Act
PAIA	Promotion of Access to Information Act
PDE	Patient Day Equivalent
PDMT	Provincial District Management Team
PDP	Provincial Development Plan
PERSAL	Personnel and Salaries
PGDP	Provincial Growth and Development Plan
PHC	Primary Health Care
PPPs	Public-Private Partnerships
PPTICRM	Perfect Permanent Team for Ideal Clinic Realization and Management
PT	Provincial Treasury
RDP	Reconstruction and Development Programme
RPHC	Re-engineering the Primary Health Care System
SDGs	Sustainable Development Goals
SCM	Supply Chain Management
SITA	State Information Technology Agency
SOP	Standard Operating Procedure
Stats SA	Statistics South Africa
SPCHD	Social Protection, Community and Human Development
TB	Tuberculosis
TROA	Total clients remaining On ART
WBPHCOTs	Ward-based Primary Health Care Outreach Teams

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EXECUTIVE AUTHORITY STATEMENT

As we embark on the seventh term of governance, the department is committed to realizing the vision of ensuring optimal health outcomes for the communities in the Eastern Cape, in alignment with the 2030 National Development Plan (NDP) and the 2024-2029 Medium Term Development Plan (MTDP). The realm of healthcare is undergoing rapid transformation through the implementation of the National Health Insurance scheme, aiming towards the achievement of Universal Health Coverage.

During the sixth term of governance, we faced an unprecedented global challenge with the outbreak of the Corona virus disease 19, which placed immense strain on the health systems. The challenges included the closure of international/national borders, disruptions in the supply chain, and socio-economic issues. The health system is still in the recovery phase, utilising the lessons learned. This, combined with global economic challenges had a detrimental impact on healthcare.

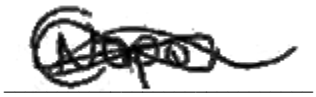
The insights gained from these global health crises have influenced our strategy, highlighting the necessity for Health Transformation, ensuring system resilience, enhancing accessibility, and promoting equity in health services. In the seventh term of governance, our focus remains on transforming health services through the implementation of the National Health Insurance, pooling resources to offer access to high-quality and affordable personal health services to all, regardless of their socio-economic status.

The Department of Health is involved in various initiatives aimed at optimising resource mobilization and ensuring prudence in the utilization of scarce resources, while embracing new technologies and methodologies that have the potential to revolutionize the care we provide. In this digital era, the provision of healthcare is intricately linked to enhancing technological infrastructure. The department is investing in digitalization aligned with the National Health Insurance and continues to introduce Health Management System2 and electronic medical records. This system will ensure continuity of care for our clients. These innovative approaches will be instrumental in improving the availability of medication in healthcare facilities.

Over the next five years, we pledge to enhance service delivery through the repurposing and reclassification of facilities. This initiative aims to improve access, equity, and the quality of care for our clients. Hospital efficiencies and effectiveness will be bolstered through the hub and spoke model. The journey of repurposing and reclassification will involve meaningful consultations with stakeholders. We are committed to providing infrastructure that is fit for purpose to support the optimization of service delivery. Maintenance of existing infrastructure and assets (equipment) remains a priority in our plans. In this realm, we are dedicated to implementing our projects within the scope of the District Development Model, from planning to execution.

Human capital remains the most valuable asset, as it directly influences the quality of care. We continue to strive towards ensuring the safety of our staff and clients within our facilities. Recent incidents of violence against staff and clients in healthcare facilities remain a significant concern that needs to be eradicated through intersectoral collaboration with community leadership.

Finally, I express my wholehearted appreciation to the departmental management and staff for their determination and resilience in aiding the Department in fulfilling its constitutional mandate. We also acknowledge the support and contributions of the Department to all Social Partners for their exceptional contributions to healthcare delivery.



Hon. N. Capa, MPL

Member of the Executive Council

02 April 2025

STATEMENT BY THE HEAD AND ACCOUNTING OFFICER OF THE DEPARTMENT

This Strategic Plan serves as the introduction and foundation for the execution of the priorities set forth for the seventh term of government. The 2024 - 29 Medium Term Development Plan (MTDP) represents the final phase towards realizing the objectives outlined in the 2030 National Development Plan and the global 2030 Sustainable Development Goals. This marks a period of accelerated service delivery in alignment with our aspirations. As we contemplate the post-pandemic renewal phase following the unprecedented global event of the Covid-19 pandemic and its adverse impact on healthcare, the Department is actively engaged in mitigating these setbacks through its turnaround strategy.

Our new 2025/30 Strategic Plan is harmonized with the government's statement of intent for the seventh term, emphasizing investments in human capital through education, skills development, and accessible healthcare. Our strategies are in sync with the Medium Term Development Plan's three core priorities: Inclusive growth and job creation; Poverty alleviation and addressing the high cost of living; and fostering a competent, ethical, and progressive state.

The department's focus to interrupt the health-poverty cycle is underpinned by various strategies including the progressive realization of universal health coverage through the implementation of the National Health Insurance (NHI) to combat disparities and financial challenges in accessing quality healthcare. Moreover, the Department recognises that the province is undergoing a demographic and epidemiological transition, as our people live longer and experience a changing burden of diseases. Our efforts are therefore directed towards strengthening Primary Health Care systems by ensuring adequate resources and staffing for home-based, community, and clinic services; and for these to deliver comprehensive health and care that encompass health promotion, disease prevention, treatment, rehabilitation, and palliative care.

Enhancing healthcare quality across all levels of facilities, both public and private, optimizing human resources and healthcare infrastructure, and implementing a unified electronic health record system are pivotal in our resource management endeavours.

Improving healthcare accessibility is paramount in our agenda, leading us to reclassify and repurpose our facilities to cater to the evolving disease burden. This transformation is undertaken through inclusive consultations with internal and external stakeholders, placing significant emphasis on the needs of our service beneficiaries.

With a target of achieving a life expectancy of 70 years for both men and women by 2030, the province has made notable progress with the current life expectancy at birth standing at 63 years. The Department's commitment to fostering healthy communities and improving health outcomes is evident through its focus on managing non-communicable diseases and mental health, prioritizing preventive and early intervention measures through collaborative engagements with stakeholders across all levels of care.

To address the challenges posed by limited fiscal resources, natural disasters, and historic medico-legal liabilities, the department remains steadfast in fulfilling its constitutional mandate as enshrined in section 27 of the Constitution of the Republic of South Africa (Act 108, 1996). Alignment of the Department of Health's enterprise architecture with the National Department's eHealth strategy is underway, with a primary focus on developing and implementing universal Electronic Medical Records in public health facilities. Efforts are concentrated on bolstering ICT infrastructure within health facilities to ensure operational efficiency and drive innovative solutions within the eHealth domain.

The HMS2 electronic medical record system encompasses key features such as patient registration integrated with the National Health Patient Registration System (HPRS), billing, and revenue management. The ongoing project aims to connect several health facilities in the initial phase over the Medium-Term Expenditure Framework (MTEF). Collaboration with the State Information Technology Agency (SITA) is being strengthened to ensure timely implementation of the eHealth project for the ECDoH. Integration of HMS² with other essential healthcare technologies like telemedicine platforms and eHealth solutions is planned to enhance service delivery. Cybersecurity and data sovereignty remain paramount to safeguard patient information while adhering to regulatory standards. Health and business intelligence, building on the rich but disparate data from our legacy systems, will find increasing expression in the term ahead and will enhance resource planning, allocation & utilisation; support data-driven decision-making; measure operational performance and promote accountability.

In pursuit of ensuring habitable health facilities, a total of 42 capital infrastructure projects are planned for completion in the 2025/26 financial year. Scheduled preventive maintenance programs are being implemented to ensure optimal functioning of facilities, prevent breakdowns, asset failures, and mitigate high maintenance costs associated with deferred maintenance.

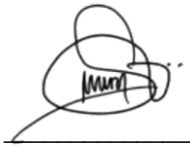
In conclusion, I call upon the stakeholders of the Department to continue to collaborate with us in the pursuit of universal health coverage and improved health outcomes for all. Together we can.

Dr R. Wagner
HOD for Health
02 April 2025

OFFICIAL SIGN-OFF OF THE 5 YEAR STRATEGIC PLAN 2025/26 – 2029/30

It is hereby certified that this Strategic Plan:

Was developed by the management of the Eastern Cape Department of Health under the guidance of MEC for Health, Hon. N. Capa, MPL. Considered all the relevant policies, legislation and other mandates for which the Eastern Cape Province is responsible. Accurately reflects Impact and Outcomes which the Eastern Cape Department of Health will endeavour to achieve over the period 2025/26 – 2029/30 financial years.



Ms. N. Mavuso
Programme Manager: 1, 6, & 8
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Dr. M. Xamlashe
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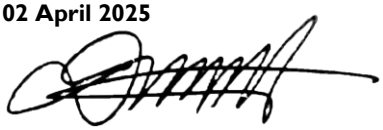
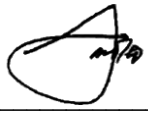
02 April 2025

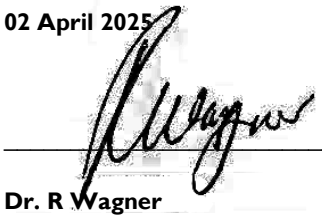


Ms. N. Nokwe
Programme Manager 2
02 April 2025



Prof. S.T. Moko
Head Official Responsible for Planning
02 April 2025

Mr. G.G. Mhlanga
Acting Chief Financial Officer
02 April 2025



Dr. R Wagner
Accounting Officer
02 April 2025

Approved by:

Hon. N. Capa, MPL
Member of the Executive Council
02 April 2025

Province of the
EASTERN CAPE
HEALTH

PART A

OUR MANDATE

STRATEGIC PLAN 2025/26 – 2029/30

PART A - OUR MANDATE

1. CONSTITUTIONAL MANDATE

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

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

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

Section 9 of the Constitution states that everyone has the right to equality, including access to health care services. This means that individuals should not be unfairly excluded in the provision of health care. People also have the right to access information if it is required for the exercise or protection of a right.

This may arise in relation to accessing one's own medical records from a health facility to lodge a complaint or for giving consent for medical treatment.

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

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

(1) Everyone has the right to have access to:
   (a) Health care services, including reproductive health care.
   (b) Sufficient food and water; and
   (c) Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights; and

(3) No one may be refused emergency medical treatment.

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

2. LEGISLATIVE AND POLICY MANDATES

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

Provides a framework for a structured health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial, and local governments with regard to health services.

The objectives of the National Health Act (NHA) are to:

- Unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa;
- Provide for a system of co-operative governance and management of health services, within national guidelines, norms and standards, in which each province, municipality and health district must deliver quality health care services;
- Establish a health system based on decentralized management, principles of equity, efficiency, sound governance, internationally recognized standards of research and a spirit of enquiry and advocacy which encourage participation;
- Promote a spirit of co-operation and shared responsibility among public and private health professionals and providers and other relevant sectors within the context of national, provincial and district health plans; and
- Create the foundation of the health care system and understood alongside other laws and policies which relate to health in South Africa.

Medicines and Related Substances Act, 1965 (Act No. 101 of 1965) - Provides for the registration of medicines and other medicinal products to ensure their safety, quality and efficacy, and also provides for transparency in the pricing of medicines.

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

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

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

Health Professions Act, 1974 (Act No. 56 of 1974) - Provides for the regulation of health professions, in particular medical practitioners, dentists, psychologists and other related health professions, including community service by these professionals.

Dental Technicians Act, 1979 (Act No. 19 of 1979) - Provides for the regulation of dental technicians and for the establishment of a council to regulate the profession.

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

SA Medical Research Council Act, 1991 (Act No. 58 of 1991) - Provides for the establishment of the South African Medical Research Council and its role concerning 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, 1996 (Act No. 92 of 1996) - Provides a legal framework for the termination of pregnancies based on choice under certain circumstances.

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

Sexual Offences Act 2007 – Ensures that children of certain ages are not held criminally liable for engaging in consensual acts with each other. Also to give presiding officers a discretion in order to decide in individual cases.

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

Council for Medical Schemes Levy Act, 2000 (Act No. 58 of 2000) - Provides a legal framework for the Council to charge medical schemes certain fees.

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

Mental Health Care 2002 (Act No. 17 of 2002) - Provides a legal framework for mental health in the Republic and in particular the admission and discharge of mental health patients in mental health institutions with an emphasis on human rights for mentally ill patients.

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

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

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

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

Other legislation applicable to the Department:

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

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

Occupational Health and Safety Act, 1993 (Act No. 85 of 1993) - Provides for the requirements that employers must comply with in order to create a safe working environment for employees in the workplace.

Compensation for Occupational Injuries and Diseases Act, 1993 (Act No. 130 of 1993) - Provides for compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment, and for death resulting from such injuries or disease.

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

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

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

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

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

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

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

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

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

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

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

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

Disaster Management Act 2002 (No. 57 of 2002) – establish a framework to prevent and reduce the risk of disasters, mitigating the severity of disaster, emergency preparedness, rapid and effective response to disasters and post-disaster recovery through the establishment of national, provincial and municipal disaster management centre.

3. INSTITUTIONAL POLICIES AND STRATEGIES OVER THE FIVE-YEAR

National Health Insurance (NHI) Act

The National Health Insurance bill was passed by both houses of parliament (National Assembly and National Council of Provinces) in 2023. The phased implementation of National Health Insurance (NHI) is intended to ensure integrated health financing mechanisms that draw on the capacity of the public and private sectors to the benefit of all South Africans. The policy objective of NHI is to ensure that everyone has access to appropriate, efficient, affordable, and quality health services.

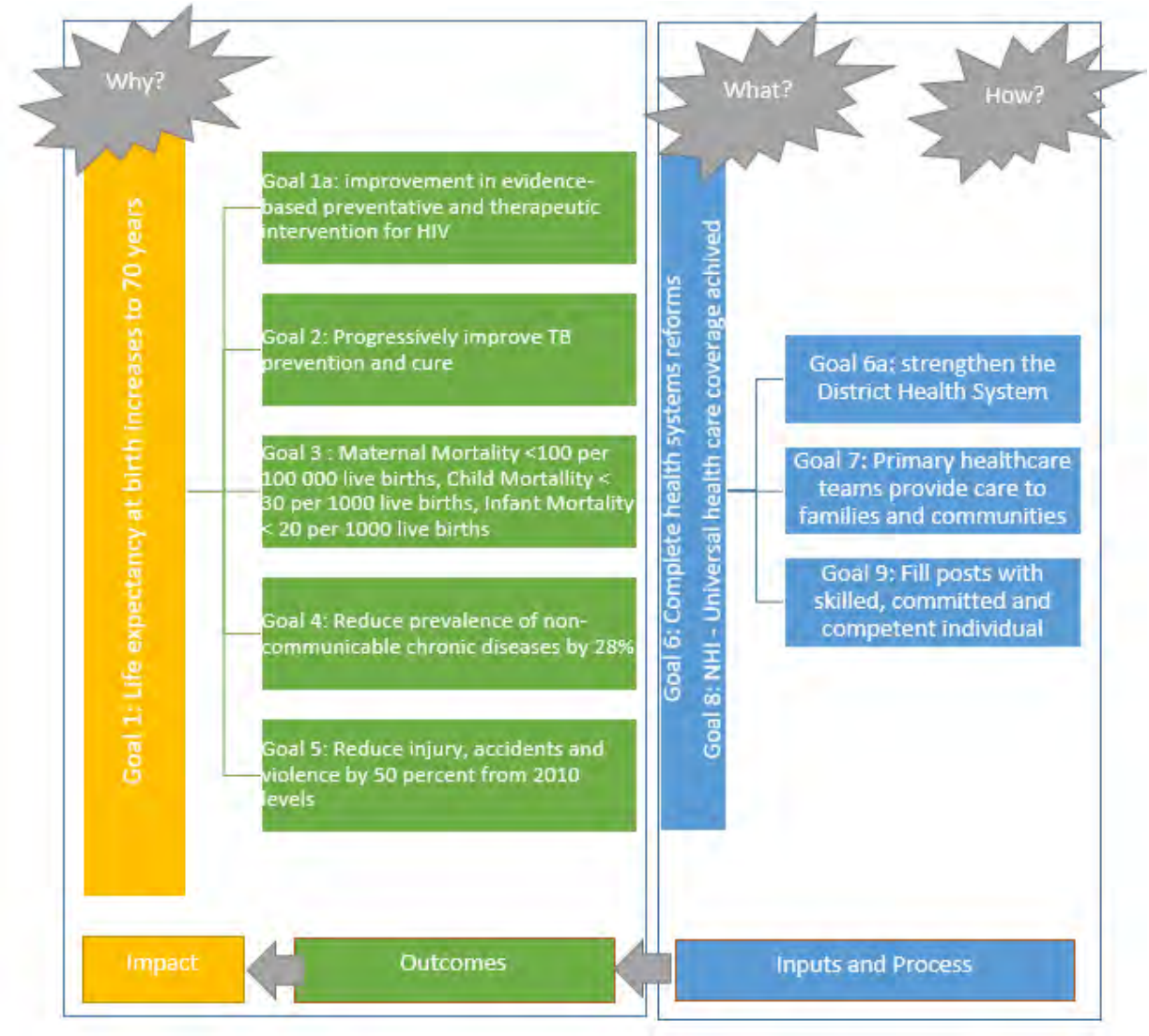
The act will improve the operations of the department through Ideal Clinic Realisation and Maintenance (ICRM) model which will improve our infrastructure and quality improvement of services and the enrolment of Contracting Units of Primary Health Care (CUP) which is at the initiation stage of the Re-engineering of Primary Health Care to improve health outcomes through Integrated School Health Programme (ISHP), Ward-Based PHC Outreach Teams, District Clinical Specialist Teams (DCSTs) and General Practitioners (GP) contracting services.

The NHI bill was assented into in May 2024.

National Development Plan (NDP): Vision 2030

The South African Government is entering its last 5 year cycle towards the 2030 vision. The overarching goal that measures impact is "Average male and female life expectancy at birth increased to at least 70 years". The NDP goals measure health outcomes, requiring the health system to reduce premature mortality and morbidity. Also tracking the health system that essentially measure inputs and processes to derive outcomes.

Figure 1: National Development Plan



Sustainable Development Goals

The Department is committed in implementing Goal 3 of the Sustainable Development Goals (2030) - to ensure healthy lives and promote well-being for all at all ages, particularly focussing on the following:

- Reduction of the maternal mortality ratio to less than 70 per 100,000 live births.
- End preventable deaths of new-borns and children under 5 years of age, aiming to reduce neonatal mortality and under-5 mortality.
- Reduce the impact of the epidemics of HIV/AIDS, Tuberculosis, Malaria and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases like COVID-19.
- Reduce premature mortality from non-communicable diseases through prevention and treatment and promotion of mental health and well-being, deaths and injuries from road traffic accidents.

- Achieve Universal Health Coverage (UHC), including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

2024-2029 Medium-Term Development Plan (MDTP)

The plan comprehensively responds to the priorities identified by the cabinet of the 7th administration of democratic South Africa, which are embodied in the Medium-Term Development Plan for the period 2024- 2029.

Strategic Priority 2: Reduce poverty and tackle the high cost of living. The following outcomes and sub-outcomes guide the 2025/26 – 2029/30 planning cycle.

Outcome: Improved access to affordable and quality healthcare

Sub outcomes:

i Pursue the achievement of universal health coverage, in which everyone in South Africa has equal access to equitable, accessible, quality health services.

ii Implement the National Health Insurance through, among other things, finalising the implementation of the National Quality Improvement Plan to ensure public and private facilities pass inspection and are accredited to provide health care under the NHI Fund.

iii Fast-track the strengthening of healthcare infrastructure, employ more personnel and finalise the creation of a single electronic health record.

iv Strengthen the delivery of Primary Health Care (PHC) and ensure that clinics are well-resourced and appropriately staffed.

v Strengthen the implementation of the National Drug Master Plan to ensure a South Africa free of substance abuse.

Provincial Medium-Term Development Plan and Mandate Paper

The Eastern Cape Provincial Administration is strengthening and consolidating planning and promotes government departments to operate in an integrated manner. There are nine Integration Areas (IAs) the province has identified. The Department of Health must develop plans for Integration Area eight (8) – Non-Communicable Diseases, Mental Health and Social Determinants of Health.

Table 1: Provincial Integrated Programmes led by Social Protection, Community and Human Development (SPCHD) Cluster

FINAL NINE INTEGRATION PROGRAMMES	LEADER	SUPPORTING INSTITUTIONS
1. Inclusive Early Childhood Development and Learner Attainment	**DOE**	**DSD, DOH, DSRAC, DOCS, DRDAR, DHS, DHA, ECLB**
2. Transformation, Governance & Municipal Support	COGTA	OTP, PT, MISA, ECSECC, DWS, StatsSA, DHS, Amatola Water, Municipalities
3. Social cohesion, moral regeneration, community safety & GBVF	DOCS	DSRAC, DOE, DSD, DOH, OTP, COGTA, ECBGB, ECLB, ECPACC
4. Anti-Poverty & Sustainable Livelihoods	**DSD**	**DRDAR, DEDEAT, PT, DHS, DOH, DSRAC, ECRDA, ECDC, DOE, DHA, ECPTA, ELIDZ**
5. Infrastructure, human settlements & broadband	DPWI	OTP, PT, DoT, DHS, DSRAC, ELIDZ, CDC, DOE, **DOH,** DRDAR, DSD, DoEL, DWS, ECSECC, ECPTA, Municipalities
6. Food Security, Land reform & agriculture commercialisation	DRDAR	DSD, DEDEAT, DoT, DOE, ECRDA, DALRRD, COGTA, Amatola Water, CDC, DOH, DHS, ELIDZ, AIDC
7. Inclusive Economic Growth	DEDEAT	DPWI, DRDAR, DoT, **DOH**, OTP, DSRAC, DOE, ECRDA, ECSECC, ECPAC, DME, COEGA SEZ, ELIDZ, AIDC-EC, ECDC, StatsSA, DoEL, ESKOM, Transnet, ECGB, ECLB; Local Government; Municipal Agencies
8. Non-Communicable Diseases, mental health & social determinants of health	**DOH**	**DOE, DSRAC, DSD, OTP, COGTA, DHS, DPWI, DOCS, DWS, DRDAR, Municipalities, Development & Social Partners**
9. Youth development, skills development & training for the Economy	OTP	ALL INSTITUTIONS, DoT, DOE, DOH, DSRAC, DSD, OTP, COGTA, PT, DOCS, DRDAR, SETA, Municipalities, CDC, ELIDZ, ECDC, ECPACC, DoEL, HRD Council

Table 2: Integration Priorities with Health interventions and Health support

MTDP/ P-MTDP STRATEGIC PRIORITY	PRIORITY FOCUS	INTEGRATION PROGRAMMES	INTERVENTIONS	2025/26 TARGETS	MTEF BUDGET
2. REDUCE POVERTY AND TACKLE THE HIGH COST OF LIVING	**Social Security**	**4. Anti-Poverty & Sustainable Livelihoods**	i. Ensure regular access to adequate and nutritious food to mitigate against Child Poverty & Malnutrition. ii. Develop sustainable Integrated Community Development interventions and increase economic opportunities towards self-reliant communities.	9 % of children under 5 years severe acute malnutrition case fatality to be reduced 77% children 12-59months on vitamin A supplementation to reduce micro nutrient malnutrition	R39 000 000
	Education & Health	**1. Inclusive Early Childhood Development and Learner Attainment**	i. Universal availability of comprehensive age-, and stage-appropriate quality Early Childhood Development services. ii. Increase Social Support to education for improved learner attainment.	13 000 Grade 1 Learners to be screened 10 000 Grade 8 Learners to be screened	R43 823 000
		Non-Communicable Diseases, mental health & social determinants of health	i. Strengthen the implementation of Prevention and Control of Non-Communicable Diseases. ii. Strengthen the implementation	2% Hypertension positivity rate >_45 years 2% Diabetes positivity rate >_45 years	R873 307

MTDP/ P-MTDP STRATEGIC PRIORITY	PRIORITY FOCUS	INTEGRATION PROGRAMMES	INTERVENTIONS	2025/26 TARGETS	MTEF BUDGET
			of Integrated Mental Health Services.	Enrol 490 050 aactive patients on Central Chronic Medicines Dispensing and Distribution (CMDD)	
				94 % of Grade 5,6 and 7 girl Learners in public and special schools vaccinated with the single dose HPV	R43 823 000
				0.2% of headcount - New clients Primary Health Care mental health condition treated	R951 900 000
3. BUILD A CAPABLE, ETHICAL AND DEVELOPMENTAL STATE	DOCS	**3. Social cohesion, moral regeneration, community safety & GBVF**	I. Community conversations through Local leaders and heroes having conversations with communities and youth. II. Improve GBVF provincial response by upscaling early Interventions and Prevention Measures.	Reduction of child and teenage pregnancy to < 330 births	

MTDP/ P-MTDP STRATEGIC PRIORITY	PRIORITY FOCUS	INTEGRATION PROGRAMMES	INTERVENTIONS	2025/26 TARGETS	MTEF BUDGET
1. INCLUSIVE GROWTH AND JOB CREATION	DPWI	**5. Infrastructure, human settlements & broadband**	i. Respond to ageing infrastructure in order to meet universal access to basic services and support economic growth ii. Improve access to social amenities iii. Increase access to water, sanitation and electricity for health facilities and schools iv. Integrated urban space and public transport programme v. Rollout of broadband connectivity to various government facilities across the province vi. Support the development of the electricity transmission grid in the province. vii. Enable pipeline of utility scale energy projects	70% % awards of Infrastructure capital expenditure items (monetary value) Procured from local Suppliers / Manufacturers	R7.5bn
				6 Solar panels in health facilities installed	R60mil
				Connect 67 hospitals and 349 Primary Health care facilities to internet	
1. INCLUSIVE GROWTH AND JOB CREATION	DEDEAT	**6. Inclusive Economic Growth**	i. Revenue generation ii. Creation of public employment opportunities	Rand value of revenue generated	339.7mil

MTDP/ P-MTDP STRATEGIC PRIORITY	PRIORITY FOCUS	INTEGRATION PROGRAMMES	INTERVENTIONS	2025/26 TARGETS	MTEF BUDGET
			ii. Skills development for the economy		
3. BUILD A CAPABLE, ETHICAL AND DEVELOPMENTAL STATE	OTP	**8. Youth development, skills development & training for the Economy**	I. Job Creation II. Inclusive Economy III. Development) IV. Food Security	205 nursing students complete training Six (6) Emergency care Practitioners complete the qualification 889 youth placed on youth training programs 64 bursary students complete their training 25 registrars complete their specialist training	
Cross Cutting Priorities			i. Addressing Social Determinants of Health & Education & Social Development. ii. Strengthen Provincial Coordination and implementation of Provincial Integrated	1 500 000 households reached through Community based Outreach Services	R212 602 000

MTDP/ P-MTDP STRATEGIC PRIORITY	PRIORITY FOCUS	INTEGRATION PROGRAMMES	INTERVENTIONS	2025/26 TARGETS	MTEF BUDGET
			Anti-Poverty Strategy (PIAPS).		
Department-specific (but critical) priorities			i. National Health Insurance - Accelerate implementation National Health Insurance. ii. Medico-legal - Strengthen the implementation of Integrated Medico-Legal Strategy to mitigate and manage medico- legal risks.	65% Ideal PHC facilities status obtained	150 000 000 (excluding infrastructure budget)
				Reduce Contingent liability of medico – legal cases – rand value to R21,471bn Strengthen implementation of administrative interventions with a specific focus on patient records and medico-legal claims through digitalisation of records management e.g. ePAIA, HMS2	R186 000 000

Theory of change – Health Care Delivery

Problem Statement

The Province is undergoing a demographic and epidemiological transition, experiencing a increasing burden of disease and mortality associated with inadequate access, structural inequality, system inefficiencies and high cost of delivering health services, within a constrained fiscal environment.

Impact

The department of health impact is "Long, healthy and quality life for the people of the Eastern Cape". To achieve the above-mentioned impact, the department will strive to implement these outcomes. Only high-level outputs that were included in the table below.

Table 3: Theory of change for Health Care Delivery

Theory of change	
Inputs : Resources and Investments	• Human Resources: Trained healthcare workers, community health workers, Developmental partners' workers • Financial Resources: Equitable share, conditional grants, other funding sources • Infrastructure: Hospitals, clinics, telemedicine platforms, mobile clinics, WBPHCOT, pharmaceutical depots, EMS, forensic pathology; Colleges of Nursing and EMS; plant, machinery and equipment • Technology: Electronic Medical Records (EMRs), diagnostics equipment, mobile apps, health information systems and infrastructure • Policy & Governance: Health regulations, universal healthcare policies • Community Engagement: Awareness programs, patient education initiatives, ICROP
Activities: Key interventions	• Implement National Health Insurance Prevention and promotion of healthy living e.g. immunisations, healthy eating etc. • Implement re-engineering of Primary Health Care through implementation of Ward Based Primary Health Care outreach teams (WBPHCOT), • Implementation of school health services • Increase access to mental health services in Primary health care • Early detection and management of Non-communicable diseases • Implement the 95-95-95 UNAIDS strategy for management of HIV/AIDS and TB. • Prevent childhood illnesses and death • Promote contraception to prevent unwanted pregnancies and reduce maternal deaths • Strengthening hhealth wworkforce through training and capacity building for healthcare workers • Implement digital health solutions for data-driven decision-making • Improve patient experience of care and curb medico legal litigations
Outputs: High level outputs	• Unwanted and teenage pregnancies prevented • Early and good quality antenatal care services rendered • Hypertension and diabetes screening and treatment. • Mental health care services integrated in Primary Health Care • 95% of people know their HIV/TB status, 95% are on treatment and 95 % are viral suppressed and cured for TB. The above outputs are possible if the health system is strengthened through management of resource like human, material (medication, laboratory, health technology, equipment, digital, information management)
Outcomes: To achieve the Impact	• Reduce maternal, neonatal and child mortality • Reduced mortality due to Communicable and Non-Communicable Diseases • Mental health care integrated into Primary Health Care • Quality of health services improved, including improved patient experience of care • Financial management strengthened in the health sector

4. UPDATES TO RELEVANT COURT RULINGS

The department has been affected negatively by the Ikamva matter, which was a ruling against the ECDOH and DPWI. IKAMVA matter is a service-related matter. The default judgement was issued against the Department and the Department of Public Works on 01 December 2015, in the amount of R41 031 279,48. Interest accrued from 18 August 2008 to 31 July 2024 was at R114 540 608,65. The payment above amounts were to be shared equally between the two Departments.

The Nalithemba matter deals with the PPP arrangement involving Port Alfred and Settlers hospitals where the department has also been negatively impacted by the court order and is still battling another claim against Nalithemba Pty Ltd.

The department has been waiting, since 2024 September the court outcomes on the TN obo BN matter. This matter was taken on appeal by the plaintiffs challenging the February 2023 ruling on the provision of health care services in lieu of lumpsum payments.

Province of the
EASTERN CAPE
HEALTH

PART B

STRATEGIC FOCUS

STRATEGIC PLAN 2025/26 – 2029/30

PART B: STRATEGIC FOCUS

5. VISION

Optimal health outcomes for the people of the Eastern Cape Province.

6. MISSION

To attain Universal Health Coverage (UHC) for the people of the Eastern Cape Province, through Primary Health Care (PHC) approach utilising resources efficiently, to enable present and future generations to achieve optimal health outcomes and quality.

7. VALUES

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

- Professionalism
- Fairness
- Accountability
- Commitment
- Team work
- Compassionate
- Responsive

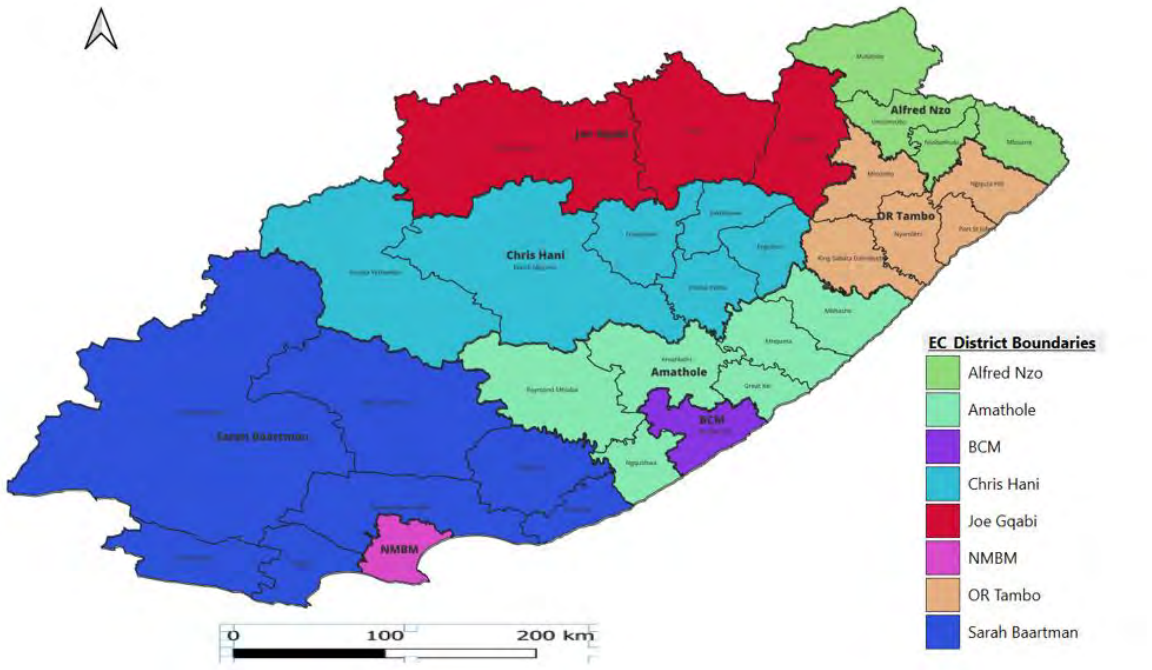
8. SITUATION ANALYSIS

8.1 External environmental analysis

8.1.1 Overview of the Province

The Eastern Cape is located on the east coast of South Africa between the Western Cape and KwaZulu-Natal provinces. Inland, it borders the Northern Cape and Free State provinces, as well as Lesotho. The region boasts remarkable natural diversity, ranging from the semi-arid Great Karoo to the forests of the Wild Coast and the Keiskamma Valley, the fertile Langkloof, and the mountainous southern Drakensberg region.

Figure 2: Map of the Eastern Cape



Source: EC DoH

8.1.2 Demographic Profile of the Eastern Cape Province

According to Statistics South Africa 2024 mid-year population estimates, the Eastern Cape Province is home to 7,176,232 people, comprising 46.7% males and 53.3% females. The youth (15-34 yrs) constitute about 31.5% of the provincial population and about 10.9% of the general population are children under 5 years of age. The Census is, however, showing a declining youth cohort (15-34) years. This decline may have a substantial impact on the Province, leading to the skills drainage.

At birth, both males and females have almost the same numbers until becoming young adults. With males having a slight edge over their female counterparts up to age 35 years. More women live beyond the age of 35 years when compared to men. As a result, the capacity of the EC province is usually overstretched due to the high demand for basic services like education, health care services, social services, employment opportunities and housing.

The Province is divided into two metropolitan municipalities (Buffalo City and Nelson Mandela Metropolitan) and six district municipalities (Alfred Nzo, Amathole, Chris Hani, Joe Gqabi, OR Tambo and Sarah Baartman), which are further divided into 31 local municipalities.

Population Pyramid

Figure 3: Eastern Cape Population by age and sex (Stats SA mid-year population estimates, 2024)

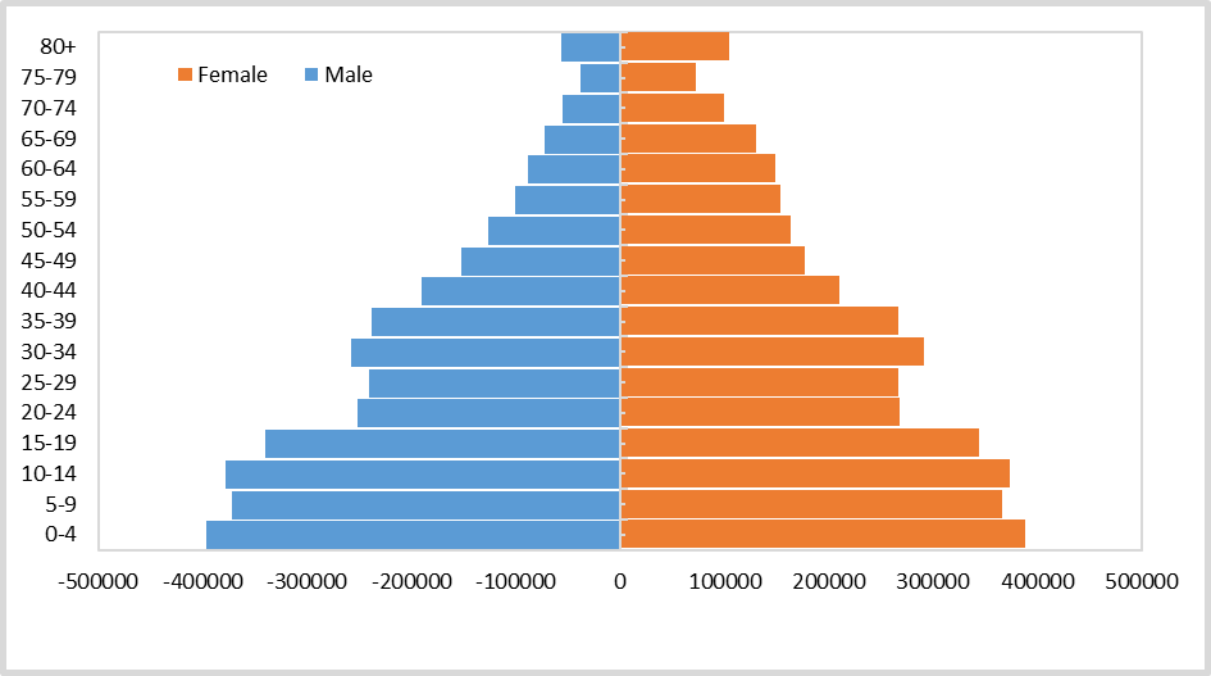


Table 4: Population Distribution by Health District Municipality (DM), 2022 estimates

District	% of total population[1]	Total population[1]	Males[1]	Females[1]	Size of area (km²)[2]
Alfred Nzo	12,5	899 932	383 096	516 836	10 731.2
Amathole	11,8	844 253	399 609	444 644	21 594.9
Buffalo City Metro	12,3	880 910	419 706	461 204	2 535.9
Chris Hani	10,5	752 480	348 123	404 357	36 143.5
Joe Gqabi	5,1	368 767	172 959	195 808	25 662.7
N Mandela Metro	17,6	1 262 388	600 737	661 651	1 958.9
OR Tambo	23,0	1 647 014	774 893	872 121	12 095.5
Sarah Baartman	7,3	520 485	249 478	271 007	58 243.3
Eastern Cape	100.0	7 176 229	3 348 601	3 827 628	168,966.0
Data Sources: [1]Stats SA mid-year population estimates 2024; [2]Population Census, 2022					

8.1.3 Social Determinants of Health: EC Province

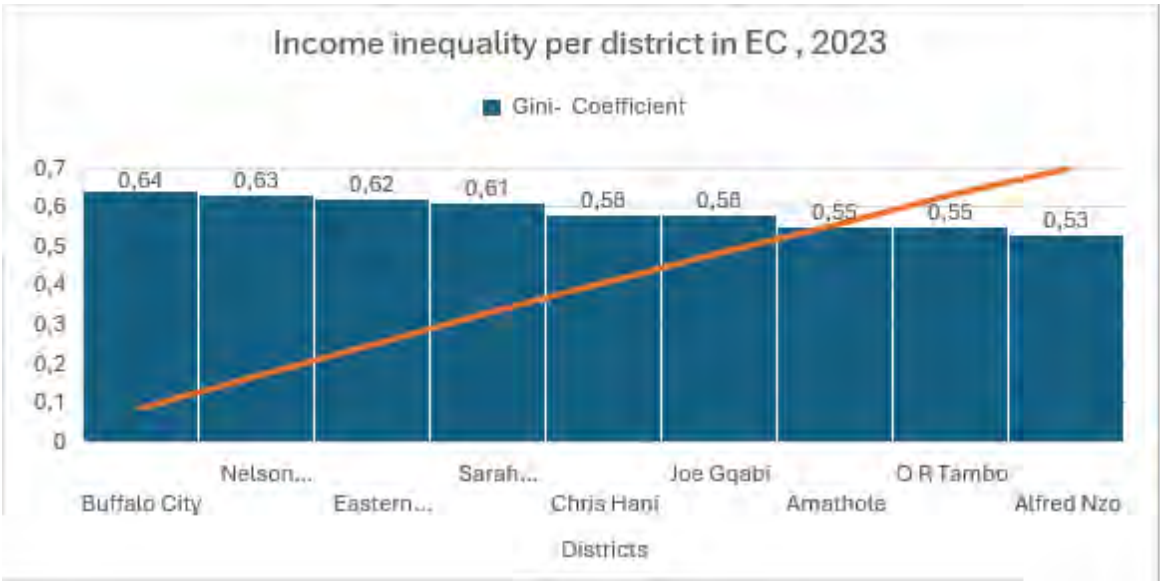
Poverty, unemployment, low literacy rates, poor housing, access to piped water and sanitation are the social determinants of health that characterize the Eastern Cape Province. The Census 2022 revealed an overall improvement in basic services to households, including access to clean water, sanitation, energy, refuse removal, and shelter. Eastern Cape has the lowest proportion of households residing in formal dwellings (83.5%) Access to proper housing is a fundamental human need that promotes physical and mental well-being.

Working-Age Population: The working-age population (15-64 years) increased by 2.3 percentage points in 2022. A larger working-age population can contribute to increased economic productivity and growth potential. Given high levels of unemployment in the Eastern Cape, the Province should focus on creating job opportunities to absorb the increasing number of working-age individuals entering the labor market, supporting entrepreneurship, and providing access to skill development programs to harness this potential.

Dependency Ratio: The dependency ratio has decreased by 6 index points. A declining dependency ratio presents both challenges and opportunities for societies. In the Eastern Cape, this ratio is influenced by a declining population of children. Effective policies addressing the social and economic implications can help navigate these changes and promote the well-being of individuals across different age groups.

Income Inequality in the Eastern Cape: Figure 4 below illustrates the Gini coefficient, which quantifies the degree of economic inequality within a society, ranging from 0 (perfect equality, where everyone has the same income or wealth) to 1 (perfect inequality, where one person has all the income or wealth). Both metros, Buffalo City (0.64) and NMB (0,63). Higher levels of inequality can hinder overall development outcomes in the Province, exacerbating poverty and limiting access to services.

Figure 4: Income Inequality per district in EC, 2023



Source: ECSSECC report, 2024

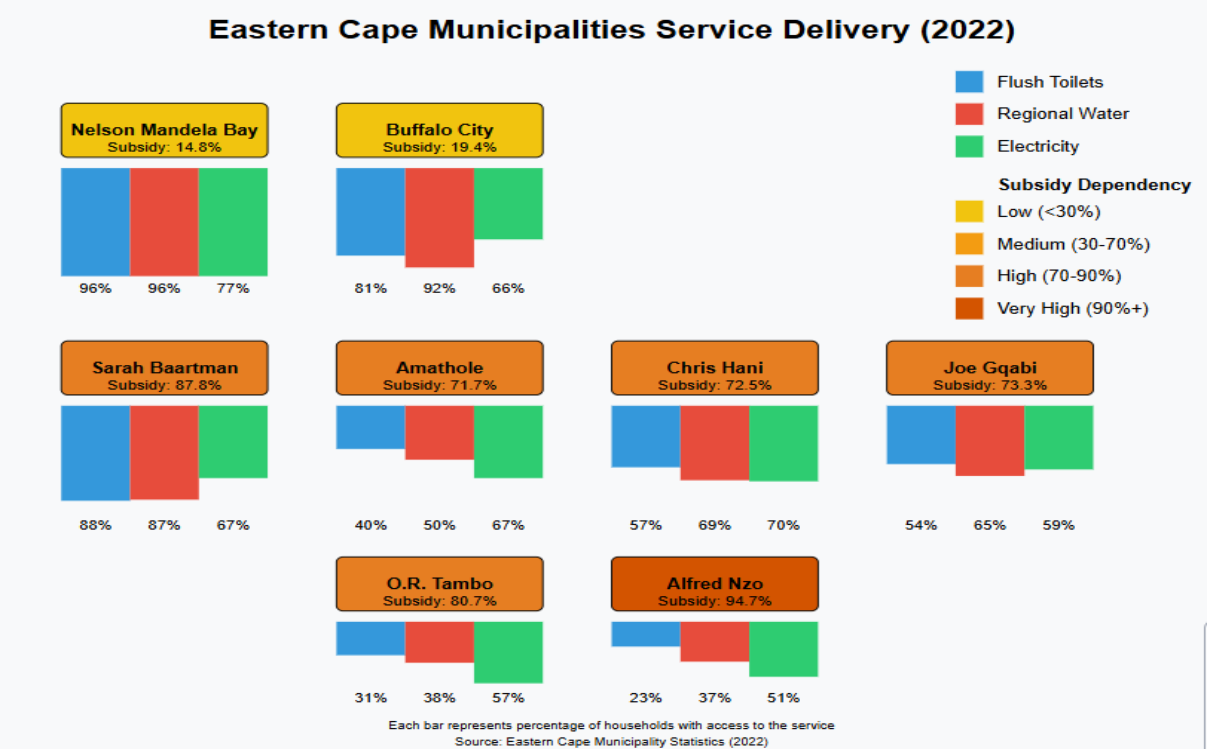
Educational Attainment: The percentage of individuals aged 20 and older with no education has decreased by 3.3 percentage points, while those with a high level of education increased by 1.5 percentage points. The socio-economic implications of an increased number of highly educated individuals are generally positive, as they can drive economic growth, innovation, and improved living standards.

The figure 5 below reveals significant inequities in basic services throughout the districts of Eastern Cape. Although the Nelson Mandela Bay Metro, Buffalo City Metro and Sarah Baartman have achieved almost

complete coverage of piped water, sewage, and electricity, areas such as Alfred Nzo and Joe Gqabi still face challenges, with just 50% having access to piped water and 56% having access to electricity. The uneven distribution of resources emphasizes a need for prioritized efforts to address these disparities and ensure that all individuals have fair and equal access to essential services for their health and well-being.

The Eastern Cape Municipality Service Delivery 2022 visualization demonstrates the district inequalities in basic service delivery, with the correlation between subsidy dependency and the service delivery outcomes. Metropolitan areas with low dependency show higher service levels in water, sanitation, and electricity, while rural district areas struggle with access to basic services. This draws attention to the systemic problems in rural districts and advocates for focused infrastructure investment.

Figure 5: Eastern Cape Municipalities Service Delivery (2022)



8.1.4 Epidemiology and Burden of Disease

Generally, the disease burden is high, and the service platform is overburdened due to social determinants of health that the Department alone has no control over. The intervention that the Department had put in place is Inter-Governmental Relations (IGR) collaboration and integrated planning across sectors. According to Stats SA 2022, the causes of mortality as per the mortality report; were COVID-19, Diabetes, Hypertension and Tuberculosis were among the top causes of mortality in the Eastern Cape Province in 2020. Other external causes of accidental injury, assault and transport accidents were among the top unnatural causes of death.

Most common underlying causes of natural and un-natural deaths in EC

Figure 6: Natural causes

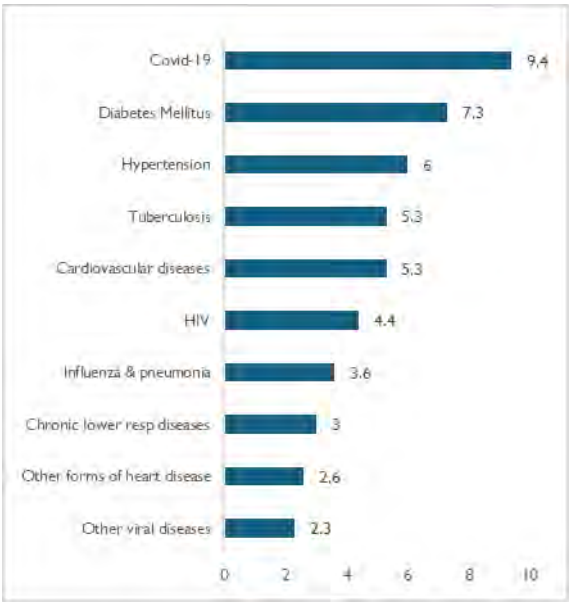
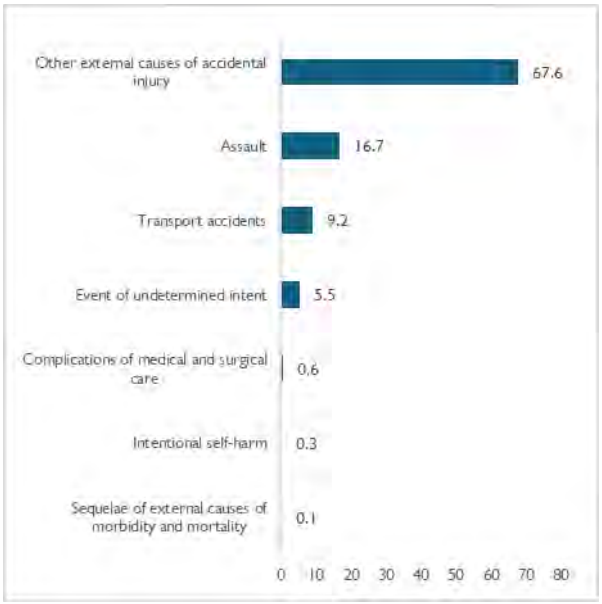


Figure 7: Un-natural causes



Source: Stats SA Mortality and causes of death report 2024

Disability

Figure 8: Disabled prevalence by Province

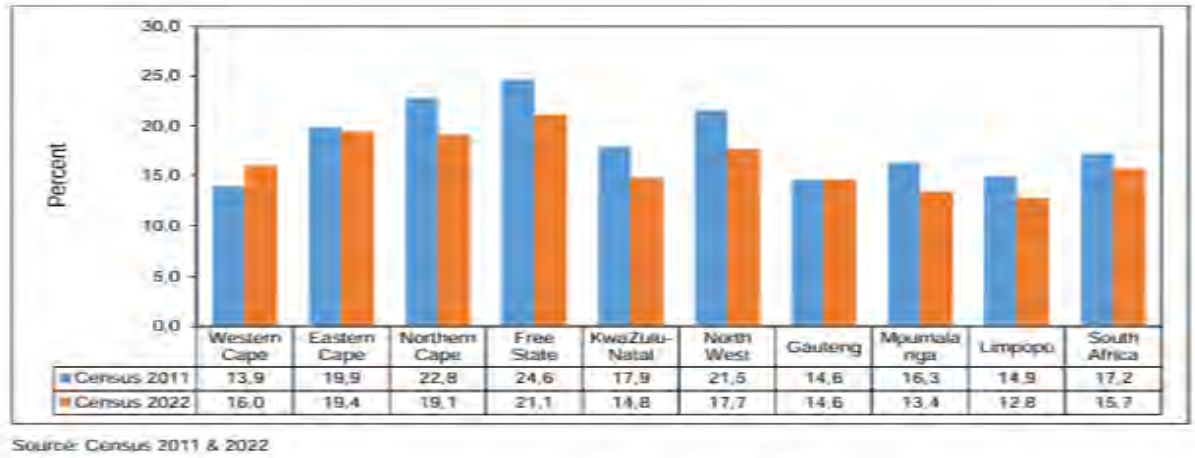


Figure 8 above depicts provincial variations in disability prevalence for 2011 and 2022. The results show that Free State had the highest disability prevalence rates for both years. For the reference period, all the provinces recorded a decrease in proportion of persons with disabilities except the Western Cape, while Gauteng remained the same. In 2022, Limpopo and Mpumalanga recorded the lowest prevalence of persons with disabilities (12.8% and 13.4% respectively).

HIV/AIDS & STI

The country has subscribed to the global vision of achieving an HIV-free generation by implementing strategies that are guided by the World Health Organization (WHO), among those strategies is the mandate to reach 95-95-95 by year 2028. 95% of people living with HIV (PLHIV) should be aware of their status, 95% of PLHIV should be on antiretroviral treatment (ART) and 95% of PLHIV on ART should be viral logically suppressed.

As of Feb 2025, Eastern Cape is at 93-81-93 for the total population serviced through the Public & Private sector. Results for each of the sub-populations vary, with Adult Females at 94-84-93; Adult Males at 92-74-93 and Children (<15) at 83-67-73.

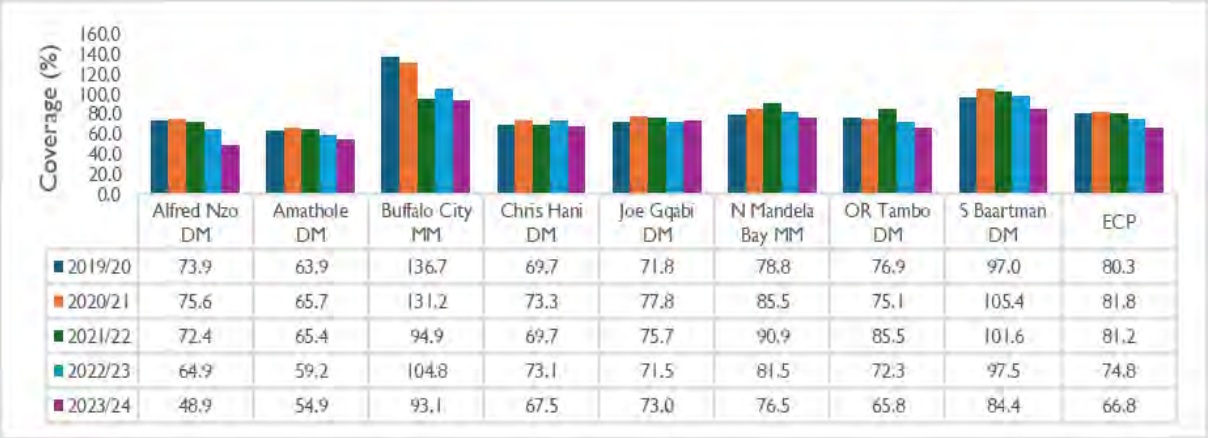
Figure 9: 95-95-95 Cascade in Public & Private sector (EC, Feb 2025)

Source: NDoH 2024

To achieve 95-95-95 targets, Eastern Cape must increase the number of Total Clients on ART by 134,662; Adult Females on ART by 66,767; Adult Males on ART by 59,440 and Children (<15) on ART by 8,455.

The HIV pandemic remains among the leading causes of morbidity and mortality in the province. Some HIV-positive clients continue to be picked when attending antenatal care. The DS-TB HIV-positive clients on ART remains above 90% in the last five financial years.

Figure 10: Antenatal client HIV 1st test positive rate, 2018/19-2023/24



	Alfred Nzo DM	Amathole DM	Buffalo City MM	Chris Hani DM	Joe Gqabi DM	N Mandela Bay MM	OR Tambo DM	S Baartman DM	ECP
2019/20	73.9	63.9	136.7	69.7	71.8	78.8	76.9	97.0	80.3
2020/21	75.6	65.7	131.2	73.3	77.8	85.5	75.1	105.4	81.8
2021/22	72.4	65.4	94.9	69.7	75.7	90.9	85.5	101.6	81.2
2022/23	64.9	59.2	104.8	73.1	71.5	81.5	72.3	97.5	74.8
2023/24	48.9	54.9	93.1	67.5	73.0	76.5	65.8	84.4	66.8

Source: DHIS 2024

Figure 11: TB outcomes

	2019	2020	2021	2022
All DS-TB client death rate	7.7	7.7	7.8	4.9
All DS-TB client lost to follow-up rate	12.4	13.1	14.2	10.7
All DS-TB client treatment success rate	79.1	78.4	77.1	54.0

Source: DHIS 2024

Maternal & Child Health

Consistent increases on maternal mortality rate were observed in Nelson Mandela Metro and OR Tambo districts in the past three years. Maternal mortality increased from 108,2 per 100 000 in 2019/20 to 136.2 per 100 000 in 2023/24 with the highest increase (146.2 per 100 000) noted in 2020/21 during the COVID-19 pandemic.

Figure 12: Maternal Mortality (per 100,000) per District in the EC, 2019/20 - 2023/24

	Alfred Nzo DM	Amathole DM	Buffalo City MM	Chris Hani DM	Joe Gqabi DM	N Mandela Bay MM	OR Tambo DM	S Baartman DM	ECP
2019/20	42,6	31,9	182,4	81,9	38,8	85,2	171,0	62,3	108,2
2020/21	74,2	60,3	209,6	133,8	71,5	128,4	221,2	74,0	146,2
2021/22	68,4	19,6	130,6	157,4	37,5	114,1	160,4	72,6	114,6
2022/23	29,5	44,2	164,6	187,6	0,0	151,0	173,7	31,0	124,3
2023/24	51,5	62,1	136,9	126,0	85,5	199,8	190,0	49,6	136,2

Source: DHIS 2024

The province has reported an increase in early neonatal deaths in the past financial year from 10.3% in 2022/23 to 11.8% in 2023/24. OR Tambo district remained the most affected when compared with the other districts. There is a concern with the Amathole, Chris Hani and Nelson Mandela Metro where there were constant increases over the past 5 financial years.

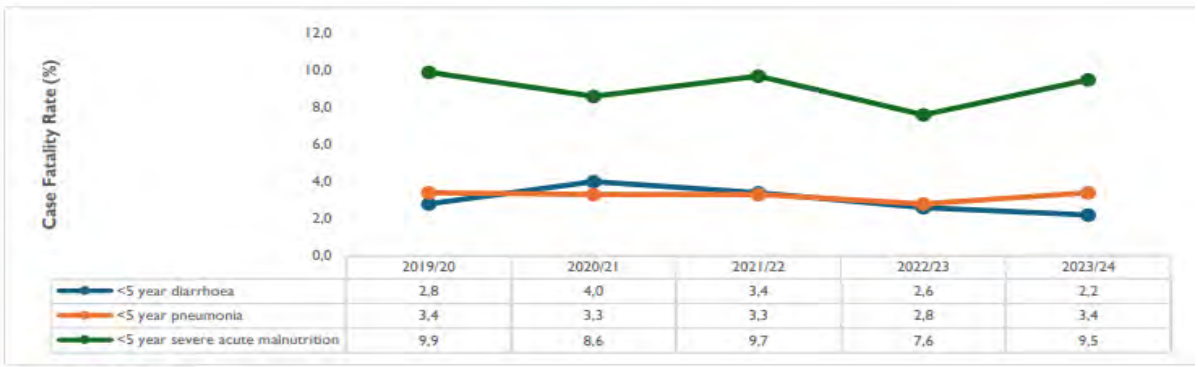
Figure 13: Neonatal Mortality per District in the EC, 2019/20- 2023/24

	Alfred Nzo DM	Amathole DM	Buffalo City MM	Chris Hani DM	Joe Gqabi DM	N Mandela Bay MM	OR Tambo DM	S Baartman DM	ECP
2019/20	9,5	5,6	10,6	8,5	8,3	6,4	14,3	9,9	10,0
2020/21	9,7	6,7	10,6	10,1	7,5	9,1	14,1	5,4	10,4
2021/22	9,0	6,7	10,2	10,9	6,7	9,5	12,9	10,0	10,3
2022/23	7,3	7,2	10,8	11,3	6,8	10,6	12,7	8,8	10,3
2023/24	9,4	8,2	11,4	12,0	12,2	13,6	14,0	6,1	11,8

Source: DHIS 2024

There was a steady decline in the diarrheal case fatality rate among children under 5 years of age in the past four financial years. The case fatality rate for severe acute malnutrition has been fluctuating over the years.

Figure 14: Early neonatal death in facility rate by district in the EC, 2019/20 - 2023/24



	2019/20	2020/21	2021/22	2022/23	2023/24
<5 year diarrhoea	2,8	4,0	3,4	2,6	2,2
<5 year pneumonia	3,4	3,3	3,3	2,8	3,4
<5 year severe acute malnutrition	9,9	8,6	9,7	7,6	9,5

Source: DHIS 2024

Non Communicable Disease (NCDs)

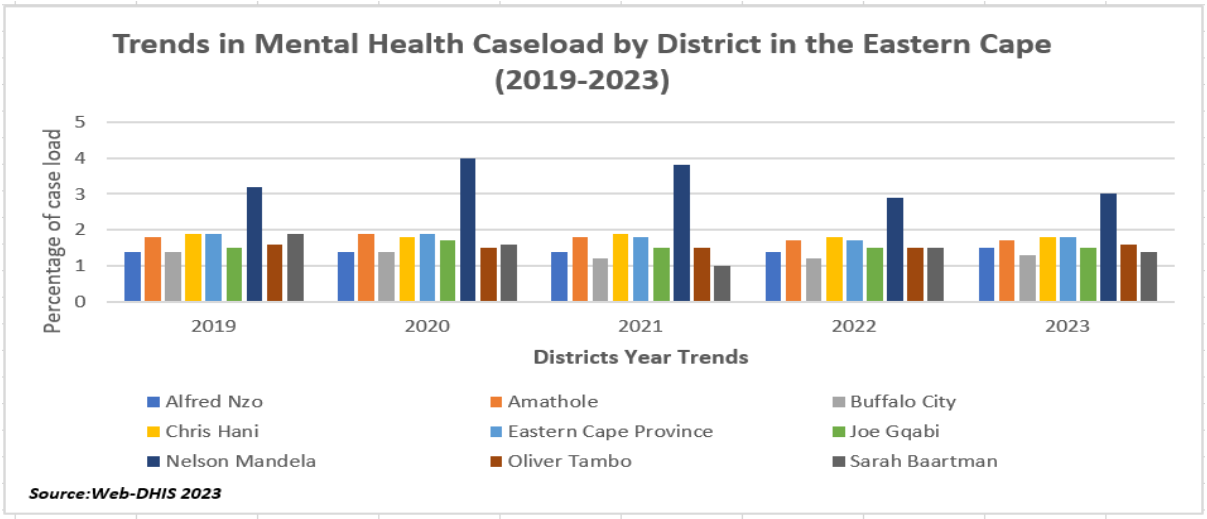
The global trend of escalating Non-Communicable Diseases is evident in South Africa and the Province. Diseases of lifestyle such as obesity, hypertension, and diabetes result, inevitably, in costly hospital admissions for complications such as stroke, renal failure, heart disease and blindness. The COVID-19 pandemic has escalated the importance of dealing with Non-Communicable Diseases and co-morbidities.

According to the Stats SA NCD report of 2023, deaths due to major non-communicable diseases, cardiovascular, cancer, diabetes and chronic lower respiratory diseases increased by 13,1% between 2008 and 2018. The biggest increase was for diabetes-related deaths, which increased by 36,5%, and cancer-related deaths increased by 29,3%. The province plans to establish a surveillance system for Non-Communicable Diseases. Strengthen the digitalisation of information management in NCDs management e.g. Vula app; SYNCH etc. The Department in partnership with the Department of Sport Recreation Arts and Culture have started a partnership in implementing a "Move for Health" project.

Mental Health

Overall, the mental health caseload appears to be relatively stable across all districts over the years. Nelson Mandela Bay Health Metro consistently has the highest caseload, while Sarah Baartman district has the lowest caseload. There was a slight increase in caseload for Alfred Nzo and Joe Gqabi districts in 2023.

Figure 15: Mental Health caseload by District in the EC.



The province appointed a child and adolescent psychiatrist thus paving the way to open the mental health unit with 14 beds capacity in Fort England hospital to manage acute and subacute mentally challenged children in the province. Mental illness associated with substance abuse is a public health concern and partnerships will be explored to render the relevant services to prevent and treat substance abuse effectively.

The burden of disease has shown a radical increase in substance abuse in the province and the country, thus increasing the need for social service and rehabilitation services. There is a critical need for facilities offering

rehabilitation services to augment the 91 beds available from the public and private sectors.

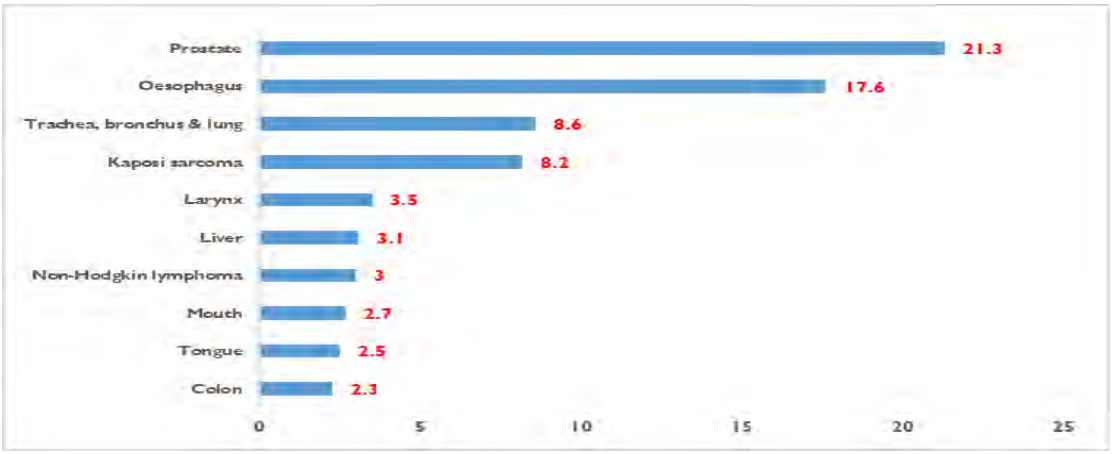
Cancer

Prostate cancer is the most leading amongst males with 21.3 % and cervix uteri is the most leading amongst females with 35% of population in Eastern Cape Province.

This data presents a clear and striking image, however, knowledge serves as the first weapon in this battle. Early identification, preventive measures such as social and behaviour change interventions and immunizations, improved access to health care, and allocation of resources towards research are essential measures for overcoming cancer in Eastern Cape Province.

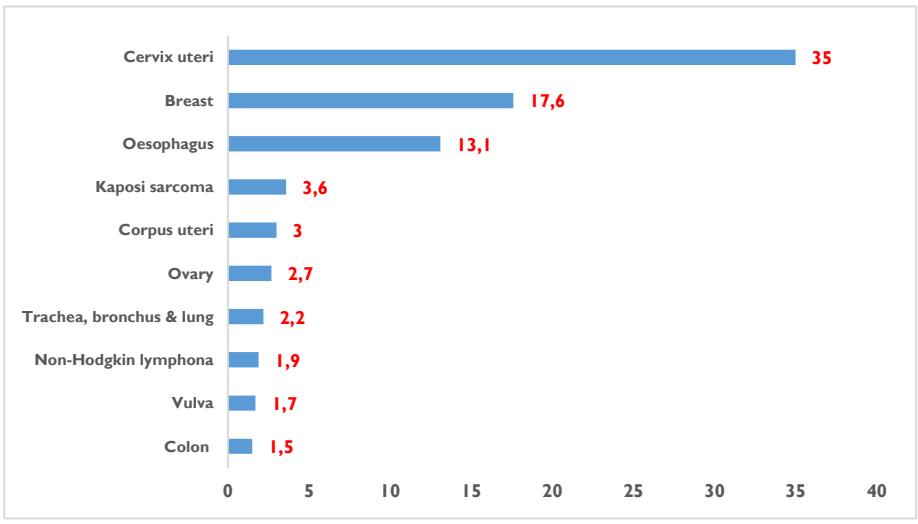
Figures 16 & 17 below are showing the 10 most common cancers by sex in the Eastern Cape Province. Prostate cancer is leading among the males and cervix among the female population.

Figure 16: Male common cancers in EC



Source: SAMRC 2020

Figure 17: Female common cancers in EC



Source: SAMRC 2020

8.2 Internal Environment Analysis

8.2.1 Service Delivery Platform / Public Health Services

The EC service delivery platform has 1 091 facilities as listed below in Table 5

Table 5: Delivery platform per facility type

Org Unit Type	Alfred Nzo DM	Amathole DM	Buffalo City MM	Chris Hani DM	Joe Gqabi DM	N Mandela Bay MM	O Tambo DM	S Baartman DM	Grand Total
Clinic	72	143	74	152	52	39	142	60	734
Community Health Centre	3	5	5	7	-	9	11	3	43
District Hospital	6	12	2	14	11	1	9	10	65
EMS Station	7	11	3	18	10	4	9	23	85
Mobile Service	9	23	11	28	13	7	12	26	129
National Central Hospital	-	-	-	-	-	-	1		1
Provincial and Tertiary Hospital	-	-	1	-	-	1	-	1	3
Regional Hospital	-	-	1	1		1	2		5
Satellite Clinic	-	-	2	-	2	3		2	9
Specialised Clinic	-	-	-	-	-	1	-	-	1
Specialised Hospital	1	2	2	1	-	4	1	5	16
Grand Total	**98**	**196**	**101**	**221**	**88**	**70**	**187**	**130**	**1091**

Seven hundred and seventy-seven (777) fixed PHC facilities exist across the province, which are made up of 734 Clinics and 43 Community Health Centres (CHCs). PHC facilities are the entry points to the health system and provide PHC package relevant for each level; and are referral points for the community-based services. The EC has 90 hospitals, the highest number in the country, despite being the fourth-largest province by population and second-largest by land mass. The province is implementing service delivery optimisation to improve efficiencies in the service delivery platform to address the 19 hospitals, which have less than 50 beds and do not fit the formal definition of a district hospital in terms of "Policy on Management of Public Hospitals (2012).

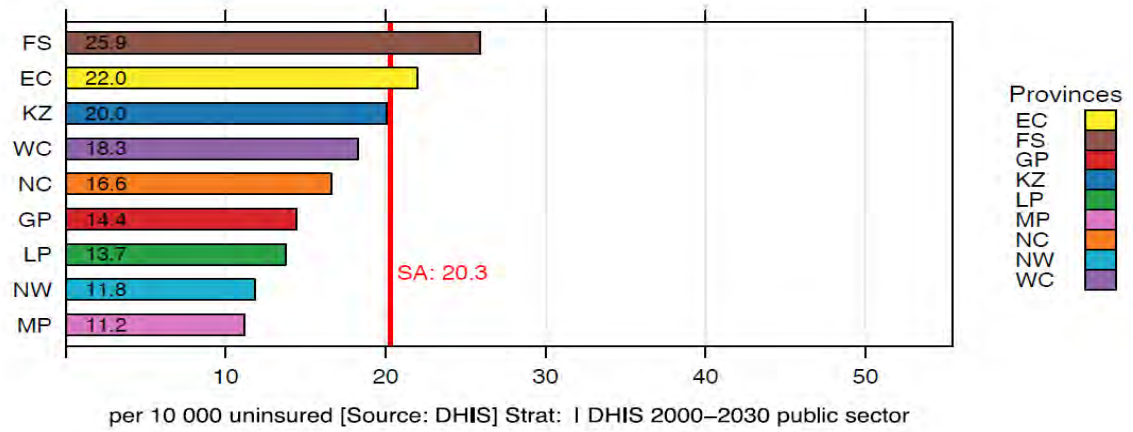
According to the district Health Barometer 2022, the district hospital PDE declined by 21% from 2021/22 to 2022/23 and this contributed to the increase in expenditure per PDE where the province moved from being the lowest-spending province to fifth place in spending. This may partly explain the increase in PHC headcount which also resulted in a decline in PHC expenditure per headcount from R655 in 2021/22 to R600 in 2022/23.

The province relies more on the PHC service platform with its utilisation rate per uninsured person at 2.3 visits, which is above the national average of 2.0 visits. However, a concern is that the PHC expenditure per capita and per headcount remains below the national average. This may signal possible underfunding which may result in compromised quality care.

The decline in PHC expenditure per capita and DHS expenditure per capita from 2021/22 to 2022/23 varies across districts, which suggests that some districts may have been slightly protected over others during budget reductions. However, the order of expenditure in the districts did not change significantly from the previous year, as the rate at which districts spend did not shift so much from previous years. For instance, Alfred Nzo remained the lowest-spending district under PHC expenditure per capita in 2021/22 and 2022/23, with a decline of 1.8% in the same period, while Buffalo City was the highest-spending district under PHC expenditure per capita, with a decline of 12.8% in the same period.

Hospital services according to the 2022/23 District Health Barometer, hospital bed ratios differ markedly across provinces, the figure below outlines those variations. There are significant variances between the provinces, with the Free State (FS) recording the highest number of beds per 10,000 population at 25.9 and Mpumalanga (MP) the lowest at 11.2 beds

Figure 18: Hospital bed ratios per 10,000 population per Province as of March 2023.



In hospital services, bell weather surgical and orthopaedic capabilities must be developed at selected district hospitals, forming a hub to treat communities closer to where they live and work. In addition, specialist outreach services to these facilities are essential to take services closer to communities. Ten district hospitals were identified to receive basic specialist services in the province. For phase one, Dr Malizo Mpehle, Madzikane kaZulu, All Saints, St Barnabas, Taylor Bequest (Matatiele), Aliwal North, Butterworth, Uitenhage, Settlers and Victoria hospitals are prioritised.

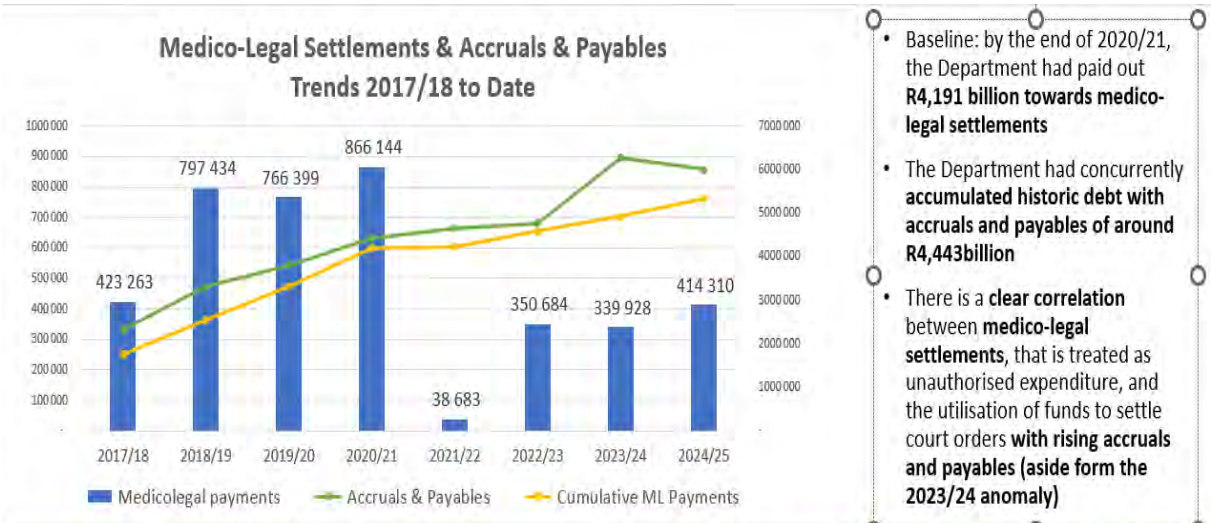
8.3 Organisational Environment

Towards Sustainable Financing for Health and Care

The department continues to operate within a fragile financial space and experiences intractable service pressures daily. This is in the face of increased demand for care as we recover from COVID19 and undergo the epidemiological and demographic transition. According to StatsSA 2022 census, 64% of our people are under the age of 35 years – this typically equates to a high demand for basic services, women's reproductive health, and child and adolescent services; but, at the same time, around 11% of our people are over the age of 60 years. The latter requires us to provide for diseases typically seen in the elderly such as diabetes, hypertension, strokes, cardiovascular diseases, cancers and so on.

The greatest challenge we face is the accruals and payables that arise out of the historic medico-legal settlements in prior years (see correlation between accruals and payables and medico-legal settlements in Figure 20 below.

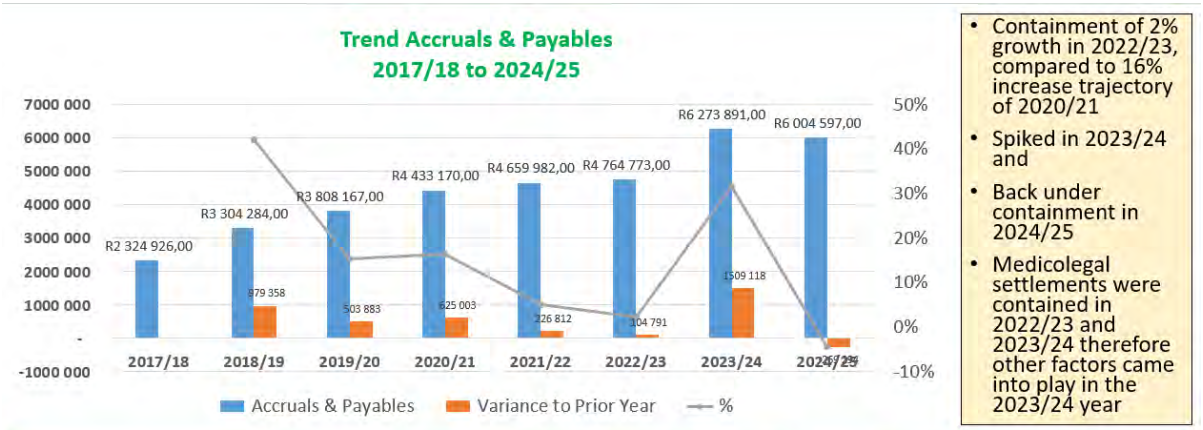
Figure 19: Medico Legal settlements, accruals and payables trends (2017/18 – 2024/25)



	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Accruals & Payables	2 324 926	3 304 284	3 808 167	4 433 170	4 659 982	**4 764 773**	6 273 891	6 004 597
Medicolegal payments	423 263	797 434	766 399	866 144	38 683	350 684	339 928	414 310
Cumulative ML Payments	1 761 018	2 558 452	3 324 851	4 190 995	4 229 678	**4 580 362**	4 920 290	**5 334 600**

The Department has made some headway in 2024/25 with containing accruals and payables (preliminary figures) once more, despite the significant budget cuts and the allocations not keeping pace with medical inflation (see Figure 20 below).

Figure 20: Trend accruals and payables (2017/18 – 2024/25)



- Containment of 2% growth in 2022/23, compared to 16% increase trajectory of 2020/21
- Spiked in 2023/24 and
- Back under containment in 2024/25
- Medicolegal settlements were contained in 2022/23 and 2023/24 therefore other factors came into play in the 2023/24 year

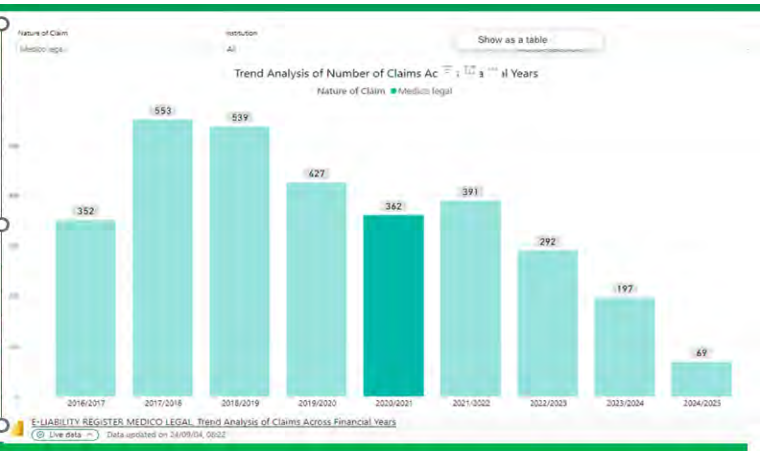
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Accruals & Payables	2 324 926	3 304 284	3 808 167	4 433 170	4 659 982	4 764 773	6 273 891	6 004 597
Variance to Prior Year		979 358	503 883	625 003	226 812	104 791	1 509 118	- 269 294
%		42%	15%	16%	5%	2%	32%	-4%

The integrated medico-legal strategy is yielding some benefits in that the number of new claims continues to decrease; and the lump sum settlements have decreased significantly since the inception of the strategy However, the ultimate solution is the establishment of a Compensatory Fund for medico-legal claims and requires the Law reform processes to be concluded.

The Department is working with the National Department of Health and the Department of Justice in pursuit of this remedy.

Figure 21: Trend analysis of number of claims accumulated in years

YEAR	Number of claims	Variance Yr on Yr No	Variance Yr on Yr %
Yr 2012/13	104		
Yr 2013/14	207	103	99%
Yr 2014/15	334	127	61%
Yr 2015/16	458	124	37%
Yr 2016/17	352	-106	-23%
Yr 2017/18	553	201	57%
Yr 2018/19	539	-14	-3%
Yr 2019/20	427	-112	-21%
Yr 2020/21	362	-65	-15%
Yr 2021/22	391	29	8%
Yr 2022/23	292	-99	-25%
Yr 2023/24	197	-95	-33%
Yr 20234/25	69	-128	-65%



There has been a steady decrease in new claims against the State, especially post the Landmark Judgement
And a **64% reduction** compared to the peak number of 553 claims in 2017/18

The accruals and payables are an albatross on the neck of the department, making it extremely difficult to manage the day-to-day operations with service providers threatening to withdraw their services for delayed payments. The debt restructuring proposal will find expression in the year ahead, as we work technically with

the Treasuries and the World Bank, setup negotiations with the top creditors and take the unauthorised expenditure and Finance Bill through the condonement processes of SCOPA.

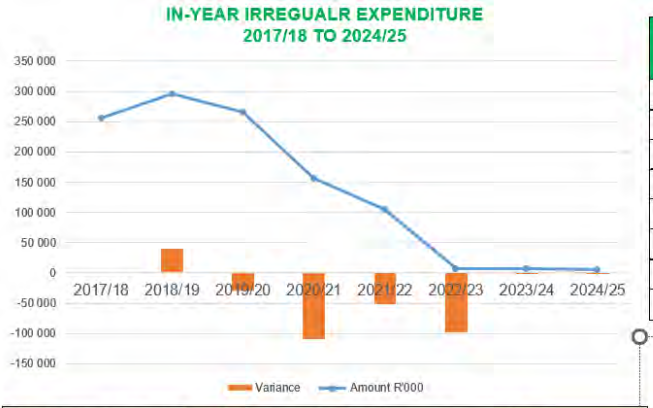
y the same token, the Department is committed to the implementation of the cost-savings and efficiency projects like the service delivery model and optimisation with an appropriate organogramme; containing and minimising leakages in the cost-drivers like NHLS, security, medicines and commuted overtime, to name a few of the critical interventions.

Financial stability with respect to the debt and COE pressures required hard decisions in the 2024/25 financial year – we managed to flatten the debt curve and significantly reduce the projected COE over-expenditure from over R900m projection to around R450m by year end. However, this came with a heavy price because we had a net loss of staff.

This will become better in the year and MTEF ahead as we adjust our Annual Recruitment Plan 2025/26 to accommodate the additional budget for employing critical staff recently announced by the Honourable MEC for Treasury in the Budget speech.

The department has also strengthened controls with a steady decrease in In-year irregular expenditure, year-on-year, since 2021/22, and decreased further in 2024/25 (see Figure 22 below)

Figure 22: In – year irregular expenditure (2017/18 – 2024/25)



Current Year IE	Amount R'000	Variance	% Variance
2017/18	255 628		
2018/19	295 354	39 726	16%
2019/20	265 761	-29 593	-10%
2020/21	156 538	-109 223	-41%
2021/22	104 900	-51 638	-33%
2022/23	6 877	-98 023	**-93%**
2023/24	6 844	-33	-0,5%
2024/25	5 411	-1 433	**-21%**

Department reduced In-year Irregular Expenditure Performance by **strengthening SCM systems and controls:**

- A **33% improvement In 2021/22** compared to the 2020/2021
- A **93% reduction to under R7m in 2022/23** compared to the R104m in the 2021/22 year which was sustained in 2023/24 and further recued to R54,m in 2024/25

- The 2021/22 cases arose from previous years contracting; all were **replaced with 36-month contracts** and the IE for the 22/23 thus dropped dramatically to R6,877m, sustained in 2023/24
- The six cases that resulted in the R5,4m IE of the 2024/25 year have all been investigated with three of them finalised. Appropriate DC action to follow.

The department has also implemented drastic austerity measures to contain spiralling expenditure and mitigate against over expenditure of the departmental budget vote.

Notwithstanding the dire financial picture above, the department continues to put measures into place to address the bottlenecks that have resulted in the tight financial position which threatens the delivery of quality health care. The measurable improvements shared above, encourages us to accelerate our interventions with the right technical support in the MTEF ahead.

The Department is implementing the turnaround plan supported by the National Department of Health, Office of the Premier and Provincial Treasury. Five working streams that focus on the following areas were established during the 2024/25 year: a) Human Resources, Leadership and Change Management b) Financial Sustainability c) Clinical Services Management d) Infrastructure and e) Digitisation and Medico-Legal.

There are good strides in some of the streams, notwithstanding slower progress in others. The primary objective is to materially and progressively reduce the department's gross debt over a three-to-seven-year period identified for development and implementation during the 7th administration.

The Department's Financial Management Strategy has a programme of action and projects to achieve five strategic objectives in our bid to obtain financial liquidity.

Digital Journey: Path to Evidence-Based Organisational Performance & Accountability

The department has made significant progress in the rollout of the Health Management System 2 (HMS2), with phase one rolled out to 40 facilities and phase 2 rolled out to the regional, tertiary and central hospitals. The CSIR is assessing the scalability of the system as a potential national solution for NHI, following the successful implementation of our HMS2 in 14 facilities in the Free State. Other provinces have already demonstrated an interest in the system, coming to our province to benchmark our innovation.

Through the HMS2 Patient billing and electronic database interchange, the direct billing of insured patients for National Health Laboratory Services and South African National Blood Services are on schedule - the interoperability capabilities of the system allow us to do this. The patient billing module has been rolled out to thirty-nine (39) health facilities that have been identified as revenue generating facilities.

Our digital transformation journey in the MTEF includes following:

1) The accelerated development and roll out of HMS^2 to identified facilities
2) The scanning of hard copy patient folders and saving them electronically at digitisation hubs and
3) The enhancement of HMS^2 and other software applications with AI-driven systems & analytics
4) The rollout of the Call and Dispatching EMS system
5) Electronic SCM systems - as part of our digital transformation journey, the department has embarked on various interventions in the past year to automate the systems for quotations and records management – we stand ready to launch these systems with effect from the 1st April 2025:
    a) CSD e-Quotation system that involves the distribution of requests for quotations and the submission of quotations by potential bidders. The solution was developed by National Treasury and adopted by the Eastern Cape Province
    b) A tender management tool that involves tracking our procurement plan and managing the records for quotation and bid processes valued at R30 000 and above
    c) e-Tender Portal for the advertisement of bids, recording received bids and awards for transparency to the market.
6) HR electronic systems- consolidating the eRecruitment system and the internally developed NMIR (National Minimum Information Requirements) reporting and eLeave which is in the pipeline through OTP

The Department is intentional in bringing AI capabilities into these projects because AI can:

- Enable data-driven resource allocation in our constrained environment
- Automate routine tasks to relieve our overburdened healthcare workers
- Transform our ability to predict and prevent health system challenges before they affect patient care
- Improve our ability to monitor and respond to public health trends across our diverse province
- Promote accountability and transparency with routine performance reporting

The Eastern Cape Department of Health's decade-long investment in HMS2 has established more than just a digital healthcare infrastructure; it has laid the groundwork for a transformative healthcare revolution that we believe, humbly, that South Africa urgently needs. Our Digital Transformation programme is an investment in the people of the Eastern Cape Province, and a commitment to ensuring that every citizen has the right to access quality healthcare, regardless of their location.

Human Resources Management

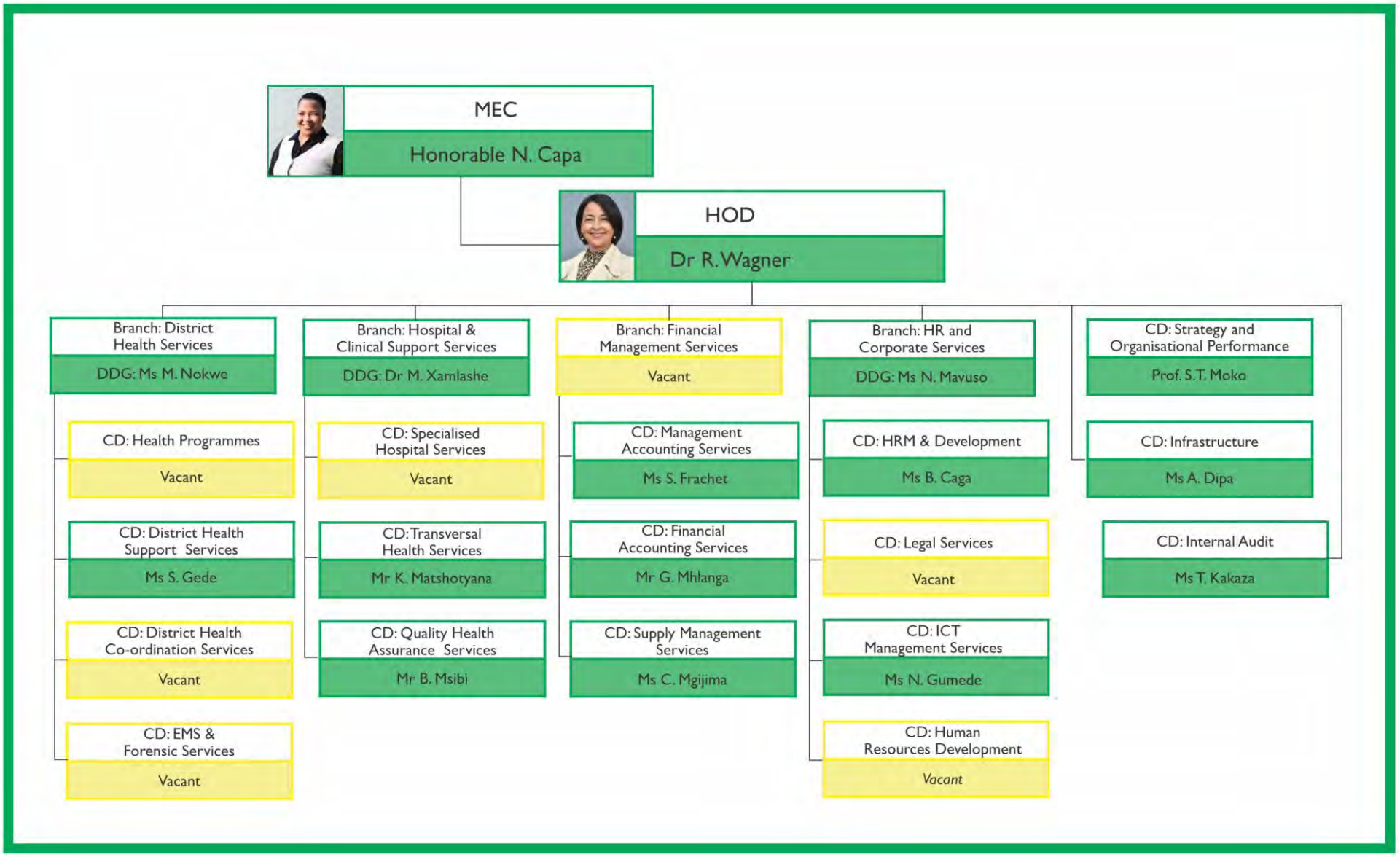
The department has 45 779 approved posts of which 40 307 were filled and 5 472 vacant. The vacancy rate is at 11.96% and it is quite high when compared to the national norm of 5%. The Department spent almost 70% of its budget on the Cost of Employees (COE), spending R19,952 151 billion against a final adjusted appropriation of R19,983 901 billion for the financial year ending 31 March 2024.

Employment and Vacancies

Table 6: Employment and vacancies by programme as of 31 March 2024

Programme	Number of Posts on Approved Establish-ment	Number of Posts Filled	Vacancy Rate (Includes Frozen Posts)	Number of Employees Additional to the Establish-ment
PRG2: District Health Services, Permanent	12,00	6,00	50,00	0,00
PRG1: Administration, Permanent	738,00	645,00	12,60	18,00
PRG2: District Health Services, Permanent	26 677,00	23 983,00	10,10	1 050,00
PRG2: District Health Services, Temporary	53,00	53,00	0,00	0,00
PRG3: Emergency Medical Services, Permanent	2 795,00	2 487,00	11,00	0,00
PRG4: Provincial Hospital Service, Permanent	8 019,00	7 470,00	6,80	206,00
PRG4: Provincial Hospital Service, Temporary	16,00	16,00	0,00	0,00
PRG5: Central Hospital Services, Permanent	6 753,00	6 144,00	9,00	533,00
PRG5: Central Hospital Services, Temporary	17,00	17,00	0,00	0,00
PRG6: Health Sciences & Training, Permanent	679,00	525,00	22,70	20,00
PRG7: Health Care Support Services, Permanent	193,00	169,00	12,40	2,00
PRG8: Health Facilities Management, Permanent	44,00	41,00	6,80	0,00
TOTAL	**45 996,00**	**41 556,00**	**9,70**	**1 829,00**

Figure 23: Organisational Structure



9. MTEF budgets

Table 7: Summary of payment estimates by programme: Health

R thousand	Outcome 2021/22	2022/23	2023/24	Main appropriation	Adjusted appropriation 2024/25	Revised estimate	Medium-term estimates 2025/26	2026/27	2027/28	% change from 2024/25
1. Administration	716 793	773 703	758 667	988 331	968 331	862 946	888 753	912 159	944 412	3,0
2. District Health Services	15 094 877	15 077 221	15 618 193	15 568 004	15 660 045	15 739 260	15 773 326	16 666 348	17 350 499	0,2
3. Emergency Medical Services	1 353 522	1 452 877	1 360 385	1 562 632	1 564 583	1 496 420	1 638 706	1 650 100	1 749 214	9,5
4. Provincial Hospital Services	3 686 353	3 926 710	4 253 340	4 231 168	4 350 027	4 647 012	4 701 833	4 702 086	4 957 257	1,2
5. Central Hospital Services	4 751 526	4 713 574	4 928 873	5 036 282	5 085 431	4 979 798	5 760 414	5 291 362	5 502 618	15,7
6. Health Sciences and Training	774 759	985 706	1 076 571	1 165 111	1 123 111	1 015 205	1 186 843	1 128 613	1 180 850	16,9
7. Health Care Support Services	112 986	115 053	112 696	248 787	248 787	194 175	248 101	250 631	263 799	27,8
8. Health Facilities Management	1 087 913	1 071 575	1 018 088	1 306 528	1 306 528	1 372 027	1 454 706	1 425 666	1 450 518	6,0
Total payments and estimates	**27 578 729**	**28 116 419**	**29 126 813**	**30 106 843**	**30 306 843**	**30 306 843**	**31 652 682**	**32 026 965**	**33 399 167**	**4,4**

Table 7 above shows the summary of payments and estimates by programme. The total payments increased from R27.578 billion in 2021/22 to a revised estimate of R30.306 billion in 2024/25. In 2025/26, the budget increases by 4.4 per cent from R30.306 billion in 2024/25 to R31.652 billion due to additional allocation to strengthen medical records for the reduction of medico legal contingencies, COE adjustments for wage agreement and funding for payables and accruals of non-negotiable items, as well as additional funding on conditional grants. The department reprioritised funds from other programmes to fund Programmes 5, 6 and 7 as evident by growth which more than 10 per cent.

Table 8: Summary of provincial payments and estimates by economic classification

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2024/25
	2021/22	2022/23	2023/24	2024/25			2025/26	2026/27	2027/28	
Current payments	**26 074 390**	**26 295 225**	**27 499 448**	**28 168 389**	**28 367 353**	**28 256 403**	**29 727 939**	**30 138 008**	**31 466 127**	**5,2**
Compensation of employees	18 479 937	18 712 799	19 952 151	20 011 717	20 010 479	20 010 479	21 196 760	21 439 161	22 095 691	5,9
Goods and services	7 589 769	7 543 539	7 528 082	8 156 672	8 356 874	8 245 924	8 531 178	8 698 847	9 370 436	3,5
Interest and rent on land	4 684	38 887	19 215	–	–	–	–	–	–	
Transfers and subsidies to:	**332 597**	**519 529**	**520 844**	**352 565**	**456 230**	**567 180**	**311 256**	**416 825**	**435 582**	**(45,1)**
Provinces and municipalities	–	–	–	–	–	–	–	–	–	
Departmental agencies and accounts	13 075	16 866	14 721	14 401	14 401	14 401	14 886	21 867	22 851	3,4
Higher education institutions	–	–	–	–	–	–	–	–	–	
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–	
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–	
Non-profit institutions	–	26 528	35 450	35 942	35 942	35 942	17 892	29 874	31 218	(50,2)
Households	319 522	476 135	470 673	302 222	405 887	516 837	278 478	365 084	381 513	(46,1)
Payments for capital assets	**1 171 742**	**1 301 665**	**1 106 521**	**1 585 889**	**1 483 260**	**1 483 260**	**1 613 488**	**1 472 132**	**1 497 458**	**8,8**
Buildings and other fixed structures	575 252	461 114	352 588	602 057	683 004	683 004	795 925	742 725	715 119	16,5
Machinery and equipment	596 490	840 551	753 933	983 832	800 256	800 256	817 562	729 407	782 339	2,2
Heritage Assets	–	–	–	–	–	–	–	–	–	
Specialised military assets	–	–	–	–	–	–	–	–	–	
Biological assets	–	–	–	–	–	–	–	–	–	
Land and sub-soil assets	–	–	–	–	–	–	–	–	–	
Software and other intangible assets	–	–	–	–	–	–	–	–	–	
Payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**27 578 729**	**28 116 419**	**29 126 813**	**30 106 843**	**30 306 843**	**30 306 843**	**31 652 682**	**32 026 965**	**33 399 167**	**4,4**

Table 8 above shows the summary of payments and estimates by economic classification. Compensation of Employees shows an increase of 5.9 per cent from R20.010 billion in 2024/25 to R21.196 billion in 2025/26 when compared to revised estimate due to additional funding for wage agreement.

Good and Services show a growth of 3.5 per cent from R8.245 billion in 2024/25 to R8.531 billion in 2025/26 when compared to the revised estimate due to additional allocation for strengthen medical records for the reduction of medico legal contingencies and funding for payables and accruals of non-negotiable items.

Transfers and subsidies show a negative growth of 45.1 per cent from R567.180 million in 2024/25 to R311.256 million in 2025/26 due to high revised estimate emanating from the payment of medico legal claims in 2024/25.

Payments for capital assets show a growth of 8.8 per cent from R1.483 billion to R1.613 billion when compared to the 2024/25 revised estimate due to additional allocation on Health Facilities Revitalisation Grant for the benefit of Buildings and other fixed structures projects particularly the upgrades and additions of the Oncology Building at Nelson Mandela Academic Hospital.

Compensation of Employees shows an increase of 5.9 per cent from R20.010 billion 2024/25 revised estimate to R21.187 billion in 2025/26 budget allocations.

Good and services show a positive growth of 1.4 per cent from R8.156 billion in 2024/25 to R8.271 billion in 2025/26 when compared to the revised estimate. A further growth is expected in 2026/27 and 2027/28 due to medicine to cater for dollar/exchange rate and cost pressures on medical supplies, fleet and diesel for non-exempted facilities.

Transfers and subsidies show a negative growth of 4.3 per cent from R352.565 million to R337.494 million when compared to the 2024/25 revised estimate due to high revised estimate as a result of payment of medico legal claims. In 2026/27 and 2027/28, the department received additional allocation for the payment of medico legal claims.

Payments for capital assets show a negative growth of 6.5 per cent from R1.585 billion to R1.483 billion when compared to the 2024/25 revised estimate due to additional allocation on the NTSG and Health Facility Revitalisation Grant.

Province of the
EASTERN CAPE
HEALTH

PART C

MEASURING OUR PERFORMANCE

STRATEGIC PLAN 2025/26 – 2029/30

PART C – MEASURING OUR PERFORMANCE

9. Institutional Performance Information

9.1 Measuring the Impact

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

9.2 Measuring Our Outcomes

Table 9: Outcome indicators

Medium Term Development Plan Priority		Reduce poverty and tackle high cost of living	
Outcomes	**Indicators**	**Baseline 2023/24**	**Five-year targets 2025/30**
1. Maternal Mortality Ratio reduced	1.1 Maternal Mortality ratio (per 100 000 live births)	136.2 / 100 000 live births	<100/100 000 live births
	1.2 Delivery in 10-19 years in facility rate	18%	15%
2. Neonatal deaths (0-28 days) in Facility rate reduced	2.1 Neonatal (0-28 days) in facility rate (neonatal deaths as a proportion of live births)	15.1/1 000 live births	<10/1000 live births
3. Under 5 mortality rates reduced	3.1 Death under 5 years rate	2.3%	<2%
4. HIV/ AIDS related deaths reduced	4.1 Proportion of people living with HIV who know their status	New Indicator	95%
	4.2 Percentage people living with HIV on ART	New Indicator	95%
	4.3 Percentage of ART with viral suppression	New Indicator	95%
	4.1 ART death rate	2.6%	<2.5%
5. TB incidence reduced by 10%	5.1 TB incidence rate	692 per 100 000	600 per 100 000
6. TB Mortality reduced by 10%	6.1 All DS TB client treatment success rate	72%	85%
	6.2 All DS TB client death rate	6.2%	<6%
	6.3 TB pre-XDR death rate	19%	15%
7. Mortality due to NCDs reduced	7.1 Number of deaths due to NCDs	18 896	17 951
	7.2 Cervical Cancer screening rate	New indicator	49%
8. Mental Health Care Integrated into Primary health care	8.1 PHC mental health condition treatment rate new	0.03%	0.3%
9. Malaria related deaths reduced	9.1 Malaria deaths reported	0	0

Medium Term Development Plan Priority		Reduce poverty and tackle high cost of living	
Outcomes	**Indicators**	**Baseline 2023/24**	**Five-year targets 2025/30**
10. Financial Management strengthened in the health sector	10.1 Audit opinion of Provincial DoH	Qualified	Unqualified
11. Improved Patient Experience of Care	11.1 Patient Satisfaction Rate	86%	90%
12. Quality of health services improved	12.1 Human Resource Plan approved	New indicator	Approved Human Resource Plan
	12.2 Reduction in contingent liability of medico -legal claims	R23,857bn	R15,654bn
	12.3 % health facilities with connectivity	32%	80%
	12.4 Ideal health facility status obtained rate	63%	85%
	12.5 % of health facilities with completed infrastructure projects	67%	80%
	12.6 Life expectancy at birth	58.7 years	70 years and above

9.3. EXPLANATION OF PLANNED PERFORMANCE OVER THE FIVE-YEAR PLANNING PERIOD

Nine outcomes have been identified to address the quadruple burden of diseases.

Maternal, Neonatal and Child health

The maternal mortality rate is a key indicator for Goal 3 of the SDGs with a global target of fewer than 70 maternal deaths for every 100 000 live births by the year 2030. There has been a decline in the provincial maternal mortality in facility ratio since 2020, however, it is still higher than the national average. Among the interventions planned is the prevention of unwanted teenage pregnancies. The Province will continue to implement and upscale interventions like Essential Steps in Managing Obstetric Emergencies (ESMOE), Basic Antenatal Care (BANC) and K2 trainings.

Currently the leading causes of maternal deaths as per the recent audited report include HIV and TB. To address this challenge there is an increased effort to screen all women of reproductive age at a community and facility level to boost early booking of pregnant women before 20 weeks. The Province has clustered district hospitals to conduct safe caesarean sections to assist with resource sharing, and reduction of distances travelled by inter-facility obstetric ambulances to reduce mortalities.

Furthermore, the following interventions are planned for the next five years:

- Improving and maintaining effective clinical skills levels through structured skills training and mentoring and
- Proper placement and retention of competent clinical staff.

- The Department will link interventions to strong clinical accountability and governance through the District Clinical Specialist Teams
- Coordination and strengthening of clinical interventions through Clinical Governance at all levels of care and leverage usage of limited resources.

The Province is planning to increase access to neonatal units to reduce overcrowding in the existing units and also strengthen outreach services by neonatologists and neonatal nurses. There is equipment that has been procured to boost functioning of neonatal units. Helping Babies Breathe (HBB) project.

The Province is establishing Youth Zones in health facilities to improve the appeal of Sexual Reproductive Health services to the youth. The department is currently working with United Nations Population Fund Agency (UNFPA) and Beyond Zero a Non-Governmental Organisations (NGO) to improve sexual reproductive health services and to revive the Nzululwazi project in Alfred Nzo District.

In an effort to reduce under five child mortality rate, Expanded Programme on Immunisation (EPI) catch-up drives are conducted to improve immunisation coverage. Cold Chain Management will continue to be improved by ensuring proper storage of available vaccines through the procurement of specialised vaccination refrigerators and continuous temperature monitoring devices. Integration of EPI and HIV is implemented in the facilities to improve management of children on antiretroviral treatment.

The department will continue facilitating Integrated Management of Childhood Illnesses (IMCI) and Integrated Management of Children with Acute Malnutrition (IMAM) training to reduce child mortality rate. To address social determinants of health associated with malnutrition and diarrhoea, inter-sectoral collaboration will be strengthened through cluster system of government and Inter-Governmental Relations (IGR) architecture.

The child malnutrition incident rate in the Province compelled South Africa Human Rights Commission (SAHRC) to hold an enquiry in order to establish causes and the role of various departments in reducing and managing child malnutrition.

The inter-sectoral collaboration through the provincial integrated planning is critical in addressing social determinants of health associated with child malnutrition. Currently, Department of Social Development is coordinating all relevant sector departments to address the underlying causes of food insecurity and poverty, through antipoverty and mother-child development programmes.

There are also health education activities covering important elements (nutrition in pregnancy, hygiene, handwashing, breastfeeding and infant feeding) which influence the adoption of healthy practices. In the Eastern Cape, teenage pregnancy and HIV infection contribute to the exclusive breastfeeding rate that is consistently below 50% which is a target set by the World Health Organisation (WHO). The Mother Baby Friendly Initiative (MBFI) programme will be strengthened to improve breastfeeding rates to reduce child malnutrition. There is strong scientific evidence confirming breastfeeding as a cost-saving intervention to reduce under-five child mortality rate.

HIV/AIDS and TB

- In the next five years, the plan focuses on upscaling five pillars: Communicate and Advocate; Find and Link; Treat and Retain; Prevent and Prepare; Monitor and Assess to achieve the 95-95-95 targets. 1st 95: Scaling up implementation of the case-finding strategies for TB, HIV and STIs to close the minor gap by implementing Operation Phuthuma and TB Recovery Plan, the programme will ensure that demand creation takes place through communication and advocacy; intensify finding the missing TB and HIV cases through screening in health facilities and communities (TB health-check, HIV self-screening, and digital chest x-ray) and link them to care.

- 2nd 95: The focus is to have 95% of people with confirmed drug-susceptible TB (DS-TB) initiated on treatment, whether confirmed clinically or bacteriologically. For multidrug-resistant TB (MDR), Bedaquilline, Pretonamide, Lenozinade and Levofloxacin (BPAL-L) have been introduced as the shortened 6 months regimen following the successful study conducted in Nelson Mandela Metro and Buffalo City Metro. For the HIV programme, Universal Test and Treatment (UTT) have been promoted the practice and further anchored by the Undetectable = Untransmittable (U=U) campaign to encourage treatment uptake and retention.

- 3rd 95: The province will strengthen intervention to ensure good treatment outcomes for both TB and HIV that will achieve 95% treatment success. Treatment success will be monitored by strengthening the management of viral load and sputum tests at scheduled intervals in line with the guidelines. Patients on ART who are treated successfully, with suppressed viral load will be enrolled into Differentiated Models of Care (DMOC), to collect their medication either in a Facility Pick-up Point, Community Pick-up Point or Adherence Clubs. This intends to reduce the facility congestion where stable patients can access their medication outside the facilities.

In partnership with Department of Justice, the Department has Thuthuzela care centres located in various hospitals to offer support for survivors of Sexual and Gender Based Violence. The Department offers medical examination and evidence collection, trauma counselling and psychosocial support, treatment and post exposure prophylaxis.

Non-Communicable Diseases (NCDs) and Mental Health

The Province has lifted Non-Communicable Diseases and Mental Health as the priority among the nine Key Integration Areas (KIAs). The National Strategy on Prevention and Control of NCDs 2022-2027, introduced an NCD cascade of 90, 60 50 for hypertension and diabetes:

- 90% of all people 18 years and over will know whether or not they have raised blood pressure and /or raised blood glucose;
- 60% of people with raised blood pressure or blood glucose will receive intervention.
- 50% of people receiving interventions are controlled.

The Province strives to achieve NCD cascade targets of 60, 50, and 50 in the next 5 years.

In light of the National Health Insurance Policy, a PHC level is the first point of contact or entry with the health system and it is key in ensuring health system sustainability. Community-Based Mental Health is a priority for the next term, coupled with increasing access to 72-hour mental health observations in district hospitals increase access to community-based mental health services. Strengthen inter sectoral collaboration in mental health care. Re-evaluate and redesign the referral pathways to cover the currently neglected areas on the eastern side of the Eastern Cape (Alfred Nzo and OR Tambo districts).

Emergency Medical Services

The emergency medical services continue to be under tremendous pressure in the Province. The EMS call centres receive over a million calls annually requesting ambulances. Of this number, 20% are categorized as priority 1, which means they are very critical; and any delay could lead to medical complications or loss of lives, in some cases. They receive urgent attention, even if received after other lower priority calls have been waiting in the queue.

The Department will endeavour to get to the scene of the call in less than 30 minutes in urban areas and under 60 minutes in rural areas. Over the past financial year, we have managed to achieve these target times in 55% of calls in urban areas and in 65% of these calls in rural areas, respectively.

The major challenges include the state of the road infrastructure in rural areas and the impact of rains and other natural events on access to certain communities. Our sister department of transport is seized with this task of addressing the condition of our roads.

The next financial year will see further improvements in our response times to life threatening events. We are making improvements in our service by recruiting registered paramedics, especially for rural areas, within available budgets. This will ensure that highly skilled personnel are deployed to the scene quickly to stabilize complex emergency cases. The Department will incrementally increase the number of ambulance fleet and the personnel to improve access to health care by local communities.

Rehabilitation Services

There is a notable increase in the number of people seeking assistive devices, due to their level of disability. The increase is linked to the prevalence of non-communicable diseases including diabetes, as well as the cases of trauma and injury that lead to disability. We are appealing to motorists to drive responsibly on our roads because these have a ripple effect on the healthcare system in the long run. The available resources far exceed the demand hence the Department is actively inviting partners in the corporate and Non-Government Organisation (NGO) sectors to assist in servicing more clients.

Over the medium term, the Department has plans to introduce the latest technology to orthotic and prosthetic services. These technologies include the use of a direct socket system that enables same day fabrication and fitting of a prosthesis. This will reduce the waiting time, and the level of effort involved in, the manufacturing of prosthesis. Secondly, the department plans to introduce 3-D foot scan and milling, a digital machine that manufactures foot orthoses in 20 minutes. Currently the average waiting time for a foot orthosis is 4 weeks from the date when foot impressions have been taken.

ICT

Over the next five years, the HMS² system will undergo continuous expansion to all hospitals within the province, ensuring that every facility benefits from its advanced healthcare management capabilities. The rollout will prioritise high-traffic hospitals first, highly litigated facilities, followed by district and rural facilities, ensuring equitable access to streamlined patient management, digital records, and improved operational efficiency. Additionally, ongoing user training and system enhancements will be key focus areas, ensuring that healthcare professionals can maximise the benefits of the system while adapting to evolving healthcare needs. Continuous refinement of reporting and analytics features will further support data-driven decision-making at both hospital and provincial levels. A key priority will also be the strengthening of the Eastern Cape Department of Health's (ECDoH) internal capacity to become self-sustainable in system implementation, as well as in the effective use of business intelligence and artificial intelligence for enhanced decision-making and operational efficiencies.

A critical component of HMS²'s five-year plan will be its close collaboration and integration within the National Health Insurance (NHI) ecosystem. This includes aligning with NHI's digital health strategy to enable seamless data exchange, improving patient referral management, and ensuring interoperability with national health databases. Efforts will also be made to integrate HMS² with other critical healthcare technologies, such as telemedicine platforms and eHealth solutions, to enhance service delivery. Cybersecurity and data protection will remain top priorities, ensuring that patient information remains secure while complying with regulatory standards. By fostering strong partnerships with stakeholders, including hospital administrators, policymakers, and technology providers, HMS² will continue to evolve into a robust, future-ready healthcare management solution.

Teaching and Training

Lilitha College of Nursing in the next five-year Strategic Period years to Develop speciality nurses (Post Graduate level) as aligned with NQF to be responsive to priority service delivery needs. Establish a digitized education and training platform by acquisition of the Learner Management System (LMS). Enhance an academic training platform through infrastructure and teaching and learning technology improvements. Develop capacity of academic and key support staff in alignment with the transitional fundamentals of Higher Education bend. Strengthen partnerships with key stakeholders in Higher Education Institutions, Clinical Practice Institutions and Social Partners. Align College governance structures with Higher Education legislation.

Our province continues to be challenged by delays in the accreditation of academic institutions and programmes by Council for Higher Education (CHE) and the South African Qualifications Authority (SAQA). This affects our public colleges and universities alike - Nelson Mandela University (NMU), Walter Sisulu University (WSU), Lilitha Nursing College, and Eastern Cape College of Emergency Care (ECCOEC).

The delays put the production pipeline of certain critical health professional categories at risk. The Department will continue to engage with these bodies, supported by the National Department of Health. The

Department will strengthen Academic Governance Committees (AGCs) functionality with WSU, NMU, UFH and Rhodes to ensure the teaching and training platform is conducive and effective.

Research and Public Health Surveillance

The Eastern Cape Province has borne the brunt of both biological and natural disasters over the past three years. This has been evidenced by morbidity and mortality arising from COVID - 19 and the recent floods. It has therefore become more evident, subsequent to intra-action reviews, that our province will need to be better prepared in dealing with similar threats going forward. We realise from the International Health Regulations (2005) [IHR (2005)] that it is important for us as a province and collectively as a country to utilize the relevant tools to:

- Undertake a comprehensive all hazard risk assessment (using the WHO Strategic Tool for Assessing Risk (STAR), and
- Establish a Public Health Emergency Operating Centre (PHEOC) to prevent and respond to public health emergencies.
- To implement Integrated Diseases Surveillance and Response (IDSR) and strengthen Provincial and Districts Outbreak Response Teams.
- To strengthen Field Epidemiology Training Programme (FETP) and Systems Analysis Improvement Approach (SAIA) – TB

The Department is strengthening clinical and public health research platform to increase research productivity in terms of reports, policy briefs and publications in accredited journals and graduate many postgraduate students especially medical registrars, advanced nurses etc to increase specialist skills availability in the province. The Department is also expanding the clinical trials studies that attract local and international companies and universities to invest in the provincial economy, transfer skills and create employment opportunities whilst expanding their skills base.

11 Key Risks

Table 10: Key Risks and mitigating factors

Outcome	Risk	Mitigating factors
• Maternal Mortality in Facility Ratio reduced	• High Maternal and Perinatal Mortality Rate	• Implementation of the quarterly community mobilisation and education in each district. • Establish rehabilitation units for cerebral palsy children in priority hospitals to improve the quality of life. • Implementation of prioritised Annual Recruitment Plan to fill vacant positions. • Conduct monitoring support visits at health facilities to address service gaps and further conduct continuously

Outcome	Risk	Mitigating factors
		trends analysis of reports.
• Neonatal deaths (0-28 days) in facility rate reduced	• High Neonatal Mortality	• Revive & strengthen District hospitals Neonatal Units by increasing resources and training opportunities).
• Death under 5 years against live birth rate reduced	• High Child Mortality Rate	• Continuous training and capacitation of personnel on Child Health Policy Guidelines. • Implement Child Health Identification Programme (CHIP) at all hospitals (inclusive of PHC personnel) • Strengthen the implementation of Expanded Programme on Immunisation (EPI) catch-up campaigns in all affected districts.
• HIV/ AIDS related deaths reduced • Malaria related deaths reduced • TB incidence reduced by 10% • TB Mortality reduced by 10%	• Non adherence to National Guidelines and Policies on communicable diseases (Management of TB, HIV&AIDS, STI, Measles and Malaria)	• Conduct HAST awareness campaigns and roadshows in all districts/metros. • Conduct a comprehensive training of HAST Programmes for the Ward-Based PHC Outreach Teams. • Enforce compliance with policies, procedures and Standard Operating Procedures (SOPs) strengthened operations management. • Twelve decentralised sites to be converted to fully fledged MDR sites with the necessary resources.
• Quality of health services improved	• Exposure of the Health System and Patient Management outcomes to undue burden (i.e. Treatment failures, Loss to follow-up, High death rate, Containment of the allocated budget, Increased adverse events, Litigations against the Department)	• Enforce compliance with policies, procedures and Standard Operating Procedures (SOPs) strengthened operations management.
• Mortality due to NCDs reduced	• Challenges with Prevention, Early Detection and Management of Non-Communicable and Chronic Diseases	• Enforce implementation of NCDs policies through supervision by Clinic Supervisors and Operational Managers at all facilities. • Implement continuous in-service trainings for staff on management of chronic diseases.

Outcome	Risk	Mitigating factors
• Quality of health services improved • Improved Patient Experience of Care	• Inadequate Primary Health Care Services.	• Increase the number of Ward-Based Outreach Teams for hard-to-reach areas. • Expand the number of Mobile Clinics to reach farming and hard to reach communities. • Increase the Central Chronic Medicine Dispensing and Distribution pick up points (sites) throughout the province. • Expand the implementation of Health Patient Registration System (HPRS). • Filling of vacant funded posts. • Strengthen and coordinate the implementation of the referral policy / protocols. • Strengthen the Quality Improvement Plan (QIP) • Continuous Implementation of the Ideal Clinic Realisation and Maintenance (ICRM).
• Financial Management strengthened in the health sector	• Perpetration of Fraudulent and Corrupt Activities.	• Continued Improvement of Consequence Management. • - Enforce compliance with the Policies, Procedures and SOPs.
• Quality of health services improved	• Inadequate provision of ICT (Information Communication Technology) Services to support service delivery (poor connectivity, Cyber/ Hacking, data backup and integrity)	• Influence the prioritisation of the connectivity of Health Institutions with OTP
• Quality of health services improved	• Inadequate provision of Human Resource Services	• Leverage financial resources through implementation of Committed OverTime (COT) policy effectively. • Fund Annual Recruitment Plan through savings from COT. • Full Implementation of migration plan and its terms of reference • Consultation with the relevant stakeholders. • Ensure correct implementation of the organogram
• Quality of health services improved	• Increased Litigation • Inadequate provision of Infrastructure services	• Conduct District Training on legal strategies, compliance and awareness on the impact of Medico legal claims • Linking Management of Adverse Events

Outcome	Risk	Mitigating factors
		with Litigation prevention strategies • Appointment of paralegal secretaries for deployment at districts and the targeted highly litigated facilities. • Contracting of Medico legal expert firms to defend the cases in court. • Strengthen and monitor compliance to the terms of the existing contracts and Service Level Agreements (SLAs). • Update / Review of the SLAs between ECDOH and Implementing Agents to include the previous omitted stages i.e. Communication Stage, IDMS Stages. • Gradually handover some of the maintenance functions to DPW.
• Quality of health services improved	• Lack of leadership in coordination of Primary Health Care Services at sub district level	• Filing of funded strategic posts in the Annual Recruitment Plan (ARP). • Conduct monitoring support visits to districts and facilities quarterly.

10. Public Entities

None

Province of the
EASTERN CAPE
HEALTH

PART D

TECHNICAL INDICATOR DESCRIPTION (TID)

STRATEGIC PLAN 2025/26 – 2029/30

PART D: TECHNICAL INDICATOR DESCRIPTION (TID)

Table 11: Technical Indicator Description for Strategic Plan Indicators

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
1.1 Maternal Mortality ratio - Per 100 000 live births	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 100,000 live births in facility	PHC Comprehensive Tick Register Ward; Tick register OPD delivery and ICU Register, Midnight census	Maternal death in facility	Live births known to facility Hospitals] **Formula:** Live births in facility + Born alive before arrival in facility	Accuracy dependent on quality of data submitted by health facilities	Females	All Districts	Lower ratios	MCW&H Programme Manager
1.2 Delivery in 10-19 years in facility rate	Delivery where the mother is 10-19 years old. These deliveries are done in facilities under the supervision of trained medical/nursing	Birth Register	Number Delivery 10-19 years in facility	Not applicable	Accuracy dependent on quality of data submitted by health facilities	Females	All Districts	Lower	MCW&H Programme Manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
	staff								
2.1 Neonatal (0-28 days) in facility rate (neonatal deaths as a proportion of live births)	Infants 0-28 days who died during their stay in the facility per 1000 live births in facility.	Midnight Census, Inpatient sick neonatal admission register (ISNAR), Birth Register, Paeds Register	Neonatal deaths (under 28 days) in facility **Formula:** Death in facility 0-6 days] + [Death in facility 7-28 days	Live birth in facility	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Lower rate	MCW&H Programme Manager
3.1 Death under 5 years rate	Children under 5 years who died during their stay in the facility as a proportion of all live births	Midnight Census, Inpatient sick neonatal admission register (ISNAR), Birth Register, Paeds Register	Death in facility under 5 years total **Formula:** Death in facility 0-6 days + Death in facility 7-28 days + Death in facility 29 days - 11 months + Death in facility 12-59 months	Live birth in facility	Accuracy dependent on quality of data submitted by health facilities	Children under 5 years	All Districts	Lower rate	MCW&H Programme Manager
4.1 Proportion of people living	Estimated number of people living with	Tembisa model	Number of people tested	Estimated number of	Accuracy dependent on	Not applicable	All Districts	Higher	HIV/ AIDS Programme

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
with HIV who know their status	HIV who have been diagnosed		HIV positive	people living with HIV	quality data				manager
4.2 Percentage people living with HIV on ART	Proportion of HIV known clients started ART treatment against those who tested positive	DHIS	Clients start on ART during the period	Client HIV test positive	Accuracy dependent on quality data	Not applicable	All Districts	Higher ART Uptake	HIV/ AIDS Programme manager
4.3 Percentage of ART with viral suppression	Proportion of clients with viral load below 1000 copies per mil	DHIS	Number of clients with viral load below 1000 copies per mil at 12 months	Clients started ART 12 months ago	Accuracy dependent on quality data	Not applicable	All Districts	Higher Viral load suppression	HIV/ AIDS Programme manager
4.4 ART death rate	ART cumulative death - total as a proportion of ART start minus cumulative transfer out	HTS Register (HIV Testing Services) or HTS module in TIER.Net; Publications: StatsSA, Causes of Death Report	ART cumulative death - total	ART start minus cumulative transfer out	Accuracy dependant on Individuals self-reporting HIV-positive status and/or individuals with detectable ART metabolites among all PLHIV (antibody test)	All	All Districts	Lower incident rate	HIV/ AIDS Programme manager
5.1 TB incidence rate	TB Incidence reduced	NICD TB Surveillance	Number of new TB cases	Population per 100 000	Accuracy dependent on	All	All Districts	Lower number of	TB Programme Manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
		Report	in a given year		quality of data submitted by health facilities			incidence	
6.1 All DS TB client treatment success rate	All TB clients who started drug susceptible tuberculosis (DS TB) treatment and subsequently successfully completed treatment as a proportion of all those who started DS-TB treatment	Clinical stationery	All TB client successfully completed treatment **Formula:** Count of all DS -TB clients successfully completed treatment	All DS TB Treatment Start **Formula:** Count of all DS-TB treatment start	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Higher	TB Programme Manager
6.2 All DS TB client death rate	ALL TB clients who started drug-susceptible tuberculosis (DS-TB) treatment and subsequently died as a proportion of all those who started DS TB treatment	Frequent data monitoring: EDR Web; TIER.Net; DHIS; StatsSA, Publications: Causes of Death Reports	All DS-TB client death	All DS TB treatment start	Accuracy dependent on quality of data submitted by health facilities	All	All Districts	Lower number of deaths	TB Programme Manager
6.3 TB pre-XDR death rate	TB Pre-XDR clients who died during treatment as a proportion of TB Pre-XDR clients	Frequent data monitoring: EDR Web; TIER.Net; DHIS; StatsSA, Publications:	TB Pre-XDR clients who died	TB Pre-XDR clients started on treatment	Accuracy dependent on quality of data submitted by health facilities	All	All Districts	Lower	TB Programme Manager

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
	who started on treatment	Causes of Death Reports							
7.1 Number of deaths due to NCDs	Number of deaths due to NCDs reduced	Publications: StatsSA, Causes of Death Reports	Number of deaths due to NCDs	Not applicable	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Lower number	Health programmes-Disease Prevention and Control Programme
7.2 Cervical Cancer screening rate	Cervical smears in women 30 years and older as a proportion of the female population 30-50 years (80% of these women should be screened for cervical cancer every 10 years and 20% must be screened every 3 years) which should be included in the denominator because it is estimated that 20% of women 20 years and older are HIV positive	PHC Comprehensive Tick Register; OPD tick register, Inpatient register	Cervical cancer screening done **Formula:** Cervical cancer screening in non-HIV woman 30-50 years + Cervical cancer screening in HIV positive woman 20 years and older	[(80% women aged 30-50yrs/10)+(20% women aged 20 years and above /3)	Accuracy dependent on quality of data submitted by health facilities	Women	All Districts	Higher Rate of Cervical Cancer Screening	
8.1 PHC mental health condition treatment rate new	Mental health care visits as proportion of total PHC plus OPD plus A&E	PHC Comprehensive tick register OPD headcount	Mental health visits- total (This was clients before	PHC plus OPD headcount – total **Formula:**	Accuracy dependent on quality of data submitted by	Not Applicable	All Districts	Higher	Health programmes

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
	headcount		but changed to exclude possibility that clients on register will be counted and to be in line with hypertension and diabetes case load definition)	PHC headcount under 5 years + PHC headcount 5-9 years] + PHC headcount 10-14 years] + PHC headcount 15-19 years + PHC headcount 20 years and older] + SUM[OPD headcount not referred new] + SUM[OPD headcount referred] + SUM[OPD headcount follow-up	health facilities				
9.1 Malaria deaths reported	Malaria deaths reported in South Africa. The death resulting from primary malaria diagnosis at the time of death	Malaria Information System	Malaria deaths reported	None	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Lower	Environmental Health- Malaria Program
10.1 Audit	Audit opinion for	Documented	Not	Not applicable	Not applicable	Not applicable	All districts	Unqualified	Finance

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
opinion of Provincial DoH	Provincial Departments of Health for financial performance	Evidence: Annual Report Auditor General's Report	applicable					Audit Opinion from the Auditor General	Manager
11.1 Patient Satisfaction Rate	Total number of Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	Patient Surveys	Patient Experience of Care survey satisfied responses	Patient Experience of Care survey total responses	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Higher	Quality Assurance Manager
12.1 Human Resource Plan approved	Approved Human Resource Plan for Health	Human Resource Plan	Human Resource Plan approved	Not applicable	Plan developed and approved	Not applicable	Not applicable	Higher	HRM manager
12.2 Reduction in contingent liability of medico -legal claims	Total rand value of the medico legal claims for all backlog cases that were on the case register as at 31 March 2024	Medico-legal case management system	Total rand value of the medico legal claims for all backlog cases that were on the case register as at 31 March 2024	Not Applicable	Accuracy dependent of reporting of data into the system	Not Applicable	All Districts	Lower	Legal Services
12.3 % health facilities with connectivity	Provision of health facilities with alternative connectivity or broad band	Rollout report (spreadsheets) for sites that are live or with alternative connectivity	Total Number of hospitals with minimum 2 Mbps and fixed PHC	Total Number of Hospitals and fixed PHC facilities	Depending on Provincial broadband Provision of departmental alternative connectivity	Not applicable	All districts	Higher	ICT Directorate / Chief Directorate

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
			facilities with minimum 1Mbps connectivity						
12.4 Ideal health facility status obtained rate	Health facilities that obtained Ideal status (bronze, silver, gold) as a proportion of fixed PHC clinics and CHCs and or CDC and or Hospitals	ICS	Health facilities have obtained Ideal status	Fixed PHC clinics or fixed CHCs and or CDCs and or hospitals	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Higher	Quality Assurance Manager
12.5 % of health facilities with completed infrastructure projects	Number of health facilities with completed capital infrastructure projects (i.e. Practical Completion or equivalent achieved for projects categorised as New & Replacement, Upgrade & Additions or Rehabilitation, Renovations & Refurbishments) expressed as a percentage of the number of health facilities planned to	Project Management Information System	Total number of health facilities with completed capital infrastructure projects i.e. Practical Completion Certificate (or equivalent) issued	Total number of health facilities planned to have completed capital infrastructure projects i.e. Practical Completion Certificate (or equivalent) planned to be issued	Project Management Information System is updated frequently and accurately	Not Applicable	All Districts	Higher percentage of Health facilities with completed capital infrastructure projects	Provincial Head of Infrastructure Unit

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
	have completed capital infrastructure projects.								
12.6 Life expectancy at birth	Average number of years that a newborn could expect to live	Stats SA	Average number of years	Not applicable	Depending on the environmental conditions at the time of birth	Not applicable	All Districts	Higher	Health Programmes

ANNEXURES TO THE STRATEGIC PLAN

ANNEXURE A: NSDF AND THE DISTRICT DELIVERY MODEL

Table 12: DDM Projects

#	Work Streams	Project Name	Project Description	Budget Programme Name	District	Latitude	Longitude	Budget 2025/26	Budget 2026/27	Budget 2027/28	Project Leader	Social Parter
1.	Capital Infrastructure	Upgrading of Zithulele District Hospital - Construction of the Main Hospital Complex and Staff Accommodation	Replacement of existing hospital to a Level 1 District Hospital - Services to include: • 157 Bed Inpatient Facilities • General Male & Female Wards • Obstetric & Basic Gynaecology Inpatient Care • Paediatric Care • Infectious diseases Unit • General Outpatient Services • 24hr Emergency Unit • Clinical Support Services • Rehabilitation and sub-acute services • Gateway Clinic • Staff Accommodation	District Hospital	OR Tambo	32.04918228000	29.06018109000	R108 750 000,00	R23 359 246,63	-	Manager Infrastructure	NDOH, ECDOH & COGTA
2.	Capital Infrastructure	Upgrading of Bambisana District Hospital - Construction of the Main	**Phase** 1-Clinical Services, Infectious Diseases and General Ward, Theatre, Maternity and Clinical Support • Staff Accommodation **Phase 2** – Paediatric Ward and Male General	District Hospital	OR Tambo	31,45045408000	29.45394919000	R 206 250 000,00	R40 901 644,93	-	Manager Infrastructure	NDOH, ECDOH & COGTA

#	Work Streams	Project Name	Project Description	Budget Programme Name	District	Latitude	Longitude	Budget 2025/26	Budget 2026/27	Budget 2027/28	Project Leader	Social Parter
		Hospital Complex and Staff Accommod ation	Ward Rehabilitation Unit Services Buildings (Laundry, Kitchen, Mortuary, Stores, Wo r k s hopand Waste Management									

CONCLUSION

This is the Final 2025/26 – 2029/30 Strategic Plan Document of the Department, which stands as a proposal to accelerate service delivery towards the achievement of its vision and mission. The department is committed to supporting districts, sub-districts and the facilities to deliver outcome-based results so that the impact is achieved.