PROVINCE OF THE EASTERN CAPE

DEPARTMENT OF HEALTH

STRATEGIC PLAN 2003/4

OVERVIEW BY MEC

In the past few years we have been through an exciting and challenging programme to transform the organs of state both mentally and physical so as to accelerate service delivery. The public health system has been transformed from a racially divided and fragmented system biased towards urban population into integrated comprehensive Primary Health Care responding to the needs of the people with particular bias towards historically disadvantaged communities.

The Province of Eastern Cape is an area of land that stretches from Umzimkhulu in the east to the Storms River in the west, measuring about 169,580 square kilometers. It constitutes 13% of the land surface of the Republic of South Africa and is the second largest province in the country. It serves a population of 7,130,480 with the following resources-:

- 92 Hospitals,
- 28 Community Health Centres, and
- 711 clinics.

The wideness and vastness often impacts on access to health care facilities for critically ill persons. Furthermore the province is still haunted by objective condition of two worlds in one with 64% of the population in rural areas facing conditions of poverty, illiteracy and lack medical facilities.

Whereas there are many challenges that we have had to face and noting that there are still many more, there are notable and tangible achievements, these includes :-

- Significant improvement in the hospital revitalization and rehabilitation programme

- Primary health Care objectives has taken off the ground with inroads being made in disease management and related health matters.

- Management and Administration of the Department has been significantly improved through a number of interventions including filling of critical posts, recruitment and appointment of suitable qualified personnel in all fields.

Noting that there are still many challenges ahead of us, the budget for 2003/2004 aims to improve on many areas e.g,

- Management of HIV /AIDS
- Retention of professional staff as well as
- Ensuring access to Health services

In line with the above, the total amount allocated for Health Service Delivery is R5,117,886,000, which reflects an increase in expenditure of 44% since 2000/01, and is therefore most significant.

SIGNED BY:

DR B.M. GOQWANA
MEC FOR HEALTH
DATE:

PART A

1. INTRODUCTION

I, Michael James Earle Fraser in my capacity as an acting accounting officer of the Eastern Cape Department of Health, herein submit this strategic plan for the year 2003 – 2006 to the Honourable Member of the Executive Committee for Health Dr. B.M. Goqwana. It is intended that this Strategic Plan, the In-Year Report, the Annual Report and the Budget Statement 2 will talk to one another. All efforts will be made to ensure implementation of this strategic plan.

2. OVERVIEW

The Department's Strategic Plan is informed by legislative or constitutional mandates and aligned to the Ten Point Plan of the National Department of Health, the Batho Pele Principles, the Eastern Cape Provincial Government Strategic Plan, and the Strategic Position Statement of the Eastern Cape Department of Health.

The plan is set to provide strategic direction and inform all operational and tactical plans of the Department of Health. An annual review of the plan will be conducted as a monitoring mechanism and as an aid in determining the relevance of previously identified health priorities within the context of changing demographic, political and socio-economic conditions. The strategic review also entails scrutinizing budget realities and ensuring integration of human resource planning into the overall organizational planning.

This year's strategic plan aims at reshaping health delivery in the province in line with the Strategic Position Statement where affordability and sustainability guide the planning and implementation processes.

This province serves a population of 7,130,480 with the following resources:

FACILITIES	NUMBER
Hospitals	
Provincial/Regional Hospitals	10
Psychiatric Hospitals	5
District Hospitals	47
Provincial Aided	18
Life Care managed hospitals	4
SANTA Hospitals	8
Sub-total	92
Clinics and CHCs	
Community Health Centres	28
Clinics	711

The historical service configuration is not the most optimal for the population and the new demarcation of boundaries. Future service planning would ensure a configuration that addresses access to previously least serviced areas

(former Transkei area), and ensures efficiency. This issue needs resources for service and human resource capacity improvement.

3. VISION

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

4. MISION

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

5. VALUES

The Department formulated a policy to ensure that all its residents have access to essential health services. The policy encapsulated the following VALUES:

- Equity of both distribution and quality of services
- Service excellence including customer satisfaction
- Fair labour practices
- Good work ethic and a high degree of accountability
- Transparency demonstrated through consultations with all stakeholders in the health industry/field

SIGNED:

ACTING SUPERINITENDENT GENERAL
DATE:

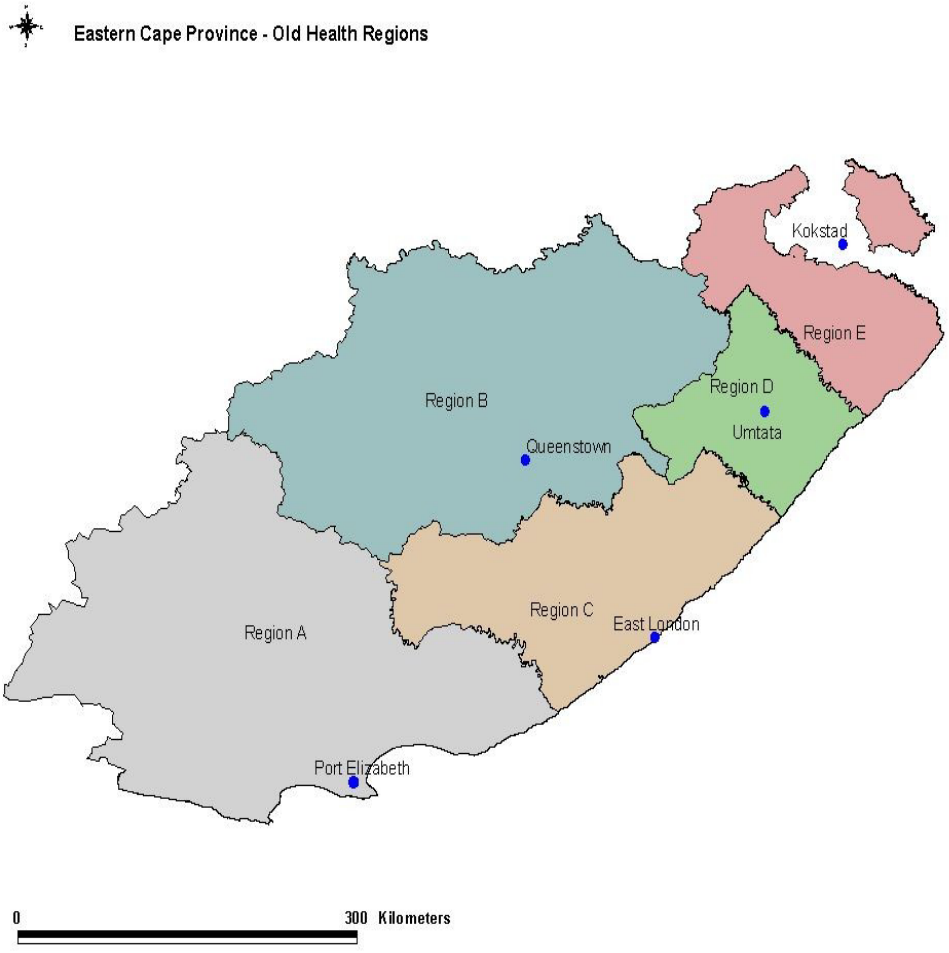
6. SECTORAL SITUATIONAL ANALYSIS

6.1 SIZE OF THE PROVINCE

The Province of the Eastern Cape is an area of land that stretches from Umzimkhulu in the East to the **Storms** river in the west, measuring about 169,580 square kilometres. It constitutes 13.9% of the land surface of the Republic of South Africa and is the 2nd largest province in the country.

There has been a shift in the boundaries of the province from the 5 regions during the transition period to district municipalities and health sub-districts in line with the Local Government demarcation. The maps below clearly depict the situation.

Figure 1 :Map showing the old Eastern Cape boundaries during the transition period.



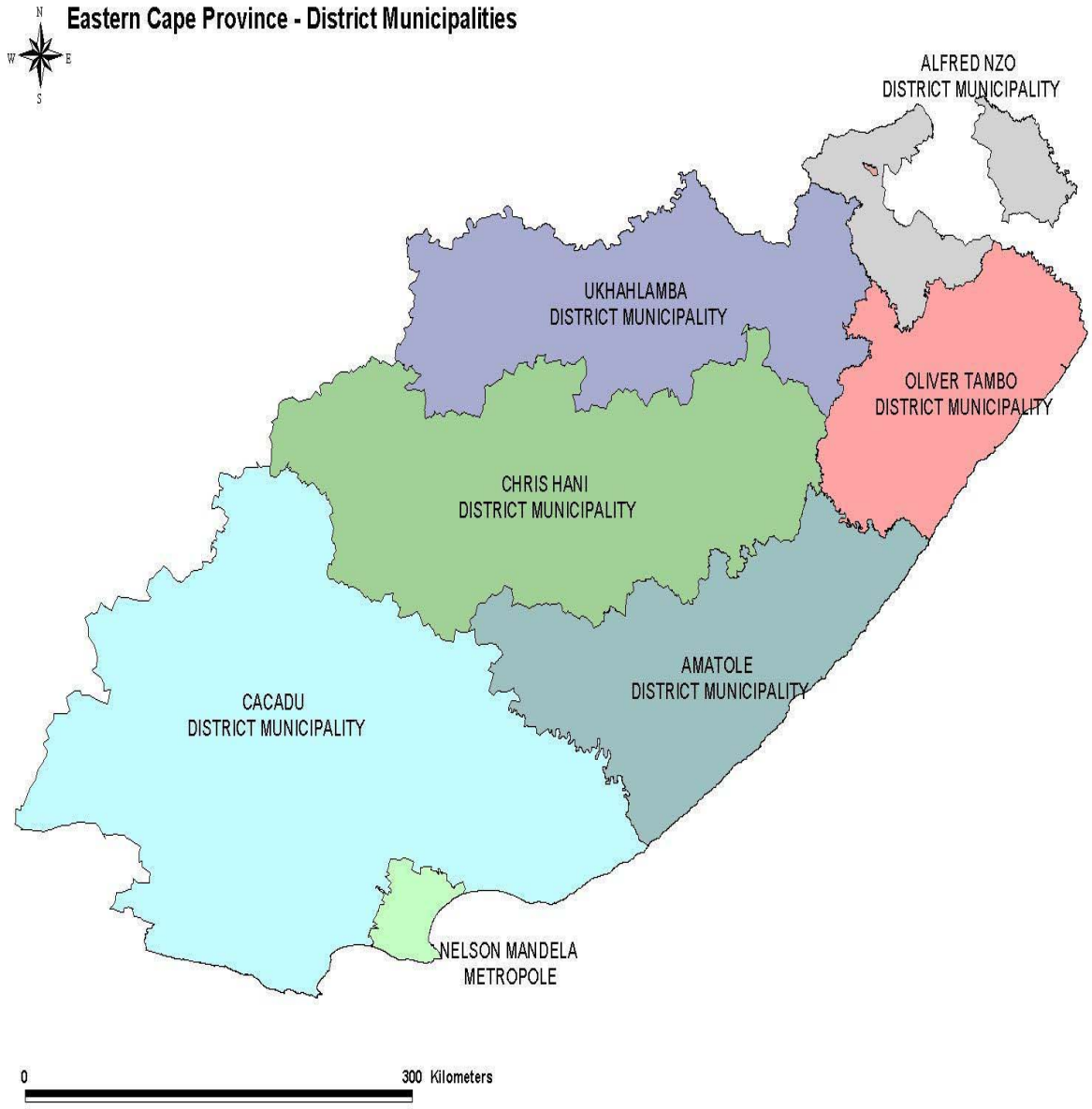


Figure 2 :Map showing the 6 district Municipalities and the Nelson Mandela Metropole.

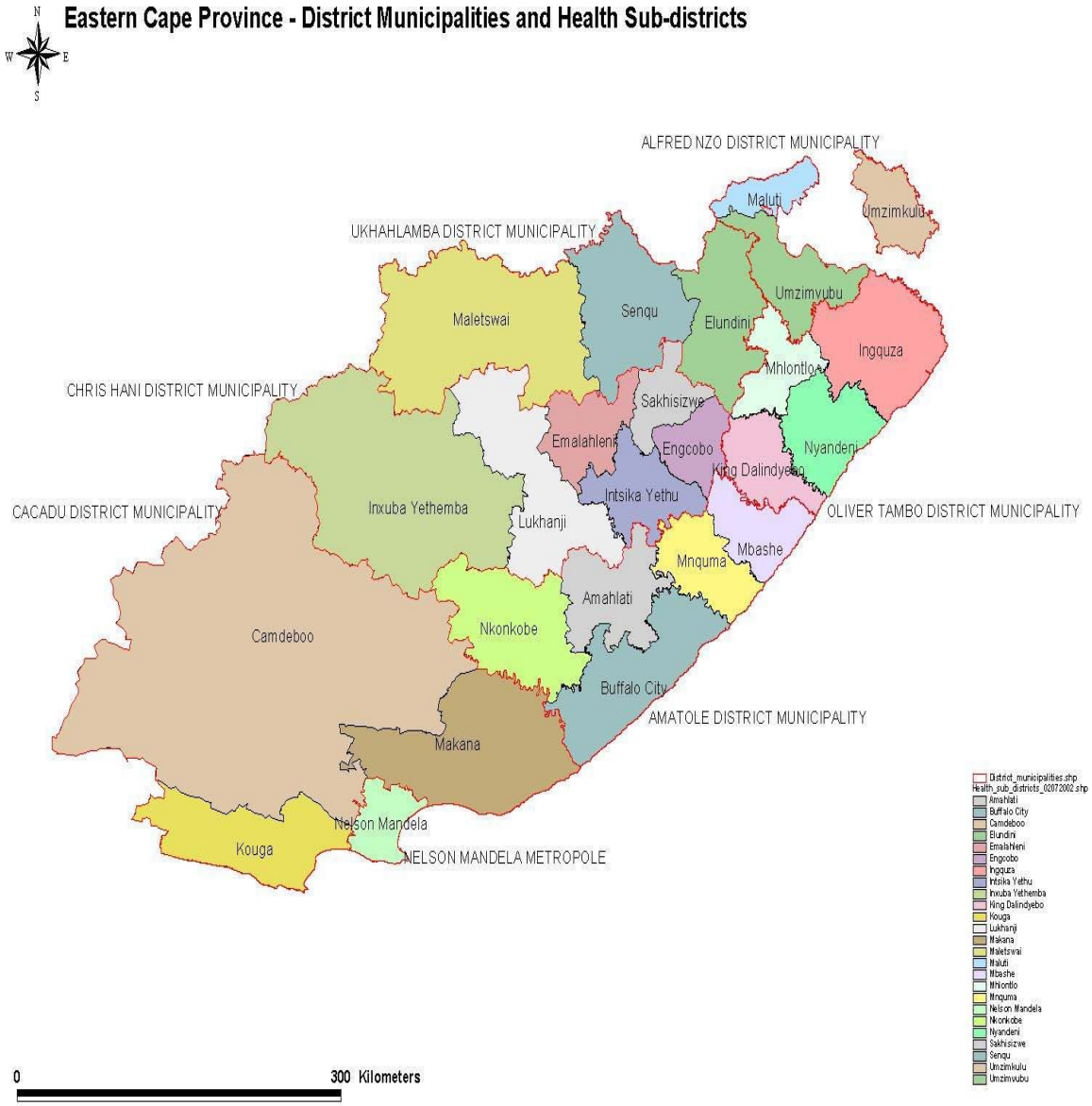


Figure 3 :Map showing the 25 Health Sub-districts. The last 2 maps are in-line with the local government.

6.2 POPULATION

The EC has a population of approx. 6,302,525 million based on the 1996 census and comprising of the following population groups.

Table 1: Population by Racial distribution

RACIAL GROUP	NUMBER	%
African	5,448,495	86
Coloured	468,532	7.4
Indian	19,356	.3
White	330,294	5.2
Unspecified	35,849	.6
TOTAL	6,302,525	100%

Source: Population census 1996

- Population distribution: Urban : 36.6%

  Rural : 63.4%

The national average on urban population is 54%. The majority of the province's people of which 86.4% are black, reside in the former homelands where poor infrastructure is reflected in poor health indicators.

Table 2 : Population by health district

HEALTH DISTRICT	NUMBER	%	SQ KM	%	DENSITY
Alfred Nzo	614,973	8.6	8138.20	4.79	78.14
Amatole	1,877,565	26.3	23577.10	13.9	79.64
Cacadu	418,950	5.9	58244.00	34.3	7.19
Chris Hani	929,514	13	36963.70	21.8	25.15
N Mandela	1,097,248	15.4	1952.20	1.2	562.05
O R Tambo	1,820,547	25.5	15946	9.4	114.16
Ukhahlamba	371,616	5.2	26401.20	15.6	14.63
EC	7,130,480	100	169,580	100	41.95

Source: Stats SA Mid-Year Population Estimates 2002

EC has an average population density of 41.95 per square km, with 2/3 of the population residing in less than 1/3 of the province's total area that is in the Eastern side of the province at OR Tambo and Alfred Nzo district municipalities following the old homeland distribution. This information has significance in future planning of service delivery as bringing services to the people is paramount.

6.2.1 Population by age distribution

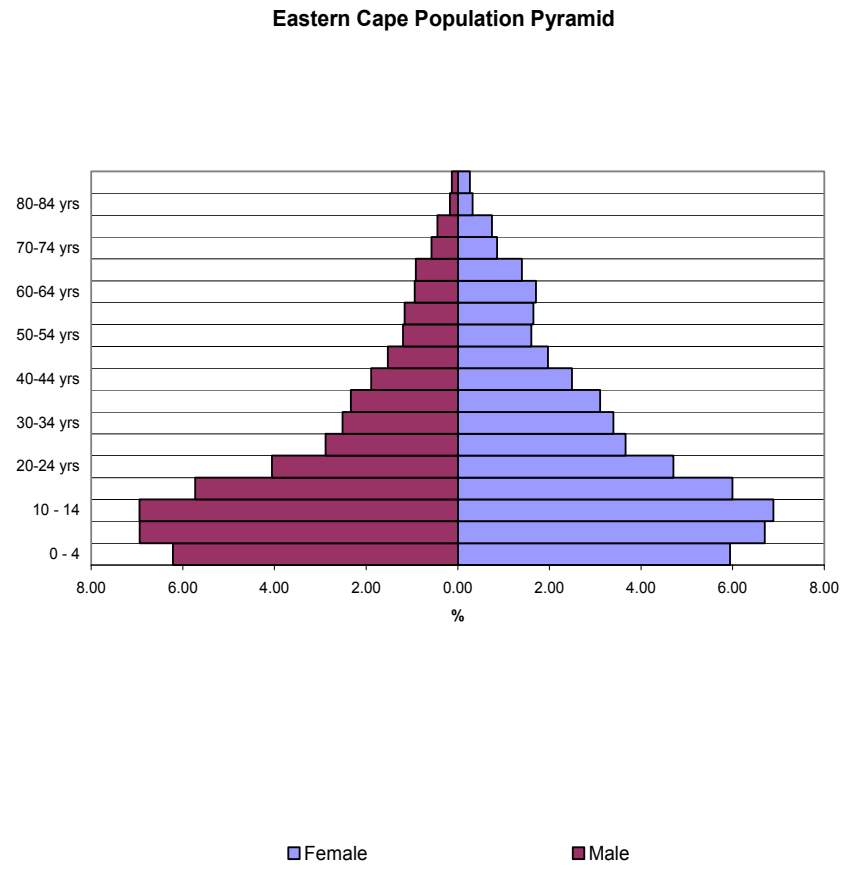


Figure 4 : Population pyramid Source DHIS: 2002

Analysis of the EC population pyramid shows

- 45% of the population are children under the age of 15 years with an even composition of males and females.

- In the 20-24 age bracket there are more females than males. This pattern becomes significant until in the 60-64 years category.
- 8% being over 60 years of age.
- The overall population is composed of 55% females and 45% males.

This explicitly demonstrate the effects of the historical migrant labour system in which men leave their families behind to go and work in major urban centres in the country. The eastern region which is more affected by migrant labour becomes home for the young, sick and elderly. (Although this is based on the 1996 estimates, the status quo remains).

The skew ness towards females and the high percentage of the population below 15 years of age has implications for the provision of maternal, child and women's health services. The overall focus of priority health interventions in the ECP is directed at improving the health of

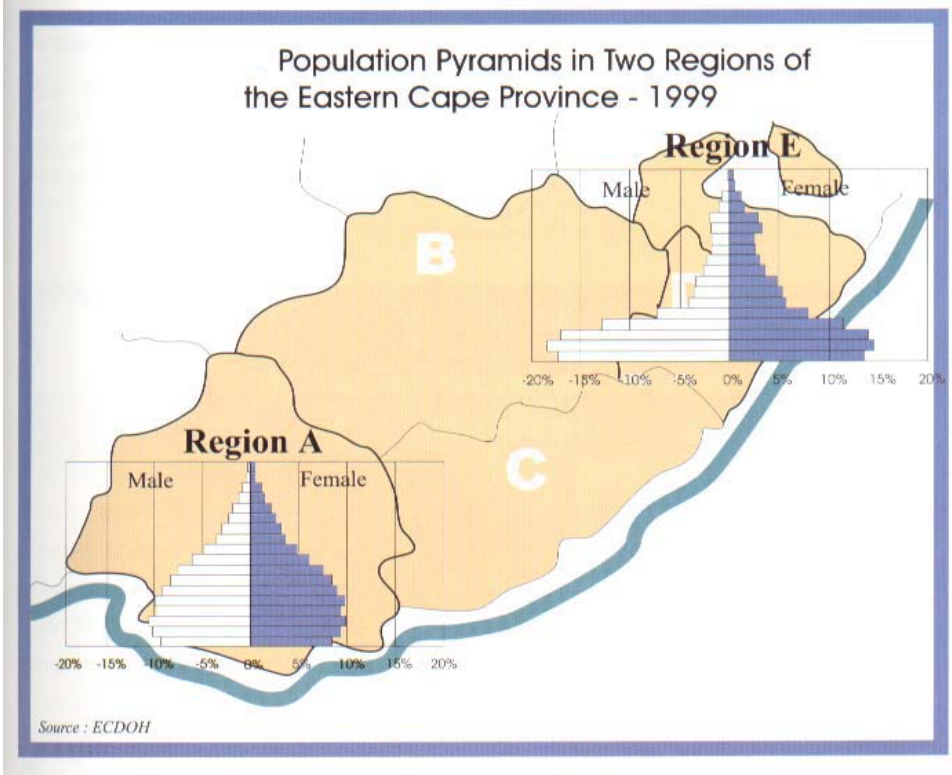


Figure 5: population pyramid comparing western and eastern regions of the EC.

the women, children and the poor in rural areas.
This figure shows Region A having a narrow base which is typical of developed country , reflecting a lower fertility rate and a larger proportion of the population aged 15 – 45 years, the most productive age. In contrast, region E displays a pyramid typical of a third world country with children accounting for a large proportion of the population.

Typical of a country in transition this clearly reflects two worlds within the same province.

6 .3 SOCIO ECONOMIC STATUS

- The Eastern Cape is one of the provinces that have the worst health and socio-economic indicators in the country. On the human development index (HDI 1998) developed by the United Nations, based on infant mortality, literacy and income, the province has a score of 0,603 which is lower than the country's average score of 0.697 and below that of Namibia which is 0,632.
- Poverty affects rural communities hardest and 63,4% of the EC population is rural.
- Statistics South Africa has mapped the distribution of poverty in South Africa, based on the 1996 census and the Income and Expenditure Survey of 1995. EC was identified as the poorest province in terms of average monthly household expenditure. The poorest magisterial districts being OR Tambo and Alfred Nzo (former Transkei) where 60-80% of households subsist on R800 per month or less. People living in poverty constitute 74.3% of the ECP population.
- EC has the highest unemployment rate of 48.5% in the country.

TABLE 3 : Population characteristics

%Population living in formal housing	46.9
%Unemployment rate	48.5
%GDP per capita	2.856
%Annual population growth	2.65
%Females	53.8
%Adult literacy rate	76.5
% of over 20 years not having received any schooling	20.9
% Xhosa speaking	83.8
% Afrikaans speaking	9.6
%English speaking	3.7
%Access to electricity	31.3
% Having tap water inside dwelling	24.4

The high unemployment rate puts a the high demand and dependency on public facilities and contributes to the ill-health in the province.

7. EPIDEMIOLOGICAL PROFILE

The annual population growth rate in EC is 2.65 with a birth rate of 3.5 as compared to the national average of 2.9 The average household size of 4,6.

7.1 HEALTH NEEDS ASSESSMENT

The ten top causes of mortality in both male and female adults in order of priority, this data is from a study done in 1996 and does not incorporate the impact of HIV/AIDS: TABLE 4.

CAUSES	**FREQUENCY**	
	MALE	FEMALE
Undetermined injuries	30.2	14.7
Ill defined natural	13.4	14.4
Tuberculosis	9.7	8.7
Stroke	3.5	5.9
COPD	2.7	2.6
Lower Respiratory Infections	2.5	3.4
Diarrhoeal Disease	2.2	3.4
Road traffic accidents	2.1	3.4
Heart failure	2.1	3.4
Ischaemic heart disease	2..0	1.7
HIV/AIDS	1.6	3.8
Diabetes Mellitus		2.8

Source: South African Cause of Death Profile in 1996.

The 1st four causes are top in both males and females and further down the causes vary as the life styles between male and female differ.
These figures indicate the need to focus in both communicable and non-communicable conditions and a need to intensify our health education programmes.

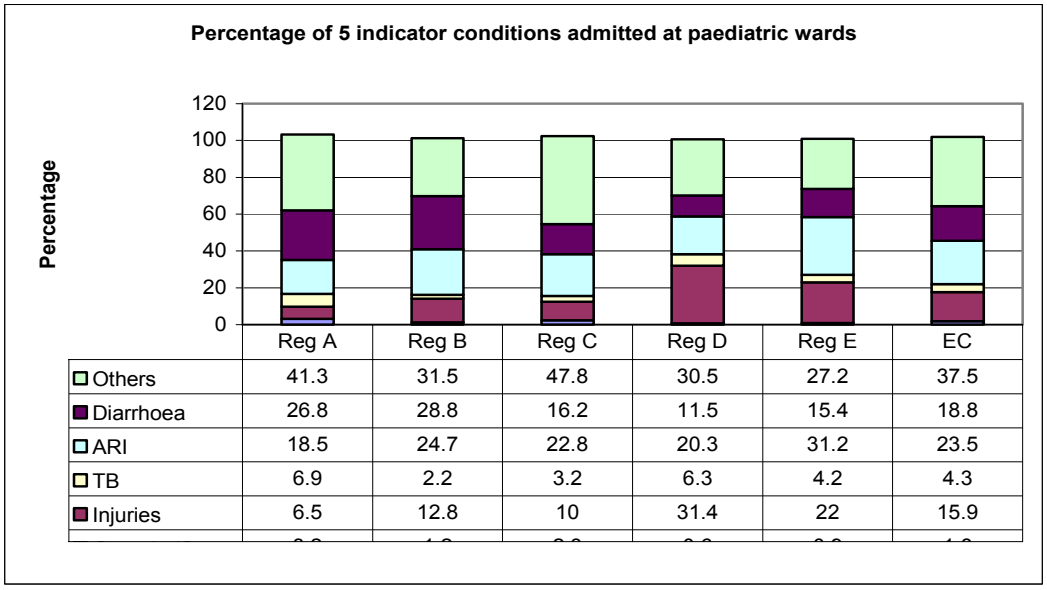
7.2 CHILD HEALTH

7.2.1 PAEDIATRIC HOSPITAL ADMISSIONS IN THE ECP

A review on hospital admissions was done 2000 (Eastern Cape Epidemiological Notes July 2000) and the following seven conditions accounted for most of the admissions in paediatric wards:

- acute respiratory infections
- diarrhoeal diseases
- PEM/kwashiorkor
- HIV/AIDS
- injuries and burns
- tuberculosis
- congenital or genetic disorders.

An alarming 23% of all the admission to paediatric wards were acute respiratory infections. Diarrhoeal diseases accounted for 18,8% of admissions, and injuries and burns 15,9%.



	Reg A	Reg B	Reg C	Reg D	Reg E	EC
Others	41.3	31.5	47.8	30.5	27.2	37.5
Diarrhoea	26.8	28.8	16.2	11.5	15.4	18.8
ARI	18.5	24.7	22.8	20.3	31.2	23.5
TB	6.9	2.2	3.2	6.3	4.2	4.3
Injuries	6.5	12.8	10	31.4	22	15.9

Figure 6: This graph shows a survey of hospital services that was conducted during 1999.

Diarrhoea

1996 census found alarming levels of lack of access to safe drinking water: < 20 % households in the former Transkei had access to safe drinking water. This accounts directly to the high incidence of diarrhoea in this area, and other parts of the E.CP. The graph shows decrease admissions for diarrhea in the said area as compared to the western region. Various reasons can be responsible for that including access to health care facilities or the old ways/practices of dealing with the problem still persisting and children dying before they reach the health care facilities.

Nutrition

Severe malnutrition, marasmus, kwashiorkor or weight of less than 60% of the expected weight for age, continues to be seen in the province with 350 new cases per month spread across the province. It is a contributory cause for hospitalisation and mortality of young children

Focused interventions to address infant and child health and the high mortality rates are a priority for the Eastern Cape during this strategic period. The improved funding for PHC will assist with health care interventions.

Immunisation against major childhood diseases

There are disparities between proportions of fully vaccinated children in the former RSA (64.5) and Transkei (36.5) regions. The proportion is also higher among children of more educated mothers, those living in urban areas and in the higher income quartiles. The 2000 Facility Survey (records review) reflected that 69% of children were fully immunised while the DHIS 2000 showed 68.4% .

These figures indicate that the province has a long way to go in order to reach its goal of 85% immunisation coverage.

7.2.2 CHILD MORTALITY

The Infant Mortality Rate(IMR) of 61.2 per 1000 live births is the highest in South Africa (SADHS 1998) In rural areas the IMR is 75.3% compared to urban areas of 32.8%. In the eastern part of the province where poverty is rife it reaches alarming rates of 99 deaths per 1,000 live births. The average IMR for South Africa is 45.4. The IMR has been identified as one of the major challenges of the province and is a priority during this strategic period.

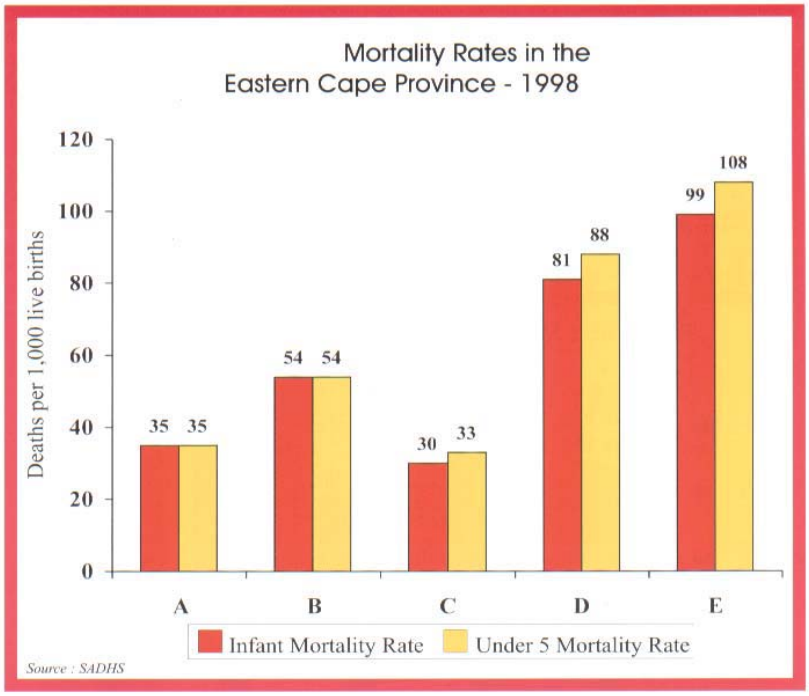


Figure 7: Mortality rates in the ECP (1998) the map still shows the old regional demarcations. What is being highlighted is the increase in child mortality in the rural areas.

In summary, in relation to infant and child health,

- Infant and child mortality are unacceptably high in the former Transkei area, and across the ECP as a whole
- A lack of access to safe water for households is one of the determinants and poses a major threat to health in the region
- The management of diarrhoea in children has improved but proper integrated care for childhood illnesses needs attention

- Immunisation coverage is improving slowly but still falls far short of expected levels
- Poor growth in children and severe malnutrition are problems that persist across the province
- HIV/AIDS poses a major threat to an already poor infant and child health profile

The improved funding for PHC will enable the province to impact on these mortality statistics, and to improve the health of the children of the region.

7.3 WOMEN'S AND MATERNAL HEALTH

In 1999 the ECDOH conducted a survey on maternal deaths(EC Epidemiological

- 90% were among the African population group
  10% in the coloured population group.
- According to the study, the provincial hospital maternal death rate was calculated at 133maternal deaths per 100 000 hospital deliveries. Nationally Maternal Mortality Rate (MMR) is estimated at 150 per 100 000 births according the SA Demographic and Health Survey of 1998.
- In 2000 108 deaths were reported and 53% of these were from the Eastern regions.
- No deaths from outside public hospitals were included in this review of hospital records. It seems likely that maternal mortality amongst women delivering at home would be significantly higher, especially in the north-eastern parts of the province.
- There were no reported maternal deaths among whites and Asians.
- The 32% of reported maternal deaths were among primigravida.

The primary causes of maternal deaths were identified as:-

- Eclampsi/pre-eclampsia and high blood pressure
- Hypovolumic shock and haemorrhage
- Tuberculosis and AIDS
- Septiceamia and septic shock
- Acute pulmonary thrombo-embolism
- Abruptio placentae

General comments on maternal death in the ECP:

- Maternal death is still one of the challenges facing the Maternal, Child and Women's health programme in SA in general and in particular in the Eastern Cape Province
- A high proportion of the pregnant women do not have access to qualified health professionals when they deliver
- A very low percentage of cases of maternal death received the minimum required number of antenatal visits, (the majority did not have adequate number of visits or did not attend the service at all)
- Under-reporting of maternal deaths is very common in facilities
- The rise in HIV related deaths is a matter of considerable concern.

7.4 MEDICAL CONDITIONS

DISEASE PATTERN IN THE ECP FOR ADULTS

The disease pattern for adults concurs with the 1996 MRC Survey quoted above on leading causes of death. The management of all these conditions could be enhanced with improved access to and quality of PHC. The quality relates in particular to the skills of nurses and therefore their ability to implement national guidelines and manage patients at the primary care level.

7.4.1 TUBERCULOSIS

The prevalence per district varies widely from 100 – 700 per 100 000 population. The reason for this variation is mainly that those districts that screen for TB, find the TB cases. This may mean that the prevalence of the disease is actually higher than recorded. This would concur with the previous data where TB was identified as the 3rd highest cause of death in both men and women. 1996 MRC Survey, records TB as the leading cause of death in the ECP following undetermined causes of death.

7.4.2 HYPERTENSION

The condition is prevalent in the ECP with 15 % urban adults and 12 % rural adults found to have the condition (1998 SADHS). Out of 13.5 % adults diagnosed, only 19.6% were taking medication to control this chronic condition. In region E only 11 % adults were
compliant. This is being addressed through the chronic disease management programme.

7.4.3 DIABETES MELLITUS

1 % of adults are currently being treated for diabetes in public clinics, ranging from 2% in north western parts to a low 0.2 % in east. Glucometers are basic equipment required to diagnose and manage Diabetes mellitus. Only 6 % in Region D and 13 % in Region E have this basic equipment in a functional order. Glucostix supplies are only marginally better. These issues will be addressed in the current year.

7.4.4 ASTHMA AND SMOKING

Based on SADHS findings, Region E has the highest percentage of adults with asthma (9.8%) and bronchitis (8.8%). The other regions report between 6.2% and 7.9%. The incidence is higher amongst females (8.0%) than males (6.9%). Bronchitis ranges from 3.8% to 8.8% of the population.

Smoking is a huge problem, especially amongst males, which is the case in urban as well as rural areas. This raises high risks for men of heart and lung disease. The percentage of smokers in Region E males is 40% as compared to 1 % females. The impact of urbanisation can clearly be seen, with a higher percentage of female smokers in Region A and the other urban regions compared to rural areas (6 % province – wide).

7.4.5 OBESITY

Area	Males	Females
Urban	12%	33%
Rural	7.8%	24.8%

The findings on obesity correlate well with the high rates of hypertension, diabetes and arthritis, all associated with obesity. As being “well-fed” is viewed as a sign of affluence in certain cultures, addressing this issue poses quite a challenge from a cultural point of view.

7.4.6 EYE CARE

Eye care is a particular problem for adults in the ECP. A lack of staff hampers the rendering of a suitable service. There is a constant pressure for cataract removals but a lack of trained personnel to meet the need.

7.4.7 RAPE

One of the challenges facing the EC Province is high crime which is evidenced by the rape statistics. This is evidenced by the admissions that the province is having in our casualty departments. Health professionals need to be equipped with counseling skills to deal with rape victims.

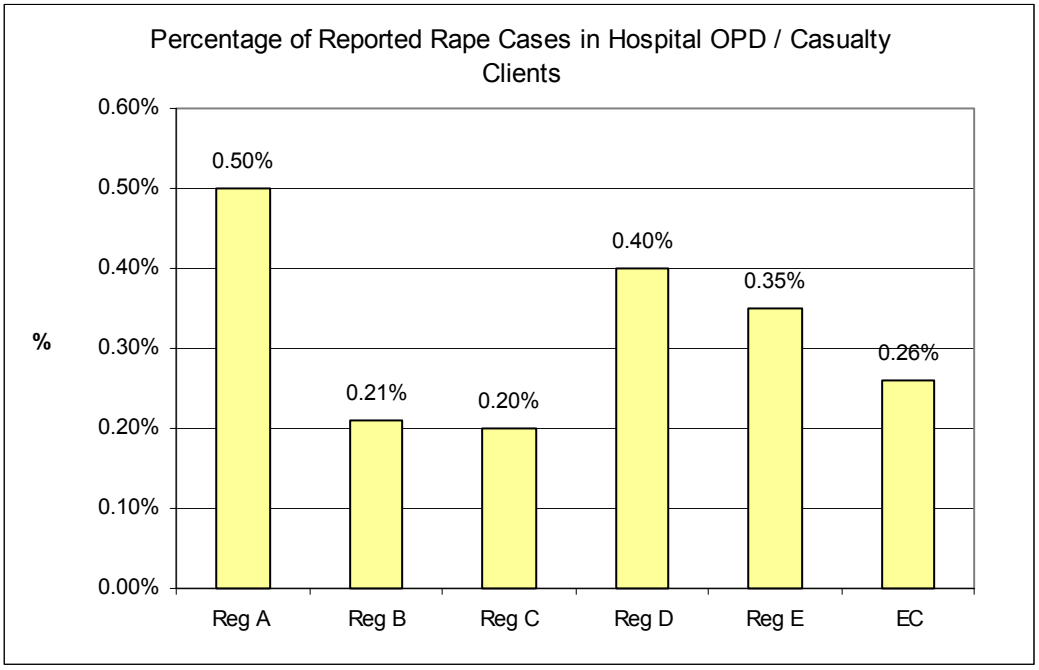


Figure 8: Reported rape cases per region

7.5 SERVICE UTILISATION

7.5.1 Surgical Admissions.

Table 5: Surgical Admissions

Services	Utilisation
% Trauma related admissions in surgical wards	32.6
% Emergency operations	26.5
%Assault related OPD attendances excluding rapes	11
% MVA related OPD attendances	3.5
% Reported rape cases as OPD patients	.26 (this was a total of 4,939 cases)

Source : 1999 EC Record review (.(EC EPIDEMIOLOGICAL Notes July 2000).

7.5.2 Caesarian Section Rate

- Provincial Caesarean Section rates in 1999, was 14%
- Highest rates were recorded in old regions C and A with rates of 18.2% and 16.1% respectively.
- The rate was lower in regions B and E

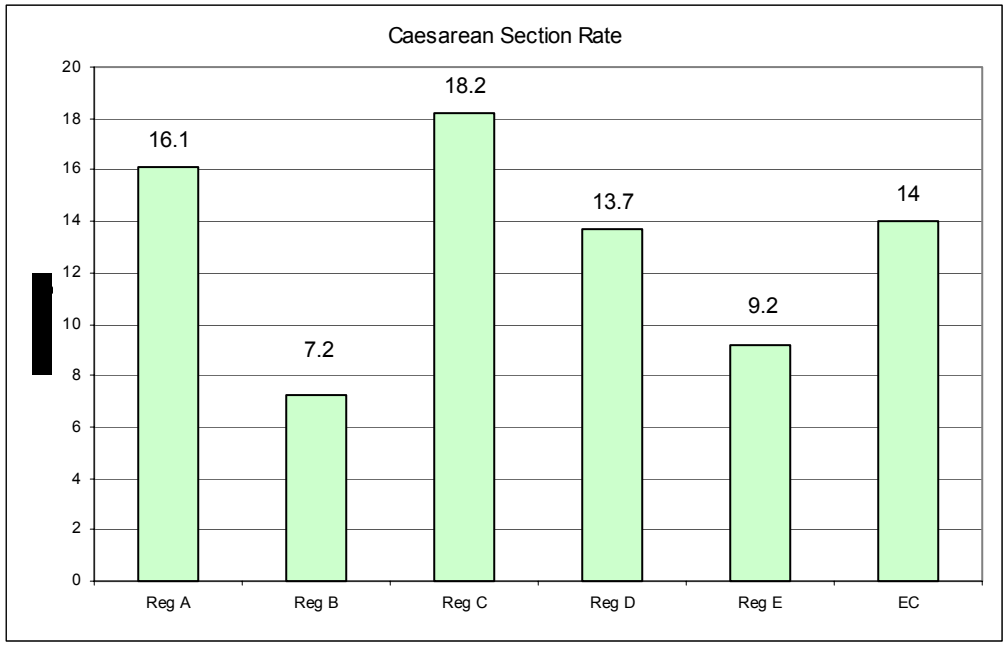


Figure 9 Caesarean Section rate EC Hospital Review 1999

There is need to investigate the cause of the high caesarean section rate in our province especially in the 2 mentioned regions.

7.5.3 Medical Admissions

- Provincially, 15.7% of all medical admissions were respiratory tract infections (excluding TB)
- TB patients accounted for 10.2% of all medical admissions
- Gastrointestinal tract diseases and cardiovascular conditions had prevalence of 13% and 11%, respectively.

7.5.4 Mental Health

Due to absence of any reliable national and provincial epidemiological studies, estimating accurate figures for the prevalence of mental illness in the EC is difficult. However, the majority of admissions are for:

- Anxiety and Depressive Disorders
- Schizophrenia
- Substance-induced psychiatric disorder

- Bipolar Disorder
- Mental Retardation
- Personality Disorders

7.5.5 IMPACT OF HIV/AIDS

HIV has already affected our health system and it is placing huge demands on health and social services. It is threatening productivity through undermining the hard-earned gains of development efforts of the recent years.

The statistics do not adequately convey the magnitude of the HIV/AIDS crisis facing communities including the health sector. The majority of beds (60-80%) in some hospitals are occupied by HIV/AIDS patients, both children and adults. Paediatricians estimate that >50% of children with PEM have AIDS, and therefore do not respond to feeding programs.

The recent review of maternal deaths identified AIDS as the most common cause of maternal deaths at all levels of care in SA.

8. CONCLUSION

The situation reflected above indicate that the Province has a long way to go to address the inequities of the past; this entails health facilities and service provision as well as alleviation of poverty through partnerships and joint ventures.

HIV/AIDS has been identified as the most threatening condition and will remain a priority in this strategic period.

9. BROAD STRUCTURE OF PUBLIC HEALTH SERVICE

Table 6: Fixed public primary health care facilities [clinics plus community health centres]

PHC facilities	Number	Average population Per facility
Province wide	739	9,600
Least served health district	3 District Municipalities: - Alfred Nzo, OR Tambo district municipality and Nelson Mandela Metropole	13,600
Best served health district	4 District Munipalities:- Amatole, Cacadu Chris Hani and Ukhahlamba district municipalities	6.300

In terms of the national target of 1 clinic per 10,000 population, the province has a shortfall of at least 42 PHC facilities in underserved sub-districts and may have a surplus of 160 clinics in over-serviced sub-districts. However population per PHC facility is a very crude measure of geographical access to PHC services.

As an illustration, the high population per facility in urban/ metropolitan areas such as Port Elizabeth is not an indication of poor geographical areas, but rather reflects higher population density of a city environment. Likewise the relatively low population per facility in a communal area in the northern part of the province (Cala) is not necessarily an indication of good geographical access to PHC services.

Spatial determination of PHC facilities in relation to population and other geographical features on an information system is what the province will be looking at in order to provide more detailed information to address equity in access to PHC facilities.

Table 7 : Public Hospitals

Hospital type	Number	Number of beds	Beds per 1000 people	Beds per 1000 uninsured people
District	47	7407	1.21	1.33
General [regional]	10	4137	0,68	.75
Central	Nil	Nil	Nil	NIL
Sub-total Acute hospitals				
Tuberculosis	12	2333	0,38	.42
Psychiatric	5	1225	0,20	.22
Chronic medical and other specialized	18	4884	0,80	.88
Total	92	19,953	3,26	3.6

Source : Hospital Transformation Project 1999

- Only 10.2% of EC population is insured.

Overall provision of level II and III beds may appear higher than recommended by the HSP (0.6 beds /1000). This is due to the fact that the six large regional hospitals in Port Elizabeth, East London and Umtata do not differentiate between Level 1 care and higher levels of care.
Provision of acute psychiatric beds is lower than the national guideline of 0.28 beds/1000).
Total chronic beds are almost three times the national guideline of 0.4 beds/1000.

High-level analysis disguises the considerable variations in access to hospital care. There are major differences in access district level and even within districts illustrated by the following examples:
Overall bed provision varies from 3.16 beds/1000 in former Region C to 1.64 beds/1000 in the Eastern Region E. For planning and equity in access one will have to analyse right down to district level.

TABLE 8 :Public Health Personnel in the Eastern Cape Province

	Code	Number Employed	% of total number employed	Number per 1000 population	Number per 1000 uninsured population	Vacancy Rate	% of total personnel budget	Total Annual Cost	Average annual cost per staff member *	Average annual c per staff memb based on avera salary scales *
HPDT	Health Professional Dental Therapy	7	0.02%	0.000982	0.001093	90.91%	0.74%	1,257,725.88	179,675.13	180,183.15
AM	Administration Management	96	0.33%	0.013463	0.014993	37.66%	5.79%	9,818,192.91	102,272.84	71,680.48
AP	Administration Production	1860	6.30%	0.260852	0.290481	33.14%	2.60%	4,407,654.26	2,369.71	105,313.78
AS	Administration Supervisor	576	1.95%	0.08078	0.089955	35.93%	0.02%	39,459.75	68.51	85,034.61
HPDEN	Health Professional Dentist	47	0.16%	0.006591	0.00734	11.32%	0.42%	704,250.78	14,984.06	164,368.00
HPEH	Health Professional Environmental Health	112	0.38%	0.015707	0.017491	60.14%	0.54%	920,169.87	8,215.80	113,437.13
HPM	Health Professional Management	259	0.88%	0.036323	0.040449	64.13%	2.82%	4,776,750.91	18,443.05	230,763.39
HPML	Health Professional Medical Laboratory	129	0.44%	0.018091	0.020146	20.86%	0.54%	907,060.25	7,031.47	95,746.83
HPMP	Health Professional Medical Practitioner	820	2.78%	0.114999	0.128062	20.93%	7.39%	12,524,494.50	15,273.77	129,497.26
HPSPE	Health Professional Medical Specialist	177	0.60%	0.024823	0.027643	23.71%	1.48%	2,505,513.19	14,155.44	127,874.95
HPN	Health Professional Nursing	7054	23.91%	0.989274	1.101642	17.92%	31.80%	53,898,924.14	7,640.90	107,148.48
HPOT	Health Professional Occupational Therapy	12	0.04%	0.001683	0.001874	78.57%	0.05%	91,977.75	7,664.81	106,422.08
HPOA	Health Professional Other Allied Services	107	0.36%	0.015006	0.01671	66.03%	0.42%	704,395.49	6,583.14	89,073.27
HPPHA	Health Professional Pharmaceutical Services	104	0.35%	0.014585	0.016242	54.19%	0.52%	877,342.18	8,435.98	115,373.43
HPPHY	Health Professional Physiotherapy	26	0.09%	0.003646	0.00406	71.43%	0.09%	158,426.57	6,093.33	85,614.67
HPPSY	Health Professional Psychology	23	0.08%	0.003226	0.003592	81.60%	0.09%	146,486.87	6,368.99	96,162.87

HPRAD	Health Professional Radiography	230	0.78%	0.032256	0.03592	36.64%	0.92%	1,559,646.42	6,781.07	93,091.32
MHWCS	Midlevel Health Worker Clinical Support	651	2.21%	0.091298	0.101668	46.24%	1.98%	3,355,718.04	5,154.71	71,998.44
MHNCS	Midlevel Health Worker Non-Clinical Support	282	0.96%	0.039549	0.044041	28.97%	0.85%	1,446,079.89	5,127.94	72,906.50
MHWN	Midlevel Health Worker Nursing	7374	24.99%	1.034152	1.151617	12.46%	22.45%	38,050,962.96	5,160.15	71,818.88
TOM	Technical Operations Management	7	0.02%	0.000982	0.001093	53.33%	0.05%	89,609.50	12,801.36	167,894.40
TOP	Technical Operations Production	9515	32.25%	1.334412	1.485982	16.03%	18.28%	30,986,818.44	3,256.63	42,678.56
TOS	Technical Operations Supervisor	36	0.12%	0.005049	0.005622	84.21%	0.15%	245,803.50	6,827.88	89,598.41
TP	Technical Professional	1	0.00%	0.00014	0.000156	88.89%	0.02%	27,364.00	27,364.00	207,905.28
	Totals	**29,505**	**100.00%**	**413787**	**4607873**	**47.30%**	**100.00%**	**169,500,828**		
	Total Population Figure (96 census + 14,4%)	**7130480**								

COMMENTS

- Contract workers and sessional payments distorts the average annual costs per staff member

INFLATOR FORMULAS AND INFLATION RATES FOR PROVINCIAL STRATEGIC PLANNING TABLES

Developed by David Collins, EQUITY Project, for the National Department of Health

Table 1: Trends in provincial public health expenditure by budget programme in current prices (R million)

Programme	1995/96 (actual)	1996/97 (actual)	1997/98 (actual)	1998/99 (actual)	1999/00 (actual)	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget[2)]	2004/05 (MTEF projectio
Administration	111,788	221,784	184,780	125,568	122,528	142,699	168,947	532,443	273,426	288,692
District Health Services	457,072	1,112,771	1,580,678	1,569,333	1,882,178	2,073,758	2,124,751	2,155,833	2,252,759	2,523,756
Emergency Medical Services	-	90,094	75,630	74,405	93,799	117,032	87,314	119,488	364,774	385,110
Provincial Hospital Services	1,636,686	1,333,642	1,107,774	1,088,553	1,260,207	1,250,272	1,237,958	1,171,894	1,736,779	2,053,528
Central Hospital Services	-	-	-	-	-	-	-	-	-	
Health Sciences and Training	-	39,101	45,340	44,237	44,713	42,362	76,756	15,531	63,690	67,053
Health Care Support Services	-	15,545	26,412	15,033	16,205	12,316	6,765	7,642	15,197	15,992
Health Facilities Management	-	63,553	156,203	95,319	76,686	151,190	189,962	349,370	411,261	377,026
Total DOH	**2,205,546**	**2,876,490**	**3,176,817**	**3,012,448**	**3,496,316**	**3,789,629**	**3,892,453**	**4,352,201**	**5,117,886**	**5,711,157**
Municipal own expenditure	3	3	3	3	4	4	4	4	4	5
Department of Public Works	20	21	22	23	24	26	27	28	30	31
Total (R million)	**2,205,569**	**2,876,514**	**3,176,842**	**3,012,475**	**3,496,344**	**3,789,658**	**3,892,484**	**4,352,233**	**5,117,920**	**5,711,193**

Table 2: Trends in provincial public health expenditure by economic classification in current prices (R million) ***OPTIONAL***

Programme	1995/96 (actual)	1996/97 (actual)	1997/98 (actual)	1998/99 (actual)	1999/00 (actual)	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget[2)]	2004/05 (MTEF projectio
Recurrent										
Personnel	1,234,512	1,742,851	1,845,860	1,977,930	2,356,508	2,385,313	2,429,383	2,544,702	2,928,542	3,109,254
Transfer payments	222,559	410,800	344,596	379,157	402,759	619,569	502,180	534,131	810,036	888,533

Administrative expenditure	153,786	48,503	49,547	50,050	69,697	72,723	109,643	100,856	94,839	128,195
Stores	318,489	340,529	390,528	340,725	404,748	372,011	413,103	497,835	455,379	617,738
Professional and special services	128,691	251,680	303,373	227,259	212,601	308,122	348,646	226,554	243,406	406,676
Other current expenditure	109,132	270,153	240,192	257,056	36,992	18,937	6,542	71,219	3,673	3,875
Total DOH Recurrent Expenditure	**2,167,169**	**3,064,516**	**3,174,096**	**3,232,177**	**3,483,305**	**3,776,675**	**3,809,497**	**3,975,297**	**4,535,875**	**5,154,271**
Capital										
Equipment	38,400	63,678	52,293	7,557	13,039	12,954	82,956	95,972	169,180	178,203
Infrastructure	-	-	-	-	-	-	-	280,932	412,831	378,682
Total DOH Capital Expenditure	**38,400**	**63,678**	**52,293**	**7,557**	**13,039**	**12,954**	**82,956**	**376,904**	**582,011**	**556,885**
Total DOH Expenditure	**2,205,569**	**3,128,194**	**3,226,389**	**3,239,734**	**3,496,344**	**3,789,629**	**3,892,453**	**4,352,201**	**5,117,886**	**5,711,156**
Municipal own expenditure (recurrent)	-	-	-	-	-	-	-	-	-	
Department of Public Works (capital)	-	-	-	-	-	-	-	-	-	
Total (R million)	**2,205,569**	**3,128,194**	**3,226,389**	**3,239,734**	**3,496,344**	**3,789,629**	**3,892,453**	**4,352,201**	**5,117,886**	**5,711,156**

Table 3: Trends in provincial public health expenditure in current prices (R million)

Programme	**1995/96 (actual)**	**1996/97 (actual)**	**1997/98 (actual)**	**1998/99 (actual)**	**1999/00 (actual)**	**2000/01 (actual)**	**2001/02 (actual)**	**2002/03 (estimate)**	**2003/04 (budget[2])**	**2004/05 (MTEF projectio**
Total	2,205,569	2,315,847	2,431,640	2,553,222	2,680,883	2,814,927	2,955,673	3,103,457	3,258,630	3,421,561
% of total spent on:										
District Health Services	20.7%	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	
Provincial Hospital Services	74.2%	0.8	0.8	0.9	0.9	0.9	1.0	1.0	1.1	
Central Hospital Services	0.0%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Personnel	57.0%	0.6	0.6	0.7	0.7	0.7	0.8	0.8	0.8	
Total Capital	38400.0	63678.0	52293.0	7557.0	13039.0	12954.0	82956.0	376904.0	582011.0	55688
Health as a % of total public expenditure	17.2%	17.0%	16.9%	16.8%	17.2%	17.3%	16.9%	17.2%	17.2%	17.

Municipal own expenditure is included with DHS expenditure

It would be better to compare the figures without including DPW expenditure unless that figure is broken down ober programmes.

Personnel is calculated as a % of Total DOH Recurrent Expenditure, unless there is a breakdown of municipal own expenditure by economic classification.

Define total public expenditure?

Table 3: Trends in provincial public health expenditure in constant 2002/03 prices (R million)

Programme	1995/96 (actual)	1996/97 (actual)	1997/98 (actual)	1998/99 (actual)	1999/00 (actual)	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	Average annual change %	2003/04 (budget
Total	3659080.7	4494811.8	4527499.9	4024921.9	4357929.3	4399265.3	4204179.4	4352233.4	2.5%	481084
Total per person	3,659,081	4,415,336	4,368,807	3,815,172	4,057,785	4,023,845	3,777,414	3,841,296	0.7%	4,170,989
Total per uninsured person	4,065,645	4,905,929	4,854,230	4,239,080	4,508,650	4,470,939	4,197,127	4,268,106	0.7%	4,634,433
Average change										
Total		22.8%	0.7%	-11.1%	8.3%	0.9%	-4.4%	3.5%		10.
Total per person		20.7%	-1.1%	-12.7%	6.4%	-0.8%	-6.1%	1.7%		8.
Total per uninsured person		20.7%	-1.1%	-12.7%	6.4%	-0.8%	-6.1%	1.7%		8.

The Treasury formula for calculating the annual average change is ((outer yr/base year) to the power of (^on excel) times (1/number of years from base to outer)) -1 .
In the above table that is 7 years from the base year of 1995/96 to the last year of 2002/03

Table 4: Inflation rates and population figures

	1995/96 (actual)	1996/97 (actual)	1997/98 (actual)	1998/99 (actual)	1999/00 (actual)	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget[2)]
Inflation rate (financial year average)	6.2%	9.6%	6.7%	7.2%	7.4%	7.5%	8.0%	8.0%	8.0%
Population growth rate		1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%
Population	1,000,000	1,018,000	1,036,324	1,054,978	1,073,967	1,093,299	1,112,978	1,133,012	1,153,406
Medical aid membership %	10%	10%	10%	10%	10%	10%	10%	10%	10%
Uninsured population %	90%	90%	90%	90%	90%	90%	90%	90%	90%
Uninsured population	900,000	916,200	932,692	949,480	966,571	983,969	1,001,680	1,019,711	1,038,065

Table 5: Evolution of expenditure by budget programme and sub-programme in current prices (R million)

Sub-programme	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget[2)]	2004/05 (MTEF projection)	2005/06 (MTEF projection)
District Management	18,780		68,895	75,335	81,478	88,367

		33,811				
Coomunity Health Clinics	315,491	555,452	656,880	423,487	470,987	513,524
Community Health Centres	143,891	87290	0	189,494	199,916	227,212
Community Based Services	9,864	5,984	0	14,305	15,092	15,997
Other Community Services	522	316	0	650	686	727
HIV/AIDS	0	0	0	70,947	92,988	114,111
Nutrition	106,274	131,838	114,609	172,465	202,698	222,133
Coroner Services	0	0	0	-	-	-
District Hospitals	1,478,936	1,310,060	1,315,449	1,306,076	1,459,911	1,543,695
Total Programme (R million)	**2,073,758.0**	**2,124,751.0**	**2,155,833.0**	**2252759.0**	**2,523,756.0**	**2,725,766.0**

The above table is for use for all budget programmes and uses the DHS as an example.

Note that the total must be the same as that shown for the programme in Table 1

Table 6: Evolution of expenditure of budget programme in constant 2002/03 prices

Expenditure	**2000/01 (actual)**	**2001/02 (actual)**	**2002/03 (estimate)**	**Average annual change %**	**2003/04 (budget[2])**	
Rands						
Total (R million)	2,407,344.1	2,294,893.1	2,155,833.0	-5.4%	2,117,593.5	
Total per person (Rand)	2,201,909	2,061,939	1,902,745	-7.0%	1,835,948	
Total per uninsured person[5]	2,446,565	2,291,043	2,114,162	-7.0%	2,039,942	Provincial level only
Average change						
Total		-4.7%	-6.1%		-1.8%	
Total per person		-6.4%	-7.7%		-3.5%	
Total per uninsured person		-6.4%	-7.7%		-3.5%	Provincial level only

May be interesting to project Table 1.6 out for 2004/05 and 2005/06

Table 7: Inflation Rates per Stats SA (may be included in document)

Change by financial year

	March 1995	March 1996	March 1997	March 1998	March 1999	March 2000	March 2001	March 2002	March 2003	March 20
CPIX Index			79.5	84.8	90.9	97.6	104.9	113.3	122.4	13
Calculated annual change				6.7%	7.2%	7.4%	7.5%	8.0%	8.0%	8.
CPI Index	71.3	75.7	83.0							
Calculated annual change		6.2%	9.6%							

10. MAJOR HEALTH CHALLENGES

- Escalating HIV/AIDS occurrence exerting pressure on all our resources
- Escalating TB prevalence accompanied by poor rate cure due to Multiple Drug Resistance
- Brain drain of health professionals especially doctors and nurses to countries like UK and Saudi Arabia necessitating recruitment , training and use of incentives to attract staff. Presently the doctor patient ratio is 1 per 3000.
- Low immunization coverage
- Cross boundaries movement of people
- Legislative reforms influenced by cultural factors e.g. circumcision, and recognition of alternative medicine including traditional healing
- Escalating crime calling for more security for staff working in primary health care facilities, establishment of crisis centers and counseling facilities for victims of abuse as well as calling for more collaborative endeavours with other sectors
- The impact of increased motor vehicle accidents on Emergency Medical services and other services
- Backlog in health facilities development
- High Infant and Maternal mortality

10.1 Strategic goals and objectives of the Department of Health

Strategic Goal 1: Ensuring equitable access by all communities to essential package of services through DHS:

Strategic Objectives

1 Effective delegation of Primary Health Care services to the municipalities
2 Implementation of health programmes to reduce morbidity and mortality in our communities
3 Improve infrastructure development

Strategic Goal 2: Health services in the province meet quality standards

Strategic Objectives:

1 Set norms and standards for quality assurance
2 Implement monitoring and evaluation systems
3 Revitalization of our facilities
4 Strengthen drug distribution and information systems

Strategic Goal 3: Communities throughout the province become active, responsible partners in health issues which affect them

Strategic Objectives:

1 Strengthen governance structures for effective participation of civil society in healthcare issues
2 Improving external and internal communication to harness service delivery

Strategic Goal 4: Build capacity in the Department to support improved implementation of its goals

Strategic Objectives:

1 To implement programmes for attraction and retention of essential human resources skills
2 To provide ongoing training and skills development for health workers
3 To streamline nursing education and training
4 To implement results driven PMS programme

Strategic Goal 5: Effective utilization of the Department's finance and assets to achieve effective service delivery

Strategic Objectives:

1 Equitable resource allocation across the Province
2 Rationalise hospital services
3 To ensure effective cash flow forecasting, efficient financial and asset management as well as financial controls.

10.2 PRIORITIES FOR 2003/4

The strategic priorities of the DoH of the Eastern Cape Province are:

- To manage and improve health outcomes for HIV/AIDS, STDs and TB
- To reduce infant and child mortality
- To control communicable diseases
- To develop the district health system and the delivery of the PHC Package
- To improve emergency and patient transport
- To improve logistical and other support
- To implement the hospital revitalization programme
- To improve capacity and access to regional and tertiary services in the province
- To develop human resources for quality management and service delivery

11. Legislative Framework

The core functions of the Eastern Cape Department of Health is the provision of health services – promotive, preventive, curative and rehabilitative services. It derives its mandate from the following legislative framework :

The Constitution of the Republic of South Africa (Act No. 108 of 1996) Section 27.

- White Paper on the Transformation of the Health System in South Africa
- The Reconstruction and Development Programme
- Policy and budget speech 1999/2000 – MEC for the Department of Health
- Labour Relations Act (Act No. 66 of 1995)
- Basic conditions of employment Act (Act No. 75 of 1997)
- Skills development Act (Act No.97 of 1998)
- Skills levy Act of 1999 (Act 9 of 1999)
- Mental Health Act (Act No. of)
- The Public Service Amendment Act 1999 (No. 5 of 1999)
- Public Service Regulations 2001
- National Health Laboratories Act (Act No. 37 of 2000)
- Occupational Health and Safety Act (Act No. 85 of 1993)
- Eastern Cape Provincial Health Act (Act No. 10 of 1999)

PART B: SPECIFIC PROGRAMMES

PROGRAMME 1: HEALTH ADMINISTRATION

AIM: To render administrative support services to the Department

KEY OBJECTIVES:
1. Manage administrative, corporate and auxiliary services
2. Provide guidelines, support and strategic intervention
3 .Provide a framework of management, Human Resource Labour Relations policies and procedures
4.Addressing HIV/AIDS epidemic in the workplace
5.Adequately staff the department with critical staff
6.Complete Resolution 7 / Restructuring

KEY CHALLENGES

- Hiv/aids
- Brain drain and attraction and retention of key medical staff
- Ensuring competent and trained management staff

BUDGET R273, 426,000

Budget allocation by Sub-programme:-

Office of the MEC: R6, 851,000
Management: R266, 575 ,000

Legislative Framework

- Public Finance Management Act, No. 1 of 1999
- Public Finance Management Amendment Act, No. 29 of1999
- Employment Equity Act, No 55 of 1998
- Public Service Act, No. 103 of 1994

1 OBJECTIVE	Indicator	2001/02 (actual)	2002/03 estimate	2003/04 target	2004/05 target	2005/06 target
Organisational Development interventions to improve management capacity at Head Office and in the districts	Improved management and controls	25% of all managers trained	40% of all managers trained	60% of all managers trained	80% of all managers trained	100% of all managers trained 100% of all supervisor and managers trained
Provide coaching and training through MESOL and DHIS, and District Management and Leadership Programmes	Improved leadership and management	10% of supervisor and managers trained	25% of supervisor and managers trained	40% of all supervisor and managers trained	70% of all supervisor and managers trained	Revisit
Strategic Management – Operationalise the vision and mission statement of the ECDOH	Common vision and goals	10% trained	50 % trained	75% trained	100% trained	
Roll out of HR and Labour Relations Policy & Procedure manuals to ensure common understanding of policy and regulations and to ensure uniformity in application of disciplinary procedures	Road shows workshops with OTP	Awaiting OTP	15% reached and given manuals	45% reached and given manuals	75% reached and given manuals	100% reached and given manuals
Improve service delivery turnaround time in HR and	Training Coaching	60% improve	100% improvement	Maintain 100%	Maintain 100%	Maintain 100%

lessen the complaints Improve district HR management to ensure accountability	Workshops	ment				
Performance Management System implemented to ensure performance standards and improved service delivery	Workshops Training	10% complete	100% to be completed to meet deadline of OTP	Update each year	Update each year	Update each year
Incentives to attract and retain key staff – process started with Critical Post filling as new senior medical posts were created and higher salaries paid, including promotions of doctors	Utilise grant funds to attract and retain	Process has started	Retain 75% of medical staff	Retain 100% of medical staff	Retain 100% of medical staff	Retain 100% of medical staff
Asset Management implementation	List of new acquisitions for disclosure in financial statements. Draft implementation document on asset management		List of new acquisitions in the current financial year	List of assets acquired in financial year 2002/3	Updating and maintaining assets registers	Updating and maintaining assets registers
Qualitative PFMA strategy	Improved PFMA compliance matrix	Department ranked 8th in the Eastern Cape	Department ranked 3rd in the Eastern Cape	To be ranked2nd	To be ranked 1st	
Expression of Audit opinion`	Qualified opinion by	Disclaimer issued	Implementation of the	Reduction in the number of the AG	Reduction in the number items included under	Unqualified Audit opinion

	the office of the AG		recommendations contained in the AG report		"Emphasis of the matter '' AG report per	
					Unqualified Audit opinion	
Improved skills and cross-training of Human Resources and Training staff	Develop programme	10% of HR/HRD staff cross-trained	25% of HR/HRD staff cross trained	50% of HR/HRD staff cross trained	75% of HR/HRD staff cross trained	100% of HR/HRD staff cross trained
Effective management of Bursary Scheme and get an increase in the budget allocation to cover 12.5 million shortage New Bursary Scheme rules and application produced	Documents in place	Budget to be trebled to cover students	Maintain at R21 million	Increase to R23 million	Maintain at R23 million	Increase to R25 million
Special Programmes HIV/AIDS in the Workplace, Employment Equity, Gender and Youth programmes to be developed and implemented to correct the imbalances of the past	Draft policies in place	Workshop and get buy in from all	50% of policies implemented	100% of policies in place	Maintain and update	Maintain and update
Procurement reforms	Increased delegations and decentralization of		Readiness assessment completed and submitted to the PTB.	Increased delegations awarded by the Tender Board. Tenders to be adjudicated and	Tenders to be adjudicated and awarded at cluster level	Tenders to be adjudicated and awarded at cluster level

	tendering processes to clusters		Clusters set up for tenders	awarded at cluster level		
Develop Risk Management and Fraud Prevention Strategy	Draft implementation document on risk management and fraud prevention		Document draft commenced	Implementation of plan	Maintaining and updating the plan	Maintaining and updating the plan
Accounting reform	A cost center accounting management system		Investigate current solutions in the market in conjunction with National Department of Health	Identification of a new accounting system	Implementation of new system	Maintaining the new system
Budget reform (Departmental)	Draft implementation document to address budget planning for the department		Commence the drafting of the document	Implement the contents of the document	Maintain and update	Maintain and update
Revenue retention policy	Draft policy on revenue retention		Awaiting Legislature and Provincial Treasury approval	When approval obtained to implement policy	Annual review of policy	Annual review of policy

PROGRAMME 2 : DISTRICT HEALTH SERVICES

AIM :

- To develop and support District Health Services in the Eastern Cape

KEY OBJECTIVES:

- To develop government structures and delegate PHC functions to competent Local Government structures
- To improve maternal, child and women's health
- To strengthen the HIV/AIDS, Sexually Transmitted Infections and Tuberculosis programmes
- To decrease communicable and non-communicable diseases
- To reduce mortality and morbidity rates by at least 30% by year 2005
- Improve district hospital services

BUDGET: R2,252.759,000

Budget allocation per Sub-programme:-

District management:	R75,335 ,000
Community Health Clinic Services:	R423,487,000
Community Health Centers:	R189 ,494 ,000
Community Based services:	R14,305, 000
Other Community Services	R650,000
HIV/AIDS:	R70,947,000
Nutrition :	R172,465,000
District Hospitals	R1,1306,076,000
TOTAL:	R2,252,759,000

1. Situational Analysis

The Eastern Cape Department of Health when it took the responsibility to provide health services in line with their constitutional imperative were faced with certain challenges. The challenges related to three areas:

- Development of policy implementation plans to enhance services delivery
- Deliver according to certain prioritized areas like the Presidential Lead Projects, provision of free health services to children under the age of five years, and improvement of access to services by providing facilities e.g. Clinic Upgrading and Building Program (CUBP).
- Amalgamation of previously fragmented administrations.

In late 90's the Department had developed policies and built facilities (especially clinics) but was now faced with new or un-addressed challenges. These related to back-office operations like improving systems, work processes and institutional structures that make service delivery possible, the front-office operations (interface between government and the public), as well as efforts to improve internal and external communication

A total of 14 375 842 patients were reported to have visited Primary Health Care (PHC) clinics and mobile facilities in 1999, an increase from 12 088 773 the previous year. Reports for the year 2000 indicate that over 14 million PHC visits were recorded in this year.

The 2000 facility survey confirms findings of the 1999 survey showing accelerated integration of the four maternal, child and women's health (MCWH) services, from 51% in 1997, to 79% in 1999 and 78% in 2000. This increase has largely been due to ante-natal care (ANC) being offered at least five days a week in 80% of clinics in 1999, a remarkable increase

since the baseline survey when only half of all clinics were providing the service all week days.

In the year 2000, 92% of clinics surveyed were offering TB services five days a week, results that show constant increase (though slight) from 87% in 1997 to 89% in 1999 (and now 92%). These results are limited in Region D & E due to the poor transport facilities to deliver specimens.

The main challenges in the provision of PHC and level 1 hospital services are

Poor management and difficulty to recruit and retain professional staff in district hospitals.

- Poorly developed PHC infrastructure and services especially in the prioritised rural nodes.
- Functional integration of different PHC services at sub-district level and district level (Provinicial, municipal and local government authorities).
- Poor Health indicators in the following programmes: MCWH services (especially Integrated Nutrition Program, EPI, AFP, IMCI, ANC) and communicable disease control (especially TB/HIV/AIDS conditions).

Table: District Health Services facilities by health district

Health District	**Facility type**	**No.**	**Average population per facility**	**District hospital beds (no.)**	**District hospital beds per 1000 people**
Alfred Nzo	Clinics and CHCs	57	10789		
	District hospitals	4		672	1.1
Amatole	Clinics and CHCs	255	7363		
	District hospitals	11		2560	1.4
Cacadu	Clinics and CHCs	98	4275		
	District hospitals	5		599	1.4
Chris Hani	Clinics and CHCs	159	5846		
	District hospitals	8		1369	1.5
N Mandela	Clinics and CHCs	68	16136		
	District hospitals	1		315	0.3
O R Tambo	Clinics and CHCs	163	11169		
	District hospitals	11		2265	1.2
Ukhahlamba	Clinics and CHCs	56	6636		
	District hospitals	7		756	2.0
Province	Clinics and CHCs	856	8330		
	District hospitals			8536	1.2

The above table illustrates the distribution of our facilities (clinics and district hospitals) as well as beds across the Eastern Cape. There is a fair distribution of hospital beds across the province (average 1.2 beds per 1000 population) except in NMMM where there is gross shortage (0.2 beds per 1000).

There is however gross mal-distribution of clinic facilities. This information indicates that Cacadu and Amatole are well resourced at about 5000 per facility as compared to OR Tambo, Alfred Nzo. NMMM show shortage of district level facilities with average in excess of 10 000 per facility. This position is further exacerbated by the fact that some of the facilities in OR Tambo and Alfred Nzo District Municipalities are poorly resourced, partially staffed and sometimes poorly accessible.

Physical condition of district facilities as reflected in the National Health Facilities Audit of 1996 indicate that 30% need total replacements and 65% need major upgrading.

Table: Basic infrastructure services in district facility network by health district

Health district	Facility type	No.	No. (%) with electricity supply from grid	No. (%) with piped water supply	No. (%) with fixed line telephone
Alfred Nzo	Clinics	48	45.65	12	38.30
	CHCs	3	Included in above	Included in above	*Included in above
	District hospitals	4	100	100	100
Amatole	Clinics	194	91.33	51	50.59
	CHCs	6	As above	As above	As above
	District hospitals	18	100	100	100
Cacadu	Clinics	84	94.74	100	97.30
	CHCs	4	As above	As above	As above
	District hospitals	10	100	100	100
Chris Hani	Clinics	140	78.48	52	68.48
	CHCs	3	As above	As above	As above

	District hospitals	13	100	100	100
N Mandela	Clinics	60	100	91	95.92
	CHCs	7	As above	As above	As above
	District hospitals	1	100	100	100
O R Tambo	Clinics	142	54.17	15	32.17
	CHCs	5	As above	As above	As above
	District hospitals	12	100	100	100
Ukhahlamba	Clinics	43	9310	69	68.97
	CHCs	0	As above	As above	As above
	District hospitals	11	100	100	100
Province	Clinics	711	77.23		59.63
	CHCs	28	As above	As above	As above
	District hospitals	68	100	100	100

Table: Personnel in district health services by health district

Health district	Personnel category	Number employed	Number per 1000 people
Alfred Nzo	Medical officers	15	0.02
	Professional nurses	157	0.26
	Pharmacists	1	0.00
Amatole	Medical officers	272	0.14
	Professional nurses	2096	1.12
	Pharmacists	35	0.02
Cacadu	Medical officers	63	0.00
	Professional nurses	230	0.55
	Pharmacists	122	0.29
Chris Hani	Medical officers	59	0.06
	Professional nurses	626	0.67
	Pharmacists	5	0.01
N Mandela	Medical officers	200	0.18
	Professional nurses	674	0.61
	Pharmacists	37	0.03
O R Tambo	Medical officers	128	0.07
	Professional nurses	823	0.45
	Pharmacists	4	0.00
Ukhahlamba	Medical officers	20	0.05
	Professional nurses	148	0.40
	Pharmacists	6	0.02
Province	Medical officers	757	0.11
	Professional nurses	5511	0.77
	Pharmacists	100	0.00

Note: Information obtained from PERSAL (Not 100% accurate due to incomplete GTRS, translation to CORE)

2. Policies, Priorities and broad strategic objectives

2.1 Legislative Framework

- Medicines and related substances Act (Act 101 of 1995 as amended)
- Pharmacy Act (Act No.53 of 1974 as amended)

- Sterilisation Act (Act No.44 of 1998)
- Choice on termination of Pregnancy Act (Act 92 of 1996)
- Local Government Municipality Structures Act (Act No.of 1998)
- Local Government Municipality Demarcation Act (Act No. 27 of 1998)
- Municipal Systems Act (Act No.32 of 2000)
- Transfer of staff to Municipalities Act (Act No. 17 of 1998)
- Application of Standards in Traditional Circumcision Act (Act No. 6 of 2001)
- Provincial Health Act

- The National Health Policy is Unified Health System that is based on District Health System. The MinMEC has provided the framework for the development of the DHS services (that included the definition of the Municipal Health Services and delegation of Primary health Care services to the district municipalities).
  ECDOH is implementing functional integration of DHS services between the municipalities and the province. PHC services will be jointly planned (integrating IDP's and provincial priorities) through a framework that includes Strategic Plan, District Health Planning (DHP), Strategic Position Statement (SPS) and HTP. This planning will also be aligned with the Provincial Budget Cycle and process.

- The Province has prioritized HIV/AIDS, water and sanitation, poverty alleviation and victim empowerment (that includes food security).
  These programmes will be provided within the broad framework of the Social Needs Cluster in the province.

- The ECDOH will be implementing the clustering of the district hospitals (organizational design) that will improve the management

echelon and at the same time optimize the utilization of the scarce resources (pooling of the scarce skills like medical and pharmaceutical personnel). There will be implementation of the shared support services program on a pilot basis in the first year. The infrastructure programme will also be prioritized on integrated planning approach (capital and non-capital).

- On the quality side the DHS Branch will roll out the Patients Rights Charter, the District Hospitals Norms and Standards as well as the accreditation programme of the 18 district hospitals with the assistance of COHSASA. Incentive schemes will be implemented to promote development of quality and DHIS.

- In terms of the Ten Point plan the Department has prioritized the following programmes:
  - HIV/AIDS/TB/STI conditions
  - EPI
  - Nutrition programme (intensive implementation of INP with collaboration from the Home Affairs, Social Development and Agriculture departments)
  - Revitalisation of hospitals.
  - Improvement of quality of services.

3. Analysis of constraints and measures planned to overcome them

DISTRICT HOSPITALS

The Branch has to address the following constraints:

- Managerial capacity at district office and District Hospital levels
- Recruitment and retention of professional staff especially in rural areas

- Infrastructure development and maintenance (physical building, health technology and equipment)
- Development and implementation of management systems
- Implementation of key health programs
- Implementation of the DHS Policy

The DHS branch has identified the following strategies to deal with the above challenges:

- Clustering of district hospitals for shared Support Programme.
- Development of clinical program to support the district hospitals and clinics (with the support of the specialists from the complexes and the flying doctors program)
- Rural Allowance for health professionals in a phased in approach in rural clinics and designated district hospitals.
- Functional integration of our services with District Municipality health services, progressing to delegation of services.
- Program to implement DHIS, Accreditation of hospitals, PFMA, UPFS and PAAB

4. Description of planned quality improvement measures

The DHS Branch has recognized the importance of quality assurance program in the department. The following focus areas will be attended to:

- The campaign to popularize the Patients Rights Charter and Batho Pele in all our facilities and areas where we provide health services.
- The acceleration of the Accreditation program in the 18 district hospitals with the objective of achieving accreditation from COHSASA for at least 5 institutions by the end of the financial year 2003/04.There will be an incentive to our hospital for reaching accreditation as well as staying there.

- The clustering of our district hospitals will improve management capacity, and the clinical support program will improve clinical quality of our health services.
- Improve quality of services.
- Awards incentive programme.

5. Specification of measurable objectives and performance indicators

Objective	Indicator	2002/3 Estimate	2003/4 (Target)	2004/5 (Target)	2005/6 (target)
1. To improve access to Primary Health Care services	-% of fixed public facilities offering the full package of PHC services - No. of visits (headcount) at PHC facilities per person per year - population served per fixed clinic - No. of nurses per public PHC per 1000 people - DHS expenditure per person - Percentage of fixed PHC facilities with functioning community participation structure	2 8,330			
2. To control communicable and non- communicable diseases	- Mortality and morbidity rates	Rates reduced by 1%	1%	1%	2%
3. To improve programmes targeting maternal, child and women's	- Infant mortality rates - Immunization coverage - Maternal mortality rates - Statistics reflecting utilization of maternal and child health services	60 per 1000 50% 50per 100,000 3ANC visits per patient	55 per 1000 70% 30 per 100,000 3ANC visits per patient	50 per 1000 80% 20 per 100,000 3ANC visits per patient	40 per 1000 85% 10 per 100,000 5ANC visits per patient

4. To implement promotive and preventive health care programmes **District hospitals** 1. Provide quality health care in all district hospitals .	- Prevalence of disease outbreaks Percentage of district hospitals achieving accreditation from COHSASA. Average length of stay (ALOS) in district hospitals. Percentage of health districts with District Managers Customer satisfaction	 60% 7 95% 50%	 80% 5 100% 55%	 90 % 5 100% 60%	 100% 5 100% 80%
2. Provision new health facilities _____ 1. Upgrading of existing health facilities _____ 2. Regular servicing of equipment and general maintenance work in Institutions	No. of new hospitals No. of new CHCs No. of new clinics _____ - No. of upgraded facilities - _____ - Implementation	 _____ On-going _____	2 3 14 – _____ 24 clinics and 1 CHC _____ On-going	2 - Complete – _____ Complete _____ On-going	2 - Complete _____ 20 _____ On-going

Service Level Agreements and transfers to municipalities and non-governmental organizations.

Program 2 provides transfer payments to various institutions and organizations to provide PHC, general hospital services and institutionalized TB services. These transfer payments are regulated by Service Level Agreements (that indicate what services will be provided at what costs or budget as well as how that will be monitored and accounted for). The following organizations and public entities receive some of these transfer payments:

- Municipalities (district and local)
- Provincially-aided hospitals
- Privately-run hospitals (currently by Life-care organizations)
- SANTA hospitals

Table: Transfers to municipalities and non-governmental organizations (R '000)

Municipalities	**Purpose of transfer**	**Base year 2002/03 (estimate)**	**Year 1 2003/04 (budget)**	**Year 2 2004/05 (MTEF)**	**Year 3 2005/06 (MTEF)**
1. Amatole District Council (DC)	Primary Health Care	R4,169			
2. Baviaans Municipal Council (MC)	Primary Health Care	R616			
3. Blue Crane Route MC	Primary Health Care	R1,654			
4. Buffalo City MC	Primary Health Care	10,320			
5. Cacadu DC	Primary Health Care	13,518			
6. Camdeboo MC	Primary Health Care	2,134			
7. Chris Hani DC	Primary Health Care	2,249			
8. Gariep MC Total	Primary Health Care	853			

9. Ikwezi MC Total	Primary Health Care	643			
10 Inxuba Yethemba MC Total	Primary Health Care	3,049			
11.King D Sabata MC Total	Primary Health Care	9,198			
12. Kouga MC Total	Primary Health Care	2,496			
13. Lukhanji MC Total	Primary Health Care	2,951			
14 Makana MC Total	Primary Health Care	3,106			
15. Maletswai MC Total	Primary Health Care	855			
16. Ndlambe Total	Primary Health Care	1,895			
17. Nelson Mandela Metropole	Primary Health Care	40,594			
18. Nkonkobe MC	Primary Health Care	3,734			
19. Sakisizwe MC	Primary Health Care	776			
20. Senqu MC Total	Primary Health Care	284			
21. Stutterheim TLC Total	Primary Health Care	1,020			
22. Ukuhlamba DC Total	Primary Health Care	5,104			
23. Nelson Mandela & W.DC. NGO'S	HIV/AIDS	1,040,480			
24. Nelson Mandela Metropole and Western District Council	HIV/AIDS	R1.040.480			
Amatole District Council	HIV/AIDS	R379.000			
Chris Hani Distrct Council	HIV/AIDS	R350			
Ukhahlamba	HIV/AIDS	R300, 000			

O.R TAMBO	HIV/AIDS	R437,520			
Alfred Ndzo	HIV/AIDS	R1,149,530			

Note: Information on 2003\04 and outer years not available as yet

For 2003 to 2004 a sum of R7m will be decentralized to district municipalities for NGOs performing HIV/AIDS activities. Previously funds were allocated from the Provincial Office directly to NGOs.

SUB- PROGRAMMES

SUB-PROGRAM: HIV & AIDS, Sexually Transmitted Infections (STI) and TB Control

Budget: Provincial allocation: R70,947 plus

Conditional Grant : R38,934.00

1. .Situational Analysis

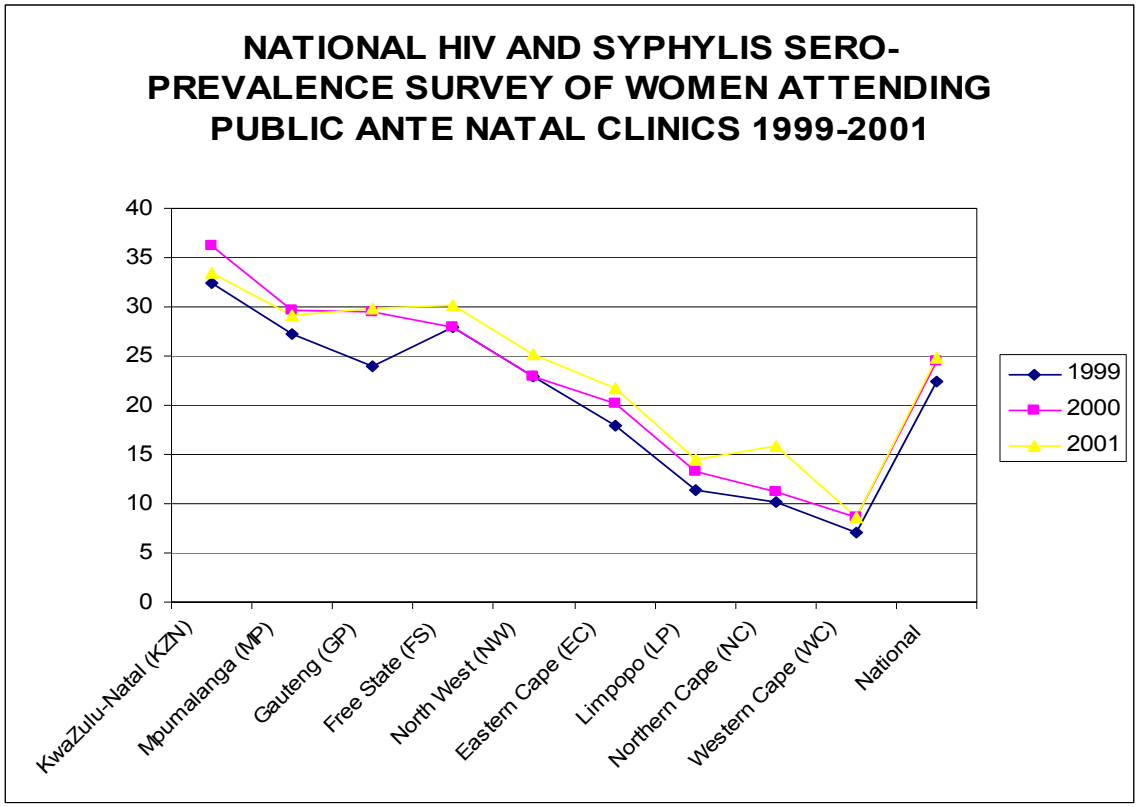
The spread of HIV/AIDS is driven by poverty, the inferior status of women, and other socio-economic conditions. Along with continued action in the health sphere, strategic alliances are needed to tackle these underlying social and economic factors. According to the Ante natal survey, conducted in October annually since 1990, HIV prevalence in the Province escalated from 12.6% in 1997 to 21.7% in 2002.

Profile of the Eastern Cape HIV/AIDS & STI Statistics

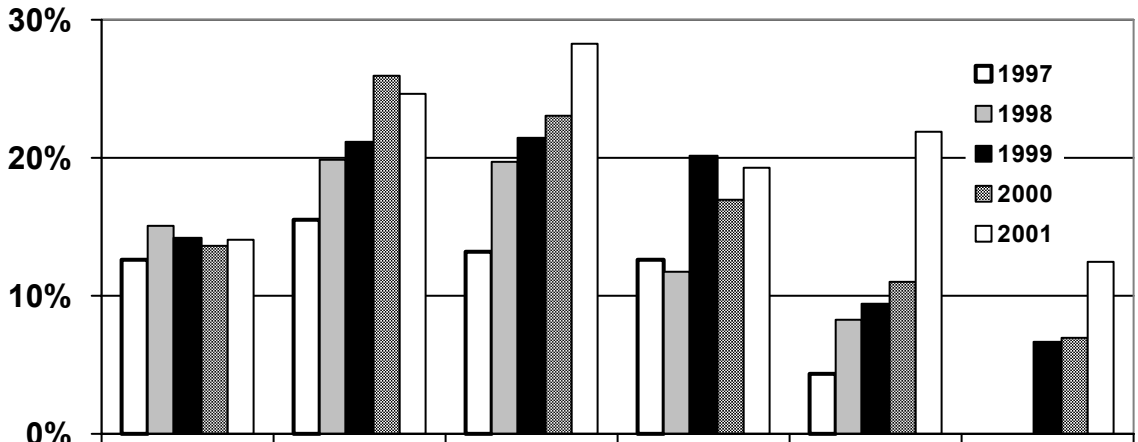
Region	Population Size	% HIV positive among antenatal clinic attendees				
		1997	1998	1999	2000	2001
A	1,411,990	15.2	21.8	22.1	23.1	19.3
B	864,272	14.2	13	15.2	16.9	22
C	1,772,299	11.6	15.8	17.1	17.8	22.9
D	1,253,373	10.7	16	17.5	22.1	23.1
E	1,397,897	12.2	21.5	22.0	24.0	22.9
Eastern Cape	**6,699,831**	**12.6**	**15./9**	**18.0**	**20.2**	**21.7**

The prevalence is more pronounced is in the Western and Eastern parts of the Province. These areas have more or less the same rate of escalation of HIV infection. The Epidemiological notes stipulate that while these areas seem to be affected the same way, HIV infection is not homogeneously distributed in a certain regions as there are different clusters of very high and very low rates in all the regions.

However, parts of O R Tambo and Alfred Nzo District Municipalities show a relatively homogeneous pattern of distribution of the virus in different sub- districts. The most heterogeneous pattern method of distribution of HIV infection is in Cacadu District Municipality and Nelson Mandela Metropolitan Municipality. In this area sentinel sites in the urban areas of the District Municipality show an average of 26% while the average HIV prevalence in the rural sentinel sites of this region is lower than 7%.



Age Distribution of HIV/AIDS: 1997-2001



	< 20	20-24	25-29	30-34	35-39	> 39
1997	12.6%	15.5%	13.2%	12.6%	4.4%	0%
1998	15.1%	19.8%	19.7%	11.8%	8.3%	0%
1999	14.2%	21.1%	21.5%	20.1%	9.4%	6.7%
2000	13.6%	25.9%	23.1%	17%	11%	7%
2001	14.1%	24.6%	28.30%	19.30%	21.90%	12.5%

Syphilis in Ante-Natal Clients

The prevalence of syphilis has decreased significantly since 1997. This can directly be related to the syndromic management of STI's. Research has shown that the control of sexually transmitted infections can help to combat the spread of HIV infection since there is a great association between the two. The syphilis prevalence of 3.3 % in 2001 reflects a reduction of about 25% compared to the figure in 1999.

Like in the HIV infection, the highest level of syphilis prevalence among antenatal clients appears in under 30 years old women.

1.2 TB Prevalence in the Eastern Cape

Our epidemiological findings show that there is a dramatic rise in TB cases from mid-1980s and this rise is directly associated with HIV. The most common cause of death among HIV positive people is TB. In many African countries

more than half of TB patients are also HIV positive. The table below shows TB incidence bin the years 2000 and 2001 in the Eastern Cape.

TB Stats	2000	2001
New Smear positive TB cases	15325	15420
All TB cases reported	34702	36720
PTB cases reported	28428	30010

Baseline Data on HIV/AIDS on PMTCT Sites

Condition	No.	1999 no./ 100 000 population	No.	2000 No. /100 000 population	No.	2001 No./100 000 population
HIV antenatal seroprevalence	18%		20.2%		21.7%	
PMTCT (Total enrolled)					17 262	
HIV Negative					3222	
HIV Positive					1336	
Total Counseled					7588	
Counseled /Tested					4713	
On Nevirapine					838	

Appraisal of Existing Services and Performance in the Past Year

The HIV/AIDS Strategic Plan of the Eastern Cape Province is in line with the National HIV/AIDS & STD Strategic Plan 2000-2005 for South Africa.

Outputs and service delivery trends in 2000/2001 Financial year.

Sub-programme	Outputs	Output performance measures/service delivery indicators	Actual Performance against target	
			Quantity	
			Target	2 Actual
Voluntary Counseling and Testing	70 sites providing VCT in the Province	70 sites operational	70 sites operational	60 sites operating
PMTCT	Two sites fully operational	Two sites operating	Two sites	Four sites
Management of Sexually Transmitted Infections	80% staff trained on syndromic management of STIs	80% staff trained	80% staff trained on syndromic management of STis	95% staff trained
Sub-programme	Outputs	Output performance measures/service delivery indicators	Actual Performance against target	
			Quantity	
			Target	3 Actual
Home/Community Based Care(Integrated National programme DoH, DoEd &Social Development)	Two sites established	Two sites operational	Two sites	Two sites operating in Mhlakulo- Tsolo & Butterworth

TB/HIV Services	Two districts East London and Qumbu Providing combined services for TB & HIV	Two districts providing full package of TB and HIV services in its facilities	Two districts with full package	One district was fully operational i.e East London
High Transmission area projects	4 sites Fully operational in East London, P.E(2), Albany district	4sites functioning	4 sites operational	Three sites one in East London and two in PE well functioning

Key Challenges over the Strategic Plan Period

- **Challenges Related to the HIV/AIDS NGO Program**

  - Lack of personnel specific for NGOs related activities at district level
  - Lack of adequate staff to monitor and evaluate funded NGOs /CBOs
  - Too large a number of mushrooming organization that need capacity building and mentoring
  - Provincial coordinators have some other line functions above that of NGOs)
  - Absence of a data base for the Provincial NGOs/CBOs and this affects planning for the needs of the next financial year funding processes.
  - Lack of coordination of funding among different departments leads to double funding of same activities and sometimes the same NGOs.

- Lack of Infrastructure: Voluntary Counseling and Testing services need adequate space for privacy and confidentiality. There is a great need to prioritize to revamp and improve health facilities at the sites that provide HIV/AIDS interventions.

- Lack of Capacity /Skills: Training and retraining seems to be one aspect that consumes a lot of our budget as most of the new interventions require

specialized skills. Most of our staff including professionals lacks some of these skills.

- Staff Shortages: This epidemic has greatly increased the demand on nursing care services for our communities. In services like counseling, there is increased consultation time (approximately 45minutes to 1 hour per client). Home-based care services also demand scarce resources like time, transport and staff. We need a greater number of lay counselors and Home Carers categories of workers.

- Cultural Barriers: Sometimes the cultural beliefs of some of our people provide challenges to the implementation of programs like condom promotion and usage. Interventions like infant feeding are faced with similar challenges in these value systems when one is implementing PMTCT Program. Counseling services become critical in dealing with these challenges.
- The Stigma Attached to the Disease: The fact that HIV/AIDS still carries some stigma makes it difficult for people to come out voluntarily for counseling and testing. Those tested do not want to disclose their status which defeats the purpose of knowing the extent of the disease and getting support and treatment at an early stage.
- Threats: Media/ Politics having a negative role on the HIV/AIDS agenda
  - Increasing pressure and burden → burnout of staff
  - Growing burden on the public health system with increased demand and decreasing staff numbers
  - Increase in orphanage and numbers of children in need of care.

Baseline Data on HIV/AIDS/STI/TB Control Program

CONDITION	1999		2000		2001	
	No.	No per 100 000	No	No per 100 000	No.	No per 100 000
HIV antenatal seroprevalence	18%		20.2%		21.7%	
VCT uptake					67%	
PMTCT					17 262	
-HIV positive					28%	
-HIV negative					72%	
- Counseled/Tested					67%	
-On Nevirapine					100%	
STIs(total cases)						
Syphilis cases			3.3%		3.3%	
New smear positive TB cases			15 325		15 420	
All TB cases reported			34 702		36 720	
PTB cases reported			28 428		30 010	

Policies, Priorities and Broad Strategic Objectives

The Department is using the 9 National Policy Guidelines in addressing the following;

- Home based care
- Step down care
- VCT services
- PMTCT
- Condom distribution etc.
- Post exposure prophylaxis (violence/abuse related exposure of women and children).

A set of nine HIV/AIDS Guidelines were received from the National Department of Health, comprising of the following:

- Management of occupational exposure to HIV
- Post exposure prophylaxis
- Ethical consideration for HIV/AIDS clinical and epidemiological research
- Rapid HIV testing
- Prevention of mother –to –child HIV transmission and management of HIV positive pregnant women
- Feeding of infants of HIV Positive mothers
- Testing for HIV
- Tuberculosis and HIV/AIDS
- Prevention and Treatment of opportunistic and HIV related diseases in adults
- Managing HIV in children

Constraints and Measures to Overcome Them

- **Finance and Financial Management**:

There is under spending of current budget in Public service.
There is a need to streamline our systems so as to speed up delivery.

- **Human Resources**

There is shortage of personnel to provide quality services
There is need to allow different service providers including NGO's to render these services. It is also important that we afford contributions by communities and civil organizations in the fight against this disease.
Training of Community Health Workers to provide DOTS and Home Based care support.

- **Logistics**

There is shortage of drugs and inadequate distribution of condoms to rural areas.

We need flexible procurement procedures in respect of outsourcing some of the services including condom distribution

- **Clinical & Technical constraints**

There is shortage of laboratory staff for testing leading to overburdening of nurses.

There is need to train and employ laboratory assistants in heavily loaded clinics to do testing. We need more innovative ways of doing things and alternative solutions especially for rural areas.

Quality Improvement Measures

- Community involvement in HIV & AIDS management; increased number of civil organizations involved in the care of those infected and affected by the epidemic.
- Development of CHWs programme to support TB and HIV/AIDS programmes
- Increased access to VCT programmes.
- Increased number of people seeking VCT
- Increased number of people living with HIV who have access to Home Community based care.
- Proper and effective management of Opportunistic infections.
- Increased productivity and quality of life among clients living with the disease

4 Objectives and Evolution of Performance Indicators

Objectives	**Indicator**	**2001/02 actual**	**2002/03 (est.)**	**2003/04 target**	**2004/05 Targ.**
To reduce the incidence of HIV/AIDS and STDs	Decrease in the number of new infections	21.7%	Static		
Improve treatment of O.I, care & support for people living with & affected by HIV	No of Health facilities providing Rx of opportunistic infections- No Linking to HBC	50%	75%	100%	100%
Improve access to HIV Counselling & Testing	No of Facilities providing VCT	8%	20%	50%	100% Health Facilities
Increase access to youth friendly reproductive health services	50% facilities providing youth-friendly services	0.5%	5%	25%	50% of all facilities
Improve Treatment and management of STI	100%facilities of all types offering syndromic management of STIs	95%	100%	100%	100%
Reduce the Transmission of HIV during child birth	% of facilities implementing clinical guidelines to reduce MTCT	65%	80%	100%	100%
Reduce the mortality and morbidity of **TB**	TB cure rate increased to 85 by 2006	61.7%	65%	75%	85%
	Decreased treatment interruption	21%	18%	15%	10%
	Smear Conversion rate	64%	70%	75%	85%

Intergrated Nutrition Programme

Budget: R172,465,000

Situational Analysis:

The budget 2002/2003 for the INP was 131 million of which 114 million was allocated to the PSNP, the balance being apportioned to the other KPAs as mentioned.

The primary school feeding commenced on the 22nd July 2002 after an absence of 3 months. This scenario will result in an under expenditure for the 2002/03 to the tune of about 41 million.

The PSNP is but one of the key performance areas, however it constitutes about 84% of the total INP Budget.

The major challenges are:

1. The seamless transfer of the PSNP from Health to Education in the 2004/05 financial year. A joint technical working group has already been established between the two departments.
2. Filling of vacant posts.
3. Community involvement, in terms of the PSNP.
4. The referrals system.
5. integration with other sectors has been mentioned above, again driven and ensured by Social Needs Cluster. The exact trend of integrating all the initiatives is in progress, but already we are seeing the benefits through poverty alleviation initiatives.

6.

The INP's strategic objective is to decrease morbidity and mortality rates through strategic interventions to prevent and manage malnutrition. The relevant key implementation strategies are:

- To intensify implementation of INP as guided by the UNICEF Conceptual Framework and the Triple A Approach.
- To promote community based growth monitoring.
- To strengthen nutrition interventions at health facility and community levels to rehabilitate malnourished children.
- To work with other sectors in tackling the root causes of malnutrition and poverty.
- To promote food fortification.
- Food security

The Eastern Cape is one of the poorest provinces in the country with high unemployment rate and single parent households. Poverty has greatly affected food security and child nutrition.

TABLE: OBJECTIVES AND PERFORMANCE INDICATORS

OBJECTIVES	INDICATORS	2001/02 ACTUAL	2002/03 ESTIMATE	2003/04 TARGET	2004/05 TARGET
Disease Specific Nutrition Support Treatment & Counseling To contribute to the reduction on the prevalence of • Low birth weight • Malnutrition in children <5 years • Underweight • Stunting • <5 years mortality rate	Number of children under the 3rd percentile Children above 10th percentile Mortality rate under 5 years	12.2 2.47 61.2%	2.00 61.2	1.5% 55%	1% 50%

Growth Monitoring & Promotion • To prevent & reduce growth faltering among children 0-24 months. • To ensure that all new born babies are provided with Road to Health Cards.	Availability of RtHC & increase number of children with RtHC Train the community on growth monitoring	 60%			85% 85%
Nutrition Promotion, Education & Advocacy • To ensure the development of policies that would support & contribute to the goals & objectives of INP • To improve nutrition related knowledge, practices, perception & attitudes. • To improve awareness of the INP, its focus areas & nutrition in general.	Number of Policies developed Improved Nutrition related knowledge practices, perceptions & attitudes Improved awareness & knowledge of INP focus areas.				
Micronutrient Malnutrition Control • To reduce child Vit A deficiency • To reduce child iodine deficiency • To reduce child iron deficiency from to	No of children <5 yrs with Vit A deficiency No of children <5 yrs with iodine deficiency No of children <5 yrs with iron deficiency.	.			

Table: Baseline nutrition indicators*

Indicator	Provincial status	Data source
Child stunting	23.2%	National Food Consumption Survey 1999
Child wasting	2.8%	National Food Consumption Survey 1999
Child underweight	10.6%	National Food Consumption Survey 1999
Child severe underweight	2.1%	National Food Consumption Survey 1999
Adult overweight	23.1%	South African Demographic and Health Survey 1998
Adult obesity	20%	South African Demographic and Health Survey 1998
Child vitamin A deficiency	31.1%	South African Vitamin A Consultative Group Survey 1995

Child iron deficiency	20.6%	South African Vitamin A Consultative Group Survey 1995
Iodine deficiency disorders	9.5%	National Iodine Deficiency Disorder Survey 1998
Exclusive breast feeding	-	South African Demographic and Health Survey 1998
Continued breast feeding	-	South African Demographic and Health Survey 1998

*Definitions of the indicators are given in the appendix to this annex.

Table: Performance indicators for the integrated nutrition programme*

Indicator	**Province wide value**	**By health district**	**National target by 2005**
Input			
1. Percentage of nutrition posts filled at all levels against nutrition staff establishments	28%	✓	100%
Process			
2. Provincial monthly financial reports in terms of Division of Revenue Act submitted to national department by 10th working day of following month	submitted		Each province
Output			
3. Percentage of newborn babies given road to health chart**	60%		85%
4. Number of actual school feeding days as percentage of target number of school feeding days	120	✓	156 days
Quality			
5. Percentage of facilities with maternity beds certified as baby friendly against total facilities with maternity beds	7.5%		15%
Efficiency			
6. Percentage of INP conditional grant spent	69%	✓	100%
Outcome			
7. Percentage of stunted children under five years***	23.2%		< 20%
8. Percentage of underweight children under five years***	10.6%		< 10%
9. Percentage of wasted children under five years***	2.8%		< 2%
10. Percentage of severely underweight children under five years***	2.1%		< 1%
11. Percentage of iron deficient children under five years***	31.1%		0%
12. Percentage of iodine deficient children under five years***	9.5%		0%

*The symbol ✓ means that the indicator value should be reported. Definitions of indicators are given in the appendix to this annex.

**Indicator should be reported on after the findings of the next South African Demographic and Health Survey are known.

***Indicator should be reported on after the findings of the next five year nutrition survey are known.

WEIGHTING PER PROVINCE ACCORDING TO THE REVISED INDEX

PROVINCE	INDEX POVERTY GAP (65%)	INDEX POPULATION 0-15 YEARS LIVING BELOW THE POVERTY LINE (30%)	INDEX ANTHROPOMETRY				TOTAL INDEX (100%)	Adjusted index (Adjusted as a result of changes to baseline to ensure no province receive less than their original allocation prior to the change in methodology
			HEIGHT FOR AGE INDEX (1.2%)	WEIGHT FOR AGE INDEX (1.5%)	WEIGHT FOR HEIGHT INDEX (0.3%)	TOTAL ANTHROPOMETRY INDEX (5%)		
Eastern Cape	22.05%	21.99%	9.88%	6.91%	4.84%	7.89%	21.3%	21.78%

Table: Baseline nutrition indicators*

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

AIM: To render efficient and effective emergency medical services to all the inhabitants of the Province of the Eastern Cape

Programme objectives:-

- Provision of pre-hospital emergency care
- Transportation of the sick and injured

Budget : R364,774,000

Budget by Sub-programme:-

Emergency Transport :- R151,111,000

Planned Patient Transport R 213,663,000

Total R364,774,000

1. Situational analysis - This strategic plan contains issues pertaining to the provincialisation of the EMS and short , medium rationalization and redistribution of assets.
Presently the EMS is operating ambulance services with a single demand. This is contrary to the national norms and standards.

1.1 Staff
Number of posts 1,148; Vacant 400
These figures include Local Government Posts. Currently Municipalities of these areas have advertised about 80 posts.

1.3. Total Number of vehicles - 348. These includes ambulances, Rescue vehicles, Patient transport vehicles, Service vehicles and response vehicles. Presently an order of 100 vehicles has been placed and more that 50% of these are ambulances and rescue vehicles.

1.4 Number of patients conveyed and kilometers traveled

	2000/01	**2001/02**	**2002/03 (Est.)**	**TOTAL**
PATIENTS	340,000	400,000	390,000	1,130,000
KILOMETERS	9,100,000	11,000,000	9,000,000	29,100,000

1.5 Cost

R45.00 per kilometer to run an ambulance
This is against the national norm of R15.00

1.6 Services currently rendered
Emergency medical services
- Rescue services
- Planned patient transport services
- Aero- Medical evacuation services – fixed and non – fixed wing.

1.7 EMS derives its mandate from the following

- The Constitution of South Africa Act (Act 108 of 1996) which stipulates that Emergency services are a provincial competency
- Disaster Management Act
- Batho Pele principles
- Service Level agreements with Municipalities
- The vision of the national committee on EMS

1.8 Challenges and Constraints
- Inadequate resources i.e staff, budget, vehicles and equipment
- High maintenance costs of vehicles
- Terrain / bad roads especially in certain areas in the former Transkei region

1.9 Planned quality improvement Measures
Reduce response time
- Provision of a two men ambulance crew by filling vacant posts
- To reduce the maintenance of costs of the Provision has been replaced made in the 2003/4
- In the next financial year additional staff will be employed. Municipalities have already been provided funds to fill their vacant posts.
- The implementation of the Pilot project in aeromedical evacuation is addressing the problem of inaccessibility to certain rural areas.
- Maintenance plan for equipment including vehicles is to be developed
- Developing norms and standards for emergency medical services
- Increasing the number of staff trained in life support at advanced level

2. OBJECTIVES AND PERFORMANCE INDICATORS

Objective	Indicator	2000/01	2001/2	2002/3	2003/4	2004/5
1. To provide an effective and efficient emergency medical services	- No. of patients transported per 1000 per year - Total number of kilometers traveled per year	23 9,1 m	20	43 9m	- 50 patients per 1000 inhabitants 11,000,000 kilometers per annum	60 12m
2. To improve accessibility to Emergency Medical services	- No. of vehicles per 1000 people	1	1	1	1 vehicle per 1000 inhabitants	2
3. To establish an effective communication system	Response times within current National targets	Not recorded	Not recorded	Rural 45mts – 1hour Urban 20mts – 30mts	Response time 20 mins: Urban 50 mins: Rural against the National target. Urban: 15 minutes Rural: 40minutes Integrated control centres in East London, Umtata and Kokstad	15 mins: Urban 40 mins: Rural because of additional vehicles and personnel
4. To establish an adequate Planned Patient Transport system in the province	-% of callouts answered by a single ambulance crew - Total kilometers traveled p.a.	2%	3%	3%	3% of callouts answered by a single crew	1%
5. To provide and maintain medical equipment and vehicles	- No. of vehicles repaired per year Maintenance plan and costs	6% replaced	8%	3%	Replacement of 35% of the existing fleet by March 2004	40%
6. Provide adequately trained staff to render EMS	- % of staff trained in Basic, Intermediate and Advanced life support courses	BAA = 35% AEA =24%	BAA = 40% AEA 30%	BAA = 41% AEA = 30%	- 44% of staff to be trained in BAA, 52% in AEA and 30% in Advanced Life Support -	BAA = 60% AEA = 68% ALS = 36%

					Single crew ambulances abolished	

3. Past expenditure trends

Evolution of expenditure by budget programme

Sub-programme	2000/01	2001/2	2002/3	2003/4	2004/5	2005/
1.Emergency Transport	117,032,000	87,314,000	119,488,000	151,111,000	159,422,000	168,9
2.Planned Patient Transport	156,668,000	185,103,000	181,541,000	213,663,000	225,595,000	239,1
3.Medical Evacuation –Fixed & Non – fixed wing	Nil	Nil	Nil	9,727,000	10,641,000	15,92
Total	**273,700,000**	**272,417,000**	**119,488,000**	**374,772,000**	**395,658,000**	**424,0**

PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES

AIM : To provide cost effective, good quality, high level specialized services to the people of the Eastern Cape in collaboration with the Health Sciences Faculties

BUDGET:	R1,736,779,000
General Hospitals:	R1.373,953,000
T.B. Hospitals:	R94,712,000
Psychiatric/Mental Hospitals	R268,114,000

1.1 SITUATION ANALYSIS

There is at present no standardized functional hospital management information system that will provide up to date information about the cases that are managed by the provincial & academic hospitals in the EC. The most recent information is a survey of these hospitals that was conducted at these institutions in 1999.The findings of this survey were consistent with the socio-demographic profile of the EC province.

The disease burden (in terms of case management at these institutions) and health status of the EC was ***typical of a developing country undergoing a demographic transition:***

- High infant mortality and morbidity related to diarrhoea, upper respiratory tract infections and injuries
- High maternal mortality rate of 131 maternal deaths per 100 000 hospital deliveries
- An increase in the chronic diseases of lifestyle such as cardiovascular disease and gastrointestinal tract diseases with a prevalence of 11% and 13%, respectively
- In urban area high number of cases and deaths related to violence (trauma such as rape and accidents)
- HIV/AIDS just beginning to appear as cases in the medical wards

There was also evidence of ***inequity of health status and health care delivery***. For example, in institutions in the former Transkei there was a higher incidence of and death related to malnutrition and diarrhoea when compared to the eastern half of the province. This reflects the lower socio-economic position of people in the eastern half of the province enforced through decades of Apartheid. It also reflects the inconsistent application of the Ten Steps of the Hospital Management of Malnutrition.

The pattern for maternal deaths in 2000 was consistent with the 1999 sceaniro-53% of maternal deaths in 2000 occurred in the north-eastern part of the province. No deaths from outside the public sector were included in this review of hospital records. It seems likely that maternal mortality amongst women delivering at home would be significantly higher, especially in the north-eastern part of the province

.

1.2 CONFIGURATION OF HOSPITAL SERVICES

The Provincial & Academic Hospitals (PAH) unit consists of 3 Hospital Complexes and 2 regional hospitals (see table 1 below). The theoretical referral patterns are from PHC clinics and community health centers to the 65 district hospitals and 14 provincially aided hospitals, and from these to the hospital complexes and regional hospitals listed in table 1. In practice, in the absence of a fully functional district health system, referrals are sometimes directly to secondary and tertiary level, bypassing community health centers and district hospitals. A provincial guideline for the development of practical referral systems has been developed, but not yet implemented.

TABLE 1: PROVINCIAL & ACADEMIC HOSPITALS IN THE EC

HOSPITAL COMPLEXES CONSISING OF:	
1. East London Hospital Complex	4.1 Cecilia Makiwane
	Frere
2. Port Elisabeth Hospital Complex	*Dora Nginza*
	Livingstone
	PE Provincial
3. Umtata Hospital Complex	*Bedford Orthopaedic*
	Umtata General
	Nelson Mandela Academic
REGIONAL HOSPITALS	
St Elisabeth's	
Frontier	

1.3 DEMAND FOR HOSPITAL SERVICES & UTILISATION

The Performance Expenditure and Analysis Review (PEAR) system is not fully functional within the PAH unit as yet. The poor quality of the data currently available on this computerized system makes it difficult to quantify the utilisation and efficiency of these hospital services with any great degree of accuracy.

However, a thorough study of these factors was made in 1999 during the execution of the Hospital Transformation Project in the EC (see table 2). *All*

hospital beds (district and provincial / academic hospitals) by level of care were assessed during 1999. Of the level I beds listed in table 2, 7007 beds were located at district hospitals; and the level II and III beds were located in the PAH as listed in Table 1 above. Although there may be slight variations in the actual data at present, the trends and deductions that were true in 1999 are still applicable in 2002.

TABLE 2. SUMMARY OF HOSPITAL BED DISTRIBUTION, UTILISATION AND EFFICIENCY BY LEVEL OF CARE IN 1999

Level of care	Beds 1999	Beds/1000	Admissions per year	Admission rate/1000	Inpatient Days	ALOS	Occ %
LI	7407	1.21	286,525	46.8	1,796,895	6.3	66
LII and LIII	LII=3858 LIII=516	0.62 0.08	207,685	33.9	1,358,895	6.5	90

- The EC exceeded the national affordability guidelines of 1.0 beds/1000 population for level I, and 0.5/1000 for level II beds in 1999. However, the EC was below the national guideline of 0.1/1000 for level III beds. Beds numbers needed to be rationalised accordingly.

- The efficiency indicators of ALOS were just outside the national norm of 3-5 days. The occupancy was too low for the level I beds and too high for the level II and III beds when compared with the national norm of 85%. Possible explanations for the low occupancy rate include that there are too many level I beds in the province and that efficiency is low within these institutions.

- Similarly, high occupancy rates with higher than normal ALOS indicates that the hospitals are not functioning at maximum efficiency. Again, there is a need to rationalise institutions in order to improve efficiency of service delivery.

As can be seen from the summary information above, there is a need to rationalize the number of hospital beds and thus align affordability, and efficiency of hospital service provision.

This means:

Step 1: Calculating the appropriate number of beds by level of care that are required for the EC population, factoring in affordability ratios and distributing these amongst the 3 referral zones of the 3 hospital complexes; Frontier falling within ELHC and St Elisabeth falling within the Umtata HC zones, respectively. See Table 3 below.

Step 2: Allocating these beds by level of care for each discipline within each hospital complex (see annexure 1)

Whilst these steps appear quite straightforward, rationalisation must be seen within the context of the broader strategic position statement and must be reconciled through active consultation with communities and all levels of health workers. Rationalisation is the first step in the direction of redressing inequity of service provision. It is not a destination, but an iterative process in the quest for high quality hospital services.

TABLE 3 : PROPOSED RATIONALISATION OF BEDS IN PAH

Facility	LII Beds	LIII beds	Total Beds	L II beds /1000	L III beds /1000
Actual Beds 1999					
Port Elizabeth Hospital Complex Zone	1372	244	1616	0.82	0.15
East London Hospital Complex Zone	1798	178	1976	0.82	0.08
Umtata Hospital Complex Zone	688	94	782	0.30	0.04
Total actual beds	**3858**	**516**	**4374**	**0.63**	**0.08**
HTP recommended beds 1999					
Port Elizabeth Hospital Complex Zone	842	254	1096	0.51	0.15
East London Hospital Complex Zone	1123	220	1343	0.51	0.10
Umtata Hospital Complex Zone	760	100	860	0.34	0.04
Total HTP recommended beds	2725	574	3299	0.44	0.09
Bed requirements to achieve equity at 0.5 beds/1000 for LII and 0.1 bed/1000 for LIII					
Port Elizabeth Hospital Complex Zone	833	167	1000	0.50	0.10
East London Hospital Complex Zone	1100	220	1320	0.50	0.10
Umtata Hospital Complex Zone	1132	226	1358	0.50	0.10
Total beds	**3065**	**613**	**3678**	0.50	0.10
Bed adjustments to HTP recommendations to achieve equity					
Port Elizabeth Hospital Complex Zone	-9	-87	-96	0.50	0.10
East London Hospital	-23	0	-23	0.50	0.10

Complex Zone					
Umtata Hospital Complex Zone	372	126	498	0.50	0.10
Total beds	**340**	**39**	**379**	0.50	0.10

Population of PEHC Referral Zone in 1999:	1,665,733
Population of ELHC Referral Zone in 1999:	2,200,007
Population of Umtata HC Referral Zone in 1999:	2,263,092
Total public sector population in 1999:	6,128,832

1.4 PROGRAMME PERFORMANCE ANAYSIS OVER 2001/2002

STANDARD ITEM	ACTUAL EXPENDITURE 2001/02	ALLOCATION 2001/02	VARIENCE
PERSONNEL	784 629 953.46	829 089 397	44 459 443
ADMINISTRATION	11 187.596,55	4 977 420	(6 210 176)
INVENTORY	180.115.247,88	129.731.926	503.833.321
PROF. & SPEC.	654.62109,50	775.19342	120.57232
EQUIPMENT	443.07742,17	718.52983	275.45240
TOTAL	R1 090 178 535.46	R1 113 942 311	R23 760 337

Expenditure Per Standard Item

Personnel
This reflected an under expenditure of R44 459 443, which is5.7% of the Personnel budget. The reason for this under expenditure was that no new appointments were done, to replace exited personnel, who were already budgeted for, also no critical posts were filled.

Administration
This reflected an over expenditure of R6 210 176 which is 55.5% of the Admin budget. The main areas of over expenditure were:

- Government motor transport. This showed a 130.7% expenditure above the budgeted amount. This reflects mainly on the state of the vehicles which need constant repairs. This also reflects the petrol increases that took place in the financial year.
- Telephones. This showed a 264.4% expenditure above the budgeted amount. This reflects under budgeting. It may also be a reflection of poor controls, with abuse from internally in the institutions, and externally, where institutions are paying for lines they do not own.

- Regional Services Council Levy. This showed a 138% expenditure above budgeted amount. This is however 0.05% of Salaries (should be 0.03-0.04%).

Stores and Livestock (Inventory)
This showed an over expenditure of R50 386 759, which is 38.8% of this budget. The major cost drivers are, Medical consumables, which include, medicines, surgical and dental bandages and instruments, as well as surgical implants. These reflect an under budgeting, as reflected by our cost per patient day equivalents, which are below National norms. This means that we are not budgeted as tertiary service providers, even though we do offer these services. There is also what seems to be an obvious discrepancy in Stationery, where actual expenditure is R2 249 082.42, but the budget started with a negative figure of (R26 405 043), leading to a variance of (R28 654 125).

1.5 KEY CHALLENGES OVER THE STRATEGIC PERIOD

There are four key areas that will challenge PAH service delivery during the strategic period 2003-2006:

(a) Service Delivery

- Inappropriate staffing with critical vacancies across all categories of health workers and yet surpluses across others
- Implementation of the rationalization proposal
- Revitalisation of hospital services including the organization development of PAH and the improvement of quality of care at all institutions
- Burden of HIV/AIDs on PAH services
- Increased ALOS

(b) Management and Organisational Development

- Decentralisation of management to CEOs
- Implementation of key policies regarding financial and HR management
- Recruitment and retention of professional staff, especially to rural areas

(c) Financial management

- Appropriate allocations of the equitable share and improved expenditure of these allocations
- Monitoring of budgets in the absence of skilled institutional staff and well defined financial systems and controls

(d) Training & Learning

- No corporate memory of HR management and development at institutions
- Non-compliance with interns and community service doctors accreditation standards

2. POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

The policies, priorities and broad strategic objectives are determined by the health status of the EC population, the patterns of disease and the environmental and service delivery challenges anticipated during the strategic period. These have all been outlined in Section A as well as in this section on PAH.

The broad goals of the 2003-2006 period as well as the corresponding strategic objectives can be found in the table 4 below:

TABLE 5 : STRATEGIC GOALS & OBJECTIVES 2003-2006 FOR PROVINCIAL & ACADEMIC HOSPITAL SERVICES

(A) SERVICE DELIVERY

STRATEGIC GOAL	***OBJECTIVE***	***INDICATOR***	***2002/2003***	***2003/2004***	***2004/2005***	***2005/2006***
1.Improve hospital management through appropriate staffing	Finalise organogram	Proportion of PAH with finalized organogram	In progress	100%		
	Appoint identified staff	Proportion of identified staff appointed	50%	65%	80%	100%
	Appoint support staff for CEOs	Proportion of identified support staff for CEOs appointed		50%	80%	100%
2. Rationalisation of PAH services	Ratify service plans	Proportion of service plans ratified		100%		
	Detailed institutional work plans	Proportion of institutions with detailed work plans		100%		
	Monitor implementation of work plans	Percentage reduction/increase in beds by level of care for each institution		Commence June 2003	Complete March 2005	
3. Revitalisation of PAH	Infra-structural development & rehabilitation	- All institutions to have costed maintenance priority lists - Expenditure on hospital maintenance as a percentage of total hospital expenditure		100% by June 2003	Yearly reviewal of priorities	

STRATEGIC GOAL	OBJECTIVE	INDICATOR	2002/2003	2003/2004	2004/2005	2005
3. Revitalisation of PAH	Equipment available and in working order	Proportion of hospitals with completed technology audit		25%	65%	100%
	Quality of Care institutionalized	Maternal mortality rate in PAH deliveries	130/100 000	130/100 000	120/100 000	<100/10
		Infant mortality rate	61.2%	61.2%	55%	50%
		Case fatality rates				
		ALOS	7-9	6-8	5-7	4-6
		Bed occupancy rate	78%	80%	82%	85%
	Development of strategic plan for organizational development over 5 years	Plan developed				
4. Development of Tertiary Services	Set up coordinating structure at provincial level for clinical service delivery	Provincial structure launched				
	Draft provincial strategy for development of tertiary services in the EC	Provincial strategy drafted				

	Implement strategy	Variance in NTSG expenditure		25%	15%	<10%
5. Management of HIV/AIDS	Step down facilities at 3 complexes and 2 regional hospitals	Proportion of PAH with step down facilities		3 out of 9 PAH	5 out of 9	7 out of
	Impact assessment of HIV/AIDs on hospital service delivery & staff	Impact Assessment Report				
	Provincial strategy informed by impact assessment	Provincial strategy drafted				
5. Research in PAH	Develop a framework for research being conducted in PAH	Regulatory Framework drafted				
	Monitor research being conducted in PAH, ensuring compliance with the regulatory framework	Database of research being conducted at PAH		Commence June 2003/2004		

(B) MANAGEMENT & ORGANISATIONAL DEVELOPMENT

STRATEGIC GOAL	*OBJECTIVE*	*INDICATOR*	*2003/2004*	*2004/2005*	*2005/2006*
1. Decentralise management	Framework drafted	Decentralisation framework	June 2003		
	Work plans detailed for systematic transfer of authority and responsibilities to CEOs	Decentralisation Work Plans	September 2003		
	Monitor implementation of work plans		Until March 2003		
2. Policy Coordination	Identify relevant policies and verify applicability	Database of key policies	Commence		
	Communicate policies internally/ externally	Proportion of policies in database distributed to PAH		80%	100%
3. Improve Organisational Culture	Retention of staff strategy	Strategy drafted			
	Instill a disciplinary culture	Proportion of disciplinary cases resolved	Baseline determined	Depends on baseline	Depends on baseline

	Improve labour relations	Proportion of institutions with functional ITU	70%	80%	100%
4. Improve management systems	Develop and implement a standardized management reporting system	Standardised report Proportion of CEOs submitting standardized reports	Report Completed and tested in 2003/2004	100% submitting reports	Improved quality of data with time
5. Recruitment of professional staff	Develop a recruitment plan related to identified critical posts	Recruitment plan drafted			
	Develop a recruitment plan for professionals to rural	Recruitment plan drafted			
6. Strengthen Co-operation with international partners, NGOs and local private health care providers	Identify international partners and NGOs involved in health care	Database of international partners and local private health care providers	Commence 2003/2004	_____	_____

(C) FINANCIAL MANAGEMENT

STRATEGIC GOAL	*OBJECTIVE*	*INDICATOR*	*2003/2004*	*2004/2005*	*2005/2006*
1. Processes to ensure financial systems and controls in place	Implementation of PFMA and PPPFA	Proportion of CEOs underwent PFMA training Incidence of irregularities in institutional financial management	100% Baseline to be determined	Depends on baseline	Depends on baseline
	Budget in line with MTEF	Percentage of under/ over-expenditure across various standard items	Less than 20%	Less than 15%	<5%
	Institutionalise PEAR	Percentage of institutions complying with PEAR	100%	Improve quality of the data	_____
2. Skilled financial staff	Fill vacant posts	Proportion of vacant posts filled	30%	60%	85%
	Train staff	Proportion of staff trained from identified training needs	50%	70%	85%
3. Cost-centred accounting (cca)	Design an approved cost-centre structure	Approved cost-centre structure	March 2003		
	Build capacity to implement cca	Proportion PAH with report on existing capacity Proportion of PAH with strategies to build capacity	100%		

STRATEGIC GOAL	OBJECTIVE	INDICATOR	2003/2004	2004/2005	2005/2006
4. Donor funds	Improve utilisation of donor funds	Variance between donor funds and expenditure	Baseline to be determined	Depends on baseline	Depends on baseline
	Identify opportunities for foreign investment	Database of opportunities for foreign investment	Commence	_____	_____

(D) TRAINING & LEARNING

STRATEGIC GOAL	OBJECTIVE	INDICATOR	2003/2004	2004/2005	2005/2006
1. Ensure skills development plan in place	Needs assessment at each institution	Percentage of PAH with needs assessment completed	60%	75%	100%
	Develop and implement a work plan	Percentage of PAH that have completed the implementation of their work plans	3 out of 9	5 out of 9	7 out of 9
2. Establish and maintain a training database	Create a database	Database created			
	Collect, collate and capture data on an ongoing basis	Percentage of institutions that are collecting data for 6 consecutive months of a financial year		30%	65%
	Continuous review of database	Percentage of PAH that submit quarterly reports on training profile		Commence April 2004	_____
3. Utilisation of learning to support organizational goals	Implement a system of pre- and post-training	Percentage of PAH with up to date records of feedback during annual	Commence September 2003	_____	_____

	assessment	random employee record review			
3. Utilisation of learning to support organizational goals	Establish skills development committees as part of the OD of PAH	Proportion of PAH with established skills development committees	3 out of 9	5 out of 9	7 out of 9
4. Ensure institutions comply with HPCSA standards for intern and COSMOS training	Set up and run induction programmes for interns and COSMOS	Annual induction programmes held	Commence 2003/2004	_____	_____
	Inspect all institutions to ensure they comply with HPCSA standards & take necessary corrective measures	Percent of PAH with work plans to ensure compliance with HPCSA standards	100%	Phased implementation over 2 years	_____

B SUB-PROGRAMME: SPECIALISED SERVICES (PSYCHIATRIC HOSPITALS & MEDICO LEGAL SERVICES)

Situational Analysis:

The sub-programme encompasses five Psychiatric hospitals and two Mental Health units plus Medico Legal Services

The hospitals and Mental Health units in programme

1. Tower hospital - Fort Beaufort
2. Fort England - Grahamstown
3. Umzimkulu - Umzimkulu
4. Komani Hospital - Queenstown
5. Elizabeth Donkin - Port Elizabeth
6. Mental Health Unit - East London Hospital complex
7. Mental Health Unit - Umtata General Hospital

The cabinet has taken decision to transfer Medico Legal Mortuaries from SAPS to the Department of Health. Awaiting the transfer of
funds from National Office to the ECDOH

The Mental Health Services like many other services are fragmented . There is inequity in the distribution of hospitals and beds
Transformation plan has been developed which requires implementation. The plan recommends downsizing of chronic beds and
Increase acute beds with emphasis to develop community Psychiatric Services.

The Eastern part of the province has been virtually deprived of Psychiatric Services. According to the Norms and HTP, there should be
150 acute psychiatric beds in Umtata and 50 acute beds each in Libode & Flagstaff

The department has been experiencing problem in attracting and retaining of professionals due to rural nature of the Eastern Cape.
There is a need of a strategy to attract and retain professionals

Achievements During 2001/2002 include:

1. The deinstitutionalization project has be started at tower Psychiatric hospital. 25 patients have been discharged to the community

2. Transformation plan is complete and has been approved

3. Clinical guidelines have been developed

Constraints

- Services are currently largely custodial. Conditions in many institutions are extremely poor.
- Services, both hospital and community, tend to be medical rather than rehabilitative.

- Mental health is mainly run as a vertical service, and is currently not intergrated into health care.
- Lack of Community Psychiatric services

Budget analysis

ACTUAL EXPENDITURE 2001/02	ALLOCATION 2001/02	VARIENCE	% VARIENCE
R90 961.38	R127 303 493	R36 341 771	28.5

The above analysis is also reflective of the situation in the specialised hospitals(Mental Health) even
Though there was a much higher under spending. The total budget was R127 303 493, and there was under expenditure of R36 341 771, which was 28.5%. The major under spending was in Personnel, which was R32 764 721 (58.8% of Personnel allocation)
the reason for the under spending in the Personnel was due to the fact that the employees in Specialised Hospitals were paid
through the Programme I. This problem is being rectified .

Key Challenges over Strategic Period

- Geographical access to mental health services is severely limited – especially in rural areas. e.g Umtata, Flagstaff & Libode
- Inequity in distribution of hospitals and beds, especially in Eastern part of the province (Umtata etc.)
- Lack of Quality Assurance Programme.

- Implementation of Mental Health Care Act.
- Shortage of staff and insufficient training
- The transfer of Medico Legal Mortuaries from SAPS to Eastern Cape Department of Health

STRATEGY	OBJECTIVE	INDICATORS	TARGETS
1. Improve Hospital Management	1.1. 90% of Hospital Managers appointed	Percentage of Hospital Managers appointed	Dec. 2002
	1.2. Ensure hospital managers have adequate support staff	Percentage of Support Staff appointed	March 2004
	1.4. Enhance Management capacity and training	Proportion of hospital managers trained	March 2004
2. Rationalisation of psychiatric services to ensure equity & access	2.1 To establish 60 bedded mental health unit in Umtata (with the intention to expand to 150 beds in the next 5 years)	Functional Mental unit	June 2004
	2.2 To establish rehabilitation centre at Tower Hospital	Functional Rehab Centre	Dec. 2002
	2.3 To establish 50 bedded Mental health units one each in Libode & Flagstaff	Functional Mental units	2006
3. Rehabilitation & Revitalisation of hospitals	3.1 To develop plans for maintenance of hospitals	Proportion of maintenance work done	Dec. 2002
	3.2 To develop plans for capital project	Proportion of Capital work done	Dec 2002
4. Improve quality of care	4.1 Ensure all Psychiatric Hospitals have programme for quality assurance	Proportion of Psychiatric Hospitals which have quality assurance teams Proportion of Psychiatric Hospitals which have implemented the COHSASA programme.	March 2004 June 2005
5. Improving Financial	5.1 To ensure all hospitals comply with PFMA	Proportion of Psychiatric hospitals complying with PFMA	End of 2003

Financial Management	5.2 Ensure efficient utilization of National Tertiary Service Grant (Forensic grant)	Percentage of Forensic Conditional grant utilized	Every year
6. Implementing Legislative Framework	6.1 Ensure all the Managers comply with Mental Health Care Act	Mental Heath Care Act promulgated	March 2005
	6.2 To draft Regulations and dissemination	Draft regulations in place	March 2004
	6.3 Establish Mental Health Review Boards	Mental Health Review Boards established	March 2004
	6.4 Establish designated psychiatric facilities in general hospitals	Proportion o f hospitals having designated Psychiatric facilities	June 2004
7. Improve communication	* 100% Psychiatric Hospital meetings held	Percentage of psychiatric hospitals attending meeting	October 2002
8. Development of Medico Legal service	8.1 Develop a business plan for Medico Legal service	Business plan in place	October 2002
	8.2 Establish Organogram	Organogram in place	June 2002
	8.3 Appointment of 50% Medico Legal Staff as according to the organogram	Proportion of staff appointed	April 2003

PROGRAMME: 6 :- HEALTH SCIENCES & TRAINING

Aim :- To provide training of all Health professionals in the Province of the

Eastern Cape

This Programme comp[rises of the following sub-programmes:

Sub-programme	Training
Nurse Training College	For Training of Nursing Personnel
Emergency Medical Services Training college	For training of ambulance and rescue personnel
Bursaries	To provide bursaries for nursing, medical personnel and allied health workers for candidates from within & outside the department
PHC Training	To train health workers in the PHC skills & management in order to provide effective health care services .
Training Other	To develop the knowledge, skills & attitude of the personnel in all occupational categories.

BUDGET : **R 63690,000**

SUB PROGRAMME	

- Nurse Training Colleges - Ambulance Training -Bursaries -Any other	4,6 million 1 million 6.7 million

Situational Analysis

Training Needs Assessment and Gap Analysis

Advanced Primary Health Care curriculum has been developed this includes PMTCT, HIV/AIDS children's diseases. Tutors have been trained by Equity Project.

Numbers and types of Institutions

4 – Nursing colleges
18 -Campuses
4 – Training schools
3 – Universities full- time
2 – Universities part- time
Personnel trained in these areas are nurses i.e. Degree students, 4 year Programmes and Post Basic Courses.

Eastern Cape Province has inherited the following different pieces of the legislation namely.

- Ordinances no.4 of 1984 from former RSA for training nurses and modules Eastern Cape College in the Port Elizabeth .

- Transkei Act No. 28 of 1985 i.e. Establishment of the Transkei Nursing college in terms of the health Act
- Health act 1986 Act No 24 of 1986 Regulation for the Ciskei Nursing College in terms of the health Act
- The said college were developed along the racial lines and this resulted inequitable service and resource allocation
- Duplicated fragmented services
- Absence of a uniform curriculum to standardize quality
- Shortage of the trained nurses more especially in rural areas

Nursing education is guided by the following Legislative framework

- Nursing Act (Act 50 of 1978as amended)
- Skills development Act (Act no 97 of 1978)
- Skills levies Act (Act of 1999

Policy for nursing education has been formulated this will help us in rationalization of nursing education in the Province. This is not only to improve efficiency of educational institutions but also as a means of establishing co-ordinated nursing education system that will enable nurse educators to deliver services that are responsive to the needs of all communities in the Eastern Cape.

Formal Contracts for Students Completed the Course

Absorption of trained nurses in the Province is a concern to the Nursing Colleges of the Province. Students are trained at a basic Annual Package of R42 000-00 each at 168 000-00 for four years.

This policy has been developed so that post contractual binding for those who have trained in the Province to serve after completion. Signing of the contract has been included in the Bill for the single college. It would be of great help if finance and treasury end of the year tallies with students academic year and examinations.

Disciplinary policy :

This is the policy which ensures control standards corrective action behaviour modification it is implemented in all colleges and campuses.

Appraisal of Training Programmes

Basic and Post Basic Students
Senate and college meetings for unfortunately of standards accreditation of colleges campuses clinic facility South African Nursing Council and memory done by the Province for faculty care moderation of the colleges campuses by universities of affiliation. Follow up of gaps identified and in service education of tutors in marking and evaluation of students.

RESEARCH

Problem based education community based education projects e.g. case students. This is done because the provision of knowledgeable responsible, accountable creative thinking practitioner is the focus of all efforts we make to meet the health needs of over Province. Application of research oriented training, follow steps in problem solving, decision making and utilization of research results in the communities.

A Provincial health research Committee came into existence in 1998 with the role

- Research co-ordination
- Priority setting
- Information sharing
- Funding co-ordination

Provincial tertiary institutions are all members. Provincial epidemiologist chairperson.

Achievements so far:

4. Conferences - 1999 UPE

- 2000 UNITRA
- 2001 UFH
- 2002 UNITRA

2003 effort will be at uniting the efforts of this committee with other role players.

Weaknesses

- Not clear who should generate research priority
- Lack of capacity within the department
- No clear leadership and representation
- Inability to attract funding thru competition with other Research bodies

PROPOSAL

- Department to approach MRC to strengthen research
- Employ epidemiologist and other skilled manpower
- Should be placed outside the dept

Key challenges

- One nursing education legislation or Act to repeal all old acts from 3 previous governments.
- Merger of colleges to avoid duplication of training programmes.
- Uniformity of nursing education curriculum so that the province use one curriculum as part of rationalization, free movement of students uniformity.
- Brain drain of experienced Tutors to Western countries for greener pastures.
- Poor infrastructural development e.g. renovation of buildings and roads upgrading
- More than 80% of the Province is rural with second highest population in the country.

- Poor transport especially in rural areas with poor graveled road.
- Poor conditions of service i.e. prolong process in facilitating appointments.
- Capacity building to eradicate inequities and ensure high quality standards improvement of caring ethos to communities for the Eastern Cape filling of critical posts to enhance service delivery.

Strategic objectives

1. To develop relevant programmes and one curriculum integrating Natural Health Priorities for the province of the Eastern Cape.
2. To centralize the nursing education budget into programme 6.
3. To produce competent nurse practitioners that would be able to render comprehensive primary health care

Measuring objectives and performance indicators

Activity Strategy	**Indicator**	**Targets**
1. Promulgate new nursing education legislation Act.	New law promulgated	June 2003
2. Establishment of administrative office for the provincial college.	One single provincial college administration.	Organogram to be ready April 2003
3. Merger of college establishment	Mergers of colleges completed	December 2003
4. To develop capacity of nurse educators.	Number of tutors who have attended capacity building programmes.	50% educators to have attended by December 2003
5. Development of detailed strategic plans by each campus.	Strategic plans detailing costed campus Requirements and plans to improve standards and service delivery.	By May 2003
6. Create a data base and place all nursing education personnel and students in one	Nursing education personnel budget in programme 6.	By June 2003

programme (prog. 6)		

Structured In-service Education and Skills Development

Management of HIV and clients
Home based care of Aids Patients
Management of childhood illness structured programmes by equity project

Curriculum Innovation and Development
A task team from colleges and colleges and campuses and training schools has been established curriculum development and standardisation has been done so that the curriculum gives direct benefit to the community as it looks at the problems of each specific community. Students are accompanied by tutors to community for implementation of community based education.

Use of conditional grant : Heptar
Conditional grant has been of great advantage to improve resources in training institutions. Most training institutions have been given transport for the implementation of Community Based Education. All training institutions have been issued with computers, equipment for clinical laboratory and library resources.

Constraints
In adequate transport especially in rural areas this is due to the fact that the road are poor with a lot of gravel it is worse during summer season because of rain.

Training Institutions for Health Professionals

A. Universities		
Fort Hare University	Amatole District	Alice/Bisho
Rhodes University	Council	Grahamstown
University of Port	Western District	Port Elizabeth
Elizabeth	Council	
University of Transkei	Western Distirct	Umtata
	Council	
B. Technikons		East London
	0.R. Tambo	
B. Technikons		Port Elizabeth
P.E. Technikon	Amatole	
C. Colleges Nursing	Western District	Port Elizabeth
Eastern Cape College	Council	East London
Ciskei Nursing College		East London
Frere Nursing College		Umtata
Umtata Nursing College	Western District	
	Council	Sterkspruit
D. College Campuses	Amatole District	Lady Frere
Umlamli	Council	Queenstown
Glen Grey	Amatole District	
Frontier	Council	Butterworth
	OR Tambo	Engcobo
Butterworth Campus		Kentani
All Saints	Ukhahlamba D.C.	Alice
Tafalofefe	Ukhahlamba D.C.	
Victoria Campus	Ukhahlamba D.C.	Libode
		Elliotdale
St Barnabas	Amatole D.C.	Qumbu
Madwaleni	Amatole D.C.	Tsolo
Knessie Night	Amatole D.C.	Umzimkulu
St. Lucy's	Amatole D.C.	Lusikisiki
Rietvlei		Bizana
St. Elizabeth	OR Tambo	
St. Patricks	ORTambo	
	ORTambo	
	ORTambo	

	Alfred Ndzo “ “ “ “	

INSTITUTION	PROGRAMME OFFERED	DURATION
University of Fort Hare	Bur I et A BCur	3 years 4 years
Rhodes University	BSc Pharmacy Clinical Psychology	4 years
University f P.E.	Post Graduate masters in Health Welfare	2 years part-time
University of Transkei	BCur B.A. in Health Promotion	 3 years
P.E. Technikon	Diploma in Environmental Health Biomedical Technology	3 years 3 years
Eastern Cape College	Diploma in Nursing Bridging course Diploma in Midwifery Diploma in Psychiatry Diploma in Operating Theatre Nursing Science Diploma in Child Nursing Diploma in Orthopedics	4 years 2 years 1 year 1 year 1 year 1 year 1 year
Ciskei Nursing College	Diploma in Nursing Bridging course Diploma in Child Nursing Diploma in Community Health Diploma in Clinical Nursing	4 years 2 years 1 year 1 year 1 year

INSTITUTION	PROGRAMME OFFERED	DURATION
Frere Nursing College	Diploma in Nursing Bridging Course	4 years 2 years

	Diploma in Psychiatry Diploma in Theatre Nursing Science Diploma in ICU	1 year 1 year 1 year
Umlamli Campus	Diploma in Nursing Bridging course Diploma in Primary H.C.	4 years 2 years 1 year
Frontier	Bridging course	2 years
Butterworth Campus	Diploma in Nursing Diploma in Midwifery	4 years 1 year
Tafalofefe Campus	Bridging Course Diploma in community Health	2 years 1 year
Victoria Campus	Bridging Course Diploma in Midwifery	2 years 1 year
Umtata Campus	Diploma in Nursing Diploma in Orthopedic Nursing Science	4 years 1 year
All Saints Campus	Diploma in Nursing Diploma in Clinical N. Science	4 years 1 year
St. Barnabas Campus	Diploma in Nursing	4 years

INSTITUTION	PROGRAMME OFFERED	DURATION
Madwaleni Nursing School	Bridging course	2 years
Knessie Knight N. School	Bridging course	2 years
St Lucy's Nursing School	Bridging course	2 years

Rietvlei campus	Bridging course	2 years
St Patricks Nursing School	Diploma in Midwifery	1 year
St Elizabeth Campus	Diploma in Nursing	4 years

INSTITUTIONS FOR DISTANCE LEARNING		
Potchestroom University	B.A. Cur	
University of Pretoria		
Natal Technikon	B. Tech in Community Nursing (Bisho Hospital)	2 years

INSTITUTION	NUMBER of TUTORS
Eastern Cape College	29
Frere College	24
Ciskei College	24
Victoria Campus	5
Butterworth Campus	9
Tafalofefe Campus	3
Nompumelelo	3
Umlamli	8
Glen Grey	7
Frontier	4
Umtata Campus	17
St Barnabas	8
All Saints	10
Madwaleni	3
St Lucy's	5
Knessie Knight	4

RietVlei	5
St Elizabeth	8
St Patricks	2

NUMBER OF STUDENTS IN EACH INSTITUTION

INSTITUTION	PHYSICAL LOCATION	PROGRAMME	NO. OF STUDENTS
Eastern Cape College	Port Elizabeth	4 years	383
		Bridging	69
		Diploma in Midwifery	18
		Diploma in Psychiatry	11
		Diploma in Theatre	5
		Diploma in Child Nursing	6
Umlamli Hospital	Sterkpruit	Diploma in Orthopaedics	43
		4 years course	40
		Bridging	10
Glen Grey	Lady Frere	Primary Health Care	120
Frontier	Queenstown	4 years course	60
Frere College	East London	Bridging course	239
		4 years	112
		Bridging course	14
Ciskei Nursing College	East London	Diploma in Psychiatry	14
		Diploma in Theatre	4
		I C U	30
		Diploma in Midwifery	240
		4 year course	156
		Bridging	15
		Diploma in Child Health	13
Butterworth Campus	Butterworth	Diploma in Community Health	10
Tafalofefe	Kentane	Diploma in Clinical Nursing	80
		4 year course	21
Victoria	Alice	Diploma in Midwifery	60
		Bridging course	5

		Diploma in Community Health Bridging course	63 12
Umtata Campus	Umtata	Midwifery 4 years course Diploma in Orthopaedics	175 14 120
St Barnabas	Libode	4 years course	14
Madwaleni Training	Elliotdale		
School	Qumbu		71
Knessie Knight Training	Tsolo	Diploma in Clinical	54
St Lucy's	Umzimkulu	Nursing Science	39
Rietvlei	Lusikisiki	4 years course	54
St Elizabeth	Bizana	Bridging course	60
St Patricks	Alice	Bridging course	105
Fort Hare		Bridging course	16
		Bridging course 4 year course Diploma in Midwifery B. Cur students	141

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

AIM: To render specialized clinical orthotic and prosthetic support services

Budget: R15,197,000

5. SITUATIONAL ANALYSIS

5.1 Personnel Stats Medical Orthotics and Prosthetics

Category	No. Filled	Vacant
Assistant Director	2	1
Chief MOP	12	
Senior MOP	NIL	NIL
MOP	1	7
Student MOP	NIL	NIL
Assistant MOP	7	
Orthopaedic Foot wear Tech	5	5
Student Orthop Foot wear Tech.	NIL	

OUTREACH SERVICES:

Both P E and E L centers were contributing towards this service before (Cape Provincial Administration). P E Center still does, but on a limited scale. East London discontinued a few years ago.

These centers were sharing transport with the respective institutions (Frere and P E Provincial Hospitals). Because of transport constraints and heavy demand by these hospitals, evidently it became difficult for these centers to get transport with result curtailment of the program (outreach). Also, staff that retired or resigned for greener pastures without replacement affected service delivery. Staff could not be easily replaced due to the limited number within the public sector.

The 3rd center, at Bedford in Umtata had been used as a Satellite (outreach program) by East London center with a view to develop it.
Sketch plans for the Bedford center have already been submitted to the Head of Orthopedics – Umtata Hospital Complex. He has indicated that the building should be ready before the end of 2003.

6. CHALLENGES:

1. Eradicate wheelchair backlog and other assistive devices e.g. Prosthesis backlog at Frere Center where limb prosthetics is ± 4 years.
2. Retain qualified professionals for the province by devising ways and means of attracting them. The centers tend to lose professionals to private sector and abroad. It has been a struggle to recruit, but currently two posts have been advertised and extensive consultation through out the country has been put in place, with the hope of getting a good response.

STRATEGIC OBJECTIVES:

- Improve access to health care for persons with disability.
- Provide on- going training and skills development for health workers in the centers.
- Facilitate recruitment of medical orthotists and prosthetists (MOP's) from outside the country.
- Equitable allocation of resources.

CONSTRAINTS:

- Under allocation of budget for the services rendered at the centers.
- Unfilled posts with reduced number of posts as a result of the HTP (Hospital Transformation Project) exercise which does not cater for outreach programme.
- Scarcity of MOP's in the country.
- Back-log of assistive devices especially limb prosthetics.
- Lack of capacity to effect out-reach programmes.

PLANNED MEASURES TO OVERCOME CONSTRAINTS:

- Two students will start their training at Frere O & P Center in January 2003, and will be attending at Pretoria in the 2nd half/semester (July 2003).
- Facilitate bursary allocation for deserving candidates from previously disadvantaged communities.
- Start training O & P's and Orthopedic Foot wear Technicians for the Bedford Center.
- Empower Heads of centers and support functionaries on financial management.
- Resuscitate outreach programmes for the centers.
- Liaise with Port Elizabeth Complex for a rationalization decision in terms of the location or relocation of the P.E. Center.

MEASURABLE OBJECTIVES:

STRATEGY	INDICATOR	2003/2004	2004/2005
Accessible services to persons with disability	Reduction of backlogs for assistive devices	40%	60%
Quality service to persons with disability	Human and material resourced centers	30% posts filled	70% posts filled
Liaise for training of different levels of workers at the centers	Lower and semi-skilled posts filled.	70%	30%
Accessible repairs and maintenance outlets	Repair and maintenance centers at each district.	20%	30%

SUB-PROGRAMME PHARMACEUTICALS

1. SITUATION ANALYSIS

Pharmaceutical Services in the Eastern Cape Province has been a sadly neglected area for a long time, yet **pharmaceuticals, medical and surgical supplies** are the second largest cost drivers in the health care delivery system. Indeed, anyone who walks into a health facility expects to get medicine otherwise they consider that to be lack of delivery

of health care. In spite of the fact that **Pharmacists** were the second group of health professionals to be targeted for Community Service, they are still not given any rural allowance, no overtime pay, and no preferential accommodation in institutions.

Facilities are being built, renovated and generally maintained, but one finds that the pharmaceutical, medical and surgical items are stored all over the Institution, at totally inappropriate storage areas, with no consideration of the temperatures, sufficient and proper space and inconvenience caused to those tasked with handling these items. It would seem that it is remembered at the last minute that these items have to be catered for. There are no proper patient counselling areas, nor are there tea rooms, adequate ablution areas which improve working conditions of the pharmacy personnel.

According to current legislation, the State will become subject to the requirements of its own Acts. The Pharmacy Act 54 of 1974, as amended, requires that every pharmacy should be under the direct control of a pharmacist. With the shortage of available pharmacists, hospital pharmacies are often managed by any available staff member, e.g. nursing personnel, general workers, dark room attendants, housemothers or Specialised Auxiliary Services Officers (SASO's) or more recently Auxiliary Workers (Pharmacy).

In addition, the Act requires that anybody who handles medicine should be trained and registered with the South African Pharmacy Council as a Basic or Post-Basic Level **Pharmacist's Assistant**. Yet this cadre of health worker does not exist! Due to this lack of accountability by the personnel providing a Pharmaceutical Service, the allocated **drug budget** in excess of R300 million does not translate to that amount of medicines reaching the patient. A significant amount is lost to theft, expiry, and damage during transportation and storage.

1. **POLICIES AND BROAD OBJECTIVES**.

This will be done utilising health personnel who are adequately trained and accountable through their registration with the South African Pharmacy Council. It is with this goal in mind that a massive drive has been undertaken to train Pharmacist's Assistants and register them so as to ensure the delivery of quality Pharmaceutical Services. The Eastern Cape Province subscribes to these objectives and strives to appoint pharmacy personnel in all facilities during working hours so as to ensure accountability and quality of Pharmaceutical Services.

The broad objectives are thus:

- To facilitate the training of Pharmacist's Assistants such that all Pharmacies are manned by this mid-level health worker.
- To recruit and retain Community Service Pharmacists to areas of greatest need.
- To recruit and retain Pharmacists in the public sector by offering them incentives, allowances and improved service conditions.
- To monitor the availability of an identified basket of drugs on a regular basis.
- To monitor drug expenditure at all levels.
- To develop and make available standard operating procedures that will ensure good quality pharmaceutical care and optimal management of drug supplies.
- To improve service delivery by the Pharmaceutical Depots by entering into a Public Private Partnership for management support and Distribution of pharmaceutical and surgical supplies.
- To provide pharmaceutical support to ensure the effective roll-out of priority health programmes

2. CONSTRAINTS AND MEASURES TO OVERCOME THEM

(a) Pharmacists

The Eastern Cape Province is mostly rural and thus makes it very difficult to attract and retain health professionals to our most needy health facilities. A recruitment drive has already been initiated with a resultant **44 Pharmacists** being employed. Approximately 30% of these appointments were recruited from outside the Eastern Cape public service. This was made possible by the availability of funds allocated to employ onto critical posts, by advertising in the 2-monthly Pharmacy Council Newsletter (at no cost to the Province) I that ensures that the target market is reached and by upgrading the posts to appropriate (more market-related) levels. Filling of vacant Pharmacist posts will ease the burden on existing staff and improve the working conditions of Pharmacists. A motivation will also be put forward to make provision for rural allowance and overtime pay where it happens. Accommodation for Pharmacists and Community Service Pharmacists is also being added to medium term plans for upgrading of facilities. There is still however vacancies that exist, especially in the eastern part of the province. Negotiations are to be initiated to grant this cadre of health worker rural allowance and overtime just like their counterparts.

(b) Community Service Pharmacists

33% of the current Community Service Pharmacists have been retained in the public sector. This is an achievement of the aims of community service of attracting Pharmacists into the public service, even though these appointments are in the western part of the province. Due to the fact that currently Community Service Pharmacists are being employed against vacant funded posts, this achievement may end up being a constraint as we will not have these vacant funded posts with which to remunerate them. It is thus suggested that a central fund or conditional grant be utilised for this purpose. This will result in the Community Service Pharmacist being deployed to areas of greatest need and not only where the funds are.

© Pharmacy Assistants

The training of Pharmacist's Assistants is a legal requirement for all persons who handle medicines. The challenge is to have enough Pharmacists to act as Tutors to Pharmacist's Assistants at a ratio of 1:3. The South African Pharmacy Council has been requested to relax this requirement, but this has been granted only until October 2003. As many of our facilities do not comply with the minimum requirements of the S-outh African Pharmacy Council, these cannot be accredited for training of Pharmacist's Assistants. Efforts are being made to buy enough reference materials to comply with Good Pharmacy Practice. The other structural adjustments have been communicated to the Infrastructure unit to address the shortcomings where possible. Input has also been given to architects to ensure that new facilities comply with the minimum requirements.

Pharmacist's Assistants do not have a career path and thus cannot progress any further than where they already are. Due to the varying nature of appointments of pharmacy support staff, some are at Level 2 and others at Level 6! The suggested level of remuneration for the Auxiliary Worker (Pharmacy) is Level 4. Work study has been approached to assist with sorting out this anomaly.

(d)Public Private Public Partnership (PPP) for Pharmaceuticals

The PPP for management support for the pharmaceutical depots aims to provide a Pharmaceutical Service that is affordable, adds value and transfers risk to ensure that pharmaceutical, medical and surgical supplies are available

and accessible at all times. There will be a skills transfer to ensure that the expertise so gained is sustainable and is kept within the department.

Few pharmacists have knowledge of how to develop a drug budget. Training programmes will be sourced to teach them financial management for non-financial persons. This will result in improved budgeting and an improved availability of funds to purchase essential drugs and ensure that they are available and accessible at all times.

(c) QUALITY IMPROVEMENT MEASURES

The employment of adequately trained and remunerated Pharmacists will result in improved management of pharmaceuticals.
The Job Evaluation process has enabled the appointment of Regional and District Hospital Pharmacy Managers to be at Level 10. This puts this person at an appropriate level to make management decisions.

The clustering of the Tertiary Hospitals to form Health Complexes and the resultant appointment of Pharmacy Managers at Level 11 means that the management of drug supplies will be afforded the respect it deserves and should translate into savings.

Ensuring that all personnel who handle medicines, even at Primary Health Care level, are trained, registered and thus accountable for drug supplies will result in quality management of this very high cost driver.

The National Drug Policy clearly specifies that the broad aim of Pharmaceutical Services is to ensure that essential drugs are made available and accessible to the majority of the population at a price that we can

➢ **MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS**

➢ Objective	Indicator	2001/02 Actual	2002/03 Estimate	Budget for 2003/04	2003/04 Target	2004/05 Target	2005/06 Target
To facilitate training of Pharmacist's Assistants on the accredited training programme	200 Pharmacist's Assistants initiated training on accredited training programme	0 trained on accredited training	65 trained on accredited training	R1,5 million (R700,000 donor funds)	100 started on accredited training	The rest started on accredited training	
To provide at least 1 Community Service Pharmacist to each of the 4 Nodal Municipalities annually	Each of OR Tambo, Alfred Nzo, Chris Hani, Ukhahlamba have at least 1 C.S.P every year	5 C.S.P allocated	4 C.S.P allocated	R50,000	4 C.S.P allocated	4 C.S.P allocated	4 C.S.P allocated
To recruit District Pharmacists	All Districts with a Pharmacist	None	15 Districts Pharmacists	R100,000	5 more Pharmacist recruited	10 more Pharmacist recruited	All 25 Districts with Pharmacists
To monitor availability of key basket of drugs, including those required in the priority programmes	90% of key drugs available at all times	Ongoing	Ongoing	R250,000	Ongoing	Ongoing	Ongoing
To monitor that drug expenditure is on essential drugs in the E.C Formulary	80% of drug budget spent on drugs that are in the E.C. Formulary	Ongoing	Ongoing	R100,000	Ongoing	Ongoing	Ongoing
To develop and distribute Standard operating procedures for all pharmaceutical activities	SOPs on identified activities developed	None completed	24 priority SOPs developed and distributed	R100,000	Further 20 SOP developed and distributed	All identified SOPs developed and distributed	SOPs reviewed for relevance, accuracy
To enter into PPP for management support and distribution of pharmaceutical, medical and surgical supplies	PPP Contract awarded and signed	None	Calls for expression made & Transaction Advisor engaged	R30 million	Preferred Bidder awarded contract	Supplies delivered to all hospitals	Supplies delivered to all Clinics

PROGRAMME 8 : HEALTH FACILITIES DEVELOPMENT AND MAINTENANCE

AIM: To improve access to health care services by providing new health facilities, upgrading and maintaining existing facilities.

BUDGET : R 411,261,000

2003/04 Budget Allocation as per sub- programme

	TOTAL
District Health Services	R299,480,000
Provincial Hospital Services	R111,781,000
TOTAL	R411,261,000

SUMMARY OF EXPENDITURE AND ESTIMATES BY SUB- PROGRAMEMES

2000/01	**2001/02**	**2002/03**	**2003/04**	**2004/05**	**2005/06**
District	80,961,000	80,798,000	271,587,686	219,000,000	192,000,000

Services					
District Maintenance	20,000,000	40,000,000	27,892,314	76,078,000	87,000,000
Regional Hospitals	78,000,000	114,963,000	53,525,000	117,325,000	155,000,000
Maintenance	11,000,000	61,037,000	52,150,000	77,675,000	89,229,000
Planning & Project Management	Nil		6,106,000	6,000,000	6,000,000
Total	**189,961,000**	**296,793,000**	**411,260,000**	**506,078,000**	**529,439,000**

8.1 SITUATIONAL ANALYSIS

8.1.1 New facilities

From 1994 to date the following health facilities have been constructed .

Hospital	1 (Nelson Mandela Academic Hospital)
Clinics	130
Community Health Centres	5
Hospital OPDs	16
Academic Health Resource Centres	3
Doctor's houses	14
Students Accommodation	3
Guard Houses	3
Regional Offices	8

Security Fencing to clinics	100 clinics
Security Fencing to Hospitals	31
Electrical Upgrade to Hospitals	20
Electrical upgrade to clinics	104 +69 Alternative Energy

Provision of Health Facilities is biased towards under serviced areas (ex homelands)

8.2. General condition of health facilities

A Facilities Audit that was conducted throughout the province reflected the following:-

Category 1: 2%
Category 2: 40%
Category 3: 30%
Category 4: 28%
Category 5: 0%

Poor estate management was detected as well as poor reconfiguration of wards which were totally unsuitable for the current health needs and services to be rendered. From the above it became obvious that a comprehensive CAPEX programme was required.

8.3 Health Technology

A Health Technology audit conducted in 2001 revealed that 90% of major equipment needed total replacement and there was also no maintenance strategy.

8.4 Infrastructure Maintenance

The department has just allocated substantial sums of money for maintenance to institutions. The department however has noticed poor progress in the spending of the money.

Problems identified

- Lack of qualified artisans in the institutions (hospitals and clinics).
- Lack of spares and tools in the maintenance workshops
- Lack of committed leadership as most senior administrative managers are on acting positions and in most cases they are unable to instill discipline.
- Backlogs on disciplinary hearings have a demoralizing effect on staff morale.
- Absence of institutional maintenance operational plans.
- Unfilled funded Districts Artisan superintendents post.
- Maintenance posts filled with unqualified personnel who sometimes are not doing maintenance work (this is wide ranging phenomenon).
- Inability to procure services from private providers.
- Huge number of vacant maintenance posts at institutional level.
- Long tender periods.

Possible Solutions:

District Level

- Appointment of a maintenance co0ordinators at district levels (An artisan or an environmental Health Officer)
- Pooling of all maintenance resources within a district and cluster them according to skills level e.g. painters, carpenters, etc. and task them to work as a district team and fix all infrastructure within a district.
- Draw up planned institutional operational plans (guidelines being developed)
- Monitoring of implementation of the plan (Competition/Awards)
- Fill maintenance Artisan Superintendent's posts urgently.
- Training of personnel on procurement practices.

8.5 ASSET MANAGEMENT

Strategy for asset management is being developed for ensuring that the existing and future stock is properly maintained. This includes buildings fixed and loose equipment .

8.6 CAPEX PROGRAMME

After considering the above findings a comprehensive Capex strategy was developed in 1999 for a ten year programme. Issues of consideration included improving access to under serviced areas, addressing the backlogs estimated to be more than five billion over this period. In the ensuing MTERF years projects will be initiated until target is reached in 2010.

The guiding factors for implementation of the CAPEX programme are:-

- Strategic position statement (vision 2010)
- Geographic health service plans for each Municipal District including systemic referral patterns.
- Optimum utilization of resources for Equity across the Province
- Elimination of fragmentation and duplication and,
- Essential health package rendered at appropriate levels i.e. PHC (clinics and CHCs), District/ Level 1 hospitals, general/level 2 hospitals and 3rd level/Tertiary level hospitals

The budget is held and managed within the Department of Health and Department of Public Works provides expert and technical support services in compliance with the PFMA.

What came out from the Audit was that buildings were poorly maintained ,there was no budget allocated for preventive maintenance. Poor estate management was also detected i.e. land-scaping, clean grounds, small plumbing jobs etc. Some hospitals were previously built by missionaries who had no orientation to an efficient hospital configuration. So these have to be re arranged. Old regime also had hospitals not properly situated or to reject the double standards for whites and black. All this requires redress to cater for new health needs, trends and for the future. Technical capacity at PWD was found to be progress due to lack of insight in hospital plan

Due to the huge backlogs, plus the extension of services to the unserviced including maintenance this province needs a budget of more than R5 billion over the 10 year period. In the ensuring MTEF years the projects will be added till we reach our target.

ANNEXURE A

CONDITIONAL GRANT- (H R AND R)

Previous expenditure

YEAR	ALLOCATION	SPENT
1998/9	R15,110,000	R6,717,587
1999/2000	R27,2000,000	R26,181,703
2000/01	R84,000,000	R38,943,495
2001/2002	R69,000,000	R33,682,847
2002/03	R110000,000	R111,747,176

CONDITIONAL GRANT - PROJECTS:

PROJECTS				
A. NEW CONSTRUCTION				
	2002/2003	2003/ 4	2004/5	2005 /6
Prog 2: District Hospitals				
1. Mary Teressa Hosp.	R11,660,877	R51,120,000	R25,000,000	R12,500,000
2. St. Lucy's Hosp.	-	-	-	R46,500,000

SUB-TOTAL:	R11,660,877	**R51,120,000**	R25,000,000	R59,000,000
B. UPGRADING				
Prog 3: Regional Hospitals.				
1. Frontier Hosp.	R19,062,406	R14,800,000	R35,500,000	R26,250,000
2. St.Elizabeth	R5,335,364	R18,725,000	R25,350,000	R13,000,000
3. Cecilia Makiwane	-	-	-	R23,000,000
SUB-TOTAL :	R24,397,770	**R33,525,000**	R60,850,000	R62,250,000
C. PROJECT PLANNING & MANAGEMENT		**R6,106,000**		
TOTAL	**R36,048,642**	**R90,751,000**	**R85,850,000**	**R121,250,000**

*N.B Rietvlei Hospital will be a fall back on should there be a slippage in one of the above three projects. Frontier Hospital is in Queenstown, St Elizabeth in Lusaka's, Rietvlei in Umzimkhulu and Cecilia Makiwane Hospital in East London.

PROJECTS	2002/3	2003/4	2004/5	2005/6
Rietvlei	-	R18,36,000	R21,000,000	R23,000.000

ANNEXURE B

PROJECTS

PROJECTS	2002/3	2003/4	2004/5	2005/6
A. Provincial Hospitals				

A**.1. NEW**				
1. Nelson Mandela Hospital	R86,000,000	-	-	-
B. District Hospitals				
B.1 NEW				
St. Lucy's	1,446,386	18,360,000	20,000,000	46,500,000
B.2 UPGRADE: DISTRICT HOSPITALS				
1. Aliwal North- Cas/OPD	110,000	2,615,000	2,300,000	2,524,217
2. All Saints – New Wards, Admin. Cas/OPD	4,195,617	12,000,000	14,000,000	15,364,798
3. Bambisana OPD	263,641	4,090,000	13,000,000	14,267,312
4. Canzibe Hospital Upgrading	-	350,000	2,200,000	2,414,468
5. Cofimvaba Hospital upgrading	--	150,000	2,500,000	2,743,714
6. Glen Grey	6,093,077	10,240,000	10,500,000	11,523,598

– Kitchen, mortuary phase 3 upgrade				
7. Holy Cross wards & infrastructure upgrade	4,209,561	44,302,340	20,000,000	21,949,711
8. Madwaleni OPD &	740,000	3,500,000	8,120,000	8,911,583
9. Midlands wards, CAS/OPD	2,335,404	2,588,886	6,000,000	6,584,913
10. Nessie Knight Hospital	-	215,000	8,400,000	9,218,879
11. Nompumelelo Phase 2, Female ward & maternity	9,533,152	4,842,245	8,000,000	8,779,885
12. Settlers Hospital upgrade	-	150,000	10,000,000	10,974,856
13. Sipetu Hospital upgrade		400,000	6,450,000	7,078,782
14. St Barnabas, Maternity,	6,786,520	9,690,000	9,000,000	9,877,370

Theatre, Admin. Phase 2.				
15. St Patricks – upgrade	799,094	9,000,000	9,657,000	10,598,418
16. Stutterheim – Ext. works	3,849,623	170,000	-	
17. Tafalofefe Hospital upgrade	260,000	2,500,000	7,000,000	7,682,399
18. Taylor Bequest Hospital upgrade	-	1,150,000	9,000,000	9,877,370
19. Victoria Hospital – maternity & paediatric, CAS/OPD	5,424,593	15,600,000	14,000,000	15,364,798
20. Zitulele Hospital upgrade	495,000	7,500,000	9,000,000	9,877,370
TOTAL	R46,541,668	R149,413,445	R189,127,000	R111,770,000
C. Community Health Centres				
C.1 New				

Community Health Centres				
1. Idutywa CHC	500,000	1,750,000	3,750,000	4,115,571
2. N.U. 2 Mdantsane	500,000	5,000,000	3,100,000	3,402,205
3. Umzimkhulu CHC	300,000	2,000,000	5,700,000	6,255,668
C.2 Upgrade CHC				
1. Ngqamakwe CHC	300,000	1,700,000	2,000,000	2,194,971
2. Maluti CGC	400,000	400,000		438,994
3. Mt Coke	700,000	2,651,000	3,149,000	3,455,982
4. Dimbaza	500,000	3,000,000	4,500,000	4,938,685
D Clinics				
D.1 New				
1. Soto Clinic	200,000	1,100,000	400,000	438,994
2. Kwa-Mkoloza	200,000	1,200,000	1,000,000	1,097,486
3. Mxhalanga Clinic	200,000	1,200,000	700,000	768,240
4. Gompo Dental Unit	400,000	1,554,544	700,000	768,240
5. Makwantini clinic	200,000	550,000	-	
6. Ncembu	200,000	500,000	-	

Nurses Home				
7. Mqhekezweni Nurses Home	200,000	800,000	100,000	109,749
8. Upper Xhongora Nurses Home	200,000	1,000,000	100,000	109,749
9. Mpunzana Clinic	200,000	1,300,000	300,000	329,246
10. Mpeko Clinic	200,000	1,100,000	100,000	109,749
11. Manzimahle Clinic	200,000	1,000,000	1,000,000	1,097,486
12. Lower Gqaga	425,000	693,165	400,000	438,994
13. Mt Arthur Clinic	600,000	500,000	100,000	109,749
14. Afsondering	850,000	1,300,000	-	
15. Upper Tele Clinic	200,000	1,200,000	300,000	329,246
TOTAL	R7,675,000	R33,844,165	R27,499,000	
D2. RELOCATION				
1. Mvenyane Clinic	200,000	1,200,000	900,000	987,737
2. Nyaniso Clinic	200,000	1,200,000	900,000	987,737

3. Lubaleko Clinic	400,000	1,000,000	400,000	438,994
4. Isilindini Clinic	200,000	1,400,000	900,000	987,737
5. Likhetlane Clinic	200,000	1,400,000	900,000	987,737
6. Seqhobong Clinic	200,000	1,200,000	800,000	877,988
7. Shepherd's Hope	200,000	1,200,000	900,000	987,737
8. Mpoza Clinic	200,000	250,000	-	
9. Machibini Clinic	200,000	1,200,000	800,000	877,988
10. Ibisi Clinic	100,000	1,400,000	1,100,000	1,207,234
11. Sihleza clinic	200,000	1,300,000	1,000,000	1,097,486
12. Ngcwanguba Clinic & Nurses Home	500,000	400,000		
13. Gura Clinic & Nurses Home	500,000	38,720		
14. Mahlungulu Clinic & Nurses Home	500,000	1,297,670		
15. Goso Forest Clinic	200,000	1.200,000	1,000,000	1,097,486

16. Mkemane Clinic	200,000	1,400,000	1,000,000	1,097,486
17. Tshungwane Clinic	200,000	1,400,000	900,000	987,737
19. Mcambala Clinic	200,000	1,400,000	1,250,000	1,371,857
20. Nocora Clinic	200,000	1,500,000	1,300,000	1,426,731
21. Nquqhu Clinic	200,000	1,200,000	800,000	877,988
22. Qitsi Clinic				
TOTAL	R2,300,000	R22,586,390	R14,850,000	
D.3 UPGRADING				
1. Gwadu clinic	200,000	1,200,000	1,000,000	1,097,000
2. Fort Malan clinic	200,000	550,000	-	
3. Frankfort	130,000	30,000	-	
4. Jingqi	200,000	1,200,000	900,000	987,737
5. Twecu	200,000	1,200,000	1,100,000	1,207,234
6. Willow	200,000	900,000	1,400,000	1,536,480
7. Ngubechanti Nurses Home	100,000	450,000	-	
8. Buttingville Nurses Home	100,000	450,000	-	
9. Nywara	200,000	1,400,000	900,000	987,737

Clinic				
10. Mongoalamen g	100,000	160,000	-	
11. Kotana Clinic	200,000	1,400,000	900,000	987,737
12. Upper Ncera	105,000	100,000	-	
13. Seymour	100,000	96,000	-	
14. Balfour	150,000	200,000	-	
15. Lukolweni	200,000	1,400,000	1,400,000	1,536480
16. Tabachicha	300,000	170,000	-	
17. Ntlabeni	200,000	250,000	-	
18. Cancele	700,000	450,000	-	
19. Ladam Iren Clinic	200,000	1,200,000	900,000	987,737
20. River Side	200,000	1,200,000	1,200,000	1,316,983
21. Malenge	200,000	1,200,000	1,200,000	1,316,983
22. Sphamandla	200,000	1,500,000	1,000,000	1,097486
23. Gugwini	300,000	1,400,000	1,300,000	1,426731
TOTAL	R4,685,000	R30,706,000	R13,200,000	
D.4 NEW PROJECTS	2003	2004	2005	2006
1. Magadla Clinic	200,000	1,400,000	500,000	548,743
25. Hlomendlini Clinic	200,000	1,400,000	500,000	548,743

2 Walaza	200,000	1,400,000	500,000	548,743
3. Kibastone Village	200,000	1,400,000	500,000	548,743
4. Mfiki Ridge	200,000	1,400,000	500,000	548,743
5. Rietfontein Village	200,000	1,400,000	500,000	548,743
6. Sterkspruit town	200,000	1,400,000	500,000	548,743
7. Gqaqhala	200,000	1,400,000	500,000	548,743
8. Bolotwa	200,000	1,400,000	500,000	548,743
9. Mkapusi	200,000	1,400,000	500,000	548,743
10. Mahasana	200,000	1,400,000	500,000	548,743
11. Pilani (Lady Frere)	200,000	1,400,000	500,000	548,743
12. Mbokotwana	200,000	1,400,000	500,000	548,743
13. Who-can-tell village (Queenstown)	200,000	1,400,000	500,000	548,743
14. Tyelera (Cofimvaba)	200,000	1,400,000	500,000	548,743
15. Govan Mbeki	200,000	1,400,000	500,000	548,743
16. Xhwili	200,000	1,400,000	500,000	548,743
17. Nqwati	200,000	1,400,000	500,000	548,743
18. Zitatele clinic	200,000	1,400,000	500,000	548,743
19. Ngubesizwe (Mqanduli)	200,000	1,400,000	500,000	548,743

20. Mgudu Clinic	200,000	1,400,000	500,000	548,743
21. Mntwana Clinic (Mt Frere)	200,000	1,400,000	500,000	548,743
22. Zwelichumile	200,000	1,400,000	500,000	548,743
23. Cabavale	200,000	1,400,000	500,000	548,743
24. Kalankomo (Qumbu)	200,000	1,400,000	500,000	548,743
25. Ngqwaru	200,000	1,400,000	500,000	548,743
26. Lower Siplani	200,000	1,400,000	500,000	548,743
27. Nier (Peddie)	200,000	1,400,000	500,000	548,743
28. Ndwayana	200,000	1,400,000	500,000	548,743
29. Khuze	200,000	1,400,000	500,000	548,743
30. Luthuli	200,000	1,400,000	500,000	548,743
31. Qwiliqwili	200,000	1,400,000	500,000	548,743
32. Gceza	200,000	1,400,000	500,000	548,743
33. Tsilitwa	200,000	1,400,000	500,000	548,743
34. Soga	200,000	1,400,000	500,000	548,743
35. Bomvana	200,000	1,400,000	500,000	548,743
36. Winterbergen	200,000	1,400,000	500,000	548,743
37. Mevana	200,000	1,400,000	500,000	548,743
38. Walmer Health Centre				
TOTAL	R7,400,000	R32,200,000	R15,500,000	

HEALTH	R402,935,000	R411,261,000	R377,026,000	R469,046,000