

PART A

I. DEPARTMENT GENERAL INFORMATION

PHYSICAL ADDRESS:	Dukumbana Building Independence Avenue Bhisho, Eastern Cape
POSTAL ADDRESS:	Private Bag X0038 Bhisho, 5605 REPUBLIC OF SOUTH AFRICA
TELEPHONE NUMBER/S:	+27 (0)40 608 1111
FAX NUMBER:	+27 (0)40 608 1112
EMAIL ADDRESS:	info@impilo.ecprov.gov.za
WEBSITE ADDRESS:	www.ecdoh.gov.za

GENERAL INFORMATION

SUBMISSION OF THE ANNUAL REPORT TO THE EXECUTIVE AUTHORITY

I have the honour of submitting the Annual Report of the Department of Health for the period 1 April 2012-31 March 2013 in compliance with section 40(1)(d) of the Public Financial Management Act.



Mr. M.D. Qwase

Acting Accounting Officer: Department of Health

31 August 2013

CONTENTS

PART A: GENERAL INFORMATION

1.	Department General Information	1
2.	List of Abbreviations/Acronyms	5
3.	Strategic Overview	8
3.1.	Vision	8
3.2.	Mission	8
3.3.	Values	8
3.4.	Strategic outcome orientated goals.....	8
4.	Legislative and other Mandates	10
5.	Organisational Structure	12
6.	Entities Reporting to the MEC	12
7.	Foreword by the MEC	14
8.	Overview of the Accounting Officer	16

PART B: PERFORMANCE INFORMATION

1.	Statement of Responsibility for Performance Information	20
2.	Auditor General's Report: Predetermined Objectives	21
3.	Overview of Departmental Performance	21
3.1.	Service Delivery Environment	21
3.2.	Service Delivery Improvement Plan.....	
3.3.	Organisational environment	67
3.4.	Key policy developments and legislative changes.....	68
4.	Strategic Outcome Oriented Goals	69

5. PERFORMANCE INFORMATION BY PROGRAMME

5.1.	Programme 1:.....	75
5.2.	Programme 2:.....	87
5.3.	Programme 3:.....	143
5.4.	Programme 4:.....	151
5.5.	Programme 5:.....	173
5.6.	Programme 6.....	185
5.7.	Programme 7:.....	203
5.8.	Programme 8:.....	215

6. SUMMARY OF FINANCIAL INFORMATION

6.1.	Departmental receipts.....	229
6.2.	Programme Expenditure	231
6.3.	Transfer payments, excluding public entities	232
6.4.	Public Entities.....	233
6.5.	Conditional grants and earmarked funds paid	234
6.6.	Conditional grants and earmarked funds received	235
6.7.	Donor Funds	243
6.8.	Capital investment, maintenance and asset management plan	245

PART C: GOVERNANCE

1. Introduction	250
2. Risk Management	250
3. Fraud and Corruption	251
4. Minimising Conflict of Interest	252
5. Code of Conduct	252
6. Health Safety and Environmental Issues	253
7. Internal Control Unit	254
8. Audit Committee Report	254

PART D: HUMAN RESOURCE MANAGEMENT

1. Legislature that Govern HR Management	260
2. Introduction	260
3. Human Resource Oversight Statistics	260
3.1. Personnel related expenditure	260
3.2. Employment and Vacancies	265
3.3. Job Evaluation	274
3.4. Employment Changes	277
3.5. Employment Equity	293
3.6. Performance Rewards	302
3.7. Foreign Workers	312
3.8. Leave utilisation	314
3.9. HIV/AIDS & Health Promotion Programmes	318
3.10. Labour Relations	321
3.11. Skills development	324
3.12. Injury on duty	326
3.13. Utilisation of Consultants	327

PART E: FINANCIAL INFORMATION

Report of the Accounting Officer	329
Report of the Auditor-General	356
Appropriation Statement	365
Notes to the Appropriation Statement	387
Statement of Financial Performance	391
Statement of Financial Position	392
Statement of Changes in Net Assets	393
Cash Flow Statement	394
Notes to the Annual Financial Statements (including Accounting policies)	395
Disclosures Notes to the Annual Financial Statements	417
Annexures	438

2. LIST OF ACRONYMS

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

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

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

3. STRATEGIC OVERVIEW

3.1 Vision

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

3.2 Mission

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

3.3 Values

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

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

3.4 Strategic Outcome Oriented Goals

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

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

STRATEGIC GOAL TITLE	GOAL STATEMENT	EXPECTED OUTCOMES
I. Public Health System	To facilitate a functional quality driven public health system that provides an integrated and seamless package of health services and is responsive to customer needs.	<p>By 2015, the organisation should demonstrate the following outcomes:</p> <ul style="list-style-type: none"> * Functional district health characterised by well managed and effective clinics, CHCs, district and specialised hospitals, * Each district to have a fully functional EMS METRO Centre. * Fully functional regional and tertiary hospitals.
2. TB and HIV/AIDS	To combat and reduce the impact of TB and HIV/AIDS with a special focus on preventing the emergence of drug – resistant strains.	<p>By 2015, the organisation should demonstrate the following outcomes:</p> <ul style="list-style-type: none"> * Reduction of HIV prevalence * % coverage of ART * Improved TB cure rate * Reduction of TB Incidence * Arrest rate of progression to MDR/XDR

STRATEGIC GOAL TITLE	GOAL STATEMENT	EXPECTED OUTCOMES
3. Mother and Child Health	To improve and strengthen the mother and child health services.	By 2015, the organisation should demonstrate the following outcomes: <ul style="list-style-type: none"> * % reduction of maternal morbidity * % reduction of maternal mortality * % reduction of infant mortality * % reduction of <5 child morbidity * Reduce no. of underweight children <5 – nutrition/social needs cluster * Greater awareness of women's sexual and reproductive rights.
4. Non-communicable diseases and mental conditions.	To combat and reduce diseases of lifestyle and mental conditions.	By 2015, the organisation should demonstrate the following outcomes: <ul style="list-style-type: none"> * Reduction in incidence of mental conditions. * Reduction in re-admissions of mental patients. * Reduction in substance abuse. * Reduce complications in hypertension and diabetes. * Improved health promotion. * Reduce incidence of obesity. * Reduction in morbidity, mortality resulting from circumcision. * Reduction in epilepsy and asthma morbidity. * Reduction in morbidity and mortality of the most common cancers (breast, cervix, prostate, oesophagus and lung).
5. Institutional capacity	To enhance institutional capacity through effective leadership, governance, accountability and efficient and effective utilization of resources.	By 2015, the organisation should demonstrate the following outcomes <ul style="list-style-type: none"> * Unqualified audit opinion received from the Auditor General * Effective leadership and audit * Effective planning and monitoring system * Achieve % of norms and standards re ratios fully-fledged and independent Lilitha College of Nursing that is able to produce ready, able and capable nurses to service the health system. * Fully-fledged EMRS College is able to produce ready, able and capable EMRS Practitioners to service the health system.

4. LEGISLATIVE MANDATES

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

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

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

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

- **Council for Medical Schemes Levy Act, 58 of 2000**
Provides a legal framework for the Council to charge medical schemes certain fees
 - **Mental Health Care Act, 17 of 2002**
Provides a legal framework for mental health in the Republic and, in particular, the admission and discharge of mental health patients in mental health institutions, with an emphasis on the observation of human rights for mentally ill patients
 - **National Health Act, 61 of 2003**
Provides a framework for a uniform structured health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services. The objects of the Act are to:
 - unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa;
 - o provide for a system of co-operative governance and management of health services within national guidelines, norms and standards, in which each province, municipality and health district must address questions of health policy and delivery of quality health care services;
 - o establish a health system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognised standards of research and a spirit of enquiry and advocacy which encourage public participation;
 - o promote a spirit of co-operation and shared responsibility among public and private health professionals, providers and other relevant sectors within the context of national, provincial and district health plans.
 - **Nursing Act, of 2005**
Provides for the regulation of the nursing profession
- 4.2. Other legislations in terms of which the Department operates includes the following:**
- **Criminal Procedure Act, Act 51 of 1977, Sections 212 4(a) and 212 8(a).**
Provides for establishing the causes of non-natural deaths
 - **Child Care Act, 74 of 1983**
Provides for the protection of the rights and well-being of children
 - **Occupational Health and Safety Act, 85 of 1993**
Provides for the requirements that employers must comply with in order to create a safe working environment for employees in the workplace
 - **Compensation for Occupational Injuries and Diseases Act, 130 of 1993**
Provides for the compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment and for death resulting from such injuries or diseases
 - **The National Roads Traffic Act, 93 of 1996**
Provides for the testing, analysis and implementation of the applicable law against drunk driving by drivers under the influence of liquor.
 - **Constitution of the Republic of South Africa Act, 108 of 1996**
Pertinent sections provide for the rights of access to health care services, including reproductive health and emergency medical treatment
 - **Employment Equity Act, 55 of 1998**
Provides for the measures that must be put into operation in the workplace in order to eliminate discriminatory practices as well as to promote affirmative action.
 - **State Information Technology Act, 88 of 1998**
Provides for the creation and administration of an institution responsible for the state's information technology systems
 - **Skills Development Act, 97 of 1998**
Provides for the measures that employers are required to take to improve the levels of the skills of employees in their workplaces.
 - **Public Finance Management Act, 1 of 1999**
Provides for the administration of state funds by functionaries, their responsibilities and incidental matters
 - **Promotion of Access to Information Act, 2 of 2000**
Amplifies the constitutional provision pertaining to accessing information under the control of various bodies
 - **Promotion of Administrative Justice Act, 3 of 2000**
Amplifies the Constitutional provisions pertaining to administrative law by codifying it.

- **Promotion of Equality and the Prevention of Unfair Discrimination Act, 4 of 2000**

Provides for the further amplification of the Constitutional principles of equality and the elimination of unfair discriminatory practices.

- **The Division of Revenue Act, 7 of 2003**

Provides for the manner in which revenue generated may be disbursed.

- **Broad-based Black Economic Empowerment Act, 53 of 2003**

Provides for the promotion of black economic empowerment in the manner which the state awards contracts for services to be rendered, and such incidental matters as they relate to such law.

5. ORGANISATIONAL STRUCTURE

The organisational structure of the department (high-level structure) is attached hereto. This structure reflects the Office of the MEC, the Superintendent General, and each of the four clusters namely, Clinical Services, Finance,

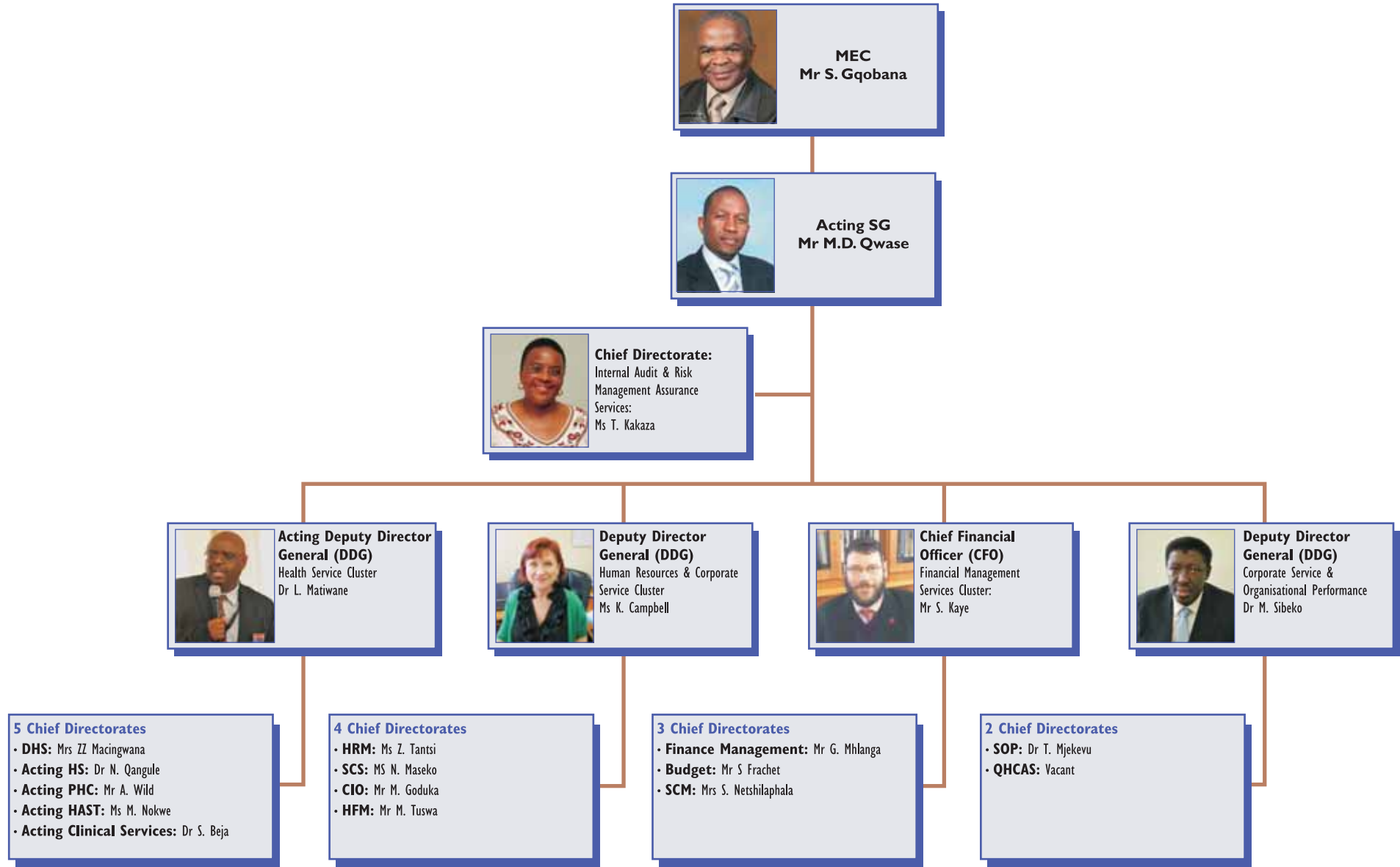
Corporate Services and Corporate Strategy & Organisational Performance. In addition, there is the Chief Directorate: Risk Assurance and Internal Audit.

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

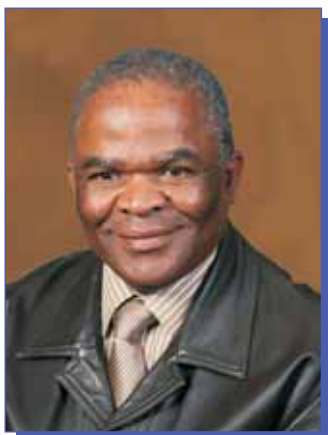
6. ENTITIES REPORTING TO THE MEC

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

Organogram of the Eastern Cape Department of Health



MEC'S STATEMENT



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

Achievements in relation to policy directives and strategic outcome

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

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

851 per 100 000 in 2009 and 2012 respectively and an increase in TB cure rate from 66% to 68.9% during the same period.

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

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

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

Challenges for the financial year under review

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

The medium to long term goals of the department

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

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

Acknowledgements /Appreciation

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

Conclusion

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



Honorable S Gqobana
MEC for Health
31 August 2013

ACCOUNTING OFFICER'S OVERVIEW



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

Reducing Burden of Disease

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

Over the past four years the department has substantially increased its capability to provide ARV program to all who need this service including pregnant mothers, TB patients and the general population. The latest statistics shows the percentage

of pregnant women tested for HIV and testing positive (HIV prevalence) to be at 29.3%, and prevention of mother to child transmission (PMTCT) resulted in significant decrease in HIV infected babies tested around six weeks of birth, from 8% in 2009/10 to 3% in 2012. There were 49 286 new clients put on ART programme increasing the number from 188 544 in 2011 to a total of 237 830 clients on the ART programme by end of the year under review. HIV and TB co-infected clients are prioritised on the FDC drug.

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

Revitalization of PHC

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

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

Human Resources for Health

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

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

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

The department will undertake a capability and best practice development in HR, ensure improved integrity of all HR related data and implement readiness for an end-to-end HR process integration and future Enterprise Planning Software (ERP) implementation initiative (based on the Department of Public Service

Administration (DPSA) and Integrated Financial Management System (IFMS) frameworks and directives). The departmental HR Plan will be reviewed and aligned to the DPSA Framework and to the departmental Strategy. The plan will identify priorities, challenges and weaknesses in strategic areas of human resources and put in place an action plan to address potential HR risks.

Governance and Leadership

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

Strengthening Information Technology

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

Eliminating Infrastructure Backlog

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

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

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

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

Equitable Share allocation for infrastructure will largely be used for general repairs and maintenance of all facilities in the province with particular focus on electro-mechanical areas and clinics. Procurement and maintenance of medical equipment will be procured through this funding source.

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

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

Strengthening Financial Management (Monitoring & Evaluation)

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

personnel is a prerequisite for the improved financial management in the department. The department will collaborate with the PCMT to ensure that critical financial management posts are filled in the coming financial year.

Supply Chain Management Initiatives

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

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

Conclusion

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



Mr M D Qwase
Accounting Officer for Health
31 August 2013

PART B



PERFORMANCE INFORMATION

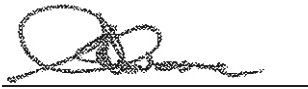
IA. STATEMENT OF RESPONSIBILITY FOR PERFORMANCE INFORMATION

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

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

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

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



Mr. M.D. Qwase

Acting Accounting Officer: Department of Health

31 August 2013

2. AUDITOR GENERAL'S REPORT: PREDETERMINED OBJECTIVES

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

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

3. OVERVIEW OF DEPARTMENTAL PERFORMANCE

3.1. Service Delivery Environment

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

to implement its Strategic Plan and its Annual Performance Plan.

Demographic information

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

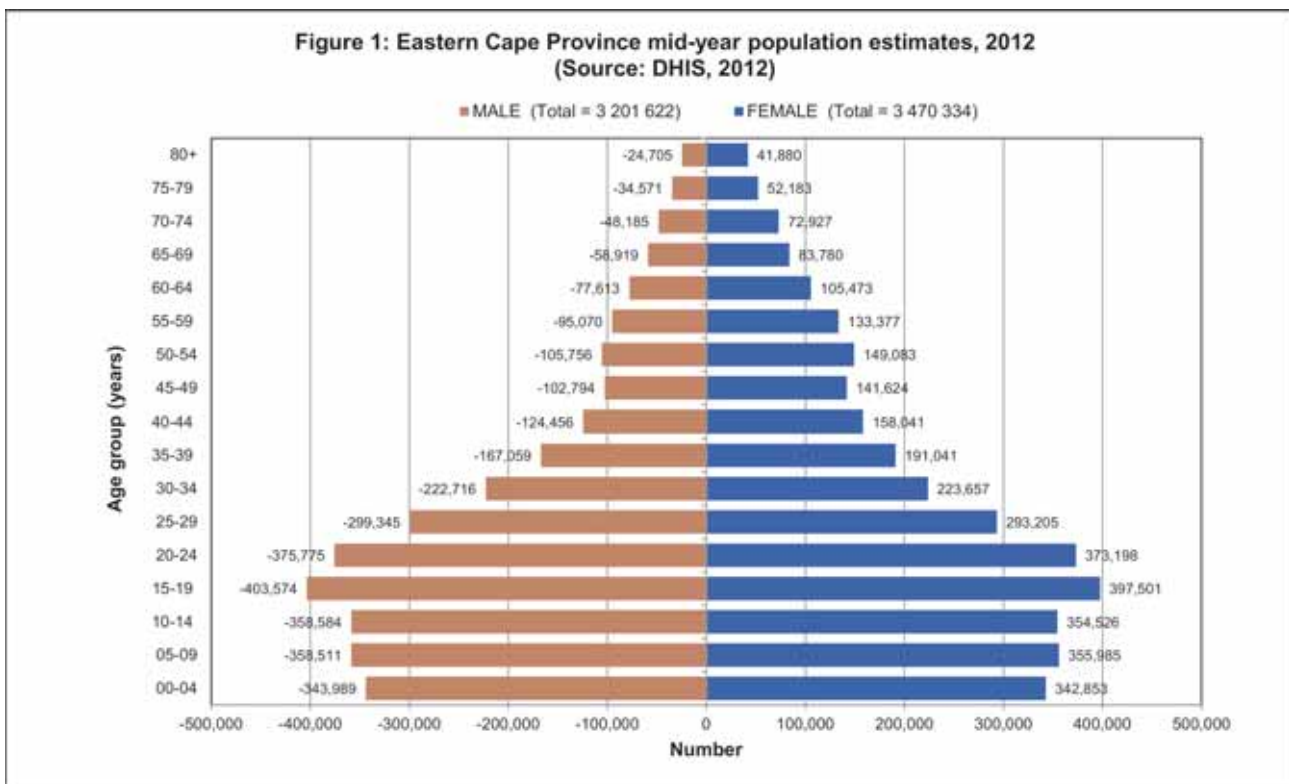
Approximately 65% percent of the population is younger than 30 years. About one third (31.7%) of the population is children; one third of these children (11% of total population) is under the age of five years (Figure 1). Six percent of the total population is 65 years and older.

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

Table BI: EC population distributed by health districts, 2012

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

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



Developmental indicators influencing the health status

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

Table B2: Key developmental indicators in the Eastern Cape Province

Indicator	Year	Eastern Cape
Demographic indicators		
Population density (people per km ²)	2011	39/km ²
Average household size (ECSECC, 2012)	2011	3.9 pers/hh
% public sector dependant population	2011	88.9
% of households for which the usual place of consultation is a public facility	2010	79.7
Total fertility rate (No. of children per woman)	2011-2016	2.72
Life expectancy at birth (females)	2011-2016	59.3
Life expectancy at birth (males)	2011-2016	53.7
% disabled population	2011	6.1
Socio-economic indicators		
% Main source of household income - Grant	2011	37.9
% Main source of household income - Salary	2011	42.5
% of persons with medical aid coverage	2011	11.1
% of households with informal housing	2011	6.5
% households connected to the mains electricity supply	2011	74.7
% households using electricity from mains for cooking	2011	59.8
% of households using wood for cooking	2011	19.3
% of households using paraffin for cooking	2011	16.7
% of households with access to piped water	2011	74.8
% of households with no water supply infrastructure	2010	26
% of population 20 years and older with no formal education (ECSECC, 2012)	2011	11
% of households with no toilet facility or using a bucket toilet	2011	17

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

Services rendered by the department:

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

Programme 1: Administration

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

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

Management: This sub-programme is responsible for the management of human, financial, information and infrastructure resources. It is made up of the Office of the Superintendent General and the policy, strategic planning, co-ordination and regulatory functions of the head office located in the different clusters namely Clinical, Corporate and Financial Services

Programme 2: District Health Services

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

- The **Other Community Services** sub-programme manages the devolution of MHS to the municipalities and implements a 'port health' strategy to control the spread of communicable diseases through ports of entry in the Eastern Cape Province; provides oral health services at a community level (including schools and old age homes); strengthens the traditional health services through health education campaigns for role players; prevention of substance, drug, and alcohol abuse to reduce unnatural deaths and geriatric services as a supportive and rehabilitation service.
 - The **HIV/AIDS sub-programme** renders primary health care services in respect of the prevention of HIV and AIDS infections through campaigns, continuous care, management and treatment (CCMT) and strengthening the accreditation process of ART sites for accessibility.
 - The **Nutrition sub-programme** sub-programme renders nutrition services as a poverty alleviation program, providing nutrition supplements including inter alia Vitamin A, Iodine, Zinc aimed at specific target groups (children, pregnant mothers, & the aged) to address malnutrition. This ensures provision of formula feeds for health facilities; establishment of food gardens at clinics, CHCs and hospital gardens as well as assisting communities to start community gardens in consultation with the Department of Agriculture to fight poverty.
 - The **Coroner Services sub-programme** renders forensic pathology services in order to establish the circumstances and causes surrounding un-natural deaths.
 - The **District Hospitals** sub-programme is to provide a comprehensive and quality district hospital service to the people of the Eastern Cape Province.
- **District Management** manages the effectiveness and functionality of seven districts and municipalities within the social needs cluster, especially in ISRDP, URP nodes and the identified twelve poorest municipalities. It also manages the co-ordination of health services, referrals, supervision, evaluation and reporting mechanisms as per Provincial and National policies
 - The **Community Health Clinics** sub-programme manages the provision of preventive and curative care and priority health programme implementation through accessible clinics and mobile services in twenty four sub-districts.
 - The **Community Health Centres** sub-programme renders a 24 hours health services, maternal health at midwifery units and the provision of trauma services as well as the integration of community-based mental health services within the down referral system.
 - The **Community Based Services** sub-programme manages the implementation of the community based health services framework.

Programme 3: Emergency Medical Services

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

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

Programme 4: Provincial Hospital Services

The objective of this programme is to provide cost-effective, good quality, effective and efficient secondary hospital services. The programme has three sub-programmes with the following objectives:

- General (Regional) Hospitals: Rendering of hospital services at general specialist level and providing a platform for research and the training of health workers
- TB Hospitals: To convert current tuberculosis hospitals into strategically placed centres of excellence in which a small percentage of patients may undergo hospitalisation under conditions which allow for isolation during the intensive phase of treatment, as well as the application of the standard multi-drug resistant (MDR) protocols.
- Psychiatric Mental Hospitals: Rendering a specialist psychiatric hospital service for people with mental illness and intellectual disability and providing a platform for training of health workers and research.

Programme 5: Central Hospital Services

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

Programme 6: Health Sciences and Training

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

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

Programme 7: Health Care Support Services

This Programme deals with Orthotic and Prosthetic services and in addition houses Clinical Support Management. The latter is composed of Laboratory

services, Radiography services and Rehabilitation services. All the clinical support services are budgeted for under programmes dealing with hospital services; i.e. Programmes 2 (District Health Services), 4 (Provincial Health Services) and 5 (Central Hospital Services).

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

Programme 8: Health Facilities Management

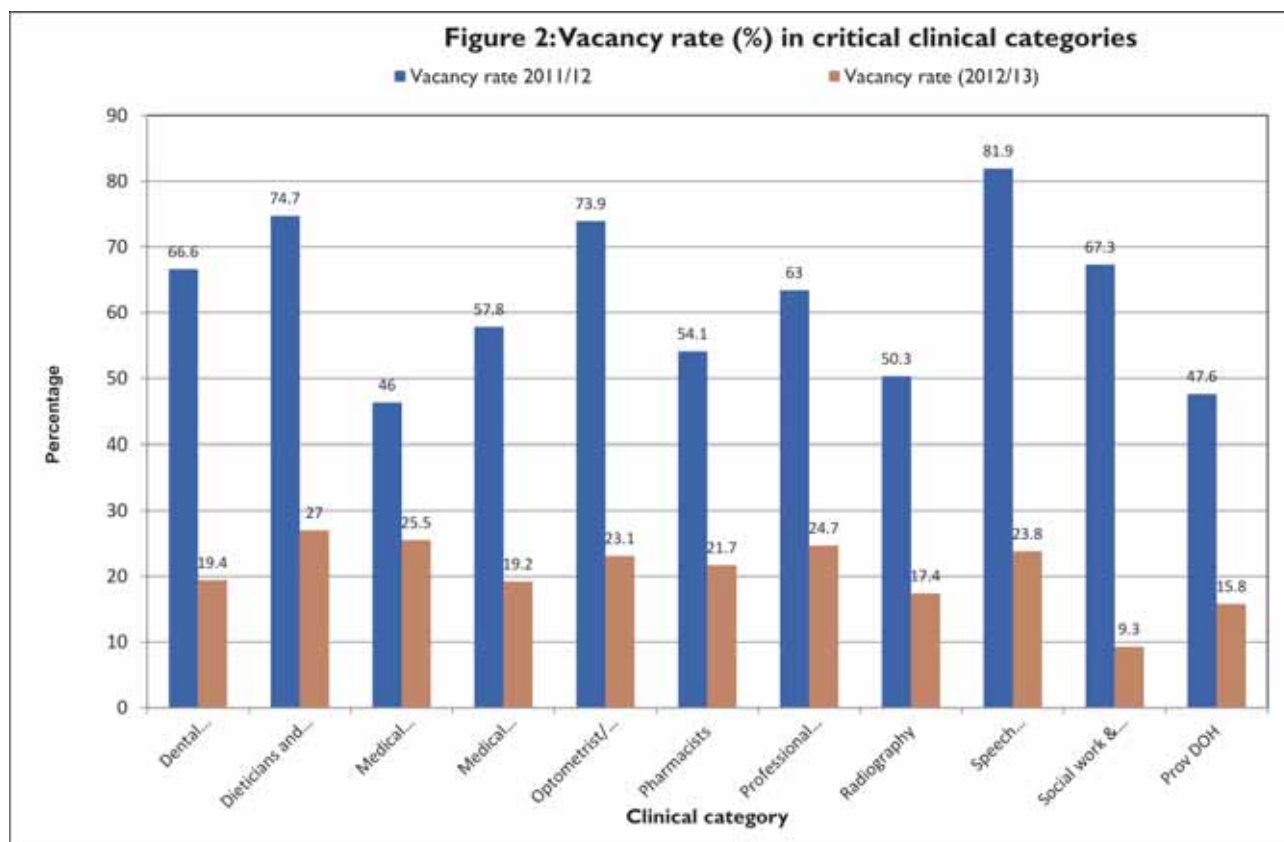
This programme aims at improving access to Health care services by providing new health facilities, upgrading and maintaining existing facilities. The objectives of the three sub-programmes of this programme are as follows:

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

Indicators reflecting service platform

Human Resource

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

**Table B3: Employment by critical occupation, 31 March 2013**

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

Service delivery outputs

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

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

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

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

KEY SERVICE DELIVERED	2008/09	2009/10	2010/11	2011/12	2012/13
Total antenatal clinic visits	458,081 ¹	465,225	456,193	464,377	455,862
Total deliveries	120,593	117,213	120,746	128,194	128,194
PHC case seen by a doctor	345,972	402,535	200,698	502,356	484 824
HIV tests conducted (excluding tests in Antenatal Clinics)	344,505	575,792	1,019,792	1,089,282	1,089,282
Male condom distributed	22,761,216	25,200,487	30,404,275	31,494,278	33,601,670
Female condom distributed	733,856	1,277,257	1,206,009	861,126	738,698
Total PHC head count	26,386,635	18,607,861	17,679,064	18,268,852	17,740,496
Psychiatric illness visits	323,347	341,997	342,289	282,157	145,455
New STIs treated	197,512	205,099	205,391	195,603	198,086
Women screened for cervical cancer	4,586	16,845	47,879	49,663	53,245
Vitamin A supplement supplied to mother	83,685	84,614	92,126	103,287	86,164
Vitamin A supplement supplied to child	541,236	594,597	572,877	642,595	609,896
Immunization: Hep B doses	282,511 ⁵	276,4705	294,813	243,992	243,317
Measles doses	222,7406	257,3526	292,804	233,825	219,413
OPV doses	309,5917	322,3367	260,212	136,966	120,851
Emergency total headcount	178,085	209,169	394,080	501,174	486 213
Assistive devices issued (Wheel chairs, hearing aids, orthoses & prostheses)	4,878	2,152	3,122	3,196	2,746

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

NSDA OUTPUTS

I. INCREASING LIFE EXPECTANCY

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

Prevention strategy to control increase and for effective management of these diseases include campaigns through integrated health programme

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

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

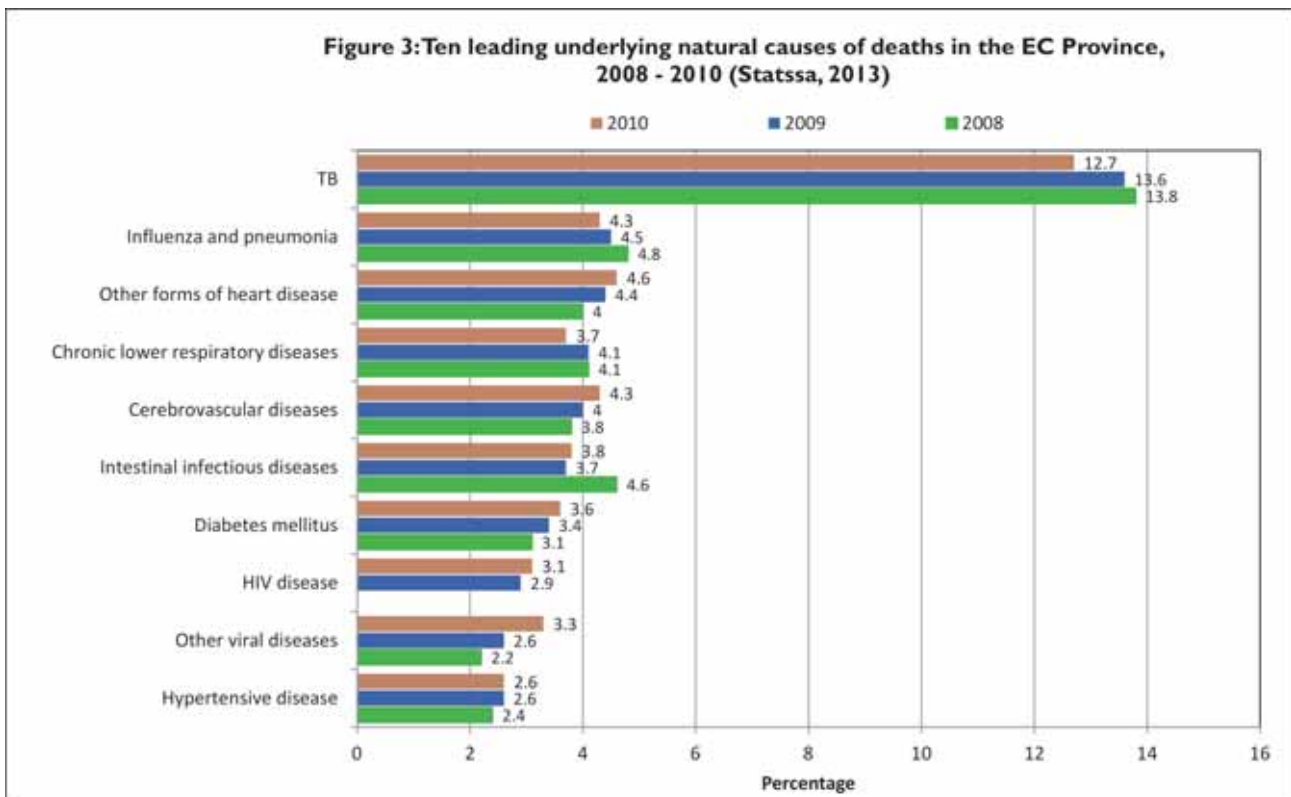


Figure 4: Top 20 leading causes of admissions in EC hospitals, 2004 (Buso et al, 2006)

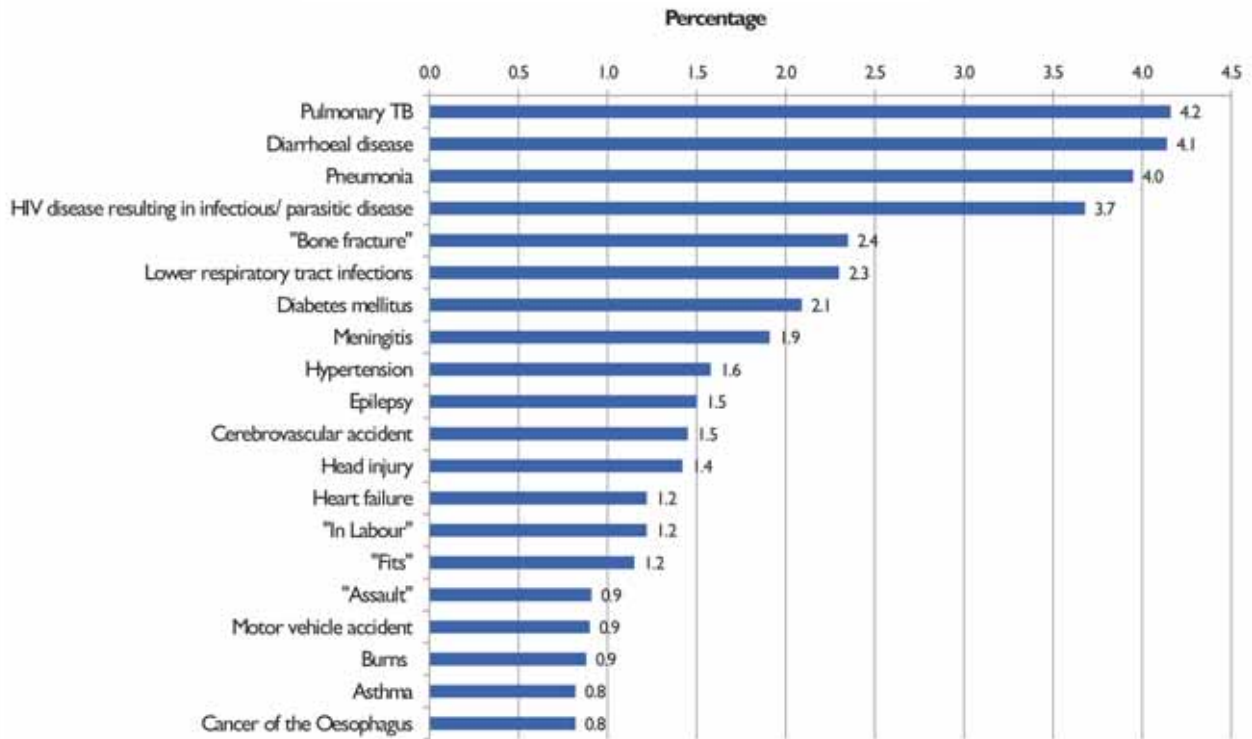
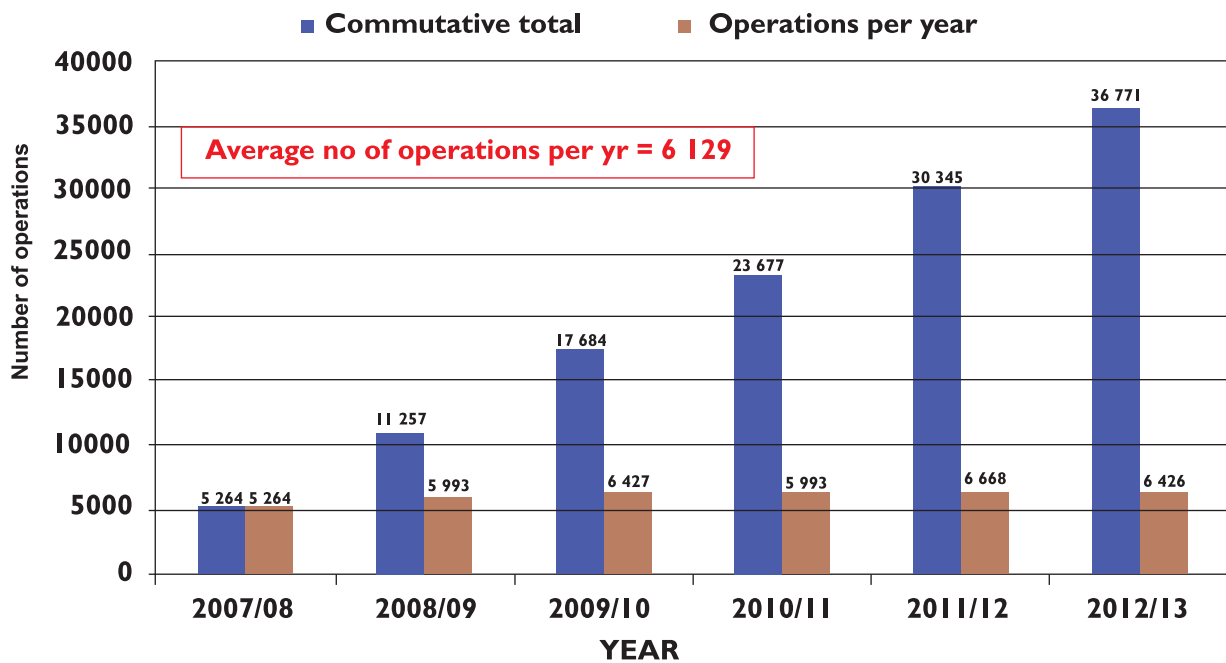


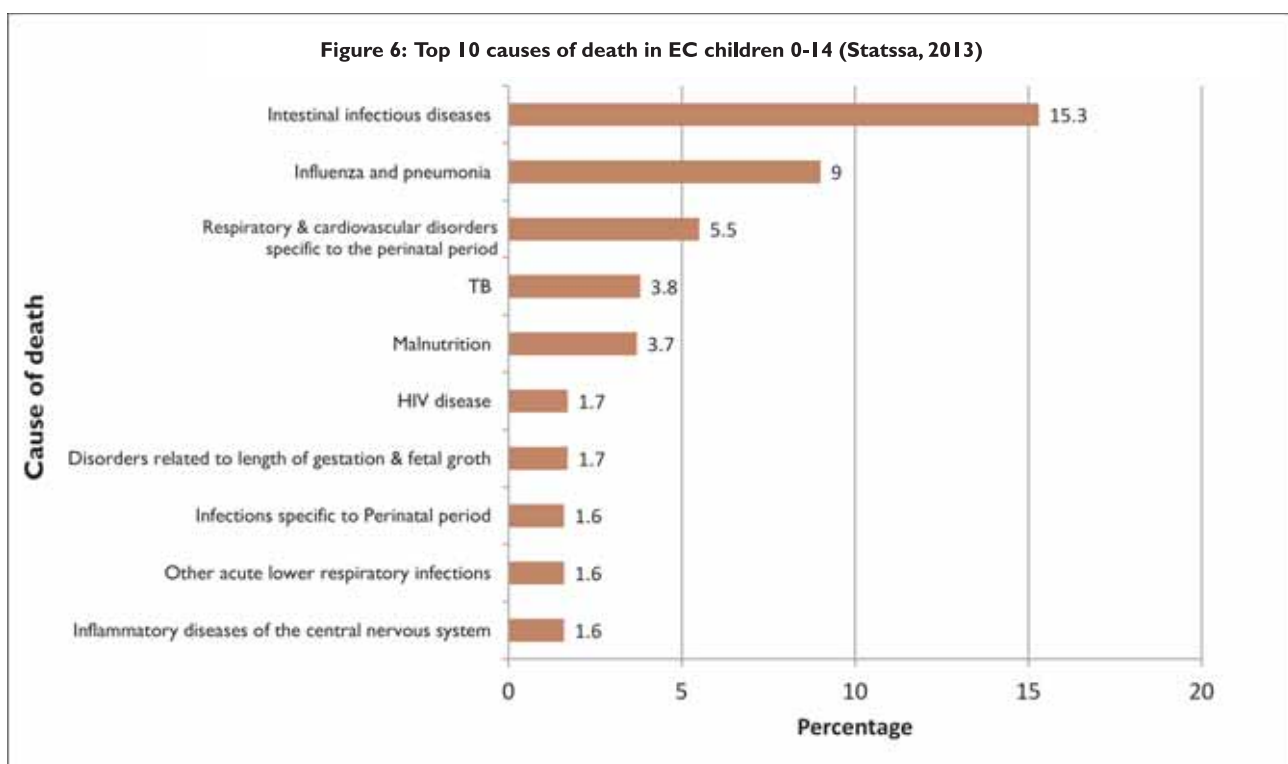
Figure 5: Distribution of catart operations performed by year, 2007-2013 (Baseline = 2007)



2. DECREASING MATERNAL AND CHILD MORTALITY RATE

Decreasing Infant and Child Mortality

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



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

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

Figure 7: ASSA Estimates 2008: Infant and Under five Mortality Rate (per 1000 live births) 2006-2012 (data source: SAHR 2013)

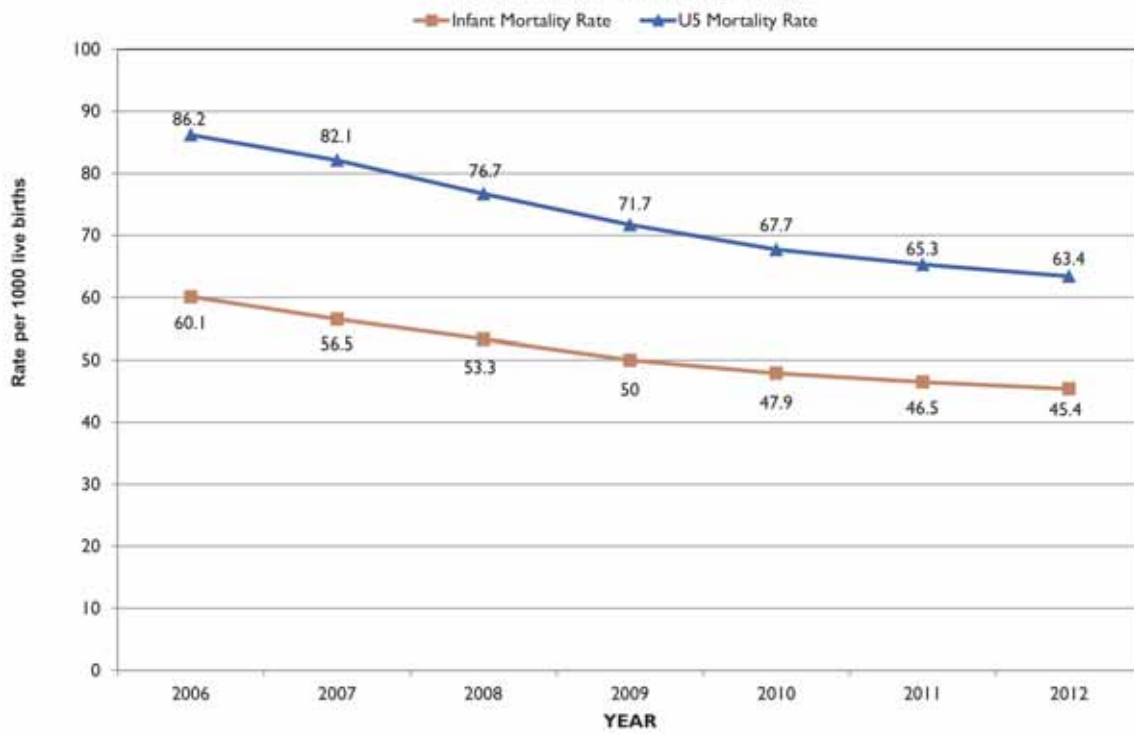


Figure 8: Infant mortality rate (per 1000) distributed by districts, 2007-2010 (Statssa mortality data 2007-2010)

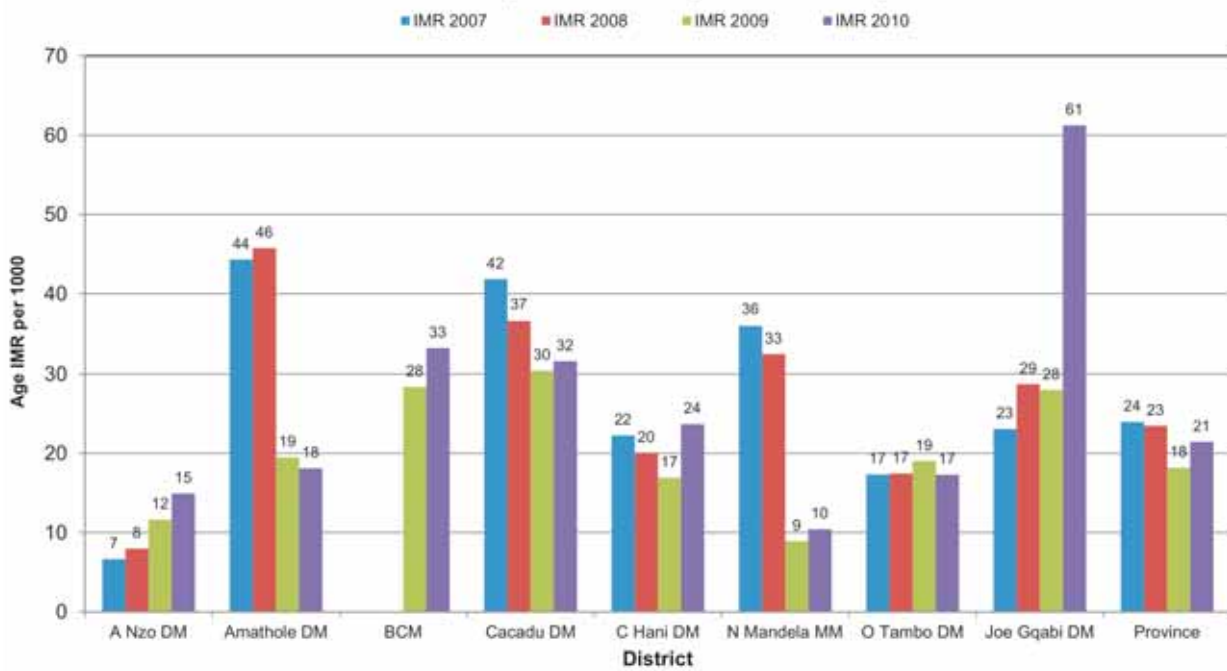


Figure 9: Number of registered under five deaths by district, 2008-2010
(Statssa mortality data 2011-2013)

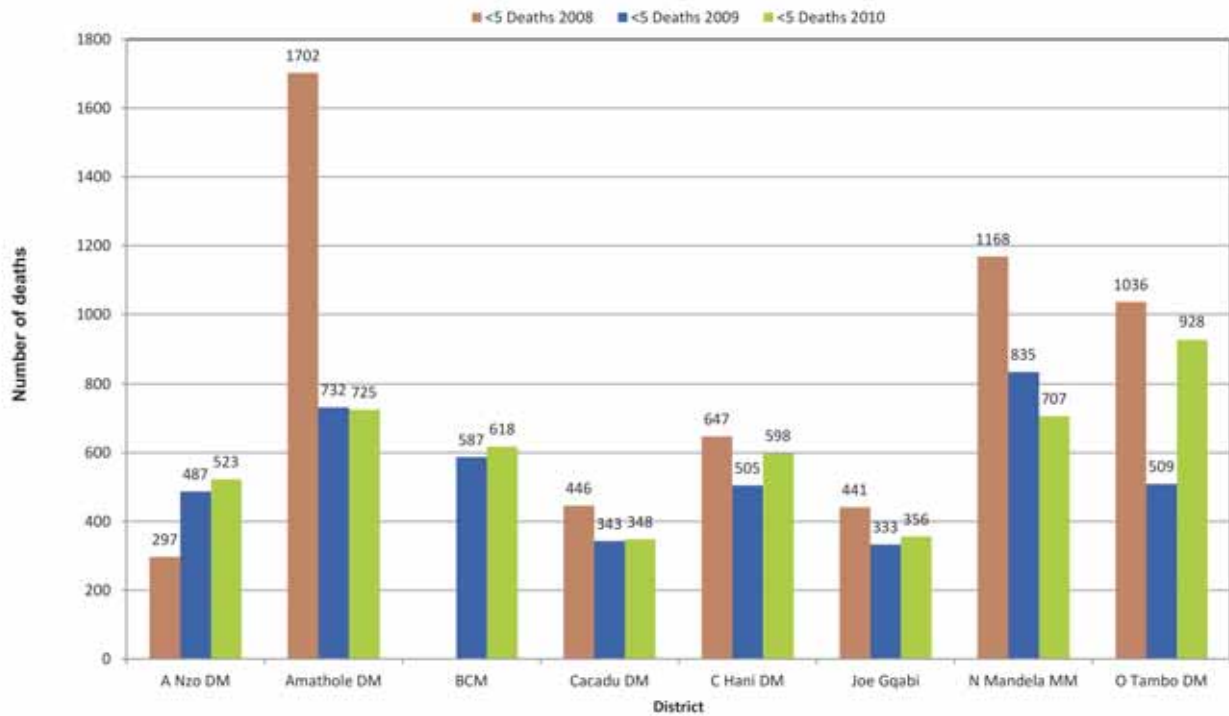
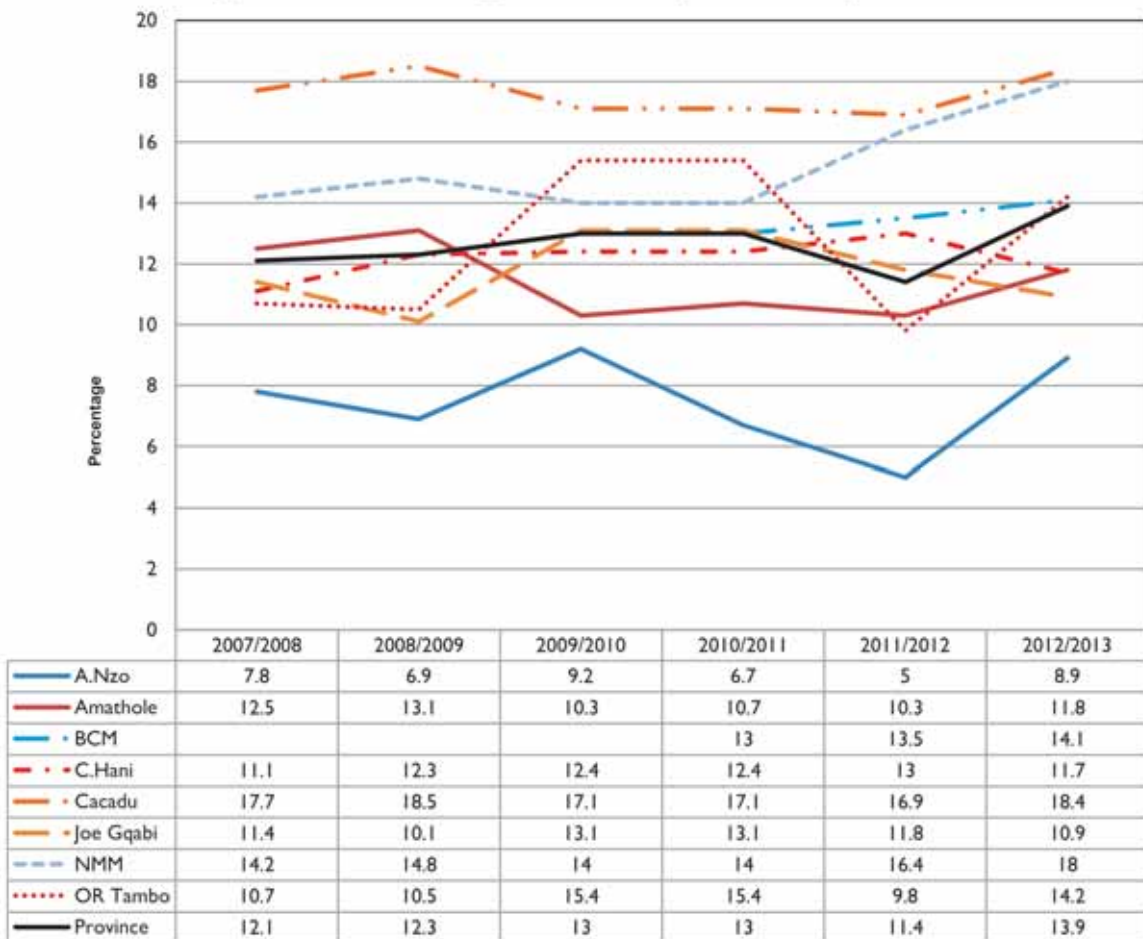


Figure 10: Low birth weight rate in facility distributed by district, 2007-2012



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

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

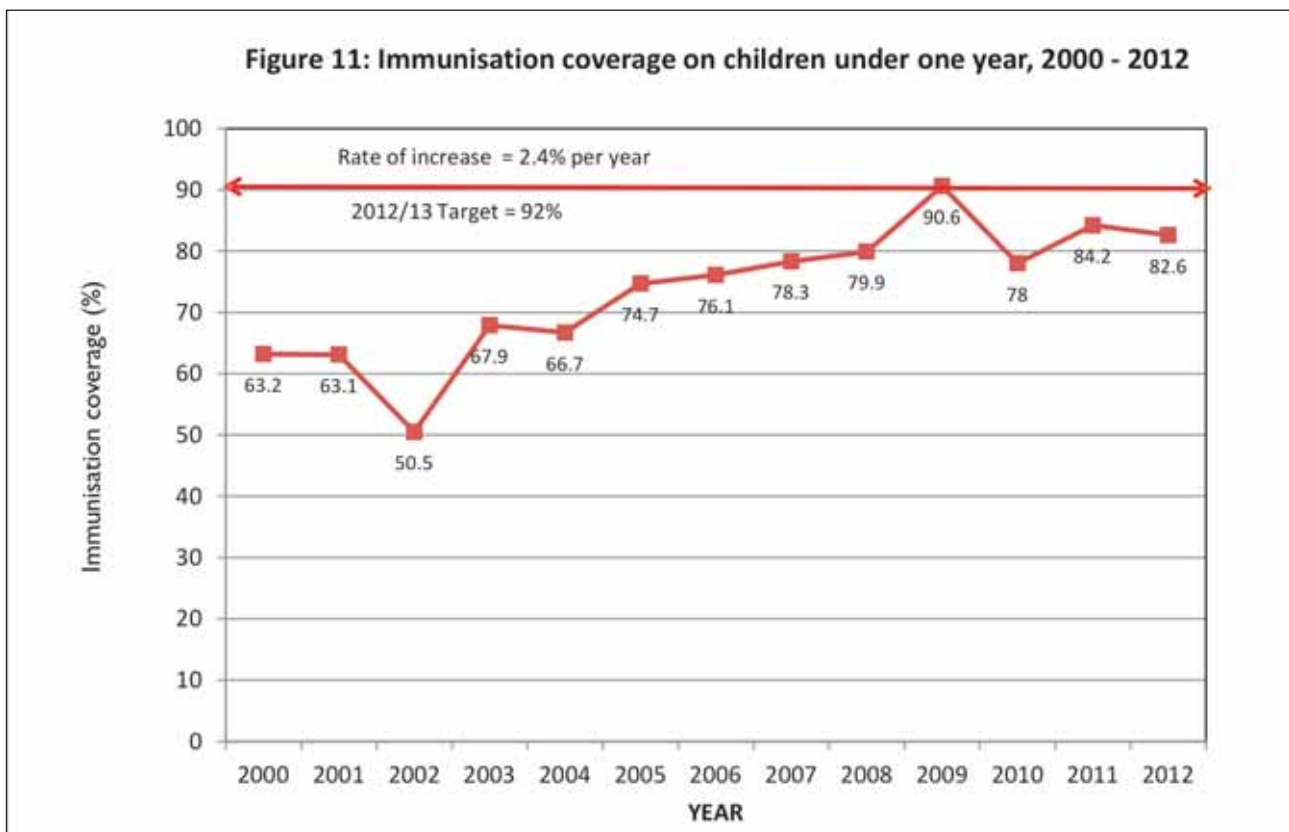
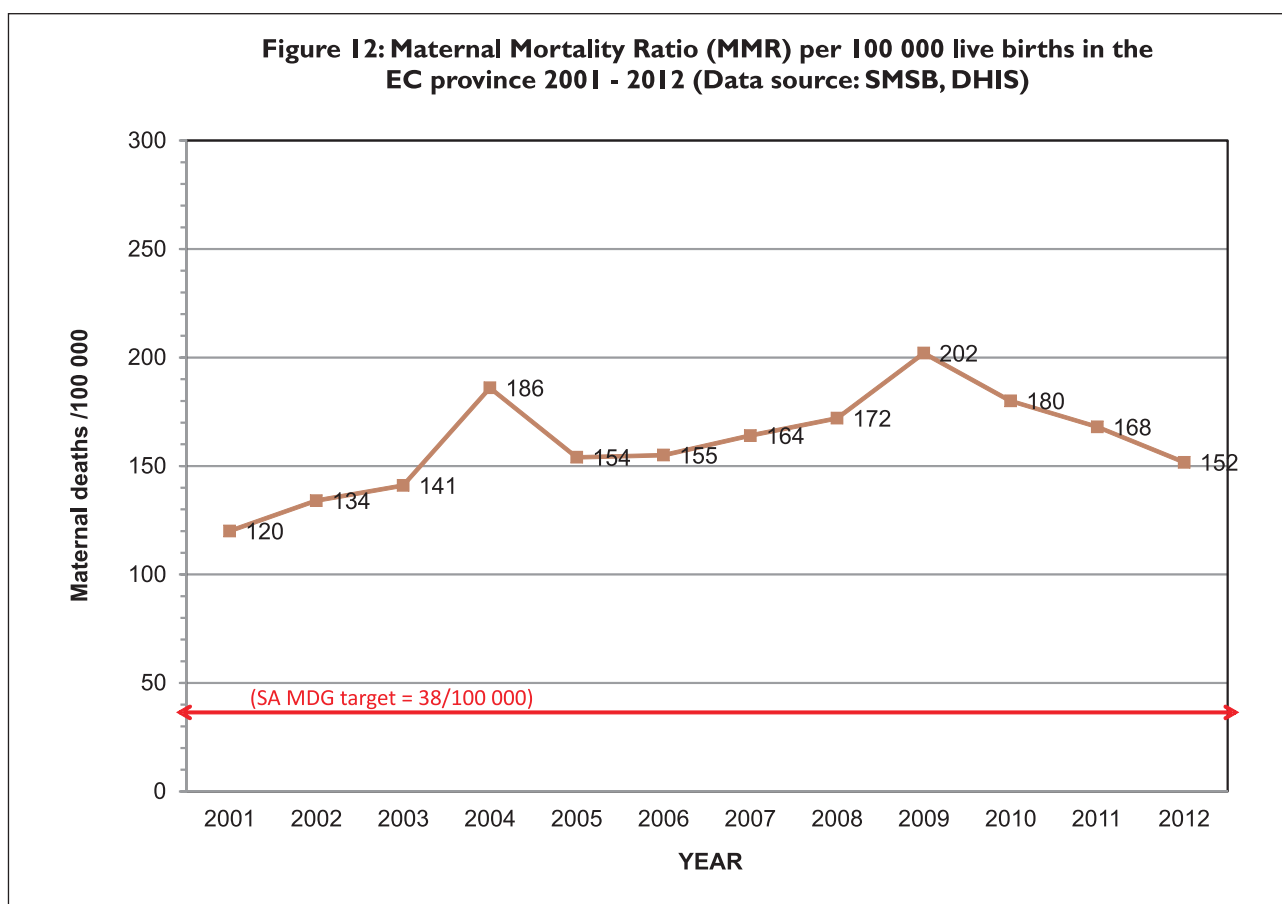


Table B6: Measures to prevent deaths of infants and children under the age of five years

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

Decreasing Maternal Mortality

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



Maternity awaiting homes:

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

Training:

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

Decentralisation of Emergency Medical Services:

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

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

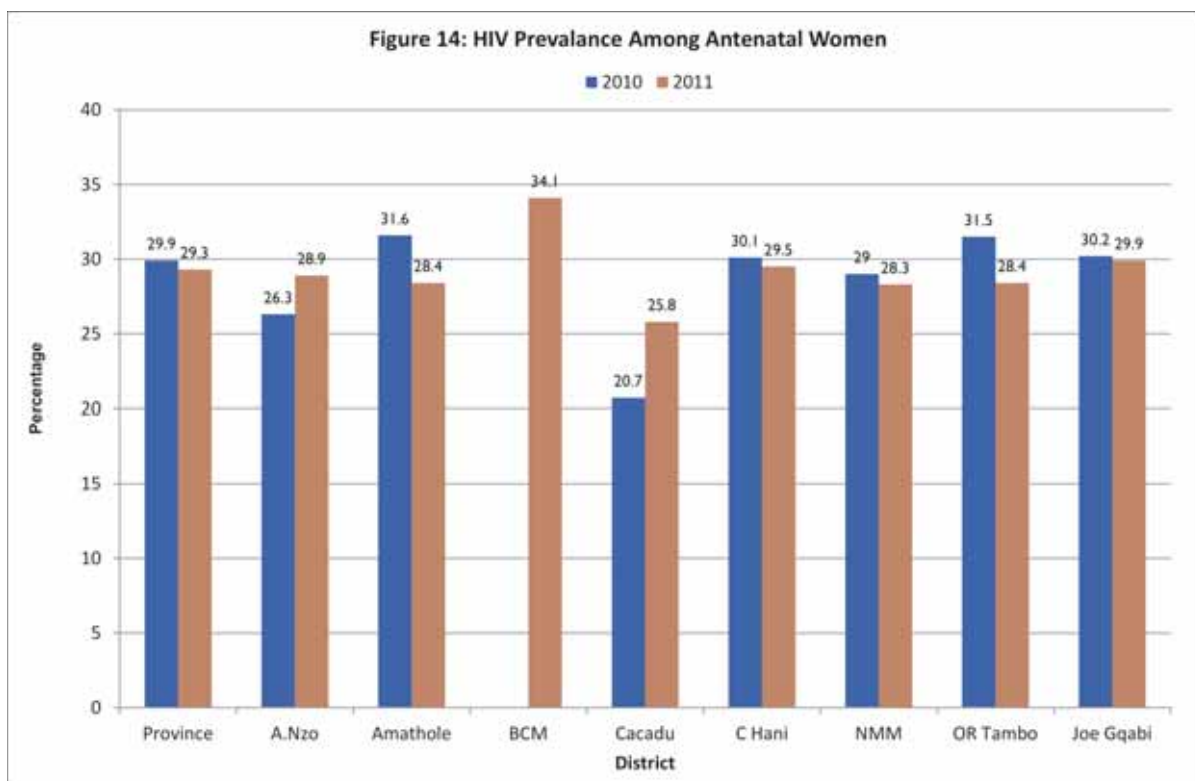
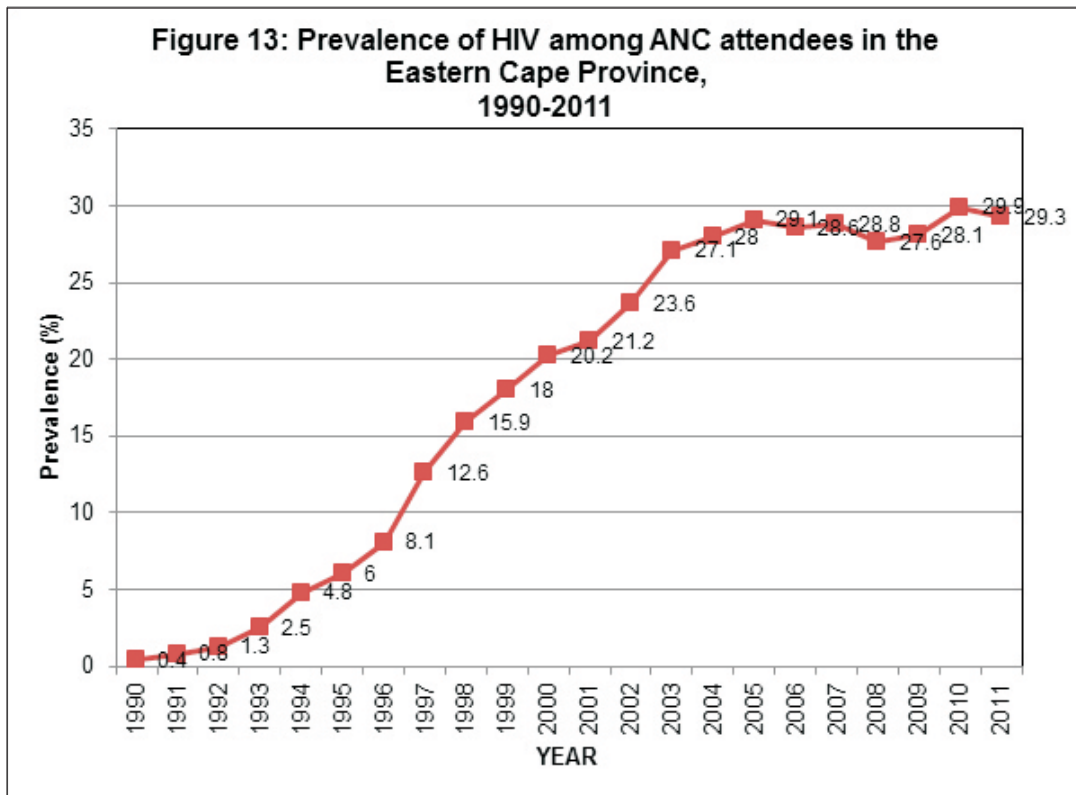
Whilst the EC DOH has achieved a high ANC coverage, the rate of attending ANC before 20 weeks of pregnancy is still very low (Table B7). The department needs to invest in educating the communities regarding the health benefits of early attendance.

Table B7: Measures to prevent deaths of pregnant mothers

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

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

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



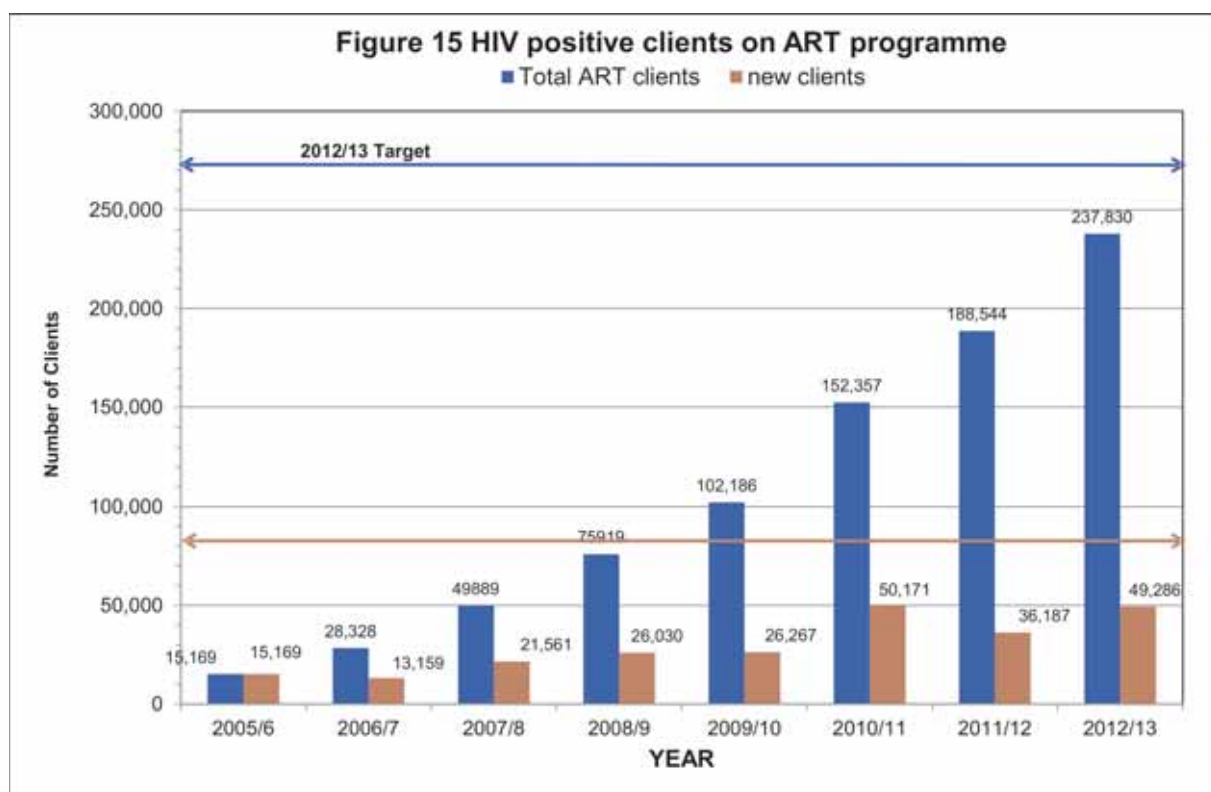
Strategies for HIV prevention and control

Prevention of Mother to child Transmission (PMTCT)

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

Nurse Initiated Management of ART (NIMART)

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



HIV Counselling and Testing (HCT)

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

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

Medical Male Circumcision

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

Other significant interventions

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

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

TB management and Control

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

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

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

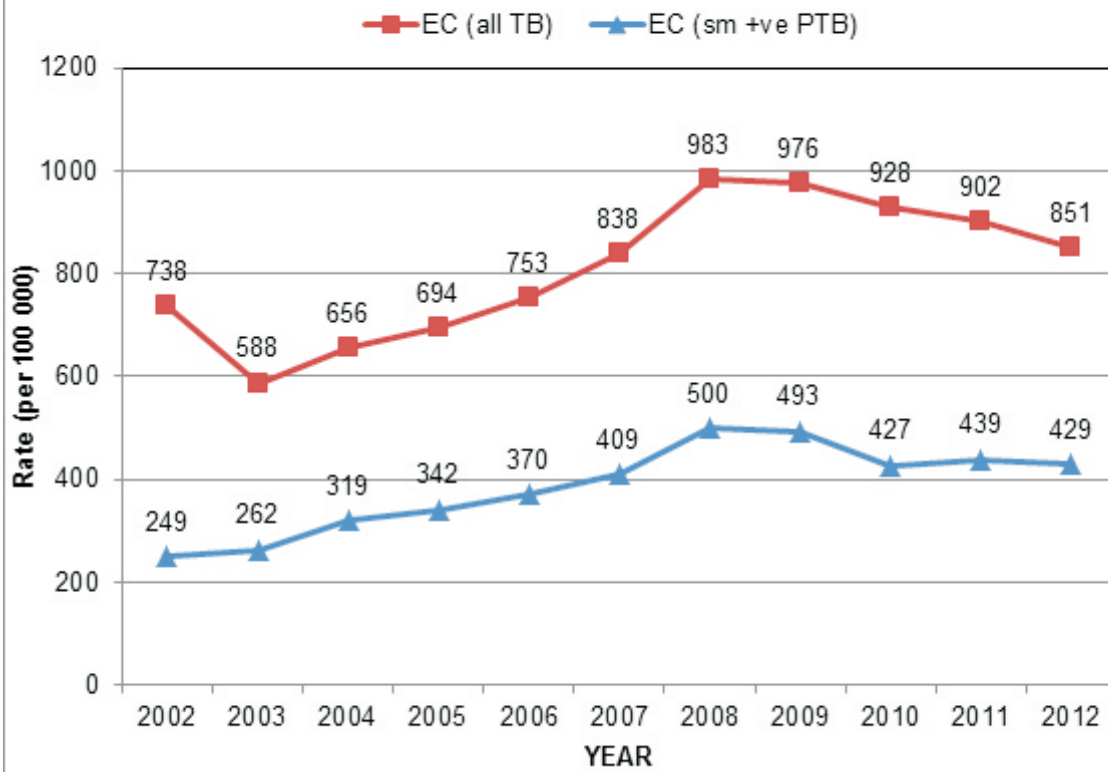
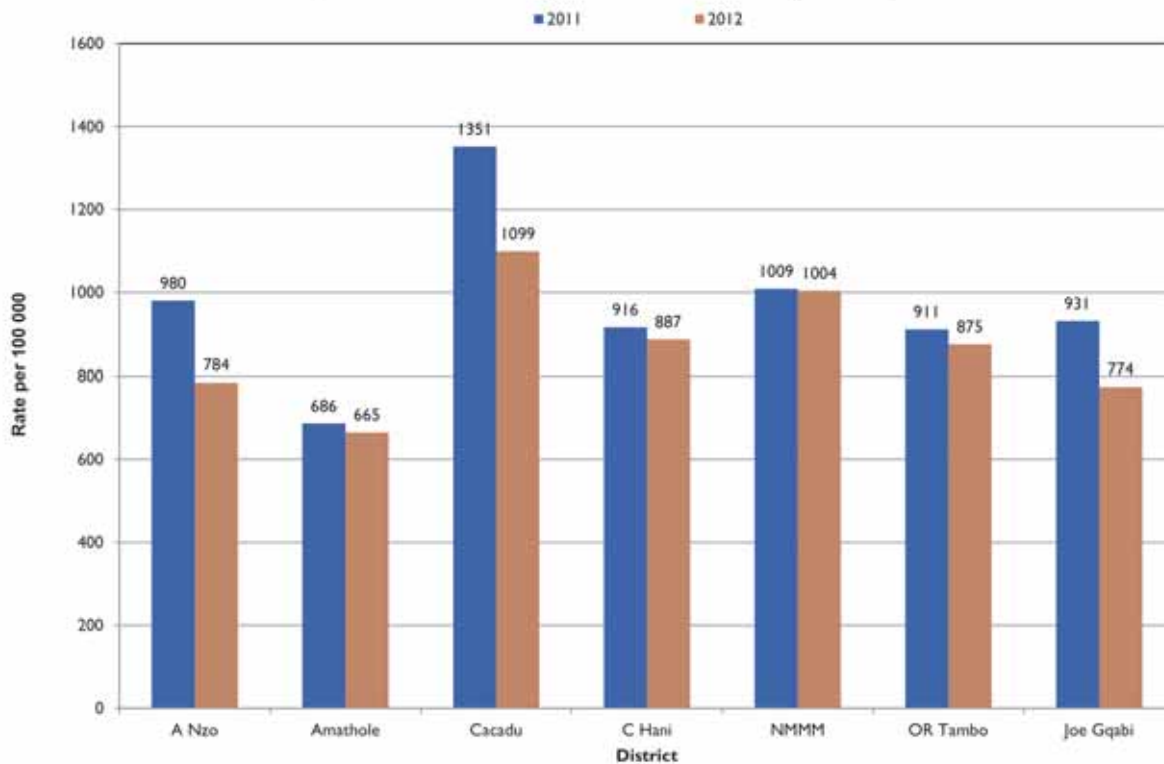


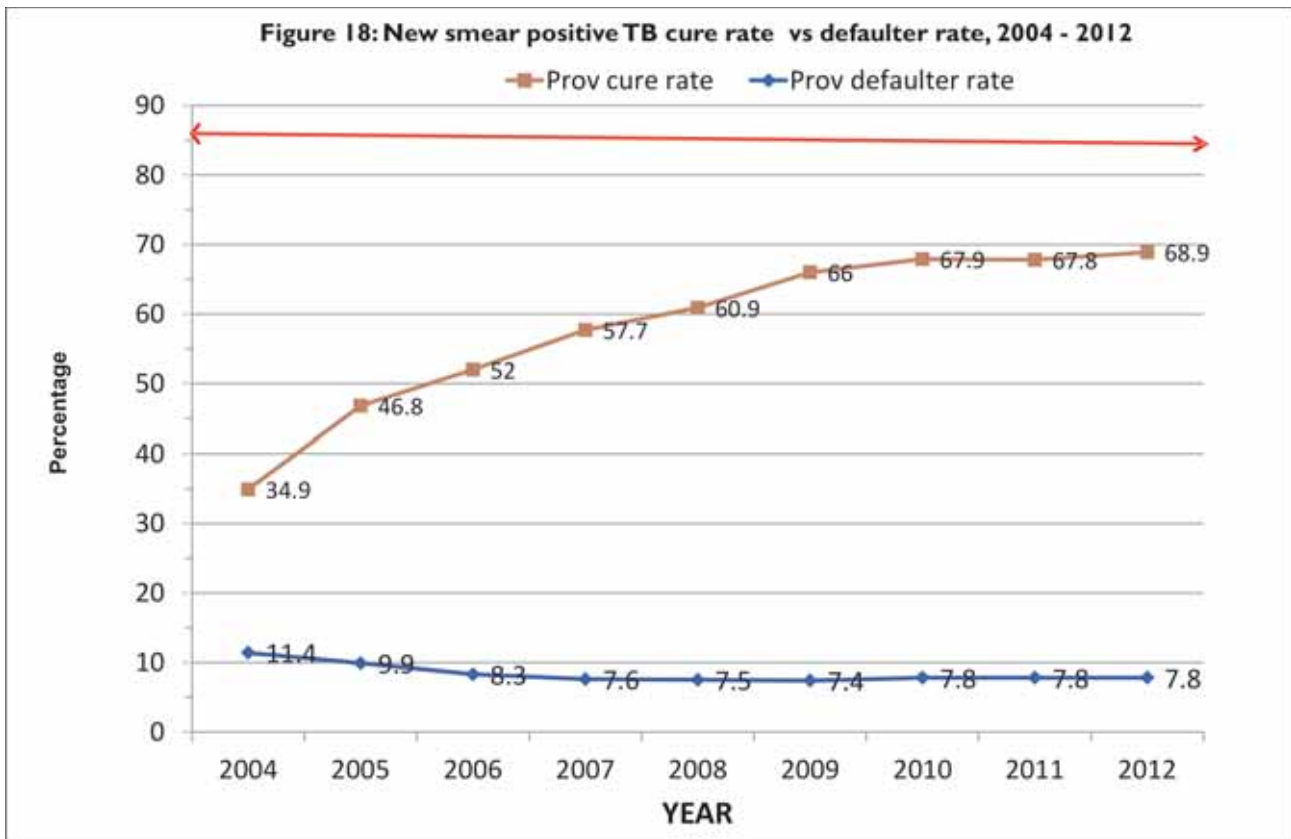
Figure 17: New TB clients per 100 000 distributed by district, 2011 & 2012

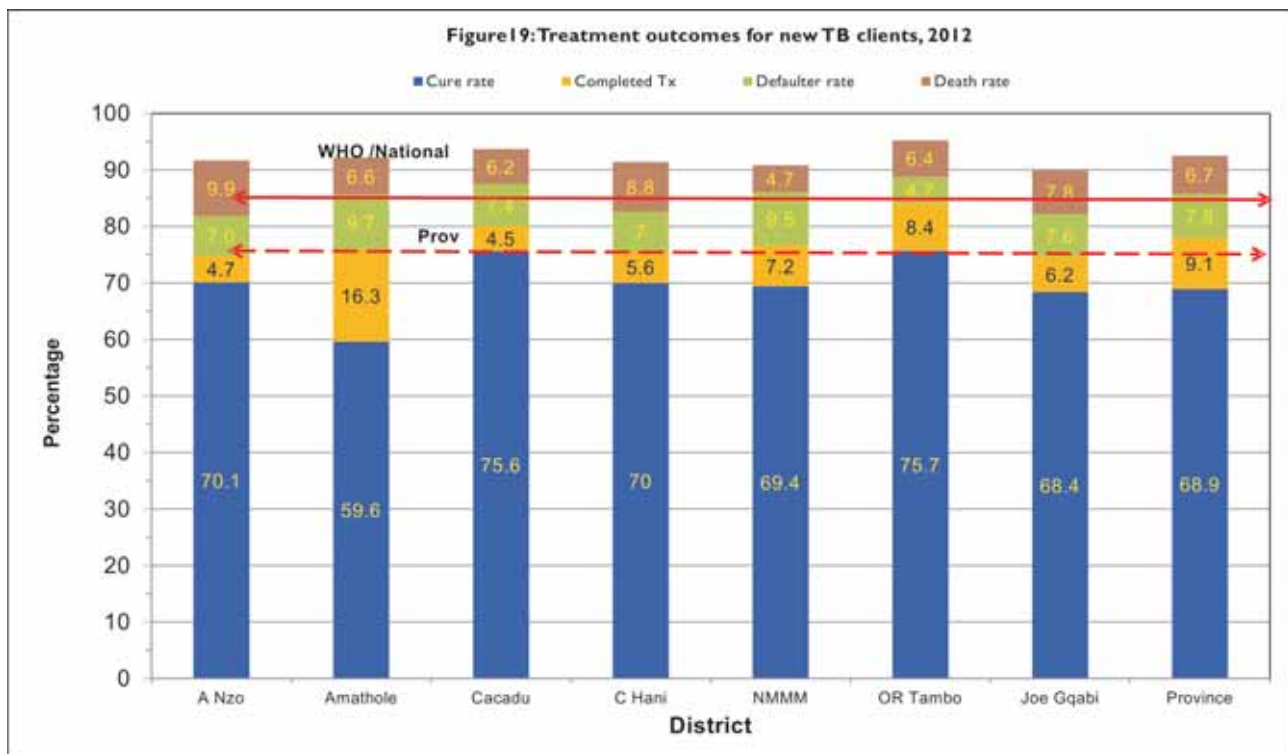


TB Treatment Outcomes

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

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





TB interventions

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

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

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

MDR and XDR-TB

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

Integration of TB with HIV and AIDS

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

FINANCIAL OVERSIGHT REPORT

I. Spending Trends

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

Table B8: High Level Financial Performance

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

Table B9: Appropriation per Economic classification

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

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

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

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

The department has applied for Conditional Grants funds totalling R132,911 million - appropriated but not spent in the 2012/13 financial year, which amount is to be rolled over to the 2013/2014 financial year. The request for roll over is supported by commitments where capital expenditure and goods and services had been delivered or rendered and therefore funds were committed and the department is either awaiting submission of invoices by suppliers or invoices had been received but will be paid in the next financial year.

The decreased spend on COE is attributable mainly to the control measures put in place by the OTP and Provincial Treasury on the filling in of vacant posts.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Virement

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

Unauthorised expenditure

The department has, for the year under review, incurred unauthorised expenditure amounting to R52,019 million in its vote, due to over spending in goods and services in Programme 2 District Health Services, which overspending was caused primarily through the reimbursement of provincialisation

(provincial setting-ups)? of primary health care claims received from various municipalities and metros.

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

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

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

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

3.1. Service Delivery Improvement Plan

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

These are:

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

3.2.1 Customers of the Eastern Cape Department of Health.

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

Primary customers of the Department of Health:

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

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

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

- Other Government Departments/ work places/

correctional facilities

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

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

3.3. Service Delivery Improvement Plan

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

Table B10: Main services provided and standards

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

MAIN SERVICES	ACTUAL CUSTOMERS	POTENTIAL CUSTOMERS	STANDARD OF SERVICE	ACTUAL ACHIEVEMENT AGAINST STANDARDS
				<p>During the 2012/13 FY, a total of 101 retired nurses were recruited onto the school health programme. These teams are also used to provide Vitamin A to the 12-59 months aged children (current tendency is for mothers not to continue bringing these kids once they have finished their first year immunization program), and to identify and refer all children who missed or have gaps on their immunization profile.</p> <p>The programme is mainly collaborating with two government Departments namely, Department of Education and Social Development and with other government departments as well though on a lesser scale. The two main Departments are also sharing resources including weighing scales, transport and height measures.</p> <p>The model of the school health programme is based on sharing of resources with the ward-based (RPHC) teams, clinics in the catchment areas, supply from the NGOs and resources from other government departments including DOE.</p> <ul style="list-style-type: none"> • District Specialist Teams (DST): in strengthening the PHC system, the DSTs are based at the district level and their primary function is to advise and mentor health facility staff at all levels in the district. These teams complement the PHC teams in the RPHC model. DSTs had been appointed for all 7 districts but these are not yet complete. Four districts namely Alfred Nzo, C Hani, OR Tambo and NMM have the full complement of nurses (i.e PHC specialist, advanced midwife, Paediatric nurse and Anaesthetist). Recruitment of doctors for these teams has in the meantime proved to be difficult.

MAIN SERVICES	ACTUAL CUSTOMERS	POTENTIAL CUSTOMERS	STANDARD OF SERVICE	ACTUAL ACHIEVEMENT AGAINST STANDARDS
Provision of the emergency medical service to all the patients of the Province.	Primary customers		<ul style="list-style-type: none"> • 1 Ambulance rostered per 10 000 population • To achieve this a total of 667 rostered ambulances required to service the entire Province 	<p>The Department currently, has a total of 306 ambulances and on average 178 of these are rostered at any point in time. This translates to 0.27 ambulances on a roster per 10 000 population, which is less than one third of the national standard. This results in poor ambulance response times.</p> <p>The Department has two helicopters and one fixed wing for hard-to-reach areas and for airlift emergencies. These are stationed at Port Elizabeth and East London.</p> <p>To address the ambulance fleet shortages, the department entered into an agreement with Government Fleet Management Services (GFMS), a trading entity of the Department of Transport for the provision of Fleet Services to the Department. During the Financial Year under review, the department received 60 replacement ambulances. The agreement will continue for an indefinite period.</p> <p>Ambulances and MOUs: Ambulances are deployed mainly in the rural areas of the Eastern Cape to ensure equity, access and to improve response times. These are all efforts and strategies to reduce maternal deaths and improve pregnancy outcomes.</p> <p>To enhance the EMS programme's Advanced Life Support capability within the province, Paramedics were increased from 12 to 34. Seventeen EMS candidates attended the Paramedic course at the Durban University of Technology during the 2012 academic year. All 17 candidates successfully completed the program and graduated in December 2012. These Paramedics have been redeployed to their districts of origin. There was no student from the Joe Gqabi district.</p>

MAIN SERVICES	ACTUAL CUSTOMERS	POTENTIAL CUSTOMERS	STANDARD OF SERVICE	ACTUAL ACHIEVEMENT AGAINST STANDARDS
The rendering of Specialised Services such as clinical orthotic and prosthetic services.	Primary customers; designated groups (disabled)	Designated groups (elderly)		<ul style="list-style-type: none"> • A total of 10 854 orthoses were issued to eligible clients exceeding a target of 8000. • 14 615 Walking devices were issued to clients • Against a target of 6000, a total of 3 411 prostheses were supplied to amputees. • Against a target of 2 875, a total of 1 720 wheelchairs were issued • Against a target of 1 475, a total of 977 hearing aids were issued <p>Off-shelf devices such as orthoses are readily available to clients, hence the consistent and good performance was maintained throughout the year. However, challenges are experienced with regards to other assistive devices leading to some targets not being met. This was as a result of delays in service provision by the supplier. The department procures these on national tender resulting into delays by suppliers who fail to deliver on time. To address these challenges and improve service delivery to our communities in future, the following strategies are to be implemented:</p> <p>ECDoH tender: On expiry of the national tender the department will be going out on its own tender.</p> <p>Staffing: Six Orthotic and Prosthetic students graduated in August 2012 from Tanzania, and presently are in the employ of the ECDoH</p> <p>Training and Development: Walter Sisulu University obtained a full accreditation to start offering Orthotics and Prosthetics course in South Africa; new intake is expected during the 2014 academic year</p>

MAIN SERVICES	ACTUAL CUSTOMERS	POTENTIAL CUSTOMERS	STANDARD OF SERVICE	ACTUAL ACHIEVEMENT AGAINST STANDARDS
The provision of training of all health professionals employed by the Eastern Cape Department of Health.	EC DOH employees	EC DOH bursary candidates to be trained in health field; Other government department employees to be trained in health related fields; Interns and learnerships; students for experiential learning		<p>Bursary Program</p> <ul style="list-style-type: none"> A total of 37 internal candidates were awarded bursaries; two candidates graduated during 2012/13 FY <p>Training and Development of Medical Registrars</p> <ul style="list-style-type: none"> 16 Registrars completed their programme and are awaiting registration certificates with the HPCSA as specialists doctors <p>Training of Health Professionals at Rhodes University</p> <ul style="list-style-type: none"> 15 Students were enrolled on the Doctor of Pharmacy (PharmD) programme. 5 Students graduated in 2012 and are in the process of being absorbed as Clinical Pharmacist Specialists. <p>Internship and Learnership Program</p> <ul style="list-style-type: none"> In line with the national mandate on Youth development, the EC DOH hosted 655 internships in various disciplines, 264 learnerships and 146 experiential learners. <p>Young Nurse Educators Development Programme at NMMU</p> <ul style="list-style-type: none"> 20 nurse educators completed the young nurse educators' programme at the NMMU and are now back at the Lilitha Nursing College campuses to improve lecturing standards 15 Students (4 PHDs & 11 Masters) were enrolled at NMMU during the 2012 academic year Three clinical laboratory managers completed training and are absorbed at Lilitha Nursing College for continuity. <p>Lilitha Nursing College</p> <ul style="list-style-type: none"> Refer to Table 6.6 of Programme 6: Health Sciences and Training Program

MAIN SERVICES	ACTUAL CUSTOMERS	POTENTIAL CUSTOMERS	STANDARD OF SERVICE	ACTUAL ACHIEVEMENT AGAINST STANDARDS
				<p><i>Establishment of the EMS College Main Campus and Satellite Campuses</i></p> <ul style="list-style-type: none"> A new Advanced Emergency Care (EMC) Degree was established at NMMU; full collaboration and memorandum of understanding between the EMS College and NMMU was drafted and is awaiting approval. The EMS College's new base in Livingstone hospital is fully refurbished and has received provisional accreditation pending full staff complement in line with the HPCSA accreditation criterion
The provision of new health facilities and revitalizing of the dilapidated facilities	Primary customers; DOH employees	External stakeholders including NGOs, CBO		<p>The Departmental focus has shifted from building of new facilities and is now firmly on maintaining the existing ones. The department took a decision to renovate clinics in all the regions in the Province following the under spending on medical equipment as well as the delays in the awarding of tenders for medium size hospitals by end of September 2012. Renovations and repairs of Primary Health Care facilities received priority. To this extent, general maintenance work in hospitals such as Cala, Elliot, Cloete Joubert, Tafalofefe, Nelson Mandela Academic hospital, Komani, Fort Beaufort hospitals is ongoing.</p> <p>Furthermore, 222 clinics covering the entire Province are being repaired and renovated. By the end of the 4th quarter 127 facilities had reached practical completion. Approximately, 112 of these will be completed during the first quarter of the 2013/14 financial year. Renovated clinics are spread as follows:</p> <ul style="list-style-type: none"> 64 in O.R.Tambo 43 in Amatole 37 in Cacadu and Nelson Mandela 27 in Chris Hani 20 in Joe Gqabi and 31 in Alfred Nzo Region

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

Table B2: Key developmental indicators in the Eastern Cape Province

TYPE OF ARRANGEMENT	ACTUAL CUSTOMERS	POTENTIAL CUSTOMERS	ACTUAL ACHIEVEMENTS
Governance structures	Hospital boards, Clinic Committees Provincial Health Council, District Health Council (DHC), Sub-district Consultative Forum (SCF), National Health council (NHC), Audit Committee (AC), Portfolio Committee, SCOPA		<ul style="list-style-type: none"> • Hospital boards and clinic committees were re-constituted, trained and are fully functional in all health facilities in the eight districts • The Department is accountable to the Health Standing Committee and complies with all legislative requirements regarding this committee and the SCOPA. • A Member of Executive Council meets with the Provincial Health Council every quarter. • The District Health Plans at district level is presented to governance structure before these can be approved by the district manager
Social compact with the communities within the RPHC model	Communities		The departmental objectives of recruiting according to a specific HR profile for each sub-district with the aid of local social compact committees were met. The selection of bursary candidates is done at sub-district level through the social compact committees. The department has developed a more stringent social compact bursary contract and directed obligation policy targeting rural district health facilities. The contract is now signed by three (3) parties, i.e. bursary recipient, community member and the department official.
MEC Roadshows	Governance structures at district level	Hospitals and management communities	The MEC visits the hospitals and hold meetings with the hospitals boards

Table B I I: Consultation arrangements with customers

TYPE OF ARRANGEMENT	ACTUAL CUSTOMERS	POTENTIAL CUSTOMERS	ACTUAL ACHIEVEMENTS
Governance structures	Hospital boards, Clinic Committees Provincial Health Council, District Health Council (DHC), Sub-district Consultative Forum (SCF), National Health council (NHC), Audit Committee (AC), Portfolio Committee, SCOPA		<ul style="list-style-type: none"> • Hospital boards and clinic committees were re-constituted, trained and are fully functional in all health facilities in the eight districts • The Department is accountable to the Health Standing Committee and complies with all legislative requirements regarding this committee and the SCOPA. • A Member of Executive Council (MEC) meets with the Provincial Health Council every quarter. • The District Health Plans at district level is presented to governance structure before these can be approved by the district manager
Social compact with the communities within the RPHC model	Communities		The departmental objectives of recruiting according to a specific HR profile for each sub-district with the aid of local social compact committees were met. The selection of bursary candidates is done at sub-district level through the social compact committees. The department has developed a more stringent social compact bursary contract and directed obligation policy targeting rural district health facilities. The contract is now signed by three parties, i.e. bursary recipient, community member and the department official.
MEC Roadshows	Governance structures at district level	Hospitals and management Communities	The MEC visits the hospitals and hold meetings with the hospitals boards

Table B12: Service delivery access strategy, 2012/13

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

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

ACCESS STRATEGY	ACTUAL ACHIEVEMENTS																																								
<p>Poor health technology, old and poorly maintained equipment.</p>	<p>Healthcare Technology</p> <p>Provincial and District Healthcare Technology Committees (PHTC & DHTC) were established during the FY under review in compliance with the National Health Technology Strategy. The aim of establishing these forums is to provide a platform to discuss provision and proper management of healthcare technology related issues, development of norms and standards as well as the approval of procurement of major equipment. In February 2013, the EC DOH hosted a Healthcare Technology workshop in which relevant delegates including national, Clinical Engineering personnel, Hospital CEOs, Hospital Managers and stakeholders from other provinces participated. Following the institution of the PHTC and DHTC,</p> <ul style="list-style-type: none"> • A draft essential equipment list for institutions is under development by the national DOH. • A transversal tender to ensure timely and smooth procurement of new medical equipment in the next three years was advertised in November 2012 • Skills development & training: The department planned to award 10 bursaries towards clinical engineering training however, no bursary was awarded in this category as none of the applicants were admitted at relevant institutions of higher learning (see Health Sciences and Training section on page 185). <p>Provision of Medical Equipment</p> <p>The Department procured and installed Radiology equipment in three district hospitals namely: Madwaleni, Mt Ayliff and Bambisana hospitals as well as two CHCs i.e Gompo and Port st Johns. Furthermore, new equipment including patient beds, dental equipment, stretcher beds, theatre tables etc. were procured and distributed to health facilities as shown in the Table below. Distribution of health facilities supplied with new equipment by district and type of facility</p> <table border="1" data-bbox="893 860 1902 1294"> <thead> <tr> <th>DISTRICT</th> <th>HOSPITAL</th> <th>CHC</th> <th>CLINIC</th> <th>Total facilities</th> </tr> </thead> <tbody> <tr> <td>Amatole</td> <td>15</td> <td>2</td> <td>16</td> <td>33</td> </tr> <tr> <td>OR Tambo</td> <td>2</td> <td>-</td> <td>25</td> <td>27</td> </tr> <tr> <td>Chris Hani</td> <td>1</td> <td>1</td> <td>11</td> <td>13</td> </tr> <tr> <td>Cacadu</td> <td>3</td> <td>-</td> <td>2</td> <td>5</td> </tr> <tr> <td>Alfred Nzo</td> <td>-</td> <td>-</td> <td>5</td> <td>5</td> </tr> <tr> <td>Joe Gqabi</td> <td>-</td> <td>-</td> <td>8</td> <td>8</td> </tr> <tr> <td>Total</td> <td>21</td> <td>3</td> <td>67</td> <td>91</td> </tr> </tbody> </table> <p>Maintenance of equipment</p> <p>Tenders for maintenance of medical equipment contracts were advertised in 2012 to be effective in the new financial year. Currently, ad hoc maintenance is implemented at all levels. (also see section 6.8 on page 246)</p>	DISTRICT	HOSPITAL	CHC	CLINIC	Total facilities	Amatole	15	2	16	33	OR Tambo	2	-	25	27	Chris Hani	1	1	11	13	Cacadu	3	-	2	5	Alfred Nzo	-	-	5	5	Joe Gqabi	-	-	8	8	Total	21	3	67	91
DISTRICT	HOSPITAL	CHC	CLINIC	Total facilities																																					
Amatole	15	2	16	33																																					
OR Tambo	2	-	25	27																																					
Chris Hani	1	1	11	13																																					
Cacadu	3	-	2	5																																					
Alfred Nzo	-	-	5	5																																					
Joe Gqabi	-	-	8	8																																					
Total	21	3	67	91																																					

ACCESS STRATEGY	ACTUAL ACHIEVEMENTS
<p>Inefficient internal process e.g. Supply chain management; poor revenue collection and generation</p>	<p>Strengthening Financial Management (Monitoring & Evaluation)</p> <p>Financial management in the department remains a huge challenge due to lack of qualified, skilled and competent finance personnel mainly at operational level as well as fragmented and non-integrated systems.</p> <p>As a result of lack of integrated systems the department has had to implement a number of compensating manual systems to consolidate financial information from districts and various units including information for the preparation of annual financial statements. The glaring risks of human error associated with use of manual system exist.</p> <p>Over the past 3 years the department implemented interventions that were designed to improve the financial outcome of the department. This entailed improving accounting practices and control environment, introducing Generally Recognised Accounting Practices (GRAP) best practices, ensuring integrity of financial data and implementing systems and controls.</p> <p>The result was the improvement of the audit opinion from nine item qualified opinion to a three item qualified opinion, which needs to be enhanced in the 2013/14 financial year.</p> <p>The challenge that still faces the department in the area of financial management is the lack of skilled, proficient and competent personnel. The appointment and retention of skilled financial management personnel is a prerequisite for an improved financial management in the department. The department will collaborate with the PCMT to ensure that critical financial management posts are filled in the coming financial year.</p> <p>There are specific capacity control measures in the area of revenue collection and generation, including among others, the lack of sufficient automated patient billing systems, insufficient and inexperienced officials in hospital revenue components. Accordingly, the department continues to be challenged in the full implementation of policies.</p> <p>Currently the following areas have been prioritised for implementation:</p> <ul style="list-style-type: none"> o Addressing HR capacity issues in the revenue units in terms of staff complements o Enhanced training and mentoring of revenue officials at facility level o Enhanced telephonic, Electronic Data Interchange (Medical Aids) and internet connectivity of all facilities o Enhanced monitoring capacity within the head office unit o Extended collection of revenue to include EMS, TB Hospitals and Community Health Centres

ACCESS STRATEGY	ACTUAL ACHIEVEMENTS
	<ul style="list-style-type: none"> o Ramping up income from applications fees for and inspection fees of private healthcare facilities. o Standardisation of the Revenue Retention Policy <p>MAWG will continue with the intervention to focus on the procurement system of the department. It is anticipated that this intervention will lead to an improved functioning of the department which will in turn, enhance the capacity of the department to provide more and better quality health services.</p> <p>Supply Chain Management Initiatives</p> <p>The Goods and Services budget of the department is the second highest cost driver. The public sector procurement prescripts are based on the principle of “value for money” and the development of the previously disadvantaged communities or households.</p> <p>Given the capacity challenges the department faced in the SCM area, Provincial Planning and Treasury seconded a number of officials to the department to oversee the SCM processes.</p> <p>The Department continued to capacitate its' officials through in-service training and short-term courses to ensure timeous, effective and efficient procurement. It also strengthened its internal procurement structures such as the bids specification, bids evaluation and adjudication committees and also ensured the rigorous application of national and provincial SCM prescripts.</p> <p>In its broad plans to review the state procurement system and develop broad level mechanisms to optimise its functioning, the department participated as a pilot site for the implementation of MAWG, a structure that was formed by the Minister of Finance.. The Department has prioritised the implementation of the SCM Reform Project, the objective of which is to provide a set of priorities and proposals with appropriate action plans to deliver a rapid improvement in the departments' procurement system. It is anticipated that this intervention will lead to an improved functioning of the department which will in turn enhance the capacity of the department to provide better quality health service.</p> <p>The three main objectives of this project are: to make SCM activities visible and controllable by management, to strengthen SCM capabilities and to provide sufficient human resources for the SCM function. The main aspects of the project cover the following:</p> <ul style="list-style-type: none"> • Strengthening of procurement capabilities and resourcing of the function; • LOGIS Implementation;

ACCESS STRATEGY	ACTUAL ACHIEVEMENTS
	<ul style="list-style-type: none"> • ICT Infrastructure upgrade; • Provisioning of office accommodation; • Document management; and • Strengthening of asset management capabilities and resourcing of the function. <p>It is expected that the implementation of the project will enable the department to turn around its negative SCM audit outcomes into unqualified opinions in the future. R15 million was allocated in 2012/13 while an additional R72 million is allocated for the 2013/14 financial year. The department will ensure the rigorous implementation of the project not only to enhance audit outcomes but also significantly improve the service delivery performance of the department.</p>

Table B13: Service information tool, 2012/13

TYPES OF INFORMATION TOOL	ACTUAL ACHIEVEMENTS
Facility registers	The implementation of NIDS 2010 in October 2010 had a change of data collection tools in the facilities. This led to the designing of a new register to accommodate the data elements to be reported. These were designed and templates sent to district managers for procurement. All the facilities had to register accommodating NIDS 2010 data element
DHIS	This is a standard desktop system which accommodates or reports on aggregated data. All the hospitals had their DHIS system which, the PHC facilities still lagging behind, thus led to the sub districts to capture their data. Every two years the DHIS data base changes in order to accommodate the NIDS (National Indicator Data Set). DHIS serves as the national reporting tool. It is also used as a data register tool of other systems.
TIER.NET	<p>Tier.net is a national Programme initiated in 2011 aiming at improving reporting of ART services and tracking of clients on the ART. It consists of 3 Tiers; Tier 1 being paper-based; Tier 2 is mandatory computer and Tier 3 is network based computer program. At present 314 and 85 facilities are implementing Tier 1 and 2 respectively. Tier 3 has not yet been implemented. The implementation of this system is preceded by preparation (connectivity and buying of computers), installation as well as training of users. After this initial phase, the following five phases are then implemented:</p> <ol style="list-style-type: none"> 1) Back capturing 2) Back capturing with live capturing 3) Live capturing and data cleaning in program 4) Data sign off by DIT, PIT 5) Live site able to produce monthly and quarterly reports

Table BI4: Complaints mechanism

COMPLAINTS MECHANISM	ACTUAL ACHIEVEMENTS
<p>Complaints are received via a number of sources, namely: the National Department of Health, Office of the MEC; office of the Superintendent General; Departmental Call Centre; Office of the Public Protector, complaints boxes at health facilities and from individuals. These complaints are acknowledged within 72 hours and are investigated within 5 working days</p> <p>The departmental complaints policy classifies complaints into eight categories namely:</p> <ul style="list-style-type: none"> • Class 1 – Death Related cases • Class 2 – Clinical Care where a serious damaged has occurred • Class 3 – Fraud related cases • Class 4 – Staff attitudes • Class 5 – Hotel or Hospitality, Infrastructure • Class 6 – Leave Gratuity and Pension Benefits • Class 7 – Staff concerns or Grievances • Class 8 – Non Payment of Suppliers <p>The national norm is that complaints are to be resolved within 25 Days of receipt by the Department. In the event that they are not resolved they should not exceed 60 days. This is applicable to all facilities of the ECDOH. The head of a facility is the complaints manager but currently this function is delegated to the Quality Assurance Managers where these are available. The complaints procedure is displayed in each facility and all health facilities are required to submit statistics on a monthly basis to Customer Care Directorate at provincial head office.</p>	<p>Approximately 70% of complaints received were resolved within 25 days. Class 1-3 complaints take longer to resolve. Poor reporting and non-submission of statistics by some facilities remain a challenge.</p> <p>The Department is moving towards establishing electronic complaints database which is believed will resolve some of the challenges that are currently being experienced.</p>

COMPLAINTS MECHANISM

ACTUAL ACHIEVEMENTS

The complaints coming through the EC DOH Shared Contact Centre are captured on a CRM system with database and are categorized according to Clinical, Integrated Human Resource Management and Finance related calls.

All these are further categorised according to the resolution rate:

- Level 2 complaints – are those complaints resolved within 72 hrs. by the Contact Centre
- Level 3 complaints – exceeded 72hrs and within 25 days. These are either sent to the facilities or the Head of Clusters for investigation and resolution.

Those that exceeded 25 days become accumulative to the following financial year. These are cases that relate to litigations and some of them are handled by the Departmental Legal Unit.

Level 2: Resolved within 72hrs

Clinical - 60%
IHRM - 46%
Finance - 33.4%

Level 3: Resolved within 25 days

Clinical - 67%
IHRM - 86%
Finance - 96%

Actual total resolution : 69.1%

Clinical - 63.3%
IHRM - 76%
Finance - 96.4%

3.3. Organisational environment

Human Resource Capabilities

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

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

Industrial Action

During the period under review the Department experienced a number of unprotected industrial action (illegal strikes) sporadically occurring across the province. For some institutions like Mthatha Hospital Complex, Mthatha Pharmaceutical Depot and

Emergency Medical Services, a Court Order prohibiting the employees from striking was sought and granted. The causality was mainly unpaid HR backlogs which in some instances were outstanding for a long time.

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

Review of Organisational Structure

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

Fleet Management Services

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

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

3.4. Key policy developments and legislative changes

- **The Eastern Cape Finance Act I of 2013** was approved by the Premier of the Province of the Eastern Cape on 28 March 2013. In terms of the Eastern Cape Finance Act (2013), the Department's unauthorised expenditure totaling R1,286 billion (2011/12 (R297,6 million), 2010/11, (R116,4 million) and 2009/10 (R871,9 million)) has been condoned with funding.
- **Revenue Collection and Retention within the Enhanced Amenities domain:**
- In implementing the **social compact in the area of human resource development**, the Department is using the social committees in the sub-districts to select bursary candidates. The students awarded bursaries sign the contract with the communities, sub-district and the EC DOH; the purpose being to ensure that after graduation, these students will get back to serve their communities.

4. STRATEGIC OUTCOME ORIENTED GOALS

Table B2: Key developmental indicators in the Eastern Cape Province

STRATEGIC GOAL TITLE	GOAL STATEMENT	EXPECTED OUTCOMES	PROGRESS MADE AT END 2012/13			DEVIATION
			INDICATOR	2010/11	2012/13	
I. Public Health System	To facilitate a functional quality driven public health system that provides an integrated and seamless package of health services and is responsive to customer needs.	By 2015, the organisation should demonstrate the following outcomes: <ul style="list-style-type: none"> • Functional district health characterised by well managed and effective clinics, CHCs, district and specialised hospitals, • Each district to have a fully functional EMS METRO Centre. • Fully functional regional and tertiary hospitals. 	PHC utilisation rate	2.7	2.7	0
			Nurse workload (PHC) (Average number of patients seen)	14.1	31.6	17.5
			BUR (district hospitals)	65.5%	62.2%	-3.3%
			BUR (Regional hospitals)	70.1%	68.4%	-1.7%
			BUR (Tertiary hospitals)	75%	75.5%	0.5%
			Exp/PDE (district hospitals)	R1128	R1688	R560
			Exp/PDE (Regional hospitals)	R1411	R1978	R568
			Exp/PDE (Tertiary hospitals)	R1722	R1831	R109
			Number of districts with EMS METRO centres	5	6	1

STRATEGIC GOAL TITLE	GOAL STATEMENT	EXPECTED OUTCOMES	PROGRESS MADE AT END 2012/13			DEVIATION
			INDICATOR	2010/11	2012/13	
			Number of domains implemented in Tertiary hospitals	Mthatha complex: 30 PE complex: 30 EL Complex: 25	Mthatha-complex: 30 PE complex: 30 EL Complex: 25	Mthatha-complex: -7 PE complex: -7 EL Complex: -12
			Number of domains implemented in Regional hospitals (Only Frontier)	8	8	0
2.TB and HIV/AIDS	To combat and reduce the impact of TB and HIV/AIDS with a special focus on preventing the emergence of drug – resistant strains.	By 2015, the organisation should demonstrate the following outcomes: <ul style="list-style-type: none"> • Reduction of HIV prevalence • % coverage of ART • Improved TB cure rate • Reduction of TB Incidence • Arrest rate of progression to MDR/XDR 	Prevalence of HIV among ANC attendees	28.1% (2009)	29.3% (2011)	1.2%
			Total clients on ART	152 357	237 830	85 473 (56.1%)
			New Smear positive PTB cure rate	66%	68.9%	2.9%
			PTB incidence	722 per 100 000	778 per 100 000	56 per 100 000
			Smear positive PTB incidence	353 per 100 000	425 per 100 000	72 per 100 000
			Number of MDR clients MDR arrest rate	947	1062	115 (12.5%)
			Number of XDR clients XDR arrest rate	242	204	38 (-15.7%)

STRATEGIC GOAL TITLE	GOAL STATEMENT	EXPECTED OUTCOMES	PROGRESS MADE AT END 2012/13			DEVIATION
			INDICATOR	2010/11	2012/13	
3. Mother and Child Health	To improve and strengthen the mother and child health services.	<p>By 2015, the organisation should demonstrate the following outcomes:</p> <ul style="list-style-type: none"> • % reduction of maternal morbidity • % reduction of maternal mortality • % reduction of infant mortality • % reduction of <5 child morbidity • Reduce no. of underweight children <5 – nutrition/social needs cluster • Greater awareness of women's sexual and reproductive rights 	Public Health Facility Maternal Mortality Rate (per 100,000 live births)	142/ 100 000	112/ 100 000	-30/ 100 000
			Facility Infant Mortality (under 1) rate (per 1000)	86/1000	49/ 1000	-37/ 1000
			Facility Child mortality (under 5) rate (per 1000)	63/1000	48/ 1000	-15/ 1000
			Baby tested PCR positive six weeks after birth as a proportion of babies tested at six weeks	7.3%	3%	-4.3%
			Underweight for age rate under 5 years	0.4%	0.3%	-0.1%
			Delivery rate for women under 18 years (%)	10.5%	10.3%	-0.2%
			Couple year protection rate	31.6%	31.7%	0.1%
			Termination of pregnancy rate	0.4%	0.7%	0.3%

STRATEGIC GOAL TITLE	GOAL STATEMENT	EXPECTED OUTCOMES	PROGRESS MADE AT END 2012/13			DEVIATION
			INDICATOR	2010/11	2012/13	
4. Non-communicable diseases and mental conditions.	To combat and reduce diseases of lifestyle and mental conditions.	<p>By 2015, the organisation should demonstrate the following outcomes:</p> <ul style="list-style-type: none"> • Reduction in incidence of mental conditions. • Reduction in re-admissions of mental patients. • Reduction in substance abuse. • Reduce complications in hypertension and diabetes. • Improved health promotion. • Reduce incidence of obesity. • Reduction in morbidity, mortality resulting from circumcision. • Reduction in epilepsy and asthma morbidity. • Reduction in morbidity and mortality of the most common cancers (breast, cervix, prostate, oesophagus and lung). 	Cervical screening coverage	3.3%	39.4%	36.1%
			Mortality rate in Traditional circumcision	11 deaths	0.2% (74 deaths)	- (63 deaths)
			Asthma under 18 years rate	5%	13.5%	8.5%
			Epilepsy under 18 years rate	5.5%	15.4%	9.9%

STRATEGIC GOAL TITLE	GOAL STATEMENT	EXPECTED OUTCOMES	PROGRESS MADE AT END 2012/13			DEVIATION
			INDICATOR	2010/11	2012/13	
5. Institutional capacity	To enhance institutional capacity through effective leadership, governance, accountability and efficient and effective utilization of resources.	<p>By 2015, the organisation should demonstrate the following outcomes</p> <ul style="list-style-type: none"> • Unqualified audit opinion received from the Auditor General • Effective leadership and audit • Effective planning and monitoring system • Achieve % of norms and standards re ratios • Fully-fledged and independent Lilitha College of Nursing that is able to produce ready, able and capable nurses to service the health system. • Fully-fledged EMRS College is able to produce ready, able and capable EMRS Practitioners to service the health system. 	New intake at Lilitha Nursing College		1758	
			Number of nurses graduating from Lilitha Nursing College		1459	
			Compliance level with MPAT	Not implemented	EC DOH complied at level I	Two level below target
			% District Hospitals with appointed CEOs		100% (66/66)	
			% Regional Hospitals with appointed CEOs		50% (1/2)	
			% Tertiary Hospitals with appointed CEOs		67% (2/3)	
			% TB Hospitals with appointed CEOs		72.7% (8/11)	
			% Psychiatry Hospitals with appointed CEOs		75% (3/4)	
			% Executive management posts filled	40% (2/5)	40% (2/5)	
			% District Hospitals with appointed CEOs		77.3% (51/66)	

PART B

PROGRAMME I



HEALTH ADMINISTRATION

PROGRAMME I: HEALTH ADMINISTRATION AND MANAGEMENT

PROGRAMME PURPOSE

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

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

1.1 Office of the MEC

PURPOSE

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

STRATEGIC OBJECTIVES

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

PROGRAMME PRIORITIES

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

Table 1.1: Performance against Strategic Objectives for Health Administration

STRATEGIC OBJECTIVES	Actual Achievement 2011/2012	Planned target 2012/13	Actual achievement 2012/13	Deviation from planned target to Actual Achievement for 2012/2013	Comment on deviations
5.1 To facilitate the provision of strategic leadership and the creation of social compact to achieve 100% accountability	5 Statutory planning and reporting compliance documents submitted to the legislature	Submit 5 statutory planning and reporting compliance documents to the legislature	5 Statutory planning and reporting compliance documents submitted to the legislature	0	Target achieved.
5.2. To facilitate 100% achievement of an effective and compliant planning and monitoring system	Not measured	Department to comply at level 3 with the Management Performance Assessment Tool (MPAT)	EC DOH complied at level 1 with the MPAT	2 levels below target	Under-achievement on this target is attributed to the electronic system flaws. Some of the evidence that was submitted electronically with the completed tool did not go through to the DPME at the Office of the Presidency as these were big files. The EC DOH assessment was therefore based on incomplete
5.3 To provide 100% Financial Management and SCM to achieve full accountability and a clean audit	A qualified audit outcome	A qualified audit outcome with: <ul style="list-style-type: none"> • Reduced qualifications • Conversion of qualification to emphasis of matter 	A qualified audit outcome with: <ul style="list-style-type: none"> • Qualifications reduced from 9 to 4 • Some qualifications were converted to emphasis of matter 	Target achieved	

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

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

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

I.2 MANAGEMENT

PURPOSE

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

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

1. Finance cluster

- Financial Management Services
- Budget
- Supply Chain Management (SCM)

2. Corporate Strategy and Organisational Performance

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

3. Corporate Services

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

4. Clinical cluster

- District Health Services
- Communicable Diseases
- Primary Health Care Services
- Clinical Support Services

STRATEGIC OBJECTIVES

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

Table I.2: Performance against Provincial Targets from 2012/13- 2014/15 Annual Performance Plan for the Management

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

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

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

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

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

CHANGES TO PLANNED TARGETS

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

LINKING PERFORMANCE WITH BUDGETS

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

Programme I: Health Administration expenditure by sub-programme

SUB- PROGRAMME NAME	2012/2013			2011/2012		
	FINAL APPROPRIATION	ACTUAL EXPENDITURE	(OVER)/UNDER EXPENDITURE	FINAL APPROPRIATION	ACTUAL EXPENDITURE	(OVER)/UNDER EXPENDITURE
	R'000	R'000	R'000	R'000	R'000	R'000
I.1 Office of the MEC	5,734	4,251	1,483	5,502	5,061	441
I.2 Management	528,897	530,812	(1915)	543,908	538,837	5,071
Total	534,631	535,063	(432)	549,410	543,898	5,512

PART B

PROGRAMME 2



DISTRICT HEALTH SERVICES

PROGRAMME 2: DISTRICT HEALTH SERVICES (DHS)

PROGRAMME PURPOSE

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

PROGRAMME DESCRIPTION

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

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

PRIORITIES FOR THE NEXT THREE YEARS

- To facilitate the provision of strategic leadership and the creation of Social Compact for better health by strengthening governance structures for increased participation in health issues.
- To implement the model for the delivery of health services in Eastern Cape based on the Revitalised Primary Health Care (RPHC) approach.
- To increase access to the comprehensive Primary Health Care (PHC) Service Package
- To combat and reduce the impact of TB and HIV/AIDS with a special focus on preventing the emergence of drug-resistant strains.
- To improve and strengthen the mother and child health services within the Eastern Cape.
- To improve early detection and management of people with chronic conditions and those abusing substances at the community level through social mobilisation of communities.

2.1-2.3 District Management, Clinics and Community Health Centres

PURPOSE

- 2.1 ***District Management:*** the sub-programme manages the effectiveness, functionality as well as the coordination of health services, referrals, supervision, evaluation and reporting as per provincial and national policies and requirements.
- 2.2 ***Clinics:*** the sub-programme manages the provision of preventive, promotive, curative and rehabilitative care including the implementation of priority health programmes through accessible fixed clinics and mobile services in 26 sub-districts.
- 2.3 ***Community Health Centres (CHCs):*** the sub-programme renders 24-hour health services, maternal health at midwifery units and the provision of trauma services as well as the integration of community-based mental health services within the down referral system.

STRATEGIC OBJECTIVES

- I.3 To facilitate implementation of NHI Readiness in at least one health district.
- I.4 To ensure revitalisation of Primary Health Care in at least five sub-districts, i.e. Intsika Yethu, Sub-district B (Uitenhage), King Sabata Dalindyebo (KSD), Nyandeni and Mbashe

SUB-PROGRAMME PRIORITIES

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

SUB-PROGRAMME ACHIEVEMENTS

Health Governance Structures

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

RE-ENGINEERING OF PHC SERVICES

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

Establishment of Ward Based PHC Outreach Teams (WBPHCOTs)

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

Table 2.1: PHC teams established per sub-district

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

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

District Clinic Specialist Teams (DCSTs)

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

Revitalisation Pilot Sites

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

Provincialisation of PHC Services

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

Facility Improvement Teams (FITs)

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

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

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

Table 2.1: Performance against Strategic Objectives for Programme 2

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

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

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

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

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

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

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

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

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

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

PHC total headcount under 5 years

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

Percentage of fixed PHC facilities with a monthly supervisory visit

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

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

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

CHANGES TO PLANNED TARGETS

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

2.4 COMMUNITY-BASED SERVICES

PURPOSE

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

STRATEGIC OBJECTIVES

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

PROGRAMME PRIORITIES

- Implementation of the PGDP Priorities within the context of the Social Needs Cluster to reduce mortality and morbidity resulting from traditional circumcision.
- Enhance health outcomes within the province through education, health promotion and advocacy campaigns.
- To improve early detection and management of people with chronic conditions and those abusing substances at the community level through social mobilisation of communities.
- To implement the National Drug Master Plan to mainstream substance dependency treatment.
- To implement chronic disease priority guidelines on diabetes, hypertension and cancer.
- To increase access to and improve eye care services.

ACHIEVEMENTS

Male circumcision

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

Oral Health services

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

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

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

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

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

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

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

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

Mortality rate in traditional circumcision clients

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

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

Clinics providing Oral Health Services

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

Hypertension and Diabetes case Load in PHC facilities

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

Cataract surgery rate

- **Promoting and strengthening collaboration with external health care providers:** The department sourced support of the external stakeholders as a strategy to increase service delivery outputs in this area. During the year under review, the department received the support of the Fred Hallows Foundation which provided two professionals, an optometrist and an optical laboratory technician. In addition, the KZN eye-care coalition will, for a period of three years, be undertaking cataract camps at both St Elizabeth and Butterworth hospitals.
- **Increasing provincial output of qualified ophthalmologists and optometrists:** The Health Sciences and Training programme of the department is awarding bursaries to address the skills gap in various health disciplines in the province. The non-communicable diseases sub-directorate is in constant engagement with this training programme to increase bursary intake of students training to qualify as ophthalmologists and optometrists.

CHANGES TO PLANNED TARGETS

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

2.5 OTHER COMMUNITY SERVICES

PURPOSE

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

STRATEGIC OBJECTIVES

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

PROGRAMME PRIORITIES

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

ACHIEVEMENTS

1. The Sub-Directorate has devolved the Municipal Health Services (MHS) to two District Municipalities namely and one Metro.
 - Eleven environmental health services were devolved in Joe Gqabi District Municipality in June 2012,
 - 21 EHPs were transferred to Alfred Nzo in September 2012 and
 - 8 EHPs were transferred to Buffalo City Metro in December 2012. These EHPs were transferred with 100% funding of the Compensation of Employees (CoE).
2. The Service Level Agreement for the devolution of MHS has been signed with OR Tambo DM and the actual transfer of staff will occur in 2013-2014 financial year.
3. The department monitors and applies strict controls on Port Health Services: the Port Health Services in Port Elizabeth International airport during the AFCON in January 2012 refused entry to seven passengers from yellow fever endemic areas as they did not comply with the yellow fever vaccination requirements

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

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

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

Facilities segregating waste in line with SANS 10248

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

Inconsistencies within the service provider contract (plastic distribution):

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

Poor compliance with waste segregation requirements:

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

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

CHANGES TO PLANNED TARGETS

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

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

PURPOSE

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

STRATEGIC OBJECTIVES

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

PROGRAMME PRIORITIES

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

ACHIEVEMENTS

HIV and AIDS Sub-Programme

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

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

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

Prevention of Mother to Child Transmission

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

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

TB Management and Control

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

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

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

Community-based management for MDR-TB Patients

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

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

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

Collaboration with other health care providers

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

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

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Total number of patients (children and adults) on ART	188 544 (38 544 new)	270 000 (82 000 new)	237 830 (49 286)	-32 170	<ul style="list-style-type: none"> After provincialisation of municipal clinics, patients were moved from original ART sites to alternative newly provincialized clinic ART sites and these were lost in the system as they are not appearing at both the new and old sites. Between April and May 2012 there was a nationwide shortage of Tenofovir 300mg which is one of the drugs used by patients on 1st line regimen. This affected the number of new clients initiated on ART
Male condom distribution rate (per male population 15 yrs. and older)	14.8	16	15.7 (33 601 670/ 2 140 538)	-0.3	During quarter 1, the province experienced a shortage of condoms. This was due to challenges with Supply Chain Management processes. In previous years, condoms were procured through the National Department of Health tender.

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

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

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

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

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

Patients (children and adults) on ART

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

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

Male condom distribution

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

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

New smear positive PTB defaulter rate

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

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

PTB two months smear conversion rate

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

HIV and TB co-infected patients placed on ART

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

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

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

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

TB & HIV co-infected patients started on Cotrimoxazole

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

TB cases tested for HIV

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

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

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

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

New smear positive PTB cure rate

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

CHANGES TO PLANNED TARGETS

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

2.7 MATERNAL, CHILD AND WOMEN'S HEALTH & NUTRITION

PURPOSE

To ensure implementation of national and provincial Maternal Child and Women's Health (MCWH) policies related to the delivery of comprehensive PHC services in clinics, community health centres and mobile clinics for women and children so as to improve maternal and health care services; and to reduce neonatal, infant and child mortality and morbidity.

STRATEGIC OBJECTIVES

- 3.1 To ensure reduction of child mortality to achieve 26 per 1000 mortality in under-five children.
- 3.2 To facilitate the reduction of maternal mortality to achieve 36.8 per 100 000 live births.

PROGRAMME PRIORITIES

- Reduction of morbidity and mortality rates due to severe malnutrition in hospitalized children from 30% to 10%.
- Increasing the number of health facilities with maternity beds awarded a baby-friendly status by four annually.
- Routine Vitamin A supplementation of children less than 5 years presenting at PHC facilities to 100%.
- Incorporation of nutrition activities into the Integrated Food Security and Nutrition projects in Integrated Sustainable Rural Development Nodal Sites through intersectoral collaboration especially at provincial level.
- To conduct crèches outreach services to improve Vitamin A supplementation for 12-59 month old children.
- Contribute to household food security through establishment of clinic and hospital gardens and provision of food parcels.
- Increase the number of fixed PHC facilities implementing IMCI.
- Expansion of Community IMCI implementation to all Urban Renewal Nodes.
- Reduction of teenage pregnancy.
- Improve access to cervical cancer screening services.
- Improve immunization coverage.

SUB-PROGRAMME ACHIEVEMENTS

School Health Services

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

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

Child's Health

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

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

Integrated Nutrition Project

- MCWH and Integrated Nutrition programme is forming part of the provincial anti-poverty strategy team with other government departments to address poverty in the province. Poverty stricken families eligible for assistance are identified through outreach teams, Health Promoters and CHW as well as other community health services from other government departments. Sixteen wards in 13 local Municipalities had been identified (see Table 2.7.1 below).
- DOH visits these homes and provides health services including growth monitoring to under-five year-olds, deworming and administering Vitamin A to boost nutritional status; immunizations, create Health Posts, community gardens in early child development centers and crèches in the wards that are declared anti-poverty sites (see Table 2.7.1 below)

Table 2.7.I: Identified Anti-Poverty Strategy Sites by District

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

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

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Immunisation coverage under 1 year	84.2%	90%	82.6% (107 257/129 778)	-7.4%	<p>The availability of vaccines has improved significantly in the current financial year; challenges however, exists with regards to:</p> <ul style="list-style-type: none"> • Data quality as some sub-districts have rates in excess of 100% and • Interpretation of the data element fully immunized less than one year. <p>This requires in-service training of service providers in PHC facilities. In addition, this needs to be coupled with provision of standardised data collection tools including training in data audits.</p>
Vitamin A coverage – 12-59 months	45.1%	77%	43.5% (484 178/1114 118)	-33.5%	<p>The main challenge with this indicator is that parents fail to bring their children to PHC facilities once they are above one year old and are not sick.</p> <p>With the implementation of the PHC teams and the PHC re-engineering strategy whereby Vit. A in this age group is administered by community health workers</p>

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

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

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

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

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

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

- ***Immunization Coverage***

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

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

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

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

- ***Cervical cancer screening coverage***

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

- ***Antenatal visits before 20 weeks rate***

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

- ***Couple year protection rate***

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

- ***Public Health Facility Maternal Mortality***

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

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

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

CHANGES TO PLANNED TARGETS

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

2.8 CORONER SERVICES

PURPOSE

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

STRATEGIC OBJECTIVES

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

PROGRAMME PRIORITIES

The rendering of an efficient and effective service by:

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

SUB-PROGRAMME ACHIEVEMENTS

- The sub-programme has developed the provincial forensic policies in line with the national policies for all mortuaries. The policy communicates and guides the national standards that Forensic Pathology should be adhering to and complying with.
- Approval of Forensic Pathology Officers' overtime contract. According to policy the forensic pathology service is a 24 hour service, but the EC province has not complied with this requirement as yet. The organogram still has to be approved. In the interim the Departmental strategy to address this is to allow stand-by and overtime allocations until such time that the programme complies with the 24 hours service requirement.

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

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Percentage of post-mortem performed within 72hrs	84%	95%	73% (6903/9400)	-22%	<ul style="list-style-type: none"> Staffing: The main challenge contributing to non-achievement of the target is that the Mthatha Region does not have full time doctors to conduct postmortems; all existing doctors are employed on sessional basis. In the East London region staff shortages result in very limited outputs particularly when other staff members are on leave. Only 21% of postmortems were for example performed during the 3rd quarter as some staff were on leave with only one operational doctor The situation in Mthatha is further aggravated by the fact that post mortems are conducted in the presence of police investigating officers and these are at times difficult to get within 72 hrs.

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

Shortage of vehicles:

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

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

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

CHANGES TO PLANNED TARGETS

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

2.9: DISTRICT HOSPITALS

PURPOSE

The District Hospitals sub-programme facilitates the implementation of the district hospital package. The purpose of the District Hospital Sub-programme is to provide comprehensive, integrated and quality district hospital services to the people of the Eastern Cape.

STRATEGIC OBJECTIVES

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

SUB-PROGRAMME PRIORITIES

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

ACHIEVEMENTS

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

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

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

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

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Caesarean Section rate	16.2%	15.5%	18.4% (10 825/ 58 749)	2.9%	<p>The caesarean section rate has exceeded its target. This excess is likely due to the following factors:</p> <ul style="list-style-type: none"> Hospitals that have private doctors and medical aid patients tend to perform high number of caesarean sections e.g. Uitenhage hospital Small, rural district hospitals that lack qualified staff to perform the caesarean sections refer to bigger district hospitals that have the necessary competencies. The absorption of post-community service doctors in district hospitals has assisted in reducing referrals to higher levels of care, thus increasing this indicator.

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Separations -Total	295 864	361 260	280 788 C	-80 472	<ul style="list-style-type: none"> The target setting follows the trends from previous years whilst the actual output depends on disease burden, patient-health seeking behaviours and visits as well as the rate at which patients get cured. There are hospitals with the average length of stay that is in excess of the target of 4.9% that range from 7 – 17 days. These mainly admit clients with chronic diseases for example TB patients that take long to be discharged. Improvement in management of patients at PHC level as a result of RPHC and doctor outreach from the district hospitals will in addition see a reduction in this indicator. <p>The decline may also be attributed to the reduction in the number of patient transfers out to higher levels of care especially maternity patients. The absorption of Post Community Service doctors has made it possible for more patients to be provided the necessary care at this level and only refer really critical patients.</p>

Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Patient Day Equivalents – Total	1 926 914	2 016 394	1 888 480	-127 914	<p>The target has not been met and the following factors are likely to be contributing:</p> <ul style="list-style-type: none"> • Decrease in inpatients due to improvement in the management of patients at PHC level mainly contributes to the reduction in PDE. • Implementation of an effective referral system between the PHC facilities and the district hospitals will ensure further reduction in PDE. • The decline is due to the reduction in the number of patient transfers out to higher levels of care especially maternity patients.
OPD Headcount - Total	1 145 320	1 024 984	1 176 371	151 387 (14.8%)	<ul style="list-style-type: none"> • Communities in proximity of the district hospitals will continue to use the closest health facilities, which in this case are the district hospitals. • Some communities are still doctor-centric

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

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

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

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

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

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

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

- ***Utilisation of Usable Beds***

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

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

- ***Monthly Maternal Mortality and Morbidity meetings***

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

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

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

CHANGES TO PLANNED TARGETS

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

LINKING PERFORMANCE WITH BUDGETS

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

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

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

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

Table 2.10: District Health Services expenditure by sub-programme

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

PART B

PROGRAMME 3



EMERGENCY MEDICAL SERVICES

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

PURPOSE

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

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

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

STRATEGIC OBJECTIVES

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

PROGRAMME PRIORITIES

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

PROGRAM ACHIEVEMENTS

Decentralisation of Emergency Medical Services

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

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

EMS Human Resource Management

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

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

EMS Call Centres

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

Improving EMS Data Quality

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

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

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

Table EMS 3.I: Performance against Strategic Objectives for Emergency Medical Services

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

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

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

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

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

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

CHANGES TO PLANNED TARGETS

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

LINKING PERFORMANCE WITH BUDGETS

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

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

Table 3.3: Emergency Medical Services expenditure

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

PART B

PROGRAMME 4



PROVINCIAL HOSPITAL SERVICES

PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES

PURPOSE

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

SUB-PROGRAMMES

- General (Regional) Hospitals: Rendering of hospital services at general specialist level and providing a platform for research and the training of health workers.
- TB Hospitals: To convert current tuberculosis hospitals into strategically placed centres of excellence in which a small percentage of patients may undergo hospitalisation under conditions that allow for isolation during the intensive phase of treatment, as well as the application of the standard multi-drug resistant (MDR) protocols.
- Psychiatric Mental Hospitals: Rendering a specialist psychiatric hospital service for people with mental illness and intellectual disability and providing a platform for training of health workers and research.

STRATEGIC OBJECTIVES

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

PRIORITIES FOR THE NEXT THREE YEARS

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

Programme achievements

Hospital	Achievements
Frontier Hospital	<ul style="list-style-type: none"> • Functional Intensive Care Unit continues to reduce the number of referrals to Frere and Cecilia Makiwane hospitals. Patients receive prompt care thus reducing preventable and unnecessary morbidity and mortality. • High quality Radiology Services have enabled clinicians from various disciplines to reach appropriate diagnosis thus reducing the unnecessary, costly and long patient stay in hospital.
St Elizabeth hospital	<p>Staff employment: 9 doctors (6 of which are comm serves), pharmacists (2), radiographers (2) and a community service Occupational Therapist.</p> <p>Equipment: A new digital X-ray machine was installed.</p>
TB hospitals	<ul style="list-style-type: none"> • Nkqubela TB hospital completed construction of a 64 bedded mechanically ventilated unit which is going to admit MDR-TB patients. • All the 11 TB hospitals have health and Safety officers; this will promote close monitoring of employees and ensures that the pre-medical screening and periodic medical screening is done for the employees especially nurses and doctors.
Psychiatric hospitals	<p>Access to mental health care was improved in OR Tambo district by increasing the number of beds from 10 to 20 at the Flagstaff Mental Health Unit.</p> <p>Staff employment:</p> <ul style="list-style-type: none"> • Fort England Hospital appointed a Chief Executive Officer who is a clinician. • A specialist child psychiatrist was appointed at Mthatha Mental Health Unit. • Clinical psychologists were appointed at East London mental health unit and at Tower hospital. • The mental health service programme is training a cadre of specialists; 4 have completed their training. Four other Registrars will write their final examinations in March 2014.

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

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

Strategic objective	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
	100% (11/11) of TB hospitals had appointed CEOs	Appoint CEOs in 100% (11/11) of TB hospitals	72.7% (8/11) TB hospitals had appointed CEOs	27.3% (3/11)	Deviation is due to death, resignation and re-deployment
	100% (4/4) of psychiatric hospitals had appointed CEOs	Appoint CEOs in 100% (4/4) of psychiatric hospitals	75% (3/4) of psychiatric hospitals had appointed CEOs	25%	CEO from Elizabeth Donkin Hospital was transferred to Livingstone hospital
	67.2% utilization of usable beds achieved in Regional hospitals	Achieve 75% utilization of usable beds in Regional hospitals	68.4% utilization of usable beds achieved in Regional hospitals	-6.6%	Shortage of staff (nurses and doctors) contributes towards non-achievement of this target.
	Utilization of usable beds in TB hospitals not measured	Achieve 75% utilization of usable beds in TB hospitals	59.7% (343 894/ 575 746) utilization of usable beds achieved in TB hospitals	-15.3%	The bed utilization rate in TB hospitals is reduced because: <ul style="list-style-type: none"> • Patients are down referred to PHC facilities for continuation of treatment. • The PHC outreach teams are giving injections to patients who require injections and are clinically stable. • Decentralization of MDR/XDR TB patient management policy is fully implemented in O.R.Tambo, Nelson Mandela, Amathole and Alfred Ndzo districts with periodic reviews booked for patients

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

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

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

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for	Comment on deviations
	Patient Day Equivalents – Total	193 720	240 555	206 848	-33 707	One or more of the following reasons could have contributed to target being not achieved i.e. <ul style="list-style-type: none"> • Poor reporting of day patients at St Elizabeth hospital • Shortage of doctors
	OPD Headcounts – Total	136 187	170 000	166 443	-3 557	Self referrals patients
	Average length of stay (days)	4.6	4.8	4.6 (145 714/ 31 488)	0.2	The target was achieved although St Elizabeth hospital did not meet the target. This is mainly due to rural nature of this region. Difficulties are experienced in recruiting the specialists. There are 20 doctors' posts filled against 110 on organogram.
	Bed utilisation rate	67.2%	75%	68.4% (145 714/ 212 982)	-6.6%	Shortage of staff (nurses and doctors) contributes towards non-achievement of this target.

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for	Comment on deviations
	Expenditure per patient day equivalent (PDE) (Rand)	R1748	R1838	R1978 (4091 12346/ 206 848)	R140	This may be due to accruals
	Percentage of complaints of users of Regional Hospital Services resolved within 25 days	79.2%	80%	88.6% (93/105)	8.6%	Complaints resolution depends on the nature of complaints; some categories take longer to resolve as these need to be investigated.
	Percentage of Regional Hospitals with monthly Maternal Mortality and Morbidity Meetings	100% (2)	100% (2/2)	100% (2/2)	0	Both Regional hospitals conduct maternal mortality and morbidity meetings.
To facilitate the reduction of maternal mortality to achieve 36.8 maternal mortality per 100 000	Perinatal mortality rate in regional hospitals	41.9/1000	30/1000	43.3/1000 (421/9 732)	13.3 /1000	Disease burden of maternal related conditions including infection with HIV and AIDS, hypertension in pregnancy and others are mainly responsible for this outcome. Also inability to recruit a paediatrician for St Elizabeth Hospital.
To facilitate 60% of facilities implementing quality & patient safety program	Number of Regional Hospitals assessed for compliance with the Core Standards	2	2	2	0	Assessment was conducted by HST following self-assessments by institutions.

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for	Comment on deviations
To reduce TB morbidity and mortality by achieving 85% cure rate	Separations – Total in TB Hospitals	Not Measured	2 354	3 236	882	<p>The likely reasons for exceeding the target are that:</p> <ul style="list-style-type: none"> • This indicator is reported for the 1st time; because of this there were no previous outputs to estimate a more accurate target. The set target could have been underestimated. • Patients are down referred to PHC facilities for continuation of treatment. • Decentralization of MDR/XDR TB patient management policy is fully implemented in O.R.Tambo, Nelson Mandela, Amathole and Alfred Ndzo districts.

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

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for	Comment on deviations
	OPD Headcounts – Total in TB Hospitals	Not Measured	2000	2761	761	<p>These are patients that had been discharged from the MDR/XDR hospitals to continue with their treatment at home.</p> <p>They are booked appointments in these hospitals for review. Since the treatment of MDR/XDR patients takes long about 24 to 36 months. After discharge these patients have to return monthly for clinical reviews, thus the OPD headcount increases in line with the separations.</p>
	Average length of stay in TB Hospitals excluding MDR/XDR-TB hospitals	Not Measured	60 days	90.3 days (232 220/ 2572)	30.3 days	<p>The policy requires patients to be admitted for two months in the TB hospital during which they complete their injections and are expected to convert to negative sputum. However;</p> <ul style="list-style-type: none"> • Many TB & HIV co-infected patients fail to convert at 2 months and take longer about 3 months hence the target was exceeded

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for	Comment on deviations
						<ul style="list-style-type: none"> Because the dedicated MDR/XDR TB hospitals are full, some ordinary TB hospitals have opened isolation wards where MDR/XDR patients are held. Therefore mix of ordinary TB with MDR/XDR patients increases the ALOS. For example, Orsmond and Winterberg TB hospitals are supposed to hospitalise ordinary TB patients but have ALOS days of 209 and 119 days respectively due to TB patient mix.

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

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for	Comment on deviations
	Bed utilisation rate in TB Hospitals	Not Measured	75%	59.7% (343 894/ 575 746)	-15.3%	The bed utilization rate in TB hospitals is reduced because: <ul style="list-style-type: none"> • Patients are down referred to PHC facilities for continuation of treatment. • The PHC outreach teams are giving injections to patients who require injections and are clinically stable. • Decentralization of MDR/XDR TB patient management policy is fully implemented in O.R.Tambo, Nelson Mandela, Amathole and Alfred Ndzo districts with periodic reviews booked for patients
	Expenditure per patient day equivalent (PDE) (Rand) in TB Hospitals	Not Measured	R 1592	R958 (330163600/344 814)	R634	Staff shortages in TB Hospitals

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

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

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

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

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

Regional hospitals

- The major challenge that affects the efficiency indicators in Regional hospitals is the difficulty to recruit doctors and specialists for St Elizabeth hospital. The departmental recruitment plan prioritises recruitment and placement of specialists and doctors in health facilities. Whilst grappling with all these efforts, the Mthatha Complex is conducting outreach to St Elizabeth to assist and reduce patients transferred out to the complex.
- The implementation of the social mobilisation approach allows the selection of bursars by the communities in the sub-districts. The bursars sign a contract with the EC DOH to serve the department after graduating.
- Allocation of community-service doctors be focused and biased towards these hospitals

Perinatal mortality

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

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

TB hospitals

- In line with the Decentralisation and the Deinstitutionalisation policy framework, that encourages MDR-TB patients to be managed in the community, the number of TB beds will be reduced, resulting in low bed occupancy. However, the reduction of TB beds has to be approved by the Executing Authority. Only, very sick patients will be admitted to the hospitals, as patients managed in the community will be followed up by Outreach teams.
- **Clinical audits:** To improve the output for the Clinical Audits, hospitals that have sessional doctors will delegate professionals to conduct clinical audits.

Psychiatric hospitals

Average Length of Stay in Psychiatric Hospitals

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

Utilisation of usable beds in Psychiatric hospitals

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

- **Sourcing service provider to provide mental health services:** Since the transfer of Umzimkhulu mental hospital to KwaZulu Natal, there had been no dedicated designated psychiatric hospital to cater for the Eastern Regional of the Province. Efforts of building a new hospital in this region have met challenges. In addition to establishing community residential homes, the plan is to regularise the tender that is currently provided by Life Esidimeni.
- **Mental Health Service Plan** is about to be finalised which promotes integration of mental health in General Health System; this includes the establishment of mental health beds in all district hospitals and access of specialized medication in all levels of care through a down referral system. In line with this plan and to address the challenge of shortage of beds, an executive decision has been taken to relocate Elizabeth Donkin hospital to Dora Nginza Hospital.

CHANGES TO PLANNED TARGETS

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

LINKING PERFORMANCE WITH BUDGETS

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

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

Programme 4.3: Provincial Hospital Services expenditure by sub-programme

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

PART B

PROGRAMME 5



PROVINCIAL TERTIARY HOSPITAL SERVICES

PROGRAMME 5: PROVINCIAL TERTIARY HOSPITAL SERVICES

5.1 PROGRAMME PURPOSE

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

5.2 Strategic Objectives

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

PRIORITIES FOR THE NEXT THREE YEARS

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

ACHIEVEMENTS

East London Hospital Complex (ELHC)

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

Mthatha Hospital Complex (MHC)

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

Port Elizabeth Hospital Complex

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

Table THS 5.1: Performance against Strategic Objectives for Tertiary Hospitals

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

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

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

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

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
	OPD Total Headcounts	1 220 038	861 005	1 225 655	364 650	<ul style="list-style-type: none"> • These are referral hospitals with patients referred from lower levels of care • Self-referrals from communities in close proximity to these hospitals e.g Cecilia Makiwane, Frere and Dora Nginza hospitals increases the OPD headcount • OPD visits after hours, during weekends and holidays also contribute a significant proportion as many of the low level of care health facilities in their vicinity are usually closed • Setting of target could have been underestimated

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

Objective	Performance Indicator	Baseline 2011/12 output	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
						<ul style="list-style-type: none"> • There are no district hospitals in their population catchment areas and therefore these hospitals also provide the district hospital services over and above the specialized services • Due to rationalization of services, these hospitals provide specific tertiary services and are therefore referral hospitals in their regions as well as for the specialized tertiary services they provide. All these hospitals experience a significant proportion of self-referral patients that may otherwise be admitted in lower levels of care hospitals

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

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

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

Tertiary hospitals:

- The major challenge that affects the efficiency indicators in Regional hospitals is the difficulty to recruit doctors and specialists for St Elizabeth hospital. The departmental recruitment plan prioritises recruitment and placement of specialists and doctors in health facilities. Whilst grappling with all these efforts, the Mthatha Complex is conducting outreach to St Elizabeth to assist and reduce patients transferred out to the complex.
- The implementation of the social mobilisation approach allows the selection of bursars by the communities in the sub-districts. The bursars sign a contract with the EC DOH to serve the department after graduating.
- Allocation of community-service doctors need to focus and be biased more in these hospitals

Perinatal mortality

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

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

CHANGES TO PLANNED TARGETS

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

LINKING PERFORMANCE WITH BUDGETS

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

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

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

Table THS 5.3: Provincial Tertiary Hospital Services expenditure

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

PROGRAMME 6



HEALTH SCIENCE AND TRAINING

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

PURPOSE

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

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

STRATEGIC OBJECTIVES

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

PRIORITIES FOR THE NEXT THREE YEARS

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

PROGRAMME ACHIEVEMENTS

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

SUB-PROGRAMME	ACHIEVEMENT/S
HPTD Grant	<p><i>Training of Medical Doctors in the Republic of Cuba</i></p> <ul style="list-style-type: none"> • 145 students were registered in the Cuban Medical Program. • 17 Doctors who graduated in December 2012 from this programme had been absorbed by the ECDOH as senior medical officers. 24 Doctors are on internship programme and an additional 2 doctors are on community service programme
	<p><i>Orthotic and Prosthetic (O&P) programme</i></p> <ul style="list-style-type: none"> • Six O&P students graduated in August 2012 from Tanzania, and are presently in the employ of the EC DOH. • Walter Sisulu University obtained a full accreditation to start offering Orthotics and Prosthetics course in South Africa. New intake is expected during the 2014 academic year.
	<p><i>Training of Health Professionals at Rhodes University</i></p> <ul style="list-style-type: none"> • 15 Students were enrolled on the Doctor of Pharmacy (PharmD) programme. • 5 Students graduated in 2012 and are in the process of being absorbed as Clinical Pharmacist Specialists.

SUB-PROGRAMME	ACHIEVEMENT/S
	<p><i>Training and Development of Medical Registrars</i></p> <ul style="list-style-type: none"> • 16 Registrars completed their programme and are awaiting registration certificates with the HPCSA as specialists.
	<p><i>Young Nurse Educators Development Programme at NMMU</i></p> <ul style="list-style-type: none"> • 20 Nurse Educators completed the Young Nurse Educators' Programme at the NMMU and are now back at the Lilitha Nursing College campuses to improve lecturing standards. • 15 Students (4 PhDs & 11 Masters) were enrolled at NMMU during the 2012 academic year. • Three clinical laboratory managers completed training and are all absorbed at Lilitha Nursing College for continuity. • Simulation Laboratories in all Lilitha Nursing College main campuses are fully established and functional.
	<p><i>E-Learning Services at Lilitha Nursing College</i></p> <p>An E-learning platform had been established at the College mainly to integrate the nursing education curriculum with information and communication technology, implement a Student Information Management System and integrate these with a comprehensive learning and management system. This will enable students to view learning material online, view assignments and test marks, access journals and books online, submit tests and assignments and receive online tuition off line.</p> <ul style="list-style-type: none"> • Moodle database had been constructed and is now live on the ECDOH website. • Full installation of the Student Management System (viz VIDLO) and configuration has been completed. • 9 x Computer Laboratories have been commissioned (one in each district) and are fully functional as well as campuses connected via internet. • 4 x Video Conferencing centers established and fully functional.
	<p><i>Establishment of the EMS College Main Campus and Satellite Campuses</i></p> <ul style="list-style-type: none"> • A new Advanced Emergency Care (EMC) Degree was established at NMMU. Full collaboration and Memorandum of Understanding (MoU) between the EMS College and NMMU was drafted and is awaiting approval. • The EMS College new base in Livingstone hospital is fully refurbished and has received provisional accreditation pending full staff complement in line with the HPCSA accreditation criterion.
	<p><i>High School Learners' Support Programme</i></p> <p>The Education and Health departments have forged ties to sensitize learners about various health fields that are awarded bursaries by the ECDOH through career exhibitions at a sub-district level and a shadowing experience in health institutions.</p>
	<p><i>Development of a Comprehensive Health Sciences Faculty at NMMU</i></p> <ul style="list-style-type: none"> • NMMU established a B.Sc. Dietetics programme with the first intake of 16 students having enrolled in January 2013. • A pharmacy assistant programme was established with first intake of 70 students enrolled in January 2013. • A short course for ultra-sonographers was established for health professionals and is expected to be implemented in 2013.

SUB-PROGRAMME	ACHIEVEMENT/S
Lilitha Nursing College	<ul style="list-style-type: none"> A total of 1 459 students graduated from the College by the end of the 2012 academic year. These consisted of 368 Enrolled Nursing Assistants (ENAs), 403 Enrolled Nurses (ENs), 578 Basic Nursing diploma and 110 Post Basic Nursing diplomas. Four satellite campuses re-opened in 2012; these are fully functional and had a total year intake of 180 students which is 10.6% of the total college intake. The college generated 80% (R16m) of the R 20 million target set for the financial year 2012/13
Bursary Program	<ul style="list-style-type: none"> The Department awarded a total of 1 485 bursaries during the 2012 academic year; 23.4% (348) of these were new bursars. Approximately 20% (286) of the total bursars completed their academic studies in December 2012.
EMS College	<ul style="list-style-type: none"> 60 Basic Life Support (BLS) practitioners graduated 24 Rescue practitioners graduated

Bursary program

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

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

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

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

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

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

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

Table 6.2.3: Equity considerations in bursary allocation 2012/13

CRITERION	TOTAL NO	NO. GRADUATING IN 2012/13
External candidates	1 448	286
Internal candidates	37	2
TOTAL	1 485	288
Cuban program	142	0
Failure	0	0
Drop-out	0	0
Bursary holders (Rural origin)	1 130	198
Bursary holders (women)	978	97
Bursary holders (African)	1 001	214

Learnership and Internship programme

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

For the past 5 years, the ECDOH did not have any Budget allocation for Learnership, Internship and Experiential Training from the equitable shares budget. As a result, the Training and Development section of the Human Resource Development (HRD) took initiative to set aside an amount of R10,1mil to fund the Learnership and Internship programme. A total of 1 065 Learnerships, Internship and Experiential Training were funded by the EC DOH during the 2012/13 financial year (see Table 6.3).

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

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

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

Lilitha Nursing College

1.1 Expansion of the College

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

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

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

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

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

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

1.3 Enrolment at Lilitha College:

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

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

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

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

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

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

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

2. EMS College

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

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

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

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

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

Strategic objective	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
5.5 To ensure 100% Effective HR planning, Development and Management	3 526 total student enrollment at Lilitha Nursing College	3 868 total number of students enrolled at Lilitha Nursing College	3 636 total number of students enrolled at Lilitha Nursing College	232	This is due to staff shortages
	1 272 Bursaries awarded Internal, Cubans, O&Ps	1 340	1 485	145	National mandate was to recruit additional students on Cuban programme
	Learnerships	64	264	200	The department received HWSETA Discretionary for nursing learnership
	Internships	302	655	353	47 Admin Support Interns deployed by NDOH 288 EMS funded interns 18 interns funded through skills levy
	Experiential learning	10	156	146	<ul style="list-style-type: none"> 83 NYDA-ECDC-DTI funded experiential learners were hosted by the department in the workplace. 63 experiential learners are from the tertiary institutions in the province.

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

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

Performance Indicator	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Number of Post-basic nurses graduated	70	200	110	-90	<ol style="list-style-type: none"> 1. The accredited education and training institution is faced with a challenge of limited capacity. 2. The majority of the Post Basic programmes are housed at the East London Campus. Both the Mthatha and Queenstown Campuses offer two of the seven academic programmes with Port Elizabeth offering one. 3. Attraction and retention of specialist academic staff to the college campuses also poses a challenge as majority prefers clinical services due to OSD allowances which is not considered in the academic platform. This limits the number of students to be registered as ratios are very low 4. Recruitment of applicants for the programmes also depends on the number of professional nurses granted study leave by the health institutions

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

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

TABLE 6.7: STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

INDICATOR	CHALLENGES	STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE
Nursing Training College:		
Number of Post-basic nurses graduated	<ul style="list-style-type: none"> • Simulation laboratories have got a shortage of medical equipment. • Only two campuses (East London and Mthatha) are accredited to offer nurse specialist courses which results in the inadequate production of nurse specialists by the college. • College does not have an internal quality assurance unit to coordinate quality assurance provisions and systems within the college. • College has 49.9% vacancy rate for Nursing Educators and an absence of researchers in the nursing fraternity. • Most campuses have no proper structures like classrooms, offices, laboratories, libraries and student accommodation. • OSD not considered in academic platform • Enrollment on course depends on number of professional nurses granted study leave 	<ul style="list-style-type: none"> • The department has signed a Service Level Agreement with Nelson Mandela Metropolitan University with these key outcomes and outputs: • Training and housing of new Nurse Educators in a full-time formal programme at NMMU for one academic year. • Masters Training (two academic years) and PhD training (four academic years). • Low fidelity Clinical Laboratory at PE campus and related training. • Student Academic Support programme (Quality of assessment). • The college has been put under the revitalization programme and has budgeted for renovations and minor maintenance of the existing campuses. New buildings are planned and construction at Cecilia Makiwane Hospital is ongoing. • Application has been made to South African Nursing Council (SANC) to roll out to the entire college institutions.
Bursary programme		
Students with bursaries from the province	The majority of learners have limited knowledge about other health related fields as they do not apply for them, e.g. Radiography, Emergency Care Services and Paramedics which are very critical in the department.	<ul style="list-style-type: none"> • Career Exhibitions to the districts to market other health related fields will be done through the social compact Program. • Local universities will also be invited to market their programmes and inform learners about admissions' requirements at their respective universities
	Limited pool of qualifying matriculants as a result of limited number students studying pure mathematics at school	Through intergovernmental relations, the DOH to engage the EC Department of Education

INDICATOR	CHALLENGES	STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE
	Candidates earmarked for bursaries from the sub-districts are not admitted into tertiary institutions for targeted study fields due to their final year results that do not make the required entry points and/ or due to late application	The department need to consider taking an initiative of negotiating for a number of guaranteed seats with relevant universities for critical bursary health fields
EMS Training College		
<ul style="list-style-type: none"> Number of emergency care technicians undergoing training Number of intermediate life support practitioners graduated Number of rescue practitioners graduated 	<ul style="list-style-type: none"> College has an organogram but the person to post matching is not completed and vacant posts have not yet been filled especially for lecturers and management of the college. There is only one college, situated in Port Elizabeth, which means there is a limited number of students that can be enrolled, and therefore targets for EMS practitioners for the province are not being met. 	<ul style="list-style-type: none"> Person matching request has been submitted to Persal Management for rectification and is currently being attended to. A plan to open a new Main Campus at East London is abreast and a memo motivating for approval to advertise critical vacant posts has been submitted for approval of the SG. The department needs to encourage the current Intermediate Life Support staff to improve their qualification to Advanced Life Support in order to increase the pool of fulltime lecturers at the EMS College. Two of the existing lecturers are on training at the Cape Peninsula University of Technology (CPUT). In the interim, the department should seek an agreement with DUT CCA to second graduated EMS practitioners to the college to facilitate short course (ILS course) and CPD activities as a short-term measure until the staff establishment is accomplished
HPTD Grant		
Number of Registrars in training	Registrars drop out of the program	Department to develop and implement a policy that will address amongst others issues of: <ul style="list-style-type: none"> contractual obligations robust selection criteria Those breaching contractual obligation will be charged

CHANGES TO PLANNED TARGETS

There were no changes made to the original planned targets

LINKING PERFORMANCE WITH BUDGETS

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

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

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

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

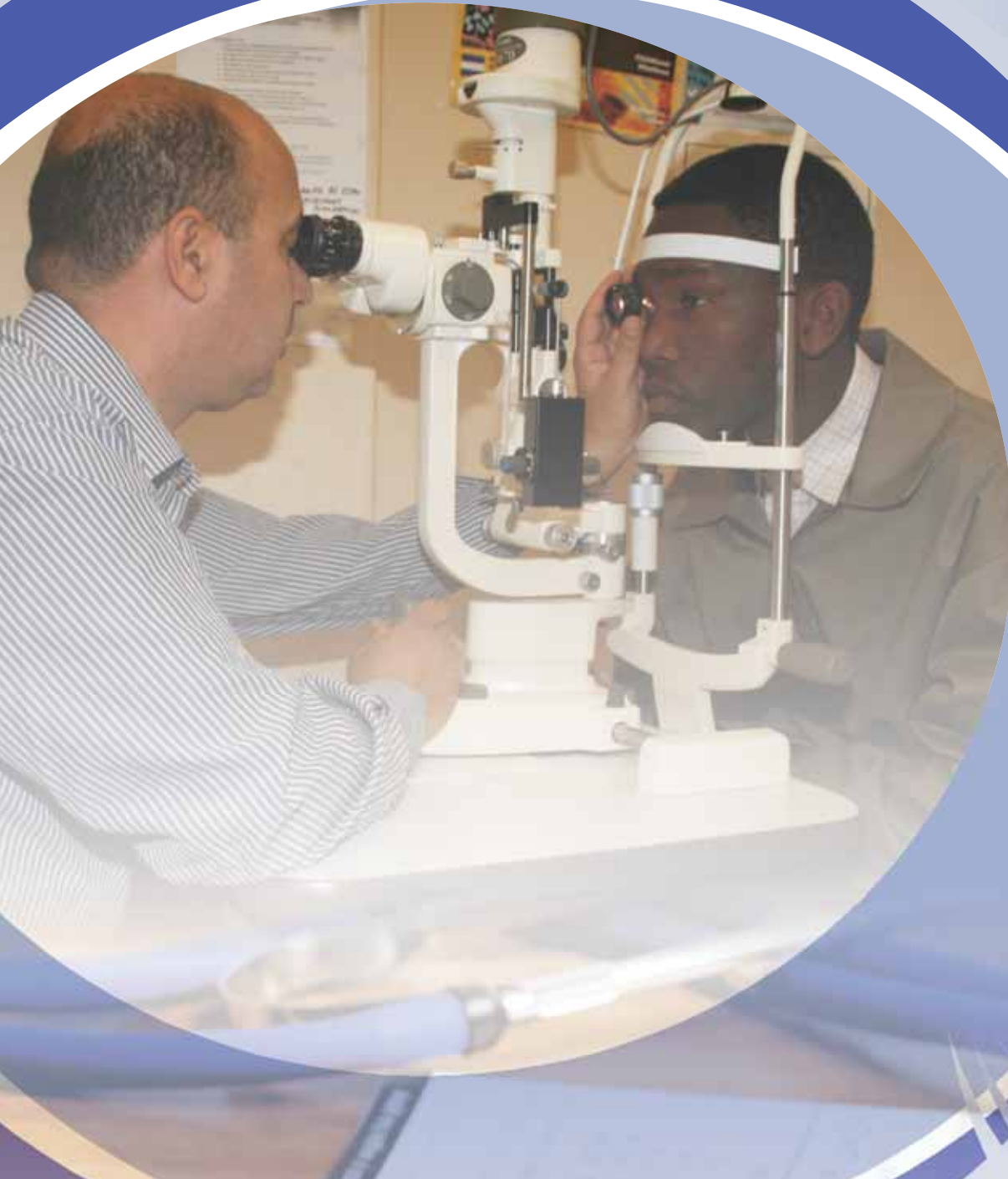
As the Other Training Sub-programme is funded through the Health Professions Training and Development Grant, rollovers amounting to R4,07 million were applied for from Provincial Treasury.

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

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

PART B

PROGRAMME 7



HEALTH CARE SUPPORT SERVICES

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

PURPOSE

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

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

i) Transversal Health Services

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

ii) Pharmaceutical Services

PROGRAMME OBJECTIVES

- I.9 To improve clinical support and rehabilitation services to achieve 60% of the demand.
I.10 To ensure 95% availability of essential drugs in all health facilities.

PRIORITIES FOR THE NEXT THREE YEARS

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

Rehabilitation

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

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

Laboratory and Emergency Blood Services

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

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

Pharmaceutical Services

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

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

Table 7.1: Performance on Strategic Objectives for Programme 7

Strategic objective	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
1.1 To improve clinical support and rehabilitation services to achieve 60% of the demand	15 280 assistive devices were issued to eligible clients	55% (18 350/33 164) of eligible applicants to be issued with assistive devices	51.1% (16 962/33 164) of eligible applicants received assistive devices	-3.9%	Challenges include delays by suppliers, lack of transport for outreach and to deliver assistive devices as well as challenges to trace clients
1.10 To ensure 95% availability of essential drugs at all health facilities	70%	80%	68.8% (31 031 8/45 133 9)	-11.2%	<p>The initial lead-time for National contracts of 90 days is still having an impact on stock that is available, as it is taking longer for the stock to be available from the supplier.</p> <p>During the last quarter of the year, 4 national DOH surgical contracts ended with no replacement contracts available to purchase from; this had a huge impact on stock availability as the province purchases under the national contract</p>

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

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

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

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

Performance Indicator	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Percentage of applicants supplied with prostheses	3270 (Number)	50% (6000 / 12000)	28.4% (3411/12000)	-21.6%	<ul style="list-style-type: none"> The target set could not be achieved on account of a combination of challenges primary among this being inability by suppliers at the beginning of the year to timeously deliver optimally on the orders. Shortage of vehicles impacted negatively on efficient delivery of prostheses to the clients. There were also challenges related to the tracing of recipient clients.
Percentage of applicants supplied with orthoses	Number= 9203	80% (8000/10000)	108.5% (10 854/10000)	28.5%	Most of these are off shelf items that are readily available and are supplied immediately on demand.

Performance Indicator	Baseline (Actual output 2011/12)	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
Percentage of immediate order fulfilment of essential drugs at the depot.	70%	80%	68.75 (310318/451339)	-11.25%	<p>The target was not reached on account of capacity challenges particularly with respect to Mthatha Depot which is grossly under resourced.</p> <p>Other factors that influenced performance included the National Transportation strike during October 2012 ; industrial action at Nelson Mandela Hospital Complex and Mthatha Depot</p>
Tracer drug stock out rate at the Depots	<3%	<5% (101/101)	<2,04% (8.16/4)	> 2.96%	<p>Performance beyond expectation is on account of</p> <ul style="list-style-type: none"> • Active communication between the Depots and Demanders as regards Tracer Drugs • Consistency in actively tracking orders with Suppliers • Proactive pack size substitution

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

STRATEGIES TO OVERCOME AREAS OF UNDER PERFORMANCE

Assistive devices

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

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

Order fulfilment of essential drugs at the depot

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

CHANGES TO PLANNED TARGETS

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

LINKING PERFORMANCE WITH BUDGETS

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

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

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

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

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

PART B

PROGRAMME 8



HEALTH FACILITIES MANAGEMENT

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

PURPOSE

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

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

STRATEGIC OBJECTIVES

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

PROGRAMME PRIORITIES:

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

ACHIEVEMENTS:

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

This project is costing the department R167 million.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 8.1: Repairs & Maintenance of EC Clinics

Phase I Contractors' Expenditure

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

PHASE 2 CONTRACTORS' EXPENDITURE

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

Table 8.2: Performance on Strategic Objectives for Health Facilities Management

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

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

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

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

Objective	Performance Indicator	Actual Annual achievement 2011/12	Annual Target 2012/13	Actual Annual achievement 2012/13	Deviation from planned target to actual annual achievement for 2012/13	Comment on deviations
						At Frere hospital works are progressing well. Sections of the building have been completed and are now in use by the hospital. The entire project will reach practical completion before the end of the 2013/14 financial year.
	Number of hospitals under revitalization programme	1 awarded	5	5	0	<p>These are:</p> <ul style="list-style-type: none"> • Cecilia Makiwane Hospital • Frontier Hospital • Madwaleni Hospital & Gateway clinic • St Elizabeth's Hospital Health Resource Centre • St Patrick's hospital

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

CHANGES TO PLANNED TARGETS

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

LINKING PERFORMANCE WITH BUDGETS

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

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

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

Programme 8.4: Health Facilities Management Expenditure

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

6. SUMMARY OF FINANCIAL INFORMATION

6.1. Departmental receipts

Departmental receipts	2012/13			2011/12		
	Actual			Actual		
	Estimate	Amount Collected	(Over) / Under	Estimate	Amount Collected	(Over) / Under Collection
Sales of goods and services other than capital assets	77,114	106,911	-29,797	75,044	81,144	-6,100
Sales of goods and services produced by department (excl. capital assets)	76,685	106,724	-30,039	74,944	81,002	-6,058
Sales by market establishments	8,936	9,128	-192	8,415	8,247	168
Administrative fees	1,098	1,116	-18	877	901	-24
Other sales	67,080	96,480	-29,400	65,652	71,854	-6,202
Of which						
Hospital Fees	47,280	75,672	-28,392	46,076	51,956	-5,880
Boarding Services	7,721	8,009	-288	8,500	8,401	99
Commission	11,650	12,799	-1,149	11,076	11,497	-421
Sales of scrap, waste, arms and other used current goods (excl. capital assets)	429	187	242	100	142	-42
Interest	168	297	-129	121	0	121
Sales of capital assets		-				
Land and sub-soil assets				360	361	-1
Financial transactions in assets and liabilities	4,112	7,230	-3,118	2,812	7,106	-4,294
Total departmental own source receipts	81,394	114,438	-33,044	78,337	88,611	-10,273

Health Services tariffs are determined by the National Department of Health (NDoH) for all the provinces through the implementation of the Uniform Patient Fees Schedule (UPFS).

The Department's tariffs in respect of HI patient categories differ from those set by NDoH in respect of services rendered at facility level 3 and also in respect of services rendered by a Specialist. This is because the Department implemented UPFS four years after it was introduced as a national Policy. A phased approach is being followed to avoid drastic tariff increases.

The tariffs applicable to externally funded patients, is an “undiscounted” tariff that applies to patients who are covered by medical schemes, persons injured in motor vehicle accidents (Road Accident Fund) and other state departments (Department of Justice, South African Police, Correctional Services) and patients injured on duty.

Patients, who do not have external funding, pay a discounted fee. The discount for patients that are formally unemployed or on social grants (H0) receive free health care (100% subsidy); patients earning below R37,000 per annum (H1) receive a subsidy of approximately 90%; patients who earn between R37,000 and R72 000 (H2) – the subsidy varies according to services rendered, ranging from 35% to 90%.

Self – funded patients (H3) exceeding the means test, receive on average a 25% subsidy.

The department increased patient tariffs to the externally funded patient fees by 5.4% in the year under review.

Free Services

The mandate of the Department of Health is to provide health care services to the citizens of this country, in exercising that mandate and in terms of policy there are circumstances under which patients will receive services free of charge independently of their classification as full paying or subsidized patients. Such circumstances include infectious, formidable diseases, pregnant women and children. Also patients classified under H0 category receive free services. It is not possible to quantify the cost of the free services rendered.

Elective healthcare services do not qualify as free services and patients are required to pay the “undiscounted” UPFS fee

6.2. Programme Expenditure

Programme Name	2012/2013			2011/2012		
	Final Appropriation	Actual Expenditure	(Over)/Under Expenditure	Final Appropriation	Actual Expenditure	(Over)/Under Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000
Health Administration	534,631	535,063	(432)	549,410	543,898	5,512
District Health Services	7,901,611	7,953,629	(52,018)	6,984,759	7,285,266	(300,507)
Emergency Medical Services	667,394	619,525	47,869	649,984	644,588	5,396
Provincial Hospital Services	3,982,958	3,979,016	3,942	3,864,011	3,860,254	3,757
Central Hospital Services	702,419	657,170	45,249	647,104	627,075	20,029
Health Science and Training	638,633	579,964	58,669	627,722	605,824	21,898
Health Care and Support Services	87,312	84,309	3,003	90,012	78,747	11,265
Health Facilities Development and Maintenance	1,217,940	1,192,168	25,772	1,397,980	1,245,044	152,936
Total	15,732,898	15,600,844	132,054	14,810,982	14,890,696	(79,714)

Reasons for variations are as per information discussed above in the organisational environment and the service delivery environment.

6.3. Transfer payments, excluding public entities

The department utilises various institutions, government entities, Universities, Technikons and CBOs as vehicles to deliver services to the communities of the province. The nature of services to be rendered and relationships with these organisations is governed by Service Level Agreements.

During the year under review, the department transferred R134.13 million to Hospices, Universities and Technikons and to Municipalities. Details on these transfer payments are given in Annexures IC, ID and IB respectively of the Annual Financial Statements section.

Funds were transferred to various Universities and Technikons for the provision of Health Sciences, Training & Development. Municipalities received funds for the devolution of environmental health. The department monitored these institutions / entities to ensure that the allocated funds were spent as planned and detailed in the Service Level Agreements.

Other than transfer payments to the Walter Sisulu University, the Department obtained assurance from each entity that received a transfer, that the entity implements effective, efficient and transparent financial management and internal control systems, as required by TR 18.3.1 ©.

The Walter Sisulu University (WSU) has been funded extensively from the Health Professions Training and Development (HPTD) Grant using multiple service level agreements (SLAs) over several years in order to strengthen the Faculty's under- and post-graduate programmes to unpin the department's human resource needs, particularly in rural communities.

Three SLAs were concluded under this partnership. The first and largest funded the Faculty in a variety of ways from a Joint Staff Establishment to operational costs related to registrar rotations, conferences and journals. The second SLA funded the four Health Resource Centres operational costs. The third and most recent funded the establishment of a Medical Orthotics and Prosthetics programme. Transfer payments to WSU represented between 80-85% of the total HPTD Grant budget.

The Department observed non-compliance by WSU to the requirements of their SLAs, in particular financial reporting, resulting in increased pressure on the ECDoH to enforce Sections 38(i) J&K of the Public Finance Management Act in keeping with the responsibilities and expectations of the Accounting Officer, the National Department of Health and the Auditor General.

At all material times, the funding provided by the Department of Health was ring fenced and governed by legislation including the Division of Revenue Act, Public Finance Management Act and Treasury Regulations.

It has now become apparent from draft financials recently submitted to the Department, that the University has loaned to itself a substantial amount of money from the Health Professional Training and Development Fund in order to meet several of its other operating expenses.

In acting as aforesaid and utilising the funding contrary to the provisions of the agreement between the parties, the Walter Sisulu University has breached a material term of the contract between the parties and in so doing has acted wrongfully, unlawfully and contradicted the applicable legislation.

In the circumstances, the Department of Health has demanded that the University repay the amount

6.4. The table below reflects the transfer payments made for the period 1 April 2012 to 31 March 2013

Name of transferee	Purpose for which the funds were used	Compliance with s 38 (1) (j) of the PFMA	Amount transferred (R'000)	Amount spent by the entity	Reasons for the funds unspent by the entity
Provinces and municipalities	For the devolution of environmental health services to municipalities	Yes	7,928	7,928	n/a
Departmental agencies and accounts	Allocation to HWSETA per Skills Development Act.	Yes	18,718	18,718	n/a
	Subsidise activities carried out by NGOs and CBOs for work done in relation to HIV / AIDS		5,709	5,709	
Universities and Ttechnikons	Activities concerned with training of health professionals and other HIV/AIDS related training	Yes	101,770	101,770	n/a
Households	Payment of leave gratuities to departmental beneficiaries, bursaries to non-employees and settlement of medico-legal claims	Yes	260,361	260,361	n/a
			394,486	394,486	n/a

6.5. The table below reflects the transfer payments which were budgeted for in the period 1 April 2012 to 31 March 2013, but no transfer payments were made.

Name of transferee	Purpose for which the funds were to be used	Amount budgeted for (R'000)	Amount transferred (R'000)	Reasons why funds were not transferred
Berlin Advice Centre	Subsidise activities carried out by NGOs and CBOs for work done in relation to HIV / AIDS	134	Nil	Organisations did not meet the terms agreed upon per SLAs
Empilisweni HIV/AIDS & Orphans		134		
Faith and Hope Integrated Aids Programme		134		
Good Samaritan Home		134		
Good Shepherd Hospice		134		
Gwebindlala HIV/AIDS Organisation		134		
Hlumani HIV/AIDS Care Givers		134		
House of Hope Hospice		134		
Ikamvelihle Rehab Centre		134		
Ikhwezi Women's Support Centre		134		
Ikwezi Lomso Child & Family Welfare Society		191		
Ilitha Community Psychological Services		134		
Inkwanca Home-base		766		
Keiskamma Trust		134		
Masibambisane Home Based Care & Support Group		134		
Mpuma Kapa Multi-Purpose		134		
Ncedisizwe HBC		134		
Never Give Up Support Group		134		
Port St Johns Creative Young Women Group		134		
Sakhimpilo Home Based Care Project	134			

Name of transferee	Purpose for which the funds were to be used	Amount budgeted for (R'000)	Amount transferred (R'000)	Reasons why funds were not transferred
Sicelusizo Development Trust		134		
Sinako Wellness and Development Organisation		78		
Sinethemba Organisation		134		
Sinothando Home of Safety		134		
Siyakhanyisa HIV&AIDS Support Group		134		
Sizanenguqu Home Community Based Care		134		
Sophumelela Clinic Incorporated		134		
Ukhamba Projects		134		
Umtata Women's Support Centre		134		
We Care		134		
Yizani Home Based Care		134		

6.4. Public Entities

No Public Entities reporting to the ECDoH.

6.6. Conditional grants and earmarked funds paid

No Conditional Grants and earmarked funds paid by the ECDoH.

6.6. Conditional grants and earmarked funds received

The Department Health spent R2,631 billion (95%) of its R2,765 billion adjusted conditional grants budget, leaving R132,911 million as unspent funds. Of this amount, the Department applied for a total of R132,911 million to be rolled over and R3,069 million to be surrendered.

Refer to the Disclosure Notes to the Annual Financial Statements, which gives the overview of grants received, including types and total amount received and actual expenditure on all allocations.

The Tables below describes each of the conditional grants and earmarked funds received by the department:

National Tertiary Services Grant

Department who transferred the grant	Health (Vote 16)
Purpose of the grant	To compensate tertiary facilities for the additional costs associated with the rendering of tertiary services provision and spillover effects.
Expected outputs of the grant	Inpatient separations, Day patient separations, In-patient days, Out-patient first attendance, Outpatient follow-up attendance.
Amount per amended DORA	R702,419,000
Amount received (R'000)	R702,419,000
Reasons if amount as per DORA was not received	Full amount received.
Amount spent by the department (R'000)	R657,292,000
Reasons for the funds unspent by the department	The department has applied for rollovers of the unspent portion, primarily attributable to machinery and equipment (Three (3) Magnetic Resonance Imaging (MRI) Scanners for Livingstone Hospital, Frere Hospital and Nelson Mandela Academic Hospital; three (3) C ARM X-Ray Machines acquired for the Department's Nelson Mandela Academic Hospital, and Mthatha General Hospital; several Anaesthetic Machines with Monitors for Cecilia Makiwane Hospital, Frere Hospital and Nelson Mandela Academic Hospital) awaiting delivery.
Monitoring mechanism by the receiving department	Adherence to reporting requirements of DORA, including inter alia in year monitoring reporting and monitoring processes, monthly certification of financial returns, quarterly certification of predetermined objectives, ongoing reviews with National Department Grant Managers.

Health Professions Training and Development Grant:

Department who transferred the grant	Health (Vote 16)
Purpose of the grant	Support provinces to fund operational costs associated with training of health professionals; development and recruitment of medical specialists in under - served provinces; and support and strengthen undergraduate and postgraduate teaching and training processes in health facilities.
Expected outputs of the grant	Under graduate Students, Registrars, Expanded specialists and teaching infrastructure in target provinces.
Amount per amended DORA	R183,021,000
Amount received (R'000)	R182,093,000
Reasons if amount as per DORA was not received	Full amount received.
Amount spent by the department (R'000)	R178,743,000
Reasons for the funds unspent by the department	The department has applied for rollovers of the unspent portion, primarily attributable to machinery and equipment of R2,6 million awaiting delivery.
Monitoring mechanism by the receiving department	Adherence to reporting requirements of DORA, including inter alia in year monitoring reporting and monitoring processes, monthly certification of financial returns, quarterly certification of predetermined objectives, ongoing reviews with National Department Grant Managers.

Hospital Revitalisation Grant:

Department who transferred the grant	Health (Vote 16)
Purpose of the grant	To provide funding to enable provinces to plan, manage, modernise, rationalise and transform health infrastructure, health technology, monitoring and evaluation of the health facilities in line with national policy objectives; supplement expenditure on health infrastructure delivered through public private partnerships.
Expected outputs of the grant	Number of Hospitals receiving funding from Hospital Revitalisation Grant.
Amount per amended DORA	R460,173,000
Amount received (R'000)	R460,173,000
Reasons if amount as per DORA was not received	Full amount received.
Amount spent by the department (R'000)	R414,560,000
Reasons for the funds unspent by the department	<p>The department has applied for rollovers of the unspent portion, primarily attributable to payments for capital assets: Buildings and Fixed Structures.</p> <p>The under spend / savings in buildings and other fixed structures occurred as a result of the stop and start of projects, including inter alia Cecilia Makiwane, St Patrick and St Elizabeth Hospitals, due to industrial action by employees employed by contactors as well certain contractors filing for Business Rescue (Chapter 6 of Companies Act 71 of 2008) and further on granted liquidation.</p>
Monitoring mechanism by the receiving department	Adherence to reporting requirements of DORA, including inter alia in year monitoring reporting and monitoring processes, monthly certification of financial returns, quarterly certification of predetermined objectives, ongoing reviews with National Department Grant Managers.

Comprehensive HIV and Aids Grant

Department who transferred the grant	Health (Vote 16)
Purpose of the grant	<ul style="list-style-type: none"> • To enable the health sector to develop an effective response to HIV and Aids including universal access to HIV Counselling and Testing (HCT); • To support the implementation of the National Operational Plan for comprehensive HIV and Aids treatment and care; • To subsidise in-part funding for antiretroviral treatment programme.
Expected outputs of the grant	Number of individuals counselled and tested, Number of MMC conducted, Number of new patients initiated on ART.
Amount per amended DORA	R1,069,137,000
Amount received (R'000)	R1,069,137,000
Reasons if amount as per DORA was not received	Full amount received
Amount spent by the department (R'000)	R1,040,502,000
Reasons for the funds unspent by the department	The department has applied for rollovers of the unspent portion, primarily attributable to machinery and equipment (X-Ray and ultrasound machines) awaiting delivery.
Monitoring mechanism by the receiving department	Adherence to reporting requirements of DORA, including inter alia in year monitoring reporting and monitoring processes, monthly certification of financial returns, quarterly certification of predetermined objectives, ongoing reviews with National Department Grant Managers.

Health Infrastructure Grant

Department who transferred the grant	Health (Vote 16)
Purpose of the grant	To supplement provincial funding of health infrastructure to address backlogs, accelerate the provision of health facilities and ensure proper life cycle maintenance of provincial health infrastructure.
Amount per amended DORA	R306,714,000
Amount received (R'000)	R306,714,000
Reasons if amount as per DORA was not received	Full amount received.
Amount spent by the department (R'000)	R302,716,000
Reasons for the funds unspent by the department	The department has applied for rollovers of the unspent portion, primarily attributable to the payment of an awaited unitary fee for the Port Alfred Settlers Co-location PPP.
Monitoring mechanism by the receiving department	Adherence to reporting requirements of DORA, including inter alia in year monitoring reporting and monitoring processes, monthly certification of financial returns, quarterly certification of predetermined objectives, ongoing reviews with National Department grant managers.

Social Sector Expanded Public Works Programme Incentive Grant for Provinces

Department who transferred the grant	Public Works (Vote7)
Purpose of the grant	To incentivise provincial social sector departments identified in the 2012 Social Sector EPWP Log-frame to increase job creation by focusing on the strengthening and expansion of social service programmes that have employment potential.
Amount per amended DORA	R13,780,000
Amount received (R'000)	R13,780,000
Reasons if amount as per DORA was not received	Full amount received
Amount spent by the department (R'000)	R13,699,000
Reasons for the funds unspent by the department	A minimal amount was not spent, caused by a link code error
Monitoring mechanism by the receiving department	Adherence to reporting requirements of DORA, including inter alia in year monitoring reporting and monitoring processes, monthly certification of financial returns, quarterly certification of predetermined objectives, ongoing reviews with National Department Grant Managers.

Expanded Public Works Programme Integrated Grant for Provinces

Department who transferred the grant	PublicWorks (Vote7)
Purpose of the grant	To incentivise provincial departments to expand work creation efforts through the use of labour intensive delivery methods in identified focus areas, in compliance with the EPWP guidelines.
Amount per amended DORA	R1,000,000
Amount received (R'000)	R1,000,000
Reasons if amount as per DORA was not received	Full amount received
Amount spent by the department (R'000)	R1,000,000
Reasons for the funds unspent by the department	All funds expended.
Monitoring mechanism by the receiving department	Adherence to reporting requirements of DORA, including inter alia in year monitoring reporting and monitoring processes, monthly certification of financial returns, quarterly certification of predetermined objectives, ongoing reviews with National Department Grant Managers

Nursing Colleges and Schools Grant

Department who transferred the grant	Health (Vote 16)
Purpose of the grant	To supplement provincial funding of health infrastructure to accelerate the provision of health facilities including office furniture and related equipment, and to ensure proper maintenance of provincial health infrastructure for Nursing Colleges and schools.
Expected outputs of the grant	Number of Nursing Colleges and schools, planned, designed, constructed, maintained and operationalized
Amount per amended DORA	R14,660,000
Amount received (R'000)	R14,660,000
Reasons if amount as per DORA was not received	Full amount received
Amount spent by the department (R'000)	R12,394,000
Reasons for the funds unspent by the department	The department has applied for rollovers of the unspent portion, which relates to the renovations and repairs work at institutions in various parts of the Province, including inter-alia the East London Campus, Andre Vosloo, PE Campus and temporary learning platforms procured for the All Saints and Queenstown Campuses respectively.
Monitoring mechanism by the receiving department	Adherence to reporting requirements of DORA, including inter alia in year monitoring reporting and monitoring processes, monthly certification of financial returns, quarterly certification of predetermined objectives, ongoing reviews with National Department Grant Managers.

National Health Insurance Grant

Department who transferred the grant	Health (Vote 16)
Purpose of the grant	<p>Test innovations necessary for implementing the National Health Insurance:</p> <ul style="list-style-type: none"> to undertake health system strengthening initiatives and support selected pilot districts in implementing identified service delivery interventions; to strengthen the resource management of selected central hospitals.
Expected outputs of the grant	<ul style="list-style-type: none"> Enhanced managerial autonomy, delegation of functions and accountability in districts and health facilities. Provision for a scalable model, including the required institutional arrangements, for a district health authority (DHA) as the contracting agency. Linkages between health service management and administration and how it relates to the functions and responsibilities of DHAs. Provision of models for contracting private providers that include innovative arrangements for harnessing private sector resources at a primary health care level. Provision for a rational referral system based on a re-engineered primary health care platform with a particular focus in rural and previously disadvantaged areas. Provision of a model for revenue collection and management model for identified central hospitals
Amount per amended DORA	R 11,500,000
Amount received (R'000)	R 11,500,000
Reasons if amount as per DORA was not received	Full amount received
Amount spent by the department (R'000)	R8,094,000
Reasons for the funds unspent by the department	<p>The department has applied for rollovers of the unspent portion of the Grant. The underspending is attributable to lengthy processes resulting in revisions of the business plan which was finally approved on the 28th of November 2012. The procurement of the equipment stems from the launch of the Facility Improvement Teams (FIT) Project, which was launched at the end of the third quarter.</p>
Monitoring mechanism by the receiving department	<p>Adherence to reporting requirements of DORA, including inter alia in year monitoring reporting and monitoring processes, monthly certification of financial returns, quarterly certification of predetermined objectives, ongoing reviews with National Department Grant Managers.</p>

Africa Cup of Nations: Medical Services Grant

Department who transferred the grant	Health (Vote 16)
Purpose of the grant	To provide health and medical services at the 2013 Africa Cup of Nations (AFCON) championship.
Amount per amended DORA	R3,000,000
Amount received (R'000)	R3,000,000
Reasons if amount as per DORA was not received	Full amount received
Amount spent by the department (R'000)	R2,353,000
Reasons for the funds unspent by the department	The grant underspent as a result of less overtime expenditure having been incurred than anticipated.
Monitoring mechanism by the receiving department	Adherence to reporting requirements of DORA, including inter alia in year monitoring reporting and monitoring processes, monthly certification of financial returns, quarterly certification of predetermined objectives, ongoing reviews with National Department Grant Managers.

6.7. Donor Funds

The following are the Department's National and International donors:

Japanese International Development Cooperation Agency (JICA):

JICA supported a project to strengthen medical equipment maintenance management. The funding is in the form of a technical assistant (personnel) based in the Department to assist with the development of a model on the maintenance and management of medical equipment. The Department does not take responsibility for the financial implications incurred by the technical assistant. The support has been effective since it is mainly the transfer of skills from the Japanese medical equipment expert to the local personnel.

Sabona Foundation – (formerly The Fred Hollows Foundation – South Africa):

A Memorandum of Agreement (MOU) was entered into between the department and the “The Fred Hollows Foundation of South Africa” to create a sustainable eye-care programme that ensure rendering of a comprehensive eye-care service package consistent with the level of care of each partner institution in the Eastern Cape Province. The foundation operates in five sites, St Elizabeth Hospital; Frontier Hospital; East London Complex; PE Complex; and these form the critical part of the province's five eye-care nodal points of the foundation.

The programme provides comprehensive eye-care services and includes high volume cataract surgery, glaucoma and refractive error; training of doctors and nurses in cataract surgery; hospital-based outreach services provided by the ophthalmologists and community-based outreach services aimed at primary health care services.

An addendum to the MOU incorporates the optic laboratory for the cutting of lenses at the Frontier hospital Sabona Sonke eye care centre.

Chamber of Mines of South Africa:

The Chamber of Mines initiated a project for the “Ex-mineworkers” to strengthen the ability of various hospitals to offer medical examinations to ex-mineworkers and the project was first rolled out to Sir Henry Elliot hospital. The project is for a period of two years beginning from ending in of May 2013.

As part of the agreement, the Chamber of Mines will provide equipment and services for the use of the new occupational health centre at Sir Henry Elliot hospital and will second certain staff members to the hospital including an occupational health-nurse and an administrative assistant.

Foundation for Professional Development:

The foundation for Professional Development is a project that provides human resources and operating support at specific HIV/AIDS/TB/VCT sites to complement the existing resources of the department with the aim of increasing the number of people being treated for HIV, receiving support of wellness programmes and receiving ART or TB treatment.

Italian Co-Operation:

The department entered into an agreement with the Italian Co-Operation. The project focuses on communicable diseases, especially on TB, HIV and AIDS.

As part of the Technical support, the Italian Co Operation donated equipment to OR Tambo to support TB HIV& Aids activities. It has also donated four motor vehicles for the TB outreach programme.

The other donated equipment includes two additional vehicles which are in the process of being accepted by the Superintendent General.

European Union:

The European Union has a long standing partnership with the department which spans over a number of years for the delivery of primary health care programmes. Funds received from the donor were utilised towards strengthening delivery of primary health care services supporting Non-Profit Organisations (NPO) who have partnered with the department to provide primary health care services.

6.8. Capital investment, maintenance and asset management plan

Infrastructure projects

The Table below shows infrastructure projects that are currently in progress. Please refer to Health Facilities Management section of the Annual Report on page 219 for all completed projects.

DISTRICT	PROJECT NAME	START DATE	EXPECTED COMPLETION DATE	PROGRESS
ALFRED NZO	(Mkhemane Clinic (Replacement))	2008/9	28 July 2013	Construction 76% - 99%
	RSDP - Khutsong Hospital (replacement)	2009/10	July 2016	Tender-and a contract awarded.
Chris Hani	Ngqwaru (new)	2006/7	01 March 2014	Retention Stage.
	Frontier Equipment (new)	01 May 2011	31 March 2014	Construction 26% - 50%
	St Patricks Hospital - Upgrading CAS/OPD, Maternity, (Replacement)	01 June 2011	01 May 2014	Construction 76% - 99%
O.R.TAMBO	Bumbane (replacement)	2011/12	14 May 2014	Tender
	RSDP - Siphetu Hospital	16/01/2013	10 May 2016	Construction 1% - 25%
	RSDP - Nessie Knight Hospital (Replacement)	01/10/2012	01 Sept 2016	Construction 1% - 25%
	Madwaleni Hospital: g/way Clinic (new)	19.02/2013	01 June 2014	Construction 1% - 25%
	Malephephe (new)	2007/08	October 2014	Construction 1%-50%
	Sibeni Clinic (replacement)	01 May 2011	31 October 2013	Construction 26% - 50%
	St Elizabeths Hospital: Equipment (Replacement)	01 June 2010	01 Sept 2013	Construction 76% - 99%
	St Patricks Hospital: Equipment (Replacement)	01 May 2011	2014/15	Construction 76% - 99%
	Mvezo Clinic (new)	January 2011/12	13 August 2013	Retention

DISTRICT	PROJECT NAME	START DATE	EXPECTED COMPLETION DATE	PROGRESS
AMATOLE	Frere Hospital - New Oncology Unit Equipment	04/01/2013	31/01/2014	Construction 1% - 25%
	Zazulwana Clinic Repairs	07 Nov 2012	2013	Construction 1% - 25%
CACADU	Cloete Joubert Hospital Building Repairs and Maintenance	01 November 2012	13 June 2013	Identified

Closing and/or down-grading of health facilities

There were no health facilities planned for closure or down-grading.

Major maintenance projects and progress made on the maintenance of infrastructure

At the beginning of the FY under review, the DOH health facilities maintenance portfolio was allocated to the Coega Development Corporation (Pty) Ltd (CDC) as an implementing agent (IA), which in turn contracted four facility management companies. The scope of works for the maintenance of healthcare facilities and equipment varies from electrical, mechanical, electronics, sanitation, water, landscaping and civils in the Province. The province was sub-divided into four maintenance clusters, each cluster serviced by one of the four appointed service providers as shown in the Table below:

Cluster No	Districts Municipalities	Service provider
1	ORTambo and A Nzo	Aurencon Superway
2	Joe Gqabi and Chris Hani	Drake & Scull
3	Amathole and Buffalo City Metro	Maximaglobal Engineering
4	NMMM and Cacadu	FM Solutions & IDC

Progress made on the Maintenance Portfolio

A total of 722 clinics, 42 Community Health Facilities (CHCs), and 66 hospitals was covered and maintained on the current financial period. Additional adhoc general maintenance projects to the total of 280 was also attended to by the Implement Agent. The scope of works includes the following; electrical, plumbing, building, HVAC, Mechanical Systems, Kitchen Equipment, Refrigeration, Boiler, Shop Fittings, Carpentry, and Fire and Safety.

Developments relating to the above that are expected to impact on the department's current expenditure.

During the 2012/13 financial year, huge strides were made in implementing a new maintenance initiative, during which time a new Implementing Agent, Facility Managers and Professional Service Providers (PSPs-consultants and contractors appointed on term contracts) per cluster were appointed. In terms of the programme scope and brief for the maintenance function the Implementing Agent and Facility Managers were required to compile a room data sheets and conditional assessment (high level and detailed) per facility. Call Centres were established and operationalized to handle all emergency, urgent and minor maintenance needs.

Progress made in addressing the maintenance backlog

Whilst significant progress has been made on Maintenance Portfolio under the Coega Development Corporation (see section on Health Facilities Management pages 219) however, challenges are experienced around maintenance across the board. Challenges are experienced around maintenance of Sewerage Plants, Power Generators, Water Boilers, Medical Equipment and Electro-Mechanical Works. There is continued shortage of funding on scheduled and adhoc maintenance of health facilities. This challenge is mainly aggravated by the following:

- The equitable share budget allocation is reduced every year to accommodate other departmental priorities
- First line maintenance strategy (preventative maintenance) should be done at the facility level and much organisational development and management is required to support this. However, the funds allocated for this purpose are generally used for crisis management
- The department need to complete its existing commitments (contracted) on new / upgrades projects to release more funds for maintenance and refurbishment of existing infrastructure and
- Generally, maintenance activities had not been addressed for some years now; the maintenance backlog has now escalated to larger refurbishment and upgrading projects

Plans to address the challenges within Health Facilities Management and Executive Management Team (EMT) are underway. On scheduled maintenance of Medical Equipment; the BAC is in the process of awarding a contract to a qualifying service provider.

Table below: Infrastructure Expenditure trends for the financial years 2011/12-2012/13

Infrastructure projects	2012/2013			2011/2012		
	Final Appropriation R'000	Actual Expenditure R'000	(Over)/Under Expenditure R'000	Final Appropriation R'000	Actual Expenditure R'000	(Over)/Under Expenditure R'000
New and replacement assets	R 209 341	R 204 449	R 4892	R 317 117	R 349 075	R 31958
Existing infrastructure assets	R 1 051 819	R 1 023 964	R 49065	R 870 874	R 914 775	R195 669
Upgrades and additions	R 581 789	R 543 329	R 38460	R 529 577	R 626 637	(R97060)
Rehabilitation, renovations and refurbishments	R 77 432	R 78 431	(R999)	R 102 684	R 26 800	R 75884
Maintenance and repairs	R 392 598	R 402 204	(R9606)	R 238 613	R 261 338	(R 22725)
Infrastructure transfer						
Current						
Capital						
Total	R 1 261 160	R1 228 413	R 53 957	R 1 187 991	R 1 263 850	R227 627

PART C



GOVERNANCE

1. INTRODUCTION

Good governance is critical in ensuring that we meet our commitment to enhancing sustainability and that we are able to render a quality health service that meets our stakeholders' expectations.

The department is committed to Good Corporate Governance practices and endeavours at all times to support those processes that contribute towards strengthening governance. As a result, we have and continue to make significant progress in implementing structures, policies and procedures that contribute towards good governance within the department.

2. RISK MANAGEMENT

In line with the recommendations of the Audit Committee in 2011/12, the department has established a Risk Committee. The Committee has adopted a formal Charter which serves as its approved Terms of Reference. The Charter has been approved by the Superintendent General of the Eastern Cape Department of Health. The Committee is chaired by a non-executive person from outside the department. Membership includes members of executive management, representatives from the Auditor General, Audit Committee and Provincial Treasury.

The activities of the enterprise risk management unit are guided by an approved risk management framework, guidelines and methodology.

The Risk Committee (RiskCo) was established to support the Executive Management Team to improve its efficiency and assist it in discharging its responsibility which is to ensure implementing, monitoring and reporting on the departments' strategy.

A close working relationship exists between the Executive Team, Audit Committee and Risk Committee.

All members of the Executive Team are standing invitees to the Risk Committee and one non-executive member of the Audit Committee sits in the Risk Committee. This process helps to ensure that overlapping responsibilities are dealt with in an efficient manner.

The RiskCo is responsible for:

- Reviewing the risk management policy and strategy and recommend for approval by the Accounting Officer;
- Reviewing the risk appetite and tolerance and recommend for approval by the Accounting Officer;
- Reviewing the Department's risk identification and assessment methodologies to obtain reasonable assurance of the completeness and accuracy of the risk register;
- Evaluating the effectiveness of mitigating strategies to address the material risks of the Department;
- Reviewing any material findings and recommendations by assurance providers (including but not limited: Auditor general, Internal Audit etc.) on the system of risk management and monitor that appropriate action is instituted to address the identified weaknesses;

Fraud prevention

1. Reviewing the fraud prevention policy and plan and recommend for approval by the Accounting Officer;
2. Evaluating the effectiveness of the implementation of the fraud prevention policy and plan;

In the current year most of the effort of the Risk Unit has been on gathering and evaluating the portfolio of evidence on mitigating strategies implemented by the Department to address the Top 10 risks of the Department. The adequacy of the evidence was evaluated by the committee with the functional team members

(Finance, Clinical, Human Resource Management and Strategic Planning). The results of the evaluation indicated that although there are significant good faith efforts put in place by management to mitigate risks, a lot of work still remains to be done to ensure that risk management is practiced continuously and that a culture of risk management is embedded in the daily activities of all employees of the department.

In the ensuing year, greater focus will be spent on ensuring that mitigations are effective, efficient and economical and are consistently implemented. Increased training and awareness workshops on Risk Management are planned for all districts in the 2013/14 financial year.

3. FRAUD AND CORRUPTION

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

The Audit Committee and the Risk Management Committee oversee and monitor implementation of the Fraud Prevention Strategy.

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

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

The fraud hotline is but one of the mechanisms available to employees, suppliers, patients and the public to report incidents of fraud and corruption. Internal and External parties can contact the departments' forensic unit by telephone, email or request a meeting. The specialised forensic investigations department resides within the Internal Audit Unit, and reports directly to Chief Audit Executive.

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

Following the recommendations of some of our investigations, a number of matters have been reported to the police for criminal investigations and follow up. Similarly, a number of matters have been referred to the labour relations unit for the appropriate disciplinary processes to take place on implicated employees.

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

We have similarly concluded settlement agreements with some service providers where a decision has been taken not to pay or where a lesser amount based on actual delivery has been agreed upon.

These actions have helped to ensure that the Specialised Forensic Unit acts as a deterrent to would be fraudsters. To further enforce our zero tolerance standpoint to fraud and corruption, the department has established a dedicated whistleblower line where whistle-blowers can phone in to report allegations. The number is toll free and operates 24 hours a day. The toll free number is 0800 00 67 93.

In the 2013/14 financial year; increased effort will be spent on marketing the whistleblowing line including the departments' successes in combatting corrupt activities.

Ensuring that all reported irregularities are followed up and investigated is a challenge to the department, given its current financial position. However, the department is engaged with inter-governmental support through the Multi Agency Workgroup (MAWG), and is also seeking ways to recover monies on investigations performed.

4. MINIMISING CONFLICT OF INTEREST

The department adheres to a strict code of conduct and discourages its employees from trading with the department.

A process of minimising conflicts of interest is in place and enforced. Such a process involves:

- a. The department conducting data analysis between the BAS and PERSAL systems to identify potential violations of the code of conduct;
- b. Employees declaring the entities they own or have shares in and whether these entities have traded with the department.

All disclosures are analysed to identify direct and indirect interests. Where a conflict or potential conflict is identified, the matter is drawn to the attention of the employee by way of written communication in terms of Chapter 3 paragraph G.I of the of the Public Service Regulations. The employee is in this regard required to disclose:

- c. The extent of his/her involvement in the entities;
- d. Whether he/she has performed any approved work outside their normal duties for the stated entities; and whether
- e. The involvement in the entities leads to any actual conflicts of interest in relation to their official duties.

Responses to such are thoroughly analysed to ensure no conflict has arisen or that where such has occurred, appropriate disciplinary steps are taken.

5. CODE OF CONDUCT

The reputation and standing in the community of a public health organisation is one of the most valuable assets it has. This reputation and standing will be affected not only by formal policies and procedures, but also by the decisions management take. The manner in which the management and staff conduct themselves will impact on the standing of the Department.

In carrying out their duties, Management and staff are by the very fact of their appointment trustees for the provision of quality health care. Management and staff have a duty and responsibility, both in law, and in the public interest to act ethically and to uphold their position of trust in relation to their department and to the communication we serve.

The department is committed to create an environment that is conducive for effective and efficient service delivery. That environment is geared towards enhancing the consistent application of the Disciplinary Code, Grievance Procedure and Code of Conduct within the Department. The Department has established policies and guidelines to support the activities of all service delivery units and has introduced standards for the investigation of fraud, corruption and maladministration. The established conduct and disciplinary standards are being reinforced through awareness campaigns and information sharing sessions throughout the districts. The Department has declared a zero tolerance on fraud and corruption including maladministration. This commitment is evidenced through the number of disciplinary cases that are managed according to the different case profiles.

The Department will ensure that all policies, procedures, processes and practices include a clause to warn management and employees about the implications of not adhering to the policies, procedures, processes and practices of the Department.

The Department must also ensure, the continuous revision of the Code and training to ensure compliance with PFMA, Treasury Regulations, Public Service Act, Public Service Regulations and Collective Agreements reached in both PSCBC and PHSDSBC

The context in which labour relations is exercised is continuously evolving. The orientation of the department is to move towards stronger management practices in order to bring about a more responsive approach to labour relations, which will include a greater level of accountability. An integrated strategic management approach and a cultural shift are both required to establish a strategic agenda and to have effective labour management relationships. This strategic approach will provide for a more responsive labour relations culture in the department.

In terms of renewing the foundation of labour relations, the department will make improvements by

- Clarify roles and responsibilities between employee relations Practitioners and Line Managers in the management of discipline and conflict management.
- Realign the delegation of grievance levels and increasing management accountabilities.
- The Institutional Transformation Units throughout the organization will be reviewed with a view to increase effectiveness at all levels of the organization.
- Dialogue and engagement with unions in various forums will be focused to move from a more transactional approach to a more strategic results-oriented approach.
- Mandatory training for managers in labour relations will be provided in order to afford a better understanding and resolve conflict at the lowest level which in turn should positively influence labour relations at all levels of the organization.
- Rigorous processes will be put into place to support compliance in the areas of grievance and dispute management, discipline management and the Code of conduct and ethical behaviour.

6. HEALTH SAFETY AND ENVIRONMENTAL ISSUES

Overall Departmental compliance with the Occupational Health and Safety Act No. 85 of 1993 is inconsistent across the province and poor. Exposure of employees, patients and communities to infection and injuries is critical due to:

- Poor infrastructure,
- Poor maintenance of emergency/medical equipment,
- Lack of dedicated staff in facilities to emphasize compliance to health and safety protocols and regulations on a constant and continuous basis,
- Unavailability and improper utilisation of Personal Protective Clothing and Equipment and
- Poor implementation of emergency drills for evacuation and disaster management.

The Department of Health has a legal requirement of complying with the National Environmental Management Act (NEMA), Act no 107 of 1998. The compliance is required in various aspects of environmental management related areas which include the following: hazardous substances management, water resources management, sanitation and hygiene, port health services, outbreak response and preparedness and malaria and vector control. All these aspects are covered in the environmental management plan (EMP) which the legislated authority in complying with the requirements of NEMA is the NDOH but Provinces and their Municipalities are the main implementers of the environmental management functions in the Department.

The Department has made some strides in complying with National Environmental Management Act, 107 of 1998, all the water services authority (WSAs) have water sampling points including public health facilities where

water samples are collected on a monthly basis and water quality reports are reported, in terms of port health services all the designated ports of entry have port health officers, on sanitation and hygiene, the EHPs at both District Municipality and Metro levels are implementing health and hygiene strategy. As a preventative measure in Malaria control all the air craft coming from malaria and yellow fever endemic countries without proof of fumigation are sprayed on arrival. There are challenges in some aspects of the EMP such as the Outbreak response committee which does not meet frequently as required.

7. INTERNAL CONTROL UNIT

- Pre-audit services have been rendered throughout the financial year, despite capacity constraints
- Irregular expenditure, fruitless and wasteful expenditure has been detected and reported to Provincial Treasury on a monthly basis. There have been challenges on returns of these expenditures, thus resulting to under-reporting which is usually reported by AGSA.
- Applications for condonation of irregular expenditure have been presented to BAC and approved
- Applications for condonation of fruitless and wasteful expenditure have been presented to Financial Misconduct Committee for recommendation and approved by Accounting Officer
- Documentary evidence in support of financial management misconduct allegations has been submitted to Employment Relations Directorate with the intention of assisting on disciplinary cases.

8. AUDIT COMMITTEE REPORT

Introduction

We are pleased to present our report for the financial year ended 31 March 2013.

Committee members and meetings

The committee is composed of five members. These are Mr. Trevor Harper CA (SA) (Chairperson), Dr. Bukelwa Mbulawa-Hans, MB Ch B, Mr. Kevin Pather CA (SA), Mr. Temba Zakuza CA (SA) CIA and Ms. Tracy Cumming CA (SA).

Member	04 May 2012	30 May 2012	29 June 2012	19 July 2012	31 Aug 2012	14 Sept 2012	03 Dec 2012	22 Mar 2013
Mr.T.Harper	P	P	P	P	P	P	P	P
Dr.B Mbulawa-Hans	P	P	P	P	P	P	P	P
Mr.K.Pather	A	A	P	P	P	P	P	P
Mr.T.Zakuza	P	P	P	A	A	P	P	P
Ms.T.Cumming	P	P	P	P	P	P	A	P

Key

- P = Present
- A = Apology

Audit Committee Responsibility

The Audit Committee reports that it has adopted appropriate formal terms of reference as its Audit Committee Charter in line the PFMA section 76(i)(a) read with Treasury Regulation 3.1.8. The Committee has regulated its affairs in compliance with this Charter, and has discharged its responsibilities as contained therein.

Duties and responsibilities

The Audit Committee is responsible for the review of the following:

- The effectiveness of the internal control systems;
- The effectiveness of the internal audit function;
- The risk areas of the Department's operations.
- The adequacy, reliability and accuracy of the financial information provided to management and other users of such information;
- Any accounting and auditing concerns identified as a result of internal and external audits;
- The Department's compliance with legal and regulatory provisions;
- The activities of the internal audit function, including its annual work programme, coordination with the external auditors, the reports of significant recommendations and the responses of management to these recommendations;
- Responsiveness of the Internal Audit coverage plan to the outcome of risk assessment and the three year rolling plan; and
- The scope and results of the external audit function, its cost-effectiveness, as well as the independence and objectivity of the external auditors.

The Audit Committee is also responsible for:

- Reporting to the Department and the Auditor General where a report implicates any member(s) or the Accounting Officer in fraud, corruption or gross negligence;
- Communicating any concerns it deems necessary to the Executive Authority and the Auditor General;
- Confirming/Approving the internal audit charter and internal audit plan;
- Recommending the Audit Committee Charter to the Accounting Officer for approval.
- Encouraging communication between, senior and executive management, Internal Audit department, Health Portfolio Committee and the Auditor General;
- Conducting investigations within its terms of reference; and
- Reviewing the Annual Financial Statements and Performance Information prior to the annual audit for approval by the Superintendent General.

We believe that we have complied with our responsibilities.

Effectiveness of Internal Control

Our review of the findings of the Internal Audit work, which was based on the risk assessments conducted in the department revealed certain weaknesses, which were then raised with the Department.

Internal Audit has reported that the controls were found to be partially adequate and in certain instances ineffective during the year under review. The leadership of the Department will have to firm up processes to ensure that significant effort and resources are put in place to further enhance control improvement to ensure that for the next year, controls are improved both in terms of adequacy and effectiveness.

The following internal audit work was completed during the year under review:

- Support with implementation of various turnaround plans in the following areas:
 - ICT
 - Clinical Services
 - Financial Management
- CAATS – various processes identified and exception reports were generated for management action
- Verification of leave gratuity and other human resources accruals prior to payment for deceased, retiring and other employees exiting the system.
- Data Analysis – Analysis conducted to identify incidences of conflict of interest with findings communicated to management for immediate action.
- Compliance with laws and regulations – focus on compliance with laws pertaining to clinical services.
- Review of the Annual Performance Plan for alignment with goals and objectives.
- Auditing of performance information for alignment with Strategic Plan and APP.
- Review of the annual report for validity.

Internal Audit also supported with the establishment of a project management office through establishment and utilization of a web based tool which facilitated standardization and tracking of progress on assignments.

- The Committee has monitored and advised on the implementation of Turnaround Plans and has not been satisfied with the rate at which the plans were being implemented with some of the turnaround plans showing zero percent or little movement at the end of the financial year. Similarly the committee has not been satisfied with the commitment displayed by management towards ensuring implementation of these plans.
- Connectivity of the institutions remains a challenge and the acquisition of a virtual private network has not been achieved.
- The capacitation of the department remained a challenge with critical positions remaining unfilled for lengthy periods of time.
- Similarly the committee has been concerned about the tone and relationships at the executive level and has escalated the matter both to the Executive Authority and former Head of Department.

In-Year Monitoring and Monthly/Quarterly Report

The department has reported monthly and quarterly to the Treasury as is required by the PFMA. The Audit Committee has reviewed the reports of Internal Audit and has not been satisfied with the figures for projected overspending as the figures appeared clouded with commitments and accruals which had not been properly accounted for and reported on.

Performance Information

The committee has evaluated performance reports submitted by the department and has not been satisfied with both the quality and the effectiveness of the performance monitoring and reporting system. Similarly, the committee has noted the reports of Internal Audit on their review of the Annual Performance Plan and has also not been satisfied that the goals and objectives are properly aligned neither were the indicators SMART in all the instances.

Internal Audit Function

The committees' role is to coordinate and monitor the activities of the internal audit function. The committee is able to report on the effectiveness and efficiency of the unit. Although the Internal Audit Unit remains operating at less than 50% of the approved capacity, the technical capacity has been enhanced by the co-sourced arrangement with a consortium consisting of PricewaterHouseCoopers, SizweNtsalubaGobodo and Umnombo

Consulting Consortium. The contract with the Consortium ended on the 14th September 2012 and the committee will continue to monitor measures put in place by the department to build the capacity of the Internal Audit Unit.

The Internal Audit Unit has issued a number of reports containing recommendations to be implemented to improve weaknesses in Internal Controls. These recommendations should be implemented by the Department or management should accept the risk inherent in not implementing such recommendations.

Risk management function

Risk Management is a proactive discipline that involves scenario planning and is intended to provide reasonable assurance that the department will achieve its objectives.

In the 2011/12 financial year the audit committee recommended that a Risk Committee (RiskCo) should be established by the department. The committee is pleased that the recommendation has been taken heed of. A Risk Committee is in place and it operates with approved terms of reference which have been endorsed by the executive management of the department.

The Committee will continue to monitor the activities of the Risk Committee through the reports submitted quarterly by the Chair of the RiskCo.

Furthermore, the committee is concerned about the capacity of the Forensic Unit; this taking into account the number of allegations of fraud and corruption reported to and being investigated by the Department. The Department needs to build on the existing capacity to ensure investigations are conducted and concluded in a timely manner.

Evaluation of Annual Financial Statements and Performance Information

Special audit committee meetings were held on the 24th and 30th May 2013 to review the draft financial statements and annual report to be presented to Provincial Treasury and Auditor General on the 31st May 2013. The Committee performed a high level review of the financial statements that was based on enquiry from the Acting Chief Financial Officer as to the completeness, accuracy and validity of balances and transactions within the financial statements. In addition, the accounting policies were reviewed and recommendations made as necessary. Following this Audit Committee review of the financial statements recommendations were made with regards to significant adjustments that are required to the format as well as the presented figures.

As at the date of the review the Audit Committee had not received the complete performance information report and is therefore unable to report on the performance information.

Following our review of the Annual Financial Statements the Audit Committee recommended that these documents be submitted to the Auditor General for auditing.

Conclusion

The Audit Committee has monitored Management's implementation of the recommendations of Internal Audit and the Auditor General, and is concerned about the low levels and pace of response in relation thereto. This concern has also been taken up with the Executive Authority.

The Leadership of the Department will have to fast track implementation of management plans and Internal Audit recommendations to deal with the weaknesses within the Department towards the achievement an unqualified audit and eventually a clean audit.

The Audit Committee accepts the Auditor Generals' findings in terms of the audit. Although the audit opinion remains qualified, there are indications that the Department is improving in certain operational areas. The Audit Committee, however, believes that there is still significant work to be done on both the systems as well as the structures within the Department before an unqualified opinion is received. The Internal Audit, Risk and Forensic Units remain understaffed and management is encouraged to look into the capacitation of the units to ensure support to the finance, strategic and clinical clusters of the department is enhanced.



JOSEPH TREVOR HARPER CA (SA)
Chairman of the Audit Committee
Eastern Cape Department of Health
31 July 2013

PART D



HUMAN RESOURCE MANAGEMENT

I. LEGISLATURE THAT GOVERN HR MANAGEMENT

The information provided in this part is prescribed by the Public Service Regulations (Chapter I, Part III J.3 and J.4).

2. INTRODUCTION

HR matters, challenges and achievements are presented in Part B Section 13.

Policy development

This is discussed in sections 3.4 of Part B of this report.

3. HUMAN RESOURCE OVERSIGHT STATISTICS

3.1. Personnel related expenditure

The following tables summarises the final audited personnel related expenditure by programme and by salary bands. In particular, it provides an indication of the following:

- amount spent on personnel
- amount spent on salaries, overtime, homeowner's allowances and medical aid.

Table 3.1.1 Personnel expenditure by programme

Programme	Total Expenditure (R'000)	Personnel Expenditure (R'000)	Training Expenditure (R'000)	Professional and Special Services Expenditure (R'000)	Personnel Expenditure as a % of total expenditure	Average personnel cost per employee (R'000)
Programme I	535568	290,597	21,332	0	54.3	8
District health services	7,953,629	5,491,541	119,992	0	69	139
Emergency medical service	619,525	366 492	13,332	0	59.2	9
Provincial hospital services	3,979,016	3,145,076	13,332	0	79	80
Central hospital services	657170	179,833	13,332	0	27.4	5
Health science & training	579,521	312,872	66,662	0	54	8
Health care and support serv	84,309	35,154	13,332	0	42	1
Health facilities dev&maint	1,192,168	7,575	5,333	0	0.6	0
TOTAL	15,600,906	9,827,472	266,649	0	63	249

Table 3.1.2 Personnel costs by salary band

Salary band	Personnel Expenditure (R'000)	% of total personnel cost	No. of employees	Total Personnel Cost of Department including Goods and Transfers (R'000)	Number of Employees
Lower skilled (Levels 1-2)	536,008	5.4	104,832	9,911,463	5113
Skilled (Levels 3-5)	2,138,292	21.6	146,438	9,911,463	14602
Highly skilled production (Levels 6-8)	2,123,963	21.4	233,968	9,911,463	9078
Highly skilled supervision (Levels 9-12)	3,755,334	37.9	454,641	9,911,463	8260
Senior management (Levels 13-16)	253,047	2.6	1,041,346	9,911,463	243
Contract (Levels 1-2)	100,040	1	145,407	9,911,463	688
Contract (Levels 3-5)	12,387	0.1	152,926	9,911,463	81
Contract (Levels 6-8)	143,237	1.4	232,906	9,911,463	615
Contract (Levels 9-12)	460,311	4.6	677,925	9,911,463	679
Contract (Levels 13-16)	70,815	0.7	1,416,300	9,911,463	50
Periodical Remuneration	14,916	0.2	210,085	9,911,463	71
Abnormal Appointment	230,762	2.3	25,179	9,911,463	9165
TOTAL	9,839,112	99.3	202264	9911463	48645

Table 3.I.3 Salaries, Overtime, Home Owners Allowance and Medical Aid by programme

Programme	Salaries		Overtime		Home Owners Allowance		Medical Aid		Total Personnel Cost per Programme (R'000)
	Amount (R'000)	Salaries as a % of personnel costs	Amount (R'000)	Overtime as a % of personnel costs	Amount (R'000)	HOA as a % of personnel costs	Amount (R'000)	Medical aid as a % of personnel costs	
Programme 1: Administration	206370	66.5	8157	2.6	7020	2.3	10947	3.5	310383
Programme 2: District Health Services	3832166	69.1	109159	2	216243	3.9	249490	4.5	5546859
Programme 3: Emergency Medical Services	236371	65.4	17708	4.9	18171	5	29544	8.2	361570
Programme 4: Provincial Hospital Services	2341099	69.8	204941	6.1	118564	3.5	148776	4.4	3354260
Programme 6: Health Science & Training	202401	68.9	4981	1.7	7744	2.6	8481	2.9	293792
Programme 7: Health Care Support Services	25922	73.1	1	0	1469	4.1	1738	4.9	35456
Programme 8: Health Facilities Management	7360	80.5	383	4.2	189	2.1	173	1.9	9143
TOTAL	6851689	69.1	345330	3.5	369400	3.7	449149	4.5	9911463

Table 3.I.4 Salaries, Overtime, Home Owners Allowance and Medical Aid by salary band

Salary Bands	Salaries		Overtime		Home Owners Allowance		Medical Aid	
	Amount (R'000)	Salaries as a % of personnel costs	Amount (R'000)	Overtime as a % of personnel costs	Amount (R'000)	HOA as a % of personnel costs	Amount (R'000)	Medical aid as a % of personnel costs
Lower skilled (Levels 1-2)	362205	67.5	424	0.1	52264	9.7	43280	8.1
Skilled (Levels 3-5)	1477284	68.6	18763	0.9	150180	7	169555	7.9
Highly skilled production (Levels 6-8)	1531370	71.7	17973	0.8	84142	3.9	121140	5.7
Highly skilled supervision (Levels 9-12)	2705377	71.3	145184	3.8	74129	2	108170	2.9
Senior management (Levels 13-16)	165993	64.4	46893	18.2	3728	1.4	2227	0.9
Contract (Levels 1-2)	88812	88.8	0	0	3214	3.2	2970	3
Contract (Levels 3-5)	10051	81	1	0	714	5.8	322	2.6
Contract (Levels 6-8)	133794	92.7	233	0.2	239	0.2	386	0.3
Contract (Levels 9-12)	324721	70.4	103506	22.4	603	0.1	778	0.2
Contract (Levels 13-16)	51592	71.5	12355	17.1	187	0.3	322	0.4
Periodical Remuneration	0	0	0	0	0	0	0	0
Abnormal Appointment	491	0.2	0	0	0	0	0	0
TOTAL	6851690	69.1	345332	3.5	369400	3.7	449150	4.5

3.2. Employment and Vacancies

The tables in this section summarise the position with regard to employment and vacancies.

The following tables summarise the number of posts on the establishment, the number of employees, the vacancy rate, and whether there are any staff that are additional to the establishment.

This information is presented in terms of three key variables:

- programme
- salary band
- critical occupations

Departments have identified critical occupations that need to be monitored. In terms of current regulations, it is possible to create a post on the establishment that can be occupied by more than one employee. Therefore, the vacancy rate reflects the percentage of posts that are not filled.

Table 3.2.1 Employment and vacancies by programme

Programme	Number of posts on approved establishment	Number of posts filled	Vacancy Rate	Number of employees additional to the establishment
Prg8: Health Facilities Management, Permanent	25	21	16	0
Prg7: Health Care Support Services, Permanent	172	159	7.6	0
Prg6: Health Sciences & Training, Permanent	1660	1131	31.9	0
Prg4: Provincial Hospital Service, Temporary	48	76	-58.3	0
Prg4: Provincial Hospital Service, Permanent	14035	12656	9.8	6
Prg3: Emergency Medical Services, Permanent	1884	1828	3	0
Prg2: District Health Services, Temporary	146	182	-24.7	17
Prg2: District Health Services, Permanent	28068	22655	19.3	677
Prg1: Administration, Permanent	765	701	8.4	1
TOTAL	46803	39409	15.8	701

Table 3.2.1 Employment and vacancies by programme

Salary band	Number of posts on approved establishment	Number of posts filled	Vacancy Rate	Number of employees additional to the establishment
Lower skilled (Levels 1-2), Permanent	5780	5144	11	136
Lower skilled (Levels 1-2), Temporary	14	14	0	1
Skilled (Levels 3-5), Permanent	16639	14564	12.5	226
Skilled (Levels 3-5), Temporary	22	22	0	6
Highly skilled production (Levels 6-8), Permanent	11326	8973	20.8	212
Highly skilled production (Levels 6-8), Temporary	54	80	-48.1	1
Highly skilled supervision (Levels 9-12), Permanent	10390	8115	21.9	93
Highly skilled supervision (Levels 9-12), Temporary	103	141	-36.9	9
Senior management (Levels 13-16), Permanent	361	242	33	1
Senior management (Levels 13-16), Temporary	1	1	0	0
Contract (Levels 1-2), Permanent	688	688	0	0
Contract (Levels 3-5), Permanent	81	81	0	0
Contract (Levels 6-8), Permanent	615	615	0	4
Contract (Levels 9-12), Permanent	679	679	0	7
Contract (Levels 13-16), Permanent	50	50	0	5
TOTAL	46803	39409	15.8	701

Table 3.2.3 Employment and vacancies by critical occupations

Critical occupation	Number of posts on approved establishment	Number of posts filled	Vacancy Rate	Number of employees additional to the establishment
Administrative related, Permanent	616	569	7.6	12
All artisans in the building metal machinery etc., Permanent	212	185	12.7	0
Ambulance and related workers, Permanent	1777	1721	3.2	0
Artisan project and related superintendents, Permanent	14	13	7.1	1
Auxiliary and related workers, Permanent	1312	1023	22	7
Biochemistry pharmacol. zoology & life science .techni, Permanent	8	1	87.5	0
Boiler and related operators, Permanent	52	47	9.6	0
Building and other property caretakers, Permanent	103	92	10.7	4
Bus and heavy vehicle drivers, Permanent	12	11	8.3	0
Cartographic surveying and related technicians, Permanent	2	2	0	0
Chemists, Permanent	68	68	0	0
Cleaners in offices workshops hospitals etc., Permanent	5180	4749	8.3	190
Client inform clerks(switchb receipt inform clerks), Permanent	268	248	7.5	0
Communication and information related, Permanent	69	65	5.8	0
Community development workers, Permanent	4	4	0	0
Compositors typesetters & related printing workers, Permanent	2	2	0	0

Critical occupation	Number of posts on approved establishment	Number of posts filled	Vacancy Rate	Number of employees additional to the establishment
Computer programmers., Permanent	1	1	0	0
Conservation labourers, Permanent	31	31	0	0
Dental practitioners, Permanent	134	108	19.4	0
Dental practitioners, Temporary	4	6	-50	0
Dental technicians, Permanent	2	2	0	0
Dental therapy, Permanent	13	10	23.1	0
Dieticians and nutritionists, Permanent	148	108	27	0
Diplomats, Permanent	1	1	0	0
Electrical and electronics engineering technicians, Permanent	15	13	13.3	0
Emergency services related, Permanent	154	154	0	0
Engineering sciences related, Permanent	3	3	0	0
Engineers and related professionals, Permanent	9	9	0	0
Environmental health, Permanent	146	75	48.6	0
Farm hands and labourers, Permanent	43	43	0	0
Finance and economics related, Permanent	142	128	9.9	0
Financial and related professionals, Permanent	83	79	4.8	0
Financial clerks and credit controllers, Permanent	304	276	9.2	0

Critical occupation	Number of posts on approved establishment	Number of posts filled	Vacancy Rate	Number of employees additional to the establishment
Food services aids and waiters, Permanent	766	679	11.4	10
Food services workers, Permanent	8	8	0	0
General legal administration & rel. professionals, Permanent	1	0	100	0
Handymen, Permanent	1	1	0	0
Head of department/chief executive officer, Permanent	10	4	60	0
Health sciences related, Permanent	854	790	7.5	4
Home-based personal care workers, Permanent	1	1	0	0
Household and laundry workers, Permanent	1010	905	10.4	19
Household food and laundry services related, Permanent	6	5	16.7	0
Housekeepers laundry and related workers, Permanent	26	24	7.7	0
Human resources & organisat developm & relate prof, Permanent	77	71	7.8	0
Human resources clerks, Permanent	274	258	5.8	1
Human resources related, Permanent	278	263	5.4	0
Information technology related, Permanent	14	14	0	0
Inspectors of apprentices works and vehicles, Permanent	5	5	0	0
Language practitioners interpreters & other commun, Permanent	42	37	11.9	0
Legal related, Permanent	1	0	100	0

Critical occupation	Number of posts on approved establishment	Number of posts filled	Vacancy Rate	Number of employees additional to the establishment
Librarians and related professionals, Permanent	2	2	0	0
Library mail and related clerks, Permanent	72	65	9.7	0
Light vehicle drivers, Permanent	237	221	6.8	3
Logistical support personnel, Permanent	74	68	8.1	0
Material-recording and transport clerks, Permanent	176	159	9.7	1
Medical practitioners, Permanent	1684	1255	25.5	6
Medical practitioners, Temporary	149	196	-31.5	10
Medical specialists, Permanent	208	168	19.2	0
Medical specialists, Temporary	15	29	-93.3	0
Medical technicians/technologists, Permanent	37	31	16.2	0
Messengers porters and deliverers, Permanent	846	721	14.8	9
Middle managers, Permanent	1	1	0	0
Motor vehicle drivers, Permanent	46	45	2.2	9
Nursing assistants, Permanent	6493	5693	12.3	53
Occupational therapy, Permanent	162	108	33.3	0
Occupational therapy, Temporary	1	1	0	0
Optometrists and opticians, Permanent	13	10	23.1	0

Critical occupation	Number of posts on approved establishment	Number of posts filled	Vacancy Rate	Number of employees additional to the establishment
Oral hygiene, Permanent	25	22	12	0
Other administrat & related clerks and organisers, Permanent	1627	1422	12.6	57
Other administrat & related clerks and organisers, Temporary	1	1	0	1
Other administrative policy and related officers, Permanent	568	533	6.2	12
Other information technology personnel, Permanent	83	77	7.2	1
Other machine operators, Permanent	1	1	0	0
Other occupations, Permanent	245	245	0	0
Other occupations, Temporary	2	2	0	0
Pharmaceutical assistants, Permanent	24	24	0	0
Pharmacists, Permanent	471	369	21.7	21
Pharmacists, Temporary	11	11	0	5
Pharmacologists pathologists & related professional, Permanent	3	3	0	0
Physicists, Permanent	7	6	14.3	0
Physiotherapy, Permanent	195	136	30.3	0
Physiotherapy, Temporary	1	2	-100	0
Printing and related machine operators, Permanent	2	2	0	0
Probation workers, Permanent	1	1	0	0

Critical occupation	Number of posts on approved establishment	Number of posts filled	Vacancy Rate	Number of employees additional to the establishment
Professional nurse, Permanent	12699	9567	24.7	201
Professional nurse, Temporary	7	7	0	0
Psychologists and vocational counsellors, Permanent	75	62	17.3	0
Radiography, Permanent	430	355	17.4	2
Radiography, Temporary	3	3	0	1
Risk management and security services, Permanent	3	3	0	0
Road workers, Permanent	4	4	0	0
Safety health and quality inspectors, Permanent	24	22	8.3	0
Secretaries & other keyboard operating clerks, Permanent	392	374	4.6	5
Security guards, Permanent	48	48	0	2
Security officers, Permanent	6	6	0	0
Senior managers, Permanent	139	121	12.9	0
Shoemakers, Permanent	4	3	25	0
Social sciences related, Permanent	4	4	0	0
Social sciences supplementary workers, Permanent	5	5	0	0
Social work and related professionals, Permanent	129	117	9.3	0
Speech therapy and audiology, Permanent	63	48	23.8	0

Critical occupation	Number of posts on approved establishment	Number of posts filled	Vacancy Rate	Number of employees additional to the establishment
Staff nurses and pupil nurses, Permanent	3515	3183	9.4	51
Student nurse, Permanent	1191	692	41.9	0
Supplementary diagnostic radiographers, Permanent	44	44	0	1
Trade labourers, Permanent	229	199	13.1	2
TOTAL	46803	39409	15.8	701

3.3. Job Evaluation

Within a nationally determined framework, executing authorities may evaluate or re-evaluate any job in his or her organisation. In terms of the Regulations all vacancies on salary levels 9 and higher must be evaluated before they are filled. The following table summarises the number of jobs that were evaluated during the year under review. The table also provides statistics on the number of posts that were upgraded or downgraded.

Table 3.3.1 Job Evaluation by Salary band

Salary band	Number of posts on approved establishment	Number of Jobs Evaluated	% of posts evaluated by salary bands	Posts Upgraded		Posts downgraded	
				Number	% of posts evaluated	Number	% of posts evaluated
Lower skilled (Levels 1-2)	5794	5794	100%	0	0	0	0
Contract (Levels 1-2)	688	0	0	0	0	0	0
Contract (Levels 3-5)	81	0	0	0	0	0	0
Contract (Levels 6-8)	615	0	0	0	0	0	0
Contract (Levels 9-12)	679	0	0	0	0	0	0
Contract (Band A)	27	0	0	0	0	0	0
Contract (Band B)	7	0	0	0	0	0	0
Contract (Band C)	16	0	0	0	0	0	0
Skilled (Levels 3-5)	16661	15577	93.5	0	0	0	0
Highly skilled production (Levels 6-8)	11380	9780	85.9	0	0	0	0
Highly skilled supervision (Levels 9-12)	10493	8441	80.4	0	0	0	0
Senior Management Service Band A	232	179	77.2	0	0	0	0
Senior Management Service Band B	29	18	62.1	0	0	0	0
Senior Management Service Band C	99	84	84.8	0	0	0	0
Senior Management Service Band D	2	2	100	0	0	0	0
TOTAL	46803	39875	85.2	0	0	0	0

The following table provides a summary of the number of employees whose positions were upgraded due to their post being upgraded. The number of employees might differ from the number of posts upgraded since not all employees are automatically absorbed into the new posts and some of the posts upgraded could also be vacant.

Table 3.3.2 Profile of employees whose positions were upgraded due to their posts being upgraded

Beneficiary	African	Asian	Coloured	White	Total
Female	0	0	0	0	0
Male	0	0	0	0	0
Total	0	0	0	0	0
Employees with a disability					0

The following table summarises the number of cases where remuneration bands exceeded the grade determined by job evaluation. Reasons for the deviation are provided in each case.

Table 3.3.3 Employees with salary levels higher than those determined by job evaluation by occupation

Occupation	Number of employees	Job evaluation level	Remuneration level	Reason for deviation
Chief Executive Officer	2	14	15	Retention
Senior Manager	1	13	14	Retention
	0	0	0	0
	0	0	0	0
Percentage of total employed				0

The following table summarises the beneficiaries of the above in terms of race, gender, and disability.

Table 3.3.4 Profile of employees who have salary levels higher than those determined by job evaluation

Beneficiary	African	Asian	Coloured	White	Total
Female	1	0	1	0	0
Male	0	0	0	1	0
Total	1	0	1	1	3
Employees with a disability	0	0	0	0	0

Total Number of Employees whose remuneration exceeded the grade determined by job evaluation in 2012/13	-
---	---

3.4. Employment Changes

This section provides information on changes in employment over the financial year. Turnover rates provide an indication of trends in the employment profile of the department. The following tables provide a summary of turnover rates by salary band and critical occupations.

Table 3.4.1 Annual turnover rates by salary band

Salary Band	Number of employees at beginning of period-	Appointments and transfers into the department	Terminations and transfers out of the department	Turnover rate
Lower skilled (Levels 1-2), Permanent	5251	80	181	3.4
Lower skilled (Levels 1-2), Temporary	17	0	10	58.8
Skilled (Levels 3-5), Permanent	15028	261	646	4.3
Skilled (Levels 3-5), Temporary	31	0	6	19.4
Highly skilled production (Levels 6-8), Permanent	8909	330	543	6.1
Highly skilled production (Levels 6-8), Temporary	77	0	12	15.6
Highly skilled supervision (Levels 9-12), Permanent	8409	150	464	5.5
Highly skilled supervision (Levels 9-12), Temporary	152	0	29	19.1
Senior Management Service Band A, Permanent	80	3	9	11.3
Senior Management Service Band B, Permanent	85	2	2	2.4
Senior Management Service Band C, Permanent	13	2	1	7.7
Senior Management Service Band D, Permanent	1	0	0	0
Contract (Levels 1-2), Permanent	1021	0	83	8.1
Contract (Levels 3-5), Permanent	131	0	16	12.2

Salary Band	Number of employees at beginning of period-	Appointments and transfers into the department	Terminations and transfers out of the department	Turnover rate
Contract (Levels 6-8), Permanent	738	300	349	47.3
Contract (Levels 9-12), Permanent	830	249	318	38.3
Contract (Band A), Permanent	18	1	16	88.9
Contract (Band B), Permanent	21	1	4	19
Contract (Band C), Permanent	3	0	5	166.7
Contract (Band D), Permanent	1	0	1	100
TOTAL	40816	1379	2695	6.6

Table 3.4.2 Annual turnover rates by critical occupation

Critical Occupation	Number of employees at beginning of period-April 2012	Appointments and transfers into the department	Terminations and transfers out of the department	Turnover rate
Administrative related, Permanent	385	7	30	7.8
All artisans in the building metal machinery etc., Permanent	199	0	14	7
Ambulance and related workers, Permanent	1770	1	42	2.4
Artisan project and related superintendents, Permanent	15	1	1	6.7
Auxiliary and related workers, Permanent	1093	1	69	6.3
Biochemistry pharmacol. zoology & life scie.techni, Permanent	3	0	2	66.7
Boiler and related operators, Permanent	51	0	4	7.8
Building and other property caretakers, Permanent	102	0	10	9.8
Bus and heavy vehicle drivers, Permanent	14	0	1	7.1
Cartographic surveying and related technicians, Permanent	2	0	0	0
Chemists, Permanent	74	0	6	8.1
Cleaners in offices workshops hospitals etc., Permanent	4888	149	256	5.2
Client inform clerks(switchb recept inform clerks), Permanent	254	0	4	1.6
Communication and information related, Permanent	67	0	2	3
Community development workers, Permanent	4	0	0	0

Critical Occupation	Number of employees at beginning of period- April 2012	Appointments and transfers into the department	Terminations and transfers out of the department	Turnover rate
Compositors typesetters & related printing workers, Permanent	2	0	0	0
Computer programmers., Permanent	1	0	0	0
Conservation labourers, Permanent	32	0	1	3.1
Dental practitioners, Permanent	107	17	14	13.1
Dental practitioners, Temporary	9	0	4	44.4
Dental technicians, Permanent	1	1	0	0
Dental therapy, Permanent	11	0	1	9.1
Dieticians and nutritionists, Permanent	109	18	18	16.5
Diplomats, Permanent	1	0	0	0
Electrical and electronics engineering technicians, Permanent	14	0	1	7.1
Emergency services related, Permanent	155	0	1	0.6
Engineering sciences related, Permanent	3	0	0	0
Engineers and related professionals, Permanent	9	0	0	0
Environmental health, Permanent	116	10	60	51.7
Farm hands and labourers, Permanent	45	0	3	6.7
Finance and economics related, Permanent	134	1	4	3

Critical Occupation	Number of employees at beginning of period- April 2012	Appointments and transfers into the department	Terminations and transfers out of the department	Turnover rate
Financial and related professionals, Permanent	82	1	4	4.9
Financial clerks and credit controllers, Permanent	278	0	5	1.8
Fire fighting and related workers, Permanent	1	0	1	100
Food services aids and waiters, Permanent	718	0	39	5.4
Food services workers, Permanent	8	0	0	0
Handymen, Permanent	1	0	0	0
Head of department/chief executive officer, Permanent	6	1	3	50
Health sciences related, Permanent	835	2	49	5.9
Home-based personal care workers, Permanent	1	0	0	0
Household and laundry workers, Permanent	974	10	77	7.9
Household food and laundry services related, Permanent	6	0	0	0
Housekeepers laundry and related workers, Permanent	27	0	3	11.1
Human resources & organisat development & relate prof, Permanent	72	0	1	1.4
Human resources clerks, Permanent	214	0	8	3.7
Human resources related, Permanent	570	0	18	3.2
Information technology related, Permanent	14	0	0	0

Critical Occupation	Number of employees at beginning of period- April 2012	Appointments and transfers into the department	Terminations and transfers out of the department	Turnover rate
Inspectors of apprentices works and vehicles, Permanent	5	0	0	0
Language practitioners interpreters & other commun, Permanent	39	0	1	2.6
Librarians and related professionals, Permanent	2	0	0	0
Library mail and related clerks, Permanent	69	0	1	1.4
Light vehicle drivers, Permanent	233	0	14	6
Logistical support personnel, Permanent	68	1	1	1.5
Material-recording and transport clerks, Permanent	165	1	6	3.6
Medical practitioners, Permanent	1274	245	292	22.9
Medical practitioners, Temporary	203	0	42	20.7
Medical specialists, Permanent	191	9	28	14.7
Medical specialists, Temporary	33	0	4	12.1
Medical technicians/technologists, Permanent	30	6	4	13.3
Messengers porters and deliverers, Permanent	737	20	30	4.1
Middle managers, Permanent	1	0	0	0
Motor vehicle drivers, Permanent	39	8	3	7.7
Nursing assistants, Permanent	5940	68	238	4

Critical Occupation	Number of employees at beginning of period-April 2012	Appointments and transfers into the department	Terminations and transfers out of the department	Turnover rate
Occupational therapy, Permanent	120	35	46	38.3
Occupational therapy, Temporary	1	0	0	0
Optometrists and opticians, Permanent	12	0	3	25
Oral hygiene, Permanent	23	1	1	4.3
Other administration & related clerks and organisers, Permanent	1284	49	28	2.2
Other administration & related clerks and organisers, Temporary	1	0	0	0
Other administrative policy and related officers, Permanent	638	13	19	3
Other information technology personnel., Permanent	80	0	0	0
Other machine operators, Permanent	1	0	0	0
Other occupations, Permanent	268	0	19	7.1
Other occupations, Temporary	2	0	0	0
Pharmaceutical assistants, Permanent	25	0	1	4
Pharmacists, Permanent	356	56	44	12.4
Pharmacists, Temporary	11	0	2	18.2
Pharmacologists pathologists & related professional, Permanent	3	0	0	0
Physicists, Permanent	8	0	1	12.5

Critical Occupation	Number of employees at beginning of period- April 2012	Appointments and transfers into the department	Terminations and transfers out of the department	Turnover rate
Physiotherapy, Permanent	131	45	38	29
Physiotherapy, Temporary	2	0	0	0
Printing and related machine operators, Permanent	2	0	0	0
Probation workers, Permanent	1	0	0	0
Professional nurse, Permanent	9577	453	729	7.6
Professional nurse, Temporary	7	0	0	0
Psychologists and vocational counsellors, Permanent	73	13	22	30.1
Psychologists and vocational counsellors, Temporary	4	0	4	100
Radiography, Permanent	356	18	23	6.5
Radiography, Temporary	4	0	1	25
Risk management and security services, Permanent	3	0	0	0
Road workers, Permanent	4	0	0	0
Safety health and quality inspectors, Permanent	22	1	1	4.5
Secretaries & other keyboard operating clerks, Permanent	387	1	12	3.1
Security guards, Permanent	53	0	3	5.7

Critical Occupation	Number of employees at beginning of period- April 2012	Appointments and transfers into the department	Terminations and transfers out of the department	Turnover rate
Security officers, Permanent	8	0	2	25
Senior managers, Permanent	135	3	15	11.1
Shoemakers, Permanent	4	0	0	0
Social sciences related, Permanent	4	0	0	0
Social sciences supplementary workers, Permanent	6	0	1	16.7
Social work and related professionals, Permanent	121	0	2	1.7
Speech therapy and audiology, Permanent	46	15	13	28.3
Staff nurses and pupil nurses, Permanent	3250	97	154	4.7
Student nurse, Permanent	1021	0	80	7.8
Supplementary diagnostic radiographers, Permanent	49	0	3	6.1
Trade labourers, Permanent	207	1	8	3.9
TOTAL	40816	1379	2695	6.6

The table below identifies the major reasons why staff left the department.

Table 3.4.3 Reasons why staff left the department

Termination Type	Number	% of Total Resignations
Death, Permanent	268	9.9
Resignation, Permanent	737	27.3
Resignation, Temporary	27	1
Expiry of contract, Permanent	693	25.7
Expiry of contract, Temporary	29	1.1
Transfers, Permanent	50	1.9
Discharged due to ill health, Permanent	20	0.7
Dismissal-misconduct, Permanent	87	3.2
Retirement, Permanent	782	29
Other, Permanent	1	0
Other, Temporary	1	0
TOTAL	2695	100

Table 3.4.4 Promotions by critical occupation

Occupation	Employees 1 April 2012	Promotions to another salary level	Salary level promotions as a % of employees by occupation	Progressions to another notch within a salary level	Notch progression as a % of employees by occupation
Administrative related	385	2	0.5	38	9.9
All artisans in the building metal machinery etc.	199	0	0	12	6
Ambulance and related workers	1770	0	0	0	0
Artisan project and related superintendents	15	0	0	1	6.7
Auxiliary and related workers	1093	0	0	29	2.7
Biochemistry pharmacol. zoology & life scie. techni	3	0	0	0	0
Boiler and related operators	51	0	0	4	7.8
Building and other property caretakers	102	0	0	4	3.9
Bus and heavy vehicle drivers	14	0	0	0	0
Cartographic surveying and related technicians	2	0	0	0	0
Chemists	74	0	0	0	0
Cleaners in offices workshops hospitals etc.	4888	0	0	271	5.5
Client inform clerks(switchb receipt inform clerks)	254	0	0	7	2.8
Communication and information related	67	0	0	0	0
Community development workers	4	0	0	0	0
Compositors typesetters & related printing workers	2	0	0	0	0
Computer programmers.	1	0	0	0	0
Conservation labourers	32	0	0	0	0
Dental practitioners	116	0	0	3	2.6

Occupation	Employees 1 April 2012	Promotions to another salary level	Salary level promotions as a % of employees by occupation	Progressions to another notch within a salary level	Notch progression as a % of employees by occupation
Dental technicians	1	0	0	0	0
Dental therapy	11	1	9.1	0	0
Dieticians and nutritionists	109	0	0	6	5.5
Diplomats	1	0	0	0	0
Electrical and electronics engineering technicians	14	0	0	1	7.1
Emergency services related	155	0	0	0	0
Engineering sciences related	3	0	0	1	33.3
Engineers and related professionals	9	0	0	0	0
Environmental health	116	0	0	0	0
Farm hands and labourers	45	0	0	1	2.2
Finance and economics related	134	0	0	11	8.2
Financial and related professionals	82	1	1.2	8	9.8
Financial clerks and credit controllers	278	1	0.4	34	12.2
Fire fighting and related workers	1	0	0	0	0
Food services aids and waiters	718	0	0	24	3.3
Food services workers	8	0	0	1	12.5
Handymen	1	0	0	0	0
Head of department/chief executive officer	6	0	0	1	16.7
Health sciences related	835	3	0.4	4	0.5
Home-based personal care workers	1	0	0	0	0

Occupation	Employees 1 April 2012	Promotions to another salary level	Salary level promotions as a % of employees by occupation	Progressions to another notch within a salary level	Notch progression as a % of employees by occupation
Household and laundry workers	974	0	0	93	9.5
Household food and laundry services related	6	0	0	0	0
Housekeepers laundry and related workers	27	0	0	0	0
Human resources & organisat developm & relate prof	72	0	0	12	16.7
Human resources clerks	214	0	0	21	9.8
Human resources related	570	1	0.2	6	1.1
Information technology related	14	0	0	0	0
Inspectors of apprentices works and vehicles	5	0	0	0	0
Language practitioners interpreters & other commun	39	0	0	1	2.6
Librarians and related professionals	2	0	0	0	0
Library mail and related clerks	69	0	0	4	5.8
Light vehicle drivers	233	0	0	8	3.4
Logistical support personnel	68	0	0	2	2.9
Material-recording and transport clerks	165	1	0.6	2	1.2
Medical practitioners	1477	6	0.4	12	0.8
Medical specialists	224	4	1.8	0	0
Medical technicians/technologists	30	0	0	1	3.3
Messengers porters and deliverers	737	1	0.1	82	11.1
Middle managers	1	0	0	0	0
Motor vehicle drivers	39	0	0	0	0

Occupation	Employees 1 April 2012	Promotions to another salary level	Salary level promotions as a % of employees by occupation	Progressions to another notch within a salary level	Notch progression as a % of employees by occupation
Nursing assistants	5940	0	0	15	0.3
Occupational therapy	121	0	0	3	2.5
Optometrists and opticians	12	0	0	0	0
Oral hygiene	23	0	0	0	0
Other administrat & related clerks and organisers	1285	0	0	45	3.5
Other administrative policy and related officers	638	0	0	13	2
Other information technology personnel.	80	0	0	2	2.5
Other machine operators	1	0	0	0	0
Other occupations	270	0	0	3	1.1
Pharmaceutical assistants	25	0	0	0	0
Pharmacists	367	0	0	8	2.2
Pharmacologists pathologist	3	0	0	0	0
Physicists	8	0	0	0	0
Physiotherapy	133	0	0	4	3
Printing and related machine operators	2	0	0	2	100
Probation workers	1	0	0	0	0
Professional nurse	9584	108	1.1	23	0.2
Psychologists and vocational counsellors	77	0	0	1	1.3
Radiography	360	1	0.3	22	6.1
Risk management and security services	3	0	0	0	0

Occupation	Employees 1 April 2012	Promotions to another salary level	Salary level promotions as a % of employees by occupation	Progressions to another notch within a salary level	Notch progression as a % of employees by occupation
Road workers	4	0	0	0	0
Safety health and quality inspectors	22	0	0	0	0
Secretaries & other keyboard operating clerks	387	0	0	12	3.1
Security guards	53	0	0	1	1.9
Security officers	8	0	0	2	25
Senior managers	135	2	1.5	19	14.1
Shoemakers	4	0	0	0	0
Social sciences related	4	0	0	0	0
Social sciences supplementary workers	6	0	0	0	0
Social work and related professionals	121	0	0	1	0.8
Speech therapy and audiology	46	0	0	2	4.3
Staff nurses and pupil nurses	3250	10	0.3	5	0.2
Student nurse	1021	0	0	1	0.1
Supplementary diagnostic radiographers	49	0	0	0	0
Trade labourers	207	0	0	30	14.5
TOTAL	40816	142	0.3	919	2.3

Table 3.4.5 Promotions by salary band

Salary Band	Employees 1 April 2012	Promotions to another salary level	Salary bands promotions as a % of employees by salary level	Progressions to another notch within a salary level	Notch progression as a % of employees by salary bands
Lower skilled (Levels 1-2), Permanent	5251	0	0	331	6.3
Lower skilled (Levels 1-2), Temporary	17	0	0	0	0
Skilled (Levels 3-5), Permanent	15028	10	0.1	257	1.7
Skilled (Levels 3-5), Temporary	31	0	0	0	0
Highly skilled production (Levels 6-8), Permanent	8909	104	1.2	181	2
Highly skilled production (Levels 6-8), Temporary	77	0	0	0	0
Highly skilled supervision (Levels 9-12), Permanent	8409	21	0.2	142	1.7
Highly skilled supervision (Levels 9-12), Temporary	152	0	0	1	0.7
Senior management (Levels 13-16), Permanent	179	5	2.8	3	1.7
Contract (Levels 1-2), Permanent	1021	0	0	0	0
Contract (Levels 3-5), Permanent	131	0	0	0	0
Contract (Levels 6-8), Permanent	738	0	0	0	0
Contract (Levels 9-12), Permanent	830	2	0.2	4	0.5
Contract (Levels 13-16), Permanent	43	0	0	0	0
TOTAL	40816	142	0.3	919	2.3

3.5. Employment Equity

Table 3.5.1 Total number of employees (including employees with disabilities) in each of the following occupational categories as at 31 March 2013

Occupational category	Male				Female				Total
	African	Coloured	Indian	White	African	Coloured	Indian	White	
Legislators, senior officials and managers, Permanent	43	3	1	7	62	4	2	7	129
Professionals, Permanent	927	116	92	294	1793	182	69	374	3847
Professionals, Temporary	90	2	7	68	51	1	1	24	244
Technicians and associate professionals, Permanent	1761	161	1	73	9412	1286	30	571	13295
Technicians and associate professionals, Temporary	0	0	0	0	0	1	0	10	11
Clerks, Permanent	646	62	3	19	1865	133	2	72	2802
Clerks, Temporary	0	0	0	0	0	0	0	1	1
Service and sales workers, Permanent	2263	245	4	77	7309	702	4	230	10834
Craft and related trades workers, Permanent	125	18	1	45	18	0	0	0	207
Plant and machine operators and assemblers, Permanent	278	30	0	5	13	2	0	0	328
Elementary occupations, Permanent	2465	164	1	46	4581	352	0	53	7662
Elementary occupations, Temporary	2	0	0	0	0	0	0	0	2
Other, Permanent	6	0	1	0	36	0	0	4	47
TOTAL	8606	801	111	634	25140	2663	108	1346	39409

Table 3.5.2 Total number of employees (including employees with disabilities) in each of the following occupational bands on 31 March 2013

Occupational Band	Male				Female				Total
	African	Coloured	Indian	White	African	Coloured	Indian	White	
Top Management, Permanent	28	3	10	28	4	2	1	12	88
Senior Management, Permanent	53	5	8	28	47	4	2	7	154
Senior Management, Temporary	0	0	0	1	0	0	0	0	1
Professionally qualified and experienced specialists and mid-management, Permanent	939	119	42	181	5769	628	44	393	8115
Professionally qualified and experienced specialists and mid-management, Temporary	62	1	3	37	28	1	0	9	141
Skilled technical and academically qualified workers, junior management, supervisors, foremen, Permanent	1643	279	9	140	5406	975	15	506	8973
Skilled technical and academically qualified workers, junior management, supervisors, foremen, Temporary	22	0	2	19	21	1	1	14	80
Semi-skilled and discretionary decision making, Permanent	3551	260	2	67	9716	763	5	200	14564
Semi-skilled and discretionary decision making, Temporary	6	1	2	5	2	0	0	6	22
Unskilled and defined decision making, Permanent	1818	92	2	13	3039	167	0	13	5144
Unskilled and defined decision making, Temporary	2	0	0	6	0	0	0	6	14
Contract (Top Management), Permanent	7	0	3	2	2	0	1	1	16

Occupational Band	Male				Female				Total
	African	Coloured	Indian	White	African	Coloured	Indian	White	
Contract (Senior Management), Permanent	18	1	2	9	2	0	1	1	34
Contract (Professionally qualified), Permanent	208	26	24	91	181	32	29	88	679
Contract (Skilled technical), Permanent	93	11	2	7	364	51	7	80	615
Contract (Semi-skilled), Permanent	21	0	0	0	54	5	1	0	81
Contract (Unskilled), Permanent	135	3	0	0	505	34	1	10	688
TOTAL	8606	801	111	634	25140	2663	108	1346	39409

Table 3.5.3 Recruitment

Occupational Band	Male				Female				Total
	African	Coloured	Indian	White	African	Coloured	Indian	White	
Top Management, Permanent	1	0	0	0	0	0	0	1	2
Senior Management, Permanent	2	1	0	1	0	0	0	1	5
Professionally qualified and experienced specialists and mid-management, Permanent	21	6	2	6	76	29	0	10	150
Skilled technical and academically qualified workers, junior management, supervisors, foremen, Permanent	36	9	0	2	182	81	1	19	330
Semi-skilled and discretionary decision making, Permanent	42	2	0	1	200	16	0	0	261
Unskilled and defined decision making, Permanent	16	1	0	0	63	0	0	0	80
Contract (Senior Management), Permanent	2	0	0	0	0	0	0	0	2
Contract (Professionally qualified), Permanent	67	14	6	35	79	8	8	32	249
Contract (Skilled technical), Permanent	35	6	2	5	138	26	7	81	300
TOTAL	222	39	10	50	738	160	16	144	1379
Employees with disabilities	0	0	0	0	0	1	0	0	1

Table 3.5.4 Promotions

Occupational Band	Male				Female				Total
	African	Coloured	Indian	White	African	Coloured	Indian	White	
Top Management, Permanent	0	0	0	3	0	0	0	1	4
Senior Management, Permanent	3	0	0	1	0	0	0	0	4
Professionally qualified and experienced specialists and mid-management, Permanent	39	6	1	9	80	10	2	16	163
Professionally qualified and experienced specialists and mid-management, Temporary	0	0	0	0	0	1	0	0	1
Skilled technical and academically qualified workers, junior management, supervisors, foremen, Permanent	48	14	1	5	162	39	2	14	285
Semi-skilled and discretionary decision making, Permanent	74	12	0	1	153	25	0	2	267
Unskilled and defined decision making, Permanent	83	3	0	2	233	9	0	1	331
Contract (Professionally qualified), Permanent	4	1	1	0	0	0	0	0	6
TOTAL	251	36	3	21	628	84	4	34	1061
Employees with disabilities	0	0	0	1	1	3	0	1	6

Table 3.5.5 Terminations

Occupational Band	Male				Female				Total
	African	Coloured	Indian	White	African	Coloured	Indian	White	
Top Management, Permanent	1	0	0	0	0	0	0	0	1
Senior Management, Permanent	4	0	1	2	3	0	0	1	11
Professionally qualified and experienced specialists and mid-management, Permanent	69	5	6	14	312	17	10	31	464
Professionally qualified and experienced specialists and mid-management, Temporary	12	0	1	5	8	0	0	3	29
Skilled technical and academically qualified workers, junior management, supervisors, foremen, Permanent	109	18	0	14	303	47	0	52	543
Skilled technical and academically qualified workers, junior management, supervisors, foremen, Temporary	4	0	1	3	1	0	0	3	12
Semi-skilled and discretionary decision making, Permanent	180	14	0	7	394	37	1	13	646
Semi-skilled and discretionary decision making, Temporary	1	0	0	3	1	0	0	1	6
Unskilled and defined decision making, Permanent	81	0	0	1	94	5	0	0	181
Unskilled and defined decision making, Temporary	0	0	0	6	0	0	0	4	10

Occupational Band	Male				Female				Total
	African	Coloured	Indian	White	African	Coloured	Indian	White	
Contract (Top Management), Permanent	2	0	1	2	1	0	0	0	6
Contract (Senior Management), Permanent	15	1	1	1	2	0	0	0	20
Contract (Professionally qualified), Permanent	79	13	7	52	93	16	10	48	318
Contract (Skilled technical), Permanent	41	7	0	5	196	26	3	71	349
Contract (Semi-skilled), Permanent	2	0	0	0	14	0	0	0	16
Contract (Unskilled), Permanent	18	2	0	3	52	7	0	1	83
TOTAL	618	60	18	118	1474	155	24	228	2695
Employees with Disabilities	2	0	0	1	2	0	0	2	5

Table 3.5.6 Disciplinary action

Disciplinary action	Male				Female				Total
	African	Coloured	Indian	White	African	Coloured	Indian	White	
Dismissal	1	0	0	0	0	0	0	0	1
Final written warning	3	0	0	0	3	0	0	0	6
No outcome	1	0	0	0	0	0	0	0	1
Suspended without payment	4	0	0	0	3	0	0	0	7
Written warning	1	0	0	0	0	0	0	0	1
TOTAL	10	0	0	0	6	0	0	0	16

Table 3.5.7 Skills development

Occupational category	Male				Female				Total
	African	Coloured	Indian	White	African	Coloured	Indian	White	
Legislators, senior officials and managers	0	0	0	0	0	0	0	0	0
Professionals	0	0	0	0	0	0	0	0	0
Technicians and associate professionals	0	0	0	0	0	0	0	0	0
Clerks	0	0	0	0	0	0	0	0	0
Service and sales workers	0	0	0	0	0	0	0	0	0
Skilled agriculture and fishery workers	0	0	0	0	0	0	0	0	0
Craft and related trades workers	0	0	0	0	0	0	0	0	0
Plant and machine operators and assemblers	0	0	0	0	0	0	0	0	0
Elementary occupations	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0
Employees with disabilities	0	0	0	0	0	0	0	0	0

3.6. Performance Rewards

There were no performance rewards paid during this financial year under Review..

Table 3.6.I Performance Rewards by race, gender and disability

Race and Gender	Beneficiary Profile			Cost	
	Number of beneficiaries	Number of employees	% of total within group	Cost (R'000)	Average cost per employee
African, Female	0	25100	0	0	0
African, Male	0	8563	0	0	0
Asian, Female	0	108	0	0	0
Asian, Male	0	111	0	0	0
Coloured, Female	0	2659	0	0	0
Coloured, Male	0	795	0	0	0
Total Blacks, Female	0	27867	0	0	0
Total Blacks, Male	0	9469	0	0	0
White, Female	0	1336	0	0	0
White, Male	0	625	0	0	0
Employees with a disability	0	112	0	0	0
TOTAL	0	39409	0	0	0

Table 3.6.2 Performance Rewards by salary band for personnel below Senior Management Service,

Salary Band	Beneficiary Profile			Cost	
	Number of beneficiaries	Number of employees	% of total within salary bands	Total Cost (R'000)	Average cost per employee
Lower skilled (Levels 1-2)	0	5113	0	0	0
Skilled (Levels 3-5)	0	14602	0	0	0
Highly skilled production (Levels 6-8)	0	9078	0	0	0
Highly skilled supervision (Levels 9-12)	0	8260	0	0	0
Contract (Levels 1-2)	0	688	0	0	0
Contract (Levels 3-5)	0	81	0	0	0
Contract (Levels 6-8)	0	615	0	0	0
Contract (Levels 9-12)	0	679	0	0	0
Periodical Remuneration	0	71	0	0	0
Abnormal Appointment	0	9165	0	0	0
TOTAL	0	48352	0	0	0

Table 3.6.3 Performance Rewards by critical occupation

Critical Occupation	Beneficiary Profile			Cost	
	Number of beneficiaries	Number of employees	% of total within occupation	Total Cost (R'000)	Average cost per employee
Administrative related	0	569	0	0	0
All artisans in the building metal machinery etc.	0	184	0	0	0
Ambulance and related workers	0	1719	0	0	0
Artisan project and related superintendents	0	13	0	0	0
Auxiliary and related workers	0	1023	0	0	0
Biochemistry pharmacol. zoology & life science techni	0	1	0	0	0
Boiler and related operators	0	47	0	0	0
Building and other property caretakers	0	92	0	0	0
Bus and heavy vehicle drivers	0	11	0	0	0
Cartographic surveying and related technicians	0	2	0	0	0
Chemists	0	68	0	0	0
Cleaners in offices workshops hospitals etc.	0	4747	0	0	0
Client inform clerks (switchboard reception inform clerks)	0	248	0	0	0
Communication and information related	0	65	0	0	0

Critical Occupation	Beneficiary Profile			Cost	
	Number of beneficiaries	Number of employees	% of total within occupation	Total Cost (R'000)	Average cost per employee
Community development workers	0	4	0	0	0
Compositors typesetters & related printing workers	0	2	0	0	0
Computer programmers.	0	1	0	0	0
Conservation labourers	0	31	0	0	0
Dental practitioners	0	114	0	0	0
Dental technicians	0	2	0	0	0
Dental therapy	0	10	0	0	0
Dieticians and nutritionists	0	108	0	0	0
Diplomats	0	1	0	0	0
Electrical and electronics engineering technicians	0	13	0	0	0
Emergency services related	0	154	0	0	0
Engineering sciences related	0	3	0	0	0
Engineers and related professionals	0	9	0	0	0
Environmental health	0	75	0	0	0
Farm hands and labourers	0	43	0	0	0
Finance and economics related	0	128	0	0	0

Critical Occupation	Beneficiary Profile			Cost	
	Number of beneficiaries	Number of employees	% of total within occupation	Total Cost (R'000)	Average cost per employee
Financial and related professionals	0	79	0	0	0
Financial clerks and credit controllers	0	276	0	0	0
Food services aids and waiters	0	678	0	0	0
Food services workers	0	8	0	0	0
Handymen	0	1	0	0	0
Head of department/chief executive officer	0	4	0	0	0
Health sciences related	0	790	0	0	0
Home-based personal care workers	0	1	0	0	0
Household and laundry workers	0	903	0	0	0
Household food and laundry services related	0	5	0	0	0
Housekeepers laundry and related workers	0	24	0	0	0
Human resources & organisat developm & relate prof	0	71	0	0	0
Human resources clerks	0	258	0	0	0
Human resources related	0	263	0	0	0
Information technology related	0	14	0	0	0

Critical Occupation	Beneficiary Profile			Cost	
	Number of beneficiaries	Number of employees	% of total within occupation	Total Cost (R'000)	Average cost per employee
Inspectors of apprentices works and vehicles	0	5	0	0	0
Language practitioners interpreters & other commun	0	37	0	0	0
Librarians and related professionals	0	2	0	0	0
Library mail and related clerks	0	65	0	0	0
Light vehicle drivers	0	221	0	0	0
Logistical support personnel	0	68	0	0	0
Material-recording and transport clerks	0	159	0	0	0
Medical practitioners	0	1450	0	0	0
Medical specialists	0	197	0	0	0
Medical technicians/technologists	0	31	0	0	0
Messengers porters and deliverers	0	721	0	0	0
Middle managers	0	1	0	0	0
Motor vehicle drivers	0	45	0	0	0
Nursing assistants	0	5686	0	0	0
Occupational therapy	0	109	0	0	0

Critical Occupation	Beneficiary Profile			Cost	
	Number of beneficiaries	Number of employees	% of total within occupation	Total Cost (R'000)	Average cost per employee
Optometrists and opticians	0	10	0	0	0
Oral hygiene	0	22	0	0	0
Other administration & related clerks and organisers	0	1423	0	0	0
Other administrative policy and related officers	0	533	0	0	0
Other information technology personnel.	0	77	0	0	0
Other machine operators	0	1	0	0	0
Other occupations	0	247	0	0	0
Pharmaceutical assistants	0	24	0	0	0
Pharmacists	0	378	0	0	0
Pharmacologists pathologists & related professional	0	3	0	0	0
Physicists	0	6	0	0	0
Physiotherapy	0	138	0	0	0
Printing and related machine operators	0	2	0	0	0
Probation workers	0	1	0	0	0
Professional nurse	0	9550	0	0	0

Critical Occupation	Beneficiary Profile			Cost	
	Number of beneficiaries	Number of employees	% of total within occupation	Total Cost (R'000)	Average cost per employee
Psychologists and vocational counsellors	0	62	0	0	0
Radiography	0	358	0	0	0
Rank: Unknown	0	48	0	0	0
Risk management and security services	0	3	0	0	0
Road workers	0	4	0	0	0
Safety health and quality inspectors	0	22	0	0	0
Secretaries & other keyboard operating clerks	0	374	0	0	0
Security guards	0	48	0	0	0
Security officers	0	6	0	0	0
Senior managers	0	121	0	0	0
Shoemakers	0	3	0	0	0
Social sciences related	0	4	0	0	0
Social sciences supplementary workers	0	5	0	0	0
Social work and related professionals	0	117	0	0	0

Critical Occupation	Beneficiary Profile			Cost	
	Number of beneficiaries	Number of employees	% of total within occupation	Total Cost (R'000)	Average cost per employee
Speech therapy and audiology	0	48	0	0	0
Staff nurses and pupil nurses	0	3180	0	0	0
Student nurse	0	689	0	0	0
Supplementary diagnostic radiographers	0	44	0	0	0
Trade labourers	0	199	0	0	0
TOTAL	0	39409	0	0	0

Notes: The CORE classification, as prescribed by the DPSA, should be used for completion of this table.

Table 3.6.4 Performance related rewards (cash bonus), by salary band for Senior Management Service

Salary Band	Beneficiary Profile			Cost		Total cost as a % of the total personnel expenditure
	Number of beneficiaries	Number of employees	% of total within salary bands	Total Cost (R'000)	Average cost per employee	
Band A	0	157	0	0	0	0
Band B	0	32	0	0	0	0
Band C	0	103	0	0	0	0
Band D	0	1	0	0	0	0
TOTAL	0	293	0	0	0	0

3.7. Foreign Workers

The tables below summarise the employment of foreign nationals in the department in terms of salary band and major occupation

Table 3.7.1 foreign workers by salary band

Salary Band	01 April 2012		31 March 2013		Change	
	Number	% of total	Number	% of total	Number	% Change
Lower skilled (Levels 1-2)	1	0.3	2	0.6	1	-2.4
Skilled (Levels 3-5)	5	1.3	5	1.4	0	0
Highly skilled production (Levels 6-8)	16	4	12	3.4	-4	9.5
Highly skilled supervision (Levels 9-12)	130	32.7	106	29.8	-24	57.1
Senior management (Levels 13-16)	18	4.5	29	8.1	11	-26.2
Contract (Levels 3-5)	1	0.3	1	0.3	0	0
Contract (Levels 6-8)	9	2.3	5	1.4	-4	9.5
Contract (Levels 9-12)	199	50	170	47.8	-29	69
Contract (Levels 13-16)	12	3	21	5.9	9	-21.4
Periodical Remuneration	3	0.8	3	0.8	0	0
Abnormal Appointment	4	1	2	0.6	-2	4.8
TOTAL	398	100	356	100	-42	100

Table 3.7.2 Foreign workers by major occupation

Major Occupation	01 April 2012		31 March 2013		Change	
	Number	% of total	Number	% of total	Number	% Change
Administrative office workers	3	0.8	3	0.8	0	0
Elementary occupations	1	0.3	2	0.6	1	-2.4
Professionals and managers	389	97.7	346	97.2	-43	102.4
Service workers	1	0.3	1	0.3	0	0
Social natural technical and medical sciences+supp	3	0.8	3	0.8	0	0
Technicians and associated professionals	1	0.3	1	0.3	0	0
TOTAL	398	100	356	100	-42	100

3.8. Leave utilisation

The Public Service Commission identified the need for careful monitoring of sick leave within the public service. The following tables provide an indication of the use of sick leave and disability leave. In both cases, the estimated cost of the leave is also provided.

Table 3.8.1 Sick leave

Salary Band	% Days with Medical certification	Number of Employees using sick leave	% of total employees using sick leave	Average days per employee	Estimated Cost (R'000)	Total number of Employees using Sick Leave	Total numbers of days with medical certification
Lower skilled (Levels 1-2)	89.6	3086	11.7	8	5,905	26343	21080
Skilled (Levels 3-5)	89	9663	36.7	8	25,780	26343	64632
Highly skilled production (Levels 6-8)	85.7	6752	25.6	8	32,224	26343	44732
Highly skilled supervision (Levels 9-12)	86.4	5806	22	7	48,814	26343	36264
Senior management (Levels 13-16)	85.3	100	0.4	7	2,227	26343	629
Contract (Levels 1-2)	95.7	162	0.6	4	191	26343	661
Contract (Levels 3-5)	59.6	26	0.1	4	34	26343	59
Contract (Levels 6-8)	79.9	399	1.5	5	1,021	26343	1625
Contract (Levels 9-12)	76.6	329	1.2	5	2,176	26343	1153
Contract (Levels 13-16)	88.6	20	0.1	4	310	26343	78
TOTAL	87.4	26343	100	7	118682	26343	170913

Table 3.8.2 Disability leave (temporary and permanent)

Salary Band	Total days	% Days with Medical certification	Number of Employees using disability leave	% of total employees using disability leave	Average days per employee	Estimated Cost (R'000)	Total number of days with medical certification	Total number of employees using Disability Leave
Lower skilled (Levels 1-2)	2850	100	146	13.3	20	719	2850	1095
Skilled (Levels 3-5)	10774	99.9	367	33.5	29	4,030	10759	1095
Highly skilled production (Levels 6-8)	9216	100	304	27.8	30	5,687	9216	1095
Highly skilled supervision (Levels 9-12)	9328	99.9	257	23.5	36	10,461	9316	1095
Senior management (Levels 13-16)	228	100	8	0.7	29	766	228	1095
Contract (Levels 6-8)	33	100	6	0.5	6	18	33	1095
Contract (Levels 9-12)	316	100	6	0.5	53	396	316	1095
Not Available	67	100	1	0.1	67	87	67	1095
TOTAL	32812	99.9	1095	100	30	22164	32785	1095

The table below summarises the utilisation of annual leave. The wage agreement concluded with trade unions in the PSCBC in 2000 requires management of annual leave to prevent high levels of accrued leave being paid at the time of termination of service.

Table 3.8.3 Annual Leave

Salary Band	Total days taken	Number of Employees using annual leave	Average per employee
Lower skilled (Levels 1-2)	103098.01	21	4960
Skilled (Levels 3-5)	295900.93	21	14093
Highly skilled production (Levels 6-8)	193128.22	21	9087
Highly skilled supervision (Levels 9-12)	186094.53	22	8336
Senior management (Levels 13-16)	4806.04	20	241
Contract (Levels 1-2)	6625.92	14	488
Contract (Levels 3-5)	1424	18	78
Contract (Levels 6-8)	9949	15	663
Contract (Levels 9-12)	11956.44	16	728
Contract (Levels 13-16)	1003	16	62
Not Available	4.32	4	1
TOTAL	813990.41	21	38737

Table 3.8.4 Capped leave

Salary Band	Total days of capped leave taken	Average number of days taken per employee	Average capped leave per employee as at 31 December 2012	Number of Employees who took capped leave	Total number of capped leave at 31 December 2012	Number of Employees as at 31 December 2012
Lower skilled (Levels 1-2)	172	4	55	42	54389	985
Skilled (Levels 3-5)	1343	6	70	224	265427	3794
Highly skilled production (Levels 6-8)	1313	7	92	201	287232	3136
Highly skilled supervision (Levels 9-12)	1915	6	99	320	438469	4409
Senior management (Levels 13-16)	4	2	82	2	6854	84
Contract (Levels 1-2)	17	17	78	1	2094	27
Contract (Levels 3-5)	3	3	118	1	6110	52
Contract (Levels 9-12)	5	5	123	1	3197	26
Contract (Levels 13-16)	4	1	82	3	1237	15
TOTAL	4776	6	85	795	1065009	12528

The following table summarise payments made to employees as a result of leave that was not taken.

Table 3.8.5 Leave payouts

Reason	Total Amount (R'000)	Number of Employees	Average per employee (R'000)
Capped leave payouts on termination of service for 2012/13	9,433	982	9606
Current leave payout on termination of service for 2012/13	9	17	529
TOTAL	9442	999	9451

3.9. HIV/AIDS & Health Promotion Programmes

Table 3.9.1 Steps taken to reduce the risk of occupational exposure

Units/categories of employees identified to be at high risk of contracting HIV & related diseases (if any)	Key steps taken to reduce the risk
<p>All Clinical, Clinical Support, Emergency Medical Services, Forensics, Maintenance, Laundry Staff Refuse Collectors and General Assistants at medical service delivery points: these categories of staff are at high risk of exposure to HIV, TB and other communicable diseases through direct contact with infected patients, body parts and body fluids. The mode of infection includes cuts, needle pricks, handling of infected body parts and fluids and soiled linen and utensils, breathing infected air.</p>	<p>Standard / Universal Precautions for infection control, Needle Prick protocol, Post Exposure Prophylaxis, Protective Barriers /Equipment and Personal Protective clothing – clothing, gloves, masks, eye wear, etc.</p> <p>Other interventions include:</p> <ul style="list-style-type: none"> • Staff training on infection control and standard / universal precautions • Warning signage • Reporting and investigation of occupational exposures • Education on sharps disposal. • Monitoring proper use of Personal Protective Clothing and equipment

Table 3.9.2 Details of Health Promotion and HIV/AIDS Programmes (tick the applicable boxes and provide the required information)

Question	Yes	No	Details, if yes
1. Has the department designated a member of the SMS to implement the provisions contained in Part VI E of Chapter I of the Public Service Regulations, 2001? If so, provide her/his name and position.	YES		Miss T Govender: Senior Manager: Employee Wellness
2. Does the department have a dedicated unit or has it designated specific staff members to promote the health and well-being of your employees? If so, indicate the number of employees who are involved in this task and the annual budget that is available for this purpose.	YES		The EW Unit has 28 designated personnel: 14 at District and Hospital Complexes and 14 at Head Office (including COID unit). The annual budget for this programme was totally inadequate at R300 000 and R643 925 ring-fenced for payment of COID. Services have been delivered within these parameters and with support from other programmes such as HRD and
3. Has the department introduced an Employee Assistance or Health Promotion Programme for your employees? If so, indicate the key elements/services of this Programme.	YES		The EW Sub-programmes include: HIV & AIDS and TB Workplace, Employee Assistance, Occupational Health & Safety, Compensation of Occupational Injuries and Diseases and Sport & Recreation. The Service Package includes: Counselling, Prevention and Education, Consultation, Marketing, Training and Monitoring and Evaluation Activities. Prevention and Education includes: health screening, HIV counselling and testing, sport and recreation activities, Health calendar events, Life Skills (including Financial), Presentations, workshops and distribution of information on various
4. Has the department established (a) committee(s) as contemplated in Part VI E.5 (e) of Chapter I of the Public Service Regulations, 2001? If so, please provide the names of the members of the committee and the	YES		The Provincial EW committee was disbanded in favour of establishing District and Hospital Complex Committees. When this process is complete the Provincial Committee will be re-established with correct
5. Has the department reviewed its employment policies and practices to ensure that these do not unfairly discriminate against employees on the basis of their HIV status? If so, list the employment policies/practices so	YES		All H R policies have been reviewed and comply with the required principles
6. Has the department introduced measures to protect HIV-positive employees or those perceived to be HIV-positive from discrimination? If so, list the key elements of these measures.	YES		Case management and Education Programmes are designed to protect the rights of HIV positive employees.

Question	Yes	No	Details, if yes
7. Does the department encourage its employees to undergo Voluntary Counselling and Testing? If so, list the results that you have achieved.	YES		The EWP has enlisted the assistance of GEMS and participates in the transversal HCT campaign. 101 HCT sessions were held with 3682 employees testing.
8. Has the department developed measures/indicators to monitor & evaluate the impact of its health promotion programme? If so, list these measures/indicators.	YES		Baseline research has been completed to establish: 1. the HIV prevalence to be at 13,9%; 2. Psychosocial Needs and 3. the general health status in terms of blood glucose/ cholesterol/ pressure and Body Mass Index. These indicators will be measured at regular intervals to monitor progress.

3.10. Labour Relations

Table 3.10.1 Collective agreements

Subject Matter	Date
Nil	

The following table summarises the outcome of disciplinary hearings conducted within the department for the year under review.

Table 3.10.2 Misconduct and disciplinary hearings finalised

Outcomes of disciplinary hearings	Number	% of total
Dismissal	16	13
Final written warning	19	15
No outcome	56	45
Suspended without payment	4	3
Counselling	2	2
Verbal Warning	7	6
Written warning	21	17
TOTAL	125	100

Table 3.10.3 Types of misconduct addressed at disciplinary hearings

Type of misconduct (based on annexure A)	Number	% of total
Type of misconduct		Percentage of Total
Absent from work without reason or permission	42	34
Assaults / Attempts or threatens to assault a person	5	4
Performs poorly for reasons other than incapacity	10	8
Possesses or uses property of the state or another person	6	5
Steals, Bribes or commits Fraud	15	12
Under influence of habit-forming/stupefying drug	2	2
Performing work outside Public Service without authorisation	4	3
Damages and or causes loss of state property	1	1
Sexual harassment	3	2
Mismanages the finances of the state	2	2
Fails to carry out lawful order or routine instruction	17	14
Disrespect / Abusive or Insolent Behaviour	3	2
Prejudices the administration or discipline of the state	2	2
Participates in unlawful industrial action	8	6
Conducts self in improper / unacceptable manner	1	1
Intimidates or victimises others	4	3
TOTAL	125	100

Table 3.10.4 Grievances logged

	Number	% of Total
Not resolved	45	90
Resolved	5	10
TOTAL	50	100

Table 3.10.5 Disputes logged

	Number	% of Total
Number of disputes upheld	15	47
Number of disputes dismissed	17	53
Total number of disputes lodged	32	100

Table 3.10.6 Strike actions

	% of Total
Total number of persons working days lost	
Total costs working days lost	
Amount (R'000) recovered as a result of no work no pay	

Table 3.10.7 Precautionary suspensions

	% of Total
Number of people suspended	
Number of people who's suspension exceeded 30 days	
Average number of days suspended	
Cost (R'000) of suspension	

3.11. Skills development

This section highlights the efforts of the department with regard to skills development.

Table 3.11.1 Training needs identified

Occupational Category	Gender	Number of employees as at 1 April 2012	Training needs identified at start of the reporting period			
			Learnerships	Skills Programmes & other short courses	Other forms of training	Total
Legislators, senior officials and managers	Female	2721	0	2177	544	2721
	Male	680	0	544	136	680
Professionals	Female	8254	1651	5778	825	8254
	Male	2064	413	1445	206	2064
Technicians and associate professionals	Female	1965	393	1376	196	1965
	Male	491	98	344	49	491
Clerks	Female	1965	393	1376	196	1965
	Male	415	83	290	42	415
Service and sales workers	Female	720	144	504	72	720
	Male	180	36	126	18	180
Skilled agriculture and fishery workers	Female	0	0	0	0	0
	Male	2	0	2	0	2
Craft and related trades workers	Female	0	0	0	0	0
	Male	0	0	0	0	0
Plant and machine operators and assemblers	Female	11	2	8	1	11
	Male	186	37	130	19	186
Elementary occupations	Female	953	191	667	95	953
	Male	238	48	167	23	238
Gender Sub Total	Female	16589	2774	11886	1929	16589
	Male	4256	715	3048	493	4256
Total		20845	3489	14934	2422	20845

Table 3.II.2 Training provided for the period

Occupational Category	Gender	Number of employees as at 1 April 2012	Training needs identified at start of the reporting period			
			Learnerships	Skills Programmes & other short courses	Other forms of training	Total
Legislators, senior officials and managers	Female	1892	0	1513	379	1892
	Male	375	0	236	139	375
Professionals	Female	8328	0	6617	1711	8328
	Male	2266	0	1654	612	2266
Technicians and associate professionals	Female	2514	2514	0	0	2514
	Male	1354	1354	0	0	1354
Clerks	Female	2522	924	26	1572	2522
	Male	870	231	6	633	870
Service and sales workers	Female	0	0	0	0	0
	Male	0	0	0	0	0
Skilled agriculture and fishery workers	Female	0	0	0	0	0
	Male	0	0	0	0	0
Craft and related trades workers	Female	0	0	0	0	0
	Male	0	0	0	0	0
Plant and machine operators and assemblers	Female	17	0	17	0	17
	Male	7	0	7	0	7
Elementary occupations	Female	385	287	98	0	385
	Male	725	72	653	0	725
Gender Sub Total	Female	15658	3725	8271	3662	15658
	Male	5597	1657	2556	1384	5597
Total		21255	5382	10827	5046	21255

3.12. Injury on duty

The following tables provide basic information on injury on duty.

Table 3.12.1 Injury on duty

Nature of injury on duty	Number	% of total
Required basic medical attention only	133	75.6
Temporary Total Disablement	43	24.4
Permanent Disablement	0	0
Fatal	0	0
Total	176	100%

3.13. Utilisation of Consultants

Table 3.13.1 Report on consultant appointments using appropriated funds

Project Title	Total Number of consultants that worked on project	Duration Work days	Contract value in Rand
PriceWaterhouse Coopers - finalization of tasks which had been started by the Consortium prior to 14th September 2012			4,919,901.00
I Chain Project	4	12 months	9,554,105.53
Neil Laverlott	1	12 months	500,000.00
EOH consulting - Provision of Movable Asset Management support services for a period of 3 months	2	3 months	1,102,635.00
Consultants for the Multi Agency Work Group (MAWG) SCM Reform Pilot Project	6	24 months	9,233,194.29
Total number of projects	14	51+	25,309,835.82

Table 3.13.2 Report on consultant appointments using Donor funds

Project Title	Total Number of consultants that worked on project	Duration Work days	Donor and Contract value in Rand

Total number of projects	Total individual consultants	Total duration Work days	Total contract value in Rand

Table 3.13.3 Analysis of consultant appointments using Donor funds, in terms of Historically Disadvantaged Individuals (HDIs)

Project Title	Percentage ownership by HDI groups	Percentage management by HDI groups	Number of Consultants from HDI groups that work on the project

PART E



FINANCIAL INFORMATION

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

ACCOUNTING OFFICER REPORT
for the year ended 31 March 2013

TABLE OF CONTENTS

Report of the Accounting Officer	329
Report of the Auditor-General.....	356
Appropriation Statement.....	365
Notes to the Appropriation Statement	387
Statement of Financial Performance	391
Statement of Financial Position.....	392
Statement of Changes in Net Assets.....	393
Cash Flow Statement	394
Notes to the Annual Financial Statements (including Accounting policies)	395
Disclosures Notes to the Annual Financial Statements	417
Annexures	438

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3ACCOUNTING OFFICER REPORT
for the year ended 31 March 2013

Report by the Accounting Officer to the Executive Authority and Provincial Legislature of the Republic of South Africa

I. General Review of the state of financial affairs

I.1 Important policy decisions and strategic issues facing the department

I.1.1 Introduction of Non-negotiable Principles

On realizing major challenges related to the failure of some provinces to pay for basic and critical services during the course of the year like vaccines, laboratory tests etc, the National Health Council (NHC) resolved to introduce the Non-negotiable principle. The principle was introduced to ensure that this challenge is fully addressed by implementing a system of continuous monitoring, reporting and accountability. The important aspect of this intervention is to ensure that at planning stage the non-negotiable elements have identified (or proxy) financial indicators (with specific SCOA items on BAS) that will be tracked on continuous basis.

List of Non-negotiable Components:

- Infection Control and Cleaning
- Medicines, Medical Supplies including Dry Dispensary
- Medical Waste
- Laboratory Services: National Health Laboratory Services (NHLS)
- Blood Supply and Services: South African National Blood Services (SANBS)
- Food Services and Relevant Supplies
- Security Services
- Laundry Services
- Essential Equipment and Maintenance of Equipment
- Children Vaccines

The NHC has stipulated quarterly reporting to NHC Technical Advisory Committee (TAC) as part of monthly Budget & Conditional Grant reporting. Further engagement with National Treasury is earmarked at ensuring the necessary additional technical support on additional Health Sector specific line items. Impacting on the developments of Annual Performance Plans for 2013/14 – 2015/16 new non-financial indicators are being developed to ensure complete reporting (financial & non-financial).

I.1.2 Implementation of NHI District Pilots

The National Health Insurance (NHI) strategic

intervention remains key in the overall transformation of our healthcare services and the success of these pilots will be absolutely critical. In the reporting period the first tranche of resource allocation in the form of R11.5million towards the NHI Conditional Grant was allocated.

The purpose of the NHI Grant was:

- To test innovations necessary for implementing National Health Insurance
- To improve access to quality Health services
- To establish district health authorities that will be the contracting agencies for the delivery and provision of health services within a strengthened district health system
- To undertake health system strengthening initiatives in selected pilot districts
- To support selected pilot districts in implementing identified service delivery interventions

The first year of performance has mainly focused on communication with critical stakeholders including municipalities, community and governance structures, academic and provider structures and individuals like GPs. The department further consolidated its planning including the development of District NHI Master Plan that cover all important issues even beyond the Conditional Grant business Plan.

On the implementation front there was wide spread mobilization of support and technical contribution from NGO sector organizations, the provincial office and spearheaded drive from the National DOH in the form of Facility Implementation Teams. Already most GPs have shown interest and enthusiasm in partaking on the GP contracting model. The 2013/14 Financial Year will see further tangible consolidation of these plans into implementable programs.

The intention of government is to pilot the NHI for the next five years. During this period, the implementation of this initiative will be aligned and integrated into the broader plans to achieve the targets of the National Development Plan (Vision 2030)

I.2 Significant events that have taken place during the year

Fleet Management Services: The department entered into an agreement with Government Fleet Management Services (GFMS), a trading entity, of the Department of

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3ACCOUNTING OFFICER REPORT
for the year ended 31 March 2013

Transport for the provision of Fleet Services to the Department. The agreement will continue for an indefinite period.

1.3 Major projects undertaken or completed during the year

In the year under review, the Department continued with the implementation of major projects through its implementing agents of Coega Development Corporation and the Department of Roads and Public Works.

Progress made in each of these projects during the 2012/13 financial year is as follows:

Remarkable progress is being made in **Cecilia Makiwane Hospital**. To date a fully functional laundry has been constructed. A new mortuary is now functioning. Completion of the main hospital is expected on the 01 December 2014 at a cost of R935,0 million. Approximately 1 600 work opportunities have been created in Cecilia Makiwane to date.

300 Student Units in **Cecilia Makiwane Hospital** are now occupied, having cost approximately R110,0 million;

In the case of **St Patricks Hospital** 356 work opportunities have been created. The project scope in this hospital involves construction various areas and is costing the department R347,0 million. The project will be completed in October 2014.

Livingstone Oncology Services Unit has been completed at a cost of R70,0 million.

In respect of **Frere** Oncology and support medical services, a project costing the department R167,0 million is expected to be completed before the end of the 3rd quarter in the 2013/14 financial year. The project includes new medical wards, adult ICU and high care, paediatrics ICU and high care, oncology unit, neurosurgery unit, chemotherapy and a maxio facial unit.

Renovations and Repairs of **Primary Health Care** facilities have and continue to receive priority in the year under review and 2013/14. The focus has shifted from new facilities and is now firmly on maintaining the existing ones. To this extent, general maintenance work in Hospitals such as Cala, Elliot, Cloete Joubert, Tafalofefe,

Nelson Mandela Academic, Komani, and Fort Beaufort hospitals are on going. Furthermore, 222 clinics covering the entire Province are being repaired and renovated. The estimated cost of this programme is R240,0 million.

In the year under review, the department approved a new organogram for the Infrastructure Unit. The emphasis of this organogram was on the appointment of qualified registered built environment professionals. An amount of R10,0 million was ring fenced for purposes of recruiting such professionals. Fourteen positions were advertised and applications were received for eleven positions. Interviews were conducted and only six candidates were found to be suitable.

Nursing Colleges Satellite Campuses are now part of the provincial infrastructure portfolio. In the year under review, extensive building repair works including the provision of learning structures were undertaken in five satellite campuses. These are Andre Vosloo, Port Elizabeth, East London, All Saints Hospital and Queenstown. All of this work will be completed during the second quarter of the 2013/14 financial year.

Temporary accommodation – the department started installing 52 temporary accommodation structures in various facilities in the Province. Of these, 33 are two bed room units and 19 single bed units. This process will be completed during the first quarter of 2013/14 financial year.

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

Four Hospitals have received **X-Ray equipment**. Amongst these, are Madwaleni, Gompo, Bambisana and Mount Ayliff.

Upgrade of St Elizabeth Hospital – focus has been the construction of the main hospital complex and finishing of the Resource Centre. This is a 4 year programme and is estimated to cost the department R740,0 million.

Upgrade of Komani Hospital – upgrading of this hospital is progressing well and is expected to be completed before 30 September 2013.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3ACCOUNTING OFFICER REPORT
for the year ended 31 March 2013

I.4 Spending Trends

The table below shows the high level financial performance of the department at the end of the financial year. Detailed performance by Programme is shown in the Appropriation Statement in the Annual Financial Statements.

Adjusted Budget	Expenditure	Variance	Expenditure as a % of Budget
R'000	R'000	R'000	
15,734,550	15,602,512	132,038	99.2

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

The Department overall under-spent its budget allocation by R132,04 million. The under spending emanates primarily from three economic classification categories: current payments, which overspent budget by a net R10,18 million; buildings and other fixed structures by R56,39 million and machinery and equipment by R77,13 million.

The department has applied for Conditional Grants funds totalling R134,051 million - appropriated but not spent in the 2012/13 financial year, to be rolled over to the 2013/2014 financial year. The request for roll over is supported by commitments where capital expenditure and goods & services had been delivered or rendered and therefore funds were committed and the department is either awaiting submission of invoices by suppliers or invoices had been received but will be paid in the next financial year.

The decreased spend on COE is attributable mainly to the control measures / control measures put in place by the OTP and Provincial Treasury on the filling of vacant posts.

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

It is historically known that the Department of Health has been under severe financial pressure over several years. This situation has been caused by inter alia, the magnitude of the current service delivery platform, growth in the burden of disease provincially, top slicing of the budgets,

various unfunded and underfunded mandates as well as limitations in the adequate management of cost of employment. The objectives of the department for 2012/13 have accordingly been largely negatively impacted on.

To address most of these challenges, the department has confirmed the centrality of government driven transformation with financial resources that are directed to the neediest areas in terms of services.

The department continues to be deeply involved in extensive turnaround processes. Accordingly, the baseline realignment exercise is currently in progress with various turnaround implementation plans. The impact thereof is still work in progress (with the impact yet to be quantified on the MTEF).

Programme 1: Administration - Under expenditure of R0,43 million

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

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

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

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

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**ACCOUNTING OFFICER REPORT**
for the year ended 31 March 2013

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

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

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

Programme 4: Provincial Hospital Services - Under expenditure of R3,94 million

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

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

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

The under-spending in machinery & equipment of R40,06 million is attributable to inter alia the delays in the delivery of various items of medical equipment, such as MRI scanners, purchased within the hospital complexes in the Province. The under expenditure in building and other fixed structures relates to fencing in Fort England Hospital.

Programme 6: Health Sciences & Training - Under expenditure of R58,67 million

The programme has an under spending of R58,67 million. Under expenditure occurred mainly in compensation of employees by R32,48 million, goods and services by R21,12 million, transfers to universities and technikons

by R2,38 million and machinery and equipment by R2,61 million.

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

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

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

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

The main contributor to this underspend is compensation of employees.

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

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

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

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

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3ACCOUNTING OFFICER REPORT
for the year ended 31 March 2013

I.5 Virement

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

PROGRAMMES	TOTAL VIREMENTS	REASON FOR THE VIREMENT
	R'000	
ADMINISTRATION		
Compensation of Employees	(7 202)	Delays in the appointment of personnel due to strict measures imposed by the OTP and Provincial Treasury have resulted in "under spending" on this line item. The amount will be used to defray over expenditure in goods and services in programme 2.
Households	(2 042)	Inability to spend allocation due to insufficient information provided by beneficiaries of leave gratuity funding resulted in under-spending on this line item. This amount will be used to defray overspending on the same line item in programme 4.
Machinery and equipment	3 498	Amounts of R1,890 million and R1,608 million received from programmes 3 and 6 respectively from the same line item will be used to defray over expenditure in this programme.
DISTRICT HEALTH SERVICES		
Goods and Services	218 265	The combined amounts of R218,265 million received from Programmes 1, 3, 4, 6 and 7 will be used to re-imburse municipalities for costs incurred whilst the finalization of the provincialisation of municipal clinics was being thrashed out. Payments to SANBS, DOT (for white fleet) and Municipalities for municipal services will also be effected.
Households	(2 648)	Inability to spend allocation due to insufficient information provided by beneficiaries of leave gratuity funding resulted in under-spending on this line item. This amount will be used to defray overspending on the same line item in programme 4.
EMERGENCY MEDICAL SERVICES		
Compensation of Employees	(37 731)	Delays in the appointment of personnel due to strict measures imposed by the OTP and Provincial Treasury have resulted in "under spending" on this line item. The amount will be used to defray over expenditure in goods and services in programme 2
Goods and Services	(17 149)	Under-spending is due to delays in the delivery of ambulances by the Department of Transport. This amount will be used to defray over expenditure in goods and services in programme 2
Machinery and equipment	(1 890)	Non-delivery of equipment resulted in under spending. This amount will be used to defray over expenditure in the same line item in programme 1.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3ACCOUNTING OFFICER REPORT
for the year ended 31 March 2013

PROGRAMMES	TOTAL VIREMENTS	REASON FOR THE VIREMENT
	R'000	
PROVINCIAL HOSPITAL SERVICES		
Compensation of Employees	(125 894)	Delays in the appointment of personnel due to strict measures imposed by the OTP and Provincial Treasury have resulted in "under spending" on this line item. The amount will be used to defray over expenditure in goods and services in programme 2
Households	4 690	Amounts of R2,042 million and R2,2648 million received from programmes 1 and 2 respectively from the same line item will be used to defray over expenditure in this programme.
HEALTH SCIENCE & TRAINING		
Compensation of Employees	(22 966)	Delays in the appointment of personnel due to strict measures imposed by the OTP and Provincial Treasury have resulted in "under spending" on this line item. The amount will be used to defray over expenditure in goods and services in Programme 2
Machinery and equipment	(1 608)	Challenges in supply chain processes resulted in under spending. The amount will be used to defray over expenditure in the same line item in Programme 1.
HEALTH CARE SUPPORT SERVICES		
Goods and Services	(7 323)	The under expenditure in this line item will be used to mitigate over expenditure in goods and services in Programme 2
DEPARTMENT OF HEALTH – VOTE 3		
Compensation of Employees	(193 793)	
Goods and Services	193 793	

1.6 Unauthorised expenditure

The department has for the year under review incurred unauthorised expenditure amounting to R52,449 million in its vote, due to over spending in goods and services in Programme 2 District Health Services, caused primarily through the reimbursement of provincialisation of primary health care claims received from various municipalities and metros.

Unauthorised expenditure as at 31 March 2013 amounts to R1,358,263 billion and is cumulative from the 2009/10 – 2012/13 financial years.

Eastern Cape Finance Act (2013): In terms of the Eastern Cape Finance Act (2013), the Department's unauthorised expenditure totalling R1,286 billion

(2011/12 (R297,6 million), 2010/11, (R116,4 million) and 2009/10 (R871,9 million)) has been condoned with funding.

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

1.7 Irregular Expenditure

During the year irregular expenditure of R255,552 million was identified and relates to the contravention of the Supply Chain Management procedures and the expired contract for psychiatric services which is deemed irregular expenditure in terms of Sections 38 (1) (g) and 45 of the PFMA.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3ACCOUNTING OFFICER REPORT
for the year ended 31 March 2013

Further, an application for condonation was made to the Interim Bid Advisory Committee in the Provincial Treasury in relation to Life Care irregular expenditure and finance leases. These matters remain unresolved and are currently being handled by the department and the Provincial Treasury.

Condonation of irregular expenditure incurred as a result of irregular appointment of foreign doctors will be sought from the DPSA as well as irregular expenditure which is as a result of over expenditure on COE will be sought from the Provincial Treasury. All these processes will be finalised during the 2013/2014 financial year.

1.8 Fruitless and wasteful expenditure

Fruitless and wasteful expenditure amounting to R127,854 million was identified during the year and of this amount, R108,288 million relates mainly to medico - legal claims and the balance is in respect of interest, damages and abuse of vehicles paid to Fleet Africa, infrastructure suppliers and other service providers as a result of late payment.

R28,014 million incurred in the previous years was condoned and written off in the current financial year. Disciplinary and recovery processes are in progress and this is being monitored by the Financial Misconduct Disciplinary Committee.

Condonation or disciplinary action on the balance of cases of fruitless and wasteful expenditure is being considered by the committee.

2. Services rendered by the department:

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

Programme 1: Administration

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

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

Management: This sub-programme is responsible for the management of human, financial, information and infrastructure resources. It is made up of the Office of the Superintendent General and the policy, strategic planning, co-ordination and regulatory functions of the head office located in the different clusters i.e. Clinical, Corporate and Financial Services

Programme 2: District Health Services

To ensure delivery of Primary Health Care services through the implementation of the District Health System. This Programme has nine sub-programmes with the following objectives:

- **District Management** manages the effectiveness and functionality of seven districts and municipalities within the social needs cluster, especially in ISRDP, URP nodes and the identified twelve poorest municipalities; co-ordination of health services, referrals, supervision, evaluation and reporting as per Provincial and National policies.
- **The Community Health Clinics** sub-programme manages the provision of preventive and curative care and priority health programme implementation through accessible clinics and mobile services in twenty four sub-districts.
- **The Community Health Centres** sub-programme renders twenty-four hour health services, maternal health at midwifery units and the provision of trauma services as well as the integration of community based mental health services within the down referral system.
- **The Community Based Services** sub-programme manages the implementation of the community based health services framework.
- **The Other Community Services** sub-programme manages the devolution of MHS to the municipalities and implements a 'port health' strategy to control the spread of communicable diseases through ports of entry in the Eastern Cape Province; provides oral health services at a community level (including schools and old age homes); strengthens the traditional health services through health education campaigns for role players; prevention of substance, drug, and alcohol abuse to reduce unnatural deaths and geriatric services as a supportive and rehabilitation service.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3ACCOUNTING OFFICER REPORT
for the year ended 31 March 2013

- The **HIV/Aids** sub-programme renders primary health care services in respect of the prevention of HIV and Aids infections through campaigns, continuous care, management and treatment (CCMT) and strengthening the accreditation process of ART sites for accessibility.
- The **Nutrition** sub-programme renders nutrition services as a poverty alleviation program, providing nutrition supplements including inter alia Vitamin A, Iodine, Zinc aimed at specific target groups (children, pregnant mothers, & the aged) to address malnutrition; provision of formula feeds for health facilities; establishment of food gardens at clinics, CHCs & hospital gardens and assisting communities to start the community gardens in consultation with the Department of Agriculture to fight poverty.
- The **Coroner Services** sub-programme renders forensic pathology services in order to establish the circumstances and causes surrounding un-natural deaths.
- The **District Hospitals** sub-programme is to provide a comprehensive and quality district hospital service to the people of the Eastern Cape Province.

Programme 3: Emergency Medical Services

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

- Rendering emergency medical services including ambulance services, special operations, communications and air ambulance services.
- Rendering planned patient transport including local outpatient transport (with the boundaries of a given town or local area) and inter-city/town outpatient transport (into referral centres).

Programme 4: Provincial Hospital Services

The objective of this programme is to provide cost effective, good quality effective and efficient secondary hospital services. The programme has three sub-programmes with the following objectives:

- **General (Regional) Hospitals:** Rendering of hospital services at general specialist level and providing a platform for research and the training of health workers

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

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

Programme 5: Central Hospital Services

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

Programme 6: Health Sciences and Training

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

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

Programme 7: Health Care Support Services

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

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3ACCOUNTING OFFICER REPORT
for the year ended 31 March 2013

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

Programme 8: Health Facilities Management

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

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

2.1 Tariff policy

Health Services tariffs are determined by the National Department of Health (NDoH) for all the provinces through the implementation of the Uniform Patient Fees Schedule (UPFS).

The Department's tariffs in respect of H1 patient categories differ from those set by NDoH in respect of services rendered at facility level 3 and also in respect of services rendered by a Specialist. This is because the Department implemented UPFS four years after it was introduced as a national Policy. A phased approach is being followed to avoid drastic tariff increases.

The tariffs applicable to externally funded patients, is an "undiscounted" tariff that applies to patients who are covered by medical schemes, persons injured in motor vehicle accidents (Road Accident Fund) and other state departments (Department of Justice, South African Police, Correctional Services) and patients injured on duty.

Patients, who do not have external funding, pay a discounted fee. The discount for patients that are formally unemployed or on social grants (H0) receive free health care (100% subsidy); patients earning below R37,000 per annum (H1) receive a subsidy of approximately 90%; patients who earn between R37,000 and R72 000 (H2) – the subsidy varies according to services rendered, ranging from 35% to 90%.

Self – funded patients (H3) exceeding the means test, receive on average a 25% subsidy.

The department increased patient tariffs to the externally funded patient fees by 5.4% in the year under review.

2.2 Free Services

The mandate of the Department of Health is to provide health care services to the citizens of this country, in exercising that mandate and in terms of policy there are circumstances under which patients will receive services free of charge independently of their classification as full paying or subsidized patients. Such circumstances include infectious, formidable diseases, pregnant women and children. Also patients classified under H0 category receive free services. It is not possible to quantify the cost of the free services rendered.

Elective healthcare services do not qualify as free services and patients are required to pay the "undiscounted" UPFS fee.

2.3 Inventories

Refer Note 12 hereunder

3. Capacity control measures

The Department has faced severe budgetary control measures which have resulted not only in over-expenditure but also a threat of not delivering adequate services in facilities. Details of over-expenditure and deferment of non-critical work is explained in the programmes. The department continues to work closely with the National Department of Health and Provincial Treasury to find solutions to this challenge.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**ACCOUNTING OFFICER REPORT**
for the year ended 31 March 2013

The capacity control measures of the Department to fulfil its mandate by way of provision of core health professionals was constrained by several factors.

These included the application of austerity measures in order to manage the cost of employment (COE) budget. The authority and functions to appoint was taken away and handed to the Provincial Treasury and this placed severe control measures on the ability of the Department to recruit and replace key health professionals and core support staff.

Funding control measures left the department unable to recruit core critical personnel. Besides the moratorium on the appointment and replacement of staff, there proved to be severe control measures in terms of capacity (knowledge, skills and attitudes) at both Head Office and District levels.

The combined effect of the above variables resulted in critical staff members not being appointed which had a direct impact on healthcare service delivery.

At year end, the department has an overall vacancy rate of 16.16%, summarised as:

- Clinical Service posts 20.43% vacant
- Clinical Support 11.02% vacant
- Admin and Management 9.46% vacant

Financial management in the department remains a huge challenge due to lack of qualified, skilled and competent finance personnel mainly at operational level as well as fragmented and non-integrated systems.

As a result of lack of integrated systems the department has had to implement a number of compensating manual systems to consolidate financial information from districts and various units including information for the preparation of annual financial statements. The risk of human error associated with use of manual system exists.

4. Utilisation of donor funds

The following are the Department's National and International donors:

4.1 Japanese International Development Cooperation Agency (JICA)

JICA supported a project to strengthen medical equipment maintenance management. The funding is in the form of a technical assistant (personnel) based in

the Department to assist with the development of a model on the maintenance and management of medical equipment. The Department does not take responsibility for the financial implications incurred by the technical assistant. The support has been effective since it is mainly the transfer of skills from the Japanese medical equipment expert to the local personnel.

4.2 Sabona Foundation – (formerly The Fred Hollows Foundation – South Africa)

A Memorandum of Agreement (MOU) was entered into between the department and the “The Fred Hollows Foundation of South Africa” to create a sustainable eye care programme that ensure rendering of a comprehensive eye care service package consistent with the level of care of each partner institution in the Eastern Cape Province. The foundation operates in five sites, St Elizabeth Hospital; Frontier Hospital; East London Complex; PE Complex; and these form the critical part of the province's five eye care nodal points of the foundation.

The programme provides comprehensive eye care services and includes high volume cataract surgery, glaucoma and refractive error, training of doctors and nurses in cataract surgery; hospital-based outreach services provided by the ophthalmologists and community-based outreach services aimed at primary health care services .

An addendum to the MOU incorporates the optic laboratory for the cutting of lenses at the Frontier hospital Sabona Sonke eye care centre ,

4.3 Chamber of Mines of South Africa

The Chamber of Mines initiated a project for the “Ex-mineworkers” to strengthen the ability of various hospitals to offer medical examinations to ex-mineworkers and the project was first rolled out to Sir Henry Elliot hospital. The project is for a period of two years from ending in May 2013.

As part of the agreement, the Chamber of Mines will provide equipment and services for the use of the new occupational health centre in Sir Henry Elliot hospital, second certain staff to the hospital including an occupational health nurse and an administrative assistant.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3ACCOUNTING OFFICER REPORT
for the year ended 31 March 2013**4.4 Foundation for Professional Development**

The foundation for Professional Development is a project that provides human resources and operating support at specific HIV/AIDS/TB/VCT sites to complement the existing resources of the department with the aim of increasing the number of people being treated for HIV, receiving support of wellness programmes and receiving ART or TB treatment.

4.5 Italian Co Operation

The department entered into an agreement with the Italian Co Operation. The project focuses on Communicable Diseases, especially on TB, HIV and AIDS.

As part of the Technical support, the Italian Co Operation donated equipment to OR Tambo to support TB HIV& Aids activities. It has also donated four motorvehicles for the TB outreach programme.

The other donated equipment includes two additional vehicles which are in the process of being accepted by the Superintendent General.

4.6 European Union

The European Union has a long standing partnership with the department which spans over a number of years for the delivery of primary health care programme. Funds received from the donor were utilised towards strengthening delivery of primary health care services supporting Non Profit Organisations (NPO) who have partnered with the department to provide primary health care services.

5. Trading entities and public entities

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

6. Organisations to whom transfer payments have been made

The department utilises various institutions, government entities, Universities, technikons and CBOs as vehicles to deliver services to the communities of the province. The nature of services to be rendered and relationship with these organisations is governed by Service Level Agreements. During the year under review, the department transferred R134.13 million to Hospices, Universities and

technikons and to Municipalities. Details on these transfer payments are given in Annexures IC, ID and IB respectively of the Annual Financial Statements section.

Funds were transferred to various Universities and technikons for the provision of Health Sciences, Training & Development. Municipalities received funds for the devolution of environmental health. The department monitored these institutions / entities to ensure that the allocated funds were spent as planned and detailed in the Service Level Agreements.

Other than transfer payments to the Walter Sisulu University, the Department obtained assurance from each entity that received a transfer, that the entity implements effective, efficient and transparent financial management and internal control systems, as required by TR 18.3.1 (c).

The Walter Sisulu University (WSU) has been funded extensively from the Health Professions Training and Development Grant (HPTDG) using multiple service level agreements (SLAs) over several years in order to strengthen the Faculty's under- and post-graduate programmes to unpin the departments human resource needs, particularly in rural communities.

Three SLAs were concluded under this partnership. The first and largest funded the Faculty in a variety of ways from a Joint Staff Establishment to operational costs related to registrar rotations, conferences and journals. The second SLA funded the four Health Resource Centres operational costs. The third and most recent funded the establishment of a Medical Orthotics and Prosthetics programme. Transfer payments to WSU represented between 80-85% of the total HPTDG budget.

The Department observed non-compliance by WSU to the requirements of their SLAs, in particular financial reporting, resulting in increased pressure on the ECDoH to enforce Sections 38(i) J&K of the Public Finance Management Act in keeping with the responsibilities and expectations of the Accounting Officer, the National Department of Health and Auditor General.

At all material times, the funding provided by the Department of Health was ring fenced and governed by legislation including the Division of Revenue Act, Public Finance Management Act and Treasury Regulations.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**ACCOUNTING OFFICER REPORT**
for the year ended 31 March 2013

It has now become apparent from draft financials recently submitted to the Department, that the University has loaned to itself a substantial amount of money from the Health Professions Training and Development Grant (HPTDG) Health Professional Training and Development Fund in order to meet several of its other operating expenses.

In acting as aforesaid and utilising the funding contrary of the provisions of the agreement between the parties, the Walter Sisulu University has breached a material term of the contract between the parties and in so doing has acted wrongfully, unlawfully and contrary to the applicable legislation.

In the circumstances, the Department of Health has demanded that the University repay the amount.

7. Public private partnerships**Humansdorp Hospital Co-Location**

The concession agreement was concluded on 27 June 2003 with Metro Star Hospital Life Healthcare Ltd (previously Afrox Healthcare Ltd). The Public Private Partnership is at Contract Management stage and operations have been running smoothly throughout the financial year.

Upgrading and Refurbishment of the Port Alfred & Settlers Hospitals in Port Alfred and Grahamstown and the establishment of co-located private hospital facilities

The concession agreement was signed on 7 May 2007 and incorporates the Port Alfred and Settlers District Hospitals. The Public Private Partnership is at Contract Management stage and operations have been running smoothly throughout the financial year.

Refer to disclosure note 31.

8. Corporate Governance Arrangements

Details of Corporate Governance Arrangements which include inter alia statements on Risk Management, Fraud & Corruption, Fraud Prevention Policies, Internal Audit, Effectiveness of the Audit Committee and Managing Conflicts of Interest are set out in Part C (Governance) of this report.

9. Discontinued activities/activities to be discontinued

For the year under review, no activities were discontinued.

10. New/proposed activities

During the year under review, non-negotiable principles (Refer 1.1.1) were introduced as well as the implementation of NHI District Pilots (Refer 1.1.2).

11. Asset management**11.1 Movable Assets**

The Public Finance Management Act (Act 1 of 1999 as amended by Act 29 of 1999) and Treasury Regulations stipulate that the department must manage and safeguard its assets, this entails amongst other things maintaining Fixed Assets Registers where all assets are recorded.

The department has and maintains asset registers for all 1,150 institutions, facilities and administration offices.

Newly acquired assets are bar coded and taken into the asset register at cost. Reconciliations between BAS and the fixed asset register is performed on a monthly basis. This exercise ensures that all assets procured are accounted for.

The challenge with asset management however is that despite the existence of fixed asset registers completeness thereof has been found to be a weakness. The Auditor-General has raised findings on the existence of assets due to some assets that are on the floor but could not be found in the asset register and vice versa.

In order to address these weaknesses the department has embarked on a project to conduct comprehensive asset verification at institutions. The National Department of Health (NDoH) procured the services of a service provider to assist provinces with the rectification of audit qualifications resulting from asset management.

The department is participating in the NDoH project. The asset verification project commenced in February 2012. Three Asset management teams were

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**ACCOUNTING OFFICER REPORT**
for the year ended 31 March 2013

responsible for clustered districts. The training of teams occurred in the areas of barcoding, standard asset descriptions, tagging of assets, scanning etc, quality assurance and compiling of asset registers, perform reconciliations between old asset and new asset registers.

The asset verification project has assisted in ensuring that the department has credible asset register.

11.2 Immovable Assets

The immovable fixed assets register for the department is maintained by the Department of Public Works. However it is important to raise an issue that my Department has full use of these assets.

12. Inventories

Inventory at the end of the year is valued at cost on a First-in-First-out basis (FIFO). The closing stock figures represent inventory counted at the hospitals, depots, Local Service Area (LSA), stores, wards and theatres. Stock holding at the end of financial year amounted to R403,4 million a decrease of 6% from the prior year figure of R423,1 million.

In order for the department to comply with the disclosure requirements integrated inventory management system is a prerequisite. Currently the department does not have an integrated inventory management system and stock is maintained in MEDSAS at the depots, LOGIS and RX Solution at the complexes and manual systems at district hospitals, LSA's, clinics and CHC's. As a result of lack of systems and poor recording it is often difficult to account for medicines issued within the institutions.

The risk of human error is high and internal controls are weak to non-existent in some facilities, district hospitals, LSA's, CHC's and clinics. All of this impact on the completeness and accuracy of figures disclosed in Annexure 5 of the AFS.

13. Events after the reporting date

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

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

14. Information on predetermined objectives

A number of strategic objectives per budget programme were identified and quantified as informed by the Strategic Goals and Objectives of the Department.

Against each strategic objective, the Department crafted Output Performance Indicators, the actual and audited performance, estimated performance and the medium term planned targets.

This Annual Report is therefore written against the determination of implementing and achieving the strategic objectives that are in the Annual Performance Plan of the Department.

The Department has therefore ensured that there is alignment in terms of the strategic objectives and its associated targets between the Strategic Plans, Annual Performance Plans and the budget documents.

The different budget programmes performance as indicated in this annual report provides a report on the department's performance against service delivery objectives and targets as identified in the Annual Performance Plans and budget documents.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3ACCOUNTING OFFICER REPORT
for the year ended 31 March 2013

15. SCOPA Resolutions

In respect of the Report of the Auditor-General on the financial statements of Vote 3 – Department of Health for the year ended 31 March 2012, the Department received written correspondence dated 2 May 2013 containing the resolutions/recommendations, adopted by the House communicated in terms of Rule 203(I).

Reference to previous audit report and SCOPA resolutions	Subject	Findings on progress
Report of the Auditor-General on the financial statements of Vote 3 – Department of Health for the year ended 31 March 2012	The Department must take appropriate steps to address all the audit findings as contained in the audit report for the 2011/2012 financial year and report quarterly to the Committee, the Audit Committee and the Provincial Treasury on the progress made.	Refer Note 13 of this report
	All Portfolio Committees must make follow-ups in their committee meetings on the progress being made by the departments in addressing audit queries.	The Accounting Officer of Health will liaise with the Chairperson of the Portfolio Committee for Health and in respect of this resolution
	Disciplinary actions must be taken against all the officials of the Department responsible for the findings as required in terms of section 38(I)(h) of the Public Finance Management Act.	The Department has established the Financial Misconduct Disciplinary Committee, which is chaired by Chief Financial Officer and includes labour relations officials. Disciplinary actions are being taken against officials who have transgressed, through the committee.
	The Department must ensure that all critical posts are filled as soon as possible with permanent incumbents.	The Department's annual recruitment plan for 2013/14 has been approved and is currently being implemented.
	The Committee must be allocated enough time to meet quarterly with the Provincial Treasury and the Audit Committee to review progress made by the Department in addressing the audit findings.	The Accounting Officer of Health will liaise with the Chairperson of SCOPA in respect of this resolution
	The Department may be called to appear quarterly before the Committee to account when necessary.	The Department will furnish the Committee with quarterly progress reports on the implementation of the audit rectification plan / self assessment tool
	All the unauthorised, fruitless and wasteful, and irregular expenditures as well as violation of the supply chain procedures should be identified and dealt with immediately by the Department and should be reported to the Provincial Treasury quarterly.	The Department has established the Financial Misconduct Disciplinary Committee, which is chaired by Chief Financial Officer and includes labour relations officials. Disciplinary actions are being taken against officials who have transgressed, through the committee. The Department will report to the Provincial Treasury quarterly

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

ACCOUNTING OFFICER REPORT
for the year ended 31 March 2013

Reference to previous audit report and SCOPA resolutions	Subject	Findings on progress
	The payment of the performance bonuses should be aligned to the audit report of the Department.	The Department is currently attending to the implementation of this resolution.
	The Department must ensure that all managers at hospitals, district offices and regional offices are accountable for the non-compliance with the provisions of the Public Finance Management Act, Treasury Regulations and supply chain procedures and these matters should form part of their performance agreements.	The performance agreements of SMS members have been amended to incorporate adherence to compliance prescripts.
	Accounting Officers must take disciplinary action against officials responsible for non-compliance with the laws and regulations as stipulated in the Public Finance Management Act, the Treasury Regulations and the Public Service Act.	The Department has established the Financial Misconduct Disciplinary Committee, which is chaired by Chief Financial Officer and includes labour relations officials. Disciplinary actions are being taken against officials who have transgressed, through the committee.
	The Executive Council must hold the Accounting Officers accountable for not implementing disciplinary action against the officials who flout the laws and regulations.	This resolution is being dealt with at the level of the Executive Council.
	The Members of the Executive Council must ensure that they are hands on in the administration of their departments and that repetitive audit findings are completely eliminated from future audits of their departments.	This resolution is being dealt with at the level of the Executive Council.
	Accounting Officers must report properly on the indicators and targets set in the performance plans as approved by the Legislature. Should there be any changes during the year, the Legislature and relevant committees must be informed.	The Accounting Officer is currently ensuring timeous compliance.
	Accounting Officers must take appropriate steps to ensure that financial statements are quality assured to avoid material changes being effected during the audit process.	The Accounting Officer is currently ensuring timeous compliance.
	Accounting Officers must give full cooperation with the audit teams assigned to their departments.	The Accounting Officer is currently ensuring timeous compliance.
	Accounting Officers must curtail the issue of civil servants performing remunerative work without prior authority and that disciplinary action must be taken against such officers.	The Accounting Officer is currently ensuring timeous compliance.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3ACCOUNTING OFFICER REPORT
for the year ended 31 March 2013

Reference to previous audit report and SCOPA resolutions	Subject	Findings on progress
	Accounting Officers must identify unauthorised expenditure, fruitless and wasteful expenditure, irregular expenditure and flouting of supply chain management procedures, and deal with them as required in terms of section 38(1) (h) of the Public Finance Management Act and report on these matters quarterly to the Committee and the Provincial Treasury.	The Department has established the Financial Misconduct Disciplinary Committee, which is chaired by Chief Financial Officer and includes labour relations officials. Disciplinary actions are being taken against officials who have transgressed, through the committee.
	Other Committees of the Legislature should make follow ups in their Committee meetings on the actions taken by their departments to address the audit findings.	This resolution is being dealt with at the level of the other Committees of the Legislature.

16 Prior modifications to audit reports

An action plan to deal with the matters reported in the audit report was developed and implemented and it incorporates matters in the audit report including those noted as important in the management report. Senior managers had the responsibility to provide leadership and guidance, ensure that action plans are implemented and audit issues are resolved. Progress was monitored regularly and reporting done.

An action plan, through the Audit Intervention Plan (AIP), to deal with the matters reported in the 2011/12 audit report was developed and implemented and incorporated qualified matters in the audit report including those noted as important and non-compliance issues in the management report. Senior managers had the responsibility to provide leadership and guidance, ensure that AIP's are implemented and audit issues are resolved. Progress was monitored regularly and reporting done on a monthly basis to Provincial Treasury.

The following are matters that resulted in qualified opinion as well as matters of non-compliance:-

Nature of qualification, qualified opinion; and matters of non-compliance	Financial year in which it first arose	Progress made in clearing/resolving the matter
Qualification Matter Areas		
Irregular Expenditure	2004/05	(1) All monthly registers are being updated to reflect all AG findings as per 2013 Irregular Expenditure register. (2) Dash board, templates and final demand for the submission of registers and payment batches on irregular, unauthorised, fruitless and wasteful expenditure have been completed as per status report. (3) Register are updated to reflect all actions taken as prescribed by the legislative framework.. (4) Completed applications for condonation and write off of the remaining cases of Irreg Expenditure for the 2010/2011 financial year of which approvals have been obtained and filed accordingly.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3ACCOUNTING OFFICER REPORT
for the year ended 31 March 2013

Nature of qualification, qualified opinion; and matters of non-compliance	Financial year in which it first arose	Progress made in clearing/resolving the matter
Movable tangible capital assets and minor assets	2007/08	(1) Established dedicated asset verification team and district coordinators. (2) Conducted training on asset verification team. (3) Conducted workshops for Chris Hani, Alfred Nzo, Mthatha Complex, Joe Gqabi & Mthatha Depot, Cacadu, PE Complex & OR Tambo iro district support to ensure compliance and monitoring. (4) Any asset purchased that does not meet the NT minimum requirements is uploaded in the register. (5) Head Office Committee has been appointed. Most of District Control Committees have not been appointed. However in the workshops districts were reminded that losses will not be adjudicated without district committee's recommendations. (5) Institutions that have verified recorded at RI have been quantified and fair market valued. Supporting documents are available. An asset valuation model has been developed and after verification, all assets that do not have financial information are currently valued. (6) A new process flow has been drafted and all districts informed through workshops and training iro all assets in the district asset registers are included in the consolidated asset register. (7) A standard operating procedure has drafted to ensure completeness. (8) Structure contained in the SCM reform programme in the context of HUBS as well as with the overall departmental organisational review process which is also now awaiting PT's revised structure so that the lead may be taken from PT from an SCM point of view.
Commitments	2009/10	(1) Commitments from the two systems are reconciled to ensure completeness. (2) Capital Commitments - The supporting documents are sourced and restatement figures will be submitted in November. The challenge for the department was substantiating the professional fee estimate as disclosed. An estimate was prepared based on industry norms and the newly development Accounting policy for capital infrastructure commitments. The department will hold workshops with the auditor general on the policy to ensure that the challenges faced in this audit are avoided going forward. The department will engage the Eastern Cape Department of Roads and Public works to assist the department with these variation orders as the Head of the Variation committee is a delegated DRPW official. A list of all the relevant Variation Order has been provided to DRPW and they are responsible to provide the proof that these variation orders are in fact approved.
Accruals	2008/09	(1) All invoice received are added on Logis system before being submitted to reconciliation section. (2) A comparison of Logis report and manual excel tracking tool and BAS has been done to ensure the completeness of all outstanding invoices. Month end procedure. (3) Reconciliation have been prepare for all suppliers. (4) 3rd party confirmations have been prepared and faxed to supplies, waiting for responses. (5) Payment process flow with time frame has been fully implemented in HO and decentralized to district for implementation. HO Invoice register tracking tool has been implemented and their turning around time was 3days for October month due to delays in batches from SCMU; Reconciliation section was 6 days delays by suppliers in submitting statements and average number of days taken for payment were 19 days.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3ACCOUNTING OFFICER REPORT
for the year ended 31 March 2013

Nature of qualification, qualified opinion; and matters of non-compliance	Financial year in which it first arose	Progress made in clearing/resolving the matter
Employee Benefits	2006/07	HR Accruals: (1) Comments on HR Accrual Guide has been received. Submission prepared for CFO Approval. (2) HR Accrual Guide presented at the various Districts at road shows. (3) Process started with development of new HR Accruals Tool. The approach would be to do the specs in October and start with developing in Nov and Dec. We engaged in a project to pay all outstanding HR Accruals, the developing of this tool will be finalized after finishing the project. Capped Leave: (1) With regards to the overstated capped leave the department has embarked on a project that involves the re-auditing of capped leave. All district offices have audit teams that are doing a complete audit of capped leave. 89.63% of the audit is complete and it is planned that the audit will be completed before the end of the year. Our internal auditors are assisting with the verification of the outcome of the audit done by the districts. On completion of the audit the PERSAL system will be updated with accurate capped leave entitlement and the financial statements will also reflect figures that have been audited and verified. (2) The leave entitlement was overstated as a result of some of the leave taken during the last financial year having been captured on the PERSAL system after the end of March 2012. The late capturing of leave is attributable to the fact that, Clinics, Community Health Centres and some District Hospitals do not have access to the PERSAL system. The high cost associated with the installation of Telkom cables and the size of the clinics prevents the department from installing PERSAL in all health facilities. Thus arrangements have to be made that leave forms from institutions that do not have access to PERSAL be captured in the nearest institutions that have PERSAL.
Expenditure	2010/11	(1) The unit is targeting all hubs to ensure compliance. The unit has developed an intervention schedule. (2) Stock-take instructions to be distributed to all institutions and fully adhered to. (3) On-site support for quarter stock counts targeting hubs.
Receivables for Departmental Revenue	2004/05	(1) Deduction of arrear rental is being addressed and has started in some institutions (2) All patient files required for audit in 2011/2012 were submitted accordingly. Security guards at hospitals are required to search patients when they leave the hospital and confiscate folders (3) It was agreed that the adjustment would not be done due to the volume of the population as it would not be possible to ensure that all patient folders are available for all institutions (4) There is no need to issue a receipt for direct deposits and the bank statement and the deposits serve as receipts.
Fruitless & Wasteful Expenditure	2009/10	(1) Register is updated to reflect all actions taken as prescribed by the legislative framework. (2) AFS lead schedule, reconciliation and register for 2010/2011 F&W expenditure have been reviewed and changes have been effected. (3) Completed applications for condonation and write off of the remaining cases of F&W Expenditure for the 2010/2011 financial year of which approvals have been obtained and filed accordingly. (4) VAT notices and advices to service providers submitted for approval, seeking acknowledgement of debt from the companies. (5) Analysis of H/O completed for 2010/2011 and 2011/2012 fin yrs for submission to the Disciplinary Committee (DC) for review and action. (6) Currently preparing 28 applications for condonation for infrastructure F&W for submission to the Disciplinary Committee (DC) for review and action.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3ACCOUNTING OFFICER REPORT
for the year ended 31 March 2013

Nature of qualification, qualified opinion; and matters of non-compliance	Financial year in which it first arose	Progress made in clearing/resolving the matter
Receivables	2009/10	(1) The balance increased February 2013 due to the yearly Income tax reconciliation by Persal system. The in service officials tax debt will be programmatically recovered during the following months. Debt take on forms for all ex officials handed over on a monthly basis not taken on debtor list. Recovery of out of service officials due to the HR Accrual Leave gratuity project from repayments of these officials. (2) Interdepartmental Debt Disagreement: Confirmation letters are prepared and distributed to various departments on a monthly basis. Processed on monthly basis (3) Interest incorrectly written off: An amount of R 45 000 has been re allocated back to various expenditure allocation. -Interest has been reversed automatically reversed back to interest receivable account when we done write off (4) Debtors balances misstated and interest incorrectly calculated: Reconciliation of debtor accounts is done on a monthly basis and interest is checked and manually calculated-Interest is not calculated manually the system automatically calculated the system. (5) Long outstanding debts not handed over for collection: Debt specification for the appointment of debt collectors was approved by the SG. Also, a demand memo was prepared and submitted for signature of the ACFO. (6) Inadequate internal controls: Review of the debt policy has not been done yet.
Emphasis of Matter Areas		
Material impairments and write-offs	2011/12	(1) The finding relates to the proportion of bad debts that must be written off amounting to R196,0 million as against debtors of R55,7 million. The difficulty the department finds itself in is that debtors can be written off only when there is budget. There has been no budget to clear this amount.
Non-compliance with Laws and Regulations Areas		
Annual Financial Statements, Performance and Annual Report	2011/12	The department has put the following systems to mitigate against the risks of errors and misstatement of AFS:- <ul style="list-style-type: none"> • Monthly accounts are done the AFS unit down loads the Trial Balance and prepare monthly accounts and schedules for disclosure notes are prepared. This process is done to institutionalize financial management at the institutions. • A template for monthly management reporting has been developed and circulated to the districts, it details documentation required to be submitted to the AFS for incorporation in the MFS; IFS and AFS. • A monitoring dashboard has also been developed to monitor completeness of submission. • District visits are being done to verify information before it is submitted to HO AFS section. • Rigorous review processes have been put in place where submissions are reviewed by the GM's on the respective Chief Directorates, the Acting CFO reviews and Internal Audit unit has the final review. • Internal Audit will give assurance of the accuracy of the AFS. The fundamental challenges are the following:- • The department does not have integrated electronic financial accounting system which should be a single source of information used to prepare annual financial statements. The annual financial statements are prepared on modified cash accounting, this includes accrual accounting. • Consolidating financial information from these institutions to the district and ultimately to Head Office for reporting is highly disintegrated and cumbersome and lends the consolidation process to errors. • poor filing of documents at the districts causes documents to be lost and therefore cannot be submitted to the AG, it must however be mentioned that this scenario has improved over the years instances of documents that could not be submitted to the auditors for audit purposes were far and few during the current year.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3ACCOUNTING OFFICER REPORT
for the year ended 31 March 2013

Nature of qualification, qualified opinion; and matters of non-compliance	Financial year in which it first arose	Progress made in clearing/resolving the matter
		<p>Document management is one of the focus areas in the department's turnaround plans.</p> <p>It must be mentioned that there is a moratorium by the National Treasury to procure financial systems and the department cannot procure financial system as a result of the moratorium.</p> <p>The misstatements and qualifications come from disclosure notes (Balance sheet accounts e.g. accruals, commitments, irregular expenditure). These balance sheet accounts are maintained on excel spread sheets and the risk of error is high.</p>
Procurement and Contract Management	2011/12	<p>(1) Declaration of Interest (SBD4) to issue with Practice Note No. 7 of 2009 to be signed by SG implemented. Additionally SCM unit is currently developing an SCM Toolkit to enforce and strengthen compliance with SCM laws, regulations and prescripts. (2) In relation to poor communication, HO has now resolved to visit institutions on a monthly basis to monitor implementation thereof. (3) The results have been submitted to HR to confirm whether officials with business interest have obtained approval from the MEC in terms of RWOPS and IA&RAMS to review. (4) Standard Quotation schedule was issued and work-shopped to the districts during district support visits started end August to Oct 2012 to record the quotations requested. (5) Currently developing an SCM Toolkit to enforce and strengthen compliance with SCM laws, regulations and prescripts. (6) Gift Policy and Register for SCM Practitioners and role-players developed and draft issued for review. (7) Training on delegations conducted as part of workshop topics to the districts which started on 27/08/12 in Chris Hani and other rolled out to other districts.</p>
Human Resource Management and Compensation	2011/12	<p>(1) There were 1664 pay-points for Feb 2013. A total number of 403 appointment letters are still outstanding. Road shows were conducted and all Districts were advised to have information sessions with pay-point managers and also to use a simplified appointment letter. (2) Payroll Return rate is at 65% as at 28 March 2013. (3) Intention to charge letters were issued to the SG to sign in the month of March for all outstanding payrolls from April - Dec 2012, the CFO did not approve letters and that we should provide the Pay point Managers with the opportunity to submit all outstanding Payrolls by the middle of April 2013, where-after they can be charged.</p>
Expenditure Management	2011/12	<p>(1) In relation to infrastructure payments, where VAT will be verified at review stage before authorization and a printout attached to the batch, printers were only received during the month end of March, this procedure will be fully implemented during 2013/2014 financial year. Currently supplier ledgers are used to verify the amount already paid, as not to exceed the VAT threshold.</p>
Revenue Management	2011/12	<p>Support visits have been done to all districts, hospital complexes and regional hospitals to reinforce implementation of relevant policies and procedures. Monitoring visits will start in November to check level of compliance. However, there are capacities control measures in this area, including inter alia lack of automated patient billing systems, insufficient and inexperienced officials in hospital revenue components, and the department will be always challenged in the full implementation of policies.</p>

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3ACCOUNTING OFFICER REPORT
for the year ended 31 March 2013

Nature of qualification, qualified opinion; and matters of non-compliance	Financial year in which it first arose	Progress made in clearing/resolving the matter
Budget Management	2011/12	<p>The over spending is primarily attributed to the increased costs arising from the absence of funding and/or shortfalls in the funding of the Human Resource Operating Project Team (HROPT), the Occupation Specific Dispensation (OSD) carry through costs, the settlement of long outstanding HR accruals as well as the carry through costs of provincialization of state aided hospitals primary health care. It is historically known that the Department of Health has been under severe financial pressure over several years, the situation of which has been caused by inter alia, the magnitude of its current service delivery platform, the growth in the burden of disease provincially, the top slicing of its budgets, various unfunded and underfunded mandates as well as limitations in the adequate management of its cost of employment.</p> <p>Actions:</p> <ol style="list-style-type: none"> 1. On 20TH June 2012, Provincial Treasury made the following recommendations to EXCO: <ul style="list-style-type: none"> * Noting progress made to date in dealing with the CoE budget pressure in DoH, including OTP's recommendations to manage appointments in DoH to end of the FY; * No new or replacement appointments to be undertaken by DoH without concurrence with PCMT. * The Appointment functions in DoH to be taken over by OTP. * Payment authorization functions in DoH to remain with PT. * Noting PT's proposal to institute a partial section 18(2) of the PFMA as a means to mitigate and manage the CoE budget pressure in DoH. * Noting the R 421,04 million budget pressure in DoH. * Noting the fact that Treasury, with the support of the Premier, has approved that the payment of R 270,20 million for Health professionals without the budget be made, with the plans to finalize financing thereof during the adjustment estimates process. 2. Vacant and unfunded posts were abolished on 21 June 2012; A total of 36,493 posts were abolished 3. Currently, National DOH has commissioned the development of Generic Organisational Structures in conjunction with DPSA 4. Approved Post Listing (APL) Effective managing of requests for the activation, de-activation and creation of posts Effective managing of the approved staff establishment that reflects both the actual number of staff employed by the Department and the actual number of activated(funded) vacancies through the deactivation of unfunded vacancies and reduction of the active staff establishment to only the filled and activated(vacant funded) posts.
Asset Management	2011/12	<p>The department in the 2011/12 financial year worked extremely hard in ensuring that assets are safeguarded in that one of the key controls and or system that was and is in place is the asset register which records assets of the; yearly asset verification which is a statutory requirement reconciling assets bought to assets in the asset register. These systems are in place, however the problem is that although the asset register is in place it is usually not complete and information is not accurate. Moratorium on employment of support staff and lack of budget make it impossible to employ. Therefore the Accounting Officer has complied with 38(1) (d) of the PFMA and TR 10.1.1(a).</p>

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3ACCOUNTING OFFICER REPORT
for the year ended 31 March 2013

Nature of qualification, qualified opinion; and matters of non-compliance	Financial year in which it first arose	Progress made in clearing/resolving the matter
Financial Misconduct	2011/12	The department has no requisite skills and capacity to investigate financial misconduct cases. Line management with the support of the Directorate: Labour Relations is required to conduct such investigations and submit reports and outcomes of the investigation including appropriate and effective action taken against the responsible officials. The Superintendent General will determine the effectiveness and appropriateness of action taken in terms of Chapter 9 of the Treasury Regulations. The DC Committee established with the assistance of the Office of the Premier is focusing on the previous cases.
Pre-determined Objectives Areas		
Usefulness of Information	2011/12	The information on District Health Information System (DHIS) is measured by the quality indices that are timeliness, completeness and validity. The issue that the department is addressing is the discrepancy on certain data elements between registers and the DHIS. The control measures that are being put in place to address this challenge include training and mentoring of health providers, data capturers, clinic supervisors and sub-district manager's data processing. A compliance tool that monitors data processing at different levels has been developed and is being communicated for implementation. In addition, the drive is towards capturing of data on a daily basis at facility level where it can be easily verified and validated as opposed to capturing at sub-district level at the end of the month; this will impact positively on the three quality indices mentioned above. Whilst this may be the case, this intervention has resource implications that limit progress most of the time; for example, facilities have to have connectivity, computers and data capturers. This intervention involves the national department of health as it affects the whole country. The national DoH has started training data capturers on this new way of capturing. As part of this strategy, there is automation of the HIV /AIDS data registers as well. The department however, remains implementing the policy for clients attending the PHC facilities to take their patient folders home.
Reliability of Information	2011/12	The many data collection tools in the DoH health facilities and the way the facilities capture their information are the major risk factors that affect the reliability of information. To address this challenge, the DoH is rationalizing registers to minimize errors and automating selected functions in health facilities that have computers. This includes the introduction of daily capturing to those areas where there are computers and data capturers.
Achievement of planned targets	2011/12	The budget cut as the budgeting process came after the submission of the APP. This resulted in huge budgetary pressures that put tremendous strain on the capability of the department to discharge fully its responsibilities. The budget shift in the economic classification to mitigate against pressure areas like CoE has rendered the institutions to fail in meeting some of their plans. At times there are policy directives that are to be reported but that come after the finalisation and tabling of the planning documents. Some of the policy shifts and responsibilities of the department were partly or fully unfunded and this had additional strain on finances.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3ACCOUNTING OFFICER REPORT
for the year ended 31 March 2013**17. Exemptions and deviations received from the National Treasury**

In the previous financial year, National Treasury issued an exemption with regards to the treatment of payments to the Government Fleet Management Services (GFMS). The exemption allowed departments to continue to account and disclose payments made to GFMS as operating leases.

The accounting and reporting of GFMS payments in the 2012/13 financial year are now treated as finance leases.

18. Interim Financial Statements

During the course of the year under review, the department complied with the requirements of National Treasury insofar as the complete and timely quarterly submission of Interim Financial Statements (IFS) to the EC Provincial Treasury is concerned.

An attempt was made to provide as much relevant information and supporting documentation, in the form of credible IFS working paper files, as possible with said IFS so that the culture of departmental co-operation and responsiveness and level of compliance may be influenced in a positive manner, especially for readiness toward the year-end Annual Financial Statements (AFS).

In addition, the department also complied with Provincial Treasury Circular 1 and 3 pertaining to reporting on progress of key finance performance indicators and the submission of monthly management accounts respectively. The afore-going can be verified with Provincial Treasury.

19 Other**19.1 HROPT**

Following the audit findings by Grant Thornton, namely that 99% of the 2009 HROPT promotions were irregular, EXCO resolved that all such promotions be reversed and over-payments recovered.

The Department's attempts to implement the resolution were met with a court injunction obtained by affected employees' trade unions, which ordered reinstatement of reversed promotions, pending consultation processes with staff.

Pursuant to previous reports, the Department of Health and employee parties (individuals and trade union led) met in court on 16 August 2012 to deal with the application to discharge the interim order. The interim order dated April 2011, prevented reversal of promotions and recovery of over-payments.

Judge Basson discharged the interim order on 16 August 2012, basically clearing the way for the Department to implement the EXCO resolution i.e. reverse promotions / recover over-payments.

With the interdict out of the way, the Department issued letters of notification to all affected employees informing them that reversals and recoveries would take place from 01 October 2012.

The delay was partly because labour unions asked for the Department's indulgence until 31 August 2012, during which time they would negotiate/present proposals for the implementation of reversals/recoveries. Unfortunately, until the agreed period labour unions had not presented any viable proposal for consideration by the Department.

Statistics: Demotions

In total, 1085 employees benefitted from irregular promotions and/or salary back-pays in lieu of such promotions. Of these only 790 could be reversed (demoted) from 01 October 2012 because:

- 167 Category 13 staff members, meaning that these staff members applied and got a post of level 8 and higher, prior or on 31 March 2009; and
- 128 staff members were identified as staff that terminated on the system

Reversals / lowering of salary levels also included SASAWU members

This means, had it not been for various terminations of service for reasons ranging from death, retirement, etc., a total 918 staff members could have been demoted.

Statistics: Recoveries

Letters informing of the planned reversals also indicated that recoveries (as per Settlement Agreement of January 2012) i.e. R100 will also be effected from 01 October 2012 (safe for SASAWU members). This means, R100 p/m would only be

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**ACCOUNTING OFFICER REPORT**
for the year ended 31 March 2013

instated against all other employee except for SASAWU members – against whom a process will soon be embarked upon to recover debts in full.

The initial indications are that for 790 staff members, that had a salary reduction, the Department saves R 53,961 million annually and R 4,497 million monthly. That constitutes an average of R 5,692 million salary reduction per staff member.

The figure above excludes benefits and is purely based on the notch, if we include 37% benefits the figures look as follows. For the same number of staff with benefits the annual saving is R 73,926 million and R 6,161 million monthly.

As far as the Department is concerned, irregular promotions have been reversed in accordance with the Settlement Agreement of 26 January 2012. Now the Department can rectify and normalise its organogram.

As previously reported, employee parties lodged an application in court seeking an order with regards to which legal instruments could be relied on when reviewing promotions. Note that the Settlement Agreement created an avenue where employees who believe their 2009 promotions to have been justified, to come before the arbitrator and present same. These instruments were argued before labour court on 26 September 2012 – and judgement is still awaited.

On 15 October 2012, counsel for the Department received a letter from PSA which raised several baseless issues (requiring the Department's clarification) and even threatening a possibility of approaching court for an interdict against reversals. Of course, this course of action would have been after the fact i.e. after reversals had taken place.

Although confident of its position, the Department has taken every step to ready itself for any eventuality. This includes a final letter issued to affected staff just before 15th October 2012, basically confirming that reversals/demotions/lowering of salary levels have taken place. It must be noted that some trade unions – have ordered their members not to accept any letters from the Department.

Relating to HROPT above, during the current year, affected employees have had R100 per month deducted from their salaries and this amounted to R0,3 million in the current year. Where affected staff resign or are dismissed, the full amount of HROPT

owing becomes receivable by the department (R456,5 million).

If affected staff pay their R100 until they retire, the department will recover R11,9 million. If affected staff die, none of the outstanding balances receivable by the department.

19.2 OSD

An OSD contingent asset amounting to R0,887 million has been raised. This is in relation to allied workers and nurses OSD overpaid in the current and previous financial years. The Allied health professionals were overpaid due to incorrect PERSAL Codes as a result of programmatic payments of 5% once-off non-pensionable gratuity to employees who were in service as at 30 June 2010 and nurses overpaid before 07 August 2009.

The issue of recovery of funds paid erroneously to nurses during the initial implementation of the nurses would be dealt with separately on the basis of guidance that will be provided by National Treasury, and subsequently communicated to provinces. No decision has yet been communicated to the Provincial Health Departments.

Engineers Cluster OSD: The Engineers Cluster OSD for Artisans, Technicians, Technologists and Engineers was signed in August 2009 with an effective date of 1 July 2009. As the Agreement was signed in the General Public Service Sector Bargaining Council, there was a technicality as it could not be implemented because the Department has a separate Bargaining Council.

The Public Health and Social Development Sectoral Bargaining Council (PHSDSBC) approved the Resolution no 2 of 2012 on 29 November 2012 and the Agreement was made available in the Department in January 2013. Information on affected employees has been collected and the estimated cost up to 31/03/2013 is R4,032 million. However, an internal audit process is underway to ensure credibility of the information.

19.3 HR Accruals

Due to the size of the department and the manual processing of transactions the department has a challenge with the completeness of HR accruals. Although compensating controls have been introduced

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**ACCOUNTING OFFICER REPORT**
for the year ended 31 March 2013

such as conducting confirmation, the risk associated with manual processes exists.

19.4 Bad Debts

The department wrote off bad debts related to salary debts but was limited by inadequate funding in order to write - off all bad debts.

19.5 Related Parties

For the year under review the department commissioned a firm of professional consultants and accountants to extract information from CIPC and BAS. The report has been received and is currently being processed to determine whether employees obtained approval for performing additional remunerated work and disclosed their financial interest in businesses that do business with the department. Disciplinary action will be instituted against employees if found not to have complied with Section 30 of the Public Service Act and departmental policy of additional remunerated work.

20 Approval

The Annual Financial Statements set out on pages 365 to 454 have been approved by the Accounting Officer.

ACCOUNTING OFFICER'S STATEMENT OF RESPONSIBILITY**Statement of Responsibility for the Annual Financial Statements for the year ended 31 March 2013**

The Accounting Office is responsible for the preparation of the department's annual financial statements and for the judgements made in this information.

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

In my opinion, the financial statements fairly reflects the operations of the department for the financial year ended 31 March 2013

The external auditors are engaged to express an independent opinion on the AFS of the department.

The Department of Health AFS for the year ended 31 March 2013 have been examined by the external auditors and their report is presented on page 356.

The Annual Financial Statements of the Department set out on page 365 to page 454 have been approved.



.....
MR. M.D. QWASE
ACTING SUPERINTENDENT GENERAL
31 MAY 2013

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

REPORT OF THE AUDITOR-GENERAL
for the year ended 31 March 2013

REPORT OF THE AUDITOR-GENERAL TO THE EASTERN CAPE PROVINCIAL
LEGISLATURE ON VOTE NO. 3: THE EASTERN CAPE DEPARTMENT OF HEALTH

REPORT ON THE FINANCIAL STATEMENTS

Introduction

1. I have audited the financial statements of the Eastern Cape Department of Health set out on pages 365 to 454, which comprise the appropriation statement, the statement of financial position as at 31 March 2013, the statement of financial performance, statement of changes in net assets and the cash flow statement for the year then ended, and the notes, comprising a summary of significant accounting policies and other explanatory information.

Accounting officer's responsibility for the financial statements

2. The accounting officer is responsible for the preparation of these financial statements in accordance with the departmental financial reporting framework prescribed by the National Treasury and the requirements of the Public Finance Management Act of South Africa, 1999 (Act No. 1 of 1999) (PFMA) and the Division of Revenue Act of South Africa, 2011 (Act No. 5 of 2012) (DoRA), and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor-general's responsibility

3. My responsibility is to express an opinion on these financial statements based on my audit. I conducted my audit in accordance with the Public Audit Act of South Africa, 2004 (Act No. 25 of 2004) (PAA), the general notice issued in terms thereof and International Standards on Auditing. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.
4. An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.
5. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my qualified audit opinion.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

REPORT OF THE AUDITOR-GENERAL
for the year ended 31 March 2013

Basis for qualified opinion

Irregular expenditure

6. The department did not have adequate systems in place to identify and disclose all irregular expenditure incurred during the year as required by section 40(3)(b)(i) of the PFMA. The irregular expenditure disclosed in note 28 to the financial statements is understated in respect of amounts of R48,4 million (2011-12: R269,2 million) incurred during the year that were identified during the audit process, while the opening balance for 2011-12 is also understated by R109,8 million in this regard. Due to the inadequate systems in place, it was impracticable for me to determine the full extent of the understatement of irregular expenditure. Consequently, I was unable to determine whether any further adjustments were necessary to the irregular expenditure disclosed at R398 million (2011-12: R1,179 billion).

Employee benefits

7. Employee benefits as disclosed in disclosure note 25 to the financial statements are overstated by R108,7 million as a result of leave days that were not captured at year-end and calculation errors relating to capped leave and other employee benefits.
8. In addition, sufficient appropriate audit evidence including employee files were not available for capped leave commitments reflected as R845,3 million, and other employee benefits reflected as R611 million (2011-12: R190,1 million) as disclosed in disclosure note 25. I was not able to confirm the disclosure by alternative means. Consequently, I was unable to determine whether any further adjustments to the disclosed amounts were necessary.

Commitments

9. Commitments of R2,7 billion as disclosed in note 23 to the financial statements are overstated by R144 million as the department did not have an effective system in place to identify and remove orders for which the commitment did not exist as the goods and services had been received before year-end.
10. During the 2011-12 financial year commitments disclosed in note 23 to the financial statement were overstated by R125,6 million as there were differences between the supporting documentation and the amounts reflected in the commitments schedules that supported the amount in the financial statements. In addition, the department did not provide adequate supporting documentation for commitments reflected in note 23 to the financial statements and I was unable to confirm the disclosure by alternative means. Consequently, I was unable to determine whether any further adjustments were necessary to the corresponding figure for commitments of R2,8 billion as disclosed in note 23 to the financial statements.

Expenditure

11. During the 2011-12 financial year, expenditure was incorrectly classified in the accounting records of the department, which resulted in expenditure for capital assets being understated by R8,3 million, current expenditure – goods and services being overstated by R96,9 million, current expenditure – interest and rent on land being understated by R6,4 million and

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3REPORT OF THE AUDITOR-GENERAL
for the year ended 31 March 2013

transfers and subsidies being understated by R82,2 million in the statement of financial performance and notes 6, 7 and 10 to the financial statements.

12. Furthermore, it was not possible to agree amounts charged by service providers for payments made of R361 million (2011-12: R393,2 million) as no reconciliations were performed by the department to ensure that services rendered and paid for were only for departmental patients. In addition, the department did not provide adequate supporting documentation that goods and services of R25,6 million (2011-12: R95,2 million) were actually received. I was unable to confirm the receipt of these goods and services by alternative means. Furthermore, management did not provide sufficient appropriate audit evidence for transactions amounting to R26,5 million. Consequently, I was unable to determine whether any further adjustments were necessary to the amount of R4,4 billion (2011-12: R4 billion) relating to goods and services as disclosed in note 6 to the financial statements.

Aggregation of immaterial uncorrected misstatements

13. The corresponding amounts in the financial statements as a whole are materially misstated due to the cumulative effect of numerous individually immaterial uncorrected misstatements in the disclosure notes to the financial statements:
- Movable tangible capital assets reflected as R779,5 million in note 35.3 to the financial statements are understated by R87,3 million and minor capital assets reflected as R131 million in note 35.4 to the financial statement are understated by R6,3 million.
 - Accruals reflected as R894,8 million in note 24 to the financial statements are understated by R80,2 million.

Qualified opinion

14. In my opinion, except for the effects, and possible effects of the matters described in the Basis for qualified opinion paragraphs, the financial statements present fairly, in all material respects, the financial position of the Eastern Cape Department of Health as at 31 March 2013, and its financial performance and cash flows for the year then ended in accordance with the *Departmental financial reporting framework* prescribed by the National Treasury and the requirements of the PFMA and DoRA.

Emphasis of matter

15. I draw attention to the matter below. My opinion is not modified in respect of this matter.

Material impairments and write-offs

16. Movable tangible capital assets to the value of R412 million as disclosed in note 35.2 to the financial statements were written off during the year. Refer to note 35.2 to the financial statements for the details thereof.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

REPORT OF THE AUDITOR-GENERAL
for the year ended 31 March 2013

Additional matter

17. I draw attention to the matter below. My opinion is not modified in respect of this matter.

Financial reporting framework

18. The *Departmental financial reporting framework* prescribed by the National Treasury and applied by the department is a compliance framework. The wording of my opinion on a compliance framework should reflect that the financial statements have been prepared in accordance with this framework and not that they “present fairly”. Section 20(2)(a) of the PAA, however, requires me to express an opinion on the fair presentation of the financial statements. The wording of my opinion therefore reflects this requirement.

REPORT ON OTHER LEGAL AND REGULATORY REQUIREMENTS

19. In accordance with the PAA and the general notice issued in terms thereof, I report the following findings relevant to performance against predetermined objectives, compliance with laws and regulations and internal control, but not for the purpose of expressing an opinion.

Predetermined objectives

20. I performed procedures to obtain evidence about the usefulness and reliability of the information in the annual performance report as set out on pages 75 to 228 of the annual report.
21. The reported performance against predetermined objectives was evaluated against the overall criteria of usefulness and reliability. The usefulness of information in the annual performance report relates to whether it is presented in accordance with the National Treasury's annual reporting principles and whether the reported performance is consistent with the planned objectives. The usefulness of information further relates to whether indicators and targets are measurable (i.e. well defined, verifiable, specific, measurable and time bound) and relevant as required by the National Treasury *Framework for managing programme performance information* (FMPPI).

The reliability of the information in respect of the selected programmes is assessed to determine whether it adequately reflects the facts (i.e. whether it is valid, accurate and complete).

22. The material findings are as follows:

Usefulness of information

23. The National Treasury *Guide for the preparation of the annual report* requires that explanations for variances between the planned and reported (actual) targets should be provided in all instances and should also be supported by adequate and reliable corroborating evidence. Adequate and reliable corroborating evidence could not be provided for 83% of major variances as disclosed in the annual performance report. The institution's records did not permit the application of alternative audit procedures due to limitations placed on the scope of my work by the institution. Consequently, I did not obtain sufficient appropriate audit evidence to satisfy myself as to the reliability of the reasons for major

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3REPORT OF THE AUDITOR-GENERAL
for the year ended 31 March 2013

variances.

24. The FMPPI requires that indicators should have clear unambiguous data definitions so that data is collected consistently and is easy to understand and use. A total of 82% of the indicators were not well defined in that clear, unambiguous data definitions were not disclosed to allow for data to be collected consistently. This was due to the fact that management had selected data definitions that did not reflect the actual source data collated for reported performance.

Reliability of information

25. The FMPPI requires that institutions should have appropriate systems to collect, collate, verify and store performance information to ensure valid, accurate and complete reporting of actual achievements against planned objectives, indicators and targets.
26. In respect of programme 2, district health services, I was unable to obtain the information and explanations I considered necessary to satisfy myself as to the reliability of information presented. This was due to limitations placed on the scope of my work due to the fact that the institutions could not provide sufficient appropriate evidence in support of the information presented with respect to the programme. The institution's records did not permit the application of alternative audit procedures.
27. The reported performance information as a whole for programme 4, provincial hospital services, is materially misstated due to the cumulative effect of numerous misstatements in the targets relevant to this programme. This was due to the lack of standard operating procedures for the accurate recording of actual achievements as well as the monitoring of the completeness of source documentation in support of actual achievements. Frequent review of the validity of reported achievements against source documentation was also found to be poor.
28. The reported performance information as a whole for programme 5, provincial tertiary hospital services, is materially misstated due to the cumulative effect of numerous misstatements in the targets relevant to this programme. This was due to the lack of standard operating procedures for the accurate recording of actual achievements as well as the monitoring of the completeness of source documentation in support of actual achievements. Frequent review of the validity of reported achievements against source documentation was also found to be deficient.

Compliance with laws and regulations

29. I performed procedures to obtain evidence that the entity has complied with applicable laws and regulations regarding financial matters, financial management and other related matters. My findings on material non-compliance with specific matters in key applicable laws and regulations as set out in the general notice issued in terms of the PAA are as follows:

Annual financial statements, performance and annual report

30. The financial statements submitted for auditing were not supported by full and proper records as required by section 40(1)(a) of the PFMA. Material misstatements of expenditure and

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3REPORT OF THE AUDITOR-GENERAL
for the year ended 31 March 2013

disclosure items identified by the auditors in the submitted financial statements were subsequently corrected and the supporting records were provided, but the uncorrected material misstatements and supporting records that could not be provided resulted in the financial statements receiving a qualified audit opinion.

31. In terms of section 38(1)(a)(i) of the PFMA, the accounting officer must ensure that the department has and maintains effective, efficient, and transparent systems of financial and risk management and internal control. However, the department did not maintain an effective and efficient system of internal control regarding performance management, which described and represented how the department's processes of performance monitoring, measurement, review and reporting were conducted, organised and managed.

Human resource management

32. The accounting officer did not ensure that all leave taken by employees was recorded accurately and in full as required by Public Service Regulation (PSR) 1/V/F (b).
33. The accounting officer did not implement effective measures to ensure that the incapacity leave processes were completed timely, as required by PSR 1/V/F(c).

Grants received

34. Quarterly performance reports for several schedule 4 and 5 grants were not submitted to the relevant transferring department, provincial treasury or the national treasury within 30 days, as required by section 11(4)(b) and section 12(2)(c) of DoRA.

Revenue management

35. The accounting officer did not take effective and appropriate steps to collect all money due, as required by section 38(1)(c)(i) of the PFMA and TR 11.2.1, 15.10.1.2(a) and 15.10.1.2(e).

Financial misconduct

36. Sufficient appropriate audit evidence could not be obtained that investigations into allegations of financial misconduct against officials were not instituted within 30 days of discovery thereof, as required by TR 4.1.2.
37. Investigations were not conducted into certain allegations of financial misconduct committed by officials, as required by TR 4.1.1.

Service delivery

38. Expired medicines were not properly managed and disposed of consistently, in contravention of Good Pharmacy Practice (GPP) as per the South African Pharmaceutical Society which is obligatory in terms of section 35 A of the Pharmacy Act (Act No. 53 of 1974) as amended.
39. The department did not adhere consistently to the general requirements for the storage of medical waste or general duties in respect of waste management at institutions visited, in contravention of section 28 of the National Environmental Management Act, 1998 (Act No.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3REPORT OF THE AUDITOR-GENERAL
for the year ended 31 March 2013

107 of 1998) and sections 16 and 21 of the National Environmental Management Waste Act, 2008 (Act No. 59 of 2008) as several medical waste storage sites were found not to be secured against unauthorised entry, not waterproofed adequately or inspected regularly to identify potential storage issues in a timely manner.

Expenditure management

40. The accounting officer did not always take effective steps to prevent irregular and fruitless and wasteful expenditure, as required by section 38(1)(c)(ii) of the PFMA and TR 9.1.1.
41. Effective and appropriate disciplinary steps were not always taken against officials who made and/or permitted irregular expenditure as required by section 38(1)(h)(iii) of the PFMA and TR 9.1.3.
42. The accounting officer did not always take effective steps to prevent losses resulting from criminal conduct, as required by section 38(1)(c)(ii) of the PFMA.
43. Effective and appropriate steps were not always taken to recover losses or damages through criminal conduct or omissions from the persons responsible, as required by TR 12.
44. The accounting officer did not ensure that effective internal controls were in place for all payment approvals and processing, as required by TR 8.1.1.
45. Not all money was committed with the approval of the accounting officer or a properly authorised official, as required by TR 8.2.1 and 8.2.2.
46. Not all contractual obligations and money owed by the department were settled within 30 days or an agreed period, as required by section 38(1)(f) of the PFMA and TR 8.2.3.

Procurement and contract management

47. Not all goods and services with a transaction value below R500 000 were procured by means of obtaining the required price quotations, as required by TR 16A6.1.
48. Invitations for competitive bidding were not always advertised in at least the government tender bulletin, as required by TR 16A6.3(c).
49. Invitations for competitive bidding were not always advertised for a required minimum period of 21 days, as required by TR 16A6.3(c).
50. Sufficient appropriate audit evidence could not be obtained that bid adjudication was done by committees which were composed in accordance with the policies of the department, as required by TR 16A6.2(a), (b) and (c).
51. Contracts were awarded to bidders who did not submit a declaration of past supply chain practices such as fraud, abuse of supply chain management (SCM) system and non-performance, which is prescribed in order to comply with TR 16A9.2.
52. Sufficient appropriate audit evidence could not be obtained that contracts were awarded to suppliers based on preference points that were allocated and calculated in accordance with the requirements of the Preferential Procurement Policy Framework Act, 2000 (Act No. 5 of 2000) (PPPFA) and its regulations.
53. Sufficient appropriate audit evidence could not be obtained that contracts were awarded to bidders that scored the highest points in the evaluation process as required by section 2(1)(f) of PPPFA and Preferential Procurement Regulations.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

REPORT OF THE AUDITOR-GENERAL
for the year ended 31 March 2013

54. Contracts and quotations were awarded to bidders who did not submit a declaration on whether they are employed by the state or connected to any person employed by the state, which is prescribed in order to comply with TR 16A8.3.
55. Not all allegations of fraud, corruption, improper conduct and failure to comply with the SCM system, laid against officials and role players in the SCM system, were investigated as required by TR 16A9.1(b).

Internal control

56. I considered internal control relevant to my audit of the financial statements, annual performance report and compliance with laws and regulations. The matters reported below under the fundamentals of internal control are limited to the significant deficiencies that resulted in the basis for qualified opinion, the findings on the annual performance report and the findings on compliance with laws and regulations included in this report.

Leadership

57. Effective leadership around performance management remains a challenge as the roles and responsibilities for collecting, coordinating and compiling performance information have been communicated to all relevant staff but there is no effective accountability at all levels and no consequences for poor performance.
58. Policies and procedures were not clearly communicated throughout the department and were not drafted with sufficient emphasis on the roles of monitoring and isolation of responsibilities. Officials at the districts throughout the province did not understand the policies and procedures relating to their job responsibilities which contributed to the repeat findings raised during the compliance audit. The SCM policy was also outdated and did not safeguard or reduce the risk of fraud within the department.
59. Senior management from the monitoring and evaluation unit, responsible for the performance reporting of the department, has not created a specific and achievable action plan to improve the reporting on performance objectives in order to resolve previously reported findings that I report again in this report.

Financial and performance management

60. The department did not have an effective records management system in place and was reliant on the use of manual systems to account for financial disclosures and non-financial information. The department still had a challenge with a shortage of staff and officials at the districts did not have adequate skills and knowledge to understand the financial reporting framework and performance management requirements.
61. The department's compliance monitoring unit has not been effective in implementing and monitoring controls to ensure compliance with its laws and regulations. This contributed to the repeat non-compliance findings in the current year.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

REPORT OF THE AUDITOR-GENERAL
for the year ended 31 March 2013

Governance

62. Action plans to address risks identified by the department's risk committee have not been effectively implemented.
63. The audit committee need to ensure that the internal audit is sufficiently capacitated and that their audit plans focuses more on compliance with laws and regulations and reporting on predetermined objectives as recurring findings in these areas have been identified during the year.

OTHER REPORTS

Investigations

64. Investigations were in progress relating to alleged fraud and financial misconduct by departmental officials, including transgressions of SCM requirements. These investigations were still ongoing at the reporting date.

Auditor-General

East London

31 July 2013



AUDITOR-GENERAL
SOUTH AFRICA

Auditing to build public confidence

**PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3**

**APPROPRIATION STATEMENT
for the year ended 31 March 2013**

Appropriation per programme									
	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
1. HEALTH ADMINISTRATION									
Current payment	531,856	(3,512)	(7,202)	521,142	521,757	(615)	100.1%	544,967	538,324
Transfers and subsidies	4,403	-	(2,042)	2,361	2,361	-	100.0%	343	275
Payment for capital assets	4,118	3,512	3,498	11,128	10,928	200	98.2%	4,100	5,211
Payment for financial assets	-	-	-	-	17	(17)	0.0%	-	88
	540,377	-	(5,746)	534,631	535,063	(432)		549,410	543,898
2. DISTRICT HEALTH SERVICES									
Current payment	7,511,218	(44,189)	218,265	7,685,294	7,761,365	(76,071)	101.0%	6,824,394	7,150,397
Transfers and subsidies	131,506	-	(2,648)	128,858	123,784	5,074	96.1%	110,154	103,076
Payment for capital assets	43,270	44,189	-	87,459	68,480	18,979	78.3%	50,211	31,793
	7,685,994	-	215,617	7,901,611	7,953,629	(52,018)		6,984,759	7,285,266
3. EMERGENCY MEDICAL SERVICES									
Current payment	718,597	(76,370)	(54,880)	587,347	539,700	47,647	91.9%	597,476	597,125
Transfers and subsidies	2,079	-	-	2,079	1,857	222	89.3%	68	68
Payment for capital assets	3,488	76,370	(1,890)	77,968	77,968	-	100.0%	52,440	47,395
	724,164	-	(56,770)	667,394	619,525	47,869		649,984	644,588
4. PROVINCIAL HOSPITAL SERVICES									
Current payment	4,058,345	(21,087)	(125,894)	3,911,364	3,905,738	5,626	99.9%	3,820,346	3,834,096
Transfers and subsidies	39,102	8,510	4,690	52,302	50,062	2,240	95.7%	10,230	10,230
Payment for capital assets	6,715	12,577	-	19,292	23,216	(3,924)	120.3%	33,435	15,928
	4,104,162	-	(121,204)	3,982,958	3,979,016	3,942		3,864,011	3,860,254
5. CENTRAL HOSPITAL SERVICES									
Current payment	590,261	-	-	590,261	587,390	2,871	99.5%	549,590	553,069
Transfers and subsidies	-	-	-	-	-	-	0.0%	-	-
Payment for capital assets	112,158	-	-	112,158	69,780	42,378	62.2%	97,514	74,006
	702,419	-	-	702,419	657,170	45,249		647,104	627,075

**PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3**

**APPROPRIATION STATEMENT
for the year ended 31 March 2013**

Appropriation per programme									
	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
6. HEALTH SCIENCE AND TRAINING									
Current payment	435,405	(2,436)	(22,966)	410,003	356,482	53,521	86.9%	408,092	390,723
Transfers and subsidies	218,852	-	-	218,852	216,311	2,541	98.8%	198,193	196,368
Payment for capital assets	8,950	2,436	(1,608)	9,778	7,171	2,607	73.3%	21,437	18,712
Payment for financial assets	-	-	-	-	-	-	0.0%	-	21
	663,207	-	(24,574)	638,633	579,964	58,669		627,722	605,824
7. HEALTH CARE AND SUPPORT SERVICES									
Current payment	91,523	(295)	(7,323)	83,905	81,844	2,061	97.5%	86,479	76,426
Transfers and subsidies	762	-	-	762	111	651	14.6%	333	270
Payment for capital assets	2,350	295	-	2,645	2,354	291	89.0%	3,200	2,051
	94,635	-	(7,323)	87,312	84,309	3,003		90,012	78,747
8. HEALTH FACILITIES DEVELOPMENT AND MAINTENANCE									
Current payment	532,795	-	-	532,795	576,052	(43,257)	108.1%	395,069	371,944
Transfers and subsidies	-	-	-	-	-	-	0.0%	13	13
Payment for capital assets	685,145	-	-	685,145	616,116	69,029	89.9%	1,002,898	873,087
	1,217,940	-	-	1,217,940	1,192,168	25,772		1,397,980	1,245,044
Subtotal	15,732,898	-	-	15,732,898	15,600,844	132,054	99.2%	14,810,982	14,890,696

**PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3**

**APPROPRIATION STATEMENT
for the year ended 31 March 2013**

Appropriation per programme									
	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
Subtotal - b/f	15,732,898	-	-	15,732,898	15,600,844	132,054	99.2%	14,810,982	14,890,696
Statutory Appropriation									
Current payment	1,652	-	-	1,652	1,668	(16)	101.0%	1,586	1,586
TOTAL	15,734,550	-	-	15,734,550	15,602,512	132,038	99.2%	14,812,568	14,892,282
Reconciliation with Statement of Financial Performance									
Add:									
Departmental receipts				33,044				10,274	
Aid assistance				4,116					
Actual amounts per Statement of Financial Performance (Total Revenue)				15,771,710				14,822,842	
Add: Aid assistance					3,378				8,707
Actual amounts per Statement of Financial Performance					15,605,890				14,900,989

**PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3**

**APPROPRIATION STATEMENT
for the year ended 31 March 2013**

Total Appropriation per Economic classification									
Programmes	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
Current payments									
Compensation of employees	10,228,158	(155,928)	(193,793)	9,878,437	9,825,805	52,632	99.5%	9,182,174	9,478,971
Goods and services	4,243,808	8,039	193,793	4,445,640	4,504,153	(58,513)	101.3%	4,044,239	4,019,161
Interest and rent on land	-	-	-	-	4,296	(4,296)	0.0%	-	13,971
Transfers & subsidies									
Provinces & municipalities	8,084	-	-	8,084	7,928	156	98.1%	-	-
Departmental agencies & accounts	29,436	-	-	29,436	24,428	5,008	83.0%	45,770	42,411
Universities & technikons	101,845	-	-	101,845	101,770	75	99.9%	138,649	133,975
Households	255,338	8,510	-	263,848	260,360	3,488	98.7%	134,915	133,914
Payment for capital assets									
Buildings & other fixed structures	654,810	-	-	654,810	598,417	56,393	91.4%	913,380	830,244
Machinery & equipment	211,419	139,379	-	350,798	273,670	77,128	78.0%	351,767	237,940
Payment for financial assets									
	-	-	-	-	17	(17)	0.0%	88	109
Total	15,732,898	-	-	15,732,898	15,600,844	132,054	99.2%	14,810,982	14,890,696

PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3

APPROPRIATION STATEMENT
for the year ended 31 March 2013

Statutory Appropriation									
Programmes	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
Member of executive committee	1,652	-	-	1,652	1,668	(16)	101.0%	1,586	1,586
Total	1,652			1,652	1,668	(16)	101.0%	1,586	1,586

**PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3**

**APPROPRIATION STATEMENT
for the year ended 31 March 2013**

Detail per programme I - HEALTH ADMINISTRATION									
Details per Sub-Programme	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
I.1 OFFICE OF THE MEC									
Current payment	5,387	(1,171)	-	4,216	4,194	22	99.5%	4,502	4,203
Transfers and subsidies	-	-	(2,042)	(2,042)	-	(2,042)	0.0%	-	-
Payment for capital assets	62	-	3,498	3,560	57	3,503	1.6%	1,000	858
I.2 MANAGEMENT									
Current payment	526,469	(2,341)	(7,202)	516,926	517,563	(637)	100.1%	540,465	534,121
Transfers and subsidies	4,403	-	-	4,403	2,361	2,042	53.6%	343	275
Payment for capital assets	4,056	3,512	-	7,568	10,871	(3,303)	143.6%	3,100	4,353
Payment for financial assets	-	-	-	-	17	(17)	0.0%	-	88
Total	540,377	-	(5,746)	534,631	535,063	(432)	100.1%	549,410	543,898

PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3

APPROPRIATION STATEMENT
for the year ended 31 March 2013

Appropriation per programme									
Programme I Per Economic classification	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
Current payments									
Compensation of employees	326,929	(30,087)	(7,202)	289,640	287,262	2,378	99.2%	293,383	287,379
Goods and services	204,927	26,575	-	231,502	232,697	(1,195)	100.5%	251,584	248,265
Interest and rent on land	-	-	-	-	1,798	(1,798)	0.0%	-	2,680
Transfers & subsidies									
Households	4,403	-	(2,042)	2,361	2,361	-	100.0%	343	275
Payment for capital assets									
Machinery & equipment	4,118	3,512	3,498	11,128	10,928	200	98.2%	4,012	5,211
Payment for financial assets									
	-	-	-	-	17	(17)	0.0%	88	88
Total	540,377	-	(5,746)	534,631	535,063	(432)	100.1%	549,410	543,898

PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3

APPROPRIATION STATEMENT
for the year ended 31 March 2013

Detail per programme 2 - DISTRICT HEALTH SERVICES

Details per Sub-Programme	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
2.1 DISTRICT MANAGEMENT									
Current payment	547,931	(51,358)	7,202	503,775	504,289	(514)	100.1%	537,019	562,499
Transfers and subsidies	39,470	(349)	(2,046)	37,075	37,074	1	100.0%	37,112	37,111
Payment for capital assets	2,952	20,559	-	23,511	23,585	(74)	100.3%	6,551	6,146
Payment for financial assets	-	-	-	-	-	-	0.0%	-	-
2.2 COMMUNITY HEALTH CLINICS									
Current payment	1,431,901	36,635	190,618	1,659,154	1,727,147	(67,993)	104.1%	1,335,720	1,397,227
Transfers and subsidies	-	175	-	175	175	-	100.0%	1,000	847
Payment for capital assets	280	(141)	-	139	139	-	100.0%	119	791
2.3 COMMUNITY HEALTH CENTRES									
Current payment	784,707	(19,928)	-	764,779	766,848	(2,069)	100.3%	613,198	729,972
Transfers and subsidies	161	-	-	161	161	-	100.0%	762	294
Payment for capital assets	58	2,130	-	2,188	2,222	(34)	101.6%	10	989
Payment for financial assets	-	-	-	-	-	-	0.0%	-	-
2.4 COMMUNITY BASED SERVICES									
Current payment	411,798	(3,248)	-	408,550	419,382	(10,832)	102.7%	396,143	398,314
Transfers and subsidies	8,084	174	-	8,258	8,102	156	98.1%	138	40
Payment for capital assets	2,950	2,558	-	5,508	5,507	1	100.0%	1,966	288
Payment for financial assets	-	-	-	-	-	-	0.0%	-	-

**PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3**

**APPROPRIATION STATEMENT
for the year ended 31 March 2013**

Detail per programme 2 - DISTRICT HEALTH SERVICES

Details per Sub-Programme	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
2.5 OTHER COMMUNITY SERVICES									
Current payment	96,964	14,428	-	111,392	115,990	(4,598)	104.1%	103,225	88,695
Payment for capital assets	1,040	(732)	-	308	308	-	100.0%	16	16
2.6 HIV/AIDS									
Current payment	982,594	-	5,335	987,929	973,311	14,618	98.5%	859,998	852,530
Transfers and subsidies	56,626	-	-	56,626	51,709	4,917	91.3%	66,980	60,617
Payment for capital assets	30,215	-	-	30,215	7,852	22,363	26.0%	13,685	10,822
2.7 NUTRITION									
Current payment	76,493	(14,599)	-	61,894	61,894	-	100.0%	58,425	56,516
Payment for capital assets	615	-	-	615	55	560	8.9%	-	-
2.8 CORONER SERVICES									
Current payment	86,480	(17,902)	-	68,578	70,346	(1,768)	102.6%	68,756	74,164
Payment for capital assets	1,800	2,790	-	4,590	4,589	1	100.0%	18,289	10,881
2.9 DISTRICT HOSPITALS									
Current payment	3,092,350	11,783	15,110	3,119,243	3,122,158	(2,915)	100.1%	2,851,910	2,990,480
Transfers and subsidies	27,165	-	(602)	26,563	26,563	-	100.0%	4,162	4,167
Payment for capital assets	3,360	17,025	-	20,385	24,223	(3,838)	118.8%	9,575	1,860
Payment for financial assets	-	-	-	-	-	-	0.0%	-	-
Total	7,685,994	-	215,617	7,901,611	7,953,629	(52,018)	100.7%	6,984,759	7,285,266

PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3

APPROPRIATION STATEMENT
for the year ended 31 March 2013

Appropriation per programme									
Programme 2 Per Economic classification	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
Current payments									
Compensation of employees	5,588,008	(92,702)	-	5,495,306	5,491,541	3,765	99.9%	4,891,224	5,164,809
Goods and services	1,923,211	48,513	218,265	2,189,989	2,269,206	(79,217)	103.6%	1,933,170	1,982,660
Interest and rent on land	-	-	-	-	618	(618)	0.0%	-	2,928
Transfers & subsidies									
Provinces & municipalities	8,084	-	-	8,084	7,928	156	98.1%	-	-
Departmental agencies & accounts	23,636	-	-	23,636	18,719	4,917	79.2%	45,770	42,411
Universities & technikons	32,990	-	-	32,990	32,990	-	100.0%	21,210	18,211
Households	66,795	-	(2,648)	64,147	64,147	-	100.0%	43,174	42,454
Payment for capital assets									
Buildings & other fixed structures	1,186	-	-	1,186	-	1,186	0.0%	14,565	7,383
Machinery & equipment	42,084	44,189	-	86,273	68,480	17,793	79.4%	35,646	24,411
Payment for financial assets									
Total	7,685,994	-	215,617	7,901,611	7,953,629	(52,018)	100.7%	6,984,759	7,285,267

PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3

APPROPRIATION STATEMENT
for the year ended 31 March 2013

Detail per programme 3 - EMERGENCY MEDICAL SERVICES

Details per Sub-Programme	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
3.1 EMERGENCY MEDICAL SERVICES									
Current payment	696,329	(76,370)	(47,576)	572,383	524,736	47,647	91.7%	587,684	587,333
Transfers and subsidies	2,079	-	-	2,079	1,857	222	89.3%	68	68
Payment for capital assets	-	77,115	-	77,115	77,115	-	100.0%	51,403	46,396
3.2 PLANNED PATIENT TRANSPORT									
Current payment	22,268	-	(7,304)	14,964	14,964	-	100.0%	9,792	9,792
Transfers and subsidies	-	-	-	-	-	-	0.0%	-	-
Payment for capital assets	3,488	(745)	(1,890)	853	853	-	100.0%	1,037	999
Total	724,164	-	(56,770)	667,394	619,525	47,869	92.8%	649,984	644,588

PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3

APPROPRIATION STATEMENT
for the year ended 31 March 2013

Appropriation per programme									
Programme 3 Per Economic classification	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
Current payments									
Compensation of employees	404,870	-	(37,731)	367,139	366,492	647	99.8%	347,043	347,043
Goods and services	313,727	(76,370)	(17,149)	220,208	173,208	47,000	78.7%	250,433	249,965
Interest and rent on land	-	-	-	-	-	-	0.0%	-	116
Transfers & subsidies									
Households	2,079	-	-	2,079	1,857	222	89.3%	68	68
Payment for capital assets									
Machinery & equipment	3,488	76,370	(1,890)	77,968	77,968	-	100.0%	52,440	47,395
Total	724,164	-	(56,770)	667,394	619,525	47,869	92.8%	649,984	644,587

PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3

APPROPRIATION STATEMENT
for the year ended 31 March 2013

Detail per programme 4 - PROVINCIAL HOSPITAL SERVICES									
Details per Sub-Programme	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
4.1 GENERAL (REGIONAL) HOSPITALS									
Current payment	3,184,805	11,274	(111,032)	3,085,047	3,079,364	5,683	99.8%	2,995,469	3,016,353
Transfers and subsidies	36,324	8,510	4,690	49,524	49,524	-	100.0%	9,731	9,731
Payment for capital assets	2,360	8,613	-	10,973	12,909	(1,936)	117.6%	22,185	13,095
Payment for financial assets	-	-	-	-	-	-	0.0%	-	-
4.2 TB HOSPITALS									
Current payment	363,154	(25,717)	(11,887)	325,550	324,307	1,243	99.6%	332,270	326,955
Transfers and subsidies	558	(56)	-	502	262	240	52.2%	93	93
Payment for capital assets	1,855	2,568	-	4,423	5,666	(1,243)	128.1%	9,000	2,419
4.3 PSYCHIATRIC MENTAL HOSPITALS									
Current payment	510,386	(6,644)	(2,975)	500,767	502,067	(1,300)	100.3%	492,607	490,788
Transfers and subsidies	2,220	56	-	2,276	276	2,000	12.1%	406	406
Payment for capital assets	2,500	1,396	-	3,896	4,641	(745)	119.1%	2,250	414
Total	4,104,162	-	(121,204)	3,982,958	3,979,016	3,942	99.9%	3,864,011	3,860,254

PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3

APPROPRIATION STATEMENT
for the year ended 31 March 2013

Appropriation per programme									
Programme 4 Per Economic classification	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
Current payments									
Compensation of employees	3,308,039	(33,139)	(125,894)	3,149,006	3,145,076	3,930	99.9%	3,134,538	3,171,127
Goods and services	752,306	12,052	-	764,358	764,358	-	100.0%	685,808	662,564
Interest and rent on land	-	-	-	-	229	(229)	0.0%	-	405
Transfers & subsidies									
Households	37,102	8,510	4,690	50,302	50,062	240	99.5%	10,230	10,230
Payment for capital assets									
Buildings & other fixed structures	-	-	-	-	-	-	0.0%	2,000	-
Machinery & equipment	6,715	12,577	-	19,292	19,291	1	100.0%	31,435	15,928
Total	4,104,162	-	(121,204)	3,982,958	3,979,016	3,942	99.9%	3,864,011	3,860,254

PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3

APPROPRIATION STATEMENT
for the year ended 31 March 2013

Detail per programme 5 - CENTRAL HOSPITAL SERVICES

Details per Sub-Programme	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
5.1 PROVINCIAL TERTIARY SERVICES									
Current payment	590,261	-	-	590,261	587,390	2,871	99.5%	549,590	553,069
Payment for capital assets	112,158	-	-	112,158	69,780	42,378	62.2%	97,514	74,006
Total	702,419	-	-	702,419	657,170	45,249	93.6%	647,104	627,075

PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3

APPROPRIATION STATEMENT
for the year ended 31 March 2013

Appropriation per programme									
Programme 5 Per Economic classification	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
Current payments									
Compensation of employees	182,431	-	-	182,431	179,833	2,598	98.6%	141,143	141,107
Goods and services	407,830	-	-	407,830	407,554	276	99.9%	408,447	411,961
Interest and rent on land	-	-	-	-	3	(3)	0.0%	-	1
Payment for capital assets									
Buildings & other fixed structures	25,478	-	-	25,478	23,158	2,320	90.9%	19,918	11,423
Machinery & equipment	86,680	-	-	86,680	46,622	40,058	53.8%	77,596	62,583
Total	702,419	-	-	702,419	657,170	45,249	93.6%	647,104	627,075

PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3

APPROPRIATION STATEMENT
for the year ended 31 March 2013

Detail per programme 6 - HEALTH SCIENCE AND TRAINING

Details per Sub-Programme	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
6.1 NURSING TRAINING COLLEGES									
Current payment	309,969	(2,436)	(22,966)	284,567	284,255	312	99.9%	295,986	293,893
Transfers and subsidies	2,710	-	-	2,710	1,938	772	71.5%	500	312
Payment for capital assets	3,208	2,436	(1,608)	4,036	4,036	-	100.0%	3,269	1,926
6.2 EMSTRAINING COLLEGE									
Current payment	5,219	-	-	5,219	4,435	784	85.0%	4,978	2,612
Transfers and subsidies	-	-	-	-	-	-	0.0%	-	38
6.3 BURSARIES									
Current payment	1,835	-	-	1,835	1,827	8	99.6%	3,920	1,287
Transfers and subsidies	85,260	-	-	85,260	85,039	221	99.7%	69,699	69,699
Payment for capital assets	-	-	-	-	-	-	0.0%	74	74
6.4 OTHER TRAINING									
Current payment	118,382	-	-	118,382	65,965	52,417	55.7%	103,208	92,931
Transfers and subsidies	130,882	-	-	130,882	129,334	1,548	98.8%	127,994	126,319
Payment for capital assets	5,742	-	-	5,742	3,135	2,607	54.6%	18,094	16,712
Payment for financial assets	-	-	-	-	-	-	0.0%	-	21
Total	663,207	-	(24,574)	638,633	579,964	58,669	90.8%	627,722	605,824

**PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3**

**APPROPRIATION STATEMENT
for the year ended 31 March 2013**

Appropriation per programme									
Programme 6 Per Economic classification	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
Current payments									
Compensation of employees	368,317	-	(22,966)	345,351	312,872	32,479	90.6%	332,998	324,974
Goods and services	67,088	(2,436)	-	64,652	43,533	21,119	67.3%	75,094	65,576
Interest and rent on land	-	-	-	-	77	(77)	0.0%	-	173
Transfers & subsidies									
Departmental agencies & accounts	5,800	-	-	5,800	5,709	91	98.4%	-	-
Universities & technikons	68,855	-	-	68,855	68,780	75	99.9%	117,439	115,764
Households	144,197	-	-	144,197	141,822	2,375	98.4%	80,754	80,604
Payment for capital assets									
Machinery & equipment	8,950	2,436	(1,608)	9,778	7,171	2,607	73.3%	21,437	18,712
Payment for financial assets									
	-	-	-	-	-	-	0.0%	-	21
Total	663,207	-	(24,574)	638,633	579,964	58,669	90.8%	627,722	605,824

**PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3**

**APPROPRIATION STATEMENT
for the year ended 31 March 2013**

Detail per programme 7 - HEALTH CARE AND SUPPORT SERVICES									
Details per Sub-Programme	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
7.1 ORTHOTIC AND PROSTHETIC SERVICES									
Current payment	34,930	(183)	(2,437)	32,310	31,229	1,081	96.7%	32,772	31,057
Transfers and subsidies	150	-	-	150	-	150	0.0%	232	131
Payment for capital assets	850	183	-	1,033	879	154	85.1%	1,200	496
7.2 MEDICINE TRADING ACCOUNT									
Current payment	56,593	(112)	(4,886)	51,595	50,615	980	98.1%	53,707	45,369
Transfers and subsidies	612	-	-	612	111	501	18.1%	101	139
Payment for capital assets	1,500	112	-	1,612	1,475	137	91.5%	2,000	1,555
Total	94,635	-	(7,323)	87,312	84,309	3,003	96.6%	90,012	78,747

PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3

APPROPRIATION STATEMENT
for the year ended 31 March 2013

Appropriation per programme									
Programme 7 Per Economic classification	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
Current payments									
Compensation of employees	37,215	-	-	37,215	35,154	2,061	94.5%	35,437	35,436
Goods and services	54,308	(295)	(7,323)	46,690	46,690	-	100.0%	51,042	40,990
Transfers & subsidies									
Households	762	-	-	762	111	651	14.6%	333	270
Payment for capital assets									
Machinery & equipment	2,350	295	-	2,645	2,354	291	89.0%	3,200	2,051
Total	94,635	-	(7,323)	87,312	84,309	3,003	96.6%	90,012	78,747

**PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3**

**APPROPRIATION STATEMENT
for the year ended 31 March 2013**

Detail per programme 8 - HEALTH FACILITIES DEVELOPMENT AND MAINTENANCE

Details per Sub-Programme	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
8.1 COMMUNITY HEALTH FACILITIES									
Current payment	128,085	437	-	128,522	125,104	3,418	97.3%	90,781	76,388
Payment for capital assets	41,736	(12,664)	-	29,072	26,670	2,402	91.7%	63,493	27,058
8.2 EMERGENCY MEDICAL RESCUE SERVICES									
Current payment	-	-	-	-	103	(103)	0.0%	-	1,236
Payment for capital assets	2,154	(1,135)	-	1,019	1,019	-	100.0%	16,594	11,571
8.3 DISTRICT HOSPITAL SERVICES									
Current payment	312,240	28,440	-	340,680	366,937	(26,257)	107.7%	203,883	203,883
Transfers and subsidies	-	-	-	-	-	-	0.0%	13	13
Payment for capital assets	165,290	24,136	-	189,426	162,816	26,610	86.0%	207,235	167,928
8.4 PROVINCIAL HOSPITAL SERVICES									
Current payment	64,775	(19,140)	-	45,635	55,591	(9,956)	121.8%	67,584	70,006
Transfers and subsidies	-	-	-	-	-	-	-	-	-
Payment for capital assets	475,965	(10,337)	-	465,628	425,611	40,017	91.4%	715,374	664,520
8.5 OTHER FACILITIES									
Current payment	27,695	(9,737)	-	17,958	28,317	(10,359)	157.7%	32,821	20,431
Payment for capital assets	-	-	-	-	-	-	0.0%	202	2,010
Total	1,217,940	-	-	1,217,940	1,192,168	25,772	97.9%	1,397,980	1,245,044

PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH
VOTE 3

APPROPRIATION STATEMENT
for the year ended 31 March 2013

Appropriation per programme									
Programme 8 Per Economic classification	2012/13							2011/12	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000		R'000	R'000
Current payments									
Compensation of employees	12,349	-	-	12,349	7,575	4,774	61.3%	6,408	7,096
Goods and services	520,411	-	-	520,411	566,907	(46,496)	108.9%	388,661	357,180
Interest and rent on land	-	-	-	-	1,571	(1,571)	0.0%	-	7,668
Transfers & subsidies									
Households	-	-	-	-	-	-	0.0%	13	13
Payment for capital assets									
Buildings & other fixed structures	628,146	-	-	628,146	575,259	52,887	91.6%	876,897	811,438
Machinery & equipment	57,034	-	-	57,034	40,856	16,178	71.6%	126,001	61,649
Total	1,217,940	-	-	1,217,940	1,192,168	25,772	97.9%	1,397,980	1,245,044

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3NOTES TO THE APPROPRIATION STATEMENT
for the year ended 31 March 2013**1. Detail of transfers and subsidies as per Appropriation Act (after Virement):**

Detail of these transactions can be viewed in the note on Transfers and subsidies, disclosure notes and Annexure I (A-H) to the Annual Financial Statements.

2. Detail of specifically and exclusively appropriated amounts voted (after Virement):

Detail of these transactions can be viewed in note I (Annual Appropriation) to the Annual Financial Statements.

3. Detail on payments for financial assets

Detail of these transactions per programme can be viewed in the note to Payments for financial assets to the Annual Financial Statements.

4. Explanations of material variances from Amounts Voted (after virement):**4.1 Per Programme**

	Final Appropriation	Actual Expenditure	Variance	Variance as a % of Final Appropriation
	R'000	R'000	R'000	%
Pr1 Health Administration	534,631	535,063	(432)	(0.1%)
Pr2 District Health Services	7,901,611	7,953,629	(52,018)	(0.7%)
Pr3 Emergency Medical Services	667,394	619,525	47,869	7.2%

Expenditure-wise, this programme, being the key service delivery platform, is always coming under pressure. This is due to the fact that it is the first port of call for patients. Overall the programme overshot its allocation by R52.02 million. Key contributors to that are goods and services in sub-programme 2.2 (Community Health Clinics). Medicines and vaccines are the items that contributed to the over expenditure of R79.22 million in goods and services. Under expenditure of R3.77 million, R4.92 million and R17.79 million occurred under compensation of employees, departmental agencies and accounts and machinery and equipment respectively. In terms of departmental agencies, non finalisation of SLAs led to the under expenditure. The under-expenditure in machinery and equipment came about as a result of non-delivery of such, even though orders had been placed. Since this programme is also funded through conditional grants, roll overs have been applied for. Details of such are in the Accounting Officer's Report. Service delivery was adversely affected.

The under-expenditure in this programme is R47.87 million and predominantly in goods and services. Of this under-expenditure 90% is related to fleet services. The department as per budget allocation intended to source 190 motor vehicles from the Department of Transport, but out of these only 60 were received by the department resulting in under expenditure.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3NOTES TO THE APPROPRIATION STATEMENT
for the year ended 31 March 2013

	Final Appropriation	Actual Expenditure	Variance	Variance as a % of Final Appropriation
	R'000	R'000	R'000	%

Pr4 Provincial Hospital Services	3,982,958	3,979,016	3,942	0.1%
---	-----------	-----------	-------	------

This programme under spent its allocation by R3.94 million. The main contributor is compensation of employees in sub-programme 4.1 (General Hospital Services). This can be attributed to strict measures imposed by Provincial Treasury with regards to employment and replacement of vacant posts. Service delivery was not adversely affected.

Pr5 Central Hospital Services	702,419	657,170	45,249	6.4%
--------------------------------------	---------	---------	--------	------

R45.25 million was under spent by this programme. R2.60 million, R2.32 million and R40.06 million was underspent in compensation of employees, buildings and other fixed structures and machinery and equipment. The buildings and other fixed structures relate to fencing in Fort England Hospital. Machinery and equipment relates to MRI scanners, CCV cameras and C-Arm X-rays for which orders were placed but delivery did not take place. Despite this, service delivery was not adversely affected as these items are meant to enhance services. As this programme is funded through the National Tertiary Services Grant, roll overs have been applied for. The details thereof are in the Accounting Officer's Report.

Pr6 Health Science and Training	638,633	579,964	58,669	9.2%
--	---------	---------	--------	------

This programme underspent in all the economic classification items. The main contributor is sub-programme 6.5 (Other Training). The inability to employ staff due to constraints imposed by the OTP and Provincial Treasury resulted in under expenditure of R32.48 million in compensation of employees. Goods and services contributed R21.12 million to the underspend. This is mainly from the Skills Levy, wherein most of its activities stalled. As Other Training is funded through the HPTD Grant, roll overs have been applied for. The details thereof are in the Accounting Officer's Report.

Pr7 Health Care And Support Services	87,312	84,309	3,003	3.4%
---	--------	--------	-------	------

The main contributor to this underspend is compensation of employees. The reasons are the same as those given before in other programmes.

Pr8 Health Facilities Development and Maintenance	1,217,940	1,192,168	25,772	2.1%
--	-----------	-----------	--------	------

Overall the programme underspent by R25.77 million. Goods and services, particularly in relation to contracted maintenance of buildings and machinery and equipment, overran the budgeted amount by R46.50 million. Buildings and other fixed structures underspent by R52.89 million due to stops and starts caused by labour relations issues at CMH. Machinery and equipment underspent by R16.18 million due to challenges with supply chain processes. Since this programme receives funding from conditional grants, roll overs have been applied for. Details thereof are in the Accounting Officer's Report. Service delivery was compromised.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3NOTES TO THE APPROPRIATION STATEMENT
for the year ended 31 March 2013

	Final Appropriation	Actual Expenditure	Variance	Variance as a % of Final Appropriation
4.2 Per Economic classification	R'000	R'000	R'000	%
Current expenditure				
Compensation of employees	9,880,089	9,827,473	52,616	0.5%
Goods and services	4,445,640	4,504,153	(58,513)	(1.3%)
Interest and rent on land	-	4,296	(4,296)	0.0%
Transfers and subsidies				
Provinces and municipalities	8,084	7,928	156	1.9%
Departmental agencies and accounts	29,436	24,428	5,008	17.0%
Universities and technikons	101,845	101,770	75	0.1%
Households	263,848	260,360	3,488	1.3%
Payments for capital assets				
Buildings and other fixed structures	654,810	598,417	56,393	8.6%
Machinery and equipment	350,798	273,670	77,128	22.0%
Payments for financial assets	-	17	(17)	0.0%

Explanation of variances**Compensation of employees**

Compensation of employees: There was underspend of R52.62 million in compensation of employees. This is attributable mainly to the constraints put in place by the OTP and Provincial Treasury on filling of vacant posts.

Goods and services

Goods and services: There was overspend of R58.51 million in goods and services. Main contributors to this overspend are programmes 2, in relation to drugs and vaccines, and programme 8 for maintenance of buildings and machinery and equipment.

Transfers and subsidies

Departmental agencies and accounts: R5.01 million was underspent. This is due to Service Level Agreements that had not been finalised with some hospices. Roll overs have been applied for. Details thereof are in the Accounting Officer's Report.

Transfers to Households: An underspend of R3.49 million in leave gratuities occurred. Incomplete documentation provided by beneficiaries caused this underspend. The affected beneficiaries suffered as a consequence.

Payment for capital assets

Buildings and other fixed structures: An underspend of R56.39 million in particular at CMH occurred. This was due to stop and start of the project due to industrial action by employees employed by contractors. As the end date keeps being pushed forward, beneficiaries of the refurbished hospital end up being adversely affected in the long run

Machinery and equipment: There was an underspend of R77.13 million. Supply chain challenges resulted in this under expenditure. As most of the machinery and equipment was bought to enhance service delivery, beneficiaries in the short term were not adversely affected. However, if this continues, then in the long run service delivery will be compromised.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3NOTES TO THE APPROPRIATION STATEMENT
for the year ended 31 March 2013

	Final Appropriation	Actual Expenditure	Variance	Variance as a % of Final Appropriation
4.3 Per conditional grant	R'000	R'000	R'000	%
National Tertiary Services Grant	702,419	657,292	45,127	6.4%
Comprehensive Hiv/Aids Grant	1,069,137	1,040,502	28,635	2.7%
Hospital Revitalisation Grant	460,173	414,560	45,613	9.9%
Health Professionals Training and Development Grant	183,021	178,743	4,278	2.3%
Health Infrastructure Grant	306,714	302,716	3,998	1.3%
National Health Insurance Grant	11,500	8,094	3,406	29.6%
Nursing Colleges and Schools	14,660	12,394	2,266	15.5%
AFCON	3,000	2,353	647	21.6%
EPWP Incentive Social Cluster	13,780	13,699	81	0.6%
EPWP Incentive	1,000	1,000	0	0.0%
	2,765,404	2,631,353	134,051	

R45.13million was under spent by this Grant. R3.31 million, R1.11 million and R40.71 million was underspent in compensation of employees, buildings and other fixed structures and machinery and equipment. The buildings and other fixed structures relate to fencing in Fort England Hospital. Machinery and equipment relates to MRI scanners, CCV cameras and C-Arm X-rays for which orders were placed but delivery did not take place. Despite this, service delivery was not adversely affected as these items are meant to enhance services. As this programme is funded through the National Tertiary Services Grant, roll overs have been applied for.

Hospital Revitalisation underspent Buildings and other fixed structures by R45.79 million due to stops and starts caused by labour relations issues at CMH.

Nursing Colleges Grant under spent in goods and Services by R2.266 million due to challenges with supply chain processes. Roll overs have been applied for.

The NHI under spending is due to delay and the lengthy process in revising the business plan which was finally approved on the 28 November 2012.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3STATEMENT OF FINANCIAL PERFORMANCE
for the year ended 31 March 2013

PERFORMANCE	Note	2012/13 R'000	2011/12 R'000
REVENUE			
Annual appropriation	1	15,732,898	14,810,982
Statutory appropriation	2	1,652	1,586
Departmental revenue	3	33,044	10,274
Aid assistance	4	4,116	-
TOTAL REVENUE		15,771,710	14,822,842
EXPENDITURE			
Current expenditure			
Compensation of employees	5	9,827,473	9,480,557
Goods and services	6	4,504,153	4,019,162
Interest and rent on land	7	4,296	13,970
Aid assistance	4	2,990	8,707
Total current expenditure		14,338,912	13,522,396
Transfers and subsidies	9	394,486	310,300
Expenditure for capital assets			
Tangible capital assets	10	872,475	1,068,184
Payments for financial assets	8	17	109
TOTAL EXPENDITURE		15,605,890	14,900,989
SURPLUS/(DEFICIT) FOR THE YEAR		165,820	(78,147)
Reconciliation of Net Surplus/(Deficit) for the year			
Voted Funds		132,038	(79,714)
Departmental revenue and NRF Receipts	17	33,044	10,274
Aid assistance	4	738	(8,707)
SURPLUS/(DEFICIT) FOR THE YEAR		165,820	(78,147)

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3STATEMENT OF FINANCIAL POSITION
for the year ended 31 March 2013

POSITION	Note	2012/13 R'000	2011/12 R'000
ASSETS			
Current Assets			
Unauthorised expenditure	11	1,358,263	1,305,814
Cash and cash equivalents	13	6	12
Prepayments and advances	14	7	-
Receivables	15	112,824	107,892
TOTAL ASSETS		1,471,100	1,413,718
LIABILITIES			
Current Liabilities			
Voted funds to be surrendered to the Revenue Fund	16	609,972	426,398
Departmental revenue and NRF Receipts to be surrendered to the Revenue Fund	17	10,812	12,536
Bank overdraft	18	822,799	957,536
Payables	19	4,803	4,861
Aid assistance unutilised	4	7,323	6,585
TOTAL LIABILITIES		1,455,709	1,407,916
NET ASSETS		15,391	5,802
Represented by:			
Recoverable revenue		15,391	5,802
TOTAL		15,391	5,802

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3STATEMENT OF CHANGES TO NET ASSETS
for the year ended 31 March 2013

NET ASSETS	Note	2012/13 R'000	2011/12 R'000
Recoverable revenue			
Opening balance		5,802	11,607
Transfers		9,589	(5,805)
Debts revised		(518)	(8,198)
Debts recovered (included in departmental receipts)		(1,779)	(660)
Debts raised		11,886	3,053
Closing balance		15,391	5,802

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3CASH FLOW STATEMENT
for the year ended 31 March 2013

	Note	2012/13 R'000	2011/12 R'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Receipts		15,852,191	14,651,495
Annual appropriated funds received	1.1	15,731,969	14,561,659
Statutory appropriated funds received	2	1,668	1,586
Departmental revenue received	3	114,438	88,250
Aid assistance received	4	4,116	-
Net (increase)/ decrease in working capital		(57,446)	(123,664)
Surrendered to Revenue Fund		(116,162)	(94,290)
Current payments		(14,286,463)	(13,221,889)
Payments for financial assets		(17)	(109)
Transfers and subsidies paid		(394,486)	(310,300)
Net cash flow available from operating activities	20	997,617	901,243
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for capital assets	10	(872,475)	(1,068,184)
Proceeds from sale of capital assets	3.4	-	361
(Increase)/ decrease in other financial assets			
Net cash flows from investing activities		(872,475)	(1,067,823)
CASH FLOWS FROM FINANCING ACTIVITIES			
Increase/ (decrease) in net assets		9,589	(5,805)
Net cash flows from financing activities		9,589	(5,805)
Net increase/ (decrease) in cash and cash equivalents		134,731	(172,385)
Cash and cash equivalents at beginning of period		(957,524)	(785,139)
Cash and cash equivalents at end of period	21	(822,793)	(957,524)

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

ACCOUNTING POLICIES
for the year ended 31 March 2013

The Financial Statements have been prepared in accordance with the following policies, which have been applied consistently in all material aspects, unless otherwise indicated. However, where appropriate and meaningful, additional information has been disclosed to enhance the usefulness of the Financial Statements and to comply with the statutory requirements of the Public Finance Management Act, Act 1 of 1999 (as amended by Act 29 of 1999), and the Treasury Regulations issued in terms of the Act and the Division of Revenue Act, Act 5 of 2013.

I. Presentation of the Financial Statements

I.1 Basis of preparation

The financial statements have been prepared on a modified cash basis of accounting.

Under this basis, the effects of transactions and other events are recognised in the financial records when the resulting cash is received or paid. The “modification” results from the recognition of certain near-cash balances in the financial statements as well as the revaluation of foreign investments and loans and the recognition of resulting revaluation gains and losses.

In addition supplementary information is provided in the disclosure notes to the financial statements where it is deemed to be useful to the users of the financial statements.

I.2 Presentation currency

All amounts have been presented in the currency of the South African Rand (R) which is also the functional currency of the department.

I.3 Rounding

Unless otherwise stated all financial figures have been rounded to the nearest one thousand Rand (R'000).

I.4 Comparative figures

Prior period comparative information has been presented in the current year's financial statements. Where necessary figures included in the prior period financial statements have been reclassified to ensure that the format in which the information is presented is consistent with the format of the current year's financial statements.

I.5 Comparative figures - Appropriation Statement

A comparison between actual amounts and final appropriation per major classification of expenditure is included in the Appropriation Statement.

2. Revenue

2.1 Appropriated funds

Appropriated funds comprises of departmental allocations as well as direct charges against revenue fund (i.e. statutory appropriation).

Appropriated funds are recognised in the financial records on the date the appropriation becomes effective. Adjustments made in terms of the adjustments budget process are recognised in the financial records on the date the adjustments become effective.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

ACCOUNTING POLICIES
for the year ended 31 March 2013

Unexpended appropriated funds are surrendered to the Provincial Revenue Fund. Any amounts owing to the Provincial Revenue Fund at the end of the financial year are recognised as a payable in the statement of financial position.

Any amount due from the Provincial Revenue Fund at the end of the financial year is recognised as a receivable in the statement of financial position.

2.2 Departmental revenue

All departmental revenue is recognised in the statement of financial performance when received and is subsequently paid into the Provincial Revenue Fund, unless stated otherwise.

Any amount owing to the Provincial Revenue Fund at the end of the financial year is recognised as a payable in the statement of financial position.

No accrual is made for amounts receivable from the last receipt date to the end of the reporting period. These amounts are however disclosed in the disclosure notes to the annual financial statements.

2.3 Direct Exchequer receipts

All direct exchequer receipts are recognised in the statement of financial performance when the cash is received and is subsequently paid into the Provincial Revenue Fund, unless stated otherwise.

Any amount owing to the Provincial Revenue Fund at the end of the financial year is recognised as a payable in the statement of financial position.

2.4 Direct Exchequer payments

All direct exchequer payments are recognised in the statement of financial performance when final authorisation for payment is effected on the system (by no later than 31 March of each year).

2.5 Aid assistance

Aid assistance is recognised as revenue when received.

All in-kind aid assistance is disclosed at fair value on the date of receipt in the annexures to the Annual Financial Statements.

The cash payments made during the year relating to aid assistance projects are recognised as expenditure in the statement of financial performance when final authorisation for payment is effected on the system (by no later than 31 March of each year).

The value of the assistance expensed prior to the receipt of funds is recognised as a receivable in the statement of financial position.

Inappropriately expensed amounts using aid assistance and any unutilised amounts are recognised as payables in the statement of financial position.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

ACCOUNTING POLICIES
for the year ended 31 March 2013

3. Expenditure

3.1 Compensation of employees

3.1.1 Salaries and wages

Salaries and wages are expensed in the statement of financial performance when the final authorisation for payment is effected on the system (by no later than 31 March of each year).

Other employee benefits that give rise to a present legal or constructive obligation are disclosed in the disclosure notes to the financial statements at its face value and are not recognised in the statement of financial performance or position.

Employee costs are capitalised to the cost of a capital project when an employee spends more than 50% of his/her time on the project. These payments form part of expenditure for capital assets in the statement of financial performance.

3.1.2 Social contributions

Employer contributions to post employment benefit plans in respect of current employees are expensed in the statement of financial performance when the final authorisation for payment is effected on the system (by no later than 31 March of each year).

No provision is made for retirement benefits in the financial statements of the department. Any potential liabilities are disclosed in the financial statements of the National Revenue Fund and not in the financial statements of the employer department.

Employer contributions made by the department for certain of its ex-employees (such as medical benefits) are classified as transfers to households in the statement of financial performance.

3.2 Goods and services

Payments made during the year for goods and/or services are recognised as an expense in the statement of financial performance when the final authorisation for payment is effected on the system (by no later than 31 March of each year).

The expense is classified as capital if the goods and/or services were acquired for a capital project or if the total purchase price exceeds the capitalisation threshold (currently R5,000). All other expenditures are classified as current.

Rental paid for the use of buildings or other fixed structures is classified as goods and services and not as rent on land.

3.3 Interest and rent on land

Interest and rental payments are recognised as an expense in the statement of financial performance when the final authorisation for payment is effected on the system (by no later than 31 March of each year). This item excludes rental for the use of buildings or other fixed structures. If it is not possible to distinguish between payment for the use of land and the fixed structures on it, the whole amount is recorded under goods and services.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

ACCOUNTING POLICIES
for the year ended 31 March 2013

3.4 Payments for financial assets

Debts are written off when identified as irrecoverable. Debts written-off are limited to the amount of savings and/or underspending of appropriated funds. The write off occurs at year-end or when funds are available. No provision is made for irrecoverable amounts but an estimate is included in the disclosure notes to the financial statements.

All other losses are recognised when authorisation has been granted for the recognition thereof.

3.5 Transfers and subsidies

Transfers and subsidies are recognised as an expense when the final authorisation for payment is effected on the system (by no later than 31 March of each year).

3.6 Unauthorised expenditure

When confirmed unauthorised expenditure is recognised as an asset in the statement of financial position until such time as the expenditure is either approved by the relevant authority, recovered from the responsible person or written off as irrecoverable in the statement of financial performance.

Unauthorised expenditure approved with funding is derecognised in the statement of financial position when the unauthorised expenditure is approved and the related funds are received.

Where the amount is approved without funding it is recognised as expenditure in the statement of financial performance on the date stipulated in the Act.

3.7 Fruitless and wasteful expenditure

Fruitless and wasteful expenditure is recognised as expenditure in the statement of financial performance according to the nature of the payment and not as a separate line item on the face of the statement. If the expenditure is recoverable it is treated as an asset until it is recovered from the responsible person or written off as irrecoverable in the statement of financial performance.

3.8 Irregular expenditure

Irregular expenditure is recognised as expenditure in the statement of financial performance. If the expenditure is not condoned by the relevant authority it is treated as an asset until it is recovered or written off as irrecoverable.

4. Assets

4.1 Cash and cash equivalents

Cash and cash equivalents are carried in the statement of financial position at cost.

Bank overdrafts are shown separately on the face of the statement of financial position.

For the purposes of the cash flow statement, cash and cash equivalents comprise cash on hand, deposits held, other short-term highly liquid investments and bank overdrafts.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

ACCOUNTING POLICIES
for the year ended 31 March 2013

4.2 Other financial assets

Other financial assets are carried in the statement of financial position at cost.

4.3 Prepayments and advances

Amounts prepaid or advanced are recognised in the statement of financial position when the payments are made and are derecognised as and when the goods/services are received or the funds are utilised.

Prepayments and advances outstanding at the end of the year are carried in the statement of financial position at cost.

4.4 Receivables

Receivables included in the statement of financial position arise from cash payments made that are recoverable from another party (including departmental employees) and are derecognised upon recovery or write-off.

Receivables outstanding at year-end are carried in the statement of financial position at cost plus any accrued interest. Amounts that are potentially irrecoverable are included in the disclosure notes.

4.5 Investments

Capitalised investments are shown at cost in the statement of financial position.

Investments are tested for an impairment loss whenever events or changes in circumstances indicate that the investment may be impaired. Any impairment loss is included in the disclosure notes.

4.6 Loans

Loans are recognised in the statement of financial position when the cash is paid to the beneficiary. Loans that are outstanding at year-end are carried in the statement of financial position at cost plus accrued interest.

Amounts that are potentially irrecoverable are included in the disclosure notes.

4.7 Inventory

Inventories that qualify for recognition must be initially reflected at cost. Where inventories are acquired at no cost, or for nominal consideration, their cost shall be their fair value as at the date of acquisition.

All inventory items at year-end are reflected using either the weighted average cost or FIFO cost formula.

4.8 Capital assets

4.8.1 Movable assets

Initial recognition

A capital asset is recorded in the asset register on receipt of the item at cost. Cost of a capital asset is defined as the total cost of acquisition. Where the cost cannot be determined accurately, the movable capital asset is stated at fair value. Where fair value cannot be determined, the capital asset is included in the asset register at R1.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

ACCOUNTING POLICIES
for the year ended 31 March 2013

All assets acquired prior to 1 April 2002 are included in the asset register at R1.

Subsequent expenditure

Subsequent expenditure of a capital nature is recorded in the statement of financial performance as “expenditure for capital assets” and is capitalised in the asset register of the department on completion of the project.

Repairs and maintenance is expensed as current “goods and services” in the statement of financial performance.

4.8.2 Immovable assets

Initial recognition

A capital asset is recorded on receipt of the item at cost. Cost of an asset is defined as the total cost of acquisition. Where the cost cannot be determined accurately, the immovable capital asset is stated at R1 unless the fair value for the asset has been reliably estimated.

Subsequent expenditure

Work-in-progress of a capital nature is recorded in the statement of financial performance as “expenditure for capital assets”. On completion, the total cost of the project is included in the asset register of the department that is accountable for the asset.

Repairs and maintenance is expensed as current “goods and services” in the statement of financial performance.

4.8.3 Intangible assets

Initial recognition

An intangible asset is recorded in the asset register on receipt of the item at cost. Cost of an intangible asset is defined as the total cost of acquisition. Where the cost cannot be determined accurately, the intangible asset is stated at fair value. Where fair value cannot be determined, the intangible asset is included in the asset register at R1.

All intangible assets acquired prior to 1 April 2002 can be included in the asset register at R1.

Subsequent expenditure

Subsequent expenditure of a capital nature is recorded in the statement of financial performance as “expenditure for capital assets” and is capitalised in the asset register of the department.

Maintenance is expensed as current “goods and services” in the statement of financial performance.

5. Liabilities

5.1 Payables

Recognised payables mainly comprise of amounts owing to other governmental entities. These payables are carried at cost in the statement of financial position.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

ACCOUNTING POLICIES
for the year ended 31 March 2013

5.2 Contingent liabilities

Contingent liabilities are included in the disclosure notes to the financial statements when it is possible that economic benefits will flow from the department, or when an outflow of economic benefits or service potential is probable but cannot be measured reliably.

5.3 Contingent assets

Contingent assets are included in the disclosure notes to the financial statements when it is probable that an inflow of economic benefits will flow to the entity.

5.4 Commitments

Commitments are not recognised in the statement of financial position as a liability or as expenditure in the statement of financial performance but are included in the disclosure notes.

5.5 Accruals

Accruals are not recognised in the statement of financial position as a liability or as expenditure in the statement of financial performance but are included in the disclosure notes.

5.6 Employee benefits

Short-term employee benefits that give rise to a present legal or constructive obligation are disclosed in the disclosure notes to the financial statements. These amounts are not recognised in the statement of financial performance or the statement of financial position.

5.7 Lease commitments

Finance leases

Finance leases are not recognised as assets and liabilities in the statement of financial position. Finance lease payments are recognised as an expense in the statement of financial performance and are not apportioned between the capital and the interest portions. The finance lease liability is disclosed in the disclosure notes to the financial statements.

Operating leases

Operating lease payments are recognised as an expense in the statement of financial performance. The operating lease commitments are disclosed in the disclosure notes to the financial statements.

5.8 Impairment

The department tests for impairment where there is an indication that a receivable, loan or investment may be impaired. An assessment of whether there is an indication of possible impairment is done at each reporting date. An estimate is made for doubtful loans and receivables based on a review of all outstanding amounts at year-end. Impairments on investments are calculated as being the difference between the carrying amount and the present value of the expected future cash flows / service potential flowing from the instrument.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

ACCOUNTING POLICIES
for the year ended 31 March 2013

5.9 Provisions

Provisions are disclosed when there is a present legal or constructive obligation to forfeit economic benefits as a result of events in the past and it is probable that an outflow of resources embodying economic benefits will be required to settle the obligation and a reliable estimate of the obligation can be made.

6. Receivables for departmental revenue

Receivables for departmental revenue are disclosed in the disclosure notes to the annual financial statements.

7. Net Assets

7.1 Capitalisation reserve

The capitalisation reserve comprises of financial assets and/or liabilities originating in a prior reporting period but which are recognised in the statement of financial position for the first time in the current reporting period. Amounts are recognised in the capitalisation reserves when identified in the current period and are transferred to the Provincial Revenue Fund when the underlying asset is disposed and the related funds are received.

7.2 Recoverable revenue

Amounts are recognised as recoverable revenue when a payment made in a previous financial year becomes recoverable from a debtor in the current financial year. Amounts are either transferred to the Provincial Revenue Fund when recovered or are transferred to the statement of financial performance when written-off.

8. Related party transactions

Specific information with regards to related party transactions is included in the disclosure notes.

9. Key management personnel

Compensation paid to key management personnel including their family members where relevant, is included in the disclosure notes.

10. Public private partnerships

A description of the PPP arrangement, the contract fees and current and capital expenditure relating to the PPP arrangement is included in the disclosure notes.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013**I. Annual Appropriation**

Included are funds appropriated in terms of the Appropriation Act (and the Adjustments Appropriation Act) for the Department.

I.1 Annual Appropriation

		2012/13	2011/12
		Actual Funds Received	Appropriation Received
		Funds not requested/ not received	
		R'000	R'000
Programmes	Final Appropriation R'000	R'000	R'000
Pr1 Health Administration	534,631	540,075	543,899
Pr2 District Health Services	7,901,611	7,685,943	6,949,687
Pr3 Emergency Medical Services	667,394	723,979	644,801
Pr4 Provincial Hospital Services	3,982,958	4,104,090	3,847,681
Pr5 Central Hospital Services	702,419	702,219	627,075
Pr6 Health Science and Training	638,633	663,204	615,824
Pr7 Health Care and Support Services	87,312	94,535	84,747
Pr8 Health Facilities Development and Maintenance	1,217,940	1,217,924	1,247,945
Total	15,732,898	15,731,969	14,561,659

Funds not requested was mainly due to underspend on conditional grants.

I.2 Conditional grants

Total grants received	38	2,764,476	2,678,208
Provincial grants included in Total Grants received		302,715	376,764

2 Statutory Appropriation

Member of executive committee/parliamentary officers		1,652	1,586
Total		1,652	1,586
Actual Statutory Appropriation received		1,668	1,586

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

	Note	2012/13 R'000	2011/12 R'000
3 Departmental Revenue			
Sales of goods and services other than capital assets	3.1	106,911	81,144
Interest, dividends and rent on land	3.2	297	-
Sales of capital assets	3.4	-	361
Transactions in financial assets and liabilities	3.5	7,230	7,106
Total revenue collected		114,438	88,611
Less: Own revenue included in appropriation	17	81,394	78,337
Departmental revenue collected		33,044	10,274
3.1 Sales of goods and services other than capital assets	3		
Sales of goods and services produced by the department		106,724	81,002
Sales by market establishment		9,128	8,247
Administrative fees		1,116	901
Other sales		96,480	71,854
Sales of scrap, waste and other used current goods		187	142
Total		106,911	81,144
3.2 Interest, dividends and rent on land	3		
Interest		297	-
Total		297	-
3.4 Sales of capital assets	3		
Tangible assets		-	361
Machinery and equipment		-	361
3.5 Transactions in financial assets and liabilities	3		
Receivables		1,600	1,965
Stale cheques written back		103	110
Other Receipts including Recoverable Revenue		5,527	5,031
Total		7,230	7,106

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

	Note	2012/13 R'000	2011/12 R'000
4 Aid Assistance			
4.1 Aid assistance received in cash from RDP			
Local			
Opening Balance			
Revenue		2,115	-
Expenditure		-	-
Current		-	-
Capital		-	-
Closing Balance		2,115	-
Foreign			
Opening Balance		6,585	15,292
Revenue		2,001	-
Expenditure		(3,378)	(8,707)
Current		(2,990)	(8,707)
Capital		(388)	-
Closing Balance		5,208	6,585
4.2 Total			
Opening Balance		6,585	15,292
Revenue		4,116	-
Expenditure		(3,378)	(8,707)
Current		(2,990)	(8,707)
Capital		(388)	-
Closing Balance		7,323	6,585
4.3 Analysis of balance			
Aid assistance unutilised		7,323	6,585
RDP		7,323	6,585
Closing balance		7,323	6,585

Note: The net movement in the 2012/2013 financial year is R866.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

	Note	2012/13 R'000	2011/12 R'000
5 Compensation of Employees			
5.1 Salaries and wages			
Basic salary		6,462,942	6,273,046
Performance award		-	6,995
Service Based		9,410	14,680
Compensative/circumstantial		862,447	815,607
Periodic payments		16,831	23,453
Other non-pensionable allowances		1,242,709	1,170,637
Total		8,594,339	8,304,418
5.2 Social Contributions			
Employer contributions			
Pension		782,619	752,331
Medical		449,318	422,351
UIF		1	238
Bargaining council		1,196	1,219
Total		1,233,134	1,176,139
Total compensation of employees		9,827,473	9,480,557
Average number of employees		48,121	47,840

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

	Note	2012/13 R'000	2011/12 R'000
6 Goods and services			
Administrative fees		2,055	3,832
Advertising		5,087	4,708
Assets less than R5,000	6.1	47,463	41,592
Bursaries (employees)		2,722	464
Catering		3,764	5,904
Communication		109,226	90,250
Computer services	6.2	61,345	42,012
Consultants, contractors and agency/outsourced services	6.3	1,186,895	1,151,448
Entertainment		140	149
Audit cost – external	6.4	19,806	20,141
Fleet services		151,368	99,510
Inventory	6.5	1,859,114	1,672,406
Operating leases		41,088	434,198
Property payments	6.6	801,522	324,712
Transport provided as part of the departmental activities		1,256	891
Travel and subsistence	6.7	170,528	71,649
Venues and facilities		8,262	13,214
Training and development		8,212	17,013
Other operating expenditure	6.8	24,300	25,069
Total		4,504,153	4,019,162

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

	Note	2012/13 R'000	2011/12 R'000
6.1 Assets less than R5,000	6		
Tangible assets		47,463	41,592
Machinery and equipment		47,463	41,592
Total		47,463	41,592
6.2 Computer services	6		
SITA computer services		53,652	34,338
External computer service providers		7,693	7,674
Total		61,345	42,012
6.3 Consultants, contractors and agency/outsourced services	6		
Business and advisory services		147,850	188,441
Infrastructure and planning		93	66
Laboratory services		464,681	393,246
Legal costs		44,988	51,564
Contractors		164,990	346,614
Agency and support/outsourced services		364,293	171,517
Total		1,186,895	1,151,448
6.4 Audit cost – external	6		
Regularity audits		19,806	20,141
Total		19,806	20,141
6.5 Inventory	6		
Learning and teaching support material		3	-
Food and food supplies		140,226	132,862
Fuel, oil and gas		54,347	53,582
Other consumables		119,246	121,366
Materials and supplies		17,436	17,896
Stationery and printing		50,763	46,916
Medical supplies		446,168	438,442
Medicine		1,030,925	861,342
Total		1,859,114	1,672,406

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

	Note	2012/13 R'000	2011/12 R'000
6.6 Property payments	6		
Municipal services		189,183	139,777
Property maintenance and repairs		612,339	184,935
Total		801,522	324,712
6.7 Travel and subsistence	6		
		170,528	71,649
Local		170,053	71,027
Foreign		475	622
Total		170,528	71,649
6.8 Other operating expenditure	6		
Professional bodies, membership and subscription fees		358	180
Resettlement costs		2,850	6,355
Courier and delivery services		17,948	15,630
Other		3,144	2,904
Total		24,300	25,069
7 Interest and Rent on Land			
Interest paid		4,296	13,970
Total		4,296	13,970

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

	Note	2012/13 R'000	2011/12 R'000
8 Payments for financial assets			
Material losses through criminal conduct			
Other material losses	8.1	17	109
Total		17	109
8.1 Other material losses	8		
Nature of other material losses			
Incident	Disciplinary Steps taken/ Criminal proceedings		
Theft of computer	Reported to SAPS	17	109
Total		17	109

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

	Note	2012/13 R'000	2011/12 R'000
9 Transfers and Subsidies			
Provinces and municipalities	Annexure IB	7,928	-
Departmental agencies and accounts	Annexure IC	24,427	42,412
Universities and technikons	Annexure ID	101,770	133,974
Households	Annexure IH	260,361	133,914
Total		394,486	310,300
10 Expenditure for capital assets			
Tangible assets		872,475	1,068,184
Buildings and other fixed structures	37	598,416	830,211
Machinery and equipment	35	274,059	237,973
Total		872,475	1,068,184

10.1 Analysis of funds utilised to acquire capital assets - 2012/13

	Voted Funds R'000	Aid Assistance R'000	TOTAL R'000
Tangible assets	872,087	388	872,475
Buildings and other fixed structures	598,416	-	598,416
Machinery and equipment	273,671	388	274,059
Total	872,087	388	872,475

10.2 Analysis of funds utilised to acquire capital assets - 2011/12

	Voted Funds R'000	Aid Assistance R'000	TOTAL R'000
Tangible assets	1,068,184	-	1,068,184
Buildings and other fixed structures	830,211	-	830,211
Machinery and equipment	237,973	-	237,973
Total	1,068,184	-	1,068,184

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

	Note	2012/13 R'000	2011/12 R'000
II			
II.1			
Opening balance		1,305,814	1,188,823
Unauthorised expenditure - discovered in the current year		52,449	300,507
Less: Amounts approved by Parliament/Legislature with funding	16	-	(183,516)
Unauthorised expenditure awaiting authorisation / written off		1,358,263	1,305,814
II.2			
Analysis of unauthorised expenditure awaiting authorisation per economic classification			
Current		1,104,748	1,052,299
Capital		244,994	244,994
Transfers and subsidies		8,521	8,521
Total		1,358,263	1,305,814
II.3			
Analysis of unauthorised expenditure awaiting authorisation per type			
Unauthorised expenditure relating to overspending of the vote or a main division within the vote		1,358,263	1,305,814
Total		1,358,263	1,305,814
II.4			
Details of unauthorised expenditure - current year			2012/13 R'000
Incident	Disciplinary steps taken/criminal proceedings		
Current year over expenditure Program 2			52,018
Current year over expenditure Program 1			431
Total			52,449

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

	Note	2012/13 R'000	2011/12 R'000
12	Fruitless and wasteful expenditure		
12.1	Reconciliation of fruitless and wasteful expenditure		
	Opening balance	-	3,651
	Less: Amounts condoned	-	(3,651)
	Current	-	(2,986)
	Capital	-	(156)
	Transfers and subsidies	-	(509)
	Fruitless and wasteful expenditure awaiting condonement	-	-
13	Cash and Cash Equivalents		
	Cash receipts	6	12
	Disbursements		
	Total	6	12
14	Prepayments and Advances		
	Travel and subsistence	7	-
		7	-

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

	Note	Less than a year R'000	One to three years R'000	Older than three years R'000	Total R'000	2011/12 R'000
15. Receivables						
Claims recoverable	15.1 / Ann 4			2,200	2,200	5,941
Trade receivables	15.2	-	54	1,021	1,075	9,673
Recoverable expenditure	15.3	2,453	44,783	461	47,697	4,949
Staff debt	15.4	2,340	1,601	7,581	11,522	6,169
Other debtors	15.5	10,908	20,996	18,426	50,330	81,160
Total		15,701	67,434	29,689	112,824	107,892
				Note	2012/13 R'000	2011/12 R'000
15.1 Claims recoverable	15					
National departments					42	105
Provincial departments					2,158	5,836
Total					2,200	5,941
15.2 Trade receivables	15					
Suppliers					1,075	9,673
Total					1,075	9,673
15.3 Recoverable expenditure (disallowance accounts)	15					
Dishonoured Cheques					17	16
Disallowances damages and losses					512	512
Salary rebates					5,475	4,421
Write back of 2011/12 debt write off					41,693	-
Total					47,697	4,949
15.4 Staff debt	15					
Salary Debt					11,522	6,169
Total					11,522	6,169
15.5 Other debtors	15					
Medsas debtors					118	-
Salary & Deductions					55	129
Ex-Employees					50,157	80,905
Other Debtors					-	126
Total					50,330	81,160

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

	Note	2012/13 R'000	2011/12 R'000
16 Voted Funds to be Surrendered to the Revenue Fund			
Opening balance		426,398	454,928
Transfer from statement of financial performance		132,038	(79,714)
Add: Unauthorised expenditure for current year	11	52,465	300,507
Voted funds not requested/not received	1.1	(929)	(249,323)
Paid during the year			
Closing balance		609,972	426,398
17 Departmental revenue and NRF Receipts to be surrendered to the Revenue Fund			
Opening balance			
Transfer from Statement of Financial Performance		12,536	18,215
Own revenue included in appropriation		33,044	10,274
Paid during the year		81,394	78,337
Closing balance		(116,162)	(94,290)
		10,812	12,536
18 Bank Overdraft			
Consolidated Paymaster General Account		822,799	957,536
Total		822,799	957,536
19 Payables - current			
Amounts owing to other entities	Annex 5	540	634
Clearing accounts	19.1	4,263	4,227
Total		4,803	4,861
19.1 Clearing accounts			
Salary finance and other institutions	19	506	475
Pension recoverable		3,757	3,752
Total		4,263	4,227

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

	Note	2012/13 R'000	2011/12 R'000
20 Net cash flow available from operating activities			
Net surplus/(deficit) as per Statement of Financial Performance		165,820	(78,147)
Add back non cash/cash movements not deemed operating activities		831,797	979,390
(Increase)/decrease in receivables – current		(4,932)	(9,273)
(Increase)/decrease in prepayments and advances		(7)	-
(Increase)/decrease in other current assets		-	187,167
Increase/(decrease) in payables – current		(58)	(1,051)
Proceeds from sale of capital assets		-	(361)
Expenditure on capital assets		872,475	1,068,184
Surrenders to Revenue Fund		(116,162)	(94,290)
Voted funds not requested/not received		(913)	(249,323)
Own revenue included in appropriation		81,394	78,337
Net cash flow generated by operating activities		997,617	901,243
21 Reconciliation of cash and cash equivalents for cash flow purposes			
Consolidated Paymaster General account		(822,799)	(957,536)
Cash receipts		6	12
Total		(822,793)	(957,524)

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

	Note	2012/13 R'000	2011/12 R'000
22			
Contingent liabilities and contingent assets			
22.1			
Contingent liabilities			
Liable to	Nature		
Housing loan guarantees	Employees	Annex 3A 5,638	9,473
Claims against the department		Annex 3B 1,541,766	1,110,534
Other interdepartmental payables		Annex 5 112	994
Other		Annex 3B 39,130	12,171
Total		1,586,646	1,133,172
22.2			
Contingent assets	Note		
Nature of contingent asset			
OSD		887	887
HRPOT		-	388,985
Total		887	389,872

HROPT

Relating to HROPT above, during the current year, affected employees have had R100 per month deducted from their salaries and this amounted to R0,3 million in the current year. This amount has been included in revenue and paid over to the revenue fund. If all affected staff resign or are dismissed, the full amount of HROPT owing becomes receivable by the department (R456,5 million). If all affected staff pay their R100 until they retire, the department will recover R11,9 million. If affected staff die, none of the outstanding balances receivable by the department. Due to the uncertainty relating to the combination of the above scenarios, the value of the contingent asset relating to HROPT payments is between nil and R456,5 million. The present value of R11,9 million is R6,6 million and this has been included in Staff debt per note 15 above.

OSD

PSCBC Resolution 1 of 2007 introduced Occupation Specific Dispensations (OSD) for various categories of professions in the public service. Since then, the public health sector has adopted a total of 5 categories of OSD as follows:

- Nurses' OSD – PHSDSBC Res.3 of 2007
- Social Services Occupations' OSD – PHSDSBC Res.3 of 2008
- Medical Cluster OSD – PHSDSBC Res.3 of 2009 and Res. 1 of 2010
- Allied Health Professionals' OSD – PHSDSBC Res.2 of 2010
- Engineers and Artisans PHSDSBC Res.2 of 2012

Implementation of these OSD's has proven to be a challenge for reasons of poor planning and budgeting across levels of implementation. For instance, all OSD's have been characterised by under-funding; not knowing exact numbers of intended beneficiaries; and interpretation and application that is elastic (especially with the nurses' OSD). As a result, some OSD such as nursing personnel are still being implemented to this day as implementation does not have a specific cut-off point.

In the main, the outstanding OSD for implementation is the Engineers cluster which is estimated to R5million. Payment awaits Internal Audit verification process and availability of funding as this OSD is an unfunded mandate. As part of the HR accruals a number of cases relate to OSD especially for the Allied Health Professionals, Nurses, and a few from other categories.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

Other reasons for contingent liability:

- delays in submitting proof of experience \additional information e.g. registration certificates, etc;
- availability of funds to pay for outstanding cases – OSD mandated was under-funded. For instance, additional cases following the nurses' OSD arbitration award were simply not funded – resulting in these becoming accruals.

In managing the underpayments, the Department has undertaken verification procedures with Internal Audit to verify the validity of the claims against the relevant OSD prescripts. The plan is to pay these as part of the HR accruals.

Walter Sisulu University

The department utilises various institutions, government entities, Universities, technikons and CBOs as vehicles to deliver services to the communities of the province. The nature of services to be rendered and relationship with these organisations is governed by Service Level Agreements. During the year under review, the department transferred R134.13 million to Hospices, Universities and technikons and to Municipalities. Details on these transfer payments are given in Annexures IC, ID and IB respectively of the Annual Financial Statements section.

Funds were transferred to various Universities and technikons for the provision of Health Sciences, Training & Development. Municipalities received funds for the devolution of environmental health. The department monitored these institutions / entities to ensure that the allocated funds were spent as planned and detailed in the Service Level Agreements.

Other than transfer payments to the Walter Sisulu University, the Department obtained assurance from each entity that received a transfer, that the entity implements effective, efficient and transparent financial management and internal control systems, as required by TR 18.3.1 ©.

The Walter Sisulu University (WSU) has been funded extensively from the Health Professions Training and Development Grant (HPTDG) using multiple service level agreements (SLAs) over several years in order to strengthen the Faculty's under- and post-graduate programmes to unpin the departments human resource needs, particularly in rural communities.

Three SLAs were concluded under this partnership. The first and largest funded the Faculty in a variety of ways from a Joint Staff Establishment to operational costs related to registrar rotations, conferences and journals. The second SLA funded the four Health Resource Centres operational costs. The third and most recent funded the establishment of a Medical Orthotics and Prosthetics programme. Transfer payments to WSU represented between 80-85% of the total HPTDG budget.

The Department observed non-compliance by WSU to the requirements of their SLAs, in particular financial reporting, resulting in increased pressure on the ECDoH to enforce Sections 38(i) J&K of the Public Finance Management Act in keeping with the responsibilities and expectations of the Accounting Officer, the National Department of Health and Auditor General.

At all material times, the funding provided by the Department of Health was ring fenced and governed by legislation including the Division of Revenue Act, Public Finance Management Act and Treasury Regulations.

It has now become apparent from draft financials recently submitted to the Department, that the University has loaned to itself a substantial amount of money from the Health Professions Training and Development Grant (HPTDG) Health Professional Training and Development Fund in order to meet several of its other operating expenses.

In acting as aforesaid and utilising the funding contrary of the provisions of the agreement between the parties, the Walter Sisulu University has breached a material term of the contract between the parties and in so doing has acted wrongfully, unlawfully and contrary to the applicable legislation.

In the circumstances, the Department of Health has demanded that the University repay the amount.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

23 Commitments	Note	2012/13 R'000	2011/12 R'000
Current expenditure			
Approved and contracted		666,672	662,730
Approved but not yet contracted		-	202,574
		666,672	865,304
Capital Expenditure (including transfers)			
Approved and contracted		1,658,241	1,850,971
Approved but not yet contracted		56,986	34,460
		1,715,227	1,885,431
Total Commitments		2,381,899	2,750,735

The majority of capital commitments are for large multi year projects See paragraph 1.3 of Accounting officers report for additional information in this regard

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

			2012/13 R'000	2011/12 R'000
24 Accruals				
Listed by economic classification	30 days	30+ days	Total	Total
Goods and services	343,556	44,484	388,040	774,769
Transfers and subsidies	22,631	3,008	25,639	-
Capital assets	75,597	24,111	99,708	120,030
Total	441,784	71,603	513,387	894,799
Listed by programme level			R'000	R'000
Pr1 Health Administration			74,629	115,082
Pr2 District Health Services			231,027	377,509
Pr3 Emergency Medical Services			46,309	64,192
Pr4 General Hospital Services			67,941	108,891
Pr5 Central Hospital Services			8,508	21,825
Pr6 Health Science and Training			3,689	7,362
Pr7 Health Care and Support Services			37,130	99,876
Pr8 Health Facilities Development and Maintenance			44,154	100,062
Total			513,387	894,799
Confirmed balances with departments		Annex 5	540	15,379
Total			540	15,379
<i>The majority of accruals are aged less than 30 days and this is in line with government policy.</i>				
25 Employee benefits				
Leave entitlement			393,500	306,038
Service bonus (Thirteenth cheque)			259,149	247,737
Capped leave commitments			845,397	864,621
Other			611,054	190,116
Total			2,109,100	1,608,512

Negative leave day are included in the Leave balances above and relate to the value of overdrawn leave as at 31 March 2013 which will be recovered from future monthly leave credits earned. The value of this leave is R16,4 million (2012: R15,1 million).

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

26 Lease commitments

26.1 Operating leases expenditure

2012/13

Not later than 1 year	3,226	-	3,226
Later than 1 year and not later than 5 years	706	-	706
Later than five years	-	-	-
Total lease commitments	3,932	-	3,932

Buildings and other fixed structures	Machinery, equipment, and motor vehicles	Total
R'000	R'000	R'000
3,226	-	3,226
706	-	706
-	-	-
3,932	-	3,932

2011/12

Not later than 1 year	16,741	192,360	209,101
Later than 1 year and not later than 5 years	2,180	402,825	405,005
Later than five years	-	-	-
Total lease commitments	18,921	595,185	614,106

Buildings and other fixed structures	Machinery, equipment, and motor vehicles	Total
R'000	R'000	R'000
16,741	192,360	209,101
2,180	402,825	405,005
-	-	-
18,921	595,185	614,106

26.2 Finance leases expenditure

2012/13

Not later than 1 year	89,489	15,164	104,653
Later than 1 year and not later than 5 years	58,067	5,316	63,383
Later than five years	-	-	-
Total lease commitments	147,556	20,480	168,036

Motor Vehicles	Machinery and equipment	Total
R'000	R'000	R'000
89,489	15,164	104,653
58,067	5,316	63,383
-	-	-
147,556	20,480	168,036

2011/12

Not later than 1 year	-	24,271	24,271
Later than 1 year and not later than 5 years	-	22,142	22,142
Later than five years	-	-	-
Total lease commitments	-	46,413	46,413
LESS: finance costs	-	4,682	4,682
Total present value of lease liabilities	-	41,731	41,731

Motor Vehicles	Machinery and equipment	Total
R'000	R'000	R'000
-	24,271	24,271
-	22,142	22,142
-	-	-
-	46,413	46,413
-	4,682	4,682
-	41,731	41,731

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

	Note	2012/13 R'000	2011/12 R'000
27 Receivables for departmental revenue			
Sales of goods and services other than capital assets		197,697	201,356
Total		197,697	201,356
27.1 Analysis of receivables for departmental revenue			
Opening balance		201,356	169,216
Less: Amounts received		82,242	57,008
Add: Amounts recognised		95,474	120,980
Less: Amounts written-off/reversed as irrecoverable		16,891	31,832
Closing balance		197,697	201,356
27.2 Receivables for department revenue written off			
Nature of losses			
Patient debt		16,891	31,832
Total		16,891	31,832

In the 2010/2011 Annual Financial statements, these figures were shown after deducting the provision for bad debt as disclosed in note 32 below. In the 2011/2012 annual financial statements, these balances were disclosed gross i.e. before provision for bad debts (per note 32 below). The comparative figures have been amended but there is no impact other than this disclosure note and note 32. This does not affect funds to be surrendered.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

	Note	2012/13 R'000	2011/12 R'000
28 Irregular expenditure			
28.1 Reconciliation of irregular expenditure			
Opening balance		1,179,203	873,882
Add: Irregular expenditure - relating to prior year		73,954	138,529
Add: Irregular expenditure - relating to current year		181,598	166,858
Less: Amounts condoned		(494,104)	-
Less: Amounts recoverable (not condoned)		-	(66)
Less: Amounts not recoverable (not condoned)		(542,468)	-
Irregular expenditure awaiting condonation		398,183	1,179,203
Analysis of awaiting condonation per age classification			
Current year		83,137	166,792
Prior years		315,046	1,012,411
Total		398,183	1,179,203
			2012/13 R'000
28.2 Details of irregular expenditure identified current year			
Incident	Disciplinary steps taken/criminal proceedings		
Non-compliance SCM procedures - various	Investigation Stage		181,598
			181,598
28.3 Details of irregular expenditure condoned			
Incident	Condoned by (condoning authority)		
Non-compliance SCM-Variou	BAC		494,104
			494,104
28.4 Details of irregular expenditure not recoverable (not condoned)			
Incident	Not condoned by (condoning authority)		
Life Group			542,468
			542,468
28.5 Details of irregular expenditure under investigation			
Incident			
Non-compliance SCM-Variou			398,183
			398,183

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

	Note	2012/13 R'000	2011/12 R'000
29 Fruitless and wasteful expenditure			
29.1 Reconciliation of fruitless and wasteful expenditure			
Opening balance		54,647	30,369
Fruitless and wasteful expenditure – relating to prior year		14,605	-
Fruitless and wasteful expenditure – relating to current year		113,249	23,516
Less: Amounts condoned		(28,014)	-
Less: Amounts resolved		-	762
Fruitless and wasteful expenditure awaiting condonement		154,487	54,647
29.2 Analysis of awaiting condonement per economic classification			
Current		139,084	41,620
Capital		15,403	13,027
Total		154,487	54,647
29.3 Analysis of Current Year's Fruitless and wasteful expenditure			2012/13 R'000
Incident	Disciplinary steps taken/criminal proceedings		
Damages	Disciplinary stages		108,288
Interest	Disciplinary stages		4,296
Penalties	Disciplinary stages		170
Other	Disciplinary stages		495
Total			113,249
30 Related party transactions			
During the year under review, the Department had the free use of buildings from the Department of Roads and PublicWorks.			
European Union Extended Partnerships for the Delivery of Primary Health Care including HIV and AIDS Programme ("EU EPDPHCP") National Management unit paid R10,7 million to TAT I-Chain Technologies (Pty) Ltd for an asset verification, and the preparation of a fixed asset register.			
31 Key management personnel	No. of Individuals	2012/13 R'000	2011/12 R'000
Political office bearers	1	1,668	1,586
Officials:			
Level 15 to 16	7	4,608	4,545
Level 14	15	12,356	12,169
Total		18,632	18,300

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

	2012/13 R'000	2011/12 R'000
32 Public Private Partnership		
Contract fee paid	68,863	61,739
Fixed component	57,185	58,305
Indexed component	11,678	3,434

32.1 Humansdorp Hospital Co-Location PPP

The Eastern Cape Department of Health (ECDoH) recognised the potential for the establishment of a private facility in partnership with the existing Humansdorp district hospital, as well as the need to optimally use the available resources at the hospital and allow the development and expansion of the hospital by the private sector.

This led to its decision to embark on a Public Private Partnership, as regulated by the Treasury Regulations to the Public Finance Management Act, No 1 of 1999 through the conclusion of an Agreement that started on 27 June 2003 to 30 June 2023 with Metro Star Hospital Life Healthcare Ltd (previously Afrox Healthcare Ltd).

Terms of the agreement / Obligations to acquire or build items of property, plant and equipment / other rights and obligations (e.g. major overhauls)

The Project embarked on by the Concessionaire through the conclusion of this Agreement, involves the granting of Concession Rights by the Provincial Government to the Concessionaire against the payment of variable concession fees and:

- the construction of a thirty bed private facility
- 3 bed high care unit
- the enlarging of the current Humansdorp hospital entrance and administration area for use by both Parties
- the enlarging of the casualty and outpatient ward including two consulting rooms and a dentist room
- the building and/or upgrade of two new operating theatres
- a new CSSD
- a new radiology unit
- a new laboratory and
- the refurbishment and upgrade of the existing Humansdorp hospital, which includes:
 - o the painting of all interiors and exteriors
 - o the reparation and replacement (where necessary) of all ceilings
 - o the reparation and replacement (where necessary) of all floors
 - o the upgrading of electrical and mechanical installations
 - o the upgrading of fire detection and nurse calling units
 - o the reparation and replacement (where necessary) of all windows, inclusive of existing specialized units and facilities, to be made available to the private sector party on the basis that the facilities shall consist of those being exclusively used by the private sector and others being jointly used by the Department and the private sector for the duration of this Agreement
- The Concessionaire further provides maintenance and facility management services to the Humansdorp hospital in return for the payment of service payments to the Concessionaire by the Provincial Government.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

Nature and extent of rights to use specified assets

As described above.

Obligations to provide or rights to expect provision of services

The Provincial Government has granted to the Concessionaire, the exclusive right during the Concession Period to:

- o use and operate the project facilities
- o carry out operations to combine the different strengths of both government and private sector for the more efficient utilization of government resources
- o add on existing resources through private sector investment
- o improve maintenance of existing resources through the creation of income generating activities for the benefit of both the Concessionaire and the Department.

And further as provided for in terms of the Agreement:

- o to construct and install the additional project facilities (including the installation of furniture, equipment, fixtures and fittings, as the case may be) strictly in accordance with the design documents and construction requirements;
- o generate, charge and collect revenues from the operation and management of the project facilities during the concession period;
- o use the concession area and project facilities for the purposes of the project, whether exclusively or jointly with the Provincial Government
- o And provide the Services to the Provincial Government against payment of Service Payments in accordance with the Payment Mechanism by the Provincial Government.

Obligation to deliver or rights to receive specified assets at the end of the concession period

The Concessionaire has, and will have, no title, ownership, limited ownership, lien, or leasehold rights or any other rights of title with regard to the existing project facilities which vest and shall remain to vest in the Provincial Government, for the duration of the agreement, as well as after expiry or earlier termination thereof.

The Department shall become owner of all movable additional project facilities with effect from expiry or earlier termination of this agreement and the Department shall become owner of all immovable additional project facilities and additional project facilities which are in any way affixed to the concession area or improvements thereon (such as fixtures, fittings and equipment) as soon as the same are affixed, but excluding such equipment and furniture which are listed and excluded from additional project facilities as defined.

Renewal and termination options

The agreement shall automatically be terminated on expiry of the twenty – one year concession period, unless terminated earlier in accordance with the provisions of the agreement.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

	2012/13 R'000	2011/12 R'000
Contract Fee		
Variable component		
This is based on forecast real profit target		
Contract fee paid – Unitary Charge		
Fixed component		
Building, Mechanical & Electrical Comp	3,775	519
Cleaning & Domestic	1,808	681
Gardens & Grounds	484	183
Laundry	640	240
Security	744	280
Waste Management	340	151
Catering Services	2,078	797
Other costs	922	147
TOTAL	10,791	2,998

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013**32.2 Upgrading and Refurbishment of the Port Alfred & Settlers Hospitals in Port Alfred and Grahamstown and the establishment of co-located private hospital facilities****Description of the arrangement**

The concession agreement (15 year contract to May 2022) was signed on the 7 May 2007 and incorporates the Port Alfred and Settlers District Hospitals.

It incorporates the financing, design, upgrade and refurbishment of the facilities and provision of operational and associated services including hard and soft facilities management and life-cycle maintenance, refreshment and replacement of selected equipment (including medical equipment, medical instrumentation and Durables), IM&T and furniture at the above-named Hospitals together with the co-location of private hospital facilities to be operated by the Private Party, all in terms of a Public Private Partnership, as regulated by the Treasury Regulations to the Public Finance Management Act, No 1 of 1999.

The Department at year end is currently paying the Unitary Fee on the Port Alfred component of the project and paying the Development Fee on the Settlers component of the project.

The Port Alfred co-location District Hospital was opened by the former Health MEC, Ms P Majodina in February 2009 and the Settlers co-location District Hospital was opened by the former Health MEC, Mr P Masualle in January 2010.

Terms of the agreement / Obligations to acquire or build items of property, plant and equipment / other rights and obligations (e.g. major overhauls)

The Project embarked on by the Concessionaire through the conclusion of this Agreement, involves the granting of Concession Rights by the Provincial Government to the Concessionaire against the payment of variable concession fees and:

- 30 private beds
- Private pharmacy
- Private administration
- Two Private consulting rooms
- 60 public beds
- Public outpatients facility
- Public Pharmacy
- Public administration
- Shared facilities for Labour ward, Maternity ward, Radiology, Casualty, Theatres, CSSD, Kitchen & staff facilities, mortuary, stores, linen areas and plant and workshop areas
- The refurbishment and upgrading of existing facilities at the Port Alfred and Settlers Hospitals includes:
 - roof construction which will be double pitched timber trusses with concrete roof tiles to suitable pitch;
 - rainwater goods which are to be fibre cement, positioned to divert rain water from roofs to storm water channels and painted with suitable exterior paint;
 - Floor construction which is to be concrete surface beds, screened to receive floor finish. Floor finishes and skirting will be suitable for cleaning as per service specification;

**(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**

**DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013**

- o brick walls, external and internal to be plastered with one coat of cement plaster and painted with suitable interior and exterior paint;
- o The ceilings are to be vinyl clad gypsum suspended ceilings with exposed T's suspended from trusses. Flush plastered suspended ceilings in theatres only;
- o aluminium windows with opening sections where required by regulations and suitable glazing all in accordance with applicable regulations; and
- o All steel doorframes to be galvanised door frames painted with suitable interior and exterior paint where applicable. Internal doors to be hollow core doors painted with suitable interior paint.

Nature and extent of rights to use specified assets

As described above.

Obligations to provide or rights to expect provision of services

The Provincial Government has granted to the Concessionaire, the exclusive right during the Concession Period to:

- use and operate the project facilities
- carry out operations to combine the different strengths of both government and private sector for the more efficient utilization of government resources;
- add on existing resources through private sector investment; and
- Improve maintenance of existing resources through the creation of income generating activities for the benefit of both the Concessionaire and the Department.

And further as provided for in terms of the Agreement:

- to construct and install the additional project facilities (including the installation of furniture, equipment, fixtures and fittings, as the case may be) strictly in accordance with the design documents and construction requirements;
- generate, charge and collect revenues from the operation and management of the project facilities during the concession period;
- use the concession area and project facilities for the purposes of the project, whether exclusively or jointly with the Provincial Government; and
- provide the Services to the Provincial Government against payment of Service Payments in accordance with the Payment Mechanism by the Provincial Government.

Obligation to deliver or rights to receive specified assets at the end of the concession period

The rights of use of the Project Site and Facilities afforded to the Private Party shall not confer or be deemed to confer upon the Private Party a right of ownership, mortgage, pledge, lien, a lease, a licence or any other security interest or right of limited ownership in the Project Site or any of the Facilities other than Rights of Way for purposes of performing the Project Deliverables. Title to the Project Site and Facilities, including all improvements thereto, shall at all times vest in the Institution without Encumbrance.

The Private Party shall upon expiry or early termination of this Agreement, subject to the provisions of this Agreement, hand over the Facilities (including the Private Facilities) to the Institution free of any Encumbrance or of any liabilities or debt, and shall not, save as provided for in this Agreement, be entitled to payment of any amounts in connection therewith.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013**Renewal and termination options**

The agreement shall automatically be terminated on expiry of the fifteen year concession period, unless terminated earlier in accordance with the provisions of the agreement.

	2012/13 R'000	2011/12 R'000
Contract Fee		
Contract fee paid		
Fixed component	46,394	55,307
Current expenditure		
Goods and services (Port Alfred and Settlers Hospital) (excluding leases)	11,678	3,434
	2012/13 R'000	2011/12 R'000
33 Impairment	Note	
Debtors - Departmental revenue	130,142	124,533
Debt account	80,321	71,013
Total	210,463	195,546

34 Non-adjusting events after reporting date

In terms of the Eastern Cape Finance Act (2013), the department has received authorisation, with funding, of R1,286 billion. This related to unauthorised expenditure relating to 2011/12 (R297,6 million), 2010/11 (R116,4 million) and 2009/10 (R871,9 million). This was approved by the Premier of the Province of the Eastern Cape on 28 March 2013, and received by the department on 10 April 2013.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

35 Movable Tangible Capital Assets

MOVEMENT IN MOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE
YEAR ENDED 31 MARCH 2013

	Opening balance R'000	Curr year adjustments to prior year balances R'000	Additions R'000	Disposals R'000	Closing balance R'000
Machinery and Equipment	779,480	436,105	122,013	336,639	1,000,959
Transport assets	46,512	64,710	225	1,707	109,740
Computer equipment	52,022	4,588	19,012	62,040	13,582
Furniture and office equipment	82,625	12,791	8,475	40,453	63,438
Other machinery and equipment	598,322	354,016	94,301	232,439	814,200
Total Movable Tangible Capital Assets	779,480	436,105	122,013	336,639	1,000,959

35.1 ADDITIONS TO MOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE
YEAR ENDED 31 MARCH 2013

	Cash R'000	Non-cash R'000	(Capital work-in- progress current costs and finance lease payments) R'000	Received current, not paid (Paid current year, received prior year R'000	Total R'000
Machinery and Equipment	267,516	265	(148,241)	2,473	122,013
Transport assets	136,246	67	(136,088)	-	225
Computer equipment	18,978	34	-	-	19,012
Furniture and office equipment	8,475	-	-	-	8,475
Other machinery and equipment	103,817	164	(12,153)	2,473	94,301
Total	267,516	265	(148,241)	2,473	122,013

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 201335.2 DISPOSALS OF MOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE
YEAR ENDED 31 MARCH 2013

	Sold for cash	Transfer out or destroyed or scrapped	Total disposals	Cash received Actual
	R'000	R'000	R'000	R'000
Machinery and Equipment				
Transport assets	-	1,707	1,707	-
Computer equipment	-	62,040	62,040	-
Furniture and office equipment	-	40,453	40,453	-
Other machinery and equipment	-	232,439	232,439	-
Total	-	336,639	336,639	-

35.3 MOVEMENT IN MOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE
YEAR ENDED 31 MARCH 2012

	Opening balance	Additions	Disposals	Closing balance
	R'000	R'000	R'000	R'000
Machinery and Equipment	621,653	158,188	361	779,480
Transport assets	33,911	12,601	-	46,512
Computer equipment	43,011	9,011	-	52,022
Furniture and office equipment	67,085	15,540	-	82,625
Other machinery and equipment	477,647	121,036	361	598,322
Total Movable Tangible Capital Assets	621,653	158,188	361	779,480

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 201335.4 MOVEMENT IN MINOR ASSETS PER THE ASSET REGISTER FOR THE YEAR ENDED
31 MARCH 2013

	Machinery and equipment R'000	Total R'000
Opening balance	131,027	131,027
Curr Year Adjustments to Prior Yr Balances	332,535	332,535
Additions	36,677	36,677
Disposals	(75,021)	(75,021)
TOTAL MINOR ASSETS	425,218	425,218
	Machinery and equipment	Total
Number of RI minor assets	14,275	14,275
Number of minor assets at cost	433,839	433,839
TOTAL NUMBER OF MINOR ASSETS	448,114	448,114

Minor assets

MOVEMENT IN MINOR ASSETS PER THE ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2012

	Machinery and equipment R'000	Total R'000
Opening balance	105,660	105,660
Additions	25,367	25,367
Total Minor Assets	131,027	131,027
	Machinery and equipment	Total
Number of RI minor assets	163,639	163,639
Number of minor assets at cost	146,174	146,174
Total Number of Minor Assets	309,813	309,813

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

During the year under review, the department entered into an agreement with I-chain, an external service provider, to verify, tag and conduct a condition assessment of all assets in all the institutions across the province. Teams were established from both the department and service provider as this was a co-managed project. Teams underwent a training course on how to barcode and assign proper descriptions using asset catalogues and scanners. After scanning, asset listings are printed and checked by quality controllers for final sign-off. All assets were assigned to owners or controllers to confirm existence by way of signing-off.

A process of reconciliation between the old and new asset register was performed per institution. Any unmatched assets were investigated by a dedicated team and when all processes were exhausted, these assets were then recommended for write-off. The recommendation also included assets that were broken.

A write off of R412 million was recommended by the Board of Survey and approved by the Accounting Officer (R336 for major assets per note 35 and R75 million for minor assets per note 35.4). This amount is made up of R14 million for broken assets and R398 million for assets that could not be found.

It must also be noted that in the verification process, assets to value of R768 million (R436 million for major assets per note 35 and R332 million for minor assets note 35.4) were brought onto the fixed asset register. This includes values for assets that were previously R1 as well as assets that were found on the floor but not previously included in the fixed asset register.

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 201336 MOVEMENT IN INTANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR
ENDED 31 MARCH 2013

	Opening balance R'000	Curr year adjustments to prior year balances R'000	Additions R'000	Disposals R'000	Closing balance R'000
Computer Software	336	-	-	281	55
Total Intangible Capital Assets	336	-	-	281	55

36.1 DISPOSALS OF INTANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR
ENDED 31 MARCH 2013

	Sold for cash R'000	Transfer out or destroyed or scrapped R'000	Total disposals R'000	Cash received Actual R'000
Computer Software	-	281	281	-
TOTAL DISPOSAL OF INTANGIBLE CAPITAL ASSETS	-	281	281	-

36.2 MOVEMENT IN INTANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR
ENDED 31 MARCH 2012

	Opening balances R'000	Additions R'000	Disposals R'000	Closing balance R'000
Computer Software	336	-	-	336
Total Intangible Capital Assets	336	-	-	336

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

37 Immovable Tangible Capital Assets

MOVEMENT IN IMMOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE
YEAR ENDED 31 MARCH 2013

	Opening balance R'000	Curr year adjustments to prior year balances R'000	Additions R'000	Disposals R'000	Closing balance R'000
Buildings and other Fixed Structures	-	-	-	-	-
Dwellings	-	-	-	-	-
Non-residential buildings	-	-	-	-	-
Other fixed structures	-	-	-	-	-
Total Immovable Tangible Capital Assets	-	-	-	-	-

Additions

37.1 ADDITIONS TO IMMOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE
YEAR ENDED 31 MARCH 2013

	Cash R'000	Non-cash R'000	(Capital work-in- progress current costs and finance lease payments) R'000	Received current, not paid (Paid current year, received prior year R'000	Total R'000
Buildings and other Fixed Structures	598,416	-	(695,650)	97,234	-
Dwellings	-	-	-	-	-
Non-residential buildings	598,416	-	(695,650)	97,234	-
Other fixed structures	-	-	-	-	-
Total Additions to Immovable Tangible Capital Assets	598,416	-	(695,650)	97,234-	-

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

Movement for 2011/12

37.2 MOVEMENT IN IMMOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE
YEAR ENDED 31 MARCH 2012

	Opening balance R'000	Additions R'000	Disposals R'000	Closing balance R'000
Buildings and other Fixed Structures	-	-	-	-
Dwellings	-	-	-	-
Non-residential buildings	-	-	-	-
Other fixed structures	-	-	-	-
Total Immovable Tangible Capital Assets	-	-	-	-

37.3 Assets subjected to transfer in terms of S42 of the PFMA

	No of Assets	Value of Assets R'000
Buildings and other Fixed Structures	89	1,635,166
Dwellings	-	-
Non-residential buildings	89	1,635,166
Other fixed structures	-	-
Total	89	1,635,166

**(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**

**DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013**

38. STATEMENT OF CONDITIONAL GRANTS RECEIVED

NAME OF DEPARTMENT	GRANT ALLOCATION					SPENT				2011/12	
	Division of Revenue Act Provincial Grant	Roll Overs	DORS Adjustments	Other Adjustments	Total Available	Amount received by department	Amount spent by department	Under / (over-spending)	% of available funds spent by department	Division of Revenue Act	Amount spent by department
	R'000	R'000	R'000	R'000	R'000	R'000	R'000		%	R'000	R'000
National Tertiary Services Grant	682,445	19,974	-	-	702,419	702,419	657,292	45,127	93.6%	647,104	627,075
Health Professionals and Development Grant	178,730	4,291	-	-	183,021	182,093	178,743	3,350	97.7%	194,949	190,782
Hospital Revitalisation Grant	402,679	57,494	-	-	460,173	460,173	414,560	45,613	90.1%	633,304	556,929
Comprehensive HIV/AIDS	1,060,852	8,285	-	-	1,069,137	1,069,137	1,040,502	28,635	97.3%	915,473	906,236
Forensic Pathology	-	-	-	-	-	-	-	-	0.0%	87,018	84,690
Health Infrastructure Grant	258,862	47,852	-	-	306,714	306,714	302,716	3,998	98.7%	376,764	328,572
EPWP Incentive Social Cluster	13,780	-	-	-	13,780	13,780	13,699	81	99.4%	-	-
EPWP Incentive	1,000	-	-	-	1,000	1,000	1,000	-	100.0%	16,579	-
Nursing College and Schools Grant	14,660	-	-	-	14,660	14,660	12,394	2,266	84.5%	-	-
National Health Insurance	11,500	-	-	-	11,500	11,500	8,094	3,406	70.4%	-	-
AFCON	-	-	-	3,000	3,000	3,000	2,353	647	78.4%	-	-
	2,624,508	137,896	-	3,000	2,765,404	2,764,476	2,631,353	133,123		2,871,191	2,694,284

**(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**

**ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013**

**ANNEXURE 1B
STATEMENT OF UNCONDITIONAL GRANTS AND TRANSFERS TO MUNICIPALITIES**

NAME OF MUNICIPALITY	GRANT ALLOCATION				TRANSFER		SPENT			2011/12
	Amount	Roll Overs	Adjustments	Total Available	Actual Transfer	% of available funds transferred	Amount received by Municipality	Amount spent by municipality	% of available funds spent by municipality	Total Available
	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000	%	R'000
Alfred Nzo	3,909	-	-	3,909	3,909	100%	3,909	3,909	100%	-
Joe Gqabi	2,954	-	-	2,954	2,954	100%	2,954	2,954	100%	-
Buffalo City Metro	1,221	-	-	1,221	1,065	87%	1,065	1,065	100%	-
	8,084	-	-	8,084	7,928		7,928	7,928		-

**(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**

**ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013**

**ANNEXURE IC
STATEMENT OF TRANSFERS TO DEPARTMENTAL AGENCIES AND ACCOUNTS (CONTINUED)**

DEPARTMENT / AGENCY / ACCOUNT	TRANSFER ALLOCATION				TRANSFER		2011/12
	Adjusted Appropriation Act	Roll Overs	Adjustments	Total Available	Actual Transfer	Available funds transferred	Appropriation Act
	R'000	R'000	R'000	R'000	R'000	%	R'000
Berlin Advice Centre	134	-	-	134	-	0%	-
Border Hospice	1,161	-	-	1,161	1,161	100%	-
Camdeboo Hospice	501	-	-	501	501	100%	-
Caring Hands	467	-	-	467	467	100%	-
Donald Woods Foundation	9,000	-	-	9,000	9,000	100%	-
Empilisweni Hiv/Aids & Orphans	134	-	-	134	-	0%	-
Faith And Hope Integrate Aids Programme	134	-	-	134	-	0%	-
Good Samaritan Home	134	-	-	134	-	0%	-
Good Shepherd Hospice	134	-	-	134	-	0%	-
Grahamstown Hospice	695	-	-	695	695	100%	-
Gwebindlala Hiv/Aids Organisation	134	-	-	134	-	0%	-
Hlumani Hiv/Aids Care Givers	134	-	-	134	-	0%	-
House Of Hope Hospice	134	-	-	134	-	0%	-
Ikaheng Community Assoc	430	-	-	430	-	0%	-
Ikamvelihle Rehab Centre	134	-	-	134	430	321%	-
Ikhwezi Women'S Support Centre	134	-	-	134	-	0%	-
Ikwezi Lomso Child & Family Welfare Society	191	-	-	191	-	0%	-
Ilitha Community Psychological Services	134	-	-	134	-	0%	-
Inkwanca Homebase	766	-	-	766	-	0%	-
Jongilanga Train & Dev Centre	430	-	-	430	430	100%	-
Keiskamma Trust	134	-	-	134	-	0%	-
Kwanomzamo Home Based	430	-	-	430	430	100%	-
Lifeline (EI)	236	-	-	236	234	99%	-

**(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**

**ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013**

**ANNEXURE IC
STATEMENT OF TRANSFERS TO DEPARTMENTAL AGENCIES AND ACCOUNTS (CONTINUED)**

DEPARTMENT / AGENCY / ACCOUNT	TRANSFER ALLOCATION				TRANSFER		2011/12
	Adjusted Appropriation Act	Roll Overs	Adjustments	Total Available	Actual Transfer	Available funds transferred	Appropriation Act
	R'000	R'000	R'000	R'000	R'000	%	R'000
Lighthouse Comm Develop	430	-	-	430	430	100%	-
Masakhe Peelton Support Group	134	-	-	134	-	0%	-
Masibambisane Home Based Care & Support Groups	134	-	-	134	-	0%	-
Masiphilisane Home Bas Care	430	-	-	430	430	100%	-
Matatiele Advice Centre	430	-	-	430	430	100%	-
Mpuma Kapa Multi Purpose	134	-	-	134	-	0%	-
Nazareth Haven Hospice	472	-	-	472	472	100%	-
Ncedisizwe Hbc	134	-	-	134	-	0%	-
Never Give Up Support Group	134	-	-	134	-	0%	-
Port St Johns Creative Young Women Group	134	-	-	134	-	0%	-
Sakhimpilo Home Based Care Project	134	-	-	134	-	0%	-
Sicelusizo Development Trust	134	-	-	134	-	0%	-
Sinako Wellness And Development Organisation	78	-	-	78	-	0%	-
Sinethemba Organisation	134	-	-	134	-	0%	-
Sinothando Home Of Safety	134	-	-	134	-	0%	-
Siyakhanyisa Hiv&Aids Support Group	134	-	-	134	-	0%	-
Sizanenguqu Home Community Based Care	134	-	-	134	-	0%	-
Sophumelela Clinic Incorporated	134	-	-	134	-	0%	-
St Francis Hospice	1,160	-	-	1,160	1,160	100%	-
The Mahlungulu Foundation	430	-	-	430	430	100%	-
Thusanang Home Based Care	372	-	-	372	372	100%	-
Thyilulwazi Multipurpose Centre	524	-	-	524	524	100%	-

**(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**

**ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013**

**ANNEXURE 1C
STATEMENT OF TRANSFERS TO DEPARTMENTAL AGENCIES AND ACCOUNTS (CONTINUED)**

DEPARTMENT / AGENCY / ACCOUNT	TRANSFER ALLOCATION				TRANSFER		2011/12
	Adjusted Appropriation Act	Roll Overs	Adjustments	Total Available	Actual Transfer	Available funds transferred	Appropriation Act
	R'000	R'000	R'000	R'000	R'000	%	R'000
Ukhamba Projects	134	-	-	134	-	0%	-
Umtata Womens Support Centre	134	-	-	134	-	0%	-
Umzimkhulu Develop Serv	430	-	-	430	430	100%	-
Vukukhanye Prod Health	691	-	-	691	692	100%	-
We Care	134	-	-	134	-	0%	-
Yizani Home Based Care	134	-	-	134	-	0%	-
Hw Seta	5,800	-	-	5,800	5,709	0%	-
Hospices							45,770
	29,437	-	-	29,437	24,427		45,770

**(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**

**ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013**

**ANNEXURE 1D
STATEMENT OF TRANSFERS TO UNIVERSITIES AND TECHNIKONS**

UNIVERSITY/TECHNIKON	TRANSFER ALLOCATION				TRANSFER			2011/12
	Adjusted Appropriation Act	Roll Overs	Adjustments	Total Available	Actual Transfer	Amount not Transferred	% of available funds transferred	Appropriation Act
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000
Walter Sisulu University	58,671	-	21,500	80,171	80,095	76	0%	123,174
Nelson Mandela Metropolitan	34,000	-	(21,500)	12,500	12,500	-	0%	9,500
University of Fort Hare	750	-	-	750	750	-	0%	2,463
Rhodes University	8,424	-	-	8,424	8,425	(1)	0%	3,512
	101,845	-	-	101,845	101,770	75		138,649

**(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**

**ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013**

**ANNEXURE IH
STATEMENT OF TRANSFERS TO HOUSEHOLDS**

HOUSEHOLDS	TRANSFER ALLOCATION				EXPENDITURE		2011/12
	Adjusted Appropriation Act	Roll Overs	Adjustments	Total Available	Actual Transfer	% of available funds transferred	Appropriation Act
	R'000	R'000	R'000	R'000	R'000	%	R'000
Transfers							
Districts	66,795	-	-	66,795	64,147	96%	43,446
Clinical H/Comp	37,102	-	-	37,102	50,062	135%	9,968
Other	151,441	-	-	151,441	146,152	97%	81,501
Total	255,338	-	-	255,338	260,361		134,915

**(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**

**ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013**

**ANNEXURE II
STATEMENT OF GIFTS, DONATIONS AND SPONSORSHIPS RECEIVED**

NAME OF ORGANISATION	NATURE OF GIFT, DONATION OR SPONSORSHIP	2012/13 R'000	2011/12 R'000
Received in cash			
ATLS	Aiconditioner	-	5
Broad Reach Health care	Small Assets and Stationery	260	1,671
Capitec	Various Assets	-	7
CHOC	Fax Copier Printer	-	50
Christ Embassy	Dstv Decoders	-	2
Dr BG Brown	OfficeJet Pro 8500A Printer	-	2
Dr Mashiya	Various Assets	-	5
EU Partnership for Development Prim Health Care	Various Assets	-	115
Gift of the Givers Foundation	Consumables	-	7
Icap Global Health Action	Various Assets	-	16
Icap - South Africa	Agfa DT2B Drystar film	-	47
Industrial Development Corporation	Scanner	-	1,339
Italian Co-operation	Motor Vehicles	-	155
Masivuse Medical	CAPEX	-	109
Mindset Health Network	CAPEX	-	8
Mr M Loonat	Pedal Bins	-	6
Neurosurgery	Audio Visual	-	4
Oxfam Italia	Various Assets	-	51
Prayer Group Ministries	Linen	-	8
Unicef - South Africa	Motor Vehicles	-	120
Volkswagen	CAPEX	-	691
Savoy Hotel	Various Assets	5	-
Road Accident Fund and Valerie Fellows	Various Assets	5	-
PSA	19 x cot beds	38	-

(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013

ANNEXURE II - (continue)
STATEMENT OF GIFTS, DONATIONS AND SPONSORSHIPS RECEIVED

NAME OF ORGANISATION	NATURE OF GIFT, DONATION OR SPONSORSHIP	2012/13 R'000	2011/12 R'000
DFID	Various assets	98	-
Sun Orange Farms Community Trust	Transport Incubator with Trolley	63	-
USAID	Computers and Dental Equipment	366	-
Kheth'impilo Aids Free Living	Park Home (Nompumelelo Hospital)	137	-
SANDOZ	Vuka scooters	79	-
TOTAL		1,051	4,418

**(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**

**ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013**

**ANNEXURE IJ
STATEMENT OF AID ASSISTANCE RECEIVED**

NAME OF DONOR	PURPOSE	OPENING BALANCE R'000	REVENUE R'000	EXPENDITURE R'000	CLOSING BALANCE R'000
Received in cash					
European Union		7,732	2,001	3,378	6,355
Global Fund		(1,147)	-	-	(1,147)
Subtotal		6,585	2,001	3,378	5,208

**(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**

**ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013**

**ANNEXURE 3A
STATEMENT OF FINANCIAL GUARANTEES ISSUED AS AT 31 MARCH 2013 – LOCAL**

Guarantor institution	Guarantee in respect of	Original guaranteed capital amount	Opening balance 1 April 2011	Guarantees draw downs during the year	Guarantees repayments/ cancelled/ reduced/ released during the year	Revaluations	Closing balance 31 March 2013	Guaranteed interest for year ended 31 March 2012	Realised losses not recoverable i.e. claims paid out
		R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
ABSA	Housing	-	3,268	92	975	(1,693)	692	-	-
Standard Bank	Housing	-	1,639	336	577	(189)	1,209	-	-
Nedbank	Housing	-	(999)	-	37	1,273	237	-	-
Nedbank(BOE)	Housing	-	26	-	-	(26)	-	-	-
BOE Bank Ltd	Housing	-	(219)	-	-	219	-	-	-
Nedbank LTD (NBS)	Housing	-	916	-	59	(335)	522	-	-
FNB (Firststrand)	Housing	-	1,964	-	20	(329)	1,615	-	-
FNB (Saambou Bank)	Housing	-	(7)	-	-	276	269	-	-
Peoples Bank (FBC FID)	Housing	-	781	-	235	(291)	255	-	-
GBS Mutual	Housing	-	27	-	-	85	112	-	-
Hlano Financial Services	Housing	-	13	-	-	-	13	-	-
Meeg	Housing	-	49	-	24	(7)	18	-	-
Southnet Financial Services	Housing	-	10	-	-	-	10	-	-
Old Mutual (Nedbank)	Housing	-	2,047	14	173	(1,478)	410	-	-

**(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**

**ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013**

**ANNEXURE 3A - (continue)
STATEMENT OF FINANCIAL GUARANTEES ISSUED AS AT 31 MARCH 2013 – LOCAL**

Guarantor institution	Guarantee in respect of	Original guaranteed capital amount	Opening balance 1 April 2011	Guarantees draw downs during the year	Guarantees repayments/ cancelled/ reduced/ released during the year	Revaluations	Closing balance 31 March 2012	Guaranteed interest for year ended 31 March 2012	Realised losses not recoverable i.e. claims paid out
		R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
Investec	Housing	-	(350)	-	-	407	57	-	-
NHFC	Housing	-	25	-	-	-	25	-	-
Unique	Housing	-	265	-	-	(73)	192	-	-
SA Home Loans	Housing	-	18	-	-	(18)	-	-	-
Ithala Limited	Housing	-	-	-	-	2	2	-	-
	Total	-	9,473	442	2,100	(2,177)	5,638	-	-

**(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**

**ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013**

**ANNEXURE 3B
STATEMENT OF CONTINGENT LIABILITIES AS AT 31 MARCH 2013**

Nature of Liability	Opening Balance 1 April 2012 R'000	Liabilities incurred during the year R'000	Liabilities paid/cancelled/reduced during the year R'000	Liabilities recoverable (Provide details hereunder) R'000	Closing Balance 31 March 2013 R'000
Claims against the department					
Legal Claims	1,110,534	539,580	108,348	-	1,541,766
Subtotal	1,110,534	539,580	108,348	-	1,541,766
Other					
OSD	7,929	22,093	-	-	30,022
HROPT	438	-	438	-	-
Price variation and price increase	3,804	-	3,804	-	-
Grade progression - PSCBC resolution 3 of 2009	-	9,108	-	-	9,108
Subtotal	12,171	31,201	4,242	-	39,130
TOTAL	1,122,705	570,781	112,590	-	1,580,896

**(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**

**ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013**

**ANNEXURE 4
CLAIMS RECOVERABLE**

Government Entity	Confirmed balance outstanding		Unconfirmed balance outstanding		Total	
	31/03/2013 R'000	31/03/2012 R'000	31/03/2013 R'000	31/03/2012 R'000	31/03/2013 R'000	31/03/2012 R'000
Department						
Department of Health NC	-	-	41	24	41	24
Department of Education EC	-	116	99	-	99	116
Department of Health KZN	581	2,846	720	1,755	1,301	4,601
Department of Health NW	-	-	98	-	98	-
Department of Health Gauteng	-	60	118	118	118	178
Department of Health WC	-	-	335	99	335	99
Department of Health Limpopo	-	-	-	31	-	31
Department of Public Works EC	-	-	46	388	46	388
Department of Health FS	-	-	27	270	27	270
Department of Health Mpumalanga	-	-	8	5	8	5
Police FS	-	-	-	14	-	14
SASSA EC	-	-	22	22	22	22
National Correctional Services	-	-	-	37	-	37
National Department of Home Affairs	-	-	-	44	-	44
National Department of Health	-	-	-	25	-	25
Department of Arts and Culture KZN	-	-	19	54	19	54
Department of Agriculture KZN	23	-	-	23	23	23

**(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**

**ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013**

**ANNEXURE 4 - (continue)
CLAIMS RECOVERABLE**

Government Entity	Confirmed balance outstanding		Unconfirmed balance outstanding		Total	
	31/03/2012 R'000	31/03/2011 R'000	31/03/2012 R'000	31/03/2011 R'000	31/03/2012 R'000	31/03/2011 R'000
Department of Education GP	-	-	-	10	-	10
Department of Education FS	20	-	-	-	20	-
National Department of Public Works	-	-	24	-	24	-
National Department of Justice and Constitutional Development	-	-	19	-	19	-
Total	624	3,022	1,576	2,919	2,200	5,941

**(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**

**ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013**

**ANNEXURE 5
INTER-GOVERNMENT PAYABLES**

Government Entity	Confirmed balance outstanding		Unconfirmed balance outstanding		Total	
	31/03/2013 R'000	31/03/2012 R'000	31/03/2013 R'000	31/03/2012 R'000	31/03/2013 R'000	31/03/2012 R'000
DEPARTMENTS						
Current						
WC Health	-	43	-	47	-	90
EC Treasury	-	114	-	-	-	114
EC Sports	-	17	-	-	-	17
Water Affairs	-	3	-	-	-	3
SAPS	-	7	-	6	-	13
Transport KZN	33	-	-	33	33	33
EC Social Development	-	12	18	93	18	105
PALAMA	276	276	-	-	276	276
Health Mumalanga	-	65	-	-	-	65
EC Public Works	10	14,758	-	661	10	15,419
Gauteng Shared Services	-	-	94	94	94	94
EC Education	94	43	-	52	94	95
Correctional Services	-	41	-	-	-	41
Limpompo Dept of Health and Social Development	-	-	-	8	-	8
NC Health	103	-	-	-	103	-
National Department of labour	24	-	-	-	24	-
Total	540	15,379	112	994	652	16,373

**(PROVINCE OF THE EASTERN CAPE DEPARTMENT OF HEALTH)
VOTE 3**

**ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2013**

**ANNEXURE 6
INVENTORY**

Inventory	2012/13		2011/12	
	Quantity	R'000	Quantity	R'000
Inventory				
Opening balance	-	423,058	-	342,673
Add/(Less): Adjustments to prior year balances	-	(25,093)	-	(16,013)
Add: Additions/Purchases - Cash	-	1,859,114	-	1,679,111
Add: Year end journal in respect of purchases	-	-	-	2,162
Add: Additions - Non-cash	-	57,167	-	49,922
Add: Stock in transit	-	25,398	-	25,095
(Less): Disposals	-	(252)	-	(9,316)
(Less): Issues	-	(1,919,635)	-	(1,664,721)
Add/(Less): Adjustments	-	(16,336)	-	14,145
Closing balance	-	403,421	-	423,058