FREE STATE PROVINCIAL LEGISLATURE
2016/2017 BUDGET VOTE 5, DEPARTMENT OF HEALTH
TABLED BY DR BENNY MALAKOANE, MEC FOR HEALTH

Honourable Speaker of the Free State Provincial Legislature;
The Honourable Premier;
Colleagues in EXCO and Legislature
The Director General;
Heads of Departments and Senior Managers in all spheres of Government;
Governance Structures;
Development Partners;
Officials of the Free State Department of Health and other Sister Departments
Distinguished Guests;

Ladies and Gentlemen,

Honourable Speaker, in re-establishing my credentials, my intention is not to romanticize the idiosyncrasies and sharp vicissitudes of fortune sometimes engulfing the portfolio I am responsible for, but to proclaim the moral excellence and devotion in doing our business. We are paying serious attention to our trade as the contrary might leave many feeling ambivalent. We are still the creed of our political faith, the text of our civic instruction, the touchstone by which those who trust our services try us; we re-assure them that we shall not wander from them in moments of error or alarm. That is why I fervently beseech the Almighty to avert or mitigate the evils to which they may tend, and the faults of incompetent abilities to be consigned to oblivion.

As I stand behind this rostrum, I again reiterate the noble decree of clause nine (9) of the **Freedom Charter (26 June 1955 – three score years and three months),** which states:

- A preventative health scheme shall be run by the State and;
- Free medical care and hospitalisation shall be provided for all with special emphasis on mother and child care, while;

Section 27, 1(a) of the Constitution (Act 108 of 1996), states; *"everyone has the right to have **access** to health care services, including reproductive healthcare".*

It is for this reason that we reaffirm the department's commitment to implementation of Universal Health Coverage through National Health Insurance in order to strengthen the health care system as outlined under Output 4 of the NSDA.

The NHI White Paper in this regard was released on the on the **10th December 2015** and **gazetted on the 11th December 2015.** It is in this context that I implore all the Free State Communities and the

relevant stakeholders to take keen interest in public participation programmes and submitting comments towards development of NHI Bill.

In his budget speech, Minister Pravin retorted that: "*a period of unprecedented monetary stimulus in response to the 2008 recession is not yet over and global volatility and structural imbalances are far from over. Our major exports – platinum, gold, iron and coal – have seen substantial declines in global demand and in prices. The effects on our economy are widespread: lower export earnings, lower revenue, declining investment, job losses and in some cases business failures. Economic growth is revised down to 1.3% from 2% in 2015. The forecast for 2016 is 0.9% from 2.4%. Population is growing at 1.5%. Investment growth will be just 1.2% this year. The net national debt is projected to stabilise at 46.2% of GDP in 2017/18 and to decline after that. We need agility and urgency in implementation".*

We cannot agree more with the assessment however, we are acutely aware of the fact that the communities we serve have become more modern and less traditional, more complex and sophisticated, more demanding of our services and attention, and overtly demanding quality. We have to keep up regardless, we have to be responsive to every clamour, and make interventions continuously no matter how naïve.

The Department of Health has come out of a very difficult financial situation as outlined in my budget speech of last year. At the beginning of the 2014/15 financial year, the situation was such that most of the suppliers were refusing to supply our health facilities with medication and other bare essentials. The accruals on goods and services stood at **R 657,001** million as at 31 March 2014 (Audited by AGSA). At the end of August 2014 the accruals had increased to **R 861 million**. Budget analyses and re-allocations were done and finalized in August 2014. The Compensation of Employees (CoE) was decreased and stalled by **R 430,742 million** to address critical shortages under goods and services of all hospitals. Financial policies and internal controls were strengthened, monitoring of performance and expenditure controls were enforced;

By the end of 2014/15 financial year, the Department of Health had paid **R 740,034 million**, which was 86% of the total accruals on goods and services. At the end of 2014/15, the audited accruals on goods and services were decreased to **R 217, 418 million**, and the Department had spent 99% of the total budget allocated in 2014/15 financial year. The cash flow sustained the Department to the end of February 2015 for goods and services only, which was a great improvement from the previous year. The accruals for goods and service are now at manageable levels and our financial performance is good.

Actual position as at 28 February 2016.

The current adjusted budget of the Department is **R 8,728 billion**. The total expenditure as at the end of February 2016 was **R 7,690,053,014** which is 88.1% of the total budget. The commitments amounted to **R 248,060 million**. For the month of February 2016, the Department disbursed **R 840,718,000** to pay suppliers. The total cash amount transferred from Treasury up to the end of February is **R 7,726,691,000**.

The outstanding cash balance for March 2016 is **R 1,003 billion** and the accruals for goods and services are standing at **R 232,295 million**. Following a lot of vigilance, financial prudence and reprioritisation, the Department is projecting to break even at the end of March 2016 and will continue to tackle the accruals for Human Resources (HR) and goods and services.
We can therefore firmly assert that, against all odds, the Department is now stable despite the budget cuts that we have experienced.

Outlook for the Coming Financial Year
The final budget allocation for the Department of Health for 2016/17 is **R 9,048,599,000** which represents a nominal increase of 3.7% from 2015/16 while the revised CPI projection is 6.8%. This is an actual decrease of 3.1% on the budget allocation with the revised inflation projections being as follows:

2016/17	2017/18	2018/19
6.8 percent	**6.3 percent**	**5.9 percent**

In the midst of a downward spiral of the economy, the Department is expected to increase the allocation for compensation of employees by 9.3% in 2016/17 financial year. This means that we have to fund this increase by reducing the budget allocation for goods and services taking into consideration our commitment to economic growth through job creation to address the persistent triple challenges of inequality, unemployment and poverty. The situation becomes even worse than the picture painted above if you add *Non-negotiables* and *Compensation of employees*, which exceed the equitable share allocated by Treasury by **R 1.6 billion**. Furthermore, the situation is compounded by medical costs which increase higher than the average inflation. *However, our commitment to delivering quality healthcare services remains steadfast-regardless!!.*

We will institute *efficiency measures* in order to increase outputs from the current resource levels, to apply intense financial prudence and stewardship, as well as reprioritisation of operations to focus on our key service delivery programmes, namely;

- Budget Programme 2 (*District Health Services*),
- Budget Programme 3 (*Emergency Medical Services*),
- Budget Programme 4 (*Provincial Hospitals*) and
- Budget Programme 5 (*Central and Tertiary Hospitals*).

These will be outlined under the respective budget programmes. The budget of the Department of Health as allocated by Treasury over 2016 MTEF is as follows:

The CoE stands at **R 5,879,374,000** which is 65% of the total budget allocation. Goods and services are allocated **R 2,493,252,000** which is 27.6% of the total budget. The Non-negotiables within Goods and services take 95% of the budget.

The following allocations are made to the different budget programmes of the Department, with their respective portions of the total budget allocation:

I.	Administration	: **R 268,131,000**	(3%)
II.	District Health Services	: **R 3,740,286,000**	(41.3%)
III.	Emergency Medical Services	: **R 562,587,000**	(6.2%)
IV.	Provincial Hospital Services	: **R 1,351,461,000**	(14.9)
V.	Central Hospital Services	: **R 2,236,597,000**	(24.7%)
VI.	Health Science and Training	: **R 195,927,000**	(2.2%)
VII.	Health Care Support	: **R 176,916,000**	(2%)
VIII.	Health facilities Management	: R **516,695,000**	(5.7%)

Hon Speaker, may I agree with Hon MEC Rockman on her statement on the occasion of her delivery of the Provincial budget statement 2016/17 on the Ghanaian Proverb that: ***"Money is not medicine against death"***. It is indeed so, while Shakespeare says: "***death is a necessary end, it will come when it will come."*** While we are the first to acknowledge the challenging environment under which the Department operates as spelt out above, I strongly believe that we are fully justified in proclaiming that the Department has indeed stabilised and we are on course to deliver quality health care services to the people of the Free State. "Siyaqhuba, re a Hlasela"

1. Budget Programme 1: Administration

Leadership and Governance

Our responsibility encompasses leading and coordinating the multi-sectoral endeavours towards realization of the ideal of a Long and Healthy Life for all South Africans. Our **Health System Governance & Accountability [HSGA] model** remains our framework and tool to systematically revolutionise health care service delivery in this province. Its objective is to integrate all the different levels of the health service delivery platform through READ and RED concepts while emphasising accountability across the board and to communities we serve.

The Service Transformation Plan (STP) we have developed remains our crucial long-term vision that guides our planning and how we organize the health care services in the Free State Province. To this end we have developed the Strategic Plan 2015-2020 and the Annual Performance Plan 2016-2018. These plans are being implemented through the Balanced Score Card approach across the Department. We conduct *regular performance reviews* on quarterly basis to keep track of the implementation of different departmental priorities and guide the strategies and tactics.

Key positions identified in various institutions have been filled to strengthen leadership, governance and accountability. In September 2015, all the senior managers in the Department were subjected to management competency assessments, conducted by an independent service provider. Subsequently 39 senior managers have undergone training on Financial Management for non-Financial Managers, with other targeted training programmes planned. In the last 2 financial years we have trained managers at different institutions of higher learning, which include to following:

- **ASELPH**[1] : 5 CEOs in 2014/15 and another 6 in 2015/16;
- **MDP**[2] : 19 Middle Managers in 2013/14 and another 20 in 2015/16; and
- **OTFP**[3] : 2 Senior Managers in 2015/16.

Through these training programs, managers have been capacitated to do their job well and to perform according to expected norms and standards.

In our NHI pilot site, in Thabo Mofutsanyana, the following have been successfully undertaken and we are about to roll them out to other Health Districts:

- Implementation of innovative models such as *Central Chronic Medication Dispensing and Distribution (CCMDD)* to create easy access and adherence for patients on chronic medication. Through the CCMDD the patients pick up medicines at their nearest place of choice. We had targeted ***46*** *Pick-up Points* (PuPs) throughout Thabo Mofutsanyana District and to date 44 (96%) have been established;

- *Contracting of private providers* is ongoing, albeit at a slow pace due to scarcity of health professionals willing to serve in rural areas such as Thabo Mofutsanyana. This programme has so far successfully contracted 28 **General Practitioner**s with a view to accrediting them in future. We are calling upon willing and committed health professionals to join us in our endeavour to improve and increase the accessibility of quality health care services to our communities and to enhance NHI environment;

- **Ward Based Primary Health Care Outreach Teams (WBPHCOTs)** were trained, provided with uniform, jump bags and name badges for easy identification and allocated service areas.

- *Quality data* is vital for impact studies and measurements. To this effect WBPHCOTs were provided with *electronic communication gadgets* to use for profiling households; and

[1] *(ASHELP) Albertina Sisulu Executive Leadership Programme in Health.*
[2] *(MDP) Management Development Programme.*
[3] *(OTFP) Oliver Tambo Fellowship Programme.*

- IT connectivity at **27 PHC clinics** for the Health Patient Registration System (HPRS) was implemented. **15 additional PHC Clinics** will be connected by the end of March 2016 and in the new financial year we shall be connecting 20 more clinics, leaving us with only 11 Clinics still to be connected in the District. Once all clinics are connected, it will be easy to trace the movement of patients across the province for better utilisation of resources and continuity of care. This is the precursor to the patient unique code for implementation of NHI identification and registration.

Relationship between the FSDOH and the University of Free State

Hon. Speaker, since the signing of the Memorandum of Understanding (MOU) with the UFS on 12 March 2015, the relationship between the two stakeholders has improved significantly. I would like to heartily acknowledge and appreciate the roles played by Prof. Gert van Zyl (Dean of Health Sciences) and Prof. Gibson (Head of the Medical School) in this regard.

I will now proceed to outline the achievements that were realised in terms of the goals of this agreement.

With respect to teaching and training, the FSDOH and UFS have provided an enabling environment for the HPCSA Accreditation of 21 Departments and Conditional Accreditation for 4 (Geriatrics, Plastic and Reconstructive Surgery, Paediatric Surgery and Family Medicine).

To promote clinical and racial transformation, the FSDOH has joined forces with UFS in the recruitment and retention process of all doctors. The FSDOH and UFS have participated jointly in the shortlisting, interviewing and selection processes making it a more transparent process. In January 2015, 57 Registrars were recommended for appointment. They will assume duty in the FSDOH shortly to begin their speciality training. Posts were advertised nationally to increase the pool of applicants and encourage healthy competition amongst doctors. In the last two years, the Heads of Clinical Departments, Orthopaedic Surgery (Dr Matshidza), Cardiology (Prof Makotoko) and Internal Medicine (Dr Mofokeng) were appointed. Prof Marais and Prof Makotoko were awarded Professorships for their outstanding contributions to Ophthalmology and Cardiology respectively. We also wish to acknowledge Dr Mofolo, Dr Monatisa and Prof Walubo that have assisted in bringing about this transformation. The other Heads of Clinical Departments too will shortly receive their Professorships by the UFS.

To realise the ministerial targets for the training of medical students, 165 students, consisting of Africans (56%), Coloureds (17%), Indians (6%) and Whites (21%) were taken into first year. UFS have changed the entry criteria for first year students which will transform undergraduate platform. We are confident that this is the first step by UFS to reflect the demographics of the SA population in terms of providing equal opportunity to all SA citizens. UFS still needs to attain this goal, however, they have taken a big step forward in the right direction.

We will continue to strengthen the relations between UFS and the FSDOH by also dealing with the resistance to change and transform as we have dealt with language policy. More students have expressed an interest in pursuing their studies at UFS now that the Medical Postgraduate teaching and learning is all done in English, our universal language.

Health Workforce

Remunerative Work Outside of Public Service (RWOPS) still remains a significant challenge in the Department. This is mainly due to management ineptitude and poor monitoring of the clinicians on RWOPS by the CEOs of hospitals. Our expectation is that all health professionals do not perform RWOPS during peak working hours, i.e. 07h30 until 16h00, since this increases overtime costs and expenditure on personnel if done during these times. To effectively deal with this challenge we will immediately withdraw the CEOs' delegation of approving RWOPS and set up a team at corporate level that will consider all RWOPS applications for approval.

To further alleviate the shortage of doctors, expenditure on overtime and RWOPS debacle, we have during February 2016 welcomed 23 Cuban doctors in the following specialities: **Anaesthesia, Family Medicine, Paediatrics, Psychiatry and Forensic Medicine**. We will distribute them to the peripheral areas according to the Human Resource for Health Plan and our commitment to strengthen District Health Services, in this manner:

- Lejweleputswa - 6
- Thabo Mofutsanyana - 6
- Fezile Dabi - 7
- Xhariep - 3
- Forensic Pathology - 1

Even though the Cuban doctors are linked to facilities, they are responsible for the catchment areas within the districts.

Nursing represents the backbone of health service delivery and it is imperative that we continuously strengthen the effectiveness and efficiency of management in this area. We shall do so by the flattening the management structure and getting the Operational Managers in health facilities to report directly to institutional Nursing Managers. This will result in the appropriate redeployment of nursing mangers / supervisors to service delivery units.

In this Programme, for the 2016/17 financial year we shall focus on the following:

- We shall continue to implement the Audit Action Plan that addresses the findings of the AGSA and reduce the areas of emphasis.
- We shall implement targeted management training programmes to address skills gaps.

- Strengthen Performance Assessments and implementation of the HSGA model to realise health system integration, cost effectiveness and service efficiencies.
- Implement the service improvement plan by reducing waiting times and improving referrals.
- The implementation of the *roll out* of the NHI will entail the following:
  - Enrolling 50 additional clinics on the Ideal Clinic Realisation programme and increasing the number of clinics scoring above 70% on the Ideal Clinic Dashboard from the 46 expected in 2016/17 to 106.
  - Commencing with the following impact assessment studies as of 1st April 2016:
    - The impact of the quality of data collected by WBOTs against Priority Programmes;
    - The contribution of the mobile caravans usage in improving health care services utilisation and reducing clinic headcounts; and
    - The impact of WBOTs in Health Promotion and DCST in clinical governance.
- We shall enforce the measures to reduce the cost of overtime in the Department, including the commuted overtime done by the doctors. By the end of March 2016 we will appoint a committee at corporate level to consider and pre-approve all the requests for overtime work. This approval will not be the basis for payment as practised currently. The hours worked will be paid as opposed to hours available.
- Implement the HR for Health Plan, increasing the availability and retention of health professionals and the on-going filling of funded prioritised vacancies and consideration for appointing Bursary holders that complete their qualifications.
- Improving the management and governance of health information by means of 75% of facilities implementing web-based District Health Information system and to decentralize data where there is connectivity.

*The **Budget** allocation is **R 268,131,000** [**3%** of the total budget].*

2. Budget Programme 2 : District Health Services

According to the 2015 Mid-year Population Estimates by the STATSSA, the average life expectancy at birth for male adults in the Free State during the period 2001 – 2006 was 42.0 years and 45.4 years for females. Through the Department's focus on prevention and treatment programmes, we have added on average, 10 years to the life expectancy of both adult males and females in the Free State. This is why we still maintain that health is a social activity leading to economic sustenance. Let us be the first to accept that more still needs to be done as the country has missed most of the MDG targets. But our commitment to the achievement of the Sustainable Development Goals (SDG) remains steadfast.

One of the key strategies in achieving our predetermined objectives, SDGs is through the Ideal Clinic Project. What is an ideal clinic??: *An ideal clinic will open on time in the morning, according to its set*

operating hours, and does not close until the last patient has been assisted, even if this is beyond the normal closing hours. It has good infrastructure, sufficient bulk supply of essential medicine, staffed with health care providers who treat people with dignity and offer health promotion to the community. Ideal clinic has reasonable waiting times, provide comprehensive package of good quality health service and refers people to higher levels of care timeously when required. It is very clean, promotes hygiene and takes all precautionary measures to prevent the spread of diseases. The community members call it "our own clinic", rather than a "government clinic" or a "state health facility.

The Ideal Clinic Realisation and Maintenance Programme is crucial for strengthening the public healthcare system and ensuring that good quality of Health care is delivered at PHC facilities, which is fundamental building block of the NHI. The project is implemented over a period of three years to 2018/19 when all the PHC facilities would have been enrolled to qualify as Ideal Clinics. It is one of the key national priorities reflected in Chapter 10 of the National Development Plan 2030 and the Medium Term Strategic Framework (2014-19).

On this Programme, 46 clinics were enrolled in the financial year 2015/2016. The department will expand the programme to 100 clinics for 2016/2017.

Primary Health Care and PHC Re-Engineering

We have started to notice the impact of PHC Reengineering, especially the implementation of WBOTs[4] in terms of the reduction in facility-based PHC utilisation rates. The WBPHCOTs have to date reached a headcount of **736 659** and a total of **108 037** households. It is worth noting that whilst the overall PHC utilisation has reduced, it has not come at a compromise of the under-5s as we continue to maintain the average visit rate at 4.2 visits per annum against a standard of 4 visits per annum.

Our focus on the under-5s is further informed by the increase we see in fatality rates due to diarrhoeal diseases and malnutrition. The Expanded Programme on Immunisation (EPI), coverage for children under the age of 1 year improved from 86.6% in 2013/2014 to 90.1 in 2014/2015. In terms of Rotavirus doses to prevent diarrhoeal disease, FS remains second highest after Gauteng Province. This output on the under-5s emphasizes our focus on prevention of childhood illnesses. With our expansion of the School Health Teams leg of PHC Reengineering, we managed to increase the Grade 8 screening coverage from 6.1 in 2013/2014 to 17.2 in line with Integrated School Health Programme (ISHP).

We have conducted community outreach and door-to-door visits through our Back to Care Campaign in all four districts and the Metro. To date we have covered different Municipal Wards in Mangaung Metro (43 wards); Xhariep (30 wards); Lejweleputswa (39 wards); Fezile Dabi (21 wards) and Thabo

[4] Ward Based Primary Health Care Outreach Teams

Mofutsanyana (21 wards) in collaboration with our Development Partners, Municipalities, other Government Departments and Civil Society. Re a HLASELA! #takingservicestothepeople!

In the 2016/17 financial year we shall continue to implement the re-engineering of Primary Health Care and in particular, focus on the interventions that promote health and prevent disease by doing the following:

- Expand coverage of Ward-based Primary Health Care Outreach Teams (WBPHCOTs) from the current 94 to 105 in 2016/17.
- Conduct Client Satisfaction surveys in 187 (85%) clinics and Community Health Centres.
- Improve the acceptability, quality and safety of health services by achieving 100% for the National Core Standards self-assessment.
- Improve the school health services coverage and supervision school health teams by rationalising the supervision with WBPHCOTs.
- Implement the expanded programme on immunization, including targeted campaigns to reach 95% immunisation coverage for children under 1 year.
- Strengthen rural health service provision through introduction of fully-fledged mobile clinic services.

Maternal, Neonatal, Child and Women's Health (MNCWH)

In the Budget Vote 5, 2013/2014 speech, we had declared success in the reduction of maternal mortality from 267 per 100 000 in 2008, to 125 per 100 000 by 2012. This was due mainly to the introduction of exclusive maternity ambulances, ensuring skilled attendance and improved inter-facility transport system. During the calendar year of 2015 there were 92 maternal deaths notified in the Free State and 43 548 live births and this translates into maternal mortality ratio of 211/100,000 live births, an increase compared to the previous year. In reality there were 4 less deaths than in 2014, but the number of live births in the province decreased by 1 700. The MMR in 2014 was 212/100,000. We continue to deal with the challenges of data quality with a view to ensure consistent accuracy of our data.

Hon Speaker, These are not just mere statistics, but dear lives of mothers, sisters and wives. In the Free State our data indicates that the high risk pregnancies of teenage girls before their 18th birthday and women above the age of 35 continue to be significant challenge. During the period April 2011 to January 2016 the public health facilities in the Free State had an average of 46 025 deliveries annually, with 18.8% being the mothers in the two age groups. In the current year, April 2015 to January 2016, we had deliveries by 4 466 teenagers and 2 394 mothers aged over 35 out of a total of 36 544 deliveries. The data for maternal deaths also show that 31.7% of the maternal deaths recorded were of mothers under the age of 20 years and those above 35 years.

Non-pregnancy related infections, *HIV, hypertension, haemorrhage* and the *acknowledged failures and inadequacies of the health system and health workers are the main contributors to the maternal deaths.* In response to this, we have trained an additional 42 nurses in advanced antenatal care to assist in improving the identification of at risk pregnancies and are maintaining a high level of training on management of obstetric emergencies. The Free State Province has however, next to the Western Cape, the lowest case fatality rate for caesarean deliveries at 1.2/1000 caesarean deliveries compared to the national average of 1.5/1000. This performance vindicates our current policy of consolidation of skills and other related resources and only performing caesarean sections at sites that are fit and sufficiently resourced for the purpose. We are further improving safe caesarean delivery through implementation of surgical and anaesthetic skills assessments conducted by clinical managers and the mandatory use of the caesarean safety checklist in all caesarean deliveries.

In response our Couple Year Protection Rate, which measures the extent to which women are protected against unwanted pregnancies by using any of the different contraceptive methods, has increased from 36.6% in 2012/2013 to 55.0% in 2014/2015. The Department espouses the principle of gender equality as we now actively encourage male sterilization as another contraceptive method. Our focus on prevention is also depicted by the increased antenatal first visits before 20 weeks from 56.2% in 2013 to 61.6% in 2015 as compared to the mean for the country, which stands at 60.16%, a clear indication of our intention to achieve SDG and NDP 2030 targets and to ensure that no woman dies giving life.

The MomConnect system, which is an SMS-based communication platform for pregnant mothers was implemented at full scale during 2015/2016 and more than 8 000 pregnant women have been registered and they continually receive health education and advice from our experts.

We are also concerned about the number of babies that are born before arrival (BBAs) at health facilities as well as the baby deaths outside of our health facilities. Maternity waiting homes are a proven strategy to address BBAs and we are now moving beyond the presence of the waiting facilities but their functionality. Mass mobilization continues to be conducted through community dialogues to improve Maternal Health outputs through raised vigilance and awareness of the value of taking sick children to health facilities early.

In the 2016/17 financial year our efforts to intensify the programmes that deal with maternal, neonatal, child and women's health will continue unabated and in this regard we shall focus on the following priorities:

- Maintain 20 rostered dedicated maternity ambulances to ensure timely transfer of mothers and newborns to dedicated maternity and caesarean sites.
- Continue to conduct mass mobilization on Maternal Health issues.
- In addition to improving the accessibility of other forms of contraception, we will institute roving sterilization services to increase couple year protection rate from 55% to 60%.

- All the midwives in the 40 delivering facilities will be trained on Helping Babies Breathe programme.
- Strengthen the designated caesarean section and delivery centres in each district to save 90% of mothers.
- Intensify the implementation and monitoring of compliance with the National Committee on Confidential Enquiries into Maternal deaths (NCCEMD) recommendations and the Campaign on Accelerated Reduction of Maternal Mortality (CARMMA).
- Intensify Antenatal Care (ANC), Vaccinations, including Human Papilloma Virus vaccine to save 70%.
- Intensify PMTCT and eMTCT programmes to consolidate the gains we have realised in reducing mother to child transmission of HIV and keeping it below 2%.
- Conduct impact assessment studies as of 1st April 2016 on the following programmes:
  - The programme on Prevention of Mother to Child Transmission (PMTCT) and Elimination of Mother to Child Transmission (eMTCT).
  - The implementation of Nurse-Initiated Management of Antiretroviral Treatment (NIMART).
  - Training and implementation of Essential Steps in the Management of Obstetric Emergencies (ESMOE).
  - The implementation of Integrated Management of Childhood Illnesses (IMCI) and Child Nutrition.

Non-Communicable Diseases

One of our declared burdens of disease is the non-communicable diseases, including Mental Illness, Hypertension, Diabetes Mellitus, Cancers, Obesity and diseases precipitated by inactivity, tobacco and high intake of sugar and salt, account for a significant number of mortalities among our population.

In us describing the quintuple burden of disease we acknowledge mental disorders as one of the key health challenges facing our people. This is a public health problem that is commonly disregarded by both the health care workers and the community at large.

The South African Stress and Health (SASH) DSM-IV study, a 12-month and lifetime prevalence of common mental disorders published in the SA Medical Journal (2011), found that the prevalence rate for all types of mental disorders combined in the Free State to be 37%, second after the Western Cape. Honourable Members will note with interest, that Free State was found to have the highest prevalence in the country for Anxiety and Mood disorders, while featuring among the top 3 for both Substance Abuse and Impulse. This is surely indicative of the necessity for all of us to give mental health the attention it deserves. At the beginning of the current financial year we began putting emphasis on screening the users of our PHC facilities for mental illnesses and as at the end of January 2016, a total of 211 778 people were screened for mental disorders and 6 238 newly diagnosed people underwent different treatment modalities for mental illnesses.

The Mental Health Act, 2002 requires of us to ensure the availability of the services for 72-hour assessment of mentally ill individuals in district and regional hospitals prior to admission to the 3 hospitals designated for the purpose. Based on the resource challenges the Department faces, to date 18 of the 30 hospitals provide the 72-hour assessment. We shall continue to establish the necessary capacity in the different hospitals for this important service to be provided.

The implementation of cataract surgery programme, which is crucial in the reduction of the incidence of preventable blindness, has remained a major challenge to us, mainly due to the shortage of Ophthalmologists and the incapacity of our Eye Care centres. To address this we implemented a Cataract Surgery blitz in October through which 329 operations were performed and this brought the cataract surgery rate to 923/1 000 000 uninsured people. We shall continue with this programme to give sight to more people and to establish the cornea banks and leadership of Prof Wayne Marais.

During 2016/17, as already pronounced by the Hon. Premier in the SOPA 2016, our focus will be on prevention, education, counseling and treatment.

- We will improve on our effort in cervical cancer screening which dropped from 51.1 in 2013/2014 to 40.9 in 2014/2015 and improve it to 60%.
- We shall be establishing and implementing the therapeutic research and treatment programs using regenerative medicine and cell based treatments. To this extent we shall focus on musculoskeletal diseases, autoimmune and other relevant afflictions. The initial Centres for such shall be Pelonomi and Boitumelo hospitals. This therapeutic programme shall be implemented in consultation with Orthopaedics, Internal Medicine and EMS platforms in order to deal with the backlogs and ravages of chronic illnesses.
- We will intensify screening for mental illnesses and increase the number of people screened to **632 558**.
- We will screen **700 000** people for both Hypertension and Diabetes.
- We will continue to actively recruit opthalmologists and implement Cataract Surgery blitzes through the Departmental resources.

Tuberculosis

According to STATS SA 2013 report on Mortality Trends, released December 2014, Thabo Mofutsanyana is the leading district in the country on TB death rates. In response to this fact, we continue to intensify our efforts as illustrated by our performance of 67% in TB screening as compared to only 49% in 2013. During the last budget vote speech, we committed to the screening of the peri-mining communities and the inmates of correctional centres. To this effect 30 000 miners, which represents 100% of the mine workers in the Free State were screened. 97% of prisoners in correctional facilities were screened for TB.

New Pulmonary TB Cure Rate is projected at 77% and 95% of MDR patients were put on treatment following confirmation of the diagnosis.

As from the 2016/17 financial year we shall be firmly focused on achieving the targets in line with the 90-90-90 strategy by 2020. To achieve these targets we will intensify active case finding in communities through, among others, the WBPHCOTs in order to reach those with TB that would not have presented at the clinics.

- We will conduct mass TB screening campaign, including the tracing of Tb contacts and increase the screening coverage from the projected 3 666 455 people in 2015/16 to 5 363 614 in 2016/17.
- We will find and treat all active TB patients Treat all TB found
- Increase TB cases initiated on ART to 95% and decrease TB client loss to follow up rate to not more than 5%.
- We will increase the MDR Cure Rate to 55% by adding new drugs, namely Bedaquiline / linozelid to the current treatment regimen.
- With the abovementioned interventions, we will reduce the TB death rate to not more than 7.5%.

HIV and AIDS

The prevention of HIV infections and the promotion of negative HIV status remain the foremost priority in the comprehensive management of HIV and AIDS. In the current financial year to December 2015 a total of **977 950** female condoms were distributed as compared to **624 715** during the whole financial year 2013/14. **37 930 872** male condoms were distributed during the first three quarters of 2015/16. Medical Male Circumcisions (MMCs) was implemented in different health facilities and **27 818** circumcisions were performed.

A total of **500 813** people were tested for HIV and AIDS in the Free State as end December 2015. Of this number, 46 800 tested positive, which translates to 9%. During my tenure in this Department, through the support from my team, there has been a significant decline when compared to the 2013 positivity rate of 14%.

The new ART guidelines with eligibility threshold of CD4 <500 was implemented as from the 1st of January 2015. We have initiated **27 966** people (26 897 adults and 1 069 children) on ARTs and as at the end of December 2015 we had 182 202 people remaining in care on the ART programme. Through the eMTCT programme we continue to register very good progress in reducing the transmission of HIV from mothers to their children. The Province achieved an Infant 1st PCR test around 6 weeks uptake rate of 74.1%, the 4th highest in the Country, with the PCR test positive rate is at 1.9%.

In aligning with the UNAIDS 90-90-90 strategy, all districts have developed District Implementation Plans (DIPs) to fast-track the achievement of the elimination targets by 2020, i.e. **90% (344 667)** HIV positive

people knowing their status; **90% (248 160)** eligible people to be on ART and **90% (223 334)** virologically suppressed. Working towards these targets we shall focus on the following:

- Further intensify the HCT programme and test **652 059** people, including antenatal clients, for HIV.
- Male condom distribution to reach a total of **48 995 000** from the **44 307 488** in 2015/16.
- Improve performance on Medical Male Circumcision programme and reach the total of **40 99**7 from the projected performance of 37 00**0** in 2015/16.
- Improve treatment adherence by establishing adherence clubs and expanding access to treatment by using the CCMDD system.
- Embark on the Test-and-Treat approach in line with the 90-90-90 strategy and increase the number of new patients started on ART to **52 24**9 from the projected performance of 36 000 in 2015/16 and **237 953** adults remaining on ART.
- Increase the TB/HIV co-infected client on ART rate from 78.5% in 2014/15 to **85%**.

*The **Budget** allocation is **R 3,740,286,000** [**1.3%** of the total budget].*

3. Budget Programme 3: Emergency Medical Services

We convened an Emergency Medical Services seminar in November 2014 wherein a number of service delivery debates were had and resolutions taken in order to improve EMS, including the following: [(a) Suitable Aero medical service; (b) Review of Patient transport service model; (c) Change EMS uniform to flight suits; (d) Training EMS officials; (e) Redeploy EMS managers to local areas; (f) Develop Improvement plan of EMS stations; (g) HPCSA Accreditation of ILS course; (h) ALS officials to be appointed at the Control Centre; (i) Re-training program of BLS officials; (j) Improvement of Control Centre communication system; (k) Review of service model and (l) Weight loss program for EMS practitioners.

We will briefly deal with the progress made in the implementation of the aforementioned resolutions.

Training from 2013 - 2015

- **122** EMS practitioners were re-trained on the Basic Life Support (BLS) course with the aim of ensuring that all our staff are current and offer services of higher standard to all our patients.
- **108** call takers and dispatchers were trained to improve screening and dispatching of calls.
- **376** officials have been trained on various rescue skills to close the skills gap at Fire and Rescue departments. These officials are trained to respond to disaster situations and major incidents within and outside the country.

- **96** officials were trained on **Intermediate Life Support** and **67** on **Advance Life Support**. These officials are deployed to improve care within ambulances and response vehicles. As pronounced in the 2015 Budget Vote 5, we are pleased to announce that the Department obtained the HPCSA accreditation for Intermediate Life Support training and the first class has already qualified. However we are currently having challenges to recruit and retain the scarce skilled officials within EMS, resulting in the inability to train more officials because of the criteria set by the HPCSA. We are now faced with more students than the number of lecturers required per student.

Aero-Medical Services

In 2014, a study was conducted to review the kind of aero medical service required for the Free State Province. The study indicated the need to improve on the service rendered then to avail doctors for outreach programs, to be able fly day and night and to be able to fly more than two patients at a time. In 2015 new aero-medical service was procured offering 24 hours services, could facilitate outreach, could transport mother and child, could perform rescue operations and could also take heavy patients.

Acts of criminality targeting ARV medication, consumables, medical equipment and burning of state property, including state property, have a negative impact on the capacity of the Department to deliver quality services and to respond to emergency calls. Recently emergency medical equipment amounting to more than R 120,000 was stolen in Xhariep District. Some of the equipment was subsequently recovered and the Hawks, with the Department are working together to ensure that the perpetrators are arrested and face the full might of the law.

Inter Facility Ambulance Service

We have been reaping the rewards since the introduction of Buthelezi EMS to supplement our provincial EMS on inter-facility transfers, mainly obstetric emergencies as well as trauma and other medical emergencies. We analysed our data since 2013 to date in order to understand what impact and benefits the service brought to the Department. We then concluded the following:

- We have extended the longevity of our fleet by replacing ambulances every four years instead of three years as previously used to be.
- We have seen reduction of complaints where ambulances do not arrive although we still need to improve on our response times.
- The reduction of the departmental fleet account from R 10.6 million per month in 2013 to R 4.6 million currently is indicative of efficiency gains although we believe we can achieve even more with the resources we have.

- The cost of the service to the Department, which includes 47 ambulances manned by BLS, ILS and ALS staff is R93,600,000 annually compared to the R 119,836,000 it would cost the Department to provide the equivalent service.
- The Department would also have to incur training costs amounting to R 16,967,000 for the training of 47 ILS (R 2,209,000) and 47 ALS (R 14,758,000).

The New Ambulance Act, promulgated in May 2015, grants all private and government ambulances 12 months set up time from the date of promulgation to comply with the Act. As from the 1st April 2016 all ambulance operators within the Free State Province will have to apply to the MEC: Health for license to establish and operate an ambulance service within the Province.

In the 2016/17 financial year we will prioritise the following in strengthening the EMS:

- We will recruit more than 140 emergency care officers (ILS and ALS) categories and they will be allocated to all districts to strengthen our emergency medical services.
- We will continue to monitor the efficacy of the handling of transfers and eradicate patients waiting and admission times at health facilities as this will decrease the costs of inter facility in general.
- We will maintain 20 dedicated obstetric ambulances to improve the quality and safety of maternity services.
- We will improve the efficiency of patient referrals through consolidation of routes and replacing multiple small vehicles with 60-seater buses.
- Rescue vehicles will be placed at strategic areas without fire and rescue resources within the Province.
- Patient transporters travelling long distances towards Bloemfontein specialised clinics will be decreased by introducing big buses to transport all patients which will result in less vehicles transporting patients and resulting in financial and human resource savings.

Ons Werk, Re ya sebetsa, Siya Qhuba!!

*The **budget** allocation is **R 562,587,000** [**6.2%** of the total budget].*

4. Budget Programme 4: Provincial Hospital Services

The four Regional Hospitals provide specialised level 2 hospital services in the Province. The key challenge we continue to face in these hospitals is the scarcity of medical specialists that are required to provide the 9 basic clinical specialities. We have seen a decline in the headcounts at these hospitals with

the resultant decrease in the bed utilisation rates. However this is in line with the reduction in the PHC headcounts as I spelt out under Budget Programme 2.

There were persistent media reports about shortages of staff, medicines, medical consumables and nonfunctional lifts at our hospitals. We never denied the fact that these specialist hospitals, i.e. Dihlabeng in Bethlehem, Mofumahadi Manapo Mopeli in Qwaqwa and Bongani in Welkom, which were all constructed more than 20 years ago, continue to face challenges of aged infrastructure. We have made huge strides in addressing these challenges.

In terms of medicine and consumables, all the regional hospitals maintained medicine availability of 95.7 - 97% in the current financial year in the midst of all media speculation of a collapsing hospital system.

In October2015 we experienced a sad incidence of 5 neonatal deaths over a period of 3 days at Bongani Regional Hospital due to neonatal sepsis and prematurity contrary to media speculation at the time. As a responsive and caring Department, a team was dispatched to investigate and support the facility in instituting the relevant interventions. One of the key findings over and above staff shortages was poor infection control practices by the visitors, parents and health care workers. This was further compounded by inadequate infrastructure. Regardless of these challenges the neonatal mortality rate at Bongani has actually dropped from 31.5/1000 in 2013 to 20.9/1000 live births in 2015. We have since appointed a full-time Paediatrician and 21 Auxiliary nurses and the Neonatal Unit has been relocated to a more compliant space. The Office of Health Standards & Compliance (OHSC) has, during the same period and as part of an independent investigation, assessed the entire hospital.

In this programme we will focus on strengthening level 2 services with major emphasis on recruitment and retention of specialists to outreach and support level 1 hospitals.
We shall prioritise the filling of critical clinical vacancies with the incumbents conducting regular clinical outreach on the 9 basic specialities to district hospitals.
The regional hospitals will provide only specialised OPDs and any general OPD services will be closed.

*The **budget** allocation is **R 1,351,461,000** [**14.9%** of the total budget allocation]*

5. Budget PROGRAMME 5: Central Hospital Services

Our Health System is currently top heavy. More patients are treated at higher levels of care which is costly to the health system.

In addressing this anomaly, our focus will be to:

- Enforce the implementation and monitoring of the referral system. The down referral of patients will happen with the relevant medication to prevent unnecessary follow up visits at tertiary services.

- Strengthen the clinical outreach programmes, with particular emphasis on the 9 basic clinical specialities.
- Rationalise sub-speciality training, registrarship and filling of posts on Joint Appointment platform in line with the burden of disease.

*The **budget** allocation is **R 2,236,597,000** [**24.7%** of the total budget].*

6. Budget Programme 6: Health Science & Training

In order to build the capacity of our Healthcare Work force, training and development opportunities for of the Department of Health, in 2016/17 will focus on the following priorities:

- Training of 170 Community Health Workers to cater for the expansion of Primary Healthcare Re-engineering
- The student intake at the EMS College will consist of 72 AEAs; 30 Emergency Care Technicians; 60 Emergency Care Assistants and 180 on Rescue Training, as well as 60 Emergency Medical Dispatch.
- 50 Administrative Clerks to be trained on Records Management in order to address the current challenge with poor record keeping.
- To enhance management capacity, in 2016/17 six (6) CEOs will be enrolled on ASELPH; 2 Financial Managers on Financial Management; 100 MMS members on Financial Management for Non-Financial Managers and 20 Middle Managers on MDP in 2017/18;
- All the Professional Nurses working in facilities enrolled on the Ideal Clinic programme will be trained on Basic Life Support.
- We shall enroll nurses at the facilities that are on the major arterial roads in Trauma Training, ACLS, and ATLS.

*The **budget** allocation is **R 195,927,000** [**2.2%** of the total budget]*

7. Budget Programme 7: Health Care Support Services

This budget deals with management of Pharmaceutical Services, Orthotic and Prosthetic Services and the Laundry Services.

Access to Essential Medicine

During the current financial year we had to deal with a number issues pertaining to medicine availability. Certain specific pharmaceutical items were at times reported to be out of stock during the reporting period. These were due to both management failures and those outside of the control of the Department, which negatively impacted on the availability of medicine. External factors included supplier failure to meet contractual supply obligations, challenges with production and distribution of

products, national contracts and shortage of active pharmaceutical ingredients at a global level, etc. Remedial actions were put in place to address these challenges at both National and Provincial level.

In response to the challenges above, we strengthened the active monitoring of medicine availability and the impact of non-availability of medicines at all levels of care through implementation of monitoring tools. The facility data analysed for the period, September 2015 to February 2016 on the impact of non-availability showed that, on average, only 5% of items prescribed could not be dispensed. In an event where prescribed medicine cannot be dispensed, alternatives are dispensed, available stock is rationalized between facilities and, where appropriate, the treatment regimen is switched.

In addressing lack of Governance and Leadership within Pharmaceutical Services, we have partnered with Management Sciences for Health (MSH) and developed a Pharmaceutical Leadership and Governance Initiative (PLGI) Programme. 32 Pharmacists are completing this programme at the end of March 2016. This programme also encourages a culture of Operational Research in order to gather evidence and information to support and inform decision making.

In order to strengthen active surveillance in our PHCs, the District Pharmaceutical Services structure was revised to ensure adequate monitoring, supervision and mentoring of Pharmacist Assistants in the clinics. We also have 40 Leaner Basic Pharmacist Assistants on training with the support of our developmental partner, Kheth'impilo. Community Service Pharmacists and Roving Pharmacists have been assigned to provide support and ensure timely interventions where cases of medicine stock outs, overstocking and wastage are identified. Key to these interventions is the redistribution of stock from where overstocking is identified to where there are shortages and to give expert advice to prescribers in cases where alternative therapies are applicable and available.

Two Drug Stock-out committees were established, one internally in the Department and another multi-sectoral one in the Provincial Council on AIDS (PCA), to monitor stock availability and rapidly intervene where challenges were identified. The committees have conducted monitoring visits to health facilities and reported regularly. The departmental committee reports monthly while the PCA-based committee reports to the PCA on quarterly basis.

In the Budget Vote 5 for 2015, we had committed to roll out the CCMDD Programme to Lejweleputswa. Unfortunately the Department had to hold the process back in order to take from lessons learnt from the pilot in Thabo Mofutsanyana District to mitigate the low uptake by patients. One of the lessons was the need to expand beyond the ARV Programme and include other chronic conditions, like hypertension, diabetes, and other conditions to address the stigmatization of the programme.

Furthermore we learned that some patients continued to go to the clinics to collect their medicines although they were enrolled on the programme. A snap-shot impact analysis of the programme also revealed that the Pick-up Points appointed on the programme were not suitable for patients. This necessitated for us to go back to the drawing board and engage in a wider community and stakeholder

consultation exercise to determine appropriate distribution as part of our change management effort. Adherence Clubs managed by NGOs and Community Care Givers are now considered as Pick-up Points to encourage access and adherence to treatment. To date, we have enrolled 25 193 patients on the CCMDD Programme, which means that 25 193 patients do not have to travel to our facilities, wait in long queues and further clog the health care system

In this past 11 months, for 2015/2016, the Medical Depot has paid suppliers R 565 424 370 as compared to R 455 737 566 in 2014/2015. This amounts to R109 686 804 more the 2014/2015 financial year, which is a huge improvement considering the state of the Department's financial standing in 2013/2014. This has resulted in improved relations between the Department and suppliers and has bolstered their confidence in doing business with the Department. The Medical Depot also continues to obtain an Unqualified Audit Report from AGSA.

In order to ensure that the provision of Pharmaceutical Services in the FS is sustainable, we have embarked on an exercise to investigate a more sustainable funding model for the Medical Depot. The investigation is at an advanced stage and in due course we will engage the relevant structures on the matter.

Hon. Speaker, the societal challenge of the scourge of illicit use of drugs is just as much of a challenge to us as a Department. The demand for the Fixed Dose Combination (FDC) tablets, used as ingredient in the manufacturing of illicit drugs such as ***"Nyaope"***, is unfortunately on the rise and as a result, the Department has become a victim of the theft of ARVs and other medicines. This phenomenon is compounded by poor security measures at health facilities and staff involvement in the theft. As a deterrent, we have dealt swiftly with the matter and to demonstrate our intolerance to such criminal acts. An official in Lejweleputswa who was found to have stolen drugs, including ARVs, was charged and subsequently dismissed from service. We hope that Civil Society, as they advocate for improved access and availability of medicines, will also be as vocal and vigilant when such instances come to their attention and join hands with the Department to bring all perpetrators to book.

Siya Qhuba!

Under this programme we will focus on:

- Finalising the investigation into the reconfiguration and strengthening of the medical depot.
- Intensify pharmaco-vigilance and enforcing pharmaceutical governance structures.
- Maintain tracer drug availability at 95%
- Provide orthotic and/or prosthetic devices to 10 250 patients and clients.
- Ensure zero linen stock-outs at health facilities.

The **budget** allocation is **R 176,916,000** [**2%** of the total budget].

8. **Budget Programme 8: Health Facilities Management**

- Under this programme we will implement the planned and recurrent maintenance of health facilities in line with our User Asset Management Plan.
- The **Albert Nzula District Hospital** will be officially opened in April 2016.

We will commission and operationalise the following completed clinics during the **first quarter** of 2016/17.

  - **Mandela Clinic** in Parys
  - **Schonkenville Clinic** in Parys
- In the **second quarter**, the following clinics will be completed and operationalised
  - **Batho Clinic** in Mangaung
  - **Rammolutsi Clinic** in Viljoenskroon
  - **Memel Clinic**
  - **Amelia Clinic** in Zamdela
  - **Senekal Clinic**, which is currently being vandalised.
- By the fourth quarter, we will operationalise **Makhalaneng Clinic** in Qwaqwa.
- We will also commence with the construction of the following facilities:
  - Clinic in **Thandanani** in 2010, Matjhabeng
  - Extension of **Bophelong Clinic** in Moqhaka
  - **Clocolan clinic**
  - **Lusaka Clinic** in Qwaqwa
  - **Borwa Clinic** in Tweespruit
  - **Welkom Mortuary**

*The **budget** allocation is **R 516,695,000** [**5.7%** of the total budget allocation]*

CONCLUSION: Theodore Roosevelt:

"It is not the critic who counts; not the man who points out how the strong man stumbles, or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood; who strives valiantly; who errs, who comes short again and again, because there is no effort without error and shortcoming; but who strives to do the deeds, who knows great enthusiasms, the great devotions; who spends himself in a worthy cause; who at best knows in the end triumph of high achievement and who at worst, if he fails; at least fails while daring greatly, so that his place shall never be with those cold and timid souls that neither know victory nor defeat."

THANK YOU