

Much has been heard about the so-called health crisis in the Eastern Cape over the past few years, both from politicians and the media. Since 2000 there has been a steady increase in the number of reports of health care related problems in the Eastern Cape, including overcrowded hospital wards, dilapidation of infrastructure, food shortages, broken-down ambulances and neglected state mortuaries.

The questions that this report sets out to address are: What are the various dimensions of the crisis in the provision of health care services in the Eastern Cape between 2000 and 2004? Is this crisis largely the result of the province's apartheid legacy, as politicians have often claimed, or the consequence of mismanaged health care resources? And, importantly, how can this crisis be overcome? These are serious questions that are addressed through an evaluation of the performance of the Eastern Cape Department of Health against the Constitutional and Legislative requirements established to govern public service delivery since 1994. This report assesses whether public health care resources have been effectively and accountably utilised since the transition to democracy in South Africa.

**The Crisis of Public Health Care in the Eastern Cape**

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The post-apartheid challenges of oversight and accountability



**Colm Allan, Neil Overy, Zama Somhlaba,  
Vuyo Tetyana & Lucas Zepe**

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# Glossary

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AG	Auditor-General
ARVs	anti-retroviral drugs
BAS	Basic Accounting System
CBOs	community-based organisation
CEO	Chief Executive Officer
CHC	community health centre
DG	Director-General
DORA	Division of Revenue Act
DORB	Division of Revenue Bill
DPSA	Department of Public Service and Administration
FFC	Finance and Fiscal Commission
FMS	Financial Management System
EMS	Emergency Medical Services
FMS	Financial Management System
HBC	home-based care
HEPTAR	Health, Training and Research Grant
HODs	Head of Department
IMT	Interim Management Team
JBC	Joint Budget Committee
LSA	local service area
MEC	Member of the Executive Council
MINMEC	Meeting of national Minister with nine provincial MECs
MPL	Member of the Provincial Legislature
MTBPS	Medium-Term Budget Policy Statement
MTEF	Medium-Term Expenditure Framework
NCOP	National Council of Provinces
NEHAWU	National Education, Health and Allied Workers' Union (NEHAWU)
NGOs	non-governmental organisation
NP	National Party
NHS	National Health Service
PEP	Post-Exposure Prophylaxis
PERSAL	Personnel Administration System
PFMA	Public Finance Management Act
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PFMA	Public Finance Management Act
PHC	primary health care

PMTCT	prevention of mother-to-child transmission
PPP	public-private partnership
PSA	Public Service Act
PSAM	Public Service Accountability Monitor
PSNP	Primary School Nutrition Programme
SAHRC	South African Human Rights Commission
SALGA	South African Local Government Association
SANTA	South African National Tuberculosis Association
SCOPA	Standing Committee on Public Accounts
SLA	service-level agreement
STDs	sexually-transmitted disease
STI	sexually-transmitted infection
TAC	Treatment Action Campaign
TB	tuberculosis
UNITRA	University of the Transkei
VCT	voluntary counselling and testing

# Preface

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This report arose out of the PSAM's quest to find ways to develop a more comprehensive approach to the monitoring of democratic governance, and the practical implementation of accountability provisions, in post-apartheid South Africa.

Between 1994 and 2003 the Eastern Cape provincial government earned itself a reputation for sustained service delivery failure and the weak management of public resources. The national and provincial media reported widely on instances of maladministration and corruption involving the provincial administration during this period. This begged the question of how much of what was being reported was accurate and what action was being taken by the newly elected democratic government to ensure the transformation of the apartheid era public service.

In this context, the PSAM was established as an independent research project at Rhodes University in 1999 with a relatively narrow focus on tracking corrective action taken in response to reported corruption in the provincial administration. It developed a database and public access website to keep the public informed of the steps being taken to resolve these cases. Its emerging monitoring methodology consisted of undertaking a comparison between corrective steps taken and the regulatory provisions governing the discipline, ethics and accountability of public servants in post-apartheid South Africa.

This methodology was informed by a simple principle enshrined within South Africa's new democratic Constitution – viz that those in public office are accountable to the citizens whose interests they were appointed to serve.<sup>1</sup> A literal interpretation of this principle was adopted as the basis for PSAM's engagement with government officials, which asserts that accountability is an impersonal obligation by those in positions of public power, not a personal favour.

It was not long, however, before the PSAM's engagement with the provincial government led to its realisation that there was a much broader structural context in which reports of maladministration, corruption and failed service delivery needed to be situated. In 2001, on the basis of this realisation, the PSAM began to develop a scorecarding methodology for evaluating the structural challenges and obstacles faced by provincial government departments in managing their resources effectively and delivering services efficiently. This was in addition to the existing focus on the personal conduct of government officials in executing their responsibilities. Very often the obstacles encountered by Eastern Cape government leaders, and the service delivery failures for which they were responsible, were blamed on the apartheid legacy.

In order to address the plausibility of these assertions, during 2001, the focus of the PSAM's monitoring work shifted to the budget planning, expenditure, oversight and accountability cycle within which government departments are constrained to operate. Whilst

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<sup>1</sup> Constitution of the Republic of South Africa, 1996, Act 108 of 1996, Sect. 195(1)(f).



the basic principle underpinning the PSAM's monitoring methodology remained the same, its focus expanded to include the implementation of financial and human resource management, as well as public service disciplinary regulations.

By 2003 the PSAM had emerged into a fully-fledged monitoring and research institute. It developed mechanisms for monitoring compliance by Eastern Cape government departments with the entire gamut of public finance regulations and financial reporting requirements, including strategic planning, annual reporting and audit reporting. In addition, it has sought to establish the efficacy of Legislature oversight and whether oversight committee recommendations to departments were being implemented.

Given the broad scope of this monitoring work and ongoing reports of service delivery failure within the Eastern Cape public healthcare system, there was a degree of inevitability about the need for a more in-depth focus on the province's Department of Health. By the end of 2000 the PSAM had (as the chronology set out in this report will demonstrate) become intimately acquainted with issues relating to financial misconduct allegedly involving the Eastern Cape Department of Health's HOD. It had at the same time taken up the issue of conflicts of interest involving the department's MEC.

Since 1999 the PSAM had endeavoured to track the department's responses to reports of corruption and misconduct by its staff members. These instances of unconstrained misconduct appeared to be directly linked to the department's serial inability to manage its budget allocations effectively and to the constant obstacles encountered in its efforts to deliver effective public health services in one of South Africa's poorest provinces.

The need to write up all of this information into a single report and to provide a comprehensive account of the department's performance became increasingly evident throughout the period of strong civil society engagement with the South African government between 2000 and 2004 around the right of those living with HIV in the country to effective health care and treatment. The PSAM had supported the Treatment Action Campaign's (TAC) contentions concerning the affordability and desirability of providing free antiretroviral treatment to South Africans living with HIV in order to improve their quality of life and to enable them to make a more productive contribution to society.

The PSAM had provided modest support to TAC's Pretoria High Court application to have nevirapine made available at all public health facilities for PMTCT purposes at the end of 2001. With a successful judgement being issued in TAC's favour (which was subsequently upheld by the Constitutional Court in July 2002) the PSAM developed a keen interest in monitoring government's compliance with the Court's decision. In November 2003, the PSAM held a workshop in conjunction with the TAC (and other civil society HIV/AIDS advocacy organisations in the Eastern Cape) to review the provisions necessary to monitor the roll-out of ARV use for PMTCT purposes and more broadly for treatment purposes.

At this workshop there was a mutual recognition of the importance of ensuring the effective management of the Eastern Cape Department of Health. The participants also recognised the need to ensure that the department's budget (amongst other things, for infrastructure maintenance and development) was properly utilised for purposes of ensuring the effective long-term treatment of those living with HIV.

This report sets out to address some of the challenges that will need to be met if a successful HIV/AIDS treatment roll-out is to be effected, and if a more efficient and effective public health service is to be erected in the Eastern Cape.

*Colm Allan*

*Director, PSAM*

*31 May 2004*

## Dedication

This report is dedicated to all those public health care workers and public officials within the Eastern Cape Department of Health and its various hospitals, clinics and health centres who continue to work hard to deliver health care to the province's most needy citizens despite their adverse working conditions. The report is specifically dedicated to Dr Patricia Preciado-Elliot of Victoria Hospital in Alice, who was murdered in March 1998 prior to blowing the whistle on corruption at the hospital. The report is also dedicated to Bishop David Russell, who sat on the PSAM management board from its inception in 1999 until his retirement in December 2003, for his tireless campaigning and social mobilisation to stem the tide of decaying public health care within the Eastern Cape.

## Acknowledgements

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# Key Findings and Recommendations

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## Health Budget

### Finding

In 1999/2000 the Eastern Cape per capita expenditure on health was 83 per cent of the national average. By 2002/03 this figure had fallen to 73 per cent. Figures show that the Eastern Cape per capita health budget has been increasing at a much slower rate than the national average.<sup>i</sup>

### Recommendation

The Eastern Cape provincial Treasury and the province's Finance Standing Committee should take steps to ensure that the provincial Department of Health is allocated a budget proportional to the province's needs and in line with the national average expenditure on health care. The Eastern Cape delegates to the National Council of Provinces (NCOP) should lobby vigorously to ensure that the province's budgetary allocations are in line with its social needs.

## Spending

### Finding

In the audited financial years between 2000 and 2003 the Eastern Cape Department of Health underspent its three-year R12.4 billion budget allocation by an amount of R309 million. During this period the department's programmes were found to have routinely incurred significant over- and under-expenditure. This spending pattern is attributable to the department's failure to undertake rigorous strategic planning and to utilise a zero-based budgeting approach. Instead of drawing up properly costed business plans for each programme and then combining them to make up its operational plan for the year, the department was found to have routinely drawn up its strategic plan first and its operational and business plans later.

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<sup>i</sup> See Chapter 5.

## Recommendation

The department needs to dramatically improve the quality of its strategic planning to enable it to track its expenditure more effectively. The national and provincial Treasuries need to ensure that the department utilises a zero-based budgeting approach and that it starts its planning process at the prescribed times during each financial year. In addition to these bodies the provincial Finance Standing Committee, the Standing Committee on Public Accounts (SCOPA) and the Health Standing Committee need to take steps to ensure that the department draws up properly costed business plans for each of its programme, and that it ensures that these are timeously incorporated into its operational plan for each financial year. The department, its various stakeholders and the above oversight bodies should take steps to monitor the department's expenditure in line with its operational plan.

## Infrastructure Maintenance and Development

### Finding

The Eastern Cape Department of Health failed to spend an amount of R283.3 million (or 19.4 per cent) of its R1.458 billion infrastructure budget between 1999 and 2004. None of the department's annual strategic plans for this period were found to contain accurate, time-bound and costed capital expenditure and maintenance plans.

### Recommendation

The Eastern Cape Legislature Health Standing Committee and SCOPA, as well as the provincial Treasury, need to take steps to ensure that the department annually undertakes a detailed analysis of its infrastructure maintenance and development needs, and that it draws up its maintenance and construction plans on this basis. This should include a detailed account of maintenance and upgrading needs of existing health facilities and an analysis of the need for new facilities. These bodies should also ensure that the department tracks its expenditure on these facilities year-on-year and that it reports rigorously on the implementation of its infrastructure plans.

## Strategic Planning

### Finding

None of the department's strategic plans for the period between 2000 and 2004 were found to contain accurate information on the Eastern Cape public health service delivery environment and the service delivery needs to be met by the department. Nor did these plans contain evidence of effective consultation with the department's internal and/or external

stakeholders. Of particular concern is the fact that none of the department's plans contained any reference to conditions attached to its transfer of funds to external bodies, or to any monitoring mechanisms for ensuring compliance with these conditions. This is despite the fact that the department transfers millions of rands out of its budget to municipalities and NGOs each year.

## Recommendation

The department should ensure that it identifies its strategic objectives on the basis of a detailed 'needs analysis' each year, and that in the process of compiling its strategic plans it undertakes a thorough process of consultation with internal stakeholders (including its own managers and trade unions) and external stakeholders (including health-related NGOs, experts and service providers). In addition, the department should attach a list of service-level agreements, or measurable performance indicators to be met by transfer recipients, to its annual strategic plan.

## Financial Management

### Finding

Between 1996 and 2003 the department failed to properly account for 81.9 per cent, or R20.6 billion, of its R25.2 billion budget allocation. This amount was issued with audit 'disclaimers' by the Auditor-General (AG). An audit 'disclaimer' is an opinion issued after the conclusion of a financial audit when there is a manifest lack of internal financial control measures, a lack of financial records and the failure to properly record all financial transactions.

### Recommendation

The department needs to ensure that it develops detailed business plans in order to guide and track the expenditure of each of its programmes and sub-programmes. By ensuring that each programme activity is measurable, properly costed and has a clear timeframe attached to it, programme managers will be able to track and report on expenditure (and their progress in implementing these activities) more effectively.

## Use of Conditional Grants

### Finding

The national AG found in 2003 that the Minister of Health and the National Department of Health had no monitoring mechanisms in place to ensure the proper use of funds disbursed to provinces in the form of conditional grants. Consequently, the national department could

not properly account for the use of R7.1 billion out of its R7.6 billion budget transferred to provinces for purposes of provincial hospital rehabilitation, HIV/AIDS programmes and child-feeding schemes during 2002/03 alone.

## Recommendation

The National Department of Health, the national Treasury and national Parliament's Portfolio Committee on Health, should take the necessary steps to ensure that all conditional grants transfers to the provinces comply with the provisions of the Division of Revenue Act (DORA). This includes ensuring that effective monitoring mechanisms are put in place to monitor and report back on the implementation of conditional grant programmes in all instances. The national office of the AG should issue the national Department of Health with an audit disclaimer in circumstances where it has failed to ensure the proper implementation of the Public Finance Management Act (PFMA) and the DORA.

## Financial Misconduct

### Finding

Financial audits conducted by the Eastern Cape AG's office for the three financial years between 2000 and 2003 identified numerous breaches of the PFMA, which constitute acts of financial misconduct. Financial misconduct is defined by the PFMA as the wilful or negligent failure to perform a financial duty by an official, or the wilful or negligent failure of an accounting officer (generally the HOD) to prevent unauthorised, irregular or wasteful expenditure, or to meet his/her reporting responsibilities.<sup>ii</sup> There is no evidence of departmental officials responsible for the transgressions being investigated or charged with misconduct.<sup>iii</sup>

### Recommendation

The MEC for Health, the Eastern Cape Legislature Health Standing Committee, SCOPA and the provincial Treasury need to take steps to ensure that the provisions of the PFMA governing financial misconduct are implemented.

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ii Public Finance Management Act, 1999, Sect 81 read in conjunction with Sects 38, 39, 40, 41, 42 and 44.

iii This is despite the fact that the HOD, Dr Stamper, was suspended on full pay for a period of 16 months on mismanagement charges during this period. The length of his suspension and the fact that he was eventually found not guilty seem to indicate that these charges owed more to his personal differences with the department's political head, Dr Bevan Goqwana, than his financial management capacities.

# Misconduct

## Finding

Despite having employed a Department of Health employee to work in his private specialist practice in breach of legal provisions and ethical codes governing the conduct of MECs, Health MEC Dr Bevan Goqwana has neither been investigated nor subjected to disciplinary proceedings. The Office of the National Public Protector, to whom this case was referred, has consistently failed to uphold the provisions of the Constitution and the Executive Members Ethics Act in respect of this case. This has served to set a precedent within the department that misconduct will be tolerated dependent on the circumstances of those involved.

## Recommendation

The National Parliament Portfolio Committee on Justice should review the conduct of the Office of the Public Protector given its failure to conduct a rigorous and independent investigation into alleged conflicts of interest and abuse of public office for private gain by Goqwana. The new Eastern Cape Premier, Mrs Nosima Balindlela, should conduct a rigorous investigation of these allegations in a bid to reaffirm the principle that members of the provincial Executive Council are not above the law. The Premier should take steps to ensure that the code of ethics governing conflicts of interest by members of the provincial Executive is rigorously monitored and implemented.

# Auditor-General's Oversight

## Finding

Audits conducted by the AG's office into the Eastern Cape Department of Health were found to be of a consistently high standard between 1996 and 2003. However, an inconsistency between the AG's 2002/03 audit opinion and those issued in previous years was found. Despite identifying the same internal control failures and breaches of the regulatory framework that led to the department being issued with audit 'disclaimers' in the 2000/01 and 2001/02 financial years, the department was issued with an 'unqualified' audit opinion in 2002/03.

## Recommendation

The AG's Office should uphold the highest audit standards and base its evaluations of the department's financial management and performance solely on compliance with the PFMA.



# Legislature Accountability

## Finding

There has been a manifest breakdown in the implementation of Legislature oversight committee resolutions by the Eastern Cape Department of Health. The AG reported in 2002 that none of SCOPA's resolutions between 1996 and 2002 had been implemented.

## Recommendation

The department should publish all previous oversight committee and SCOPA resolutions in its annual report. It should also provide a detailed account of its progress in the implementation of these resolutions in its annual report. For their part, Legislature and parliamentary oversight committees should be more assertive in the use of their Constitutional powers to call the MEC for Health and senior departmental officials to account for their performance in implementing oversight resolutions.

# Privatisation

## Finding

The appointment of private sector companies (in the form of public-private partnerships [PPPs] and outsourcing contracts) is rapidly becoming seen by the department as a panacea for its ongoing management problems. No evidence of the department's internal efforts to address its financial management failures prior to proposing such outsourcing arrangements could be found. Moreover, once such arrangements had been entered into, no evidence could be found of steps taken to publicise the service level standards to be met by the private contractors.

## Recommendation

Prior to the outsourcing of public services to the private sector, the department should present a detailed report on the nature of its financial management and service delivery problems and what steps it has taken to address these.<sup>iv</sup> This report should be presented to the relevant Legislature oversight committees and a justification provided for why it is that the department cannot meet its responsibilities internally. An opportunity should be afforded to civil society organisations, and especially trade unions, to provide inputs to these special

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<sup>iv</sup> This recommendation is made despite requirements recently introduced by the national Treasury stipulating that all PPPs should be preceded by the submission of a feasibility study (including an account of the proposed PPPs 'affordability' and 'value for money') in order to obtain prior approval from it before embarking on such ventures. See PFMA, 1999, Amendment to Sect 16, Government Gazette 25915, 16 January 2004.

hearings. In instances where health services are privatised the service-level agreements, setting out the standards of care and service that the public are entitled to expect from such private service providers, should be widely publicised.

## HIV/AIDS Programme Implementation

### Findings

- The lives of 15 000 children could have been saved in the Eastern Cape had nevirapine been rolled out for prevention of mother-to-child transmission (PMTCT) purposes at all state health facilities in 1998 as opposed to mid-2003. (Based on the estimation that 3 000 lives could be saved per year in the province if nevirapine had been made available to all pregnant women.)
- Between 2000 and 2004, the department failed to produce business plans for almost 40 per cent of its budget (or R93.2 million out of a total budget of R238.2 million). The department only produced business plans for the equivalent of 77 per cent of its conditional grant allocation, and 52 per cent of its provincial government allocation, for its HIV/AIDS programmes during this period.
- During the period between 2000 and 2004, not a single HIV/AIDS business plan produced by the Eastern Cape Department of Health was found to include a reconciliation with HIV/AIDS budget allocations or expenditure for previous years.
- Of R123.2 million allocated from the Eastern Cape budget for HIV/AIDS programmes in the period between 2000 and 2003, 26.7 per cent (R33 million) was unspent, whilst 73.2 per cent (R90.2 million) remains inadequately accounted for.
- Between 2000 and 2004 HIV/AIDS-related training accounted for R44.6 million or approximately one-third of the department's R145.08 million HIV/AIDS budget for which business plans were produced. Yet the department was found to have no means of monitoring the quality, content or numbers of people obtaining HIV/AIDS training within the province.

### Recommendations

The Eastern Cape Treasury, Health Standing Committee, SCOPA, national Health Portfolio Committee, national Treasury and national Department of Health need to take steps to ensure that the provincial Department of Health produces a detailed business plan to cover its entire HIV/AIDS budget each year. Each activity listed on this business plan should be measurable, properly costed and have a clear time-frame attached to it. The above bodies should also take the necessary steps to ensure that the HIV/AIDS Directorate tracks and provides detailed reports on its expenditure and progress in implementing these activities on an ongoing basis.

In addition, steps should be taken to ensure that the department publicises a list of service-level agreements entered into with external bodies to whom HIV/AIDS funds are transferred. The department should take steps to ensure that these bodies report rigorously on their use of public funds. An account of the expenditure and activities of these external bodies should be included in the department's annual report.

# INTRODUCTION

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Much has been heard about the so-called health crisis in the Eastern Cape over the past few years, both from politicians and the media. Since 2000 there has been a steady increase in the number of reports of hospital-related problems in the Eastern Cape, including overcrowded wards, dilapidation of infrastructure, food shortages, lack of clean linen and neglected state mortuaries.

The sustained failure to deliver effective health services in the Eastern Cape has taken place against the backdrop of an elaborate system of constitutional checks and balances. These include legislative oversight committees tasked with ensuring the effective implementation of health policies by the Department of Health (the Standing Committee on Health) and the department's compliance with financial management regulations (the Eastern Cape Standing Committee on Public Accounts – SCOPA). This framework also includes a range of constitutional bodies mandated to protect the public interest. These include the Public Protector, tasked to investigate impropriety and misconduct; the Auditor-General (AG), responsible for establishing financial effectiveness and efficiency; and the South African Human Rights Commission (SAHRC), mandated to ensure that health rights are upheld.

Despite interventions by these various oversight and constitutional bodies, the Eastern Cape health crisis has continued unabated.

The response of the Eastern Cape Department of Health to the crisis, led by its political head, the Member of the Executive Council (MEC) for Health, Dr Bevan Goqwana, has often been to blame the province's apartheid legacy. The inheritance of dysfunctional and under-resourced apartheid and Bantustan institutions, and the deliberate 'sabotage' by white health professionals, have variously been invoked to explain the department's failure to deliver effective health services in line with its budgeted resources. Yet, can this argument be sustained ten years into South Africa's new democratic order, particularly given the constitutional provisions set in place to guarantee the efficient and effective use of public resources?

The questions that this report has set out to address for the period between 2000 and 2004 are: What are the various dimensions of the crisis in the provision of health care services in the Eastern Cape? What are its causes? How can this crisis be overcome? These are serious questions that will be addressed via a constructive critique of the performance of the provincial Department of Health in the Eastern Cape against the constitutional and legislative requirements set in place to govern public service delivery since 1994. Only through such an investigation will we be able to assess whether health care for those who were most affected by apartheid has improved since the transition to democracy in South Africa.

# 1. PUBLIC HEALTH CARE PROVISION AND SOUTH AFRICA'S NEW CONSTITUTION

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## Health Services in South Africa and the Apartheid Legacy

### Racial segregation and healthcare in South Africa prior to 1948

Deep divisions resulting from racial and socio-economic segregation permeate the history of health care provision in South Africa. During the Dutch occupation of the Cape in the 1800s, separate health facilities were erected for slaves and officials. The first hospitals at the Cape housed sailors of the Dutch East India Company suffering from scurvy and other illnesses. Later, in the mid-1800s, military hospitals were constructed in the Eastern Cape for British soldiers injured during the frontier wars.<sup>1</sup>

During the British colonial period, South Africa's first black hospital was established in King William's Town. The hospital was erected in 1856 at the initiative of Sir George Grey, who had embarked on a policy of 'conquest through civilisation'.<sup>2</sup> His intention was to establish a system of large hospitals, each to serve several satellite hospitals, which in turn would be supported by district surgeoncies.<sup>3</sup> Grey's efforts to subdue resistance to British colonialism, through 'winning the hearts and minds' of local Xhosa inhabitants, marked the first step down a long road of manipulating health care needs for political purposes in South Africa (extending from the colonial to the apartheid era).

This manipulative attitude is neatly captured in the patronising words of Dr Fitzgerald, the first superintendent of Grey's Hospital in King William's Town:

Give me only one institution like this, give me talent and ability combined with kindness and mildness ... let pure untainted charity have free play ... let the heathen feel as free as in his kraal ... such an institution will draw the savage from the remotest part of South Africa and attach him forever to that government which entered in spirit into his sickness and provided him a remedy.<sup>4</sup>

The Act of Union in 1910, which merged the British colonies of Natal and the Cape with the previous Boer republics of the Transvaal and Orange Free State, left health matters to

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1 C. De Beer, *The South African Disease: Apartheid Health and Health Services*, Johannesburg, South African Research Services, 1994, p. 16.

2 H.J.C. Van Rensburg & S.R. Benatar, 'The legacy of apartheid health and health care', *South African Journal of Sociology*, 24(4), 1993, p. 101.

3 H.J.C. Van Rensburg & D. Harrison, in *South African Health Review*, California, Health Systems Trust, 1995, chapter 4.

4 Quoted in De Beer, *The South African Disease*, p. 17.

local, provincial and municipal authorities who were also granted responsibility for regional hospitals. It was only after the 1918–19 influenza epidemic, in which an estimated 130 000 black and coloured people and 20 000 white people died, that a national Ministry of Public Health was established.<sup>5</sup> In theory, this ministry had powers to ensure that all local authorities provided environmental health services such as water supplies, refuse removal and sewerage disposal.<sup>6</sup> However, control over hospitals and health services themselves remained in the hands of provinces and municipalities which gave rise to an exceptionally complicated set of health authorities that were wasteful, inefficient and racially fragmented. It was customary inside hospitals to treat black and white patients in separate wards, with marked differences in the quality of care administered. Few local authorities met their obligations in terms of the Public Health Act in urban black townships and locations. They objected to spending more money on these areas than could be raised through direct taxation of the black population. This gave rise to a system of fiscal segregation, which led to the poorest areas, and those living in the unhealthiest conditions, being the most neglected.<sup>7</sup>

In 1935, with the passing of the Public Health Amendment Act, the Union government decided to extend health services to the 'native territories'. In 1936 it proposed the formation of a 'native medical service', and agreed to extend training to 'native medical aids' (i.e. medical assistants) at Fort Hare in Alice. Consistent with the dominant segregationist discourse, the department of Public Health decided in 1938 to establish a completely segregated health service for Africans, which it would jointly administer with the department of Native Affairs.<sup>8</sup>

Due to a lack of policy direction, minimal effort to ensure co-ordination between the various levels within the system and a general lack of funding, health care in South Africa fell into a protracted state of neglect. Finally, a Commission of Inquiry into the state of health services (the National Health Services, or Gluckman Commission) was appointed in 1942. Its terms of reference were to 'investigate and recommend the best measures to be adopted for ensuring adequate health services for all sections of the population of the Union of South Africa'.<sup>9</sup>

The Commission's findings, which were delivered in 1944, pointed to a lack of rational planning and co-ordination in health service provision. Local and provincial authorities, the national Department of Public Health, various mining companies and a number of religious missions had all assumed varying degrees of responsibility for the provision of health services. However, there was still no centralised policy co-ordinating these various institutions. In addition, provincial authorities had failed to build sufficient hospitals in line with the growing demands of increased patient numbers.

The combined effect of this failure to properly structure national health provision led to the emergence, in the late 1930s, of a serious shortage of hospital accommodation. In 1944

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5 *Apartheid and Health*, Geneva, World Health Organisation, 1983, p. 92–93.

6 De Beer, *The South African Disease*, p. 18.

7 Van Rensburg & Benatar, 'The legacy of apartheid health ...', p. 101.

8 Van Rensburg & Harrison, chapter 4.

9 De Beer, *The South African Disease*, p. 15.

the Commission found that, countrywide, there was one hospital bed for every 304 white South Africans, but only one for every 1 198 black South Africans. In the 'reserves'<sup>10</sup>, black residents depended almost entirely on the services of mission hospitals – the majority of which were found to be 'understaffed', poorly equipped, and without a resident doctor. Moreover, there were vast disparities in the distribution of medical personnel, with 84 per cent of medical specialists concentrated in the country's four largest cities. The Commission concluded that 'Native hospital needs go largely unsatisfied'.<sup>11</sup>

The Commission's Report contained a range of what were remarkably progressive recommendations for its day.<sup>12</sup> Key amongst these was a proposal to establish a National Health Service (NHS). In a detailed blueprint for this NHS, the Commission proposed:

- The provision of free personal health services, funded out of a National Health Tax.
- The assumption of responsibility for the provision of personal health services (and preventative services such as water supply and refuse collection) by the central government.
- The establishment of one community health centre (staffed by a medical team including, doctors, dentists, radiographers, hygiene officers and community health visitors) for every 10 000 – 30 000 people.
- The establishment of a network of general practices, specialist hospitals and teaching hospitals linked to community health centres.
- The training of several thousand community health visitors, in addition to doctors, nurses, health inspectors, etc., in order to meet increased health needs. In particular, health visitors should be trained to conduct educational and preventative work in local communities.<sup>13</sup>

In 1945, General Smuts' United Party Government appointed Dr Gluckman, who had chaired the Commission, as Minister of Health. Over the next three years, 40 health centres were constructed around the country. However, due to a lack of financial and administrative support, most clinics struggled to provide basic curative (let alone preventative) services, and with the National Party's electoral victory of 1948 the proposed NHS failed to materialise. By 1960 most health centres had either been closed down or converted into ordinary clinics by provincial administrations.

## Grand apartheid and health care

The policy of apartheid, articulated by the National Party (NP) after 1948, involved a highly repressive set of controls imposed on South Africa's black majority in the context of white political domination of the state. These controls went beyond the denial of political and civil

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10 The 'reserves' were essentially rural areas of South Africa closely identified with different black cultural groups. By this time they had already started to become little more than labour pools for the South African economy and homes to the unemployed and infirm – a role which they were to continue to play into the era of apartheid.

11 De Beer, *The South African Disease*, pp. 19–20.

12 No doubt this report was influenced by the Beveridge Report in Britain which was also released in 1942 and suggested the creation of a 'welfare state', which included the creation of a national health service.

13 De Beer, *The South African Disease*, pp. 25–26.

rights to black people and provided for the regulation of the movement of black South Africans (especially 'Africans') around the country. The intention was to ensure the supply of cheap black labour to white controlled mines, farms and factories.<sup>14</sup> Permeating the philosophy of apartheid was a strong nationalist sentiment that sought to galvanise the NP's support base among marginalised middle-class Afrikaners, white workers and white farmers. The divergent interests of each of these sectors of white society stood to benefit directly from stricter control over the movement and employment of African labour.

In the words of the Sauer Commission, which informed the NP's 1948 election policies, the common thread running through the 'apartheid principle' was to be explained as follows:

The entire migration of Natives into and from the cities should be controlled by the state ... Natives from the country areas shall be admitted to the urban areas or towns only as temporary employees, obliged to return to their homes after the expiry of their employment. ... A national system of labour regulation and labour control will be established with a central labour bureau and an effective network throughout the country to allow supply and demand to operate as flexibly as possible and to eliminate the large-scale wastage of labour. A proper survey of the labour force and labour requirements will have to be made in order to effectively divert labour into the various channels of agricultural, industrial, mining and urban employment.<sup>15</sup>

After his appointment as Minister of Native Affairs in 1950, Hendrick Verwoerd, a former Stellenbosch University Professor of Social Work, set about aggressively transforming the 'apartheid principle' into the detailed policy framework which became known as 'grand apartheid'. The 1950 Population Registration Act assigned each South African to one of the following 'racial' categories: white, 'Bantu' (i.e. African), Coloured or Asian. The 1952 Native Laws Amendment Act and the 1955 Natives (Urban Areas) Amendment Act, restricted the right of permanent residence in urban townships only to those Africans who could prove they had already been resident in an urban township for ten years, or who could prove that they had worked for the same employer (uninterrupted) for at least 15 years.<sup>16</sup>

In 1959 Verwoerd introduced the Promotion of Bantu Self-Government Act, which proposed the restructuring of the Bantu authorities system in the reserves on the basis of eight 'Territorial Authorities'. These structures contained legislative assemblies that were dominated by a majority of nominated chiefs. They were later renamed 'Bantu Homelands', or 'Bantustans', and the intention was that each entity was to be gradually given powers of self-government as a first step towards eventual independence from South Africa as a sovereign 'national state'.<sup>17</sup>

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14 A. Callinicos (ed.), *Between Apartheid and Capitalism: Conversations with South African Socialists*, London, Bookmarks, 1992, p. 12.

15 Sauer Report 1948, quoted in D. O'Meara, *Forty Lost Years: The apartheid state and the politics of the National Party, 1948-1994*, Johannesburg, Ravan Press, 1996, p. 65.

16 O'Meara, *Forty Lost Years*, pp. 68-69.

17 See O'Meara, *Forty Lost Years*, p. 73, and J. Graaf, 'Towards an understanding of Bantustan politics', in N. Nattrass & E. Arlington (eds), *The Political Economy of South Africa*, Cape Town, Oxford University Press, 1990, p. 65.



In 1963 it was agreed that the department of Bantu Administration would take control of the provision of health services in the Bantustans. However, with decolonisation gathering momentum in the rest of Africa, apartheid state ideologues began to re-package the Bantustans as potential 'nation states', which would be granted their 'independence' from South Africa in due course.<sup>18</sup>

During the 1970s and 1980s, ten separate health authority and service delivery structures were erected in the Bantustans. In addition, with the passing of an amended constitution in South Africa in 1983, providing for the creation of a tricameral parliament with separate chambers for 'coloured' and 'Indian' South Africans, the racial segregation of government services was taken to its absolute extreme. Each of the separate chambers of the South African parliament were to take responsibility for their 'own affairs', including the administration of service structures within health care.<sup>19</sup>

The enforcement of influx controls, and the removal of economically inactive Africans from the urban areas to the Bantustans, was strengthened during the 1970s and 1980s. Once deposited in these areas, their health was no longer the concern of the apartheid state. In 1960 it was estimated that 37 per cent of Africans lived in the homeland areas, 31.2 per cent on white farms, and 31.8 per cent in white urban areas. By 1980 these figures had changed dramatically; 54 per cent of Africans had been shifted into the Bantustans, with 20.6 per cent remaining on white farms and 25.4 per cent in the urban areas.<sup>20</sup>

The 'success' of the 'grand apartheid' project of social engineering can be gauged from the increase in the total 'homeland' population from 4.7 million in 1960 to 11.3 million in 1980. This constitutes an increase of 239 per cent.<sup>21</sup>

## Health care and the 'independent' Bantustans of Transkei and Ciskei

The Transkei and Ciskei were granted 'independence' from South Africa in 1976 and 1981 respectively, and, although both Bantustans were nominally independent states, they were massively subsidised by South Africa. In reality they were little more than dumping grounds for black labourers (and their families) who could not be absorbed within the South African economy. The Bantustan administrations themselves, which were directly appointed by the intervention of the apartheid state, lacked legitimacy amongst the inhabitants of the homeland areas.

While the British had set out to deliberately strip traditional chiefs in the Ciskei and Transkei areas of their tributary, judicial and taxation powers during the colonial period, the Verwoerd administration brought the chiefs back into the administrative process and

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18 S. Marks & S. Trapido, 'The politics of race, class and nationalism', in S. Marks & S. Trapido (eds), *The Politics of Race, Class and Nationalism in Twentieth Century South Africa*, London, Longman, 1987, p. 22.

19 Van Rensburg & Benatar, 'The legacy of apartheid health...', p. 101.

20 De Beer, *The South African Disease*, p. 50.

21 Ibid.

restored some of these traditional powers. Subsequent Bantustan leaders emerged from these revived traditional authority systems and became dependent on them for their support. Pretoria routinely intervened within these authorities and arbitrarily appointed or replaced chiefs and headmen on the basis of their perceived loyalty to the apartheid state. The resultant lack of legitimacy suffered by these appointed leaders led to a pattern of insecure and authoritarian government in the Bantustan areas. Compliance with government rule was largely ensured by patronage, nepotism, bribery, emergency 'state' regulations and repressive force.<sup>22</sup> The loyalty and support of this manufactured, illegitimate elite was ensured through the nepotistic allocation of land and government contracts and the distribution of government loans. More directly, an institutionalised system of patronage ensured regular salaries to chiefs and headmen in the rural areas, and a range of government posts within the army, police force, civil service and schools in the urban areas.<sup>23</sup>

By the end of March 1978, just a year and a half after its independence, the Transkei Government had over 61 000 people in its employ. By contrast, the KwaZulu homeland administration, which serviced a population of roughly the same size as the Transkei (2.2 million people), employed less than half this amount (28 824 people). In 1978 the Transkei civil service of 16 000 people was twice the size of that of Botswana.<sup>24</sup>

The extent of the Transkei Bantustan's dependence on South Africa can be demonstrated by inspecting its budget revenue and the composition of its workforce. Between 1976 and 1980 the Transkei budget was subsidised by South Africa to the tune of R1 024.4 million. This amount was made up of direct cash grants, payments of taxes collected in South Africa from Transkeian migrant workers, and other occasional payments. Of the Transkei Government's R239 million budget for 1977, 71 per cent (an amount of R169.7 million) originated from South African sources.<sup>25</sup> Moreover, at the end of 1978, the South African Department of Co-operation and Development revealed that there were 500 294 Transkeian 'nationals' registered to work in South Africa.<sup>26</sup> By contrast, according to the South African Government's Bureau for Economic Research in March 1978, industry in the Transkei only employed 7 165 Transkeians.<sup>27</sup>

Similarly, in the case of the Ciskei, which was on the verge of becoming 'independent', of a total estimated budget expenditure of R87.7 million in the 1980/1981 financial year, 85 per cent (an amount of R74.5 million) was allocated by the South African Government in the form of statutory grants, additional grants, administration and technical assistance.<sup>28</sup>

The population density of the Ciskei in 1984 was 85 persons per square kilometre, compared to 25 people per square kilometre in South Africa. Only 15 per cent of the territory could be regarded as viable farming land, with only 6 per cent of its 'nationals' living on lots

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22 Graaf, 'Towards an understanding...', pp. 62–63.

23 B. Streek & R. Wicksteed, *Render Unto Kaiser: A Transkei Dossier*, Johannesburg, Ravan Press, 1981, p. 28.

24 *Ibid.*

25 *Ibid.*, pp. 134–136.

26 L. Gordon, *Survey of Race Relations in South Africa*, Johannesburg, South African Institute of Race Relations, 1981, p. 423.

27 Streek & Wicksteed, *Render Unto Kaiser*, p. 28.

28 Gordon, *Survey of Race Relations*, p. 428.

large enough to provide for subsistence agriculture.<sup>29</sup> Overgrazing and over-cultivation were so prevalent that the Quail Commission of Inquiry (into Independence for the Ciskei) found in 1980 that 47 per cent of the land was moderately to seriously eroded. In addition, it was found that 39 per cent of the economically active population was unemployed.<sup>30</sup>

Inevitably, these structural conditions of overcrowding, unemployment and poor farming possibilities gave rise to serious health threats, including malnutrition and increased susceptibility to opportunistic infections. The situation was further aggravated by the lack of basic sanitation services, with little by way of waste disposal, toilets and clean water outside of urban areas. For instance, Limehill, a notorious resettlement area during the late-1970s, was found ten years later to have only 10 taps for 350 families.<sup>31</sup>

Small wonder the Quail Commission found in 1980 that there was a high level of infant mortality and a widespread incidence of malnutrition in the Ciskei. As many as 4.5 per cent of children below the age of two suffered from marasmus, and 27 per cent from kwashiorkor. The Commission found that health services were generally inadequate. The residents of the Thornhill-Sada-Ntabathemba relocation camps, although comprising 8 per cent of the territory's population, had no doctor. Per capita expenditure on health in the Ciskei was found to be R11 per head, as opposed to R30 per head in South Africa.

In 1978, the South African Minister of Statistics indicated that whereas the South African Government had allocated an amount of R877.7 million (2.27 per cent of GDP) for health spending in South Africa, only R89.1 million (0.23 per cent) had been allocated to health services in the non-'independent' homelands, which included the Ciskei, Gazankulu, KwaZulu, Lebowa, Qwaqwa and Kwangwane.<sup>32</sup> In 1980, the total population of these homelands was 6.5 million, whereas the total South African population (excluding the 'independent' states of Bophuthatswana, the Transkei and Venda) was estimated to be 23.7 million.<sup>33</sup> In other words, the non-independent homeland areas collectively constituted 27 per cent of South Africa's population in 1980, yet received less than 10 per cent (9.2 per cent) of state health resources.

For its part, the 'independent' Transkei Government allocated an identical proportion of its budget (9.2 per cent) to health. Of a total budget of R227.8 million in 1980, Kaiser Matanzima's government allocated only R21 million to health.<sup>34</sup> It was clear that neither the South African nor the Bantustan administrations had the political will or the desire to address the health needs of black South Africans.

By the late-1970s the implementation of the grand apartheid strategy of transferring all of South Africa's economically inactive African inhabitants, with their associated socio-economic and health problems, into 'independent states' had resulted in a 'bewildering fragmentation of health services and authority structures' under the control of ten separate state departments of health.<sup>35</sup>

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29 De Beer, *The South African Disease*, p. 52.

30 Gordon, *Survey of Race Relations*, p. 404.

31 De Beer, *The South African Disease*, p. 54.

32 Gordon, *Survey of Race Relations*, p. 558.

33 *Ibid.*, p. 67 & 69.

34 Streek & Wicksteed, *Render Unto Kaiser*, p. 140.

35 Van Rensburg & Harrison, chapter 4.

Expenditure on health reflected wide disparities by 1992. Expenditure on the health of black South Africans was R138 per capita (and only R55 per capita in the 'homeland' areas), while expenditure for white South Africans topped R591. The ratio of doctors per capita was 1:282 for white South Africans, compared to 1:53 500 for black South Africans.<sup>36</sup>

Public health spending inequalities also served to subsidise the private health sector with 58 per cent of the 1993/94 budget being allocated to private health care, which benefited only 23 per cent of the population.<sup>37</sup>

## Post-Apartheid South Africa and the Constitutional Commitment to Health Rights

After 1994 the South African Government set about transforming a highly fragmented health system consisting of 14 separate apartheid-era health departments into a single national Department of Health with nine provincial departments.

South Africa's new constitution, adopted in 1996, set out to eliminate the fundamental inequalities marking apartheid-era health service delivery. Section 27 of the Constitution states that:

Everyone has the right to have access to health care services, including reproductive health care;

The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

No one may be refused emergency medical treatment.

The White Paper for the Transformation of the Health System in South Africa, published in 1997, set out to transform South Africa's fragmented and inefficient health system into a unified NHS. The locus of implementation within this system was shifted to the district level, with the White Paper emphasising the importance of introducing a new primary health care (PHC) approach. Its long-term goal, was to provide an integrated package of essential PHC services to the 'entire population at the first point of contact'.<sup>38</sup> In order to achieve this goal, it envisaged a set of distinct but complementary roles for the national, provincial and local spheres of South Africa's new government.

Since 1994, in a bid to ensure improved service delivery, the national Department of Health has attempted to shift the focus of health care from hospitals to primary health care facilities such as clinics. Patients visiting clinics are treated by trained nurses for a range of conditions and are provided with preventative health care counselling. Among others, the

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36 D. McCoy, *Restructuring the Health Services of South Africa; The District Health System*, in M.M. Khosa (ed.), *Infrastructure Mandates for Change 1994–1999*, Pretoria, HSRC Press, 2000, p. 108

37 Ibid.

38 Notice 667, Government Gazette, No. 17910, 1997, p. 12.

national Department of Health set the following policy objectives in 2001/02:

- The improvement in the quality of care.
- The revitalisation of public hospitals.
- The further implementation of the district health system and primary health care.
- A decrease in HIV/AIDS, TB and STDs.<sup>39</sup>

These objectives were to be assisted by the restructuring of health care provision. In 2001 health care administration in the Eastern Cape was split between one metropolitan council, six district councils and 24 local service areas (LSAs). The stated objective of this restructuring was to allow local government to play a 'more meaningful role in health care' as the focus shifted to primary health care facilities.<sup>40</sup>

Within South Africa's new health care system, the national Department of Health is responsible for formulating health policy and legislation and for establishing proper norms and standards for health care. It is also responsible for ensuring that health resources are properly utilised. It should do so by monitoring the performance and co-ordinating the work of provincial health departments. The National Department of Health is also responsible for ensuring that cost effective drugs and treatment are made available at provincial level. By contrast, provincial departments of health are responsible for the planning and management of the provincial health resources and the provision of health services. Provinces are also responsible for controlling the quality of service provided at all health facilities, including hospitals and clinics, and for co-ordinating the financial management and distribution of funds to district health authorities.

## Health budgeting and oversight within South Africa's new constitutional framework

Since 1994, the South African public service has been governed by a comprehensive legislative framework geared to ensure transparency around resource allocations to government departments and the accountability of officials for their management of these resources. This framework regulates the manner in which government should go about its revenue division, budgeting, strategic planning and reporting.

A good understanding of this framework is required for the purposes of evaluating the delivery of public services such as health care in post-apartheid South Africa.

### The division of revenue

Revenue is collected through tax (e.g. income tax, company tax, VAT and the fuel levy). It is divided between the national equitable share, the province's equitable share and the local equitable share. The Division of Revenue Act sets out provincial allocations and the amounts for provincial departments to spend on the policy priorities they have chosen. It also sets out

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39 *South African Yearbook*, 2001, Government Printer.

40 See, <http://www.hst.org.za/isds/dhslgnews.htm>.

amounts for conditional grants to provinces that can only be used for specific purposes (such as HIV/AIDS). The Division of Revenue Bill is published annually for discussion in December. It has to be tabled in the National Assembly and in the National Council of Provinces (NCOP) before it can be passed into law. Both parliament and the NCOP can amend the Bill, although neither have ever done so.

It is important to note that approximately 60 per cent of tax revenue is transferred to provincial governments. This is because public services, such as health care, are delivered by provincial government departments. For instance, in the 2003/04 financial year, the total budget expenditure was R280 billion, of which R165 billion (including conditional grants) was allocated to South Africa's nine provincial governments.

The overall division of revenue for 2003/04 was as follows:

Debt service costs	R50 billion (all figures for 2003/04)
Contingency reserve	R3 billion
Provincial government	R159 billion (56.9 per cent)
National government	R109 billion (38.9 per cent)
Local government	R12 billion (4.3 per cent)

It should be noted that roughly half of the total expenditure of provincial governments (49.1 per cent) goes on paying the salaries of 525 000 public officials. In 2003/04 this amounted to R81.1 billion a year. The Eastern Cape government employed roughly 127 000 (or 24.2 per cent) of these officials.<sup>41</sup>

## The budget planning process

In accordance with the new legislative framework, South Africa's budget planning process traverses the following stages:

### April

The financial year for all government departments starts on 1 April (and ends on 31 March the following year).

### April–June

The budgeting process starts in April (of the previous financial year) when national and provincial government departments draw up (or amend their existing) strategic plans. These plans set out the service delivery objectives and the proposed budgets for the next three years. They also include measurable outputs and budgets for the department's proposed programmes. In April, all departments in the Eastern Cape need to review their expenditure

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41 Intergovernmental Fiscal Review, 2003, Department of Finance, Pretoria.

outcomes for the previous year.<sup>42</sup> They list all their activities for the coming year in order of priority and prepare a 'zero-based budget' for each activity.<sup>43</sup> The departmental management conducts a review of all activities and decides on the resources to be allocated to each activity. This forms the draft budget for the department.<sup>44</sup>

## May

The Finance and Fiscal Commission (FFC) must make recommendations and proposals on the division of revenue between national, provincial and local government for the coming financial year, in May.<sup>45</sup> The FFC uses a 'costed norms approach' to look at basic social service levels (currently applied to basic education, primary health care and social services) as required by the Constitution. It identifies acceptable norms and standards for each programme area and identifies the resources needed to provide these social services for each provincial population.<sup>46</sup>

## June

Provincial heads of departments (HODs), and Director-Generals (Director-Generals) of national government departments need to submit the initial draft of their strategic plans (listing their activities and proposed budgets) to their Minister or MEC for approval by 30 June.<sup>47</sup>

## July–August

Director-Generals and HODs must refer their approved budget plan to the relevant Treasury by August. In the Eastern Cape, HODs must submit their draft budget to the Budget Office within the provincial Treasury for evaluation. This should be accompanied by a 'Ministerial letter' setting out the department's spending priorities.<sup>48</sup>

A number of Medium-Term Expenditure Framework (MTEF) sectoral teams hold discussions on sectors such as health, education, social development and justice, and on matters of joint responsibility between national government and the provinces. These teams are made up of the national Ministers and provincial MECs responsible for these sectors.

In the Eastern Cape, departments hold 'cluster' meetings to co-ordinate plans and discuss joint projects. These include the social needs cluster, the economic development cluster, infrastructure cluster, health and education cluster and a governance cluster. These clusters also participate in a two-day budget *Indibano* where they review progress in meet-

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42 Sect. 2.1, Eastern Cape Provincial Government, Budget Statement for 2003/04 Provincial Budget, 6 March 2003.

43 Zero-based budgeting requires organisations to cost all their activities and programmes anew at the start of every budget cycle. This approach calls on organisations to re-cost every item giving justification for its continued existence, variations in costing, and to re-assess the kind of inputs that go into these activities.

44 Correspondence with Eastern Cape Office of the AG, February 2003.

45 Sect. 214.2, Constitution of the Republic of South Africa, 1996, and Sect. 9 Intergovernmental Fiscal Relations Act, 1997.

46 Finance and Fiscal Commission, Recommendations 2001–2004 MTEF Cycle, May 2000, p. 9.

47 Section 2 of the Public Finance Management Act Implementation Guidelines, July 2000.

48 Sect. 2.1, Eastern Cape Provincial Government, Budget Statement for 2003/04 Provincial Budget, 6 March 2003.

ing their priorities. After this event, departments are expected to align their strategic plans to the set priorities.<sup>49</sup>

### **August–September**

The national Treasury and provincial Treasuries evaluate department's strategic plans and spending requests.

### **September**

The Budget Council (made up of the Minister of Finance and the nine provincial Finance MECs) and the Extended Cabinet (made up of the national Cabinet and the 9 provincial Premiers) hold meetings to approve a draft of the MTEF.

In the Eastern Cape, departments meet with the provincial Budget Office to discuss their budget allocations. The Finance MEC takes the recommendations of the provincial Budget Office to the provincial Cabinet Budget Committee and the provincial Executive Committee for approval.

### **October**

The Medium-Term Budget Policy Statement (MTBPS) is published in the National Assembly and provincial Legislatures. The MTBPS is a draft of the MTEF, a three-year budget that links government policy to its strategic plans and budgetary requirements.

Nationally, the Joint Budget Committee (JBC) sits to consider the MTBPS. It must report to Parliament on its recommendations. The JBC consists of 15 members of the National Assembly (nine majority party, six opposition) and eight NCOP members (five majority party and three opposition).<sup>50</sup>

In the Eastern Cape, the draft budget allocations for departments are subjected to budget hearings by the provincial Treasury and by the Standing Committee on Finance. MECs and HODs attend these hearings to substantiate their budget submissions. There is also representation from the national Budget Office at these hearings. Departments make further changes to their budget submissions as requested by the budget hearings. Departments then submit their second draft budgets to the provincial Budget Office for evaluation.<sup>51</sup>

### **November**

The national department of State Expenditure consolidates all provincial budget estimates submitted and recommends final allocations. The Extended Cabinet approves national allocations and the revised MTEF. In the Eastern Cape, allocation letters are then sent to each department. Departments prepare their 'white book' figures based on these allocations and submit these figures to the Budget Office again. The provincial Treasury produces a composite provincial budget.

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49 Sect. 2.4, Eastern Cape Provincial Government, Budget Statement for 2003/04 Provincial Budget, 6 March 2003.

50 Budget Brief No.124, Budget Information Service, Idasa, 25 February 2003.

51 Correspondence with Eastern Cape Office of the AG, February 2003.



## **December**

National departments are given their final allocations and provinces finalise their budgets. The Division of Revenue Bill is published for comment.

## **January**

The final consolidated MTEF is compiled. This includes any revised economic estimates.

## **February**

The Budget and the Division of Revenue Bill (including the latest MTEF) are tabled in the National Assembly. This gives rise to a three-month review process.

## **March**

Provincial budgets are tabled in their respective Legislatures in the first week of March (within 15 days of the tabling of the national budget).

In late February/early March, a number of national committees sit to deliberate on the budget:

- The Joint Budget Committee – sits to discuss the MTEF and the Budget Review.
- The Portfolio Committee on Finance – sits to discuss revenue issues and division of revenues between national, provincial and local government as set out in the Division of Revenue Bill (DORB).
- The NCOP Select Committee on Finance – sits to discuss the DORB and to look at the FFC's proposals on the DORB.
- Portfolio Committees meet to discuss budget allocations and internal budget divisions for their respective departments. There is a detailed debate in Parliament on each department's budget.<sup>52</sup>

In the Eastern Cape:

- The Standing Committee on Finance conducts further hearings with departments based on their budget allocations ('white book' figures).
- Standing Committees meet to discuss the budget allocations and internal budget divisions for their respective departments. The budget for each department is debated in the Legislature.
- The Legislature votes on the Appropriation Acts for each department and for the provincial Appropriation Act. These are adopted (almost three months after the tabling of the budget) in May each year.

Once the budget has been passed in the Eastern Cape, the 'Blue Book' is printed, which represents the final print of the budget. All departments then capture their final approved budgets onto the Financial Management System (FMS) or the Basic Accounting System (BAS).<sup>53</sup>

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<sup>52</sup> Budget Brief No.124, Budget Information Service, Idasa, 25 February 2003.

<sup>53</sup> Correspondence with Eastern Cape Office of the AG, February 2003.

After receiving their budget allocations, all government departments need to finalise the details of their strategic plans (including expenditure estimates for individual programmes), and table this plan before the relevant parliament/provincial legislature for approval (within 15 working days of the tabling of the provincial/national budget).<sup>54</sup>

## The strategic planning process

Two key pieces of legislation require all departments to produce detailed strategic plans on an annual basis: the 1999 Public Finance Management Act (PFMA) and the 1994 Public Service Act (PSA). The sequence of events set out in this legislation is as follows:

- Strategic plans have to be submitted to the relevant Minister/MEC for Health for their approval by 30 June each year.
- The Minister/MEC refers the approved plan (including detailed cost estimates for all individual programmes) to the relevant Treasury by August each year.
- In September, the provincial Treasury evaluates the department's strategic plan and its proposed budget and issues it with a budget allocation.
- In October, departments' strategic plans and provisional budget allocations are subjected to hearings by the Standing Committee on Finance.
- Once they are notified of their final budget allocations during the tabling of the provincial budget (in the first week of March), departments set about finalising the details of their strategic plans (including its expenditure estimates for individual programmes).
- The final strategic plan is tabled in the provincial Legislature for approval within 15 working days of the tabling of the provincial budget (i.e. by the final week of March).

The PFMA and the PSA are fleshed out by a set of Treasury Regulations and Public Service Regulations. These regulations include a number of strict requirements for department's strategic plans. In summary, all strategic plans must:

- Be drawn up by a Minister/MEC responsible for the department.
- Describe the major service delivery challenges to be met by the department.
- Include measurable objectives and outcomes for the department's programmes.
- Describe the core and support activities necessary to achieve the department's objectives.
- Describe the department's goals or targets to be attained over the medium term.
- Set out programmes for attaining these goals and targets.
- Contain details of the proposed purchase of capital equipment and details of the maintenance of physical assets.
- Determine what posts will be required to meet the department's functions and plan its human resources accordingly.
- Include details of the Service Delivery Improvement Programme for the department.

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54 Part 3, Treasury Regulations, 9 April 2001.

Besides the provisions of the PFMA and the PSA, the Division of Revenue Act, which sets out the annual allocation for conditional grants to departments, also requires the production of 'business plans' prior to the issuing of conditional grants.

The conditions set out for the use of conditional grants generally require the receiving department to produce quarterly monitoring reports containing an account of progress against a number of measurable objectives and outputs.

## The Reporting Process

In terms of the legislative framework, all government departments need to report on their progress in implementing their strategic plans and spending their budgeted funds throughout the year. This reporting assists in the identification of risks and in the management of the department.

### Monthly financial reports

The Accounting Officer for provincial departments should submit a report to their MEC within 15 days of the end of each month (a copy should also be sent to the provincial Treasury). These reports should contain the following information:

- Actual revenue and expenditure (by main division).
- Projections of revenue and expenditure until the end of the year.
- Information on the spending on conditional grants.
- Information on funds transferred outside of the department.
- An explanation of underspending/overspending and proposed corrective actions.

### Quarterly financial reports

Provincial Treasuries should submit a report to the national Treasury within 30 days of the end of each quarter. These reports should contain the following information:

- Actual revenue.
- An account of current expenditure and capital expenditure (by department).
- Any borrowing.

### Quarterly performance reports

Provincial departments should submit a report to their MEC within 15 days of the end of each quarter. These reports should contain the following information:

- Performance against measurable objectives.
- Quarterly financial information.
- An explanation of underspending/overspending and proposed corrective actions.<sup>55</sup>

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<sup>55</sup> Sect 27(4) read with Sect 36(5), Public Finance Management Act, 1999.

## Annual reports

The Accounting Officer for provincial departments should submit an annual report to their MEC by 31 August each year. The MEC should table this report in the provincial Legislature by 31 August. This report should contain the following information:

- An account of departmental performance – including the achievement of desired outcomes, the delivery of outputs and the use of resources.
- An account of human resource management issues.
- A copy of the departments audited financial statements.
- A copy of the Auditor-General's (AG) comments on these financial statements.
- A report by the department's Audit Committee.
- A report on misconduct and corrective action within the department.<sup>56</sup>

## Reports on conditional grants

The Accounting Officer for a provincial department that has received a conditional grant should submit a report to the provincial Treasury, the department's MEC, and the Director-General of the national department which transferred the grant within 15 days of the end of each month. This report should contain the following information:

- The amount of the conditional grant.
- Expenditure for the month (and until the end of the year).
- An account of the department's compliance with the conditions.
- An account of problems encountered and steps taken to deal with these problems.<sup>57</sup>

## Reports to oversight bodies

The Accounting Officer of a provincial government department must submit the department's annual financial statements to the AG for auditing by 31 May. The Office of the AG must evaluate how effectively government departments are managing their funds and whether they are complying with financial laws and regulations. Government departments must include a copy of the AG's report on their financial statements in their annual reports to the national Parliament and to provincial Legislatures.

The various Standing Committees within the provincial Legislatures inspect the content of department's annual reports during September and scrutinise the comments contained in the AG's reports.

One of the most important Legislature oversight committees is the public accounts committee or the Standing Committee on Public Accounts (SCOPA). SCOPA is responsible for ensuring that taxpayer's money is spent as cost effectively by departments as possible.

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<sup>56</sup> Sect 40 (4) (b) and (c) of the Public Finance Management Act, 1999, and Sect 5 (3)(1) of the Treasury Regulations, 2001 [read in conjunction with Section 27(4) and 36(5) of the PFMA].

<sup>57</sup> Sect 16.1 of the Division of Revenue Act, No. 5, 2002.

It must also ensure that departmental managers manage public resources as economically and as efficiently as possible. SCOPA must inspect the AG's reports on departments' financial statements and follow up on problems identified, and recommendations made, by the AG.

All Legislature Standing Committees, including SCOPA, have the right to call the Minister or MEC responsible for the department to attend committee meetings, along with the HOD, to provide answers to their questions.

## 2. THE PUBLIC HEALTH CARE CRISIS IN THE EASTERN CAPE: 2000 to 2004

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This chapter presents an account of the health crisis in the Eastern Cape as it unfolded in the media between the years 2000 and 2004. It is made up almost exclusively from media reports drawn from the two primary Eastern Cape daily newspapers, the *Daily Dispatch* and the *Eastern Province Herald*. In no way is it a complete and exhaustive account of all reports relating to the crisis that featured in these newspapers over the four year period, rather it gives an insight into the nature and scope of the crisis facing the provision of public health care in the province.

- In March 2000 the Head of the Eastern Cape Department of Health, Dr Sipiwo Stamper, noted that there were over 650 critical managerial posts unfilled in the department.<sup>58</sup>
- In September 2000 the Principal medical officer at Provincial Hospital in Port Elizabeth, Dr John Jackson, wrote an open letter to Dr Bevan Goqwana, the MEC for Health, noting his concern that over the past three-year period there had been a steady decline in the quality of service offered in the hospital.<sup>59</sup>
- In October 2000 Dr Goqwana blamed mismanagement for problems experienced within his department. He announced the appointment of two new chief directors, Dr David Buso for district health services and Dr Thobile Mjekevu for primary health care, and the planned appointment of a Chief Financial Officer, which he said would improve management capacity.<sup>60</sup>
- In October 2000 the Eastern Cape MEC for Finance, Mr Enoch Godongwana, stated that problems being experienced in the Department of Health had very little to do with money, but 'everything to do with bad management'. Goqwana agreed with Godongwana's statement and indicated that he was looking seriously for who was to blame, stating that action would be taken. Goqwana indicated that the department had experienced 'one frustration after another', stating that most of his directives regarding the financial restructuring of the department had either been ignored or not followed through. Goqwana said that for more than a year he had been trying to get medical superintendents at hospitals replaced with managers with private sector experience. He claimed that an investigation was underway as to why this had not yet taken place. Goqwana admitted that there was a lack of 'administrative capacity' in the department and that he was looking to appoint a Chief Financial Officer who would 'come in and basically revamp the way the department is spending money'.

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58 'EC needs R48.9m to upgrade health service,' *Eastern Province Herald*, 23 March 2000.

59 'Food rations at big PE hospital,' *Eastern Province Herald*, 15 Nov. 2000.

60 'Corruption blamed for hospital crisis,' *Daily Dispatch*, 4 Oct. 2000.

He noted that poor management had created a situation where money was channelled into important and less important areas 'indiscriminately'.

On the same day, and demonstrating a growing rift within the department, Dr Stamper denied Goqwana's claims that bad management was thwarting the delivery of health provision stating that he, and other managers, had 'performed as well as possible under the circumstances', citing under-funding as the real problem. He claimed that the department had managed to 'vastly improve' health services in the province.<sup>61</sup>

- In October 2000 the Public Service Accountability Monitor (PSAM) produced an affidavit into mismanagement within the Department of Health at the request of the Head of Forensic Audit in the department of Finance, Bisho. This unit, acting on behalf of Dr Goqwana, confirmed that the affidavit would be used as part of a disciplinary process against Dr Stamper. The PSAM affidavit detailed instances of alleged financial misconduct by district-surgeons in the Eastern Cape and included a forensic audit report conducted by Deloitte & Touche into these allegations. It drew attention to the fact that although the findings of the forensic audit were made available to Dr Stamper in January of 1998, he took no action between that time and October 2000 to either investigate charges against the 13 offending district surgeons, or to recover the overpayment of R4.5 million.<sup>62</sup>

- In October 2000 media reports emerged of a conflict of interests between Dr Goqwana's official responsibilities and his private health-related business interests. He had continued to own a private ambulance service and operate a private specialist practice after his appointment as MEC for Health in June 1999.<sup>63</sup> In terms of the Executive Members Ethics Act, MECs are prohibited from owning private business interests whilst in public office.

- In November 2000 Dr Stamper was suspended with immediate effect following allegations of financial misconduct. He was charged before a disciplinary inquiry with 13 breaches of the PFMA, which related broadly to mismanagement and failing to keep the necessary controls on departmental spending.<sup>64</sup>

- In November 2000 Finance MEC Godongwana told the Department of Health that it had to tighten up its management, 'instead of throwing money into a system with many holes'.<sup>65</sup>

- In November 2000 Dr Goqwana repeated his assertion that medical superintendents should not be responsible for the management of hospitals. He remarked, 'doctors are doctors, they are not trained to manage'. He argued that 'we've got to run our hospitals just like businesses'.<sup>66</sup>

- In November 2000 it emerged that food was being rationed at Provincial Hospital. Patients were given reduced portions because management feared that the hospital would soon run out of food. This was blamed on the fact that suppliers were reluctant to continue

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61 'No extra cash for hospitals,' *Eastern Province Herald*, 5 Oct. 2000, and 'Stamper insists more funding on its way,' *Daily Dispatch*, 5 Oct. 2000.

62 This affidavit was provided to Mr Leon Nel, the Head of Forensic Audit, Eastern Cape Department of Finance, on 25 October 2000.

63 'Health MEC's sideline venture', *Mail & Guardian*, 26 October 2000. See also Press Release, Office of the MEC for Health, Bisho, 31 October 2000.

64 'Stamper Out over Health Crisis', *Daily Dispatch*, 2 November 2000.

65 'Hospitals in "voodoo crisis"', *City Post*, 5 Nov. 2000.

66 "'We've got to run our hospitals like businesses,' *Eastern Province Herald*, 3 Nov. 2000.

providing food to the hospital, due to their non-payment. The hospital management claimed that it could not pay its suppliers because it did not have the financial resources to do so. It was confirmed that family members were coming into the hospital to give food to hungry patients.<sup>67</sup>

- In November 2000 it became apparent that the CAT-scanner at Provincial Hospital had been broken for over two months and was yet to be fixed.<sup>68</sup>

- In November 2000 Eastern Cape Premier Makhenkesi Stofile stated that the Department of Health had been, 'marred by financial mismanagement affecting delivery of services to the people of the province'. He continued by stating that the department needed an overhaul of its management structure to enable it to utilise its resources more effectively. Goqwana responded by saying that the posts of chief executive officer and human resources manager had been advertised.<sup>69</sup>

- In November 2000 the PSAM submitted a request to the Public Protector that he not only investigate Dr Goqwana's health-related business interests, but also whether Premier Stofile had acted constitutionally and procedurally when appointing Dr Goqwana. The Speaker of the Eastern Cape Legislature deemed these allegations against Goqwana to be of such a serious nature that he requested Stofile (in a letter on 1 November 2000) to either establish a Commission of Inquiry to investigate the allegations or to refer the case to the Public Protector. Stofile had in the interim acknowledged that he was aware of Goqwana's private health interests prior to his appointment to the provincial executive, but argued that he had a constitutional right to pursue the business interests of his choice.<sup>70</sup>

- In December 2000 it was reported that Elliot Hospital had no doctors because its two remaining doctors had resigned as they had not been paid for six months. Health MEC Goqwana promised that salary problems were being addressed.<sup>71</sup>

- In February 2001, 70 community doctors and pharmacists had their salaries delayed for over six weeks because of apparent problems with the department's PERSAL computer system. Dr Goqwana blamed the problem on the fact that the province was now responsible for payment, when it had previously been the national Department of Health's responsibility. It was not clear why the province had not prepared for this change.<sup>72</sup>

- In March 2001 Goqwana stated that no amount of money would improve public health provision in the province 'if you don't know how to spend it'. He announced that R7 million had been earmarked to revamp the way his department was run to enable it to 'strategically steer the organisation to achieve its vision and objectives'. He stated that he also remained

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67 See, 'Food rations at big PE hospital,' *Eastern Province Herald*, 15 Nov. 2000, 'Relatives bring food for patients,' *Eastern Province Herald*, 16 Nov. 2000.

68 'CAT-scan crisis for two of PE's top hospitals,' *Eastern Province Herald*, 16 Nov. 2000. The report also noted that the CAT-scanner at Livingstone Hospital had also been out of action for a month.

69 'R100m for EC health,' *Daily Dispatch*, 11 Nov. 2000.

70 Copies of the PSAM's request and correspondence with the Public Protector are available at [www.psam.ru.ac.za](http://www.psam.ru.ac.za). Click Office of the Premier. Copies of the Speakers letter to the Premier, and Premier Makhenkesi Stofile's response to Eastern Cape Speaker, Mkgangeli Matomela, on 6 November 2000 are also available on this site.

71 'Dept pledges to address Elliot Hospital crisis,' *Daily Dispatch*, 8 Dec. 2000.

72 'Relief as Bisho finally pays doctors,' *East Cape Weekend*, 17 Feb. 2001.



committed to changing the way hospitals were managed, away from medical staff to business managers. He indicated that such managers were being recruited to the three main hospital complexes in Port Elizabeth, East London and Umtata.<sup>73</sup>

- In May 2001 it was confirmed that 122 community doctors and pharmacists working in the Eastern Cape went without pay for four months due to problems with the PERSAL system. National Minister for Health Manto Tshabalala-Msimang stated that a system was now in place to ensure payments were made on time.<sup>74</sup>

- In July 2001 reports indicated that nurses were having to buy their own stationery, that there was a chronic shortage of pillows, and that cockroaches were crawling over patients at Umtata General Hospital as it had not been fumigated since 1997. In addition, the hospital was said to be short of 37 doctors, 39 medical officers and 30 nurses. These failings were blamed on a lack of funds.<sup>75</sup>

- In August 2001, 24 community service dentists went unpaid for a month due to more problems with the PERSAL system. Provincial Department of Health spokesperson Mahlubandile Mageda was reported as saying that 'the department has a problem in its system and we are working on rectifying it'. A Grahamstown-based community dentist said that he had provided the department in Bisho with his details twice but had still not been paid.<sup>76</sup>

- In September 2001 an Eastern Cape Legislature Standing Committee on Health report into the state of hospitals in the province recorded the following criticisms of Umtata General Hospital:

- The mortuary was in such a poor state that the hospital was forced to use a private contractor to store corpses.
- There was a general shortage of equipment, and what existed was generally in a poor condition. Broken equipment was not fixed in good time as suppliers demanded payment in advance.
- The hospital lacked soap to wash linen.
- The hospital lacked coal supplies to fuel the steamers which resulted in linen having to be sent to Bedford Hospital for cleaning.
- The hospital lacked adequate maintenance staff.
- The intensive care unit (ICU), while well equipped, was 'grossly understaffed.'
- The hospital had no Board – only an acting Chief Superintendent.<sup>77</sup>
- In September 2001, 300 Umtata General Hospital staff staged a sit-in because they were still waiting for their rank promotions from as far back as 1996.<sup>78</sup>
- In October 2001 reports indicated that Umtata General Hospital had had no nappies for

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73 'Goqwana to spell out priorities,' *Daily Dispatch*, 7 March 2001, and 'R258m to be spent on health facilities,' *Daily Dispatch*, 8 March 2001.

74 'EC doctors unpaid for four months,' *Daily Dispatch*, 15 May 2001.

75 'Cockroaches crawl over sick babies,' *Daily Dispatch*, 5 July 2001.

76 'Unpaid dentists to be paid this week,' *Daily Dispatch*, 6 Aug. 2001.

77 Report of the Standing Committee on Health 'to investigate the general state of hospitals in the province,' 18 Sept. 2001, pp. 362–363.

78 'Hospital urged to pay staff,' *Daily Dispatch*, 1 Sept. 2001.

four months, and that there was a shortage of linen and only a limited supply of hot water.<sup>79</sup>

- In October 2001 Premier Stofile announced that Dr Goqwana had been 'relieved of his responsibilities as MEC for Health pending his trial for allegedly defrauding a medical aid scheme'.<sup>80</sup> He had been charged with 1 424 counts of fraud for billing specialist rates under his own name whilst employing non-specialist physicians to act as locums at his private practice in Umtata. This was despite being deregistered from the register of Medical Practitioners at the end of June 1999.<sup>81</sup> Stofile announced that the Agriculture MEC Max Mamase would act as Health MEC whilst Goqwana was on fully paid leave.

- In December 2001 a meeting of local community members and National Education, Health and Allied Workers' Union (NEHAWU) members listed the problems at Umtata General Hospital:

- Food suppliers had not been paid for four months.
  - There were staff shortages in all sections. NEHAWU chairperson Mxolisi Mkafulo said that at times a single nurse was left in charge of a whole ward, meaning that they had to write the ward report, feed the patients, wash them and give them medication.
  - There was regular theft of equipment.
  - There were ghost staff who absconded but were still paid.
  - There was a shortage of pharmacists, which meant that the dispensary was being staffed with casual employees.
  - There were shortages of toilet paper, linen and gloves.
  - There was no money to buy coal to heat water.
  - Water supplies were regularly cut off.
  - Staff were demoralised. Mkafulo said that the hospital was in danger of having its status 'reduced to a health care centre'.<sup>82</sup>
- In January 2002 the Department of Health announced that three chief executive officers had been appointed to run the three hospital complexes. They were due to take up their positions in February.<sup>83</sup>
  - In January 2002 media reports suggested that R70 million set aside specifically for the appointment of senior managers for the department was due to be 'lost' as money not accessed during the current financial year was, in terms of Treasury policy, forfeited.<sup>84</sup>
  - In February 2002 acting MEC for Health Max Mamase launched a scathing attack on departmental managers claiming that they lacked moral fibre. He stated that, 'those who do not want to work must pack up and go home', noting that 'department officials have sufficient knowledge which they are lazy in implementing'.<sup>85</sup>

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79 'Hospital has no nappies,' *Daily Dispatch*, 24 Oct. 2001.

80 See 'Mamase to act as Health MEC', Premier's Office press release, 4 October 2001.

81 See Judgement, *The State and Mkhuseleli Kenneth Mashiyi, Monwabisi Bevan Goqwana*, Case 255/01, High Court of South Africa, Transkei Division, 10 June 2002.

82 'Breakdown of all systems at Umtata Hospital', *Daily Dispatch*, 5 Dec. 2001.

83 'Three CEOs appointed to run "poor hospitals"', *Eastern Province Herald* 18 Jan. 2002.

84 'Three CEOs appointed to run "poor hospitals"', *Eastern Province Herald* 18 Jan. 2002.

85 'Go out and serve the people, MEC tells officials', *Daily Dispatch*, 6 February 2002.

- In February 2002 over 200 staff staged a sit-in at Grey Hospital in King William's Town over non-payment of second and third notch payments which had been submitted to management but not acted upon.<sup>86</sup>
- In March 2002 Eastern Cape Department of Health spokesperson Mageda noted that Umtata General Hospital had 800 staff vacancies, of which 300 were being filled. He said it was hoped the rest would be filled by April.<sup>87</sup>
- In March 2002 a *Sunday Times* investigation into the state of Umtata General Hospital stated that it had run out of disinfectant, antiseptic cream, anti-tetanus injections, gauze and the re-agent necessary to process HIV/AIDS tests. At the time of the investigation 91 mothers were found to be sharing 48 beds in the maternity ward. Nurses, who were unwilling to be named, said that there were chronic shortages of staff, sheets, blankets, essential drugs and bandages. One nurse indicated that things were 'getting worse and worse'.<sup>88</sup>
- In April 2002 Dr Frederick Rank, chief medical superintendent of the Port Elizabeth hospital complex, noted a cut of R47 million in the hospital's 2002/03 budget. Rank was said to be 'shocked and horrified' at this cut. He said services at the complex, such as open-heart surgery and renal dialysis, would have to be cut back.<sup>89</sup>
- In April 2002 food shortages were again reported at Provincial Hospital due to a shortage of funds. It was reported that nurses had to purchase porridge out of their own wages to feed patients. Dr Rank said that if money was not forthcoming from the Eastern Cape Department of Health soon, the hospital would run short of basic supplies.<sup>90</sup>
- In April 2002 acting Health MEC Max Mamase noted that the continual loss of nurses was partly due to the department's failure to pay rank promotions on time and the lack of notch-based wage increases.<sup>91</sup>
- In April 2002 Dr Rank noted that there were 'critical staff shortages' at Provincial Hospital, indicating that no new nurses had been appointed since 1997. He said that there were supposed to be six nurses on duty each day, but there were only three, and less during leave and illness absences.<sup>92</sup>
- In May 2002 Dr Rank noted that the budget allocation for the new financial year for the Port Elizabeth complex of hospitals was still totally inadequate. He said, 'we have been given the same amount we have always been complaining about'.<sup>93</sup>
- In May 2002 the cardiac unit at Provincial Hospital was closed for three weeks when a specialised technician went on leave.<sup>94</sup>

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86 'King hospital staff embark on sit-in,' *Daily Dispatch*, 28 Feb. 2002.

87 "'Unhealthy state of affairs,'" *Daily Dispatch*, 20 March 2002.

88 'Dying hospitals need urgent care,' *Sunday Times*, 17 March 2002.

89 'Budget cuts: PE hospitals in dire straits,' *Daily Dispatch*, 24 April 2002.

90 'Crisis looms for PE hospitals,' *Eastern Province Herald*, 24 April 2002.

91 'Funds shortage warning,' *Eastern Province Herald*, 16 April 2002.

92 'Minister in surprise visit to Bisho to meet health officials,' *Eastern Province Herald*, 30 April 2002.

93 'Hospitals: Not enough money,' *Daily Dispatch*, 7 May 2002.

94 'Cardiac unit closes for three weeks,' *Eastern Province Herald*, 20 May 2002.

- Premier Stofile declared that the civil service was 'unable to master the art of managing hospitals' and declared that private companies were to be called in. He said that the department has 'tried everything', including appointing hospital chief executives, and nothing had produced the desired results. He said that private management companies would be given two-year contracts and if the civil service did not learn from this he said he 'did not know what we will do'. Finance MEC Godongwana stated that private companies would be given managerial contracts, but the provincial government would be responsible for personnel, budgets and the provision of care. He said: 'Costs are not an issue, but the proper management of these hospitals is an issue. We want to bury this problem once and for all.'<sup>95</sup>
- In June 2002 the Department of Health confirmed that Dr Rank had been suspended for alleged misconduct, stating that he had contravened a circular instructing him not to comment on the internal status of the health service.<sup>96</sup>

The Umtata High Court found Goqwana not guilty of fraud. It found that he was unaware that his name had been removed from the register of medical practitioners, and that he had therefore not known that it was unlawful to employ locums in his practice. The court also found no evidence of Goqwana's private practice having defrauded the medical aid scheme concerned by overcharging them at specialist rates.<sup>97</sup> The Court did establish, however, that Goqwana had employed a paid public official, Dr Kenneth Mashiyi, the superintendent of the Umtata General Hospital, to treat patients in his private surgery in Umtata between June 1999 and January 2000.<sup>98</sup> Given that this constituted a breach of civil codes governing members of the executive, rather than criminal statutes, the Court had no power to make a finding in this regard.

- In June 2002 Dr Rank's replacement at the Port Elizabeth complex of hospitals, Dr Pat Naidoo, reportedly took sick leave, allegedly for depression brought on by the pressures of his position. He was quoted as saying that the pressure was caused by a shortage of staff and noted, for instance, that the ICU which should have 24 beds in it only had eight.<sup>99</sup>
- Department of Health spokesperson Mageda acknowledged that the department was having problems trying to find someone to replace Dr Rank. He stated that, 'we now need someone of the same calibre of Dr Rank, who has expertise with hospital management'.<sup>100</sup>
- In June 2002 Finance MEC Godongwana told the provincial Legislature that the government was working to improve capacity at the Department of Health offices in Bisho and at institutional level. He indicated that to do so, the department might bring in private sector capacity to assist management.<sup>101</sup>

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95 'Health "forgot" to budget,' *Daily Dispatch*, 28 May 2002.

96 'Bisho pulls Rank,' *Eastern Province Herald*, 4 June 2002.

97 See Judgement, The State and Mkhusele Kenneth Mashiyi, Monwabisi Bevan Goqwana, Case 255/01, High Court of South Africa, Transkei Division, 10 June 2002.

98 *Ibid.*

99 'Staff shortage sickens doctor,' *Eastern Province Herald*, 19 June 2002.

100 'Battle to find someone to replace suspended Rank,' *Eastern Province Herald*, 19 June 2002.

101 'Massive health recruiting drive,' *Daily Dispatch*, 11 June 2002.

- In June 2002 the National Health Minister Manto Tshabalala-Msimang, during a visit to the province, noted that a large number of hospital management posts were vacant and that people had been acting in these positions for too long.<sup>102</sup> Dr Goqwana, having recently returned to work, stated that nurses were underpaid and that this meant that a situation was created 'where people are not eager to upgrade their qualifications as they don't get compensated'.<sup>103</sup>
- Tshabalala-Msimang told the National Council of Provinces that 'indecision' had led to 'disappointing results' in the Eastern Cape. She argued that money would not solve the province's problems alone as effective management was the 'critical ingredient'.<sup>104</sup>
- In June 2002 Health Standing Committee chairperson Mahlubandile Qwase reported that the failure to fill critical posts at senior levels in the department was the main cause of the incapacity that negatively affected its performance. The Committee demanded that the National Department of Health and the Office of the Premier institute measures to reinforce the provincial department by filling all critical posts by the end of September 2002.<sup>105</sup>
- In August 2002 the department Head, Stamper (who had returned to work in February), indicated that Rank's suspension had been lifted due to 'tardiness' in conducting the investigation. After discussions it was agreed to give Rank his job back with an apology from Bisho.<sup>106</sup>
- In September 2002 the Public Protector, Advocate Selby Baqwa, released his long awaited report into Goqwana's alleged conflicts of interest. The report took 20 months to complete and was eventually only produced after the PSAM threatened to take legal action against Baqwa, in August 2002, to compel him to deliver the report. The report found that 'no adverse conclusions' could be drawn from the fact that Goqwana owned and operated a private ambulance service and a private specialist practice whilst he was a public official. Its findings were dismissed by the PSAM as a 'whitewash', given that they relied solely on an interview with Goqwana himself.<sup>107</sup>
- In November 2002 National Health Minister Manto Tshabalala-Msimang announced that the provincial treasury had made another R121 million available to the Eastern Cape Department of Health to fill critical posts.<sup>108</sup>
- In December 2002 Goqwana announced at a press conference that over the next three years the Department of Health would spend R60 million on improving management and building capacity in 14 hospitals in the province. Goqwana stated that a 'private-sector

102 'EC hospital staff shortage critical – minister,' *Daily Dispatch*, 29 June 2002.

103 'Nurses underpaid says Goqwana,' *Daily Dispatch*, 21 June 2002.

104 'Minister critical of Eastern Cape,' *Eastern Province Herald*, 13 June 2002.

105 'Vacant top health posts must be filled – report,' *Eastern Province Herald*, 21 June 2002.

106 See, 'Bisho lifts hospital chief's suspension,' *Daily Dispatch*, 14 Aug. 2002, and, 'Suspended chief hospital chief wins back job after talks,' *Eastern Province Herald*, 28 Aug. 2002.

107 See Office of the Public Protector, *Report on the investigation into allegations of improper conduct by and relating to the appointment of Dr B Goqwana as MEC for Health in the Eastern Cape Province*, 18 September 2002. Copies of this report and all PSAM's response are available at [www.psam.ru.ac.za](http://www.psam.ru.ac.za). Click Office of the Premier.

108 'Bisho gives R121m to fill health posts,' *Daily Dispatch*, 9 Nov. 2002.

contractor' would be engaged and that by the end of the contract there would be 'a wealth of skills needed by the institutions'.<sup>109</sup>

- In December 2002 over 100 student nurses staged a sit-in at Bisho over the non-payment of their salaries, claiming that payments were overdue from 1999. It was reported that over R10 million was then paid in backdated pay to nurses at the University of the Transkei.<sup>110</sup>
- In January 2003 Goqwana blamed chronic service delivery problems, which saw patients being turned away from Dora Nginza Hospital in Port Elizabeth, on Provincial Hospital. Goqwana claimed that Provincial Hospital practised racism by referring black patients to other hospitals such as Dora Nginza, thus creating problems such as those experienced at Dora Nginza. Contradicting this assertion somewhat, Goqwana then announced that two managers from Bisho would be sent to Dora Nginza to assist its management team. In addition, two new directors would be employed at the hospital – one in human resources and one for finance.<sup>111</sup>
- In January 2003 nurses at the Mary Teresa Hospital in Mount Frere went on a go-slow as they were waiting for payment of late rural incentives. Department of Health spokesperson Sizwe Kupelo was reported as saying that the nurses should realise the incentives were 'perks' and that the department was not compelled to pay them.<sup>112</sup>
- In March 2003 a newly appointed paediatric medical officer was reportedly still waiting to be paid after his appointment in January. Dr Barry van Emmenes was reported as saying, 'is this the deserving respect for our doctors, particularly the ones that have resisted the power and allures of the pound? We ought to be treated like precious gems.'<sup>113</sup>
- In March 2003 MEC Goqwana announced that his department had failed to pay district-surgeons throughout the province going back to 2000. One surgeon was reportedly owed over R200 000, and the total owed was said to run into millions. The MEC for Health said the backlog arose because the department changed from a regional to a district system. He said that this had caused confusion and difficulties in payment.<sup>114</sup>
- In April 2003 Chief Human Resources director Karen Campbell announced that R155 million was to be made available to the department to fill critical posts at the department's head office in Bisho (managers) and at health institutions (doctors and senior nurses). She blamed the shortage of staff in the province on the fact that salaries offered to medical professionals in South Africa could not compete with those offered overseas.<sup>115</sup>

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109 'R60m boost to improve skills at EC hospitals,' *Daily Dispatch*, 10 Dec. 2002.

110 'Bisho steps in with R10 million to pay salaries,' *Eastern Province Herald*, 14 Dec. 2002.

111 'Matron has to mop floors,' *Eastern Province Herald*, 24 Jan. 2003. Dora Nginza matron, Florence Peter, stated that the hospital was short of 441 nurses.

112 'Nurses to receive rural incentives,' *Daily Dispatch*, 31 Jan. 2003. This seems to contradict the purpose of the incentives which were announced as bonuses paid to nurses as compensation for working in rural areas. The Department of Health had not indicated at any stage that they should be considered 'perks' or could be withdrawn.

113 'Doctor fights for unpaid salary,' *Daily Dispatch*, 20 March 2003.

114 'District surgeons owed "millions,"' *Daily Dispatch*, 28 March 2003. Once again, no preparations seem to have been made before the transition from regional to district took place.

115 'Health posts advertised,' *Daily Dispatch*, 2 April 2003.

- In April 2003 reports indicated that a contractor stated that he had not been paid the more than R88 000 owed to him by the Department of Health for the initial construction of a clinic in Mount Ayliff. The contractor said the department repeatedly blamed the late payment on technical difficulties associated with loading a new system onto their computers and that that the delay was holding up construction of the clinic. Department of Health spokesperson Kupelo hinted that other contractors were in a similar position when he apologised to all those rendering services to the department.<sup>116</sup>
- In May 2003 the South African Human Rights Commission (SAHRC) published a report on Eastern Cape hospitals. It noted that Umtata General Hospital lacked 'important equipment' – e.g. there was no mammogram or ultrasound equipment and only one operating theatre was being used out of three. The report stated that the hospital had no ambulances and relied on an inadequate service provided by the metro. It noted that the hospital had 430 beds, all of which were full. In maternity wards women regularly shared beds, even in advanced stages of pregnancy, and several pregnant women were actually on floor beds.

The report noted that the hospital experienced a serious shortage of medicine. This was blamed on corruption and mismanagement. It noted in this regard that the hospital had only three qualified pharmacists instead of the regulatory 19. Delivery of medicine to the hospital was also said to be problematic, with delays occurring on a regular basis.

The SAHRC report acknowledged that patients had gone without food on occasion and that beds often did not have linen. It confirmed that where there was linen, it was inadequate and often dirty as the laundry was not functioning adequately. In addition, linen was said to be washed by hand, or patients simply took their own. Lastly, the report remarked on the serious shortage of staff at the hospital.<sup>117</sup>

The report also highlighted the following problems among the province's hospitals:

- Chronic staff shortages, both medical and non-medical.
- A lack of equipment and failure of older equipment, both medical and non-medical.
- A lack of basic items such as linen, nappies, basic medical supplies.
- The late payment of service bills – leading to food shortages, power outages and a shortage of vital medical services such as oxygen supply.
- A lack of ambulances.
- Poor security.
- Corruption.
- The late payment of staff salaries and notch increments.
- The poor management of drug supplies.<sup>118</sup>

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116 'Health Dept fails to pay contractor,' *Daily Dispatch*, 16 April 2003.

117 'Site visits and investigation: Eastern Cape hospitals,' South African Human Rights Commission, May 2003, pp. 22–28. The SAHRC team that visited the hospital indicated that staff at the hospital were defensive and reluctant to speak about their experiences.

118 It is not only hospitals that have experienced the problems mentioned above. Clinics, often at the forefront of primary health care provision, have experienced numerous similar problems. Problems which also relate to inadequate funding, chronic shortages of staff (nurses, doctors and pharmacists), shortages of basic equipment, lack of ambulances, poor infrastructure (poor roads and lack of electricity), inadequate drug controls and poor security. See for example, 'Clinics run short of basics,' *Daily Dispatch*, 8 Sept. 2001, 'At least 27 E Cape clinics have closed,' *Eastern Province Herald*, 20 Nov. 2001, 'Clinics may be shut due to inadequate funds,' *Daily Dispatch*, 30 April 2003, 'Mdantsane nurses fear for their lives,' *Daily Dispatch*, 5 Sept. 2003.

- In July 2003 the PSAM requested that the Office of the Public Protector conduct a review of its report on Goqwana. It requested that the Public Protector 'reconsider the rigor of the investigation which formed the basis for this report and the conclusions reached'. The PSAM asked that part of this review consider the allegations of misconduct arising from Goqwana's criminal trial where, although he was found not guilty, it was established that he had employed a public servant (Dr Kenneth Mashiyi) to work in his private medical practice. It pointed out that although these allegations arose during the course of the 20-month period in which the Public Protector's report was produced, and fell within the scope of the investigation into Goqwana's private business interests, they were excluded from this report.<sup>119</sup>
- In August 2003 newspaper reports confirmed that a woman gave birth to a stillborn child after waiting more than 40 hours for an ambulance to arrive. Goqwana stated that the incident would be looked into 'urgently'.<sup>120</sup>
- In October 2003 a report tabled before the Standing Committee for Health noted that the Department of Health still had 9 860 vacant positions.<sup>121</sup> Newly appointed Public Protector Advocate Lawrence Mushwana declined to review the report produced by his predecessor, Selby Baqwa, into Gowana's private business interests or to re-open the investigation into his abuse of office. Incomprehensibly, Mushwana's letter reads, 'A review of a report by the Public Protector can only be considered in exceptional circumstances. From what you have submitted, it appears that, apart from the investigation conducted by this office, allegations of misconduct by Dr Goqwana were also the subject of a criminal trial where he was convicted of fraud.'<sup>122</sup> Mushwana had clearly failed to apply his mind to the facts of the case.
- In October 2003 Goqwana admitted to the Standing Committee on Health that his department had overspent by R6.3 million on the Cuban doctor programme. He said that this was due to a 'quantitative shortage of doctors' in the province.<sup>123</sup>
- In January 2004 spokesperson for the department, Kupelo, acknowledged that the department was still short of 426 doctors. He blamed the shortfall on a lack of infrastructure which he said 'is still a hindrance to more doctors coming to rural areas'.<sup>124</sup>
- In January 2004 newspaper reports indicated that a 16-year-old girl had been charged with fraud and theft after it had been found that she had been posing as a doctor at Umtata General Hospital for over three months.<sup>125</sup>
- In February 2004 a teenage girl fell from a block of flats in Port Elizabeth and, despite suffering serious injuries, waited over six hours for an ambulance to arrive. Department spokesperson Kupelo was quoted as saying that an investigation would be carried out.<sup>126</sup>

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119 Letter addressed to Advocate Stoffel Fourie, Office of the Public Protector, 14 July 2003.

120 'Baby stillborn after 40-hour wait for help,' *Daily Dispatch*, 28 Aug. 2003.

121 'Health Dept met most objectives,' *Daily Dispatch*, 14 Oct. 2003.

122 Letter from Public Protector, ML Mushwana, 23 October 2003.

123 'Health dept overspends on Cuban programme,' *Daily Dispatch*, 28 Oct. 2003.

124 'Shortfall of 426 doctors in Eastern Cape,' *Daily Dispatch*, 21 Jan. 2004.

125 'Umtata hospital ensures patient safety,' *Daily Dispatch*, 27 Jan. 2004.

126 'Call for probe into 6-hour ambulance wait,' *Daily Dispatch*, 17 Feb. 2004.



- In March 2004 a women was reported to have died in Port Elizabeth’s magistrate’s court building after waiting more than 90 minutes for an ambulance to arrive.<sup>127</sup>
- In April 2004 a newspaper investigation found that at Cecilia Makiwane Hospital in East London there were only four doctors running its medical wards, despite the recommended number being 14. It also emerged that the 40-bed male ward had only six nurses when it needed a minimum of 14.<sup>128</sup>
- In April 2004 reports indicated that Umtata General Hospital was having to carry out a large number of caesareans because none of the district hospitals in the former Transkei had any anaesthetists. Because of this Umtata General was delivering between 400–500 babies each month, leading to chronic overcrowding in the maternity ward. CEO of the Umtata Hospital Complex Rod Allen was quoted as saying that the situation at the hospitals was ‘pathetic and unacceptable’.<sup>129</sup>
- In April 2004 media reports indicated that MEC Goqwana was to launch an investigation after psychiatric patients were told that there was no medication for them at a number of East London clinics.<sup>130</sup>
- In April 2004 Psychiatric Aftercare Havens Director John Meyer stated that the psychiatric ward at Dora Nginza Hospital in Port Elizabeth was in a ‘shocking state’. He said that when he arrived no nurses were on duty as they had, according to a security guard, decided to take the afternoon off. He also noted that there was no linen on many of the beds and no doors on solitary confinement rooms. A follow-up visit found that electrical wires were hanging down from many ceilings, there was no hot water, only one room could be locked and no rooms had basins. Health spokesperson Kupelo said that each institution would be given R200 000 to spend on improvements.<sup>131</sup>
- In April 2004 staff at clinics throughout East London confirmed that clinics in the city had run out of many drugs for chronic patients and were being referred to nearby hospitals. MEC for Health Goqwana stated that this was due to a ‘communication problem’.<sup>132</sup>
- In May 2004, after being re-elected to the Eastern Cape Legislature, Goqwana was reappointed as MEC for Health for a second five-year term of office.<sup>133</sup>
- In May 2004 it was alleged that a baby died in Indwe after waiting more than seven hours for an ambulance to arrive. The baby was said to have been suffering from bronchial pneumonia.<sup>134</sup>

There is little doubt that the crisis being experienced within the Eastern Cape public health service highlighted in this chapter has its roots in a number of factors. The following four chapters identify four key weaknesses within the department which help to explain why

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127 ‘Granny dies waiting for ambulance,’ *Eastern Province Herald*, 10 March 2004.

128 ‘Eastern Cape emergency,’ *Mail & Guardian*, 15 April 2004.

129 ‘Eastern Cape emergency,’ *Mail & Guardian*, 15 April 2004.

130 ‘Psychiatric medicine shortages to be probed,’ *Daily Dispatch*, 16 April 2004.

131 ‘One psychiatric ward left in PE – and it is in a “shocking state”,’ *Weekend Post*, 10 April 2004.

132 ‘No drug supply problems – Goqwana,’ *Saturday Dispatch*, 17 April 2004.

133 ‘Eastern Cape, Limpopo retain most old hands’, *Business Day*, 3 May 2004.

134 ‘Ambulance blamed for baby’s death,’ *Daily Dispatch*, 6 May 2004.

it failed, and continues to fail, to meet its Constitutional obligations to the citizens of the Eastern Cape. The four key weaknesses identified are: poor leadership, staff shortages, failed financial management and a lack of effective oversight and accountability. It is vitally important to note, however, that none of these weaknesses can be viewed in isolation, as all are interrelated in a number of ways. For example, a lack of accountability has created the opportunity for poor and ineffective leadership to remain at the helm of the Department of Health which has, in turn, led to many of the problems that it continues to experience.

# 3. The Leadership Crisis

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## Goqwana and Stamper

The crisis experienced within the Eastern Cape public health service during the period between 2000 and 2004, has to be situated against the backdrop of a number of problems involving the political and administrative leadership of the provincial Department of Health during this time. It is obvious that strong and effective political and administrative leadership is vital to the successful negotiation of the inevitable challenges and obstacles that are posed by a context of social transformation. Such leadership is essential to ensure the successful establishment of new systems and organisational structures. By contrast, the Eastern Cape Department of Health has, since 1994, been marked by a failure to establish effective financial management systems and administrative structures to organise its staff and control health care resources. Moreover, since 1999 the department has been blighted by a state of weak political leadership.

The Department experienced a protracted two-year period of crisis, between November 2000 and November 2002, involving its top management structure and political head. During this two-year period, both the MEC for Health and Head of Department (HOD) each spent substantial periods of time on fully-paid leave pending the outcome of internal disciplinary hearings or criminal charges that they faced. The resulting lack of leadership severely disrupted the effective management of the department and led to over R1 million of fruitless expenditure.

Dr Sipiwo Stamper, the HOD, was suspended with full pay during the course of a disciplinary hearing against him on charges of misconduct and maladministration, which lasted for a period of 16 months from November 2000 to February 2002. Aside from the impact on its effective management, assuming a basic remuneration package of R600 000 per year, or R50 000 per month, this suspension cost the department an amount of R800 000 in fruitless expenditure. Stamper was merely issued with a disciplinary warning at the end of this process.

During an overlapping period the MEC for Health, Dr Bevan Goqwana, took fully paid leave for nine months, between October 2001 and June 2002, to defend himself in the Umtata High Court against the criminal charge that he had defrauded a medical aid scheme. Aside from the impact of this lack of political leadership, assuming a basic remuneration package of R550 000, Dr Goqwana's paid leave would have cost the province an amount of R412 000 over this nine-month period. During the period between December 2000 and September 2002, Dr Goqwana was also investigated by the Public Protector's office concerning allegations that he had continued to own a private specialist practice and an ambulance service while in public office.

The list of responsibilities to be met by the MECs and HODs of provincial government departments below provides an indication of the likely impact of the 9-month absence of the MEC, and the overlapping 16-month absence of the HOD, on the management capacity of the department:

## **Responsibilities of Provincial MECs**

MECs obtain a remuneration package of R612 000 a year (at 2003/04 rates). The role played by MECs is vital to the efficient running of their departments. Their responsibilities include:

### **Strategic planning**

The MEC of a provincial department is responsible for:

- Drawing up a clear strategic plan and setting measurable objectives for his/her department.
- Identifying the people to be served by the department, their service delivery needs and any current barriers preventing access to these services.
- Drawing up a service delivery plan for the department and ensuring that services are provided efficiently and in a way that represents value for money.
- Deciding on the department's organisational structure and determining how many staff should be employed, and in what positions.

### **Appointment and evaluation of HODs**

MECs are responsible for:

- Appointing a HOD after consultation with the provincial cabinet.
- Drawing up a written contract of employment and performance agreement for their HOD setting out their duties.
- Continually evaluating the department's delivery and the performance of their HOD.

### **Discipline and efficiency**

MECs are responsible for:

- Ensuring the maintenance of discipline in their departments.
- Establishing a disciplinary committee to oversee the investigation of misconduct.
- Discharging employees who commit serious acts of misconduct.
- Discharging employees who are incapable of carrying out their duties efficiently.

### **Financial responsibilities**

MECs are responsible for:

- Tabling the department's budget in the Legislature by mid-March each year.
- Monitoring the monthly financial reports on their department's spending.
- Ensuring that the department remains within budget and spends all funds.

- Tabling an annual report on the department's financial statements, and an audit of these statements, in the Legislature by the end of August each year.
- Implementing all recommendations by SCOPA to improve the department's financial performance.

The performance of all MECs should be evaluated on the basis of their ability to meet these responsibilities.

## **Responsibilities of HODs**

The HOD can obtain a package exceeding R790 000 (at 2003/04 rates). HODs have a critical role to play in the delivery of effective public services.

HODs are responsible for the day-to-day running of government departments. Their responsibilities are listed in the Public Service Act and Public Finance Management Act. These include:

- Drawing up job descriptions and objectives for all posts.
- Monitoring and recording all leave and overtime taken by employees.
- Ensuring that funds are available for the training of employees.

HODs have a range of vital financial management responsibilities, which include:

- Maintaining internal financial controls and a risk management system in the department.
- Setting up a system of internal audit.
- Ensuring a transparent, competitive and cost-effective procurement system.
- Drawing up, before April each year, a planned breakdown of the department's anticipated monthly revenue and expenditure for the year.

HODs must take appropriate steps to:

- Collect all money due to their department.
- Prevent unauthorised, irregular and fruitless or wasteful expenditure.
- Ensure officials who make or permit irregular, fruitless or wasteful expenditure are disciplined.
- Prevent losses through criminal conduct.
- Maintain the assets of the department.
- Settle all contractual obligations and pay monies owing by the department,
- Prevent overspending, and under-collection, of revenue.

Finally, HODS have the following reporting responsibilities:

- To ensure their departments keep full and proper financial records.
- To prepare annual financial statements, which must be submitted to the Auditor-General (AG) by the end of May each year.
- To submit an annual report to the department's MEC by the end of August each year.
- To submit this annual report and audited financial statements to the Legislature by the end of September each year.

- To account to Legislature oversight committees on the performance of their department.

The performance of all provincial government HODs should be evaluated on the basis of their ability to meet these responsibilities.

After his return to work in February 2002 Stamper continued in his job until he died suddenly at the end of December the same year. A new permanent HOD for the department was only appointed some 16 months later in April 2004. What this means is that during the 41-month period between October 2000 and April 2004 the Department of Health had a permanent HOD for a mere 11 months. This is despite the critical role that the incumbent of this post is mandated to play within the department. After the new HOD was appointed in April 2004, Goqwana indicated the difficulties that this absence had caused for the department when he commented, 'we hope that all the problems we have had without a department head will now be a thing of the past'.<sup>135</sup>

As noted, Goqwana was found not-guilty of fraud during his Umtata High Court trial. However, the trial Judge accepted evidence to the effect that Goqwana had employed a paid public official, Mashiyi, the then Superintendent-General of the Umtata General Hospital, to consult patients in his private practice.<sup>136</sup> Given the continuing crisis at Umtata General Hospital it is inconceivable how Goqwana could justify asking Mashiyi to spend time consulting private patients.

In terms of the 1999 Public Service Act, public servants are strictly prohibited from engaging in additional paid remuneration without prior permission. In a press interview Mashiyi reportedly denied that he needed permission to work as a private practitioner.<sup>137</sup>

Goqwana's action also demonstrates a flagrant disregard for the provisions in Section 136 of the Constitution (and repeated in the Executive Members Ethics Act of 1998) which state that MECs of a province may not:

- 'Undertake any other paid work.'
- 'Act in any way that is inconsistent with their office, or expose themselves to any situation involving the risk of a conflict between their official responsibilities and private interests.'
- 'Use their position or any information entrusted to them to enrich themselves or improperly benefit any other person.'

As MEC for Health, and previous Superintendent-General of Umtata General Hospital, Goqwana would have been aware of the number of pressing issues to be addressed at the Umtata General Hospital and the lack of time available to Mashiyi to conduct private work.

135 'Three challenges for new health man,' *Eastern Province Herald*, 26 April 2004. Goqwana remarked that, in particular, the department had had financial management problems.

136 Judgement, *The State and Mkhuseleli Kenneth Mashiyi, Monwabisi Bevan Goqwana*, Case 255/01, High Court of South Africa, Transkei Division, 10 June 2002.

137 'MEC's 'fraud' costs medical aids R128 000,' *The Star*, 11 April 2001.

Besides representing a disregard for his public responsibilities, this constitutes the illegitimate use of Goqwana's public office for his private gain.

Given the vital responsibility that MECs have in ensuring the establishment of appropriate strategic objectives for their departments, the public has a legitimate right to expect MECs to approach their tasks motivated by a spirit to serve the public interest rather than their personal financial interests.

In the instance of provincial health departments, this includes a legitimate expectation that when health MECs witness the state of disrepair of emergency medical rescue vehicles in the public sector they are not prompted to establish private ambulance companies in response. It also includes the expectation that when health MECs witness the state of infrastructural decay in public health facilities they are not motivated to establish private medical practices or private hospital facilities in an effort to profit from this state of affairs. The assumption is that every ounce of their energy will be directed toward finding innovative and cost-effective solutions to solve these problems within the parameters of the public health care system.

Goqwana's curriculum vitae, posted on the Eastern Cape government's official website (at the time of writing in May 2004), proudly declares that he is Director on the Board of St Mary's Private Hospital in Umtata.<sup>138</sup>

## Misconduct

The failure of political and administrative leadership to abide by regulatory and disciplinary codes designed to ensure the transparent and effective use of public funds, sets a dangerous precedent in terms of these very codes which govern the behaviour of all public officials. If public officials see their senior management acting with what appears to be impunity with regard to these codes, what compulsion will they themselves feel to abide by these same codes? Only in an environment where misconduct is dealt with effectively and efficiently in terms of the regulatory code, will public officials be dissuaded from engaging in acts defined as misconduct (by the various pieces of legislation which govern misconduct within the workplace). Between 2000 and 2004 the Department of Health has been generally ineffective in its handling of misconduct, although recent developments within the department suggest that it is adopting a more proactive approach to managing the problem.

Misconduct committed by officials within the Department of Health has clearly contributed to the health crisis within the province given its adverse effect on the department's ability to fulfil its constitutional mandate. Misconduct, both in terms of acts of commission, such as corruption, and acts of omission, such as incapacity and some forms of negligence, act as a drain on departmental resources. This drain takes place via actual material losses sustained by the department (theft, fraud, etc.), or via employees not fulfilling their work obligations despite being fully remunerated by the department. Naturally, any drain on de-

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<sup>138</sup> See, [http://www.ecprov.gov.za/departement\\_ministry.asp?contactID=16&departmentID=4](http://www.ecprov.gov.za/departement_ministry.asp?contactID=16&departmentID=4).

partmental resources hinders its ability to deliver quality public health services to the citizens of the province. It is, therefore, essential that acts of misconduct committed by employees of the department of Health are addressed swiftly and competently to ensure that its resources are used effectively and efficiently.

### **The Legislative Framework Governing Misconduct in the Public Sector**

Since the transition to democracy in South Africa an excellent regulatory framework governing employment relations in the public service has been established which, among many other things, deals extensively with misconduct within the workplace in terms of the Constitution and Bill of Rights. The Constitution itself details a set of basic values and principles governing public administration. Section 195 (1) states that public administration must be governed by democratic values and principles, including:

- a. A high standard of professional ethics must be promoted and maintained.
- b. Efficient, economic and effective use of resources must be promoted.
- c. Public administration must be development-oriented.
- d. Services must be provided impartially, fairly, equitably and without bias.
- e. People's needs must be responded to, and the public must be encouraged to participate in policy-making.
- f. Public administration must be accountable.
- g. Transparency must be fostered by providing the public with timely, accessible and accurate information.
- h. Good human-resource management and career-development practices, to maximise human potential, must be cultivated.
- i. Public administration must be broadly representative of the South African people, with employment and personnel management practices based on ability, objectivity, fairness, and the need to redress the imbalances of the past to achieve broad representation.

The Public Service Act of 1994 (and the subsequent Public Service Regulations, 2001), the Labour Relations Act of 1995, the Public Service Co-ordinating Bargaining Council Resolutions of 1999 and the Public Finance Management Act of 1999 have all created a framework which empowers public service employers to successfully identify and discipline those whom it has been proven have committed acts of misconduct.

In particular, the Public Service Act of 1994 has a comprehensive section dedicated to inefficiency and misconduct. It details a process by which all public officials, from the lowest grades to HODs, can be dismissed for incapacity and maladministration. It also defines the act of misconduct in great detail, offering 20 definitions of action that is now considered misconduct. Importantly, it also sets in place a rigorous and thorough disciplinary process, which protects both the interests of employers and employees by establishing time-frames and rules according to which departments must discharge their disciplinary responsibilities.



The Public Service Act is also supported by the Public Service Regulations, which promotes ethical conduct within the public service by setting out a number of ethical principles which all public servants should abide by. The Public Finance Management Act (PFMA) is another significant piece of legislation, which legally enforces compliance with a strict set of conditions which govern the process of financial reporting within government departments. Sections 38 through to 42 of the Act detail the responsibilities of departmental accounting officers concerning the presentation, analysis and reporting of financial statements with the objective of creating a transparent system which enables risk, in terms of misconduct and maladministration, to be managed. Significantly, if an accounting officer fails to comply with the requirements of sections 38–42, they are themselves, under Section 81 of the Act, deemed to have committed an act of financial misconduct which could potentially lead to imprisonment.

The Interim Management Team's (IMT)<sup>139</sup> report on the Department of Health in April 2003 pointed to a number of problems relating to misconduct within the department. It noted that staff and managers often ignored reporting requirements, that managers and supervisors were reluctant to act against ill-disciplined staff, and that internal controls were weak, leading to a 'high corruption vulnerability'.<sup>140</sup> Its suggested remedies for these problems were limited, and revolved around addressing the chronic staff shortage within the department (especially among managers),<sup>141</sup> improving internal controls, and creating and fostering a performance driven culture among employees.<sup>142</sup> Specifically in relation to corruption, it advised that staff should be educated to be aware of its consequences and how to competently and successfully report it to managers.<sup>143</sup>

How seriously these recommendations have been taken on board by the department is difficult to say, although signs are, at this early stage, cautiously encouraging. In late 2003, a new Director of Employment Relations was appointed within the department and some progress appears to have been made in terms of holding employees accountable for acts of misconduct.

Through a fruitful period of negotiation between the PSAM and the Department of Health, it is now clear that the department has created a database of cases of misconduct to enable it to systematically keep track of all the cases it is currently pursuing. This is, as far as the PSAM knows, a unique development among Eastern Cape government departments and

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139 See chapter 7.

140 Late in 2002, in the wake of consistent reports of failed service delivery and corruption within the Eastern Cape, President Thabo Mbeki deployed an IMT to deal with the chronic administrative and management problems being experienced in the province. The IMT was specifically mandated to tackle challenges of service delivery, back office support and poor discipline and ethics. Report of the Interim Management Team, April 2003, p. 32.

141 See chapter 4.

142 Ibid, p. 80.

143 Ibid, p. 75.

should be commended. In addition, in January 2004, the department supplied the PSAM with a list of all misconduct cases that it was currently investigating which, at this early stage, signalled a commitment on the part of the department to be transparent and accountable regarding its efforts to deal with the problem.

These developments are also important because they enable the department to communicate its misconduct and disciplinary strategy to two audiences. Firstly, it enables the department to demonstrate its commitment to fighting misconduct to the public, which should begin changing current negative perceptions held by the public regarding misconduct, and corruption in particular. Secondly, and more importantly, it fosters an environment within the department itself which dissuades employees from committing acts of misconduct in the first place for fear of being investigated and punished.<sup>144</sup>

### **Despite these steps problems still exist:**

- Out of 242 cases on the PSAM database which relate to alleged misconduct committed by members of the Department of Health reported between 1996 and 2004, the PSAM considers only 19 of these resolved in terms of the regulatory code which governs misconduct (highlighted above). What this means is that according to the PSAM some 223 of these cases remain unresolved. These cases are deemed to be unresolved for one of two reasons: either, the department has failed to indicate to the PSAM what corrective action it took (if any) in regard to the cases, despite repeated requests from the PSAM for this information; or, the department has failed to take the appropriate corrective action as required in terms of the regulatory framework governing misconduct.<sup>145</sup>
- The shortage of staff that the department experiences, especially at managerial level,<sup>146</sup> inevitably hampers the creation of an environment which fosters a sound work ethic. It is clear that competent managers conversant with the regulatory code which governs misconduct need to be in place within all sections of the department to ensure the proper enforcement of disciplinary standards.
- The department does not apply Eastern Cape Treasury Directives and Instructions in all instances where criminal impropriety has taken place. In terms of Provincial Treasury Directives (12.11.1–2) and Treasury Instruction W11.1, all cases where the State has suffered losses or damages through criminal or possible criminal acts should be referred to the responsible accounting officer and the South African Police Service. This is with a view to recovering any money or property lost and ensuring a criminal investigation into the case as well as an internal departmental investigation. PSAM's research illustrates that the department does not always refer cases to the police or attempt to recover any losses that the state has incurred via misconduct.

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144 In addition to these important innovations the department is also in the process of creating a disciplinary handbook. The intention of this handbook, which is to be distributed to managers and supervisory staff within the department, is to assist them in identifying acts of misconduct and, importantly, to encourage and empower them to report acts of misconduct.

145 See PSAM's Case-Monitoring website at <http://www.psam.org.za>.

146 See chapter 4.

- During the period in question the department has held back internal disciplinary processes in light of pending criminal prosecutions. In some instances this has erroneously resulted in persons not being disciplined internally because of the failure to secure a criminal conviction. However, the new Director of Employment Relations has recognised that this position is not consistent with disciplinary codes,<sup>147</sup> and has assured the PSAM that internal disciplinary processes will proceed regardless of any criminal proceedings which may also be taking place.
- Despite numerous instances of breaches of sections 38–42 of the PFMA (considered acts of financial misconduct) reported by the AG since 2000, no action has been taken against those responsible.<sup>148</sup>

### **Failure to Enforce the Disciplinary Code**

The following are two typical cases from the PSAM database which illustrate the failure of the department to enforce the disciplinary code governing employees.

#### **Case 1**

A part-time district-surgeon from Willowmore, Dr Jacobus van Ravensteyn, is alleged to have defrauded the Eastern Cape Department of Health of more than R500 000 during the 1995/96 financial year. He is one of 14 district-surgeons put under investigation by the Special Investigative Unit (SIU) in January 1998 after the AG picked up discrepancies in their claims. Dr van Ravensteyn allegedly submitted a claim for R1.075 million for treating 40 596 patients for the 1995/96 financial year and was paid accordingly. This amounts to a claim to have worked 886 eight-hour working days during this year. In a normal eight-hour day, this would mean treating one patient every 72 seconds. Van Ravensteyn's travel claims of 49 157km would have required him to be on the road (travelling at 100km an hour) eight hours a day for an additional 61 days.<sup>149</sup>

The PSAM established that Van Ravensteyn resigned as district-surgeon for Willowmore at the end of July 2000. However, he continued to work in the same practice as the current Willowmore district-surgeon, Dr Schwartz, who by October 2000 was also implicated in the alleged fraud. The SIU was instructed to close its three-year investigation of the 14 Eastern Cape district-surgeons in August 2001, after an audit of the unit's outstanding workload by the National Directorate of Public Prosecutions. Despite press reports in October 2000 claiming that the alleged fraud had been handed over to the police for investigation, no reports of criminal charges could be found.

<sup>147</sup> This position is not consistent with disciplinary codes as the burden of proof necessary to convict an individual in an internal disciplinary is considerably lower than the burden of proof required to secure a criminal conviction.

<sup>148</sup> See chapter 6.

<sup>149</sup> Ibid.

In May 2003 the PSAM requested more information about this case from the department. In October 2003 the department simply confirmed in correspondence to the PSAM that Dr van Ravensteyn resigned as district surgeon in July 2000. The department failed to indicate if it had taken any corrective action against him or Dr Schwartz or attempted to recover any of the monies owed to it.

### Case 2

A doctor at the Greenville Hospital in Bizana, Eastern Cape, Dr Tapson Ally Mwangi, was arrested on charges of stealing medicines worth around R20 000 from the hospital, according to press reports in August 2000. The doctor was arrested after security guards searched his vehicle as he was driving out of the hospital. Mwangi had reportedly been with the hospital for eight years before he resigned to go into private practice in Port Edward. Police found more drugs when they raided his residence at the hospital prior to his resignation. Goqwana said theft of medicines had cost the government thousands of rands, and that staff members were the main culprits in the theft of medicines from public health centres. He warned that staff at provincial health centres were to be searched before leaving hospitals to curb the high incidence of theft of medicines.

In May 2003 the PSAM requested more information about this case from the department. In October 2003 the department informed the PSAM that Mwangi had left the service of the department on 28 June 2000. The department failed to indicate if any corrective action had been initiated against him for the alleged theft of drugs or if any attempt had been made to recover the value of the stolen goods from Mwangi.<sup>150</sup>

In both instances the doctors should have been dismissed and attempts should have been made to recover the large sums of money owed by them to the public purse.

Perhaps the greatest obstacle to ensuring that misconduct, and corruption in particular, are dealt with effectively in the Department of Health is the shortage of managerial staff (considered elsewhere in this report).<sup>151</sup> However, equally concerning is the lack of will at times from within the department itself to actively pursue these cases. There is little use in having an excellent disciplinary framework in place if the will to actually use it to secure sanctions, both internal and criminal, is lacking.

Of particular concern is the department's unwillingness to hold the accounting officer of the department (the HOD) accountable for breaches of the PFMA. The PFMA makes it clear in Section 84 that any accounting officer referred to in relation to Section 81 (on a charge of financial misconduct), 'must be investigated, heard and disposed of in terms of the statutory or other conditions of appointment or employment applicable'. This means that not only has the department failed to comply with the financial reporting requirements of the PFMA by breaching sections 38–42, but it has also not taken the appropriate corrective action in terms of the Act itself.

<sup>150</sup> Ibid.

<sup>151</sup> See chapter 4.

This failure to make the HOD of Health accountable for serious breaches of regulatory codes speaks of a lack of political will on the part of those responsible for the department to ensure the accountability of those who work within the department and the transparency of the department more generally. This is, of course, a failure that has far-reaching ramifications because it sends out a message both to the public and to employees of the department at all grades that the HOD can act with impunity regardless of the laws which govern his or her activity as a public servant.

The apparent disinclination to hold officials accountable is only possible within an environment where effective oversight is lacking. Both the Eastern Cape SCOPA, which is charged with ensuring the department's compliance with financial management regulations, and the Standing Committee on Health, tasked with ensuring the effective implementation of health policies by the department, have failed to ensure that its senior officials are held accountable for breaching the PFMA. This is despite the fact that such an oversight role is intrinsically part of both their mandates.<sup>152</sup> The failure of such oversight committees can only demonstrate either a lack of understanding of this mandate, or a lack of political will across the political spectrum to uphold and enforce the regulatory framework which governs the public service.

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<sup>152</sup> See chapter 6.

# 4. The Staffing Crisis

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## Vacancy Rates

The failure of political and administrative leadership to offer effective management of the Department of Health is made all the more serious due to the chronic staff shortages that the department experiences year on year.

The problem of staff shortages, especially critical at the management level, has plagued the provincial health system for a number of years. It has been attributed to a number of factors: the relatively low wages offered in the province; the rural nature of much of the province; the poor state of the health service within the province more generally; and the poaching of medical staff by the British<sup>153</sup> and Australian health services (as well as other provincial health departments within South Africa).

Whatever the reason for this shortage, the Intergovernmental Fiscal Review for 2003 noted that the Eastern Cape Department of Health had the second-lowest staff to population ratio in the country. In the past financial year (2003/04) the department employed 28 498 staff, which is a ratio of 4.4 staff for every 1 000 members of the population in the province. This compares with a national average of 5.8.<sup>154</sup>

What is significant about this shortage is that it has been a long-term problem which has not been successfully addressed. In March 2000, Stamper indicated that the need to fill 16 649 posts in the department.<sup>155</sup> By the end of the following financial year the department reported a 34.6 per cent vacancy rate, with a 48.8 per cent vacancy rate for critical posts.<sup>156</sup> At the end the next financial year the overall vacancy rate had fallen to 22 per cent. Disturbingly, however, the vacancy rate for critical posts had risen to 51.96 per cent.<sup>157</sup>

In April 2002 Acting MEC for Health Mamase noted that over the past five years 7 000 professional and non-professional staff had left the provincial Department of Health.<sup>158</sup> By the end of financial year in 2003 the department reported an overall vacancy rate increase to 25.6 per cent. With regard to critical occupations, the department gave a detailed breakdown of vacancy rates per occupation. The following are examples of acute shortages in critical professions:

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153 A recent memorandum of understanding was signed between the South African government and the British government to try and stem the flow of professional health workers to Britain. See, <http://news.bbc.co.uk/2/hi/health/3210419.stm>.

154 Intergovernmental Fiscal Review 2003, p. 79.

155 'EC needs R48.9m to upgrade health service,' *Eastern Province Herald*, 23 March 2000.

156 Eastern Cape Department of Health, Annual Report 2000/01, pp. 12–13.

157 Eastern Cape Department of Health, Annual Report 2001/02, pp. 15–16

158 'Funds shortage warning,' *Eastern Province Herald*, 16 April 2002.

Critical profession	Vacancy rate (%)
Medical specialist	79%
Principal pharmacist	62%
Physiotherapist	100% <sup>159</sup>

According to recent statistics, the Eastern Cape continues to lead the country in shortages of critical professional occupations. It is reported that there is one medical specialist for every 47 529 people (the third highest ratio in the country), one professional nurse for every 1 278 people (the highest ratio in the country), one pharmacist for every 53 662 people (the highest ratio in the country), and one occupational therapist for every 554 507 people (also the highest in the country).<sup>160</sup>

Figures from the department regarding the number of posts that need to be filled appear to vary from one month to the next. In July 2003 it was reported that there were still 5 998 vacancies within the department.<sup>161</sup> Two months later the department indicated that it had 4 796 vacant posts.<sup>162</sup> Only a month later a report tabled before the Standing Committee on Health noted that the department employed some 28 585 workers, but still had 9 860 vacant positions.<sup>163</sup> This opens a question to the degree to which the department has mechanisms in place to accurately track vacant posts. The absence of such mechanisms would exert an obvious effect on the department’s ability to ensure that these posts are filled.

### The shortage of nurses

As this will demonstrate, the Eastern Cape suffers from a severe shortage of nurses. Perhaps the most pressing issue when it comes to this shortage is the problem that the province continues to experience with the staffing of rural clinics. In November 2000 Goqwana admitted that ‘people do not want to go there and we can’t blame them’, as he mooted the idea that rural nurses should be paid automatic notch promotions for working in rural areas.<sup>164</sup> In early 2001 he argued that keeping clinics staffed in rural areas was one of the greatest challenges that the department faced, indicating that discussions were ongoing with the national Department of Health to try and institute rural incentives for nurses.<sup>165</sup> In November 2001 it was announced that R9 million had been set aside to pay rural incentives and a pilot project was to be initiated from which special rural allowances would be paid.<sup>166</sup>

159 Eastern Cape Department of Health, *Annual Report 2002/03*, pp. 107–118.

160 National Treasury, *Intergovernmental Fiscal Review, 2002/203*, p. 79.

161 ‘E Cape has 5998 health vacancies,’ *Eastern Province Herald*, 19 July 2003.

162 ‘Health has 4796 vacant posts,’ *Daily Dispatch*, 19 Sept. 2003.

163 ‘Health Dept met most objectives,’ *Daily Dispatch*, 14 Oct. 2003.

164 ‘Promotions for rural doctors, nurses mooted,’ *Eastern Province Herald*, 24 Nov. 2000.

165 ‘EC tackles rural staff problems,’ *Daily Dispatch*, 8 March 2001.

166 ‘R388m boost for health services,’ *Eastern Province Herald*, 29 Nov. 2001.

The apparent failure of this policy was revealed a year later, in November 2002, when the Standing Committee on Health noted that 27 clinics had closed in the province due to a shortage of staff, while 60 were operating with only one nurse. Stamper noted that a 'staffing-gap' was being created in rural areas of the Transkei as nurses refused to work in areas not serviced by good roads or electricity.<sup>167</sup> It was then revealed that Mount Fletcher Hospital had 65 vacancies that had been advertised in June, but had not been filled because nobody wanted to work in rural areas.<sup>168</sup> A few days later Goqwana announced a R29-million boost to incentive payments made to nurses who worked in rural areas.<sup>169</sup> In January of the following year it was announced that 43 more nurses had been appointed in rural areas of the Transkei and that the department would be advertising another 459 before the end of March.<sup>170</sup> Another announcement was made in August to try and attract staff to rural areas, when the department indicated that rural medical staff would be offered an additional 25 per cent of their salary to ensure they remained in rural areas.<sup>171</sup> Despite these new appointments and policy statements, in a report tabled before the Standing Committee on Health in October 2003 it was noted that the department was still having problems in attracting professional staff to rural areas around Umtata and Lusikisiki.<sup>172</sup>

It is not only the recruitment of rural nurses that has proved a problem for the Department of Health, as many nurses have also left the service in urban centres. This has essentially been blamed on poor wages and poor working conditions in hospitals, both district and complex.

In January 2002 Frere Hospital temporarily closed its outpatients department because it lacked more than 20 essential staff.<sup>173</sup> In April, Rank, Livingstone Hospital's superintendent, noted that no new nurses had been appointed at the hospital since 1997, leading to a situation where nurses were struggling to cope.<sup>174</sup> In August 2003 it was admitted that the Port Elizabeth complex of hospitals, which is made up of Livingstone, Provincial and Dora Nginza, had a combined shortage of 800 staff members that was putting them under severe strain. It soon became apparent that conditions were equally fraught at the East London complex, where the Cecilia Makiwane and Frere Hospitals had 947 vacant posts between them.<sup>175</sup>

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167 'R29m for rural nurses,' *Daily Dispatch*, 22 Nov. 2002.

168 'Still not enough staff at crisis hospital,' *Eastern Province Herald*, 8 Nov. 2002.

169 'East Cape rural nurses to be paid incentives,' *Daily Dispatch*, 7 Dec. 2002. Nurses were to be paid between R400 and R600 a month extra for working in rural areas.

170 '43 rural nurses hired to work in Transkei,' *Daily Dispatch*, 30 Jan. 2003.

171 'Hospital staff crisis hurting,' *Eastern Province Herald*, 23 Aug. 2003.

172 'Health Dept met most objectives,' *Daily Dispatch*, 14 Oct. 2003. The report pointed to the outbreaks of cholera as another impediment to the recruitment of rural staff.

173 'Frere department closes to outpatients,' *Daily Dispatch*, 1 Jan. 2002.

174 'Minister in surprise visit to Bisho to meet health officials,' *Eastern Province Herald*, 30 April 2002.

175 'Health has 4796 vacant posts,' *Daily Dispatch*, 16 Sept. 2003. It was reported that the Port Elizabeth complex now had 1 181 vacancies.



## The shortage of doctors

The situation of public service doctors in the province differs little from that of the nurses. Doctors were equally unwilling to live and work in rural areas and were increasingly reluctant to work under the pressured conditions they found themselves in within state hospitals.

As early as October 2000 Goqwana admitted that the public health service faced a 'crisis' as there was a critical shortage of doctors in the province. He admitted that 60 per cent of primary health care patients were treated only by nurses. He suggested that the solution was to offer doctors working in the private sector formal employment contracts, where they could work part-time in state institutions as and when they were needed.<sup>176</sup> Another solution was the continued use of Cuban doctors in the province. This was particularly attractive to the province as Cuban doctors were more willing to work in rural areas, and by February 2001 there were 95 Cuban doctors working in the Eastern Cape.<sup>177</sup> However, in July 2001 it was reported that Umtata General Hospital was short of 37 doctors,<sup>178</sup> and in April 2002 it was reported that Port St Johns and Isilimela Hospitals had no resident doctors.<sup>179</sup>

Over a year later the situation had not improved. Goqwana noted that there were still too few doctors willing to work in the province, especially in rural areas.<sup>180</sup> In January 2003 it was revealed that Bisho Hospital had only eight doctors as five had left in the preceding six months, and that Grey's Hospital was in a similar state. The shortage of doctors at these two hospitals in particular was blamed for the continual delays in disability grant assessments.<sup>181</sup>

## The shortage of medical support staff

It is not only doctors and nurses who are in short supply. In April 2001 it was reported that 128 out of the province's 222 state pharmacy posts were vacant, most of them in rural areas.<sup>182</sup> Throughout the period under investigation the recruitment of pharmacists has proven to be another consistent problem for the Department. Psychiatrists are also desperately needed within the province. In August 2003 the South African Society of Psychiatrists indicated that the province only had one third of the psychiatrists it needed, blaming the situation on immigration and movement into the private sector.<sup>183</sup>

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176 'Health Dept outsources,' *Daily Dispatch*, 27 Oct. 2000.

177 '53 Cuban medics in rural EC,' *Daily Dispatch*, 21 Feb. 2001.

178 'Cockroaches crawl over sick babies,' *Daily Dispatch*, 5 July 2001.

179 'Health test,' *Daily Dispatch*, 10 April 2002.

180 'Bevan vows to get down and dirty,' *Weekend Post*, 27 July 2002.

181 'Doctor shortage delays grant,' *Daily Dispatch*, 18 Jan. 2003. In May 2003 a South African Human Rights Commission report into the state of hospitals in the province noted that doctors were refusing to sign performance contracts in some hospitals due to a shortage of essential equipment, see 'Site visits and investigation: Eastern Cape hospitals,' South African Human Rights Commission, May 2003, p. 31.

182 'Health workers in expired drug battle,' *Eastern Province Herald*, 13 Dec. 2001.

183 'Health dept posts to be filled in phases,' *Daily Dispatch*, 29 Aug. 2003.

National Health Minister Tshabalala-Msimang summed up the situation in the province during a visit in June 2002. She noted serious shortages throughout the province of doctors, nurses and pharmacists, and recommended to the provincial Department of Health that it fill all critical posts immediately. She was especially concerned about the closure of rural clinics due to staff shortages and recommended that the re-opening of clinics be prioritised. She argued that it was not her aim to 'undermine the provincial leadership and administration – but to make strategic and practical contributions'.<sup>184</sup>

The damaging effect these staff shortages have on service delivery are immense. Hospitals and clinics are functioning on a daily basis with too few staff being asked to shoulder too many responsibilities. This predictably puts pressure on health professionals who try and maintain a minimum level of service despite these constraints. The effect is obvious – health professionals are working longer hours than they are contracted to, leading to frustration and tiredness with the inevitable risks associated with fatigue.<sup>185</sup> In addition, such long hours naturally erode morale among staff members, a situation to which the department itself has directly contributed to through its continued inability to ensure the efficient management of its staff payroll.<sup>186</sup>

## The Department's Response

There is little doubt that the provincial Department of Health has made an effort throughout the period in question to try and address the staff shortages that it faces. We have seen how rural incentives were paid to try and attract medical staff to rural areas, but this was only one of a number of efforts to bolster staff numbers within the province.

In May 2002, Stamper noted that the department had been given R177 million to fill all vacant critical posts in the province. He promised that by the end of July all vacant critical posts would be filled.<sup>187</sup> A month later it was announced that the department was to employ another 1 417 health professionals – these include 97 doctors, 42 pharmacists, 773 professional nurses and 250 nursing assistants.<sup>188</sup> Then, in July, Goqwana stated that the department had set aside R121 million to fill critical posts.<sup>189</sup> Only three months later Karen Campbell, the director of human resources within the department, announced that in the previous three months 1 250 posts has been filled but the department remained grossly understaffed and under-funded.<sup>190</sup> By November this figure had risen to 1 400, and efforts were to be

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184 'EC hospital staff shortage critical – minister,' *Daily Dispatch*, 29 June 2002.

185 See for example, 'Overworked nurses treat 85 patients a day', *Eastern Province Herald*, 23 April 2001 and 'Doctors face major strain,' *Daily Dispatch*, 26 April 2002.

186 See next chapter.

187 'Probe into food crisis at hospital,' *Daily Dispatch*, 31 May 2002.

188 'Massive health recruiting drive,' *Daily Dispatch*, 11 June 2002.

189 'Hospitals face rationalisation,' *Eastern Province Herald*, 5 July 2002.

190 'Health appointments welcome,' *Daily Dispatch*, 21 Sept. 2002.

made to see that it rose to 2 000 by the end of the year.<sup>191</sup> In January 2003 departmental spokesperson Kupelo announced that the department intended filling 616 critical posts within six weeks to improve service delivery, especially in rural areas.<sup>192</sup> Later in the year it was announced that the department had filled 1 190 posts since January and that it was ready to approve a 25 per cent pay increase for pharmacists and nurses.<sup>193</sup> In September Goqwana announced that R155 million had been allocated for the financial year to fill vacant posts.<sup>194</sup>

The department has attempted to resolve the staff shortages by offering those who work within rural areas in particular financial bonuses. The idea was first mooted by the department some time ago, but it was not until 2002 that a sum of R29 million was set aside to pay rural medical workers a bonus.<sup>195</sup> However, in early 2004 the national Minister of Health announced that a nationwide programme of rural health care worker bonuses was to be initiated. In total a figure of R85 million was set aside for the Eastern Cape to pay both rural incentives and scarce skills bonuses. At the end of February 2004 the department processed 3 900 rural allowances and 1 200 scarce skills bonuses. The beneficiaries included nurses, graduate doctors performing community service, dentists, pharmacists and radiographers.<sup>196</sup> This is a welcome development, but it remains to be seen if it is enough to even begin to address the shortages that the department has experienced within rural areas alone.

Despite all these attempts to fill vacant posts, the fact remains that the department has suffered, and continues to suffer, from chronic staff shortages. Given that these shortages are most pronounced in senior positions which are based in urban areas, no amount of rural incentives can be expected to address these critical vacancies as these posts are graded nationally and the salaries offered are identical to those on offer elsewhere in the South African public service. This raises the important question of the desirability of the Eastern Cape Department of Health as a potential work environment from the point of view of health professionals. It is unlikely that doctors, pharmacists and nurses will be attracted to working in an environment associated with ongoing mismanagement, misconduct, ill-discipline and impropriety, and in which they cannot even be guaranteed the payment of their salaries.

Rather than address these issues, however, it has become apparent that the department has increasingly resorted to using consultants to try and overcome the problems created by its skills shortage.

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191 'Bisho gives R121m to fill health posts,' *Daily Dispatch*, 9 Nov. 2002.

192 'Health to fill over 600 key posts,' *Daily Dispatch*, 23 Jan. 2003.

193 See, 'Health Dept posts to be filled in phases,' *Daily Dispatch*, 29 Aug. 2003, and 'Health Dept employs pharmacists,' *Daily Dispatch*, 11 Nov. 2003.

194 'Health has 4796 vacant posts,' *Daily Dispatch*, 16 Sept. 2003.

195 'Medics get first rural allowance,' *Daily Dispatch*, 25 Feb. 2004.

196 'Surprise bonus for rural health workers,' *Eastern Province Herald*, 25 Feb. 2004.

## The Use of Consultants

In June 2001 the national Department of Public Service and Administration (DPSA) produced a report on the utilisation of consultants in the public service. This report attributed government dependency on consultants to institutional challenges such as long-term capacity building and short-term delivery demands, the inability of government to retain skilled personnel, and the lack of inter-governmental knowledge sharing on products developed by consultants.<sup>197</sup>

In early June 2003 it was reported that the provincial Department of Health had spent R250 million on consultants during the 2002/03 financial year to help with human resources management, department finances and other management issues.<sup>198</sup> A week later, however, department spokesperson Kupelo corrected this, saying that the department had only spent R80 million on consultants during the previous year. Kupelo announced, however, that the department would spend R130 million on consultants and other capital projects in the 2003/04 financial year. These consultants would help in the management system of ten prioritised hospitals, including Umtata General Complex, East London Complex and the Port Elizabeth Complex, while others were to be engaged in capacity building within human resources and fleet management.<sup>199</sup>

There is a need for strong control measures over the use of consultants if the province is to reduce its consultants' bill and make more funds available for the delivery of services. In 2002 the national office of the Auditor-General (AG) looked at government's (both national and provincial) expenditure in the procurement of consultant services, with a view to facilitate public accountability in this area and encourage the implementation of effective management controls, thus improving value for money through economy and efficiency. The main findings of the report included:

- Alternatives to hiring consultants were not always exhausted, ranging from training staff at necessary levels of skill, to extending work hours with overtime pay.
- Proper planning and needs analyses were not performed, often leading to more expenses, as projects need to be extended to adequately meet the needs.
- There was a lack of adequate monitoring and verification of consultants' performance in meeting agreed objectives and also in measuring the impact of their work.
- Invoices supporting the terms of reference and reports prepared by consultants were often not received by departments, rendering them unable to determine the reasonability of the amounts charged against the work done.<sup>200</sup>

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197 Department of Public Service and Administration, *Use of Consultants in the Public Service*, June 2001.

198 'Consultants cost Health R250m,' *Daily Dispatch*, 5 June 2003.

199 'Advisors, projects to cost health R130m,' *Daily Dispatch*, 12 June 2003.

200 Report of the AG on the appointment and utilisation of consultants at certain national departments and provincial administrations, August 2002.

The AG's report encouraged departmental managers to fill vacant posts and to increase productivity by setting productivity standards for employees before engaging consultants in order to reduce costs. It also recommended tighter control measures, including rigorous assessment of the need to appoint consultants, clearly defined terms of reference and regular evaluations while an assignment is in progress.

In order to address its current over-reliance on the services of private consultants, the Eastern Cape Department of Health need to fully implement existing guidelines and procurement procedures. The transfer of skills needs to be a cardinal objective in contracts and should be monitored through measurable indicators. Internal auditors can play a crucial support role for management in the evaluation of consultants' performance and their impact. In this way, departments are more able to link remuneration of consultants to achieved goals. They would also put the department in a better position to ensure the transfer of skills from consultants to their own staff. The current strategy of relying on consultants to fill the gaps in vital management functions within the department, such as strategic planning, is ultimately self-defeating as it either undermines or delays the department's own capacity to undertake these functions.<sup>201</sup>

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201 It is of serious concern, for instance, that the Eastern Cape Department of Health's strategic plan for 2004/05 was drawn up by a consultant, as opposed to having been developed by its own senior management.

# 5. The Crisis of Financial Management

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## Under-Budgeting for Public Health Care in the Eastern Cape

In 2002/03 South Africa spent a per capita amount of (US)\$663 on public health care. This compares to \$1 774 in the United Kingdom, \$2 754 in Germany, \$358 in Botswana and \$20 in Nigeria.<sup>202</sup> This spending is consistent with the middle-income GDP profile that South Africa demonstrates. Within South Africa the spending on public health provision differs from province to province.

In 1999/00 the Eastern Cape per capita expenditure on health was 85 per cent of the national average expenditure. By 2002/03 this had fallen to 73 per cent of the national average.<sup>203</sup> This means that for the Eastern Cape the per capita budget for health provision is appreciably less than the national average, and, significantly, is increasing at a much slower rate than it is nationally. Thus, compared to other provinces in South Africa, the Eastern Cape is experiencing a relative decline in its budget allocations for health provision.

This relative decline in budget allocation clearly impinges on the ability of the province to provide an effective and inclusive public health service. No matter what other factors are taken into account, and there are many, budgetary allocations are crucial to any department's ability to meet its constitutional obligations. Given this, it is all the more imperative that effective use is made of those funds actually budgeted for health provision within the province.

## General Spending

For 1999/00 the department overspent its total budget by some R84 million. The following year, 2000/01, it overspent by an amount of R87 million.<sup>204</sup> It then under-spent its budget for the following two financial years. For the year 2001/02 it under-spent its budget by some R329 million (some 7.9 per cent of the total budget), for 2002/02, it under-spent by R68 million.<sup>205</sup> Provisional figures for the 2003/04 year indicate an overall improvement in spending with the department overspending its budget by R97.5 million, or 1.9 per cent.<sup>206</sup>

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202 See World Health Organisation – <http://www.who.int/country>.

203 The actual per capita amount spent on health in the Eastern Cape from 1999/00 was R572, for 2000/01 R606, for 2001/02 R610, and for 2002/03 R668. This equates to a per capita increase in spending from 1999 to 2003 of 17 per cent. Figures for the country as a whole are as follows: 1999/00 R689, 2000/01 R749, 2001/02 R830, R2002/03 R911. This represents a 32 per cent increase. Statistics taken from the Intergovernmental Fiscal Review, 2003.

204 Department of Health Annual Report 1999/00, pp. 1–27 and Department of Health Annual Financial Statements 2000/01, p. 20.

205 See, Eastern Cape Department of Health *Annual Report*, 2001/02, pp. 72 & 83, Eastern Cape Department of Health *Annual Report*, 2002/03, p. 195 and Revenue and Expenditure Statement for the Fourth Quarter (ended 31 March 2004), (no page numbers).

206 Fourth Quarter Expenditure and Revenue Report, Provincial Budgets 2003/04, National Treasury, p. 4.

## Spending by Programme

This section examines the performance of all seven programmes within the Department of Health in terms of each programme's ability to spend the money actually budgeted to it on a year-on-year basis. It should be noted that of these seven programmes, three (Health Facilities, District Health Service and Provincial Hospital Services) account for approximately 90 per cent of all monies budgeted to the department each year,<sup>207</sup> of which the District Health Services Programme annually accounts for over 50 per cent of the budgeted total.<sup>208</sup>

The key objectives of the seven programmes administrated by the department are as follows:

### **Eastern Cape Department of Health Programmes<sup>209</sup>**

#### **Programme 1: Administration**

Responsible for the overall management and administration of the Eastern Cape Department of Health.

#### **Programme 2: District Health Services**

Responsible for primary health care services. This includes responsibility for ensuring the effective management of district hospitals, chronic diseases, TB and, most importantly, HIV/AIDS. It also includes responsibility for managing emergency medical services. The programme has five sub-programmes: District Management, Community Health, Community Health RDP, Emergency Medical Services and Community Hospitals.

#### **Programme 3: Provincial Hospital Services**

Responsible for the efficient and effective delivery of general and specialised hospital services. Key sub-programmes are responsible for the provision of provincial, regional and psychiatric Hospitals.

#### **Programme 4: Academic Health Services**

Responsible for the training of health professionals and for conducting research in the province. It carries out its functions by formulating policy and business plans for expenditure on the Health Training and Research Grant (HEPTAR).

#### **Programme 5: Health Sciences**

Responsible for the training of nurses, ambulance personnel and primary health care workers.

207 For example, in 1999/00 they accounted for 92 per cent of the budget, and in 2002/03 the figure was 91 per cent.

208 For example, in 2000/01 it accounted for 52 per cent of the total budget and for 2001/02 it accounted for 54 per cent of the total budget.

209 The list of programmes contained in this table reflect the department's programmes up until 2002/03.

### Programme 6: Health Care Support Services

Responsible for the provision of assistive devices such as wheelchairs, hearing aids, orthoses and prostheses.

### Programme 7: Health Facilities

Responsible for the provision of new health facilities and the maintenance and upgrading of existing facilities, including health care centres, hospitals and clinics.

## Budget expenditure by programme

### Programme expenditure in 2000/01

PROGRAMME	Allocated Budget (R' 000)	Actual Expenditure (R' 000)	Variance (R' 000)
1. Administration Services	131 350	142 658	(11 308)
2. District Health Services	1 950 179	2 190 789	(240 610)
3. Provincial Hospital Services	1 273 668	1 214 853	58 815
4. Academic Health Services	52 830	35 419	17 411
5. Health Sciences	52 314	42 362	9 952
6. Health-Care Support Services	15 626	12 316	3 310
7. Health Facilities	226 348	151 190	75 158
Special functions	0	41	(41)
<b>Total expenditure</b>	<b>3 702 315</b>	<b>3 789 628</b>	<b>(87 313)</b>

Source: Department of Health, Province of the Eastern Cape *Annual Financial Statements*, 2000/01.

In the 2000/01 financial year, the department overspent its R3.7 billion budget by R87.3 million, or 2 per cent. The over-expenditure in the department occurred in two programmes due to the following reasons:

- Administration: as a result of unforeseen court cases which required the services of legal practitioners. There was also back-pay for rank and leg promotions and other liabilities carried forward from the 1999/00 financial year. In addition more than R10 million was owed to Afrox. Increasing drug costs were also cited as one of the major contributors to this over-expenditure.<sup>210</sup>

<sup>210</sup> Eastern Cape Department of Health *Annual Report*, 2000/01, p. 25.



- District health: due to motor transport, telephones and faxes. Moreover, the department owed the South African Institute for Medical Research an amount of R14 million. In total, over-expenditure in the entire programme was R240 million.<sup>211</sup>

The programmes that were primarily responsible for the department's under-expenditure were its Health Facilities programme (responsible for building and maintaining hospitals and clinics), which under-spent by R75 million, and its Provincial Hospitals programme (responsible for the management and staffing of hospitals and for the procurement of medical equipment), which under-spent by R58.8 million.

### Programme expenditure in 2001/02

PROGRAMME	Allocated Budget (R' 000)	Actual Expenditure (R' 000)	Variance (R' 000)
1. Health Administration	194 749	168 752	25 997
2. District Health Services	2 291 177	2 212 065	79 712
3. Provincial Hospital Services	1 241 246	1 181 165	60 081
4. Academic Health Services	73 485	56 793	16 692
5. Health Science	76 813	76 756	57
6. Health-Care Support Services	9 301	6 765	2 536
7. Health Facilities	333 994	189 962	144 032
<b>Total</b>	<b>4 221 365</b>	<b>3 892 453</b>	<b>328 912</b>

Source: Eastern Cape Department of Health, *Annual Report*, 2001/02, p. 83. (Figures as per annual report.)

In the 2001/02 financial year, the department's budget was R4.221 billion. It under-spent its budget by R328.9 million, or 8 per cent. The programmes that were primarily responsible for the total under-expenditure were its Health Facilities programme, which under-spent by R144 million, its District Health programme (responsible for the implementation of immunization programmes, the running of voluntary counselling and testing sites as well as home based care projects), which under-spent by R79.7 million, and its Provincial Hospitals programme, which under-spent by R60 million.<sup>212</sup>

Combined, these programmes accounted for 86.29 per cent of the total under-expenditure in the department.<sup>213</sup> The major reason cited by the department for under-expenditure was the shortage of staff, mostly at the Head Office, districts and institutions.<sup>214</sup>

211 Ibid.

212 Eastern Cape Department of Health *Annual Report*, 2001/02, pp. 53 & 83.

213 Ibid, p. 53.

214 Ibid, p. 54.

### Programme expenditure in 2002/03

PROGRAMME	Total Allocation (R' 000)	Actual Expenditure (R' 000)	Variance (R' 000)
1. Administration	241 330	216 756	24 574
2. District Health Services	2 383 117	2 422 831	(39 714)
3. Provincial Health Services	1 391 450	1 375 094	16 356
4. Academic Health Services	88 756	95 100	(6 344)
5. Health Science	48 115	71 062	(22 947)
6. Health Care Support Services	9 536	9 168	368
7. Health Facilities	398 622	303 218	95 404
Special functions		13	(13)
<b>Total</b>	<b>4 560 926</b>	<b>4 493 242</b>	<b>67 684</b>

Source: Eastern Cape Department of Health, *Annual Report, 2002/03*, p. 195.

In the 2002/03 financial year, the department under-spent its R4 560 billion budget by R67.6 million, or 1.5 per cent. This marked a significant improvement from the previous year, when the department under spent by 8 per cent in total.

The under-expenditure of the Administration and Provincial Health Services programmes was reported to be due to unfilled vacancies,<sup>215</sup> and the lack of financial delegations to the department's Chief Executive Officer. This had resulted in delays due to the department's dependency on the province's centralised financial system within the provincial Treasury.<sup>216</sup> The department's Hospital Services programme, responsible for regional, TB and psychiatric hospitals, across the province, under-spent its budget by R16.3 million.<sup>217</sup> Similarly, the department's R138.5 million budget for emergency medical rescue services (responsible for ambulance and planned patient transport) was under-spent by an amount of R16.1 million.<sup>218</sup>

Yet again the Health Facilities budget was under-spent by an amount of R95.4 million, or 24 per cent.<sup>219</sup> The department's annual report indicates that its New Facilities sub-programme (with a budget of R169.5 million) was under-spent by an amount of R64.5 million,

215 Eastern Cape Department of Health *Annual Report, 2002/03*, p. 152.

216 Ibid, p. 159.

217 Eastern Cape Department of Health, *Annual Report, 2002/03, Management Report*, p. 157.

218 Eastern Cape Department of Health, *Annual Report, 2002/03*, p. 55.

219 Ibid, p. 195.

or 38.5 per cent.<sup>220</sup> Similarly, its Maintenance sub-programme, with a budget of a mere R98.2 million for the maintenance of 92 hospitals and 711 clinics, was also under-spent by an amount of R33.5 million, or 34 per cent.<sup>221</sup>

The department's District Health Services, Academic Health and Health Sciences programmes all overspent their budgets during the course of the year.

The District Health Services programme over-spent its budget by an amount of R39 million, largely due to overspending within its Community Hospitals sub-programme, and the fact that the final budget was substantially lower than the amount requested.<sup>222</sup> No explanation was given for the overspending of the Academic Health programme. It is not clear how the problems identified by the department as hindrances to service delivery within its Health Science programme, which over-spent by R22.9 million, could have contributed to this over-expenditure. These problems include the exodus of highly trained professionals to overseas countries and poor physical infrastructure at some of the institutions and facilities under the programme's management.<sup>223</sup>

#### Programme expenditure in 2003/04<sup>224</sup>

<b>PROGRAMME</b>	<b>Allocated Budget (R' 000)</b>	<b>Actual Expenditure (R' 000)</b>	<b>Variance (R' 000)</b>
1. Health Administration	273 426	302 667	(29 241)
2. District Health Services	2 253 759	2 334 080	(80 321)
3. Emergency Medical Services	364 774	311 767	53 007
4. Provincial Hospital Services	1 736 779	1 574 580	162 199
5. Health Sciences and Training	63 690	136 487	(72 797)
6. Health-Care Support Services	15 157	11 925	3 272
7. Health Facilities	411 261	447 380	(36 119)
<b>Total</b>	<b>5 118 886</b>	<b>5 118 886</b>	

Source: Province of the Eastern Cape, Budget Statement 2004/05. (Figures as per annual report.)

<sup>220</sup> Ibid, p. 89.

<sup>221</sup> Ibid, p. 90.

<sup>222</sup> Ibid, p. 181.

<sup>223</sup> Ibid, p. 81 & 160.

<sup>224</sup> The following provisional spending figures for the year 2003/04 although produced by the Eastern Cape Treasury and included in the Province's Budget Statement for 2003/04 have not yet been audited, and should not be read as such.

Unaudited financial figures produced by the Eastern Cape Treasury for the 2003/04 financial year indicate that the department spent 100 per cent of its budget allocation of R5.1 billion.<sup>225</sup> However, national Treasury figures indicate that the department overspent this allocation by an amount of R97 million, or 1.9 per cent.<sup>226</sup>

Unaudited figures for the department's expenditure on its Health Facilities and Maintenance programme in the 2003/04 financial year indicate an over-spending of this programme. On closer inspection, however, it emerges that the programme's performance has been characterised by significant over- and under-expenditure, both of which indicate continued poor budgeting. The budget (of R329.5 million) for development and maintenance of district hospitals was over-spent by an amount of R52.5 million, or 15.9 per cent; whilst the budget (of R81.6 million) for provincial hospitals was under-spent by an amount of R16.3 million, or 19.9 per cent.<sup>227</sup>

## Spending on hospital and clinic infrastructure

Despite the ailing state of public health infrastructure in the Eastern Cape's 92 hospitals, 28 primary health care centres and 711 clinics, the tables listed above indicate that there has been a pattern of under-spending in the department's Health Facilities programme, which is responsible for the maintenance and construction of health facilities. In fact, it can be established that the department consistently failed to spend its entire budget allocation for this programme during the four-year period between 1999 and 2004 (with the debateable exception of the 2003/04 financial year).

### Infrastructure spending 1999–2004

	1999/00	2000/01	2001/02	2002/03	2003/04	Total
<b>Budget</b>	R88m	R226.3m	R333.9m	R398.6m	R411.2m	R1 458m
<b>Expenditure</b>	R83m	R151.1m	R189.9m	R303.2m	R447.3m	R1 174.5m
<b>Under-spending (over-spending)</b>	R5m	R75m	R144m	R95.4m	(R36.1m)	R283.3m
<b>Per centage of budget</b>	5.7%	33%	43.1%	24%	(8.8%)	19.4%

225 Province of the Eastern Cape, Budget Statement 2004/05, p. 58.

226 Fourth Quarter Expenditure and Revenue Report, Provincial Budgets 2003/04, National Treasury, p. 4.

227 These figures represent the estimated actual expenditure for these items for 2003/04 as contained in the Province of the Eastern Cape Budget Statement, 2004/05, 26 February 2004, p. 67.

The above table shows that the Eastern Cape Department of Health failed to spend an amount of R283.3 million, or 19.4 per cent, of its R1.458 billion infrastructure budget between 1999 and 2004. This under-spending translates into almost a fifth of the budget allocated for the maintenance and construction of hospitals, clinics and health centres in the province during this five-year period. The department's failure to spend over R280 million on the upkeep of facilities in this time serve to contextualise the constant media reports of the derelict state of health facilities chronicled in chapter 2 of this book.

Significantly, this pattern of under-spending has occurred within a context of a steadily increased budget allocation for the department's infrastructure programme. The 1999/00 infrastructure budget of R88.6 million increased fourfold to R398.6 million<sup>228</sup> by 2002/03.

The continuous state of financial mismanagement of these funds can be held directly responsible for many of the service delivery problems faced by the department, such as the shortage of wards and the lack of bed space in hospitals.

This raises the important question of what explanations the department offered for the continued mismanagement of its infrastructure budget, and how it is that this state of affairs was allowed to continue for so long. An analysis of the department's annual reports for this period fail to provide a compelling account of the reasons for its underspending on infrastructure and maintenance.

In the 1999/00 financial year the department's R5-million under-spending is attributed to the abandoning of projects by contractors and the re-tendering of projects.<sup>229</sup> The under-performance of contractors is again cited to explain the department's failure to spend R75 million in 2000/01<sup>230</sup> and R144 million (43.7 per cent) in 2001/02. Although, in 2001/02, this is also blamed on the department's own slow payments process and the shutdown of the Provincial Tender Board.<sup>231</sup>

The reason advanced for the under-expenditure of R95 million during the 2002/03 financial year again includes the poor performance of contractors. The department's annual report claims the maintenance budget was under-spent because 'workmanship by the SMMEs at times was not up to the mark and had to be redone before final payment could be effected'. Other than this, a 'lack of technical expertise' and an 'over-loaded' Department of Public Works are blamed for the department's poor performance. The only specific 'problem' referred to in this report consists of a cryptic reference to the: 'Inability to spend the funds by the rural areas due to public sector capacity'.<sup>232</sup>

On the whole, the source of the department's spending problems are conveniently located outside the department itself within its annual reports to the provincial Legislature.

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228 Eastern Cape Department of Health *Annual Report*, 1999/00, p. 22, and 2002/03, p. 186.

229 Eastern Cape Department of Health *Annual Report*, 1999/00.

230 Eastern Cape Department of Health *Annual Report*, 2000/01.

231 Ibid.

232 Eastern Cape Department of Health *Annual Report*, 2002/03, pp. 88–90.

Despite consistently blaming the under-performance of external contractors for its infrastructure under-spending, it is significant that the department's operational plans during the above period consistently fail to include any provision for the monitoring of infrastructure development projects.

In any event, the department's recourse to blaming contractors for its own poor performance in managing its Health Facilities programme cannot be sustained. While poor performance on the part of contractors has hindered service delivery, it remains the responsibility of the department to ensure contractors' compliance with their contractual terms in order to ensure that public-health infrastructure remains up to standard. Yet, by the department's own admission its failure to pay contractors timeously exacerbated this situation and resulted, in certain instances, in contractors abandoning construction sites.<sup>233</sup>

Ultimately, the biggest obstacle to the effective management of Health infrastructure in the Eastern Cape is the department's ignorance of the extent of its maintenance and infrastructure development needs. In its management report of 2002/03, the department makes the disturbing acknowledgement that: '... huge infrastructure backlogs require extensive analysis and measurement of the problem. This is a project on its own ... The services branches are supposed to identify the needs for infrastructure development but they lack capacity in this area'.<sup>234</sup>

The clear implication of this acknowledgement is that the department has not conducted a recent analysis of infrastructure backlogs in the province. As a consequence, the strategic objectives of its Health Facilities programme are not based on a properly thought out needs analysis and its budget allocations for this programme have, in all likelihood, been purely speculative.

The net effect of this continued state of poor planning on infrastructure development and maintenance by the Eastern Cape Department of Health, which necessarily gives rise to weak financial controls and under or over-spending, has been the steady deterioration of a number of hospitals and clinics in the province during the 2000 to 2004 period.

## Under-Spending of Conditional Grants

The Eastern Cape Department of Health has received a range of conditional grants from the National Department of Health between 2000 and 2004 which have been ring-fenced to address specific health programmes in the province. These have included hospital rehabilitation, professional training, HIV/AIDS programmes and the integrated nutritional (or child feeding) programme. (See Appendix 1 for a detailed discussion of conditional grant spending during this period.)

The allocation of these grants for each financial year is set out in the Division of Revenue Act (DORA), which is tabled annually along with the national budget in February (see

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233 Eastern Cape Department of Health *Annual Report*, 2001/02, p. 84.

234 Eastern Cape Department of Health *Annual Report*, 2002/03, p. 160.

chapter 1 of this book). Despite the stringent conditions attached to their use, including the possibility of withdrawal, there has been significant under-spending and mismanagement of these grants.

During the 2001/02 financial year the department under-spent its conditional grant for its school nutrition programme by an amount of R36.225 million, or 27 per cent. It blamed this under-expenditure on a lack of sound financial and general administrative systems and a lack of human resources, resulting in the 'underfeeding' of school children.<sup>235</sup>

Also during 2001/02 the department failed to spend 65 per cent, or an amount of R5.382 million, of its conditional grant of R8.281 million for HIV/AIDS programmes. The explanation given for this under-expenditure was the late transfer of the grant, its 'improper loading' onto the department's financial system and delayed tendering for services earmarked for outsourcing.<sup>236</sup>

In fact, the department under-spent its total conditional grant allocation of R383.7 million (for eight separate programmes) for 2001/02 by an amount of R97.7 million or 25.4 per cent.<sup>237</sup> By contrast it claimed to have spent its entire allocation in 2000/01 and to have over-spent its 2002/03 allocation of R548.4 million by an amount of R30.7 million, or 5.6 per cent (see Appendix 1). These spending claims, however, should be treated with a healthy degree of skepticism for two reasons: firstly, the department has already acknowledged that the figures for the spending of its HIV/AIDS conditional grant were incorrectly reported in its 2002/03 annual report; and, secondly, none of these spending figures have been independently verified as a result of a financial audit by the national or provincial office of the Auditor-General (AG).

It is a matter of extreme concern that during its 2002/03 financial audit the AG's office found the National Department of Health failed to establish mechanisms to ensure the effective 'monitoring and review of compliance with the requirements of the (Division of Revenue) Act and gazetted conditions'. For this reason the AG, Shauket Fakie, concluded: 'I could not satisfy myself that the transfer payments were utilised as stipulated'.<sup>238</sup>

What is alarming about this acknowledgement is the fact that the National Department of Health transfers the bulk of its budget in the form of conditional grants each financial year. In the 2002/03 financial year the department transferred 93.3 per cent, or R7.1 billion out of R7.6 billion, in this fashion.<sup>239</sup> This means that the national Minister of Health and the national department could not properly account for the use of R7.1 billion on provincial hospital rehabilitation, HIV/AIDS programmes and child-feeding schemes during this year. Given that it had no monitoring mechanisms in place to ensure the proper use of these funds, it is questionable as to how the AG arrived at his decision to award the national Department of

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<sup>235</sup> Eastern Cape Department of Health *Annual Report*, 2001/02, p. 75.

<sup>236</sup> *Ibid.*

<sup>237</sup> *Ibid.*

<sup>238</sup> (National) Department of Health *Annual Report*, 2002/03, Report of the AG to Parliament on the Financial Statements of Vote 16 – National Department of Health for the year ended 31 March 2003, p. 82.

<sup>239</sup> *Ibid.*

Health an 'unqualified' audit opinion. Such an opinion is reserved for public entities whose financial statements reflect 'the maintenance of effective control measures' and 'compliance in all material respects with the relevant laws and regulations'.<sup>240</sup> By all accounts the national Department of Health should have been issued with an audit disclaimer for only being able to account for seven per cent of its budget for 2002/03.

## Inept Strategic Planning

As pointed out earlier, the responsibility for drawing up a clear strategic plan and for setting measurable objectives for provincial government departments rests with the MEC for that department. Amongst other responsibilities, MECs need to identify the people to be served by their department, as well as their specific service delivery needs. The MEC is then tasked to draw up a service delivery plan and an organisational structure for the department to ensure that it provides services efficiently and in a way that represents value for money. These strategic planning requirements are strictly regulated in terms of the Public Service, Public Finance Management, and Division of Revenue Acts (see chapter 1).

The following table contains an indication of the level of compliance with planning requirements by the Eastern Cape Department of Health between 2000 and 2005. (This table is a synthesis of Appendix 2, which contains a detailed analysis of the department's compliance with strategic planning requirements between 2000 and 2005.)

REQUIREMENT	COMPLIANCE				
	2000/01	2001/02	2002/03	2003/04	2004/05
1 Clear policy priorities by MEC/minister	X	X	X	X	X
2 Concise mission and strategic goals	✓	X	✓	✓	✓
3 Accurate information on service delivery environment and challenges	X	X	X	X	X

240 Ibid.



4	Rigorous evaluation of past year's performance	X	X	X	✓	✓
5	Effective consultation with relevant internal and external stakeholders	X	X	X	X	X
6	Clear separation of activities into programmes and sub-programmes	X	✓	✓	✓	✓
<b>Clear Objectives for All Activities:</b>						
7	Specific	✓	X	✓	✓	✓
	Measurable	X	✓	X	✓	✓
	Achievable	X	✓	X	✓	✓
	Realistic	X	✓	✓	✓	✓
	Time-bound	X	✓	X	✓	X
	Costed	X	✓	✓	X	X
8	Reconciliation of plan with previous budget allocation and actual expenditure by programme	X	X	✓	X	✓
9	Revenue collection plan	X	X	X	X	X

10 Mechanisms to ensure co-ordination and co-operation with other departments	X	X	✓	✓	X
11 Details of transfer agreements with external bodies and mechanisms for monitoring compliance with agreements	X	X	X	X	X
12 Details of involvement and responsibilities in public-private partnerships	X	X	X	X	X
13 Plan to address Auditor-General's queries	X	X	X	X	X
14 Accurate, time-bound and costed Capital Expenditure and Maintenance Plan	X	X	X	X	X

From the table above it is clear that, although there has been an improvement in planning over the past two financial years, none of the Eastern Cape Department of Health's strategic plans for the period between 2000 and 2005 have met these regulatory requirements. For instance, none of these plans have contained a properly researched situational analysis which provides accurate and up-to-date information on the challenges faced by the department or the service delivery needs of the people it should serve. Nor is there any evidence of the department conducting a process of stakeholder consultation (whether internal consultation with its own employees or external consultation with health related non-governmental or community-based organisations) during the course of constructing its plans.

What is clear from an analysis of the department's strategic plans for this period is that it had difficulty in setting clear objectives for its programmes and activities. For the most part the activities conducted under these objectives were not allocated measurable performance indicators, nor were they bound to clear time-frames, nor were they adequately costed.

The annual budget projections for all government departments should be based on the detailed costing of individual activities listed in the operational plans for their various

programmes. Government's zero-based budgeting approach assumes that the operational plans for all programmes will be completed first, and that the costs of the individual activities listed in these plans (added up from zero), will be used as the basis for drawing up the department's strategic plans.

By contrast, the Eastern Cape Department of Health appears to routinely draw up its strategic plans first and then complete its operational plans. For instance, during the 2000/01 financial year one of the success indicators listed in the department's strategic plan is the completion of its operational plan for that year.<sup>241</sup> Again, in 2002/03, the department acknowledges in its strategic plan that its operational plan 'is still being developed'.<sup>242</sup>

Even when the figures contained in its strategic plans have been costed, none of these have included a breakdown of individual unit costs for listed activities. An appropriate way of publishing these unit costs would be by including the department's operational or business plans for its main programmes and sub-programmes as attachments to its strategic plans.

Very few of the department's plans contain detailed information on the maintenance and upgrading of existing health care facilities or for the construction of new facilities. While detailed information is included under the department's Health Facilities programme for the 2003/04 and 2004/05 years, this dates back to 1999 or 2000.<sup>243</sup> Some of this information concerns undertakings to provide infrastructure for clinics and facilities not connected to electricity supplies, and without access to piped water and telephones. The use of such outdated information clearly defeats the object of undertaking a situational analysis in the first place and of basing strategic decisions regarding infrastructure commitments on this situational analysis.

Moreover, the department's 2004/05 plan still appears to be relying on a provincial hospital audit profile undertaken in 1998/99 to describe the infrastructure status of its hospitals.<sup>244</sup> This information is over five years old, and fails to provide an account of the sums of money spent on hospital maintenance and infrastructure in the intervening period.

In an encouraging development, an annexure to the department's 2004/05 strategic plan sets out an account of budgeted infrastructure expenditure per health facility for the financial years between 2002 and 2005. However, this annexure does not provide a schedule or time-frames for these maintenance projects. Disturbingly, it concludes with the cautionary remark: 'NB: Schedule of implementation of the clinic building will depend on available funds.'<sup>245</sup> This indicates that the department does not have a properly costed operational plan which was arrived at on the basis of a zero-based budgeting approach for this programme.

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241 Eastern Cape Department of Health, Strategic Plan, 2000/01, p. 7.

242 Eastern Cape Department of Health, Strategic Plan, 2002/03, p. 30.

243 See Health Strategic Plan for 2003/04, pp. 42–43 and Health Strategic Plan for 2004/05, pp. 49–50.

244 Eastern Cape Department of Health, Strategic Plan, 2004/05, pp. 51–57.

245 Eastern Cape Department of Health, Strategic Plan, 2004/05, p. 149.

What is disturbing about the Eastern Cape Department of Health's strategic plans for the period between 2000 and 2005 is the absence of any reference to monitoring mechanisms for ensuring compliance with the terms of budget transfers to municipalities. These transfers are often for the use of non-governmental organisations (NGOs) and community-based organisations (CBOs). None of the above plans indicate which departmental structures or officials will have specific responsibility for monitoring the implementation of the activities for which transfers are made. Neither do these strategic plans contain any detailed indication of the terms to be met by the receiving local government authorities or NGOs/CBOs. A list of service-level agreements, or alternatively, a list of conditions including measurable objectives, unit costs, and time-frames to be met by the local authorities or other transfer recipients, should be attached to the department's strategic plans.

Only on this basis will provincial Legislature oversight bodies be able to form an effective judgement about the wisdom of endorsing these transfers, or whether they are likely to deliver value for money.

## Mismanagement of the Staff Payroll

Another feature of the failure of financial management within the department has been the continual inability of the department to manage its payroll effectively. The administration of the department's salary bill is carried out on a computer database called PERSAL (Personnel Administration System). Over the course of a number of years, the AG, in his annual audits of the Department of Health's financial statements, has identified serious systemic problems with its management of PERSAL and other matters relating to personnel.

The same problems pertaining to, among other things, organisational structure, leave records, overtime allowances and general maintenance of PERSAL, are identified by the AG every year, suggesting that the recommendations made with a view to addressing these problems are seldom heeded by the department.

In the AG's report on the financial statements for the year ending on 31 March 2000 (which included a multi-disciplinary audit of the salary bill), the AG pointed out that relevant control measures should be implemented to ensure the data on PERSAL was complete, accurate and valid.<sup>246</sup> He also stated that the actual salary expenditure should be disclosed in terms of the relevant Treasury Instructions and managed effectively, efficiently and economically.<sup>247</sup>

The primary objective of the audit of the salary bill was to evaluate measures to promote effective management in terms of planning, budgeting, authorisation, control and evaluation of procurement, and utilisation of human resources, as well as to provide the provincial

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<sup>246</sup> Report of the AG on the Financial Statements of Vote 3 – Health (Including A Multi-Disciplinary Audit of the Salary Bill) of the Eastern Cape Provincial Administration) for the Year Ended 31 March 2000, p. 11.

<sup>247</sup> Report of the AG on the Financial Statements of Vote 3 – Health (Including A Multi-Disciplinary Audit of the Salary Bill) of the Eastern Cape Provincial Administration) for the Year Ended 31 March 2000, p. 11.

legislature and management with information on shortcomings in management measures and the effects thereof.<sup>248</sup>

Among other things, the report identified the following problems:

- An evaluation of the returned payrolls of some regions revealed that the whereabouts of staff members who had been transferred or whose services had been terminated, as indicated by the pay points on the payrolls, were unknown. The department had taken no steps to identify these staff members, to stop salaries if necessary, or to upgrade PERSAL.
- Comparison of PERSAL data with data of deceased persons revealed that in many cases staff members who had died were still being paid or had continued to be paid for some time after death. In some cases, where the salaries of deceased staff members had been cancelled, they were reinstated after a few months.
- Some staff members continued to be paid after absconding.
- Many staff members over the age of 65 continued to be employed by the department. In fact, salary payments to 240 staff members who had reached retirement age as far back as 1978 (i.e. were 86 years or older), were still being paid by the department. This alone was costing the department R10.9 million a year.
- The department did not timeously effect demotions and recover salary overpayments from staff members whose promotions had been found to be irregular by the White Commission.<sup>249</sup>
- The Department often failed to recover money owed to it by staff members.
- There were several cases of staff members receiving salary payments from departments in different provincial administrations.
- No accurate or complete records of leave credits existed from the Umtata, Queenstown and Kokstad regions, and hundreds of leave forms dating back to 1996 had not been captured on PERSAL.
- Late payments of pension benefits and voluntary severance packages.

Although no multi-disciplinary audit of the salary bill was undertaken for purposes of the AG's report for the year ending March 2001, he made many of the same findings, including:

- The personnel expenditure of R2.385 billion contained in the financial statements of the department could not be fully substantiated, as the province had 'not performed a reconciliation between the PERSAL data and personnel expenditure as reflected in the FMS.'<sup>250</sup>
- Controls of personnel records were found to be inadequate in a number of instances, particularly with regard to leave records. It was also found that personnel files were not regularly updated as required by legislation, leave gratuity payments were not made

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248 *Ibid.*, p. 9.

249 The White Commission, under the chairmanship of Judge Colin White, was established in February 1995 specifically to investigate all the promotions of personnel alleged to have been irregular between 27 April 1993 and September 1994.

250 Report of the AG on the Financial Statements of the Department of Health (Vote 3) for the Year Ended 31 March 2001, contained in the Province of the Eastern Cape Annual Financial Statements of Department of Health for the Year Ending 31 March, 2001, p. 9.

timeously, employees over the age of 65 were still in the employ of the department (contrary to the requirements of the Public Service Act and Public Service Regulations), and overtime and working agreements were not formulated and adopted as required by the Public Service Regulations.<sup>251</sup>

The situation seemed no better in 2001/02. With regard to personnel issues, the AG says in his report on the financial statements of the department that there had been non-compliance with a host of laws and regulations with regard to management of personnel. These included the Public Service Regulation (2001), Basic Conditions of Employment Act (1997), Public Service Co-ordinating Bargaining Council, Public Service Act (1994), Public Service and Administration Resolution 7 of 2000 and Public Service and Administration Circulars.<sup>252</sup>

Again the AG said there were insufficient internal controls in place in the areas of:

- Timeous capturing of leave forms.
- Overtime.
- Performance contracts.
- Payment of salaries.
- Salary deductions.
- Payrolls.
- Personnel files.

He again identified problems of employees being paid salaries after termination of employment and, given the history of these issues, noted that: 'Recoverability of these amounts is doubtful.'<sup>253</sup>

In addition, he again noted that the actual personnel expenditure according to PERSAL was not reconciled on a monthly basis, with the financial information on the Financial Management System resulting in an unreconciled difference of R1.1593 million between the personnel expenditure recorded on the income statement and that recorded on PERSAL. The Department had not supplied sufficient supporting documentation for the difference.<sup>254</sup>

In his report on the department's financial statements for the year ending March 2003, the AG made a special note of the department's failure to address these long-existing deficiencies. He again identified almost identical internal control weaknesses noted in previous years, including those relating to the PERSAL system. He was prompted to say: 'Audit findings revealed that actions to address these deficiencies have either not been planned or adequately maintained ... I regard these weaknesses as a serious shortcoming as it hampers the effective management of the department. It is imperative that management ad-

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251 Report of the AG on the Financial Statements of the Department of Health (Vote 3) for the Year Ended 31 March 2001, contained in the Province of the Eastern Cape Annual Financial Statements of Department of Health for the Year Ending 31 March, 2001, pp. 12–13.

252 Report of the AG to the Provincial Legislature of the Eastern Cape Province on the Financial Statements of Vote 3 – Department of Health for the year ended 31 March 2002, contained in the Annual Report of the Eastern Cape Department of Health 2001/02, p. 62.

253 Ibid, p. 62.

254 Ibid, p. 64.

dresses the shortcomings reported to them.<sup>255</sup>

Of course, how much damage to staff morale and the retention of staff this mismanagement of the staff payroll precipitates cannot be quantified, but there can be little doubt that the late payment of salaries, the failure to pay notch increments, the failure to pay leave entitlements, the late payment of pensions and the inability to ensure that promotions are processed timeously contributes in a significant manner to the staffing crisis that the department continues to face.

The systemic financial mismanagement problems that this chapter has identified, from the failure to control spending to the inability to plan effectively, are only able to continue in a situation where effective and efficient oversight and accountability is lacking. It is the job of the AG and the Legislature oversight bodies to fulfil this monitoring and accountability role, but, as the next chapter demonstrates, such effective oversight is often lacking.

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<sup>255</sup> Report of the Auditor-General to the Provincial Legislature of the Eastern Cape Province on the Financial Statements of Vote 3 – Department of Health for the year ended 31 March, 2003, p. 170.

# 6. The Crisis of Oversight and Accountability

## Auditor-General's Oversight

In the six financial years between 1996 and 2002, the Eastern Cape Department of Health was issued a budget allocation of R20.6 billion. For these six consecutive financial years the department's financial statements were issued with audit disclaimers by the Auditor-General's (AG) office. Effectively, the AG withheld an audit opinion on the state of financial management in the Eastern Cape Department of Health in the period between 1996 and 2002. The AG generally issues an audit disclaimer when there is a lack of internal financial control, and because so many transactions have been missing from a department's financial statements that it is impossible to conduct a proper audit in the first place. In other words, the state of financial management in the department was so poor that the AG could not express an opinion on the reliability of its financial statements for the year in question.

Due to the department's lack of proper financial record-keeping during this period, it is extremely difficult to evaluate whether or not this expenditure translated into effective service delivery or value for money. Surprisingly, during the 2002/03 financial year, the department was issued an unqualified audit opinion ostensibly signalling the establishment of effective control measures and compliance in all material respects with relevant laws and regulations. A closer inspection of the AG's report for this year raises a number of questions about the veracity of this dramatic improvement in respect of the department's audit opinion.

### Department of Health Audit Opinions Between 1996 and 2003<sup>256</sup>

Financial Year	Budget (R000's)	Audit Opinion
1996/1997	3 066 196	Disclaimer
1997/1998	3 030 900	Disclaimer
1998/1999	3 048 180	Disclaimer
1999/00	3 496 357	Disclaimer
2000/01	3 789 628	Disclaimer
2001/02	4 223 812	Disclaimer

<sup>256</sup> What this table indicates is that the AG issued audit disclaimers to the Eastern Cape Department of Health for an amount of R 20.6 billion out of R 25.2 billion, or 81.9 per cent, of its budget between 1996–2003.



<b>Total Disclaimer</b>	<b>R 20 655 073</b>	
2002/03	4 560 926	Unqualified Opinion
Total Budget	R 25 215 999 <sup>257</sup>	

What follows is a detailed account of the financial management issues raised by the AG in the three financial years between 2000 and 2003 in respect of the Eastern Cape department of health's management of its budget.

## 2000/01

The AG issued the Department of Health a disclaimer after conducting a financial audit for the 2000/01 financial year. Some reasons for the disclaimer included the inability of the department to account for the management of its cash flows and the existence of a number of errors and deficiencies in its financial statements. These included the failure to disclose losses from criminal misconduct, the failure to provide details for all transfer payments to organisations outside of the department, the failure to provide supporting documentation for amounts of R39.9 million for unpaid creditors (i.e. persons to whom the department owed money), R141 million for capital expenditure and R3 billion in current expenditure.<sup>258</sup>

The AG found that personnel expenditure of R2.3 billion contained in the department's financial statements could not be properly substantiated because no reconciliation between the PERSAL data and personnel expenditure as reflected on the Financial Management System (FMS) had been undertaken.<sup>259</sup> This may have resulted in the continued payment of officials who were no longer employed by the department.

The AG also noted that the department had failed to comply with basic financial management regulations. It failed to provide all requested documents on payments for goods and services, revenue payments and transfers for auditing. For instance, the province's two pharmaceutical depots in Umtata and Port Elizabeth had not submitted their financial statements for auditing since 1994.

Controls over stores and equipment, fixed asset registers, suspense accounts, payments to service providers, leave records, motor vehicles and transfers to external organisations were found to be inadequate. The department had failed to spend its entire AIDS budget of R33 million as this amount had been transferred to the Fort Hare Foundation one

<sup>257</sup> Intergovernmental Fiscal Review 2001, National Department of Finance published October 2001, Eastern Cape Budget Statement 2002/03, Department of Finance Eastern Cape, published 7 March 2002.

<sup>258</sup> Report of the AG to the Provincial Legislature of the Eastern Cape Province on the Financial Statements of Vote 3 – Department of Health for the year ended 31 March 2001, Sect 2.2.

<sup>259</sup> Ibid.

day before the end of the financial year (30 March 2001). Although the money was subsequently returned (without interest), no explanation could be provided for this transfer.<sup>260</sup> The department, in conjunction with the Department of Welfare, also failed to recover R128.3 million in debt relating to its pre-March 1998 balances.<sup>261</sup>

The AG specifically criticised the department's failure to comply with legislative requirements for transferring monies to outside bodies. It failed to request or ensure that it received audited statements from the institutions (including NGOs/CBOS and municipalities) to which it had transferred monies.<sup>262</sup> Consequently, it was not able to determine whether these monies had been used as intended. The Public Finance Management Act requires that before transferring any funds to any entity outside government, the HOD should obtain a written assurance from that entity, confirming that it has an effective financial management and internal control system. If it cannot provide such written assurance, then the department should set out the remedial measures that this entity should take to implement a proper financial management system as a condition for the transfer of funds.<sup>263</sup>

The AG also highlighted the department's non-compliance with Section 41 of the Public Finance Management Act, which requires an accounting officer of a department to submit to the AG such relevant information, returns, documents, explanations and motivations as may be required for audit purposes. Arguably, this demonstrates a degree of contempt for the AG's oversight role on the part of the Eastern Cape Department of Health.

These various acts of non-compliance with regulatory requirements were reported by the AG as constituting financial misconduct as defined in terms of Section 81 of the Public Finance Management Act. According to this Act, the accounting officer (generally the HOD) of a government department commits an act of financial misconduct if he/she, amongst other things, wilfully or negligently fails to comply with his/her responsibilities for the submission 'of all reports, returns, notices and other information to Parliament or the relevant provincial legislature and to the relevant executive authority or treasury'.<sup>264</sup>

In the terms of the Act, financial misconduct is deemed to constitute grounds for the suspension or dismissal of an 'accounting officer'.<sup>265</sup> Moreover, if it can be shown that an accounting officer 'wilfully or in a grossly negligent way' failed to comply with their reporting responsibilities, they can be charged with a criminal offence and, on conviction, are liable to a fine or 'to imprisonment for a period not exceeding five years'.<sup>266</sup>

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260 Ibid, Sect 3.5.

261 Report of the AG to the Provincial Legislature of the Eastern Cape Province on the Financial Statements of Vote 3 – Department of Health for the year ended 31 March 2001, Sect 2.2.

262 Ibid, Sect 2.2.

263 Public Finance Management Act, 1999, Sect 38.

264 Public Finance Management Act, Act 1 of 1999, Section 51(1)(f) read in conjunction with Section 83(1)(a).

265 Ibid, Sect 83(4).

266 Ibid, Sect 86(1).

## 2001/02

In 2001/02, the AG again issued the Eastern Cape Department of Health a 'disclaimer' audit opinion. The department was again criticised for failing to comply with the terms of the Public Finance Management Act and the Division of Revenue Act, 2001. The HOD, specifically, was criticised for failing to establish proper internal control measures in respect of the same issues that had been pointed out in the previous year's audit. These included a lack of sufficient controls over salary payments and deductions, leave and overtime, and the failure to sign proper performance contracts with staff. The AG also found that 'certain employees were paid salaries after their employment had been terminated'. The existence of a number of employees selected by the AG for auditing purposes could not be physically verified.<sup>267</sup>

In addition, it was found that the department had again failed to ensure proper controls over its assets, including government vehicles and equipment. It had also failed to comply with tender regulations in the awarding of tenders. It had also failed (yet again) to request or ensure that it received audited statements from the outside bodies and institutions to which it had transferred monies. Consequently, it was not able to determine whether these monies had been used as intended.<sup>268</sup>

As in the previous year, it was found that the department had failed to reconcile its personnel management system with the information on its financial management system (which may have resulted in over-payments to ex-staff). Moreover, the AG pointed out (for the fifth year in a row) that the department had failed to institute necessary controls at pharmaceutical depots in the province. The province's two drug-depots in Umtata and in Port Elizabeth had yet again failed to submit their financial statements for auditing.<sup>269</sup> Disturbingly, the department had failed to ensure the recovery of debts of R15.79 million and had no visible internal audit function.<sup>270</sup>

In total, the AG identified no less than seven breaches of the PFMA in terms of sections 38 and 40, all of which, in terms of Section 81 of the Act, constitute financial misconduct.

## 2002/03

Inexplicably, after auditing the Eastern Cape Department of Health's financial statements for the 2002/03 financial year, the AG issued the department with an unqualified Audit opinion. This audit opinion generally symbolises the successful establishment of financial control measures and compliance 'in all material respects with relevant laws and regulations' by a public entity. What is a matter of concern in respect of the awarding of this audit opinion is the fact that the AG's report for the year proceeds to list exactly the same internal control

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267 Eastern Cape Department of Health *Annual Report, 2001/2002*, Report of the AG to the Provincial Legislature of the Eastern Cape Province on the Financial Statements of Vote 3 – Department of Health for the year ended 31 March 2002, p. 62.

268 *Ibid.*, p. 63.

269 *Ibid.*, p. 64.

270 *Ibid.*, p. 63.

failures and breaches of the regulatory framework revealed in previous financial years. The difference is that for the previous six financial years these breaches were deemed to constitute grounds for the issuing of an audit disclaimer.

In fact, the AG's 2002/03 report specifically draws attention to the department's failure to implement corrective measures to deal with the internal control weaknesses identified in his previous two audits. These weaknesses included the failure by the Accounting Officer to disclose information relating to returns, documentation and proof of transfer payments to other institutions, which represents a breach of the Public Finance Management Act.<sup>271</sup>

The following instances of a lack of effective internal controls were cited in the report for the third year in a row (although in fact, many of these problems had been cited consistently for the past six financial years):

#### **Personnel**

- Personnel and leave records did not always contain essential documentation.
- Performance contracts had not been completed for all employees.
- Certain employees continued to be paid after their services had been terminated.<sup>272</sup>

#### **Expenditure**

- Supporting documentation was not always attached to payment batches.
- Not all requested audit documentation was submitted.<sup>273</sup>

#### **Transfer payments**

- The department did not request and ensure audited financial statements from the various institutions that it transferred monies to (consequently, it could not verify whether these monies were being used as intended).<sup>274</sup>

#### **Asset management**

- The department's fixed asset register is not properly maintained.
- Policies governing the acquisition control and disposal of state assets, repairs and maintenance were not implemented.
- The department failed to maintain a loss control register.<sup>275</sup>

#### **Tender process**

- The department failed to maintain a register for tender submissions and tender awards (consequently, there was 'uncertainty' as to whether tenders were invited for the supply of goods and services).
- Tenders were approved after their validity expired.
- The department failed to maintain a complaints register (consequently, complaints about tenders were not always responded to in the correct manner).

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271 Department of Health, Eastern Cape Annual Report, 2002/2003 Report of the AG to the Provincial Legislature of the Eastern Cape Province on the Financial Statements of Vote 3 – Department of Health for the year ended 31 March 2003, pp. 167–174.

272 Ibid.

273 Ibid.

274 Ibid.

275 Ibid.

- Minutes of tender committee meetings and copies of tender adverts were not submitted for audit purposes.<sup>276</sup>

### **Suspense accounts**

- The department failed to establish proper controls over its suspense accounts (amounts were allowed to accumulate which remained uncleared).<sup>277</sup>

### **Budget process**

- Zero-based budgeting principals were not adhered to in the preparation of the 2003/04 budget.
- The department failed to adhere to roll-over procedures for incomplete projects.
- The objectives listed on the department's budget did not always correspond with those on its strategic plan.<sup>278</sup>

### **Internal audit**

- No internal audit report was produced for the year.<sup>279</sup>

In addition, the AG highlighted a number of issues specific to the 2002/03 financial year. These included the fact that the department only budgeted R7.142 million for government vehicles, yet it spent a total amount of R35 million for this purpose, suggesting that this item was not correctly budgeted for. It also listed an amount of R90.4 million as unclaimed leave on its personnel and salary system which could not be substantiated. Payments of R2.7 m and R481 381 had been made to suppliers without the necessary Tender Board approval, these amounts constituted irregular expenditure.<sup>280</sup>

In total the AG reported two breaches of Section 38 and two breaches of Section 40 of the PFMA. All four of these breaches, in terms of Section 81, constitute financial misconduct.

During the period covering the three financial years discussed above, we see, to a large extent, a recurrence of the same financial management issues highlighted by the provincial AG. While there have been noteworthy improvements in the department's financial accountability over the past seven audited financial years (i.e. between 1996 and 2003), the department's jump from a disclaimer in 2001/02 to a clean financial report (unqualified audit opinion) in 2002/03 is of some concern.

This raises the question as to whether there has been a relaxing of the standards for the auditing of government departments in the province. One other possible explanation would be that these issues are no longer considered as significant or material in the way that they affect the fair presentation of the department's financial statements. It is difficult to see how such an explanation could be sustained, however, short of a relaxation or amendment of the stringent regulatory requirements contained in the Public Finance Management Act. In the

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<sup>276</sup> Ibid.

<sup>277</sup> Ibid.

<sup>278</sup> Ibid.

<sup>279</sup> Ibid, p. 173.

<sup>280</sup> Ibid, pp. 169–173.

interests of retraining public confidence the AG's office should clarify these issues within subsequent reports.

Despite the intrigue surrounding its 2002/03 audit opinion, it is clear that during the period between 2000 and 2003 the quality of the audits conducted into the state of financial management and controls within the Eastern Cape Department of Health have been of a high standard and have been exercised with rigour. In this time it has pointed to many structural and organisational problems within the department, which have then been tabled in the Eastern Cape Legislature for the consideration of the MPLs making up its Health Standing Committee and its Standing Committee on Public Accounts. In the following sections we turn to address the degree to which these committees have responded to these reports, and what steps they have taken in order to hold the department accountable for its performance.

## Accountability to Legislature Oversight Committees

The two key provincial Legislature committees responsible for holding the Eastern Cape Department of Health accountable for its performance are the Standing Committee on Health and the Standing Committee on Public Accounts (SCOPA).

### **Both committees have the following constitutional powers:**

- To summon any person (including the MEC and HOD) to appear before it to give evidence or to produce documents.
- To require any person or provincial institution to report to it.
- To compel any person (including the MEC or HOD) to comply with a summons to appear before it.<sup>281</sup>

The Eastern Cape Standing Committee on Health has a proud record of having made use of these powers. It made history in September 1999 when it summonsed Stamper, the HOD of the provincial Department of Health, to appear before it.

Stamper was summonsed after sending an apology half an hour before he was due to give evidence before a SCOPA hearing in September 1999. He was reportedly threatened with a two-month jail term or a R4 000 fine if he ignored the summons, which included orders to produce reports by accounting consultants, the main ledger for 1998/99, reconciled expense accounts and the appropriation accounts and related statements for 1997/98 and 1998/99. It also reportedly included an instruction to produce the department's training plan, and a list of courses/ workshops presented to date and the number of officials who had attended them.<sup>282</sup>

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281 Constitution of the Republic of South Africa, Act 108, 1996, Sect 115.

282 See <http://www.psam.org.za> for full details of this case.

The Standing Committee had rejected an earlier report from the department, saying it had not answered questions adequately. Dr Stamper admitted that the department had not followed proper auditing procedures and that staff shortages in the department's finance directorate included the non-existence of deputy directors for financial planning and control and of assistant directors for bookkeeping, revenue collection, transport, provisioning or administration. Despite Stamper's contemptuous conduct, no action was taken by MEC Goqwana.<sup>283</sup>

In the interim, the Legislature appeared to have lost the political will to hold Stamper personally responsible for his failure to appear before the public accounts committee. The AG's report on the Eastern Cape Legislature for the 1999/00 financial year indicates that Legislature failed to implement the decision taken by the Standing Committee on Health to recover costs of R14 500 from Stamper for the Standing Committee meeting which had to be cancelled due to his absence.

It is not clear how strongly the Health Standing Committee responded to the AG's scathing financial audit report for 2000/01. As we have seen, this report identified numerous instances of non-compliance with the provisions of the Public Finance Management Act which constituted 'financial misconduct' on the part of the department's accounting officer (at that time Mr Thobekile Mjekevu). No reference to calls by the committee for charges of misconduct to be instituted against the accounting officer could be located.

The Eastern Cape Department of Health's annual report lists 17 separate resolutions/recommendations adopted by the Legislature during the course of 2000/01 (without providing any response to these or indicating whether they have been successfully implemented).

These include a range of specific and general recommendations, a number of which have clear time-frames attached. One resolution reads: 'The department should finalised (sic) the issue of shared services of audit committees with the Premier's Office and the progress report be presented to the Standing Committee not later than 21 May 2001.'<sup>284</sup> It is worth noting that, according to the AG, this issue had still not met with a satisfactory resolution by end of the 2002/03 financial year.

In another specific recommendation the department is instructed to 'report to the Standing Committee within two weeks of May 2001 on how the R31.9 million will be spent immediately after that amount has been sent back to the department and specify whether the Treasury Instructions have been followed noting the additional amount allocated for 2001/02'.<sup>285</sup> This resolution (presumably) related to the department's unspent HIV/AIDS budget which was inexplicably transferred to Fort Hare University.

On the other hand, a number of recommendations are made which are both vague and unrealistic. For instance: 'Critical posts and their management support should be put in

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283 Ibid.

284 Eastern Cape Department of Health *Annual Report*, for the year ending 31 March 2001, p. 6.

285 Ibid.

place within two months', and 'The department of Health has to improve conditions of service and as well as (sic) filling of critical posts in the nursing fraternity in order to prevent the brain drain (sic)'.<sup>286</sup>

The department's nutrition programme was also instructed to 'put monitoring mechanisms in place as a matter of urgency'. Then again, it was instructed to put 'alternative measures for the management of the Primary School Nutrition programme' in place 'as a matter of urgency to eliminate the problems experienced'.<sup>287</sup> In September 2002 the Standing Committee indicated that it remained unconvinced that the department could run the nutrition programme effectively.<sup>288</sup> In March 2003 the committee called on the department to ensure that the scheme was effective, but failed to offer any guidance on how this would be achieved.<sup>289</sup>

During the course of 2003 the committee continued to pass important resolutions in a bid to improve the performance of the department's programmes. It again requested that the department furnish it with proper statistics on the progress of the primary school nutrition programme. In respect of the continued underspending of HIV/AIDS funds, the committee instructed the department to take steps to ensure that the transfer of funds to district municipalities was processed on the basis of service-level agreements. In addition, the department should ensure that NGOs and municipalities have the capacity to manage funds allocated for HIV/AIDS. It also recommended that there should be an audit of spending to make sure that the HIV/AIDS funds are used effectively and timeously to avoid under-expenditure.<sup>290</sup>

In response to ongoing problems being experienced in the department's Emergency Medical Services (EMS)<sup>291</sup> the committee recommended that the department 'develop a proper patient transport system'. It suggested that the department complete the purchase and conversion of EMS vehicles during the 2003/04 financial year to avoid backlogs and delays.<sup>292</sup> It also pointed to the need for the department to devise a clear maintenance plan for its facilities and equipment and provide a summary of its revenue collection plans.<sup>293</sup> Neither of these recommendations was implemented in the department's 2004/05 strategic plan.

For its part, by the end of 2003 the Standing Committee on Public Accounts (SCOPA) appeared to be losing patience with the department's HOD and MEC on account of its ongoing lack of financial controls and the continued non-implementation of Legislature resolutions. In November 2003 SCOPA complained that despite the two opportunities given to the department to respond to questions raised by the committee in respect of the AG's report for 2002/03, the Accounting Officer (presumably, Mr Michael Fraser, as Stamper died

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286 Ibid.

287 Ibid.

288 School food plan in doubt, *Eastern Province Herald*, 18 Sept. 2002.

289 Resolutions/recommendations by the standing committee on Health 2003/04 budget, 21 May 2003.

290 Eastern Cape Standing Committee on Health, Meeting, 21 January 2003.

291 See chapter 8.

292 Eastern Cape Standing Committee on Health, Meeting, 21 May 2003.

293 Ibid. Also see committee minutes for 21 January 2003, 26 May 2003, 22 August 2003 and 2 December 2003.



suddenly in December 2002) failed to respond satisfactorily. As a result, the committee came to the conclusion that the Accounting Officer was either unable or not willing to account for the issues relating to the department.<sup>294</sup>

Consequently, the committee warned that in future it would not hesitate to invoke the relevant provisions of the Public Finance Management Act, and recommend that the Accounting Officer responsible be charged with financial misconduct. It further drew the attention of the MEC for Health, Goqwana, to the committee's oversight powers set out in terms of the Constitution. It also pointed to Goqwana's financial responsibilities in terms of (Section 63 of) the Public Finance Management Act, which include ensuring 'ownership control' over the department, checking its monthly financial statements, and taking the necessary steps to ensure compliance with the Act.<sup>295</sup>

This approach appeared to be at odds with the AG's audit opinion indicating that the state of internal financial controls in the department and its compliance with legislative requirements were of the highest standards. Despite this more assertive stance, however, on balance there appears to be a near total breakdown in the implementation of Legislature oversight committee resolutions by the Eastern Cape Department of Health. In 2002 the AG reported that none of SCOPA's previous recommendations had been implemented by the department (or for that matter, any other provincial department).<sup>296</sup> A report of the Interim Management Team dispatched in early 2003 by the national cabinet to address service delivery failures in the Eastern Cape, notes that there were very few cases, if any, where those who had transgressed the Public Finance Management framework were disciplined.<sup>297</sup>

This raises concerns about the extent to which Legislature oversight bodies have been able to perform their constitutional function of promoting transparency, accountability and responsiveness in the Eastern Cape.

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294 Eastern Cape Standing Committee on Public Accounts, 20 November 2003.

295 *Ibid.*

296 Interim Management Team Report, June 2003, p. 17.

297 *Ibid.*

# 7. The Department's Reaction to the Crisis

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## The Ghosts of Apartheid and Racism

As was acknowledged at the beginning of this report, the amalgamation of three bureaucracies into one has created enormous logistical and organisational difficulties for the new administration in the Eastern Cape. These historical structural challenges have been invoked time and again by the Department of Health to excuse the continued problems it has experienced. But the question that needs to be asked is whether, after ten years of democracy, this recourse to the province's apartheid past is sufficient to explain the continuing crisis within the department. Is the argument that the problems that plague the department are simply the result of the legacy of apartheid sustainable?

- In November 2000 Goqwana stated that white employees in the provincial Department of Health were sabotaging the efforts of the government because they felt threatened by the new dispensation. Goqwana accused white employees of removing functioning equipment from hospitals and then selling it privately. He stated that such acts were part of an effort to undermine the effectiveness of the department.<sup>298</sup> He also accused some staff within the public health system of lacking the will to 'mentally transform themselves' towards the new dispensation.<sup>299</sup>
- In May 2001 Department of Health spokesperson Mageda stated that most of the problems in the health sector had been inherited from the apartheid regime. He stated that it was not the ANC that had created two nations in one country, noting that despite the best efforts of the department a 'few of the previously advantaged' had not mentally transformed. He argued that those who were leaving the service were the same ones who would not treat black patients. He indicated that, 'when a new managerial ethos is being implanted so as to improve service delivery, some managers resist and pronounce doomsday for health'.<sup>300</sup>
- In July 2001, responding to nurses' comments that cockroaches were crawling over babies in the maternity ward at Umtata General Hospital, Goqwana stated that his department could not be held accountable for such events as all the problems encountered by his department were inherited from the apartheid regime.<sup>301</sup>
- In September 2001, responding to a Health Standing Committee report criticising conditions in district and provincial hospitals in the province, Goqwana claimed that their neglect

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298 "'Threatened" white employees sabotaging Bisho – Goqwana,' *Eastern Province Herald*, 18 Nov. 2000. See Goqwana's comments in 'Goqwana hits back at doctors claims,' *Eastern Province Herald*, 2 April 2001.

299 'Hospital crisis turns political,' *Eastern Province Herald*, 14 Nov. 2001.

300 'Health Dept problems blamed on apartheid,' *Daily Dispatch*, 4 May 2001.

301 'Cockroaches crawl all over sick babies,' *City Press*.

was a 'legacy of the past'. He stated that his department was trying to rectify the situation but that 'staff with a negative mental attitude' tended to 'undermine instructions'.<sup>302</sup>

- In March 2002 Mageda accounted for continued problems at Umtata General Hospital by stating that ex-homeland managers were to blame as they 'were only thinking about their stomachs and not about services'.<sup>303</sup> This was followed by a period of concentrated attacks by Department HOD Stamper, who focused on blaming white staff members who were leaving the department for many of its problems. In April Stamper condemned Dr Pierre du Toit, who had retired earlier from Provincial Hospital. Du Toit previously chief gynaecologist at Provincial Hospital, stated that he had left the hospital as he could no longer work there because standards had fallen.<sup>304</sup> Stamper responded by accusing Du Toit of racism, stating that he was not prepared to engage in argument with Du Toit's 'dying political struggle'. Stamper continued by arguing that most white doctors were leaving the country because 'they are not prepared to deliver services to black people in former white institutions'.<sup>305</sup>
- In May 2002 Stamper blamed current problems in the Eastern Cape Department of Health on former Health MEC Dr Trudy Thomas and on sabotage. Echoing Goqwana's words from two years before, Stamper claimed that 'dead wood' within the department was destroying all the hard work going on in the department by sabotaging its efforts.<sup>306</sup> Stamper argued that the South African National Tuberculosis Association (SANTA) hospital subsidy crisis (see chapter 8 of this report) was the direct result of 'a deliberate ploy to discredit the government'. He stated that 'there are people with crooked minds using the plight of the poor and suffering for political motives'.<sup>307</sup>
- In July 2002 Goqwana again blamed apartheid for the problems that the department was experiencing. He argued that everyone was now using facilities that were only meant to serve a small proportion of the population. He stated: 'It is the same cake (budget) which in the past used to be shared among a few people but now is being distributed among many. The cake has not grown in size but the people sharing it have increased.'<sup>308</sup>
- In January 2003, responding to service delivery failures due to chronic staff shortages at Dora Nginza Hospital in Port Elizabeth, Goqwana stated that the hospital was experiencing difficulties because other hospitals and clinics turned away black patients and sent them to Dora Nginza. Goqwana stated that Provincial Hospital, in particular, 'practised racism' by referring black patients to other hospitals.<sup>309</sup>

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302 'Health MEC admits to bad state of public hospitals,' *Eastern Province Herald*, 29 Sept. 2001.

303 'Unhealthy state of affairs,' *Daily Dispatch*, 20 March 2002.

304 'Doctor quite because of Bisho,' *Eastern Province Herald*, 17 April 2002. He claimed that he could not even teach young doctors because of a lack of basic equipment and that private patients did not come to the hospital any more because it was 'falling apart.'

305 'Bisho attacks du Toit for "indecorous" words,' *Eastern Province Herald*, 19 April 2002.

306 'Health 40 per cent understaffed, 43 per cent under-spent,' *Daily Dispatch*, 9 May 2002.

307 'Payment delays a plot claims Stamper,' *Daily Dispatch*, 15 May 2002.

308 'Health's problems blamed on apartheid,' *Daily Dispatch*, 5 July 2002.

309 'Matron has to mop floors,' *Eastern Province Herald*, 24 Jan. 2003.

- In October 2003 Goqwana stated that the lack of doctors in the province was due to the fact that South African universities had a 'negative attitude' towards African students. He stated that universities in South Africa were not committed to transformation and this resulted in a lack of African students attending medical schools.<sup>310</sup>
- In January 2004, responding to the fact that the department was still short of 426 doctors, Spokesperson Kupelo blamed this on apartheid by stating that, 'everyone should acknowledge that the present government is still suffering from the ills of the past'.<sup>311</sup>
- In February 2004 Kupelo stated that the poor performance of the EMS within the province was due to individuals within the service trying to 'sabotage' its efforts.<sup>312</sup>

The persistent references made by senior departmental figures to the continuing burden of apartheid clearly represents an attempt by higher-ranking figures to deflect attention away from their, and the department's, own failures. The long-term debilitating effect that apartheid continues to have on the ability of the department to effectively provide care is acknowledged. However, senior figures within the provincial Department of Health have resorted to blaming apartheid for the department's continued difficulties in a manner which suggests that they feel that the apartheid legacy can be used to excuse them from having to accept any responsibility for the current health crisis.

In a similar fashion, the accusations of racism that have been raised against white whistle-blowers within hospitals have to be questioned.<sup>313</sup> It cannot be said with any certainty that all white staff members working within the department are committed to transformation, but equally it cannot be stated that each time a senior white doctor bemoans the state of the public health service that this is inevitably motivated by a racist agenda. This is clearly unacceptable, and demonstrates a lack of accountability within the department itself. As Eastern Cape Department of Health spokesperson Mageda admitted in 2001, 'we are in government and we have to give answers'.<sup>314</sup>

## Privatisation

Another consistent feature of the response of senior figures within the provincial Department of Health has been their willingness to publicise their readiness to outsource management to private companies. Since Premier Stofile's outburst in May 2002, when he declared that the civil service was unable to master the art of managing hospitals, there have been repeated instances where private management of health care provision has been mooted.

310 'Health dept overspends on Cuban programme.' *Daily Dispatch*, 28 October 2003.

311 'Shortfall of 426 doctors in Eastern Cape,' *Daily Dispatch*, 21 Jan. 2004. Kupelo blamed the shortage of doctors on the lack of infrastructure in the province. As we have seen, the department has consistently under-spent its infrastructure improvement budgets.

312 'Call for probe into 6-hour wait for ambulance,' *Daily Dispatch*, 17 Feb. 2004.

313 See, 'Hospital crisis turns political,' *Eastern Province Herald*, 14 Nov. 2000. 'Healthcare is "improving"', *Daily Dispatch*, 2 April 2001, 'Bisho attacks du Toit for "indecorous" words', *Eastern Province Herald*, 19 April 2002.

314 'Health Dept problems blamed on apartheid,' *Daily Dispatch*, 4 May 2001.

Following Stofile's comments in May, acting MEC Mamase stated in June 2002 that the management of the Port Elizabeth, Umtata and East London Hospital complexes would be offered to private companies. He stated that private companies would deal with issues relating to budgeting, system controls and monitoring. He stated it was not an issue of cost but of good management, and that the civil service would have to learn from the experience.<sup>315</sup> In June 2003 it was confirmed that 11 private health care groups had tendered for a R180 million contract to manage the three contracts.<sup>316</sup> It was also announced in June 2003 that a public-private partnership (PPP) had been signed between the department and a private consortium to manage Humansdorp district hospital. This followed a February announcement by the department that PPPs would be sought for Settler's Hospital in Grahamstown and Port Alfred Hospital.<sup>317</sup>

Other plans for privatisation have also been mooted. A number of comments have been made indicating that the province's pharmaceutical depots should pass into private hands.<sup>318</sup> This plan was confirmed in April 2004 when drug shortages hit some clinics in East London, resulting in Goqwana stating that a PPP had been 'embarked upon' to ensure that such problems did not arise again.<sup>319</sup> Other plans have suggested that private management companies should take control of the emergency services provided in the province.<sup>320</sup> In addition, the IMT Report itself suggested in its 'turn-around strategy' that health services would improve if the management of operational maintenance in institutions was outsourced. It also recommended that the department push ahead with all existing PPPs.<sup>321</sup>

While this is not the forum for discussions concerning the suitability of engaging the private sector in public health provision, it is of concern that the department sees private-sector intervention as a panacea for the ills of its ongoing state of weak financial management. Comments by Stofile and Mamase seem to suggest that the only solution to weak management and failed service delivery within the public sector is to bring in private capacity. Yet, realistically, the only long-term solution to many of the problems being experienced by the provincial Department of Health is to improve capacity from within. It is questionable as to whether the constitutional principle of providing basic health care to all, irrespective of their socio-economic status, can be reconciled with the profit motive.

Prior to having to resort to the outsourcing of public services to the private sector, government departments should be obliged to present a detailed report on the nature of the service delivery problems they have encountered and what steps they have taken to address these problems. This report should be presented to the relevant legislature oversight committees tasked with overseeing the department's performance, and an opportunity

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315 'Stofile remains silent on hospital budget issue,' *Daily Dispatch*, 5 June 2002.

316 'No decision on R180m hospital contract,' *Daily Dispatch*, 30 June 2003.

317 'Plans for PPPs at Settler's, Port Alfred hospitals,' *Daily Dispatch*, 26 Feb. 2003.

318 'Medicine procurement mooted,' *City Press*, 14 Sept. 2003

319 'No drug supply problems – Goqwana,' *Saturday Dispatch*, 17 April 2004.

320 'EC emergency services at standstill,' *Daily Dispatch*, 26 Aug. 2003.

321 Report of the Interim Management Team, Eastern Cape, April 2003, p. 81. See Sect 7.3.

should be afforded to civil society organisations, and especially trade unions, to provide inputs to these special hearings.

This question aside, if private companies are to become involved in public-sector health care provision, they must, as a definite prerequisite, visibly improve service delivery within a contracted period of time. This means that any service-level agreements entered into by the department must detail explicitly the firm expectations of the department, as well as detailing the commitments made to it by the private company concerned. These agreements should be widely publicised so that the public is aware of the standards of care they are entitled to. There should also be a mechanism whereby the department can effectively and efficiently disengage itself from any contract if the service being offered by the private company fails to meet the requirements stipulated in the service-level agreement. Concomitant with this, there should be in place an effective oversight and assessment capacity within the department to ensure that commitments from private companies are met as agreed. Failure to ensure effective oversight will result in the department depriving itself of the ability to ensure that private companies are meeting their contractual obligations under any such service-level agreements.

In addition, any private companies engaged by the department should be mandated to provide capacity training and skills development as part of any service-level agreement. This would enable public sector employees within the Department of Health to gain some of the skills that they lack, which in turn would enable the department to improve its ability to provide an effective public health service.

## **National Reaction to the Crisis: The Interim Management Team**

Late in 2002, in the wake of consistent reports of failed service delivery and corruption within the Eastern Cape, President Thabo Mbeki deployed an IMT to deal with the chronic administrative and management problems being experienced in the province. The IMT was specifically mandated to tackle challenges of service delivery, back office support and poor discipline and lack of ethics.

The overall goal of the IMT was to ensure that any service delivery backlogs were addressed and to establish sound management and leadership in the four target departments of Health, Education, Roads and Public Works, and Social Development. The Report of the Eastern Cape IMT in April 2003 revealed a high number of vacancies, poor financial management and the excessive use of consultants and managers who failed to maintain discipline and appropriate performance levels.<sup>322</sup> More specifically, the report listed a number of primary concerns:

- It noted that behavioural patterns among many staff were inimical to good service provision and that change in these patterns of behaviour was not forthcoming.

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<sup>322</sup> Report of the Interim Management Team, Eastern Cape, April 2003. See [www.pmg.org.za/docs/2003/appendices/030814imt.ppt](http://www.pmg.org.za/docs/2003/appendices/030814imt.ppt).

- The report indicated that managers continuously failed to take responsibility and did not display any strong sense of accountability. It stated that managers blamed problems within their departments on historical challenges, systems, inadequacies and interference from unions and other stakeholders.
- It observed that although departments continually received audit disclaimers, no action was taken against any manager and consequently problems were not rectified.
- The report lamented the fact that unions exerted undue influence over managers and their decisions.
- The IMT observed that despite high levels of corruption existing within departments, limited follow-through action took place against those responsible.
- The report noted that a culture of ill-discipline and the acceptance of the poor work ethic existed within departments which manifested behaviour such as absenteeism and unjustified demands for overtime pay.
- It was stated that managers relied significantly on outsiders to complete work that was normal business, often donors and consultants were seen as the only solutions.
- Lastly, the report notes that the power of the Tender Board far outweighed its level of accountability.<sup>323</sup>

In its analysis of the problems being experienced in the Department of Health, the IMT noted historical backlogs in the department that derived from an underdeveloped health service and the geographically inequitable distribution of resources within the province. In particular it stated that 'leadership quality and quantity' was 'limited', which resulted in poor management performance. This was especially so given that there was no management performance mechanism in place. Perhaps most alarming was its call for 'proper strategic direction' at both district and institution level, stating that there was no 'proper effective planning'.<sup>324</sup> In total the report identified four specific problems within the department:

## Budget and financial management

The report noted that that pay-point management was non-existent and that there was a need to align budgeting to planning, and to ensure that districts and institutions themselves were part of this planning process. It also noted with concern that financial discipline had moved from a position of over-spending to under-spending and cited the lack of capacity in the financial section of the Department of Health, especially at levels below management. In addition, it noted that the centralisation of the provincial administration's entire internal audit function was not helpful as it did not create a culture which reinforced internal controls. Lastly, it remarked that financial management was hampered by poor document management.<sup>325</sup>

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<sup>323</sup> Report of the Interim Management Team, Eastern Cape, April 2003, pp. 23–24.

<sup>324</sup> Report of the Interim Management Team, Eastern Cape, April 2003, p. 30.

<sup>325</sup> *Ibid.*, p. 31.

## Human resources

Unsurprisingly the report noted the serious staff shortages that continued to plague the department. It indicated that there was a 34 per cent vacancy rate overall, but this vacancy rate rose to over 50 per cent in skilled positions. To try and combat the effects of this shortage the IMT report indicated that the organisational structure within the department needed to be realigned to address management challenges and to try and deal with the issue of management shortages in particular. It stated that the department needed to deal decisively with vacant management posts in districts and institutions and generally reduce the workload imposed on a few employees due to shortages and absenteeism. It argued that in doing this, the department would ensure that its employees carried out the professional functions they were supposed to deal with. Lastly, it argued that the basic infrastructure for personnel needed to be improved so that rural incentives were implemented more effectively and employees got what was due to them, in terms of salaries, benefits, etc. timeously.<sup>326</sup>

## Ethics and anti-corruption

The report noted high levels of absenteeism which, it argued, was partly caused by excessive training but was mainly due to inadequate supervision of staff. It revealed that there was insufficient supervision at clinics in particular which led to illegal practises and clinics not even opening when they were supposed to. It highlighted weak internal controls stating that this created a 'high corruption vulnerability'. It argued that staff and managers ignored reporting requirements and deadlines and managers themselves were said to be reluctant to act against ill-disciplined staff. Finally, it remarked that there was no performance culture in the department as performance management was not applied.

## Hospital service delivery

In terms of hospital service delivery it noted that hospital transformation had been too slow and needed to be accelerated. It suggested that institutions needed to be amalgamated, a uniform fee structure introduced and hospitals had to make use of proper information systems. It highlighted the fact that conditional grants were not spent by hospitals contributing to the problems they experienced. Mention was made of the continual shortage of basic equipment at hospitals and essentials such as linen. Reflecting on what it had reported on under 'ethics and corruption', it stated that there was a high incidence of medicine theft because controls and systems to prevent such theft were inadequate. The report also commented on the general state of hospitals themselves, noting that they were generally poorly

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<sup>326</sup> Ibid, p. 31.



maintained and lacked even basic cleanliness in many instances. It concluded this section by remarking that most of the problems at institutional level were due to poor support services, lack of accountability at management level and the failure to delegate properly at this level.<sup>327</sup>

## **IMT Turn-Around Strategy**

The IMT report proposed that guidelines be developed for new staff establishments in all four target departments, a funding pool be created from abolished vacancies, capacity be redirected to areas of strategic need, cost burden be reduced without retrenchments, management overload be reduced and the productivity of lower skilled employees be improved. As part of its mandate, the IMT also developed turn-around strategies for all four departments in an attempt to ensure improved service delivery. In the Department of Health this strategy focused on three key areas.

### **Improving the management of health services**

It called on the Head Office to be restructured to enable it to effectively drive policies forward and monitor and evaluate its efforts. It recommended that hospitals be reorganised into clusters, with three complexes, two regional hospitals and district hospitals arranged into 20 clusters. At each level corporate support had to be provided, and efforts made to ensure that staff vacancies were filled, especially at senior and middle management level. It also suggested adjusting the reporting structure so that Head Office could keep a closer eye on developments within hospitals and clinics.

It argued in a number of recommendations, which simply re-state the concerns reported by the Auditor-General (AG) over the past seven financial years, that the management of institutions had to be strengthened by filling at least all middle-management posts. Crucially it recommended that a performance-driven culture be implemented with managers being held accountable for agreed performance targets. In line with previous recommendations, it called for internal controls to be tightened, in particular suggesting that asset registers should be created to ensure the effectiveness management of state resources. Lastly, it called for pay point management to be implemented.

### **Improving front-line services in the eastern region**

The report suggested that basic primary care could be improved in a number of ways. It maintained that Community Health Centres should be open 24 hours a day, should have a constant drug supply, and should have improved clinician mentoring. It called for TB,

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<sup>327</sup> Report of the Interim Management Team, Eastern Cape, April 2003, p. 32.

HIV/AIDS and general mother-and-child health to be improved at 11 out of 25 local service areas. In addition, and somewhat vaguely, it noted that supervision and use of transport should be 'increased'. Lastly, it reported that all facilities should have laboratory services.

## Improving back office support to health institutions

In an attempt to meet the mandate of the department the IMT suggested that back office support at institutional level should be improved. One way in which it suggested this could happen would be for the management of operational maintenance to be outsourced to private companies. It also recommended that all 'non-core' services within institutions, such as cleaning and catering, be privatised. More generally, it also argued that for health services to improve all existing PPPs should be continued. The quick-fix philosophy underpinning these recommendations appears to contradict the long-term intention of filling all vacant posts and of developing a performance culture within the department referred to earlier.

In September 2003, the IMT reported that implementation of the departmental turn-around plans had begun and there had been progress in certain areas, though budgeting issues had hindered this progress.<sup>328</sup> The final report of the IMT was due to be presented to the public in early March 2004, but this was delayed due to ongoing discussions within the provincial government,<sup>329</sup> and no doubt the proximity of the report's release date to South Africa's 2004 general election. It was, however, due to be presented to President Thabo Mbeki by the end of March.

While the intervention of the IMT within the department is welcomed, doubts remain as to its long-term efficacy. Many of the problems it highlighted had already been noted year on year within AG's reports. It is not clear how departmental managers and legislative oversight bodies will be able ensure that these recommendations are implemented given the department's consistent failure to adhere to the recommendations of the AG. This is especially so given that the IMT has left the province before its turn-around strategy has been implemented. The IMT's turn-around strategy relies heavily on the ability of the department to fill vacant staffing positions, especially those in middle and senior management.

Moreover, despite identifying the need to build the local capacity of provincial managers, the IMT's own year-long intervention in the Eastern Cape failed to contribute to this capacity-building exercise, given its sole reliance on the services of private sector consultants. Numerous private sector auditing firms were appointed by the IMT to undertake its investigations and to draw up its reports. This is something which should raise questions in the minds of Legislature oversight committees in respect of the numerous outsourcing proposals listed in the IMT's turn-around strategy. But, perhaps the IMT's greatest weakness is the lack of detail on how the Department of Health is expected to overcome this long-term staffing and management problem to ensure that it implements this turn-around strategy. No

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328 Summary of the report of the Eastern Cape Interim Management Team, 10 September 2003.

329 'Delay in report on Bisho departments,' *Eastern Province Herald*, 18 March 2004.

policy directives have been formulated or presented to the department on how to recruit adequate staff to fulfil its mandate.

Much of what is written in the turn-around strategy represents a set of long-term goals, more so than an effective practical strategy to improve service delivery. This criticism can be levelled at the IMT's desire to see the department adequately staffed, which is a goal, rather than a strategy. Another example of this confusion between goals and strategy is the turn-around strategy's desire to see community health centres opening 24 hours a day. How is this possible given the chronic staff shortages and associated problems within the department?

The strategy also calls for seven districts and 20 hospital clusters to 'improve supervision' but there is no mechanism indicated in the report for achieving this goal. Lastly, as we have seen above, the report relies heavily on privatisation as a quick-fix for long-term systemic problems, and yet the efficacy of the privatisation of public health care provision is as yet unproven.

# 8. Case Studies

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## The SANTA Hospital Crisis

In May 2002 a crisis emerged over the payment of subsidies to hospitals and eight provincial SANTA hospitals came within days of closing due to the late payment of their government subsidies. These hospitals have operated in the province for more than 50 years and provide comprehensive care for TB sufferers. They are partially funded by state subsidy, with the remaining funding coming from voluntary contributions – in money, work and supplies.

On 11 May 2002 SANTA provincial chairperson Neil Cooper stated that they would have to close 'within a week' if their R3 million-a-month subsidy (which was two months late) was not paid. He contended that patients would have to be released as the hospitals could not function without their subsidy.<sup>330</sup>

Conditions at the Grahamstown Temba SANTA Hospital were said to be 'grim', with the institution running out of food and being unable to pay its 42 staff members. The hospital's telephone connections were cut off as they could not pay their Telkom bill and food suppliers were having to loan food to them.<sup>331</sup>

The acting MEC for Health Max Mamase said at the time that the hospitals had been paid two weeks before and denied that they were short of funds, accusing the SANTA management of 'playing games'.<sup>332</sup> This was denied by Cooper who claimed that they had been phoning the department every day to try and secure the release of the funds.<sup>333</sup> It appears that Mamase was referring to the subsidy crisis that had hit district and provincial hospitals in April 2002 and had been addressed throughout May. Thus, Mamase appears to have confused this subsidy crisis with the one facing the SANTA hospitals. On 13 May 2002 the head of the Department of Health, Stamper, contradicted Mamase by stating that SANTA hospitals had not been paid their subsidies. He blamed the BAS computer system that the department had blamed only a month before for the late payment of general hospital subsidies.<sup>334</sup>

On 15 May 2002 the outstanding subsidy payments were made to the department. Cooper immediately demanded a public apology from Mamase for his accusation that SANTA management had been 'playing games'. The department responded through Stamper by

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330 'All 8 Santa hospitals in E Cape to close in new cash crisis,' *Eastern Province Herald*, 11 May 2002.

331 'TB hospitals in desperate wait for subsidies,' *Daily Dispatch*, 10 May 2002.

332 'Santa subsidy crisis – Mamase denies claims,' *East Cape Weekend*, 11 May 2002.

333 'Shock for E Cape patients,' *Eastern Province Herald*, 13 May 2002.

334 'Bisho to take action in TB hospital crisis,' *Daily Dispatch*, 14 May 2002.

blaming the whole incident on a plot within the department. Stamper stated that the late subsidy payments were 'a deliberate ploy to discredit the government'. He contended that employees with 'crooked minds' were using the suffering of others for political motives.<sup>335</sup> Stamper claimed a top-level investigation was underway. The PSAM has been unable to recover any details of any investigation into the matter.

Only a day later, the suggestion of a conspiracy was contradicted by Department of Health spokesperson Mageda who stated that subsidies had been paid late because 'we (the department) had problems loading the payments onto the new system, because personal still need to be trained'. Somewhat bizarrely, after the multi-million rand subsidy payments had been made, he then stated that SANTA's claims that they were owed millions were 'grossly inaccurate'.<sup>336</sup>

Later in the month a forensic audit into the accounts of SANTA disclosed financial mismanagement at its head office. However, this mismanagement had nothing to do with the problems that were faced in the Eastern Cape, as they only related to 25 staff members at the SANTA head office who had no responsibility for the distribution of government subsidies.<sup>337</sup> Thus, the problems faced by the Eastern Cape SANTA hospitals were entirely due to the inability of the department to manage its subsidy payment system. Just as it had been unable to pay provincial and district hospitals on time, so it had been unable to ensure that SANTA hospitals received their payments timeously.

## The School Feeding Scheme Crisis

The failure of the Eastern Cape Department of Health to effectively and efficiently manage projects under its care is clearly demonstrated by the persistent service delivery failures associated with the Primary School Nutrition Programme (PSNP). The school feeding scheme, as it is more popularly known, has been beset over the last few years with problems which have led to its suspension on more than one occasion. Established by former President Nelson Mandela in 1994, its intention was to provide needy children with one nutritious meal a day to enhance their wellbeing and learning capacity. A brief examination of the failure of the programme over the last few years provides an excellent insight into the inability of the department to ensure the effective monitoring, and thus the delivery, of projects under its supervision.<sup>338</sup>

In March 2001, MEC Goqwana announced that due to persistent problems with the feeding scheme an 'alternative delivery strategy' was to be hammered out. This was

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335 'At last Bisho pays TB hospital subsidies,' *Daily Dispatch*, 15 May 2002.

336 'Santa hospitals receive first payments from department,' *Business Day*, 16 May 2002.

337 In late June it also emerged that 'The Haven' psychiatric aftercare unit in Port Elizabeth had also been surviving without subsidy payments for three months. The institution was forced to arrange for a bank overdraft after Bisho blamed the late payment on the money being 'lost' within the computer system. See, 'Haven takes Bisho to court over payment,' *Eastern Province Herald*, 25 June 2002.

338 As a note of explanation it should be remembered that the government ran the scheme via NGOs and women's groups. The government contracted NGOs to oversee the project. These NGOs in turn then contracted manufacturers and suppliers to provide the food for the scheme. In addition, women's groups, sometimes related to the NGOs themselves, were then tasked with the responsibility to ensure the actual provision of food within the schools. Thus, the women's groups were involved in the cutting of bread and the distribution of food within schools.

followed in May 2001 by an admission by the department that the scheme was 'badly managed' and that changes had to be made to ensure effective delivery of the scheme. Goqwana stated that departmental employees within the section responsible for the programme were 'causing havoc', and were prejudicing the delivery of service. He acknowledged that the scheme suffered from inconsistent food deliveries, delays in the payment of supplies and inadequate monitoring. He contended that there would be a 'major shake-up' of the programme, which would involve re-deploying staff members, establishing a simpler financial system, organising district co-ordination of the scheme and instituting a monitoring capacity within the project.<sup>339</sup>

The provincial Department of Health annual report for 2000/01, published in August 2001, stated that both a monitoring mechanism and a new management programme should be put in place within the scheme as a 'matter of urgency'. It indicated that only then would the department be able to eliminate the problems the scheme continued to face.<sup>340</sup> In December 2001 a Health Standing Committee report noted that 'most schools have not received nutrition for the past three terms' and subsequently made a number of recommendations. The Committee observed that the scheme contract with a financial management company called TFK had expired,<sup>341</sup> and recommended that the department fast-track the appointment of a company immediately to manage nutrition to ensure that children were fed by the end of October 2002. In addition, it recommended that a monitoring team be established to ensure the smooth running of the programme.<sup>342</sup>

Late in December 2002 it was reported that an NGO working within the programme could no longer pay its suppliers (to whom it owed R250 000) because it had not been paid by the government. Department spokesperson Mageda acknowledged that previously the department had contracted out the financial management of the scheme to TFK, but that this contract had expired. He said that the department had subsequently undertaken to pay all outstanding debts.<sup>343</sup> A month later, apparently without warning, the government suspended the feeding scheme. This was only hours after bakeries throughout the province had suspended their deliveries to schools because they claimed they were not being paid by the contracted NGOs. Un-named representatives from bakeries claimed that they had not been paid in over a month and could no longer afford to make deliveries to schools.<sup>344</sup>

In early February 2002 Mageda stated that the problem would be resolved 'very soon', announcing that new plans were being drawn up to regulate the scheme and stating that the programme had been halted 'because some NGOs are sucking money from the

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339 See, 'Department makes changes to nutrition programme,' *Daily Dispatch*, 14 May 2001, 'School feeding scheme in major shake-up,' *Daily Dispatch*, 21 May 2001.

340 Eastern Cape Department of Health *Annual Report*, 2000/01, p. 6.

341 Apparently at the end of September.

342 Report of the Standing Committee on Health, 3 Dec. 2001.

343 'Feeding scheme in debt crisis', *Daily Dispatch*, 22 Dec. 2001.

344 'Govt halts feeding scheme deliveries,' *Daily Dispatch*, 29 Jan. 2002, 'Shock for pupils as feeding scheme halted,' *Eastern Province Herald*, 29 Jan. 2002.

department'.<sup>345</sup> This was contradicted a couple of days later by acting HOD Dr Mamisa Chabula who indicated that the scheme had been suspended in error. She stated that 'incorrect' information had been distributed to district offices, and argued that the issue of the continuation of the programme would be resolved at a meeting of ministers and MECs in March.<sup>346</sup>

Over the next five months the scheme lurched from one crisis to another as all those involved blamed each other for the collapse of the programme. NGOs involved in the scheme blamed the government for its collapse, arguing that as Bisho had not paid them, they could not pay their suppliers. Un-named NGO representatives also accused corrupt government officials of taking kickbacks from corrupt suppliers who were paid for deliveries they did not make.<sup>347</sup> For their part, suppliers stated that they had ceased delivery of foodstuffs because the NGOs and the government were not paying them. Women's groups involved in the scheme blamed corrupt NGOs and the government for the non-payment of their salaries. One group in Port Elizabeth stated that it was owed over R63 000 and had not been paid since October 2001.<sup>348</sup>

As we have seen, the government blamed some NGOs for the cessation of the programme. But it became clear from April that the government did indeed owe NGOs, and consequently suppliers and women's groups, millions of rands. It emerged that some 12 contracted NGOs were owed in excess of R19 million by the government, while suppliers were said to be owed in the region of R12 million.<sup>349</sup> In mid-April 2002, Mageda admitted that there had been an 'unfortunate delay' in making payments, but that he hoped it would be resolved within a few days.<sup>350</sup>

Chairperson of the contracted NGOs Godfrey Silinga blamed the government for the scheme grinding to a halt, stating that they were facing bankruptcy. This contention was rejected by Mageda, who sharply criticised the NGOs: 'We have told them to feed school kids and payment will come as time goes. If there's no feeding taking place, it's them who do not want to feed the kids.' He said that NGOs were to be removed from the scheme 'because of their management style'.<sup>351</sup>

It subsequently emerged in the department's 2001/02 annual report that it had under-spent its conditional grant of R131.8 million for school nutrition by an amount of R36.2 million, or 27 per cent. The department blamed this under-expenditure on a lack of sound financial and general administrative systems and a lack of human resources, resulting in the

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345 'Call to re-install feeding scheme', *Daily Dispatch*, 5 Feb. 2002.

346 'School feeding to resume next week', *Daily Dispatch*, 7 Feb. 2002. The annual report for 2001/02 simply stated that the targeted number of days for scheme for 2001/02 had not been reached, Provincial Department of Health *Annual Report* 2001/02, p. 52.

347 'NGO hits out at school feeding scheme suppliers,' *Eastern Province Herald*, 14 Feb. 2002.

348 'Angry women demand payment,' *Eastern Province Herald*, 4 April 2002, 'Women supplying bread to school unpaid for months,' *Eastern Province Herald*, 11 April 2002.

349 'EC nutrition plan grinds to a halt', *Daily Dispatch*, 17 May 2002, 'Suppliers unpaid so pupils go hungry,' *Eastern Province Herald*, 18 May, 2002.

350 'School feeding suppliers demand Bisho payments,' *Eastern Province Herald*, 17 April 2002.

351 'Suppliers unpaid, so pupils go hungry,' *Eastern Province Herald*, 18 May 2002.

352 Eastern Cape Department of Health *Annual Report*, 2001/02, p. 75.

'underfeeding' of school children.<sup>352</sup>

The absurd position had thus been reached whereby the department, which had admitted that it had failed to pay its contracted NGOs (and contracted suppliers which it paid directly), was blaming the NGOs for the collapse of the feeding scheme.<sup>353</sup> Whereas in reality the scheme had collapsed because government, as the above spending figures indicate, had failed to transfer the necessary funds to the NGOs.<sup>354</sup> By the middle of May 2002, the NGOs were threatening legal action against the department to recover their money, and the NGOs themselves were facing legal action from suppliers who were demanding payment.<sup>355</sup>

On 18 May 2002 the director of district health services in the province indicated that payment would soon be made, but could not indicate when. Four days later Mageda indicated that the department was 'formalising and finalising' plans for the scheme to resume, which included making payments to all parties.<sup>356</sup> A day later, 23 May 2002, he announced that the department had set aside R20 million to meet its obligations and that it would be appearing in bank accounts within days. He also stated that, consequently, the feeding scheme was to resume within three weeks.<sup>357</sup> However, it took until 5 June 2002 before payments started to appear in some supplier and NGO bank accounts, the same day that Mageda promised that the feeding scheme would now resume in a further two week's time.<sup>358</sup> More than two weeks later, Stamper announced that the scheme was to be restarted on 22 July 2002 at the start of the new school term.<sup>359</sup>

Goqwana confirmed this in mid-July, indicating that the department had spent some R25 million resuscitating the programme, and arguing that most of those who were owed money had now been paid. He also said that the scheme was set for a major overhaul in October, but would not state how.<sup>360</sup>

The scheme did begin again in July 2002, and, despite a few initial teething problems, progressed smoothly throughout the school term. In August, Stamper defended the performance of the scheme arguing that the problems that the scheme had experienced were to be expected given its complexity.<sup>361</sup>

At a Health Standing Committee meeting in September, Goqwana announced that the scheme was to be outsourced to a private company, stating that private expertise would be

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353 One NGO head commented on the position the government was taking by saying that 'Our reputation as NGOs is at stake,' *Food scheme plea to Stofile*, *Daily Dispatch*, 22 May 2002.

354 The position that suppliers found themselves in is illustrated by the problems that one bakery owner from Mount Pleasant experienced. Vis Pillay, who supplied bread to 40 schools in the area, was owed over R200 000 by the NGO that had contracted him, Zwishare of Uitenhage. Mr Pillay had to close his bakery as the electricity department cut power to his premises for failure to pay his bill, and claimed that his bank was threatening to mortgage his home. Given these circumstances it appears obvious to see why he stopped supplying his local schools. See, 'Bakery owner faces ruin because of Bisho,' *Eastern Province Herald*, 4 June 2002 and 'Some bakeries still wait for money,' *Eastern Province Herald*, 6 June 2002.

355 See, 'Kids left hungry by bumbling Department of Health,' *Grocott's Mail*, 21 May 2002 and 'Food scheme plea to Stofile,' *Daily Dispatch*, 22 May 2002.

356 'Food Scheme plea to Stofile,' *Daily Dispatch*, 22 May 2002.

357 'Govt breathes life into feeding scheme,' *Daily Dispatch*, 24 May 2002.

358 'Bisho starts paying food suppliers,' *Daily Dispatch*, 6 June 2002.

359 'Hunger hits school attendance,' *Daily Dispatch*, 20 June 2002.

360 'School feeding to resume next week,' *Eastern Province Herald*, 17 July 2002.

361 'School feeding scheme is back on track, says Bisho,' *East Cape Weekend*, 3 Aug. 2002.



involved in the IT and finance aspects of the scheme. He stated, however, that any contracts would only be temporary, as once employees of the department could lead the programme, private companies would be withdrawn. He continued by noting that the department would continue to run the administrative side of the programme and would gradually withdraw NGOs from the scheme altogether. He stated that NGOs would, for the meantime, be contracted on a monthly basis. In addition, he indicated that the role of disempowered women's groups would be enlarged in the project, which would be totally overhauled by January 2003.<sup>362</sup>

At the same Committee hearing the department gave disturbingly contradictory responses when questioned about the state of the budget for the programme. Chief director Dr Thobile Mjekevu stated that the programme was to over-spend its budget by some R20 million by the end of the financial year, suggesting that they would have to ask the Treasury for more funds or reduce the amount of feeding days. However, director Allan Wild said that the scheme was due to under-spend its budget due to the lack of feeding earlier in the year and that an increase in feeding days was necessary to fully account for the budget.<sup>363</sup> Media reports suggest that the Standing Committee remained unconvinced that the department could sustain the programme.<sup>364</sup>

A month later Goqwana stated that he felt that the programme, as it stood, was 'in tatters' and claimed that the department was trying to reorganise it. He said that as of December all outstanding contracts with NGOs (which had been renewed on a monthly basis) would be cancelled, and that by the start of the new school year no NGOs would be involved in the scheme. He said that the department would soon be advertising new tenders via the provincial tender board. He said he wanted the department to contract suppliers directly and to further empower the women's groups involved in the scheme.<sup>365</sup>

In December 2002 Goqwana further announced that the scheme was to come under joint control of the Health and Education departments from January 2003. Education MEC Nomsa Jajula indicated that she had already appointed a director to ensure that the programme ran smoothly when the new term started.<sup>366</sup>

Despite a few minor problems the scheme appeared to function well at the start of the new school year in 2003.<sup>367</sup> Within a month of its restart, it was then announced that the Department of Education was to take over all responsibility for the programme from 2004. Premier Stofile confirmed this position during his state of the province address, when he stated that he was pleased that the scheme was being transferred to the Department of Education. Stofile stated that the programme had been riddled with problems since its inception, observing that there had been problems associated with both mismanagement and

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362 Health to outsource school feeding,' *Daily Dispatch*, 18 Sept. 2002.

363 Ibid.

364 'School food plan in doubt,' *Eastern Province Herald*, 18 Sept. 2002.

365 'School feeding contract cancelled,' *Eastern Province Herald*, 18 Oct. 2002.

366 'Two depts to run feeding,' *Daily Dispatch*, 10 Dec. 2002.

367 'Smooth start for feeding scheme,' *Daily Dispatch*, 31 Jan. 2003.

corruption. He indicated that a task-team had already visited four regions in the province to evaluate the scheme and that its findings were 'shocking'. He said that these problems had prompted the government to look at alternative ways to manage the project, which would involve its decentralisation. He did not state, however, how such decentralisation was to work.<sup>368</sup>

The new deputy director of the nutrition programme, Nomawonga Kama, then announced at the end of February 2002 that the government wanted to employ more women in the scheme. She stated, however, that NGOs would continue within the scheme until the new programme had started, despite her contention that the NGOs had previously not paid the women's groups on time. Kama said she hoped that NGOs would be removed from the scheme by April. This contradicted Goqwana's previous assurance that all NGOs would be removed from the scheme by the start of the new year. Kama also stated that school governing bodies would be appointing programme co-ordinators within their schools to ensure that the scheme worked well.<sup>369</sup>

Again, with the release of the department's 2002/03 annual report, it became apparent that it had under-spent its R168 million conditional grant allocation for child nutrition by an amount of R30.9 million, or 18 per cent, during this year.<sup>370</sup>

The department's annual report admitted that the scheme had not started on schedule in April as intended, and had only begun in July 2002. It stated that 'institutional problems' were to blame, but gave no indication of what exactly it meant by 'institutional problems'. In a somewhat bizarre twist it was also asserted in the annual report that the scheme was both a failure (because it had not started on time), and a success because it functioned well from July 2002.<sup>371</sup>

In March 2003 the Standing Committee on Health, which was reviewing the 2003/04 budget, called on the department to ensure that 'an effective school feeding programme should be implemented by 15 May 2003' and that it should focus on specifically impoverished communities.<sup>372</sup>

In May 2003 the department announced that the feeding scheme was working well with only a few minor problems being caused by the phasing out of the NGOs.<sup>373</sup> Two months later, however, reports began to surface that suppliers were again refusing to make deliveries to schools for the new term on the grounds that had not been paid by the department. Two of the main suppliers in the province stated that they were owed millions of rands as they had not been paid for the previous term and simply could not make deliveries until they had been paid.<sup>374</sup>

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368 'Education dept to run school nutrition,' *Daily Dispatch*, 22 Feb. 2003.

369 'Jobless women to run school feeding scheme,' *Daily Dispatch*, 28 Feb. 2003.

370 *Ibid.*, p. 206.

371 Eastern Cape Department of Health *Annual Report* 2001/02, pp. 50–52. The department admitted that it had deviated from its plan for the scheme by 30 per cent.

372 'Resolutions/recommendations by the Standing Committee on Health 2003/04 budget,' 21 May 2003.

373 In fact the scheme was halted in April because of unspecified problems. 'Only a few hitches in school feeding scheme,' *Daily Dispatch*, 1 May 2003.

374 'Food scheme crisis will leave learners hungry,' *Daily Dispatch*, 18 July 2003.

Department spokesperson Sizwe Kupelo acknowledged the failure to pay the suppliers but blamed this on problems associated with the installation of a new computer system. He stated that suppliers were aware of the problem and he acknowledged that their payments would be made soon. He remarked that the programme would start on time and said that 'we wish to pore scorn on misleading reports that children might face hunger when schools reopen'. This contention was rejected by one unnamed supplier who said they had been promised payment in June 2003 and it had not arrived, and that the government was so far behind with its planning that it was still contacting suppliers for quotes for the new term starting the very next day.<sup>375</sup>

Needless to say, the school term started on 22 July 2003, but the feeding scheme did not resume. Kupelo promised that it would start on the 23 July.<sup>376</sup> School feeding actually only resumed on 28 July after a compromise was reached between suppliers and the department. Kupelo was quoted as saying that some 43 out of 110 suppliers had been paid and had agreed to start delivering to schools in the province. Kupelo stated that part of the problem was that 37 suppliers had not provided proper proof of delivery with their claims, which, he claimed 'was not the department's fault'.<sup>377</sup>

In August 2003 Kupelo announced that the programme would become a public-private partnership (PPP) and that tenders were to be submitted before 15 September.<sup>378</sup> This was despite Goqwana's assertion a year before that only certain aspects of the programme would be privatised, and that a new system would be in place by January 2003. Kupelo's assertion was also contradicted by the deputy director of the nutrition scheme, Nomawonga Kama, who argued in November 2003 that nothing had been confirmed regarding private intervention and that news to the contrary was merely speculation.<sup>379</sup>

Less than a month later the scheme was again thrown into turmoil as suppliers began to withdraw from the scheme, yet again on the grounds that Bisho had not paid them. One bakery in Port Elizabeth, Ilinge Lomana Bakery, announced on 4 September 2003 that it could no longer make deliveries to the ten schools it was contracted to supply, leaving some 5 000 children without food. Bakery manager Gladys Mdongwe stated that they had not been paid since April 2003 and were owed over R100 000 by the Department of Health. She said that she had made 'numerous calls' to the department, which responded with promises to pay but failed to do so.<sup>380</sup> After a general appeal for help, the bakery was supplied with some 10 bags of flour by the Eastern Cape Relief Association, and was further supplied with R50 000 worth of supplies by South African Breweries.<sup>381</sup>

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375 'Feeding Squabbles...', *Daily Dispatch*, 22 July 2003.

376 'Many start term hungry as food supplies fail to arrive,' *Daily Dispatch*, 23 July 2003.

377 'School feeding back on track,' *Daily Dispatch*, 29 July 2003.

378 'School feeding to go public,' *Daily Dispatch*, 20 Aug. 2003. He also announced that the Department of Education was to assume control of the project from April 2004.

379 PSAM Interview with Mrs Kama, 11 Nov. 2003, Bisho.

380 'Crisis leaves 5000 school children hungry,' *Daily Dispatch*, 4 Sept. 2003.

381 'Pupils left hungry over Bisho's bakery debt,' *Eastern Province Herald*, 9 Sept. 2003 and 'SAB rescues bankrupt school-feeding scheme,' *Eastern Province Herald*, 12 Sept. 2003.

It then emerged in the middle of September 2003 that other bakeries were facing the same problems. The main supplier to Uitenhage's schools, Ikhayaletu Bakery in Kwanobuhle, stated that it would soon have to halt deliveries as it was owed over R400 000 by Bisho. Many other suppliers throughout the province were said to be in the same position. MEC for Health Goqwana responded by saying that he had established a task-team to attend to the payments.<sup>382</sup> It also emerged at the end of September 2003 that the Department of Health had seriously under-spent its conditional grant for the nutrition programme from the beginning of the financial year in April 2003. Data from the provincial treasury showed that by the end of the September the national treasury has transferred R100 million to the province, but it had only spent some R61 million of that money.<sup>383</sup>

In January 2004 the spokesperson for the department, Kupelo, stated that the feeding scheme would start on time with no 'hiccups'.<sup>384</sup> It was then confirmed that in April the scheme would be transferred to the department of Education, which it duly was. However, it quickly emerged that problems were again being encountered by the scheme. In early May 2004 it was confirmed that thousands of school children had been without food for over two weeks after the start of the second term. A Department of Education spokesperson noted that there had been some 'hiccups' within the tendering process.<sup>385</sup> In late May 2004 it was reported that the Department of Health still owed a number of suppliers 'millions of rands' in outstanding payments, despite the fact that responsibility for the programme had shifted to the Department of Education. The Department of Education then confirmed that it was using the same supplies that the Department of Health had been using, which seems to indicate that the late payment by the Department of Health of these same supplies may well have caused the stalling of the programme in early May.<sup>386</sup> It can only be hoped that the department of Education will make a better job of running the school feeding programme.

Perhaps the most revealing insight that can be gained from this brief examination of the school feeding scheme is the way in which it demonstrates the failure of the Department of Health to develop a coherent strategic plan for the scheme. Throughout the last few years long-term planning for the project has been persistently contradictory. Initially, it was to be partly privatised by January 2003, then in August 2003 it was announced that it would become a PPP. Mirroring this, it was announced that the project would be jointly run by the Health and Education departments only for it to be subsequently declared that it would, from April 2004, be exclusively under the care of the Department of Education. These inconsistencies are illustrated by the contradictory information supplied by departmental officials on a regular basis. With no long-term strategy in place, it is no wonder that officials contradict each other.

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382 'School food scheme crisis after Bisho bugles bills,' *Eastern Province Herald*, 19 Sept. 2003.

383 Conditional grants transferred from national departments and actual expenditure by province 1 April 2003 to 30 September 2003.

384 'Govt ready to feed hungry children,' *Daily Dispatch*, 20 April 2004.

385 'Feeding scheme 'glitches' leave children hungry,' *Daily Dispatch*, 7 May 2004.

386 'School feeding suppliers wait for millions,' *Daily Dispatch*, 26 May 2004.

The intention of Bisho to create a PPP for the project also continues the trend towards privatising aspects of service delivery that have persistently failed due to the department's own weak financial management. In this regard the general concerns over privatisation mentioned above should be noted when considering the creation of a PPP for the department's integrated nutrition programme.

Another area of weakness in the programme has been the lack of oversight and monitoring by the department of the scheme itself. We have seen that in May 2001 Goqwana admitted that there was insufficient monitoring of the project, and that in December 2001 the Standing Committee on Health recommended the appointment of a monitoring team; but there is little evidence to suggest that the situation regarding monitoring actually improved. In fact, in November 2003 the deputy director of the scheme called for the development of monitoring capacity within the programme.<sup>387</sup>

There can be no doubt that this lack of oversight has led to many of the problems that the scheme has experienced, especially those regarding late payments and the issue of corruption. The lack of oversight of the programme has indeed led to many allegations of corruption, with both government officials and NGOs themselves being accused of corrupt behaviour.

In July 2003, it was confirmed that the IMT in the province had passed documents to the police and had appointed a team of forensic auditors to review certain tenders dating back up to four years. Allegations arose that some suppliers had been over-paid by as much as half-a-million rand. On 22 September 2003 the PSAM requested information from the department about these claims, in particular the details of any investigations taking place and any corrective action initiated. To date the PSAM has not received a response from the department.

Another problem highlighted by the failure of the scheme is the unwillingness of departmental officials to acknowledge the department's complicity in the failings of its service-delivery programmes. Time and again, departmental officials blamed NGOs for the non-payment of suppliers and women's groups, when in reality many NGOs could not pay them because they themselves had not been paid.

On a more immediate level, an investigation should be launched into the quality of the food on offer within the programme. A 'meal' consisting of bread and jam and a single water-based drink cannot in reality be described as nutritious. Indeed, Kama admitted as much to the PSAM when she argued that the scheme was never supposed to provide a proper meal; rather it was to provide a snack which would assist children to concentrate in their classes. In fact, the national Department of Health expressed concern in both its annual reports for 2001 and 2002 over the inconsistent quality of food offered within the scheme.<sup>388</sup> An inquiry should be conducted into the possibility of providing a more substantial and nutritious 'meal', which more honestly lives up to the scheme's title as a 'Primary School Nutrition Programme'.

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387 PSAM interview with Kama, 11 Nov. 2003, Bisho. The annual reports for the national Department of Health for 2001/02 and 2002/03 also highlighted the need to adopt a monitoring system for the school feeding scheme. See National Department of Health *Annual Report, 2001/02*, p. 27 and 2002/03, p. 11.

388 See, National Department of Health *Annual Report 2001/02*, p. 27 and 2002/03, p. 11.

It should also be noted that school principals reported a 30 per cent reduction in school attendance during the extended period of the scheme's cessation. Thus, it is not only the physical cost to children that should be considered when the scheme fails to function as a result of mismanagement.<sup>389</sup> Their long-term educational prospects suffer too.

## The Emergency Medical Services Fiasco

Since 2000 the media has been full of accounts of ambulances failing to arrive at the scenes of accidents, or taking hours, sometimes even days, to arrive.<sup>390</sup> Responding to these criticisms in May 2000, MEC for Health Bevan Goqwana argued that the ambulance division 'was one of the departments which has been totally mismanaged. There is no proper co-ordination. Funds earmarked for specific projects are diverted for other uses. There is no accountability'. Somewhat predictably, he argued that the only solution to these problems was to go into partnership with a private company, centralise ambulance control at Bisho and separate emergency vehicles from patient-transfer vehicles.<sup>391</sup>

Moves towards the centralisation of control were set to begin in late 2001 when it was announced in July 2001 that all ambulance services were to be taken under provincial control from 1 October 2001.<sup>392</sup> For the remainder of 2001 problems continued with the service. In December 2001, a report of the Standing Committee on Health noted that the department had failed to appoint a fleet manager despite its previous recommendation to do so. It noted that, instead, the department had given the responsibility for the fleet to the deputy director of Auxiliary Services.<sup>393</sup> The Auditor-General's (AG) report for 2001/02 noted that there continued to be problems with management of the EMS fleet. He pointed to problems regarding internal controls – relating to monthly transaction reports and the monitoring of government vehicles themselves.<sup>394</sup>

In May 2002 the acting deputy director of the EMS, Ansley du Plessis, remarked that some 80 per cent of all ambulances in the province were 'useless'. He claimed that it was impossible 'to render an efficient service with so few resources ... lives that could be saved are lost'. Department of Health spokesperson Mahlubandile Mageda acknowledged the problems and stated that new ambulances would be purchased, but argued that difficulties also arose from the fact that the EMS had 300 vacant posts.<sup>395</sup> In June 2002 Goqwana again re-affirmed his commitment to create a PPP within the ambulance service in the hope of

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389 'Hunger hits schools attendance', *Daily Dispatch*, 20 June 2003.

390 See for example, 'Outrage over slow reaction by Bisho ambulance service,' *Eastern Province Herald*, 10 Sept. 2001, 'Ambulance service slammed,' *Daily Dispatch*, 14 Nov. 2001, 'Emergency services grind to a halt,' *Weekend Post*, 27 July 2002, 'Only one ambulance to serve district,' *Grocott's Mail*, 22 Aug. 2003, 'No report on 40 hour wait for ambulance,' *Daily Dispatch*, 10 Sept. 2003, 'Call for probe into 6-hour wait for ambulance,' *Daily Dispatch*, 17 Feb. 2004, 'Granny dies waiting for ambulance,' *Daily Dispatch*, 10 March 2004, etc.

391 'MEC seeks partnership with ambulance firms,' *Eastern Province Herald*, 20 May 2000.

392 'Hospital cutbacks have begun,' *Eastern Province Herald*, 2 July 2001.

393 Eastern Cape Legislature, Report of the Standing Committee on Health, 3 Dec. 2001, p. 1 097.

394 Eastern Cape Department of Health *Annual Report*, 2001/02, AG Report, p. 63.

395 'Most EC ambulances "useless,"' *Daily Dispatch*, 21 May 2002.

improving services.<sup>396</sup> In October, however, conflict arose over the plans for the amalgamation of the ambulance service when Goqwana argued that that the EMS central call centre should be in Bisho. He stated that it should be there and not in East London as Bisho was a disadvantaged area.<sup>397</sup> Two months later it emerged that municipal control of ambulance services were to be surrendered to the province by April 2003.<sup>398</sup>

In May 2003 it was announced that services would be transferred to the province by the end of July 2003.<sup>399</sup> In June a task-team (made up of EMS director Shank Maharaj, union representatives, members of the South African Local Government Association [SALGA] and a senior Bisho personnel officer) was then appointed to investigate the transfer, which, according to an unnamed member, had encountered 'serious issues' that needed to be addressed. For his part, Goqwana decreed that transfer had to take place before 1 August. Media reports, however, show that the transfer only took place on 9 October 2003, some two years later than initially projected. SALGA announced that all municipalities had now transferred their emergency services to the Department of Health in Bisho on the conclusion of a settlement which saw all workers retaining their existing conditions of service.<sup>400</sup>

Significantly, the department's 2002/03 annual report indicates that its R138.5 million emergency medical rescue services budget, which is responsible for ambulance and planned patient transport, was under-spent by an amount of R16.1 million, or 11.6 per cent.<sup>401</sup>

Throughout this period of negotiation, MEC for Health Goqwana highlighted the steps that were being taken to improve the service. In July 2002 he announced the arrival of 34 new ambulances for rural areas, and in May the following year he stated that 80 converted new ambulances (converted bakkies) were about to enter the service, with a further 112 to follow, in addition to another 102 mobile clinics.<sup>402</sup> Goqwana claimed that his department was 'directing the budget where it is needed. We are fulfilling the government's vision'.<sup>403</sup> Despite these reassurances, the provision of emergency services in the province continued to be beset with problems.<sup>404</sup>

At the end of August 2003 stories began to appear in the media that up to 60 per cent of the entire ambulance fleet of the province was out of commission because of mechanical problems. This appears to have been related to a contract signed between the provincial

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396 'Hospital triumphs over adversity,' *Daily Dispatch*, 26 June 2002.

397 'Ambulance amalgamation sparks new row,' *Eastern Province Herald*, 5 Oct. 2002.

398 'Province to run ambulances,' *Daily Dispatch*, 9 Dec. 2002.

399 See 'Province to run medical services,' *Daily Dispatch*, 4 April 2003 and, 'Bisho to take over ambulance services,' *Eastern Province Herald*, 13 May 2003.

400 'Rescue services now under Health,' *Daily Dispatch*, 2 Oct. 2003.

401 Eastern Cape Department of Health *Annual Report*, 2002/03, p.55.

402 'Health Dept augmented by 34 new ambulances,' *Eastern Province Herald*, 12 July 2002, 'Ambulance, clinic shortage in region "should ease soon,"' *Eastern Province Herald*, 25 May 2003. It was stated in September 2003 that in the last financial year 298 new vehicles has been purchased for the EMS at a cost of R32 million, and an additional 400 posts created. See, '40 new ambulances for EC,' *Daily Dispatch*, 5 Sept. 2003.

403 'Ambulance, clinic shortage in region "should ease soon,"' *Eastern Province Herald*, 25 May 2003.

404 See for example, 'Emergency services grind to a halt,' *Weekend Post*, 27 July 2002, 'Only one ambulance to serve district,' *Grocott's Mail*, 22 Aug. 2003, 'No report on 40 hour wait for ambulance,' *Daily Dispatch*, 10 Sept. 2003. South African Municipal Workers' Union representative Mpumelo Qhina, indicated in March 2003 that the metro service in East London was hampered by poor vehicle maintenance and shortage of staff, 'Vacancies, bad vehicles anger ambulance staff,' *Eastern Province Herald*, 11 March 2003.

Department of Transport and a private fleet servicing company, FleetAfrica. This contract, signed on 4 August 2003, saw these vehicles in the province transferred to FleetAfrica, which was tasked with the management of these government vehicles, including their repair, servicing and replacement.<sup>405</sup> Within weeks of the contract being signed it appears that the maintenance of the EMS fleet ground to a halt when Goqwana accused the company of having too few garages to handle the fleet.<sup>406</sup> Department of Health spokesperson Kupelo admitted that FleetAfrica had changed the vehicle servicing system, which had adversely affected service delivery.<sup>407</sup> An unnamed senior source in Bisho was quoted as saying: 'Ask FleetAfrica and the Transport department if they are willing to take responsibility for people dying because we cannot react to calls.'<sup>408</sup>

The situation had become so dire that on 27 August 2003 Goqwana stated that he was having a meeting with FleetAfrica representatives where he intended withdrawing all emergency vehicles from the contract. However, at this meeting it was agreed that FleetAfrica would engage a 'network of merchants and dealers' which would be used to repair ambulances and other emergency vehicles.<sup>409</sup> In response to the crisis, the department also indicated that it was looking into a PPP, but only if it would serve the province better. Presumably such a partnership would see a private company contracted to help with the day-to-day running of the ambulance service outside of the fleet deal already signed with FleetAfrica. Mageda said that such a service would have to prove its worth to the province, stating that he did not 'want to see people who want to make profits at the expense of the poor'.<sup>410</sup>

Despite the assurances from FleetAfrica, EMS director Shank Maharaj told a Standing Committee on Health on 11 November that the contract with FleetAfrica was 'not in the best interests of the department and taxpayer'. He noted that he had had 'very negative' feedback reports from Limpopo, Free State and the Western Cape provinces regarding FleetAfrica's ability to service emergency vehicles. In addition, he noted that FleetAfrica had recently purchased 40 panel vans for emergency services use 'without consultation', and despite the fact that the emergency services did not want to use such vans again. He added that the vans were also to be converted at a garage in East London which had 'always given sub-standard work'. He concluded that the deal with FleetAfrica was 'costly' and that it was a 'critical issue that needs to be looked at' so the department could be allowed to 'get out of the contract'. Acting head of the provincial Department of Health Michael Fraser noted that the deal had been signed by the Department of Transport on behalf of the province, and that it would be 'difficult' for the department to withdraw itself from the contract. He did say, however, that the issue was being negotiated at a political level.<sup>411</sup>

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405 This was part of a five-year deal worth R731 million signed between FleetAfrica and the provincial Department of Transport.

406 'Emergency service fiasco: war of words,' *Daily Dispatch*, 27 Aug. 2003.

407 'Over 60 per cent of E Cape ambulances out of commission,' *Weekend Post*, 23 Aug. 2003.

408 *Ibid.*

409 'Emergency vehicle crisis "sorted out,"' *Eastern Province Herald*, 30 Aug. 2003.

410 'EC emergency services at standstill,' *Daily Dispatch*, 26 Aug. 2003.

411 'Dissatisfaction with Fleet Africa,' *Daily Dispatch*, 12 Nov. 2003.



Again, in 2003/04 the department's EMS budget of R364.7 million was under-spent by an amount of R53 million, or 14.5 per cent.<sup>412</sup>

The desire of the EMS management to be free of the contract is made explicitly clear in the Department of Health's strategic plan for 2004/05. In this plan possible constraints which may prevent the EMS from meeting its mandate are identified. Principle among these constraints is 'contract with fleet management services' which, the plan proposes, would be 'overcome' by the department obtaining 'exemption' from it.<sup>413</sup>

In February 2004 the publicity surrounding the ongoing crisis within the service prompted Goqwana to appoint a task-team to investigate which officials within the EMS were supplying information to the media. Health spokesperson Kupelo was quoted as saying that the team would 'identify the architects and prophets of doom within the department who continue to frustrate and undermine government decisions'.<sup>414</sup> Only days later newspaper reports confirmed that an EMS employee had been temporarily removed from their position by the investigative team pending the completion of an investigation. This action however, as the PSAM pointed out, ran contrary to the objectives and spirit of the Protected Disclosures Act of 2000. This Act provides protection for any public official that tells another person about the management of their department which concerns, among other things, 'the health and safety of any person, that has been, or is likely to be endangered'.<sup>415</sup> Only days later, union representatives at the EMS claimed that the employee had been reinstated.<sup>416</sup>

This whole episode once again indicates the department's unwillingness to take responsibility for its actions. The department would have been better served by the appointment of a team tasked with trying to deal with the problems highlighted by EMS staff, rather than trying to seek out and punish those that brought the situation to the public's attention.

Given the continued parlous state of affairs within the EMS, the PSAM requested, in March 2004, that the provincial Department of Transport provide it with details of its service-level agreement with FleetAfrica. This document was requested in terms of the Promotion of Access to Information Act of 2000. The PSAM felt that gaining access to the service-level agreement would help ascertain whether sufficient conditions were incorporated into the contract to deal with compromised service delivery caused by the inability of FleetAfrica to manage the EMS fleet effectively.

In addition, the FleetAfrica service-level agreement should indicate what built-in penalties are provided for in such instances of compromised service delivery and whether the department has grounds to annul sections of the contract. Above all, it is in the public interest to establish the standards of service delivery that the public is entitled to from companies

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412 This figure represents the estimated actual expenditure on EMS for 2003/04 as contained in the Province of the Eastern Cape Budget Statement, 2004/05, 26 February 2004, p 63.

413 Department of Health Strategic Plan 2004-07, p. 87.

414 'Get snitches, Goqwana tells investigators,' *Daily Dispatch*, 17 Feb. 2004.

415 See Protected Disclosures Act, 2000. To make such a disclosure to a journalist it has to be made in good faith and must not be made for any personal gain.

416 'Union claims ambulance whistleblower reinstated,' *Daily Dispatch*, 30 March 2004.

contracted by provincial government. Without such information, it becomes difficult for the public to hold government departments accountable when standards have been breached.

To date,<sup>417</sup> the PSAM has not received a copy of the service-level agreement from the department of Transport.

When an examination is made of the state of the EMS within the Eastern Cape it is unclear how privatising the management of the fleet is intended to alleviate the systemic problems experienced. Currently, there are 337 vehicles within the service, including both rescue and patient-transfer vehicles.<sup>418</sup> Of these, the department itself acknowledges that 90 per cent are 'old and un-roadworthy'.<sup>419</sup> The costs associated with maintaining these failing vehicles is exorbitant. Nationally, it costs R15 per kilometre to keep an ambulance on the road; in the Eastern Cape it costs R45 per kilometre. The department argues that this is the case because of poor roads in the province, excessive staff overtime payments (due to staff shortages), the misuse and abuse of vehicles, a lack of referral hospitals and the age and condition of the vehicles.

In addition to these problems associated with the ambulance vehicles themselves is, the chronic shortage of staff within the EMS. Currently there is a 29 per cent vacancy rate within the service. However, as the department admits, an additional 488 staff are also needed to end the practise of sending out 'one-man' ambulances.<sup>420</sup>

Given these continuing long-term systemic issues, it is not clear how the privatisation of the management of the EMS fleet will serve to address its ongoing service delivery failures. It will not improve the department's ability to recruit and retain staff, nor will it enable the department to spend its money more effectively. It will not serve to reduce the costs associated with the service in the province. These are vital questions that have simply not been addressed by SCOPA, which has not publicly raised any concerns regarding the management of the EMS fleet by FleetAfrica. In the absence of effective oversight it is inconceivable as to how this situation is to be resolved.

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417 That is, 28 May 2004.

418 Another crisis within the EMS which has not received any media attention is the chronic shortage of patient transfer vehicles which results in patients waiting weeks, sometimes months, to be taken to hospitals for treatment, some of which is of an urgent nature. The situation is so bad that some 70 per cent of referral cases are not assisted. See, Department of Health Strategic Plan 2004–07, p. 87.

419 Department of Health Strategic Plan 2004–07, p. 87.

420 Ibid.

# 9. The HIV/AIDS Treatment Crisis

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## Introduction

By the end of 1999 the Eastern Cape Department of Health officially acknowledged that the province had one of the highest HIV growth rates in the world, and that over 450 000 people in the province had been infected.<sup>421</sup>

This raises the question of how the department planned to respond to this threat between 2000 and 2004, and what steps it took to ensure proper treatment for those living with HIV/AIDS. What programmes and activities did it propose to address changing health-care needs? Most importantly, what budget did it allocate to these programmes in the period between 2000 and 2004? How much of this was spent and what was achieved on the basis of this expenditure?

Due to the strict regulatory framework governing public expenditure (set out in chapter 1), all government spending is required to take place on the basis of pre-authorised and carefully considered strategic and operational (or business) plans. This framework also requires departments to provide rigorous progress reports on the use of these funds. For this reason, the above questions can be answered through an analysis of the HIV/AIDS business plans produced by the Eastern Cape Department of Health and by undertaking a reconciliation of these plans with its various expenditure and progress reports.

The chapter starts off by presenting a detailed chronology of the HIV/AIDS treatment crisis in the Eastern Cape. It then offers an evaluation of the coherence of the department's HIV/AIDS business plans between 2000 and 2004. Subsequent sections provide an analysis of the department's spending of funds budgeted for HIV/AIDS purposes and an evaluation of its planning and spending on the training of counsellors and health workers in order to implement its HIV/AIDS programmes.

The analysis presented in this chapter provides a unique insight into the workings of the Eastern Cape Department of Health, obtained through the inspection of the department's own internal monthly and quarterly financial reports to the provincial and national Treasuries on its expenditure of HIV/AIDS funds. These financial reports, as with the department's HIV/AIDS business plans, were obtained by the PSAM through a process involving the litigation of the department in terms of the Promotion of Access to Information Act No. 2 of 2000 (see Appendix 3 and 4).

A detailed evaluation of these documents is contained in a number of separate appendices appearing at the end of this report. The reader is encouraged to consult these documents for the purposes of obtaining a more detailed insight into the department's performance in respect of planning and reporting.

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<sup>421</sup> *Eastern Cape Epidemiological Notes*, Eastern Cape Department of Health, October 2000, Vol. 12, Issue 4.

## Elements of the Crisis

Medical science has been aware of the existence of the human immunodeficiency virus (HIV) and its causal relationship with the Acquired Immune Deficiency Syndrome (AIDS) since the early 1980s. Since this time governments across the world have taken elaborate policy steps to raise public awareness around the transmission of the virus and to introduce treatment regimes (which since the 1990s have centred around the use of anti-retroviral drugs) to prevent the development of AIDS in HIV-positive patients.

Despite being aware of the potential impact of HIV/AIDS on the health care needs of its citizens, South Africa's post-democratic government has been extremely slow to initiate policy measures to respond to this threat. When it came into office in 1994, only 7.6 per cent of women attending antenatal clinics were infected with HIV. By 1999, this number had risen dramatically to 22.4 per cent.<sup>422</sup> It was not until 2000 that the National Department of Health developed a clear policy and strategic plan for dealing with HIV/AIDS.<sup>423</sup> Prior to this, the South African cabinet had simply endorsed an apartheid-era government plan (produced by the National AIDS Co-ordinating Committee of South Africa)<sup>424</sup>, which was focused primarily on prevention.

Although the National Department of Health's 2000–2005 Strategic Plan delivered some noteworthy successes in the provision of condoms and in the training of secondary school teachers on HIV/AIDS awareness, the department has until recently remained strongly opposed to the use of anti-retroviral drugs (ARVs) to treat people living with HIV.<sup>425</sup> This is despite a long-running dispute between government and civil society organisations such as the Treatment Action Campaign (TAC), established in 1998, over the efficacy, affordability and safety of these drugs. Government's opposition to the provision of ARVs in the public sector rested on arguments concerning the expense of these drugs, their possible side-effects and the lack of sufficient health infrastructure to provide them.<sup>426</sup>

It has been argued that 'the coherence and effectiveness of state anti-AIDS programmes' in South Africa have been undermined by the public articulation of an AIDS denialist stance adopted by President Thabo Mbeki and Minister of Health Manto Tshabalala-Msimang. 'At the core of this position is a denial of the viral causation of AIDS, as well as the extent of the infection and the efficacy and safety of anti-retroviral therapy.'<sup>427</sup>

The impact that the reluctance to administer ARVs such as nevirapine has had on the lives of those dependent on public health care in Eastern Cape can be quantified. It is recognised that some 33 per cent of HIV-positive mothers transmit the virus to their

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422 A. Whiteside & C. Sunter, *The Challenge of AIDS for Africa*, Cape Town, Human & Rousseau, 2001. Figures quoted in the introduction.

423 National Department of Health, *HIV/AIDS/STD Strategic Plan for South Africa 2000–2005*, February 2000.

424 *Ibid.*, p. 9.

425 M. Mbali, 'HIV/AIDS policy making in post-apartheid South Africa', in J. Daniel, A. Habib & R. Southall (eds.), *State of the Nation: South Africa 2003–2004*, Cape Town, HSRC Press, 2003, pp. 312–322.

426 *Ibid.*, p. 317.

427 *Ibid.*, p. 318.

children. In a year this would amount to a total of approximately 10 500 HIV-positive children, given the infection rate in the Eastern Cape. Conservative estimates suggest that nevirapine has a 50 per cent success rate when used with a breast milk substitute, and a 30 per cent success rate when used alone.<sup>428</sup>

This means that a general roll-out of the drug for Prevention of Mother-To-Child Transmission (PMTCT) purposes would save at the very least 3 150 lives per year, rising to 5 250 lives if a milk substitute were used.<sup>429</sup> Approximately 50 000 women fall pregnant each year in the Eastern Cape and, at a cost of around R30 for each treatment, all pregnant women could be offered nevirapine for little more than R1.5 million a year. This total would be considerably reduced if women were voluntarily tested for HIV/AIDS before birth, and the drug was only given to those who were actually HIV-positive.<sup>430</sup> Thus, at minimum, over 3 000 lives could be saved per year in the province if nevirapine had been made available to all pregnant women when calls were first issued for the distribution of ARVs at state health facilities in 1998.

This means that 15 000 children's lives could have been saved in the Eastern Cape had ARVs been rolled out for PMTCT purposes at all state health facilities in 1998 as opposed to mid-2003. The period of delay in the implementation of an effective HIV/AIDS treatment programme between 1998 and November 2003, along with a list of instances of weak and opportunistic political leadership and examples of managerial ineptitude, make up the main themes within the Eastern Cape's HIV/AIDS treatment crisis. These themes are illustrated in the following chronology:

- On 28 October 1999 President Mbeki tells South Africa's National Council of Provinces that AZT, an ARV widely used abroad, may be harmful to the health, and asks the Minister of Health to establish 'where the truth lies'.<sup>431</sup>
- In January 2000, seemingly unaware of the President's emerging views on the causal relationship between HIV and AIDS, Dr Bevan Goqwana, speaking at an HIV/AIDS awareness raising rally, pointed to the deadly connection between the HIV and AIDS. Goqwana asserted that: 'The plague of the HIV/AIDS (sic) cannot be overemphasised or overstated. HIV is the most deadly virus we have had to deal with in this country. It is not only our problem but a disaster awaiting mankind the world over.'<sup>432</sup>
- In March 2000 Mbeki reportedly phoned United States AIDS dissident David Rasnick, 'for advice on how to proceed with his plans to review the hypothesis that HIV causes AIDS'.<sup>433</sup>
- In May 2000 Mbeki appointed a Presidential AIDS Panel to provide advice on a national AIDS policy, half of whose members were AIDS dissidents.<sup>434</sup>

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428 See 'No excuse not to use Nevirapine,' *Daily Dispatch*, 30 Jan. 2002.

429 Ibid.

430 'Health Minister's attitude an outrage,' *Eastern Province Herald*, 9 Dec. 2002.

431 'Behind the smokescreen: the record reveals President Thabo Mbeki's true stance on AIDS,' *Mail & Guardian*, 26 Oct. 2001.

432 Eastern Cape Provincial Government, Address by Dr BM Goqwana, at an HIV/AIDS Awareness Campaign Rally, held at Flagstaff, 14 January 2000.

433 'Behind the smokescreen: the record reveals President Thabo Mbeki's true stance on AIDS,' *Mail & Guardian*, 26 Oct. 2001.

434 Ibid.

- On 4 September 2000 Mbeki told *Time* magazine: 'the notion that immune deficiency is only acquired from a single virus is unsustainable'. He also said before the South African Parliament in Cape Town on 20 September 2000 that whilst public HIV/AIDS programmes are based on the viral explanation, 'a virus cannot cause a syndrome'.<sup>435</sup>
- In January 2001 the Eastern Cape Standing Committee on Health sharply criticised the provincial Department of Health for having 'no proper co-ordination of the HIV/AIDS programme, which had led to the duplication of activities and poor direction'.<sup>436</sup>
- In April 2001 President Mbeki reportedly said during a television interview that he would not take an AIDS test because this would mean accepting a certain paradigm of AIDS.<sup>437</sup>
- In July 2001 the South African government initiated a pilot study in the public sector on the use of nevirapine for PMTCT purposes by establishing two pilot sites in each province where the drug could be administered. Doctors and nurses at all other public health facilities were prohibited from prescribing the drug.<sup>438</sup>
- In July 2001 Goqwana announced the launch of nevirapine trials at two provincial pilot sites in East London, Cecilia Makiwane Hospital and Frere Hospital, for PMTCT purposes. This was despite the fact that neither hospital had supplies of the drug for fear, according to Goqwana, that they would be stolen if they were supplied before the launch. Goqwana said that the drug would be given to pregnant women after 32 weeks of gestation and that they would have to self-administer the drug at the onset of labour.<sup>439</sup>
- In November 2001, after campaigning to no avail to have ARVs introduced in the public sector, the TAC approached the Pretoria High Court with an application to compel government to provide these drugs at all state health facilities for PMTCT purposes.
- On 14 December 2001 the TAC won its court case. The court ruling compelled the government to provide nevirapine to all HIV-positive pregnant women at state hospitals where the capacity existed to test and counsel them. The government sought immediate leave to appeal. Despite the court's ruling, however, no efforts were made in the Eastern Cape to extend the supply of nevirapine outside of its two trial sites.
- On 30 January 2002 the TAC and the PSAM called upon Eastern Cape Premier Stofile to abide by the High Court ruling and provide nevirapine to HIV-positive mothers in the province. The Premier's Office replied by saying that this decision lay with national, and not provincial, government.<sup>440</sup>
- On 4 February 2002 acting Eastern Cape MEC for Health Max Mamase announced that the province would not expand the availability of nevirapine and said that anyone caught distributing the drug in the province outside of the two trial sites would be in 'hot water'. His views were endorsed by Premier Stofile who maintained that that he would not 'be

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435 Ibid.

436 'HIV/AIDS budget under-spent,' *Daily Dispatch*, 31 Jan. 2001.

437 Ibid.

438 M. Mbali, 2004, 'HIV/AIDS policy making in post-apartheid South Africa' in *The State of the Nation, 2003–2004*, p. 324.

439 'Nevirapine "trials" – but no supplies of HIV drug,' *Eastern Province Herald*, 23 July 2001.

440 'Bisho urged to issue nevirapine,' *Eastern Province Herald*, 31 Jan. 2002.

rushed into doing anything unreasonable'. Stofile, echoing the President's views on ARVs, questioned the safety of the drugs and stated that they could only be rolled-out if they were proven to be safe. Mamase had also stated that it was 'a myth' that women passed the HIV onto their unborn babies and that this could only happen if there was an exchange of fluids during the birthing process. Stofile maintained that Mamase's statement had 'dispelled many myths' for him, stating that people 'who know nothing about it' should refrain from speaking out on the issue of HIV/AIDS.<sup>441</sup>

- On 8 February 2002 ex-Eastern Cape MEC for Health Trudy Thomas, a qualified medical practitioner, responded to Mamase's claims by pointing out that it was a medically proven fact that the virus was passed from the mother to child in utero, during birth itself and via breast-feeding (especially if breast-feeding was combined with formula milk). She described Mamase's assertions as 'uninformed buffoonery'.<sup>442</sup>
- On 15 February 2002, a few days after saying that trials would have to be conducted for a year before nevirapine was rolled-out in the province, Premier Stofile announced that all hospitals and clinics were to begin administering the drug to pregnant mothers 'simultaneously'. In so doing, he implied that the drug was to become available with immediate effect. Stofile noted that he had instructed his Health MEC to begin training hundreds of health workers to administer the drug, but warned that this might take up to three months.<sup>443</sup>

This announcement had been preceded by persistent reports of the intended roll-out of nevirapine in Gauteng province. Stofile's announcement effectively meant that the Eastern Cape would become the first ANC-controlled province to announce the roll-out of nevirapine.

- On 17 February 2002 Gauteng Premier Mbhazima Shilowa announced that his province would begin to make nevirapine available at all clinics and hospitals. This was immediately condemned by National Health Minister Manto Tshabalala-Msimang, who argued that it was contrary to national policy which envisaged the roll-out of nevirapine only after the provincial trial sites had reported on its efficacy.<sup>444</sup>
- On 1 March 2002 the provincial government's confused policy on HIV/AIDS was seized upon by a group of 20 Eastern Cape traditional leaders who met with Tshabalala-Msimang. King Maxhobayakhawuleza Sandile remarked that 'our people are dying while we keep on talking a lot about this disease and nothing is being done. The government should give a clear indication of its policies'.<sup>445</sup> Tshabalala-Msimang responded by indicating that there was a clear policy and that it was newspapers and radio stations 'who change what we say to confuse you'.<sup>446</sup>

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441 'Baby, mum HIV a "myth,"' *Daily Dispatch*, 5 Feb. 2002.

442 'MEC shows signs of confusion,' *Eastern Province Herald*, 8 Feb. 2002.

443 'Stofile's "yes" to AIDS drug,' *Eastern Province Herald*, 16 Feb. 2002.

444 'EC escapes minister's ire,' *Daily Dispatch*, 20 Feb. 2002.

445 'Chiefs make plea for Aids drug,' *Daily Dispatch*, 1 March 2002.

446 *Ibid.*

- On 2 March 2002, the following day, acting MEC for Health Mamase stated that it would be 'irresponsible' of the government to 'dish out' nevirapine as though it were 'fish and chips'. He indicated that the drug was new and the government had to be sure of its safety and effectiveness, stating that this would only be known after the trial sites reported in August.<sup>447</sup> This was an apparent reversal of the policy of complete roll-out announced by Stofile in mid-February. Nevertheless, a week later Provincial MEC for Finance Godongwana announced that R85 million would be spent in the next financial year which would 'provide for the integrated mother-to-child transmission prevention programme'.<sup>448</sup>
- On 12 March, in apparent compliance with the High Court ruling, Mamase noted that the training of nurses and midwives to administer nevirapine throughout the province would cost R11 million. He said he could not say when the training would start as this depended on the decision of the provincial executive council. He did say, however, that once the nurses and midwives had been trained they would give out nevirapine 'where they work'.<sup>449</sup>
- On 15 March, a few days later, Mamase responded to the High Court's ruling in a contemptuous manner stating, 'it is not the role of the court to prescribe policy to the government. I emphasise again: We are not moving an inch in expanding our two sites ... we will stick to the policy applied by the executive.'<sup>450</sup> Three days later Mamase reasserted this position stating that 'we are not going to be driven by the courts. We have been elected by the people'.<sup>451</sup>
- On 19 March 2002, in an attempt to explain the apparent contradiction between what Stofile and Mamase were saying, provincial media services assistant director Mncedi Mgwigwi emphasised that nevirapine would be made available in all provincial state clinics and hospitals in due course. He maintained however that for this to be achieved, health practitioners like midwives and caregivers needed to receive a considerable amount of training on how to administer the drug.<sup>452</sup>
- On 4 April 2002 the national government finally accepted the High Court ruling that nevirapine was to be made available to HIV-positive pregnant women and to the survivors of sexual assault.<sup>453</sup> However, a statement from the national Department of Health stated that government was not required to undertake 'the wholesale extension' of

447 'EC hints at about-turn on Aids drug,' *Daily Dispatch*, 2 March 2002. Mamase also remarked that a 'good diet' could allow a person living with HIV to live for '10,15 or even 20 years.'

448 'Govt to spend R85m on Aids fight this year,' *Daily Dispatch*, 8 March 2002.

449 ECN, 13 March 2002.

450 'MEC refuses to budge on HIV drug,' *Daily Dispatch*, 15 March 2002.

451 'New clinic barred from providing nevirapine,' *Business Day*, 18 March 2002. Mamase's statements were potentially violations of his oath of office and the Constitution. In April 2002 national Health Minister Tshabalala-Msimang remarked that if the government did not accept the judgment of the court 'there will be anarchy,' see, 'Nevirapine and drugs for rape survivors all part of a comprehensive healthcare package, says minister,' Health-e, <http://www.health-e.org.za/news/article.php?uid=20020417>.

452 'EC Commits to providing Aids drug,' *Daily Dispatch*, 20 March 2002.

453 This was after the Constitutional Court upheld the Pretoria High Court's ruling that government must, in the interim, provide nevirapine to hospitals and clinics that have the capacity to administer the drug to pregnant women until the Constitutional Court makes its ruling on the Government's appeal against the Pretoria High Court's judgment.



nevirapine and that it could only be administered when adequate counselling and testing services were in place.<sup>454</sup> This indeed did reflect the findings of the court. The ruling had indicated that the use of nevirapine could only be extended outside of the pilot sites where hospitals and clinics had the capacity to do so in terms of testing and counselling.<sup>455</sup> This caveat to the wholesale extension of the nevirapine PMTCT programme was to become the foundation of the provincial Department of Health's refusal to expand its use of the drug over the following months.

- In April 2002 Tshabalala-Msimang announced that as soon as was possible, rape survivors would be provided with ARVs at public hospitals. She noted that this decision was part of a comprehensive health care plan for women but cautioned that 'we have not costed (the provision of ARVs for rape survivors) and we are really plunging into the dark here'.<sup>456</sup>
- In April 2002, writing in the ANC's newsletter (in the wake of the Constitutional Court ruling that government make nevirapine available for use by pregnant mothers at all hospitals and clinics in South Africa with the capacity to administer the drug), President Mbeki maintained that '... the very unfortunate reality that some in our society and elsewhere in the world, seem very determined to impose the view on all of us, that the only health matters that should concern especially the black people are HIV/AIDS, HIV, and complex ARVs, including nevirapine. We still await the results of the work being done by a number of government agencies to give us as accurate a picture as possible of the causes of death in our country ...'. He added: 'We will not be intimidated, terrorised, bludgeoned, manipulated, stampeded, or in any other way forced to adopt policies and programmes inimical to the health of our people'.<sup>457</sup>
- On 8 April 2002 the Eastern Cape Department of Health indicated that it had accepted the court ruling but did not know which hospitals could supply the drug. Department spokesperson Mageda stated that it would take three weeks before his department could identify any suitable hospitals.<sup>458</sup> This was despite an investigation reported in the *Daily Dispatch*, that nine hospitals had the capacity to dispense the drug immediately.<sup>459</sup>

From this date onwards the provincial Department of Health repeatedly indicated that it could not roll-out the use of nevirapine because its hospitals and clinics lacked the necessary trained staff.

- In mid-April, Mrs Nomalanga Makwedini, the Head of the Eastern Cape HIV/AIDS and STIs Directorate, noted that in provincial hospitals and clinics there was 'a shortage of space for counselling (and) a shortage of counsellors'.<sup>460</sup> This was followed by an assurance from Mamase that the training of doctors, nurses, counsellors and midwives was

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454 'Govt accepts Concourt ruling,' *Daily Dispatch*, 5 April 2002.

455 The responsibility of determining the capacity of a clinic or hospital to provide the drug rested solely with doctors and medical superintendents.

456 'Nevirapine and drugs for rape survivors all part of a comprehensive healthcare package, says minister,' Health-e, <http://www.health-e.org.za/news/article.php?uid=20020417>.

457 'Health, human dignity, and partners for poverty reduction', Letter from the President, *ANC Today*, Vol 2, No. 14, 5–11 April 2002.

458 'Nevirapine: EC hospitals ready,' *Daily Dispatch*, 9 April 2002.

459 Ibid, see also 'Political inertia halts supply of Aids drug,' *Daily Dispatch*, 10 April 2002.

460 'Too few staff to administer nevirapine,' *City Press*, 14 April 2002.

proceeding as 'rapidly as possible' to allow for the roll-out of the drug.<sup>461</sup> For nearly a year, statements from the department followed a similar pattern: promises were made that the department was serious about addressing the roll-out of nevirapine, but that it lacked the capacity to do so.<sup>462</sup>

- On 5 July 2002, the Constitutional Court ruled in respect of the government's appeal. It substantially upheld the High Court's original ruling and ordered that government: 'Remove all restrictions preventing nevirapine from being used in public hospitals for PMTCT purposes' and instructed that government 'take reasonable measures to extend counselling and testing facilities to all hospitals and clinics in order to expedite and facilitate the use of nevirapine for PMTCT purposes'.<sup>463</sup>
- During the period between the court rulings in April 2002 and July 2003, only nine out of a total of 93 hospitals in the Eastern Cape were actually 'allowed' by the provincial Department of Health to distribute nevirapine.<sup>464</sup>
- Two days after the 5 July court ruling, MEC for Health Goqwana said that nevirapine was 'not something that cures HIV/AIDS and one has to look at the expenses incurred and the "specialised training" necessary to administer the drug'. Goqwana argued that Eastern Cape state hospitals were 'not ready to distribute nevirapine because of financial restrictions and lack of manpower'.<sup>465</sup>
- In May 2002 Dr Gerald Boon, the head of paediatrics and child health at the East London Hospital Complex, indicated that HIV/AIDS was the cause of death for 48.6 per cent of all children over five-months old at the complex. Thus, of the 220 non-newborn deaths at the complex, 107 of these were a result of HIV.<sup>466</sup>
- In June 2002 the basis for the government's assertion that the drug could not be rolled-out for PMTCT purposes on the grounds of a lack of capacity was subjected to sustained criticism by a number of health specialists. Professor Hoosen Coovadia, a leading HIV/AIDS researcher at the University of Natal, pointed out that there was no simpler regimen than nevirapine to administer. At the onset of labour the pregnant mother is given one nevirapine tablet, and the child is given one dose of nevirapine syrup within 72 hours of delivery.<sup>467</sup>

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461 'Greater demands, less cash for health,' *Daily Dispatch*, 16 April 2002.

462 See: 'PMTCT programmes face severe challenges,' *Daily Dispatch*, 16 April 2002. "'Nevirapine training on course'", *Eastern Province Herald*, 16 April 2002. 'MEC warns on new Aids ruling,' *East Cape Weekend*, 6 July 2002. 'Nevirapine a priority for EC – Goqwana,' *Daily Dispatch*, 8 July 2002. 'Goqwana pledges to administer Aids drug,' *Eastern Province Herald*, 10 July 2002. 'CMH on track with Nevirapine,' *Daily Dispatch*, 5 August 2002. 'Eastern Cape not ready,' *Grocott's Mail Mail*, 4 October 2002. 'Aids drugs for 2 more hospitals,' *Daily Dispatch*, 24 Dec. 2002. 'Department slow with Aids drug,' *Daily Dispatch*, 7 March 2003.

463 Judgement, Minister of Health versus Treatment Action Campaign, Constitutional Court of South Africa, CCT 8/02, 5 July 2002.

464 'Department slow with Aids drug,' *Daily Dispatch*, 7 March 2003. A May 2003 report from the SAHRC on the state of hospitals in the Eastern Cape noted that Umtata General Hospital was ready to rollout nevirapine but was unwilling to do so without a directive from government. See, 'Site visits and investigations: Eastern Cape hospitals,' SAHRC, May 2003, p. 27.

465 'MEC warns over new Aids ruling,' *East Cape Weekend*, 6 July 2002. Goqwana continued somewhat bizarrely by stating that, 'We must be aware that we live in a country where there are still two-worlds. Some communities do not have voices and we as the government must look out for them and make sure that we do not follow a path that we might regret.'

466 '48 per cent hospital baby deaths due to Aids,' *Daily Dispatch*, 30 May 2002.

467 Quoted in: 'Shambles at Aids baby treatment sites,' *Mail & Guardian*, 27 June 2003.

According to media reports throughout 2002 and 2003 the primary reason for the Eastern Cape Department of Health's delay in the roll-out of PMTCT was the lack of capacity of health workers in the province to administer nevirapine. For this reason, the department had first to embark on an extensive programme of training aimed at capacity building for the roll-out of nevirapine for PMTCT.

- In October 2002, during the midst of this period of government procrastination over the roll-out of nevirapine, Goqwana made the extraordinary claim that circumcised people had less chance of contracting HIV/AIDS during sexual intercourse. In addition, he said that the most significant problem with HIV/AIDS was the depression that followed from diagnosis. Clearly aligning himself with the dissident views of Mbeki, Goqwana continued by emphasising the association between poverty and HIV/AIDS, stating (in a particularly contradictory formulation) that before supplying ARVs 'one must improve the people's state of health'.<sup>468</sup>
- In December 2002 Goqwana admitted that the province had had 'problems in getting stocks' of the necessary drugs for Post-Exposure Prophylaxis (PEP) for rape survivors. He also indicated that the court ruling from eight months before 'had taken some time to filter down into hospitals and some people who should be dispensing do not yet know that they should be giving the drugs to rape victims'. His comments were made in response to reports quoting the head of the Port Elizabeth's Rape Crisis Centre who stated that she did not know of any public hospital or clinic in the Eastern Cape that was actually dispensing ARVs to rape survivors. An unnamed doctor at Cecilia Makiwane Hospital was also reported to have said that ARVs for PEP at the hospital were not available to sexual assault survivors, as the dispensary would not supply the necessary drugs because there was 'no clarity on whether (the doctors) were allowed the give them out'.<sup>469</sup>
- In December 2002 Goqwana responded to these reports by promising that by 1 January 2003 no rape survivors would be turned away from any public hospital or clinic.<sup>470</sup>
- On 9 January 2003, despite his previous assurances, Goqwana announced that ARVs would only be available to rape survivors at nine hospitals in the province. He indicated that the department had not budgeted for the expenditure but would look into expanding its PEP programme to other hospitals once appropriate financial plans had been drawn up.<sup>471</sup> A few days later Makwedini confirmed that the nine hospitals would start ordering the necessary drugs from government pharmaceutical depots.<sup>472</sup> Rape survivors outside of these hospitals would have to wait until January 2004 to obtain ARVs.

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468 'Circumcised less likely to contract Aids – Goqwana', *Daily Dispatch*, 9 Oct. 2002. This repeated a comment first made by Goqwana in September 2000. See 'MEC Shock Aids claim,' *Eastern Province Herald*, 18 Sept. 2000.

469 'Vital drugs denied to victims of rape,' *Weekend Post*, 7 Dec 2002.

470 'HIV drugs denied to EC rape victims,' *Daily Dispatch*, 9 Dec. 2002. Goqwana's promise in effect looked to fulfil a promise made by the national Minister for Health some nine months earlier. In Port Elizabeth alone there are some 137 reported rapes per month.

471 'EC rape victims get Aids drug lifeline,' *Daily Dispatch*, 10 Jan. 2003. Police statistics indicate that more than 500 rape cases are reported each month in the province.

472 'Money available to give Aids drugs to rape victims,' *Eastern Province Herald*, 15 Jan. 2003.

- In February 2003 Stofile boasted to the Eastern Cape Legislature that the province was 'doing well on 2002 HIV/AIDS promises'.<sup>473</sup>
- In May 2003 a report from the SAHRC on the state of hospitals in the Eastern Cape noted that Umhata General Hospital was ready to roll-out nevirapine but was unwilling to do so without a directive from government.<sup>474</sup>
- In June 2003 a newspaper reported that according to the minutes of the PMTCT national steering committee there was a situation of chaos, confusion and empty promises when it came to the roll-out of nevirapine. Firstly, there was still no national protocol for the roll-out of the drug outside of pilot sites. This led to provinces adopting their own strategies which meant that, as in the case of the Eastern Cape, most provinces had not expanded the roll-out of the drug much beyond the pilot sites. Secondly, it noted that there was no national infant feeding policy, which reportedly meant that the Eastern Cape did not supply formula feed outside of the original two pilot sites'.<sup>475</sup>
- In July 2003 the offices of President Mbeki and Tshabalala-Msimang referred a report approving the costs of providing a full ARV roll out for treatment purposes back to its authors in the national Treasury. The reason cited for the delay in approving these costs included a lack of details about the type of infrastructure required in each province to provide treatment. The Treasury report had been passed by a Minmec meeting (i.e. the national Minister of Health and the nine provincial Health MECs) on 9 May 2003.<sup>476</sup>
- On 8 August 2003 the South African Cabinet instructed the National Department of Health to develop a detailed operational plan on an antiretroviral treatment programme.<sup>477</sup>
- In November 2003 the National Department of Health finally produced an operational plan for comprehensive HIV/AIDS care and treatment and a detailed implementation plan for a national HIV/AIDS treatment programme to be rolled out to all hospitals and clinics in South Africa.<sup>478</sup>

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473 Delivery on Aids 'done well,' *Eastern Province Herald*, 22 February 2003.

474 See, 'Site visits and investigations: Eastern Cape hospitals,' SAHRC, May 2003, p. 27.

475 'Shambles at Aids baby treatment sites,' *Mail & Guardian*, 27 June 2003.

476 'Manto delays anti-Aids drugs decision', *The Star*, 2 July 2003.

477 Operational Plan for Comprehensive HIV and AIDS Care and Treatment for South Africa, Executive Summary, November 2003, p. 3.

478 Ibid.

## Profile of Spread

The following brief chronology serves to indicate the Eastern Cape Department of Health's level of awareness of the threat posed by the spreading HIV in the period under review in this report.

- In August 1999 the Eastern Cape MEC for Health Bevan Goqwana acknowledged that by the end of 1998, 375 000 people were living with HIV/AIDS in the province.<sup>479</sup>
- In October 2000 the Eastern Cape Department of Health estimated that by 1999 the number of people infected with HIV/AIDS in the province had risen to 450 000. Based on the figures from its annual Antenatal HIV Survey, the department reported that 18 per cent of all women attending antenatal clinics in the province were HIV-positive. A report published by the department concluded that 'this province has one of the fastest HIV growth rates in the world'.<sup>480</sup>
- In August 2001 a subsequent report in 2001, from the Eastern Cape Health Research Conference, indicated that of 2 144 women attending 44 antenatal clinics in the province during 2000, 20.3 per cent were infected with HIV.<sup>481</sup>
- In March 2002 the department reported that it had screened 6 609 women over the last five months, of whom 1 350 were HIV-positive, an infection rate of 20.4 per cent.<sup>482</sup>
- In August 2002 it was stated that there were 44 000 HIV/AIDS orphans in the Eastern Cape.<sup>483</sup>
- In December 2002 research from the Human Sciences Research Council indicated that the Eastern Cape had the lowest HIV/AIDS prevalence rate in the country at 6.6 per cent (compared to 11.4 per cent nationally). This report, however, was drawn up from a national survey of only 8 428 people who consented to be tested.<sup>484</sup>
- In December 2002 the Amatole District Municipality reported that 60 per cent of pregnant women in their district had tested positive for HIV/AIDS.<sup>485</sup>
- On 5 February 2003 Social Development Minister Zola Skweyiya said that his department had identified a total of 7 900 HIV/AIDS orphans in the north-eastern Transkei area alone.<sup>486</sup>
- In March 2003 the Eastern Cape Department of Health's strategic plan for 2003/04 asserted that: 'the statistics do not adequately convey the magnitude of the HIV/AIDS crisis facing communities including the health sector'. It noted that 'the majority

479 Address to National HIV/AIDS launch of the ANC Youth League, King William's Town, 23 August 1999.

480 *Eastern Cape Epidemiological Notes*, Eastern Cape Department of Health, October 2000, Vol. 12. Issue 4, original emphasis.

481 'Alarming rise in E Cape HIV rate,' *Eastern Province Herald*, 21 August 2001.

482 'Mamase clarifies Bisho's nevirapine site strategy', *Eastern Province Herald*, 16 March 2002.

483 'Proper policies to tackle Aids – Thomas,' *Daily Dispatch*, 23 Aug. 2002.

484 'Eastern Cape has "lowest HIV rate in country,"' *Eastern Province Herald*, 6 Dec. 2002.

485 'ADM report points to HIV problems,' *Daily Dispatch*, 10 Dec. 2002.

486 '7 900 HIV/AIDS orphans found in Pondoland,' *Daily Dispatch*, 6 Feb. 2003.

of beds (between 60 and 80 per cent) in some hospitals are occupied by HIV/AIDS patients, both children and adults'.<sup>487</sup>

- It was reported in the local media that, between May and June 2003, 610 people were tested for HIV/AIDS at Frere Hospital of whom 263 were HIV-positive (43 per cent).<sup>488</sup>
- In August 2003 Provincial HIV/AIDS Director Nomalanga Makwedini reportedly noted that the Eastern Cape had the fourth-highest incidence of HIV/AIDS in the country.<sup>489</sup>

## HIV/AIDS Programme Planning between 2000 and 2004

The importance of effective strategic planning to the smooth financial management and administration of government departments cannot be overstated. As has been noted, all government departments should draw up business plans for each of their programmes (and important sub-programmes) as the basis for the allocation of budgets to these programmes. Collectively these programme plans make up the department's operational plan (which is always treated as the first year of the department's three-year strategic plan). Business plans for individual programmes serve a vital management role in identifying the tasks that need to be fulfilled in order to meet the department's policy objectives. They also serve as an essential communication tool to inform managers of the department's action plans and any changes in its service delivery priorities.

In the period between 2000 and 2004, the process of drawing up business plans for the Eastern Cape Department of Health's various programmes should have provided its managers with the opportunity to identify the exact human and material resource inputs required to deliver the department's intended service delivery outputs. By properly costing these resources and by attaching measurable service delivery indicators to its outputs, the department's business plans would have served as the basis for informing the Legislature about what it was buying when it approved these plans.

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487 Eastern Cape Department of Health Strategic Plan, 2003/04, p. 20.

488 'Almost 50 per cent tested for HIV at Frere positive,' *Daily Dispatch*, 13 Aug. 2003.

489 'HIV/AIDS strategy is EC priority,' *Daily Dispatch*, 1 Aug 2003.

## HIV/AIDS Budget Allocation Versus Business Plan

Financial Year	Conditional Grant		Provincial Grant	
	Budget allocation	Covered by business plan	Budget allocation	Covered by business plan
2000/01	R2.2 m	Nil	R33 m	Nil
2001/02	R8.28 m	R3.85 m	R33 m	R31.91 m
2002/03	R33.64 m	R21.13 m	R57.2 m	R17.2 m
2003/04	R38.9 m	R38.93 m	R32. m	R32 m
Total	R83.02 m	R63.91 m	R155.2 m	R81.1 m

## Percentage of Budget Covered by Business Plan

	Budget allocation	Amount covered by business plan	Percentage covered by business plan
Conditional grant	R83.02 m	R63.91 m	76.94%
Provincial allocation	R155.2 m	R81.11 m	52.2%
Total	R238.2 m	R145.08 m	60.8%

What the above tables indicate is that between 2000/01 and 2003/04 financial years, whilst the Eastern Cape Department of Health was issued a total budget allocation of R238.2 million for HIV/AIDS purposes, it only produced business plans for the utilisation of R145.08 million, or 60.9 per cent, of this amount. This means that it failed to produce business plans for almost 40 per cent of its HIV/AIDS budget (and amount of R93.19 million). The department only produced business plans for the equivalent of 76.9 per cent of its conditional grant allocation and disturbingly only 52.2 per cent of its provincial government allocation for its HIV/AIDS programmes.

This indicates that between 2000 and 2004 the standing committees of the Eastern Cape Legislature, and the national Parliament's Portfolio Committee on Health (responsible for overseeing the expenditure of health conditional grants), were not in a position to establish what the department planned to do with 39.8 per cent of its budget during this period.

More disturbingly still, this means that the department's own managers would not have been able to ensure the effective use of over R93 million in this period. It should be noted that it is only by ensuring that all activities are measurable and that each activity is properly

costed and has a clear timeframe attached to it, that the HIV/AIDS programme managers could have kept track of their expenditure and their progress in implementing these activities.

In fact, if programmes do not have measurable and sufficiently detailed business plans to guide their activities, as in the case of almost half of the Eastern Cape HIV/AIDS unit's budget, it is virtually impossible to report on their progress. As a direct result of not being able to report effectively on the use of budgeted funds, it stands to reason that the programme would not have been able to accurately track its own expenditure. Consequently, it could near enough be guaranteed that the programme would either over-spend or under-spend its budget allocation at the outset. As the following section will indicate, this is precisely what happened to the HIV/AIDS unit, which has exhibited a serial inability to spend its funds.

Moreover, in the absence of accurate and up-to-date reports on the levels of spending of existing budget allocations, it is extremely difficult for programme managers to identify their future budget needs. This gives rise to the calculation of future budget requirements on the basis of uninformed inflationary (or other speculative) projections, as opposed to using actual indicators of changing spending patterns or changing demand for services. This again inevitably results in the under- or over-estimation of future budget requirements.

An analysis of the Eastern Cape Department of Health's HIV/AIDS business plans unveils a litany of examples of spurious and ad hoc budgeting. For instance, the conditional grant business plan for 2001/02 contains a budget item of R1 million for the purchase of home-based care (HBC) kits. Yet, the plan provides no indication of the number of kits to be purchased for HBC purposes, their exact contents, their unit costs, or intended location.<sup>490</sup> Its provincial allocation budget for the same year contains an identical line item of R3.5 million for the purchase of HBC kits.<sup>491</sup> Again no additional information is provided on these kits. The figures appear to have been arrived at arbitrarily.

Similarly, the department's HIV/AIDS and TB directorate business plan for 2003/04 contains a budget allocation of R6.19 million for purposes of establishing a Centre of Excellence at the University of the Transkei. This is despite the fact that no breakdown of the costs of the individual activities, or the targets to be achieved by these activities, is provided.<sup>492</sup>

To avoid the arbitrary allocation of budget amounts to its various programmes and activities, the department would need to base these allocations on a rigorous account of its spending patterns. To do this, however, the department's business plans would need to undertake a detailed reconciliation of the activity budgets with its allocations for these activities in previous years, and its actual expenditure in each case. As the table below indicates, during the period between 2001 and 2004, not a single HIV/AIDS business plan produced by the Eastern Cape Department of Health has included any reconciliation with the budget allocations or expenditure for previous years.

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490 Eastern Cape Department of Health, Business Plan for VCT and HBC, 2001/02 (Conditional Grant). No page numbers on document.

491 Department of Health Province of the Eastern Cape, HIV/AIDS Budget 2001/02. No page numbers on document.

492 Eastern Cape Department of Health, HIV/AIDS and TB Directorate, Business Plan 2003/04, p. 16.



**An Evaluation of HIV/AIDS Business Plans 2001–2004 (see Appendix 5 for an analysis of individual plans)**

REQUIREMENT	COMPLIANCE				
	2001/02	2002/03			2003/04
		VCT	HBC	PMTCT <sup>493</sup>	
1 Clear statement of policy priorities	X	X	X	X	X
2 Concise mission and strategic goals	✓	✓	✓	✓	✓
3 Accurate information on service delivery environment and challenges faced	X	X	X	X	X
4 Rigorous evaluation of past year's performance	X	X	X	X	X
5 Effective consultation with relevant internal and external stakeholders	X	X	X	X	X
6 Clear separation into programmes and sub-programmes	X	✓	✓	✓	✓
7 Clear objectives for all activities					
Measurable	X	✓	✓	✓	X
Achievable	X	✓	✓	✓	X
Time-bound	✓	X	✓	✓	✓
Costed (per unit)	X	✓	✓	✓	✓
Name of responsible official	X	X	X	X	✓

<sup>493</sup> The PMTCT evaluation includes analyses of both the PMTCT business plan (provided to the national Department of Health in fulfilment of conditional grant requirements), as well as the provincial Department of Health's 'Implementation and Training for PMTCT' for 2002/03.

8 Reconciliation of plan with previous budget allocation and actual expenditure by programme	X	X	X	X	X
9 Mechanisms to ensure co-ordination and co-operation with other departments	X	X	X	X	X
10 Details of transfer agreements with external bodies and mechanisms for monitoring compliance with agreements	X	X	X	X	X
11 Plan to address AG's queries	X	X	X	X	X

The failure to undertake a reconciliation between its budget objectives and its previous expenditure between the 2000 and 2004 period has undoubtedly resulted in the duplication of spending on the same activities from one financial year to the next. A number of instances of the duplication of activities between successive financial years have been identified in the department's plans for the training of its staff (to be discussed in more detail below).

Clearly the articulation of a set of coherent policy objectives plays an important part in identifying the strategic goals to be addressed by the department's business plan. As noted, the MEC for Health is ultimately responsible for identifying the department's key programmes and sub-programmes and for setting clear policy priorities for these programmes.

Whilst the Eastern Cape's HIV/AIDS programme priorities would inevitably be informed by national government policy, these have also been directly influenced by a number of considerations raised by Mbeki concerning the causal linkages between HIV and AIDS. These considerations have resulted in a degree of policy confusion around the implementation of government HIV/AIDS programmes leading to the department's procrastination over the implementation of its PMTCT and ARV programmes.

Arguably, in the Eastern Cape, the President's personal views on the epidemiology and transmission of HIV have been combined with a state of weak financial management and weak political leadership, which has served to create a context of expediency and lethargy on the part of those officials responsible for the implementation of the province's HIV/AIDS programmes. Given the state of overall policy confusion caused by the President's views on HIV, it is perhaps unsurprising that during the period between 2000 and 2004, as the above

table indicates, the Eastern Cape MEC for Health, Bevan Goqwana, and the acting MEC, Max Mamase, failed to produce a clear statement of policy priorities to inform the department's HIV/AIDS programmes. This lack of overall policy direction was no doubt exacerbated by Goqwana's eight-month fully paid suspension and his constant distraction in having to defend charges of conflicts of interest whilst in office.

Aside from the lack of clear policy direction from the MEC, the process of establishing effective operational (or business) plans for the Eastern Cape Department of Health's HIV/AIDS programmes has suffered as a result of the weak and uncertain role played by its HOD. The HOD has a vital role to play in the planning process. This includes carefully examining the affordability of each of these plans, and making a realistic assessment of the resources available to the department and of the level of capacity and commitment of the people responsible for the implementation of its programme objectives.

By contrast, the following activities, which are the responsibility of the HOD of the Eastern Cape Department of Health, have not been effectively completed for the department's HIV/AIDS programmes between 2000 and 2004:

Firstly, the department failed to conduct a detailed situational analysis and needs analysis during this time in order to obtain accurate and up-to-date information on the service delivery needs of its clients and the challenges faced within its service delivery environment. Secondly, it failed to undertake a rigorous evaluation of its previous (and current) year's performance to identify which of its objectives were met and which remain outstanding, and what the problems and issues were that affected this performance. Thirdly, none of the department's business plans during this period contain any evidence of consultation with its own staff (including management and trade unions) or consultation with relevant external stakeholders to identify their views on problems and to collect their suggestions for improving delivery.

Without this process of consultation it is not possible for the department to ensure the buy-in of these stakeholders during the process of implementing the plan. Purely from a management point of view this process of consultation is necessary to ensure the accessibility of the operational plan to those who are responsible for its implementation.

Amongst the HOD's other responsibilities is the need, when drawing up the department's operational/business plans, to ensure that these are accessible to those to whom the department is accountable for their performance. This includes the Treasury and provincial Legislature oversight committees. At a very basic level, in order for these bodies to hold the department to account for its HIV/AIDS programmes, Treasury officials or committee members need to have a clear indication of who is ultimately responsible for the implementation of each programme activity. Significantly, as the above table indicates, until the 2003/04 financial year none of the department's business plans contained a clear indication of the names of officials responsible for programme activities.

Similarly, in order for the department to provide an accurate account of its performance to oversight bodies, it needs to provide an acknowledgement of the organisational and financial management problems that it has experienced in the past. For this reason, its business plans should include an indication of the problems pointed out by the AG's office,

particularly if they are specific to individual programmes, together with a plan for how these problems will be addressed. None of the department's business plans between 2001 and 2004 have contained any reference to problems pointed out by the AG.

Perhaps, even more importantly for purposes of effective oversight and accountability, Treasury officials and Legislature committee members, as well as ordinary members of the public, need to be able to track the department's budget from its initial authorisation through to its final expenditure.

For this reason, the department's HIV/AIDS business plans should provide measurable service delivery indicators (including costs and time-frames) for all of its outputs, even when these are transferred to external bodies, such as NGOs or district municipalities. This requires a detailed account of the transfer agreements entered into with NGOs and municipalities and an indication of the monitoring mechanisms put in place by the department to ensure compliance with these agreements. Significantly, none of the department's HIV/AIDS business plans have provided an account of the service-level agreements entered into with external bodies or indicated how compliance with these agreements would be monitored.

### **Civil Society Efforts to Monitor HIV/AIDS Expenditure and the Implementation of HIV/AIDS Treatment in the Eastern Cape**

By remaining vigilant and carefully monitoring government's resources and performance, civil society organisations can help to exert pressure on government to deliver more effective public services. The following chronology of interventions by the PSAM in the Eastern Cape provides an illustration of some of the steps that can be taken to hold provincial government Health departments accountable for their provision of health care services to people living with HIV.

Vital to the efforts listed below has been the PSAM's use of the Promotion of Access to Information Act, 2000. This Act gives effect to the Constitutional right of all South African citizens 'to access any information held by the state' and to 'access any information that is held by another person and that is required for the exercise or protection of any rights'. The objectives of the Act include the promotion 'of transparency, accountability and effective governance' of all public bodies 'by empowering everyone to understand (their) functions and operation' and by assisting everyone to 'effectively scrutinise and participate in decision making by public bodies that effect their rights'.<sup>494</sup>

- In November 2001 the PSAM assisted TAC in its Pretoria High Court application. The PSAM provided a supporting affidavit showing that the Eastern Cape Department of Health's contention that it could not afford to implement a general PMTCT programme in the province, could not be sustained. It was shown that the department had not spent R33 million earmarked for AIDS programmes, and yet had been spending

494 Promotion of Access to Information Act, No. 2 of 2000, Government Gazette, 3 February 2000, Chapter 3, Sect. 9.

R10.9 million a year on the salaries of 240 officials who had past retirement age. One was over 85-years-old.<sup>495</sup>

- On 4 April 2003 the PSAM made an application, in terms of the Promotion of Access to Information Act 2000, to the Eastern Cape Department of Health for information regarding its HIV/AIDS programmes. Application was made for information concerning the provincial HIV/AIDS budget and expenditure from 1999–2004 and for plans and progress reports on the implementation of these programmes.<sup>496</sup>
- On 23 April 2003 the Chief Director of District Health Services acknowledged receipt of the request for information from the PSAM and undertook to provide the requested details within the 30-day limit, as indicated in the Promotion of Access to Information Act.
- On 4 May 2003 Mrs Makwedini undertook to provide the requested information to the PSAM.
- On 27 May 2003, after nothing further was heard from Makwedini, the request for information was deemed refused and the PSAM lodged an internal appeal with the Health HOD in terms of the Access to Information Act, requesting the department comply with its legal obligation to provide the PSAM with the requested information.
- On 25 July 2003 after the department failed to respond to its internal appeal, the PSAM launched a High Court action to compel the Department of Health's HOD and MEC to provide the requested documents in terms of their Constitutional obligation to foster a culture of transparency and accountability. Amongst other records, the PSAM requested copies of all business and/or implementation plans and all monthly, quarterly or any other reports on budgeted HIV/AIDS expenditure for period of and between the financial years 1999/00 to 2002/03. (See Appendix 3 and 4.)
- On 12 August 2003 the Eastern Cape State Attorney submitted a notice of intention to oppose the application.
- On 11 September 2003 this decision was overturned and the Department of Health provided the PSAM with a selection of disorganised documents including HIV/AIDS business plans and monthly financial reports. As opposed to 36 monthly financial-reports for the three-year period between 1999/00 and 2002/03, the department could produce only 20 monthly reports. Instead of producing 12 quarterly performance reports for this period, only four reports were produced. Similarly, the department's business plans only covered a fraction of its budget. Moreover, these documents were not in any reasoned order or in accordance with any coherent set of categories.
- On 8 October 2003 the PSAM informed the department that these documents were inadequate. The PSAM requested written confirmation that the documents provided in response to its information request were the only records in the department's possession or under its control. If not, it should provide written reasons for withholding these documents.

495 For a copy of this affidavit, see <http://www.tac.org.za>.

496 See attached Notice of Motion and Founding Affidavit attached as appendices 3 and 4.

- On 25 November 2003 the Department of Health's attorneys provided a written response to the PSAM's request for clarification. In this response, with regard to its expenditure reports, the department's lawyers confirmed that 'no other documents are available' and 'the department has no other reports in its hands with regard to the above except those referred to above'. The response also stated unequivocally that the 'business plans attached and cited by yourselves are the ones used in the years in question'.<sup>497</sup>
- On 26 April 2004, in an effort to resolve the case, the PSAM met with Makwedini and the department's lawyers in Bisho. During this meeting Makwedini confirmed that contrary to the department's previous correspondence that it did possess additional monthly financial reports and quarterly progress reports on its HIV/AIDS programme. She undertook to make copies of these documents available. The PSAM asked the department to issue a sworn affidavit stating categorically, amongst other things, that it had no other records in its possession containing details of its business plans, capacity audits at its PMTCT pilot sites, or reports on training.
- In a sworn affidavit delivered to the PSAM on 13 May 2004 Makwedini confirmed that 'the department is not in possession of business plans for the expenditure of conditional grants other than the ones already provided to the applicant'. In addition, she states that 'there are no detailed reports in the department, on the implementation of PMTCT programs at the provinces pilot sites and that no detailed capacity reports were provided'. Finally, Makwedini's affidavit includes the acknowledgement that '... the department does not keep lists of training that were conducted by the districts and institutions themselves. Further lists will only be available from each local service area and such lists are not kept at provincial level'.

## Budgeting and Spending on Eastern Cape HIV/AIDS Programmes

Publicly accessible documents produced by the Eastern Cape Department of Health in the period between 2000 and 2004, such as its annual reports and strategic plans, fail to provide a conclusive account of how much was budgeted for HIV/AIDS programmes during this period. These documents also fail to provide a clear account how much of the department's HIV/AIDS budget was actually spent in this time. Access to the department's normally confidential financial reports to the Treasury (detailed above) has served to throw only slightly more light on the department's budget and spending during this period.

This is despite the existence of rigorous financial management legislation covering the South African public sector which requires a transparent budgeting process and detailed accounting for all public expenditure. The failure to comply with this legislation constitutes financial misconduct as defined by the Public Finance Management Act, 1999.<sup>498</sup>

497 Correspondence received on 25 November 2003.

498 Section 30, Division of Revenue Act 5, 2002.

According to this Act, the accounting officer (generally the HOD) of a government department commits an act of financial misconduct if he/she, amongst other things, wilfully or negligently fails to comply with his/her responsibilities for the submission 'of all reports, returns, notices and other information to Parliament or the relevant provincial legislature and to the relevant executive authority or treasury ...'.<sup>499</sup>

In the terms of the Act, financial misconduct is deemed to be a ground for the suspension or dismissal of a head of an 'accounting officer' for a department.<sup>500</sup> Moreover, if it can be shown that an accounting officer, as in the above instance, 'wilfully' failed to comply with their reporting responsibilities they are guilty of a criminal offence and, on conviction, are liable to a fine or 'to imprisonment for a period not exceeding five years'.<sup>501</sup>

Despite the poor state of the official documents published by the department, on the basis of a painstaking scrutinisation of these documents taken together with its monthly financial reports (or the limited selection thereof, that the PSAM was able to access), it has been possible to establish that a figure of roughly R238 million was allocated to the Eastern Cape Health Department for HIV/AIDS purposes in the period between 2000 and 2004.

### Eastern Cape HIV/AIDS Budget vs Expenditure

	2000/01		2001/02		2002/03		2003/04	
	Conditional grant	Provincial grant	Conditional grant	Provincial grant	Conditional grant	Provincial grant	Conditional grant	Provincial grant
Budget allocation	R2.2m 502	R33m 503	R8.28m 504	R33m 505	R33.63m 506	R57.2m 507	R38.9m 508	R32.013m 509
Amount spent	Unknown	Nil	R2.899m 510	Unknown	R24.76m 511	Unknown	R38.7m 512	Annual report due in August 2004
% spent	Unknown	0%	35%	Unknown	73%	Unknown	99.4%	

499 Public Finance Management Act, Act 1 of 1999, Section 51(1)(f) read in conjunction with Section 83(1)(a).

500 Ibid, Section 83 (4).

501 Ibid, Section 86 (1).

502 Division of Revenue Act No. 1 of 2001, Government Notice, National Treasury, No. 427, 15 May 2001

503 Province of the Eastern Cape, Annual Report of Department of Health for the year ending 31 March 2001, PR212/2001.

504 Eastern Cape Department of Health, *Annual Report*, 2001/02, PR161/2002, p. 75.

505 Ibid, p31.

506 Conditional Grants to Provinces, Monthly Report by Receiving Provincial Department to Transferring National Department, Provincial Treasury, Eastern Cape, report to the end of April 2003/04.

507 This amount is calculated by subtracting the conditional grant amount from a total amount of R90.838 million listed in Department of Health, *Annual Report* 2002/03, Province of the Eastern Cape, PR 178/2003, p. 60.

508 Eastern Cape Department of Health, HIV/AIDS and TB Directorate Business Plan for 2003/04, p.1.

509 Ibid.

510 Conditional Grants to Provinces, Monthly Report by Receiving Provincial Department to Transferring National Department, Provincial Treasury, Eastern Cape, report to the end of March 2003/03.

511 Conditional Grants to Provinces, Monthly Report by Receiving Provincial Department to Transferring National Department, Provincial Treasury, Eastern Cape, report to the end of April 2003/04.

512 Conditional Grants transferred from National Government Departments and Actual Expenditure by Province, 1 April 2003 to 31 March 2004, National Treasury.

## Utilisation of Eastern Cape HIV/AIDS Budget

	Total Conditional Grant 2000–2004		Total Provincial Allocation 2000–2003	
	Amount	Percentage	Amount	Percentage
Budget allocation	R 83 m	100	R 123.2 m	100
Spent	R 66.37 m	79	unknown	unknown
Unknown	R 2.213 m	2.6	R 90.2 m	73.2
Unspent	R 14.48 m	17.4	R 33 m	26.7

What the above tables indicate is that of the department's combined conditional grant allocation of R83.063 million between 2000 and 2004, 79 per cent of this amount was spent (R66.3 million), 17.4 per cent (R14.48 million) was unspent, and 2.6 per cent (R2.213 million) remains inadequately accounted for. More disturbingly still, of the combined amount of R123.2 million allocated from the provincial budget for HIV/AIDS programmes in the period between 2000 and 2003, 26.7 per cent (R33 million) was unspent, whilst 73.2 per cent (R90.2 million) remains inadequately accounted for.

In fact, for the three separate financial years between 2000 and 2003, the Eastern Cape Department of Health failed to provide a clear account of the expenditure of its budget. It appears that whilst the strict monthly reporting requirements imposed on the department in terms of the Division of Revenue Act ensured more effective reporting on the department's conditional grant budgets, the same standards were not adhered to in respect of its own funds.

What follows is a discussion of the expenditure of funds allocated for HIV/AIDS programmes by the Eastern Cape Department of Health (either in the form of conditional grants or from the department's own budget allocation). This discussion is based on an analysis of the department's own monthly, quarterly and annual reports, of expenditure against these amounts (for a more comprehensive evaluation of these reports see Appendix 6).

### 2000/01

During his provincial budget speech for the 2000/01 financial year, on 2 March 2000, Eastern Cape MEC for Finance Enoch Godongwana announced that 'over the next three years, we are making available R100 million' for the provincial Department of Health's HIV/AIDS Awareness Programme. He indicated that this money had been ring-fenced for the programme.<sup>513</sup>

513 E. Godongwana, Provincial Budget 2000/01, Budget Speech, Eastern Cape Legislature, Bisho, 2 March 2000.



## Conditional grant

The Eastern Cape Department of Health was allocated a conditional grant of R2.213 million for HIV/AIDS programmes by the national Department of Health during the 2000/01 financial year.<sup>514</sup> There is no indication in any of the department's official documents (including its strategic plan and annual report) as to the make-up of its HIV/AIDS budget for the year. However, the department's Annual Financial Statement for 2000/01 maintains that it spent this entire grant amount of R2.213 million.<sup>515</sup>

This claim is contradicted by acknowledgements in both the Division of Revenue Act for 2001 and the department's 2001/02 HIV/AIDS business plan that it failed to spend all of its funds during the 2000/01 financial year.<sup>516</sup>

## Provincial budget

In his policy speech in March 2000 MEC for Health Goqwana indicated that the Department of Health had established a business plan costing R33 million which was 'ready to be rolled out throughout the Province from the 1st April'.<sup>517</sup> Premier Stofile indicated in December 2000 that the Eastern Cape government had 'approved a R100-million budget for a period of three years that will be used for HIV/AIDS activities'.<sup>518</sup>

The R33 million amount referred to by the MEC for Health would appear to have formed part of this amount of R100 million (to be spent between 2000 and 2004).

Two months before the end of the financial year, at the end of January 2001, the media reported that the provincial Standing Committee on Health had expressed concern over the department's spending of only R780 000 out of a total of R33 million set aside specifically for HIV/AIDS programmes.<sup>519</sup> The committee had also criticised the lack of co-ordination of the department's programmes. This was denied by Department of Health spokesperson Nkosinathi Mjoli, who said the spending report only covered the first six months of the financial year and that the balance could still be spent.<sup>520</sup>

No official documents could be located to indicate the exact amount of this budget. Significantly, the department's 2000/01 annual report (published in September 2001) failed to provide any narrative details of the budget allocation or expenditure of HIV/AIDS funds (which it lists under 'Community Health Services').<sup>521</sup> However, the AG's report for 2000/01 revealed that the department had an 'AIDS budget' of R33 million for the year, all of which it had failed to spend. The AG pointed out that the entire sum had been transferred to the Fort Hare Foundation one day before the end of the financial year (30 March 2001). Although the money was subsequently returned (without interest) it had not been rolled over for use by the department the following year.<sup>522</sup>

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514 See Division of Revenue Act No. 1 of 2001, Government Notice, National Treasury, No. 427, 15 May 2001

515 Department of Health, Eastern Cape Annual Financial Statements, 2000/01 p. 22.

516 *Ibid.*, see also Eastern Cape, Department of Health, Business Plan for VCT and HBC, 2001/02 (Conditional Grant).

517 Eastern Cape Department of Health, Policy Speech, 13 March 2000.

518 Speech on the Challenge of HIV/AIDS in the Eastern Cape, 1 December 2000.

519 'HIV/AIDS budget under-spent,' *Daily Dispatch*, 31 Jan. 2001.

520 'Department denies Aids underspend,' *Daily Dispatch*, 1 Feb. 2001.

521 Eastern Cape Department of Health, *Annual Report*, 2000/01, PR212/2001.

522 *Ibid.*, Sect. 3.5.

It was then reported after the end of the financial year, in mid-April 2001, after protracted negotiations, that the Treasury had given permission for the funds to be rolled-over into the next financial year.<sup>523</sup> This was denied by Finance MEC Godongwana, pre-empting the findings of the AG, who observed that an 'unlawful' payment had been made, from the money ring-fenced for HIV/AIDS by the Department of Health to the Fort Hare Foundation. Godongwana indicated that this payment would be reversed and the money would be returned to the Treasury.<sup>524</sup>

It subsequently emerged, during a Legislature debate at the end of April 2001 on the departmental budget for 2001/02, that the money would, in fact, be returned to the Health department on the condition that they articulated their proposed expenditure by the beginning of May. MEC Gogwana had publicly blamed the failure to spend the money on the lack of an HIV/AIDS Directorate in the department's organogram.<sup>525</sup>

## 2001/02

Official documents produced by the Eastern Cape Department of Health for the 2001/02 financial year contain multiple and conflicting indications of what its budget allocation for HIV/AIDS programmes was for the year. This applies both to the department's conditional grant and its provincial budget allocations.

### Conditional grant

Whilst the Division of Revenue Act refers to a conditional grant of R3.85 million<sup>526</sup> the department's annual report provides a narrative account of its spending against a conditional grant allocation of R6.26 million in one place and R8.281 million in another. Similarly, the department's monthly financial reports to the provincial and national Treasuries present contradictory figures. Between August 2001 and January 2002 these reports provide updates on the expenditure of an annual grant allocation of R3.85 million, whereas those monthly reports for March and April 2002 list a budget allocation of R8.281 million.<sup>527</sup>

As regards the spending of these funds the narrative section of the department's annual report simply states that a conditional grant allocation of R6.26 million was 'allocated' and subsequently 'received'.<sup>528</sup> Again, no explanation is offered as to why this amount differs from the R3.85 million allocated in terms of the Division of Revenue Act of 2001, which is also listed in the department's monthly financial reports to the Treasury. A search through the small print contained in the department's notes to its financial statements is required to uncover the fact that the department under-spent its conditional grant allocation of R8.281 million by R5.382 million, or 65 per cent. The only explanation offered for this failure is the

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523 'E. Cape AIDS funds won't be lost,' *Daily Dispatch*, 10 April 2001.

524 'Treasury reclaims R16m Aids fund,' *Daily Dispatch*, 18 April 2001.

525 'EC's unspent AIDS millions raise questions,' *Grocott's Mail*, 26 April 2001.

526 Division of Revenue Act No. 1 of 2001, Schedule A, Government Notice, National Treasury, No. 427, 15 May 2001.

527 Conditional Grants to Provinces, Monthly Report by Eastern Cape Department of Health to Transferring National Department and Provincial Treasury for the months of August, September, October, November, December 2001, and January, March and April 2002.

528 *Ibid*, p. 33.

'late transfer of the grant and improper loading of conditional grants' and 'delayed tendering for services earmarked for outsourcing'.<sup>529</sup>

### Provincial budget

The figures listed for the department's 2001/02 provincial budget allocation for HIV/AIDS in its annual report and business plan are similarly mismatched. The department's annual report lists an allocation of R33 million, whereas the Business Plan for its HIV/AIDS and sexually-transmitted diseases (STDs) Unit is calculated against a budget of R31.91 million.<sup>530</sup> In March 2001, during his policy speech for the coming 2001/02 financial year, Goqwana had indicated that the Department of Health would be responsible for a budget of R38 million 'to fight the scourge' of HIV/AIDS.<sup>531</sup>

In terms of actual spending, the department's annual report again simply states that of the R33 million voted for 'HIV/AIDS work' in the province, R18.4 million was intended for use on its TB and STD programmes. The report points out that the remaining amount was 'earmarked' for AIDS Training and Information Centres in municipalities, for NGO's that successfully tendered to do HIV/AIDS-related work, and for Research and Capacity Building in the HIV/AIDS field. It is entirely unclear, however, whether these funds were actually spent as the annual report refers to their use in the future tense.<sup>532</sup> (See Appendix 6 for details.)

The most significant achievement of the department's HIV/AIDS programme for the year appears to have been its PMTCT pilot sites (at the Frere and Celicia Makiwane hospitals) in July 2001.

In November 2001 press reports had begun to emerge indicating that the HIV/AIDS budget for 2001/02 would again be under-spent. Department spokesperson Mageda had responded by blaming NGOs for this underspending, claiming that they did not have the administrative or financial capacity to deal with the funds and that the monies could not be misspent.<sup>533</sup> This was despite the provisions of the Public Finance Management Act which require that money can only be transferred by government departments to outside bodies if they provide a prior assurance of the effectiveness of their financial management capacity.

Subsequently, in December 2001, the provincial HIV/AIDS Director Nomalanga Makwedini maintained publicly that the department had spent more than 50 per cent of its HIV/AIDS funds and claimed that it would 'probably' spend it all before the 31 March deadline. She said that once this amount had been spent they would have access to the R31.9 million which was unspent the previous year. This was vehemently denied by provincial MEC for Finance Godongwana, who stated that the money had already been allocated elsewhere.<sup>534</sup>

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529 Eastern Cape Department of Health, *Annual Report, 2001/02*, PR161/2002, p. 75.

530 Eastern Cape Department of Health Business Plan for HIV/AIDS 2001/02 (Provincial Allocation), no page numbers in document. See also Eastern Cape Department of Health, *Annual Report, 2001/02*, PR161/2002, p. 31.

531 Eastern Cape Provincial Government, Policy Speech for 2001/02, by Dr Bevan Goqwana, 7 March 2001.

532 Eastern Cape Department of Health, *Annual Report, 2001/02*, PR161/2002, p. 31.

533 'EC activists upset over unspent funds,' *Daily Dispatch*, 15 Nov. 2001. Magenda's contentions were contradicted by Costa Gazi, ABBA Trust Director, who maintained that his organisation had applied for R200 000 and had not yet seen the money or been invited to any workshops, 'EC Aids activists upset over unspent funds,' *Daily Dispatch*, 15 Nov. 2001.

534 'Bisho denies Aids budget under-spent,' *Daily Dispatch*, 1 Dec. 2001.

Later in December 2001, in an attempt to clarify confusion over the exact amount allocated for HIV/AIDS programmes and what was being done with this, acting MEC for Health Mamase told the media that R37 million had been set aside for HIV/AIDS spending for 2001/02. This amount was made up of 'R33.5 million from the provincial Treasury and R3.5 million in the form of a national department conditional grant'. According to Mamase: 'The HIV/AIDS directorate has thus far spent R2 million of the R3.5 million national grant, and R11 million of the R33.5 million provincial allocation.'<sup>535</sup>

Mrs Makwedini's claim to have spent over half of the department's HIV/AIDS budget, and Mamase's claim to have spent over half of its conditional grant allocation, by December 2001 is contradicted by the department's monthly reports on the expenditure of its HIV/AIDS conditional grant. A monthly financial report signed by Makwedini, and submitted to the Treasury in January 2002, indicates that only 17 per cent, or R652 055 out of R3.8 million, of its HIV/AIDS grant had been spent by this point in time (i.e. after 10 months of the 2001/02 financial year).<sup>536</sup>

The claim to have spent half of the department's budget for HIV/AIDS for the 2001/02 financial year is contradicted by Mamase's own announcement in mid-December that the department would be making large cash transfers to district municipalities for HIV/AIDS programmes. He said: 'We have met with the district municipalities, and our position is that they are better placed to co-ordinate HIV/AIDS spending than we are.' This clearly indicates that the bulk of the department's budget had not yet been spent.<sup>537</sup> Mamase, in particular, had either been misinformed about the department's expenditure or he had deliberately mislead the public as to the department's performance.

It is significant that whilst Mamase was struggling to find ways to spend the provincial HIV/AIDS budget, he was actively preventing officials from utilising this budget for the purposes of providing ARVs for PMTCT purposes. As indicated in the chronology at the start of this chapter, in February 2002 Mamase had threatened that any official caught distributing nevirapine outside of the province's test sites would be in 'hot water'. Mamase's utterances were made in spite of a December Pretoria High Court ruling to the effect that state facilities should make ARVs available to pregnant women where they had the capacity to test and counsel them. Mamase would appear to have put his loyalties to the President's perceived dissident views on the use of ARVs before the interests of HIV-positive pregnant women dependent on the Eastern Cape public health care system.

Disturbingly, to date no official documentation has been published to indicate the extent of expenditure of the department's R33 million HIV/AIDS provincial budget for 2001/02.

In summary, the quality of the department's reporting on its HIV/AIDS programme expenditure and outputs in its monthly financial and annual reports is generally inadequate, and in many instances misleading. The department's annual report for 2001/02 provides no indication of the specific purposes for which conditional grant or provincial funds for HIV/

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535 'Districts take over Aids cash', *Daily Dispatch*, 13 December 2001.

536 Conditional Grants to Provinces, Monthly report by Eastern Cape Department of Health to Transferring National Department and provincial Treasury for the month of January 2002.

537 *Ibid.*

AIDS purposes were actually used. Nor does it indicate what was achieved as a result of the use of these funds. Again, the quality of reporting on the use of HIV/AIDS funds in this annual report fail to meet the requirements set out in terms of the PFMA and DORA. (For more detail, see Appendix 6.)

It is a matter of serious concern that neither the provincial Standing Committee on Health or SCOPA would have been able to evaluate the effective use of the department's HIV/AIDS funds on the basis of this report. This is despite a specific request by these oversight committees during the year that the department 'report to the Standing Committee within two weeks of May 2001 on how the R31.9 million (presumably the amount unspent on HIV/AIDS programmes the previous year) will be spent immediately after that amount has been sent back to the department and specifically whether the Treasury Instructions have been followed noting the additional amount allocated for 2001/02'.<sup>538</sup> Mamase's public utterances indicate that the department still had no clear plans for how to spend this money by December 2001. This indicates a complete disregard for the standing committee's recommendations.

## 2002/03

In March 2002 Eastern Cape Finance MEC Enoch Godongwana announced that R85 million would be spent fighting HIV/AIDS in the coming year.<sup>539</sup> No reference to this figure could be found in the Department of Health's official documents, so presumably it included allocations to the Education and Social Development Departments' HIV/AIDS programmes.

### Provincial budget

Despite Premier Stofile's undertaking to roll out PMTCT across the province, the department does not appear to have produced any coherent plan to implement this undertaking. As indicated in the table appearing at the start of this section, the best estimate for the department's HIV/AIDS budget for this year is R57.2 million. This figure was arrived at by subtracting the final conditional grant budget figure of R33.6 million (appearing in the department's monthly financial reports), from the total budget figure of R90.8 million appearing in the department's annual report.

Of the R57.2 million allocated for HIV/AIDS programmes from the provincial budget, the department only produced a business plan for the spending of R17.2 million. Similarly, it only had plans in place for the spending of around two-thirds of its R33.6 million conditional grant allocation. This appears to indicate that Stofile was more interested in making political mileage out of the HIV/AIDS treatment crisis than actually providing much needed treatment.

In October 2002 Health MEC Goqwana noted that some R111 million had been set aside for the treatment of HIV/AIDS, but cautioned that supplying ARVs to the province

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<sup>538</sup> Ibid, p. 6.

<sup>539</sup> 'Govt to spend R85m on Aids fight this year,' *Daily Dispatch*, 8 March 2002.

would cost billions.<sup>540</sup> A month later Finance MEC Godongwana, in his adjustment budget, reportedly announced that a further R11 million was to become available to assist in the fight against the virus.<sup>541</sup>

None of the Eastern Cape Department of Health's publicly available plans for the 2002/03 financial year indicate the specific amount budgeted for HIV/AIDS purposes during this year.

It should be noted, however, that the budget figure of R90.8 million listed in the department's annual report is substantially lower than the amounts reported in the press during the year. In March 2003, the final month of the financial year, it was reported that the Department of Health had spent only R39.5 million of R122.5 million set aside for HIV/AIDS programmes during 2002/03. Goqwana dismissed this report, claiming that the department had increased its spending as the year went along and that this would only be reflected at the end of the financial year. He promised that by the end of the year the entire budget would be spent.<sup>542</sup>

At no point, however, did Goqwana indicate that the budget figure of R122.5 million was overstated. This raises the fairly obvious question of whether the department's political head was aware of its exact budget allocation for the year.

As regards the department's actual expenditure for 2002/03, although its annual report fails to disaggregate its conditional grant and provincial budget spending, this report states that an amount of R48.158 million out of a total of R90.838 million had been spent. This represents a total underspending of its budget by 46.9 per cent.<sup>543</sup>

In October 2003, after presenting its annual report to the Health Standing Committee the department reportedly claimed to have spent 90 per cent of its HIV/AIDS budget for the financial year 2002/03. Makwedini blamed the 10 per cent underspending on the fact that cheques due to the University of Transkei had not been released before the close of the financial year on 31st March, due to the late arrival of invoices.<sup>544</sup>

It was subsequently pointed out by the PSAM that the department's spending claims for 2002/03, as reported in its annual report, were incoherent and could not be sustained. The report had duplicated the same figure of R48.158 million for its provincial and conditional grant expenditure. At the time of writing no further clarification of the exact amount of its provincial budget allocation, or the expenditure thereof, had been issued by the department. Despite requests for clarification the public and Legislature oversight committees were left to speculate on its actual expenditure for the 2002/03 year.

### **Conditional grant**

The Division of Revenue Act of 2002 indicates that the department initially obtained a conditional grant of R21.13 million for its HIV/AIDS programmes.<sup>545</sup> But, as with the previous

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540 'Circumcised less likely to contract Aids — Goqwana', *Daily Dispatch*, 9 Oct. 2002.

541 'Further R11m to combat Aids,' *Daily Dispatch*, 26 Nov. 2002.

542 'Flak for dept's underspending on Aids,' *Daily Dispatch*, 7 March 2003.

543 Ibid.

544 'Only 90 per cent of EC Aids budget spent,' *Daily Dispatch*, 14 Oct. 2003.

545 Division of Revenue Act No. 5 of 2002, Government Gazette, 28 March 2002, Cape Town, Vol. 441, No. 23290.

year, there is again a mismatch between the conditional grant figures listed in the department's various business plans and those contained in its monthly financial reports and in its annual report. The department's separate business plans (for voluntary counselling and testing [VCT], home-based care [HBC] and PMTCT) produce a combined total of R15.8 million. However, its monthly financial reports (to the National Department of Health and the national and provincial Treasuries) up until November refer to a total conditional grant allocation of R26.454 million, whereas after this point they indicate an amount of R33.635 million<sup>546</sup> and its annual report refers to an amount of R26.915 million.<sup>547</sup> One can only assume that the department's final conditional grant allocation was R33.6 million.

As regards the department's use of these funds, its annual report and monthly reports again contain conflicting accounts of the exact value of this conditional grant, and of how much was actually spent. The annual report claims that 179 per cent, or an amount of R48.158 million of its R26.915 million conditional grant allocation, was spent.<sup>548</sup>

By contrast, the department's monthly financial reports indicate that an amount of R24.758 million out of a total of R33.635 million had been spent by the end of the financial year. This amounts to an under-spending of 26.3 per cent.<sup>549</sup> The narrative content of these reports indicates a continuation of the department's internal financial management problems experienced in the previous financial year. For instance, in the report for May 2002 Thobile Mjekevu, the acting Accounting Officer, comments that: 'Loading of budget for the whole department of health was delayed because the province was shifting its financial systems from FMS (Financial Management Systems) to BAS (Basic Accounting Systems)'.<sup>550</sup>

From the start of this financial year it was clear that the Eastern Cape Department of Health, like its national counterpart, had only begrudgingly accepted the Pretoria High Court ruling to extend the provision of nevirapine for PMTCT purposes throughout all facilities with the capacity to do so. The acting MEC for Health had argued contemptuously, at the start of the year, that the department would not move an inch beyond its pilot sites in providing nevirapine to pregnant women. From April 2002 the department had argued consistently that it could not rollout the use of nevirapine to additional hospitals and clinics because these facilities lacked the necessary trained staff. This lack of 'specialised training' as well as alleged 'financial restrictions', was seized upon by MEC Goqwana after his return to work in June 2002.

It is a matter of serious concern that, after the introduction of a new computerised reporting format in September 2002, the Eastern Cape Department of Health ceased to provide narrative details of its performance within its monthly financial reports. The requirements set

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<sup>546</sup> See, for instance, report for June 2002, Conditional Grants to Provinces, Monthly Report by Receiving Provincial Department to Transferring National Department, Provincial Treasury, Eastern Cape, June 2002/03. This document indicates that indicate that an additional amount of R4.452 million was budgeted for Step-Down Care in the province. In addition, R745 000 was budgeted for programme management within the department's HIV/AIDS and STD unit.

<sup>547</sup> Eastern Cape Department of Health, *Annual Report*, 2002/03, PR 178/2003, p. 206.

<sup>548</sup> *Ibid.*, p. 206.

<sup>549</sup> Conditional Grants to Provinces, Monthly Report by Receiving Provincial Department to Transferring National Department, Provincial Treasury, Eastern Cape, report to the end of April 2003/04.

<sup>550</sup> *Ibid.*, May 2002.

out in the Division of Revenue Act oblige the department to provide 'an explanation for any material problems or variations experienced' and 'a summary of the steps taken to deal with such problems or variations'. Similarly, the department's annual report also failed to meet the requirement by the Public Finance Management Act requirement (introduced in April 2002) that obliges departments to report on their 'performance against predetermined objectives'.

Consequently, on the basis of its reporting during this year, the National Department of Health, the national Treasury and the Eastern Cape Treasury would not have been in a position to hold the department accountable for its effective use of its HIV/AIDS funds.

## 2003/04

During the 2003/04 financial year, the department's budget for HIV/AIDS programmes fell by almost R20 million to R70.947 million. This amount consisted of R32.013 million from the Eastern Cape Department of Health budget and a conditional grant allocation of R38.934 million from the National Department of Health.<sup>551</sup> At the time of writing no annual report had yet been published by the department. However, the national Treasury's report on conditional grant spending by provincial departments for the fourth quarter of 2004 indicated that the Eastern Cape Department of Health spent a commendable 99.4 per cent of its conditional grant for HIV/AIDS for the 2003/04 financial year. This equates to an amount of R38.713 million out of R38.934 million.<sup>552</sup>

## Budgeting and Spending on HIV/AIDS Training

As noted, shortly after the Pretoria High Court hearings at the end of 2001 the Department of Health's argument that it lacked sufficient numbers of trained staff rapidly became translated into the major reason for having to delay the roll-out of ARVs to all clinics and hospitals in South Africa.

Dr Nono Similela, Chief Director of the National Department of Health HIV/AIDS programme, initially indicated in the Pretoria High Court in November 2001 that the department had embarked on a carefully considered programme for training counsellors and health-care workers. She indicated that this training programme would have to precede the extension of the government's PMTCT programmes beyond the two pilot sites per province.<sup>553</sup>

In the Eastern Cape, as noted, Health MEC Goqwana had responded to the July 2002 Constitutional Court order that government: 'Remove all restrictions preventing nevirapine from being used in public hospitals for PMTCT purposes' by asserting that Eastern Cape Hospitals were not ready to distribute nevirapine as this would require 'specialised training'.

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551 Eastern Cape Department of Health, HIV/AIDS and TB Directorate Business Plan for 2003/04, p. 1.

552 Conditional Grants transferred from National Government Departments and Actual Expenditure by Province, 1 April 2003 to 31 March 2004, National Treasury.

553 Judgment, Treatment Action Campaign v Minister of Health, High Court of South Africa, Transvaal Provincial Division, 14 December 2001, Case No 21182/2001, pp. 17–18.



In the eyes of many of the critics of the slow pace of government's ARV roll-out, the issue of training had more to do with procrastination inspired by the government's AIDS dissident views, and less to do with the actual capacity and skills of health workers, including doctors and nurses. But given the strict regulatory framework controlling government spending, if training had indeed become one of the priorities of the Eastern Cape Department of Health's HIV/AIDS programme, it follows that this would have to be reflected in its business plans. This raises the question of what plans the provincial Eastern Cape Department of Health developed for purposes of ensuring the effective training of its staff to administer HIV/AIDS services, how coherent these training plans were, how much of this training budget was actually spent, and what outcomes were produced as a result of this expenditure.

### HIV/AIDS Training Budget for 2000–2004

Financial Year	Purpose			Other	Total
	VCT	PMTCT	HBC		
2000/01	Unknown	Unknown	Unknown	Unknown	-
2001/02	R1 606 300	-	R1 000 000	R8 000 000	R10 606 300
2002/03	R3 849 500	R9 185 300	-	-	R13 034 800
2003/04	R7 160 000	R1 572 000	R9 030 000	R3 206 000	R20 968 000
Total	R12 615 800	R10 757 300	R10 030 000	R11 206 000	R44 609 100

As the above table shows, an analysis of the Eastern Cape Department of Health HIV/AIDS unit's business plans indicates that a total of R44.6 million was allocated (out of a total of R145.08 million for which business plans were produced) for HIV/AIDS training purposes in the province between 2001 and 2004. (Please see Appendix 7 for an itemised breakdown and detailed analysis.) In other words, training accounted for almost a third (30.7 per cent) of the department's planned HIV/AIDS programme expenditure during this period.

The quality of the training provisions contained in the department's business plans between 2000 and 2004 is generally weak. Budgets allocated for training activities in these plans rarely indicate the location of the proposed training or its unit costs and generally fail to indicate the location of those to be trained. None of these plans provide a satisfactory account of what the content of this training was to consist of. These plans also contain a number of instances of the duplication of training items.

For instance, in the department's VCT business plans for the 2002/03 and 2003/04 financial years identical amounts were allocated for the training of HIV/AIDS and STI coordinators and for the training of trainers on couple counselling (R57 000 in each instance). Neither plan provides an indication of what the outputs of the same budget line items were for the previous year. In addition, there is no indication in the 2002/03 plan as to what the outcome of the department's allocation of R1.6 million allocated for VCT training during the

2001/02 financial year was. (See Appendix 7.)

Moreover, the costing of the training activities listed in the department's plans often appears to have been arrived at arbitrarily. For instance, in 2002/03 the department proposed to train voluntary counsellors on VCT at a cost of R400 per person per day for a 10-day workshop (i.e. R4 000 per person), whereas in 2003/04 this same activity was costed at R40 per person for a single day. This amounts to a one hundred-fold reduction in the cost of VCT training in the space of one year. (See Appendix 7.)

## Reporting on the implementation of HIV/AIDS Training programmes

The quality and coherence of the department's training plans aside, this brings us to the important question of how much of its R44.6 million budget for training was actually spent between 2000 and 2004, and what outputs were produced on the basis of this expenditure.

In an undated document entitled 'List of PMTCT-trained staff within the Eastern Cape Province' obtained from the Eastern Cape Department of Health as part of the PSAM's Access to Information litigation, the department claims to have trained a total of 1 099 PMTCT counsellors up until June 2003. This is indicated in handwriting on the final page of the document. The document consists of a table with a breakdown of figures for trained course directors, trainers and counsellors for the period March 2003 to June 2003 for seven district municipalities in the province.<sup>554</sup>

It should be noted that the department is obliged to provide an account of its implementation of training undertakings in its HIV/AIDS and STI Programme quarterly reports, which are required in terms of the Division of Revenue Act (for conditional grant expenditure) and by the PFMA (for expenditure from provincial allocations). The department's fourth quarter report for 2002/03 purports to provide a report on funding obtained from both sources (conditional grant and provincial allocation). However, for the most part this report fails to provide a clear indication of which budget sources it is reporting against.<sup>555</sup>

There is a lack of correlation between the outputs and targets listed in the department's Fourth Quarter report for 2002/03<sup>556</sup> and those appearing in its PMTCT Conditional Grant Business plan for 2002/03.<sup>557</sup> As a result there is a complete mismatch between the department's plans and its reporting.

In one instance of this, the department's fourth quarterly report for 2002/03 maintains that it has trained 100 out of a target of 350 lay counsellors using its budget allocation of R3.93 million.<sup>558</sup> By contrast, the department's PMTCT business plans for 2002/03 indicate that this budget amount was only part of the provincial allocation for the training of 5 490

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554 List of PMTCT-trained staff within the Eastern Cape Province, undated document received from Eastern Cape Department of Health, 25 November 2003.

555 Eastern Cape Department of Health Provincial Report 2002/03, HIV/AIDS and STI Programme: 4th Quarterly report.

556 Ibid.

557 Province of the Eastern Cape Department of Health Prevention of Mother-to-Child Transmission (PMTCT) Business Plan, signed HIV/AIDS Director, 3 June 2003.

558 Eastern Cape Department of Health Provincial Report 2002/03, HIV/AIDS and STI Programme: 4th Quarterly report.

counsellors (made up of 3 930 PHC, 280 community health centre [CHC] and 1 280 district hospital) at a cost of R5.49 million (R3.93 million combined with R280 000 and R1.28 million). In other words, the target set in the department's PMTCT business plan was in fact 5 490 lay counsellors as opposed to 350.

But what of the outputs delivered by the millions of rands allocated for training for VCT, HBC and other HIV/AIDS-related purposes (other than PMTCT)? Another undated document entitled 'Better Births Initiative Activities in Eastern Cape', obtained by the PSAM, indicates that 675 health practitioners (including doctors, managers, students and midwives) have been trained through this initiative. The document lists the date, venue, health district and number of attendees and the names of the training facilitators. The dates of training range between 30 January 2002 and 16 September 2002. A total of four individuals appear to have conducted the training sessions in this time.

In a written response obtained (by the PSAM) from the Eastern Cape Department of Health's lawyers on 25 November 2003, the department notes the following in respect of the information at its disposal on the implementation of its training programmes for PMTCT:

'List of staff trained on PMTCT as from March 2003 – July 2003 and (sic) hereby confirmed and dates provided. Other training lists might have to be requested from the districts if still needed. The department has not kept lists of trainings that were conducted by the districts and institutions themselves. Districts were requested to cascade training as Province was responsible for training trainers in each district'.<sup>559</sup>

Also in response to the PSAM's request for the department to clarify whether no other updated PMTCT training plan was produced for the Eastern Cape between July 2002 (in compliance with the Constitutional Court's ruling that PMTCT facilities be rolled out across South Africa) and April 2003, the department offered the following response:

'There were trainings in local service areas and in institutions that were introducing PMTCT for the first time, but these were not captured in a comprehensive report as in document no. 12 (the Better Births Initiative Activities in Eastern Cape document referred to above).<sup>560</sup>

What these acknowledgements indicate is that the department has failed to establish the necessary mechanisms to monitor the use of its funds transferred to districts and institutions at the local level in the province. It currently neither produces comprehensive reports on the implementation of its training programmes nor does it insist on obtaining such lists from district and local level institutions (i.e. hospitals and clinics).

Without such lists the department could not even begin to monitor compliance with training undertakings made by these institutions. Consequently, it is incapable of stating with any certainty that its training budget (of close to R45 million) is being utilised as intended. A forensic audit should be conducted to establish what exactly has become of these amounts.

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<sup>559</sup> Eastern Cape Department of Health/ Public Service Accountability Monitor, Response 25 November 2003, p. 9.

<sup>560</sup> *Ibid.*, p. 6.

# 10. Conclusion

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The ongoing health crisis raises a number of serious questions not only about the commitment of the Eastern Cape government executive to deliver efficient and effective public health services to meet the province's needs (in line with budgeted resources), but also about the effectiveness of legislature oversight committees and the ability of constitutional bodies to uphold the new constitutional framework. It is appropriate to reflect on these weighty issues of constitutional and democratic governance, as well as the practical issues affecting the quality of health service delivery, having reached the historic ten-year milestone in our new democracy.

It would appear that after ten years of having achieved what many generations of South African political and social activists struggled for, that is a democratic system of governance, this system itself remains poorly understood. On the whole, the Eastern Cape public remains ill-informed of the constitutional and legislative processes through which government should ensure social upliftment, as well as the provisions guaranteeing public participation in these processes and the mechanisms for ensuring the accountability of those in power.

Efficient and effective service delivery can only be assured if the entire constitutional framework of provisions governing transparent policy formulation and budgeting, public consultation, efficient management, effective reporting and rigorous oversight of performance, are implemented in practice. In particular, the introduction of free ARVs in the Eastern Cape public sector, in line with the national HIV/AIDS Treatment Plan, will only serve to heighten the importance of these requirements for effective service delivery. In order to implement the national Treatment plan, and given the risk of the development of multiple drug resistance if these drugs are administered incorrectly or incompetently, the Department of Health needs to address a range of existing human resource, financial management and infrastructure problems.

Effective health service delivery requires the development of strong, competent and politically independent constitutional and legislative oversight bodies capable of subjecting officials in the Department of Health, and executive members responsible for health, to account. It also requires an active civil society, which is properly informed not only about the resources available to government, but also how the government plans to use them and the extent of their implementation and delivery against these plans.

Ultimately, however, the oversight committees of South Africa's (national and provincial) legislatures and its constitutional bodies need to begin to redefine their relationship with the executive arm of government, in line with the principle of accountability. So too civil society, particularly those groups currently advocating for democratic governance and socio-economic justice. Put simply, this principle asserts that accountability is an obligation on the part of elected political leaders and government officials to answer to ordinary citizens for the performance of their duties and responsibilities. It is not a favour bestowed on ordinary citizens by those in public office.

During the first ten years of our democracy the relationship between oversight bodies, civil society and the executive arm of government has been characterised by a lack of effective critical engagement. This has in part been due to a weak understanding of the new democratic constitutional framework, but has also been the result of the close personal relationships (forged on the basis of previous 'struggle' ties) between individuals within these spheres.

In order to give effect to the principle of accountability, members of oversight bodies need to ensure that they have detailed and accurate information about the management of resources and the delivery of services by government departments. Similarly, civil society requires ongoing access to the same information to actively develop social relationships of accountability with the state.

By helping to monitor the Executive's performance – in managing the strategic direction of government departments and their delivery of services – civil society advocacy organisations can help the Legislature to take the necessary steps to ensure that government policies are implemented. This will require advocacy organisations and social activists to adopt new methods of engaging with government departments and Legislature oversight bodies. Individuals within these organisations need to develop the capacity to engage with government on the basis of detailed knowledge of its prioritisation of available resources, its plans for the utilisation of these resources, its implementation of these plans, and the effectiveness of its delivery of public services. This requires the creation of new skills to analyse and critique government's budget priorities, expenditure trends, business plans and actual performance.

This points to the vital role, played by civil society monitoring and research institutions, in the collection and dissemination of information on the performance of government officials and political leaders and the delivery of public services. It also points to the need for monitoring and research institutions, as well as oversight committees, to find more effective ways of sharing information and of working together to track service delivery.

# Appendices

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# Appendix 1

## Eastern Cape Department of Health Conditional Grant Expenditure 2000–2004

Conditional grants were first introduced in the 1998/99 financial year. They form part of the financial transfer system between the different spheres of government (national, provincial and local government) and serve to promote the idea of revenue sharing and co-operative governance between these spheres.<sup>1</sup>

Conditional grants are set to increase incrementally from R13 billion a year (between 2000/01 and 2002/03) to R24 billion by 2005/06.<sup>2</sup> They are thus becoming a critical redistributive tool for national government's efforts to ensure infrastructural and socio-economic parity amongst the provinces. It is for this reason that their efficient and effective administration is vital for provinces to improve their service delivery capacity, address backlogs in the various sectors and by so doing, progressively realise the constitutionally entrenched socio-economic rights of all citizens.

The allocations of conditional grants for each financial year are set out in the Division of Revenue Act (DORA), which is enacted along with the national budget in February each year. The DORA sets stringent conditions of use for the grants and requires rigorous in-year monitoring of spending. These conditions include the possibility of withdrawal of a grant if its conditions are not met by the incumbent provincial administration.

### Conditional grants received for 2000/01

During the 2000/01 financial year the Eastern Cape Department of Health received R431.2 million in conditional grants. Somewhat doubtfully (see chapters 5, 8 and 9), the department reported all the grants under its administration were fully spent during this year.

Received from	Purpose	Voted amount (R' 000)	Actual amount (R' 000)	Variance (R' 000) (overexpenditure)
Nutrition/National Department of Health	Feeding Scheme	131 838	131 838	0
Redistributory	Build capacity by providing tertiary care to the patient	32 510	32 510	0

1 Intergovernmental Fiscal Review, October 2001, pp. 112–113.

2 Intergovernmental Fiscal Review, October 2001, p. 117.

Received from	Purpose	Voted amount (R' 000)	Actual amount (R' 000)	Variance (R' 000)
Redistributory	Umtata Hospital Grant rollover	111 852	111 852	0
	National Grant transfer HIV/AIDS	2 213	2 213	0
	National grant	3 000	3 000	0
	Financial manag. in the prov. health departments			
Central Hospital Grant	Clinical Support Services	13 000	13 000	0
Heptar	Train all health professionals	52 830	52 830	0
Level 2 Academic Hospital	Nelson Mandela Academic Hospital	84 000	84 000	0
<b>TOTAL</b>		<b>431 243</b>	<b>431 243</b>	<b>0</b>

Source: Department of Health, Eastern Cape *Annual Financial Statements*, 2000/01, p. 22

### Conditional grants received for 2001/02

In the 2001/02 financial year, the department was allocated R383.7 million in conditional grants. It spent R285.9 million of its total allocation, thus recording an under-expenditure of R97.7 million (or 25 per cent).

Received from	Purpose	Total allocation (R' 000)	Actual expenditure (R' 000)	Variance (R' 000)
National Health Department	Professional training	73 485	56 793	16 692
	HIV/AIDS	8 281	2 899	5 382
	Central Hospital Grant	13 201	12 387	814
	Hospital rehabilitation	104 000	78 414	25 586



	Nutrition	131 838	95 613	36 225
	Redistribution special hospital services	52 938	39 877	13 061
	Nelson Mandela Academic Hospital	-	-	-
	Umtata Hospital Grant	-	-	-
<b>TOTAL</b>		<b>383 743</b>	<b>285 983</b>	<b>97 760</b>

Source: Department of Health, Eastern Cape *Annual Report*, 2001/02, p.75

The explanations offered by the department for its under-expenditure were as follows:

- Professional training: late rollovers caused delays in kick-starting projects.
- HIV/ AIDS: late transfer of grants and inappropriate loading of conditional grants. There was also a delayed tendering process for services earmarked for outsourcing.
- Central Hospital Grant: tender Board was dissolved meaning that projects could not commence.
- Hospital rehabilitation: there were some capacity problems.
- Nutrition: there was lack of financial and general administrative systems. Lack of HR resources led to underfeeding.
- Redistribution special hospital services: capacity problems were experienced and payments were delayed, something which led to under-expenditure.<sup>3</sup>

### Conditional grants received for 2002/03

In the 2002/03 financial year the Eastern Cape Department of Health was allocated R548.4 million in conditional grants. It reported spending R579.1 million of its allocation, thus recording an over-expenditure of R30.7 million.

<b>Purpose</b>	<b>Division of Revenue Act (R' 000)</b>	<b>Total Available (R' 000)<sup>4</sup></b>	<b>Actual</b>	<b>Variance</b>
Hospital Management Improvement	9 000	9 333	6 909	2 424

<sup>3</sup> Eastern Cape Department of Health, *Annual Report*, 2001/02, p.75.

<sup>4</sup> This includes adjustments and rollovers from the 2001/02 financial year.

HIV/AIDS	21 130	26 915	48 158	(21 243)
National Tertiary Services Grant	123 746	144 537	153 169	(8 632)
Intervention: District Hospitals			3 529	(3 529)
Intervention: Provincial Hospitals			5 683	(5 683)
Intervention: Specialised Hospitals			1 239	(1 239)
Hospital Rehabilitation	81 000	110 846	129 928	(19 082)
Academic Conditional Grant	70 169	88 756	93 398	(4 642)
Integrated Nutritional Project	131 838	168 063	137 160	30 903
<b>Total</b>	<b>436 883</b>	<b>548 450</b>	<b>579 173</b>	<b>(30 723)</b>

Source: Department of Health, Eastern Cape *Annual Report*, 2002/03, p. 206

The Department, however, did not provide any explanation for its over-expenditure. Moreover, three programs spent about R10 million which was not even allocated in terms of the DORA. These were: District Hospitals, Provincial Hospitals and Specialised Hospitals.<sup>5</sup> It is not clear why these programmes were not allocated conditional grants in the first instance, especially District Hospitals given the critical functions performed under this programme.

The administration of these grants is the responsibility of both the transferring (national) and receiving (provincial and local) government spheres.

National departments are responsible for the monitoring of compliance with the conditions of the grants and ensuring that the grants achieve their objectives. The provincial and local government departments are responsible for the spending of these grants and are financially accountable for this expenditure.<sup>6</sup>

5 Eastern Cape Department of Health, *Annual Report*, 2002/03, p. 206.

6 Intergovernmental Fiscal Review, October 2001, p. 113.

Failure to spend these grants as well as failure to monitor their qualitative expenditure, means that an administration loses the opportunity of timeously and adequately addressing the most pressing infrastructure and other developmental needs of its people.

Of course the problems of under-expenditure, over-expenditure, late transfers and even non-transfer of conditional grants are not unique to the Eastern Cape. The National Treasury attributes these problems, certainly during the initial stages in the evolution of the grants system, to confusion over accountability between the spheres of government (national and provincial), poor design and planning for the grants by departments, inadequate transparency in allocations, too many grants and poor monitoring by national departments.<sup>7</sup>

The effects of all these problems are borne out in the tables above, particularly for the last two financial years. With all the early warning mechanisms in the form of stringent in-year reporting to the National Department of Health, the Eastern Cape Department of Health still under-spent and over-spent on its conditional grants between 2001 and 2003.

The Interim Management Team (IMT) in 2003 identified the Eastern Cape Government as under-performing in its spending of these grants. The Department of Health, for instance, had under-spent its Hospital Management Support conditional grant by 37 per cent for the 2002/03 financial year.<sup>8</sup>

The national Department of Health was criticised by the national AG in his 2002/03 audit report for failing to comply with the DORA in terms of its duty to monitor and review the compliance of various provincial departments with transfer payment regulations and requirements. The national Department of Health transferred R7.1 billion in payments to the different provinces. This constituted 93.3 per cent of the national department's expenditure.<sup>9</sup> It is clear therefore that the national Department of Health's monitoring of conditional grants does requires significant improvement.

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7 Ibid.

8 IMT Report, June 2003, p. 17.

9 National Department of Health, *Annual Report, 2002/03*, p. 82.

# Appendix 2

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## Eastern Cape Health Strategic Planning 2000/01 to 2004/05

The following discussion contains an evaluation of the Eastern Cape Department of Health's strategic plans for the period 2000/01 to 2004/05. All strategic plans produced by public bodies in South Africa need to comply with a strict set of requirements set out in terms of the new Constitution (see Chapter 1). The two key pieces of legislation within this regulatory framework are the Public Finance Management Act (PFMA), 1999, and the Public Service Act (PSA), 1994.

### Legislative requirements and guidelines

Section 2 of the PFMA Implementation Guidelines, July 2000, on 'Actions to implement the PFMA' contains the following guidelines on strategic planning:

'In the preparation of the strategic plan the accounting officer<sup>10</sup> must have regard to the:

- (a) usefulness and appropriateness of the planned outputs in meeting the programme objectives/outcomes agreed by the executive authority for the department;
- (b) affordability of the plan, having regard to the resources likely to be available to the department and the overall fiscal policy of the Government;
- (c) achievability of the plan, having regard to the resources likely to be available and the vision, level of capacity and commitment of the people responsible for driving the process of achieving the department's objectives/outcomes; and
- (d) accessibility of the plan to those responsible for its execution and those to whom the department is accountable for their performance in executing the plan (the Executive Authority, the relevant Treasury and Parliament or the provincial legislature concerned).<sup>11</sup>

In addition, the Treasury Regulations set out the following requirements for strategic planning:

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10 In terms of the PFMA each government department must appoint an accounting officer (usually the Head of Department) who is 'responsible for the effective, efficient, economical and transparent use of the resources of the department'. In light of this, an accounting officer is held accountable for all financial matters within a department including the prevention of unauthorised, irregular and fruitless and wasteful expenditure. See PFMA Sect. 38.

11 National Treasury, PFMA Implementation Guide, July 2000, see [www.treasury.gov.za](http://www.treasury.gov.za), click Legislation, then click Public Finance Management Act, then click PFMA Implementation.

## ‘5.2 Strategic plans

5.2.1 The approved strategic plan must be tabled in Parliament or the relevant provincial legislature within 15 working days after the Minister or relevant MEC for finance has tabled the annual budget.

5.2.2 The strategic plan must:

- (a) cover a period of three years and be consistent with the institution's published medium term expenditure estimates;
- (b) include the measurable objectives and outcomes for the institution's programmes;
- (c) include details of proposed acquisitions of fixed or movable capital assets, planned capital investments and rehabilitation and maintenance of physical assets;
- (d) include details of proposed acquisitions of financial assets or capital transfers and plans for the management of financial assets and liabilities;
- (e) include multi-year projections of income and projected receipts from the sale of assets;
- (f) include details of the Service Delivery Improvement Programme;
- (g) include details of proposed information technology acquisition or expansion in reference to an information technology plan that supports the information plan; and
- (h) for departments, include the requirements of Chapter 1, Part III B of the *Public Service Regulations, 2001*.

5.2.3 The strategic plan must form the basis for the annual reports of accounting officers as required by sections 40(1)(d) and (e) of the Act.<sup>12</sup>

Finally, the 2001 Public Service Regulations set out the following requirements for departmental strategic plans:

### ‘B. Strategic Planning

B.1 An executing authority shall prepare a strategic plan for her or his department::

- (a) stating the department's core objectives, based on Constitutional and other legislative mandates, functional mandates and the service delivery improvement programme mentioned in regulation III C;
- (b) describing the core and support activities necessary to achieve the core objectives, avoiding duplication of functions;

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<sup>12</sup> Sect. 3, Treasury Regulations, 9 April 2001, Regulation Gazette No. 7048.

- (c) specifying the functions the department will perform internally and those it will contract out;
- (d) describing the goals or targets to be attained on the medium term;
- (e) setting out a programme for attaining those goals and targets;
- (f) specifying information systems that-
  - (i) enable the executing authority to monitor the progress made towards achieving those goals, targets and core objectives;
  - (ii) support compliance with the reporting requirements in regulation III J and the National Minimum Information Requirements, referred to in regulation VII H; and
- (g) complying with the requirements in paragraphs 5.1 and 5.2 of the Treasury Regulations.

B.2 Based on the strategic plan of the department, an executing authority shall:

- (a) determine the department's organisational structure in terms of its core and support functions;
- (b) grade proposed new jobs according to the job evaluation system referred to in Part IV;
- (c) define the posts necessary to perform the relevant functions while remaining within the current budget and medium-term expenditure framework of her or his department, and the posts so defined shall constitute the department's approved establishment; and
- (d) engage in the human resource planning in accordance with regulation III D with a view to meeting the resulting human resource needs.<sup>13</sup>

## Guidelines

According to the 'Guide for Accounting Officers, Public Finance Management Act' produced in October 2000 the first year of the strategic plan is known as the operational plan. The operational plan 'must provide a sufficiently detailed quantification of outputs and resources, together with service delivery indicators, for the legislature to understand exactly what it is buying' for the community when it approves the budget. The operational plan must not be a wish list, but must be flexible and adjustable while remaining within the MTEF allocation. The plan must contain:

- Descriptions of the various programmes that the department will pursue to achieve its objectives, and for each programme, the measurable objectives, total cost and intended lifespan.

<sup>13</sup> Sect. III, B, Public Service Regulations, January 2001, Regulation Gazette, No. 21951.

- Information on any conditional grants to be paid or received, including the criteria to be satisfied.
- Information on any new programmes to be implemented, including the justification for such programmes, expected costs, staffing and new capital, as well as future implications.
- Information on any programmes to be scaled down or discontinued during the financial year.
- Where two or more departments contribute to the delivery of the same service, a concise summary of the contribution of each department (the accounting officers must ensure that the summaries included in their respective plans are consistent).
- Summary information, drawn from the strategic plan, of all capital investments planned for the year, including the future impact on the operating budget (this information should be rolled forward, amended as appropriate, to the next year's strategic plan)'.<sup>14</sup>

The Guide also stipulates that 'the operational plan will include conditional grants, transfers and capital projects' and that 'the strategic and operational plans must be submitted to the relevant treasury by 30 June, together with the MTEF submissions'.<sup>14</sup>

Section 6 of the Normative Measures for Financial Management, (a guideline produced by the National Treasury, January 2003), which deals with 'Performance requirements for financial management for the public sector' states the following:

'The use of financial resources to achieve specified outputs must be monitored and controlled against the strategic and operational plans of the department by means of quantitative and qualitative data.'

In addition to the above requirements each strategic plan should comply with a guideline 'Generic Format for Strategic Plans of Provincial Departments' issued in July 2002 by the South African National Treasury.<sup>15</sup> The publication date of this document should not be interpreted to mean that departments up until this date were not expected to comply with these requirements. A reflection on the legislative provisions governing strategic planning by South African government departments and public entities (referred to in Chapter 1) indicate that this guideline simply serves to simplify, and provide more structure to, existing planning requirements.

<sup>14</sup> National Treasury, Guide for Accounting Officers, Public Finance Management Act, October 2000, see [www.treasury.gov.za/legislation/acts/pfma/gao.pdf](http://www.treasury.gov.za/legislation/acts/pfma/gao.pdf).

<sup>15</sup> Generic Format for Strategic Plans of Provincial Departments, Revised Document, National Treasury, 11 July 2002.

<sup>16</sup> This template is based on the guideline 'Generic Format for Strategic Plans of Provincial Departments', Revised Document, issued by the National Treasury, 11 July 2002.

## Evaluation Template for Strategic Planning<sup>16</sup>

All provincial government departments are required to produce strategic plans, to be presented to the Treasury by August of each year, which meet the following requirements:

### **1. Statement of policy and commitment by the MEC**

#### **Requirement:**

The executive authority of a department should set out clearly at the beginning of the strategic plan what policy priorities he or she has set for the year and which have informed the development of the strategic plan. The executive authority is responsible for ensuring that these policy priorities are in line with the provinces' overall priorities, the priorities set by the relevant national department and the priorities of the national government.

### **2. Mission and strategic goals**

#### **Requirement:**

The strategic plan should set out a clear statement of the department's vision, including its broad strategic goals and specific strategic objectives over the next three-year MTEF period. Strategic goals refer to the outcomes to be achieved by the department; strategic objectives are statements that concretely and specifically describe things that will be done to achieve the department's outputs.

### **3. Accurate profile information on service delivery environment**

#### **Requirement:**

Each government department should present accurate and up-to-date profile information relevant to the functions of the department. This information should include an assessment of the challenges facing the department, service delivery needs to be serviced by it, and a series of demographic indicators for the target population to be served. So, for instance, provincial Department of Healths should profile the health status of the people in the province, providing the latest demographic and epidemiological information on the spread of sickness and disease and the location of infected/affected groups.

### **4. Evaluation of current performance**

#### **Requirement:**

The department should provide an evaluation of its performance in the current year (based on its third-quarter 'Quarterly Report'), and indicate how this is likely to impact on its ability to meet the targets set out in the strategic plan for the current year. This will have an obvious impact on its plans and objectives for the coming year.

### **5. Consultation during the strategic planning process**

#### **Requirement:**

The usefulness of a department's strategic plan is to a large extent determined by the extent and depth of staff involvement in its development. Staff that have played a mean-



ingful role in developing a strategic plan are more likely to take ownership of it and thus actively work towards its implementation. The more effort taken to obtain stakeholder and community input into the department's planning process, the more likely the department's services will actually target the most pressing needs of the community.

## **6. Programmes and sub-programmes**

### **Requirement:**

The department's strategic objectives should be broken down into manageable programmes and sub-programmes with a set of clear programme objectives.

## **7. Measurable objectives, performance measures and targets**

### **Requirement:**

An appropriate set of measurable objectives should be set for each programme, and where appropriate for those sub-programmes that are of strategic importance. These measurable objectives should comply with the 'SMART' principle, i.e. they should be specific, measurable, achievable, realistic and time-bound. Linked to each measurable objective the department needs to provide one or more performance measures indicating the cost, quantity, quality and timeliness of the delivery of the output.

## **8. Reconciliation of plan with previous expenditure by programme**

### **Requirement:**

An account should be given of how actual spending trends have transpired in previous years and how MTEF projections correspond to strategic plan objectives.

## **9. Revenue**

### **Requirement:**

The department should provide a summary of its revenue, including a breakdown between the revenue voted by the Legislature and that obtained from conditional grants. The department should also provide a detailed explanation of its own revenue collection plans.

## **10. Co-ordination, co-operation and outsourcing**

### **Requirement:**

The department should provide details where it is jointly responsible for service delivery with another state department. It should indicate the exact extent of its responsibilities vis-à-vis the other departments. It should also state what mechanisms have been put in place to ensure good co-ordination among departments.

## **11. Local Government**

### **Requirement:**

Departments should give details of any service delivery agreements or arrangements they have with local authorities. This should include details of all funds that the

department will be transferring to local authorities for the delivery of such services. For instance, in certain provinces local authorities operate clinics for which they receive funding from health departments. Details of these service-level agreements should be listed in the strategic plan.

## **12. Public-private partnerships and outsourcing to NGOs**

### **Requirement:**

The department should provide a detailed account of its involvement in public-private partnerships, including their cost implications and division of responsibilities, and of its outsourcing and transfers to individual NGOs.

## **13. Financial management issues**

### **Requirement:**

The department should provide a detailed strategy for how it intends to follow up and address audit queries identified by the office of the AG in its annual audit report.

## **14. Capital expenditure and maintenance**

### **Requirement:**

In accordance with the PFMA, detailed information on the department's capital investment programme should be given:

1. What building projects are in progress, and when are they expected to be completed?
2. What new building projects are being planned, when will they commence and when will they be completed?
3. Are there any facilities whose closure or down-grading is being planned?
4. What plans are there for major refurbishing projects?
5. What is the department's maintenance backlog, and what are its plans to deal with the backlog over the MTEF period, and over five years and ten years?
6. How are the above developments expected to impact on current expenditures?

Information should also be given on the management of key moveable assets, such as plans to replace important items of medical equipment. This section should also give details of medium term maintenance plans, focusing on the following issues:

1. What is the current state the department's capital stock? (i.e. What per centage is in good, medium or bad condition?)
2. How much is the department planning to spend on maintenance? And what is the split between major maintenance expenditure and routine maintenance expenditure?
3. What is the schedule for major maintenance projects? The department should give detailed lists of assets under its control, and how its asset holding have changed over the past number of years and how they are likely to change in future.

# An Evaluation of the Eastern Cape Department of Health's Strategic Plans Between 2000/01 and 2004/05

## Strategic plan for 2000/01

The Eastern Cape Department of Health produced a ten-page strategic plan for the 2000/01 financial year. This plan does not indicate an overall costing of the department's planned activities and consequently does not reconcile with previous expenditure. MEC Goqwana's foreword to the plan does not detail clear policy priorities for the department but discusses a range of unrelated issues, such as the skills competencies that departmental managers are required to have in order to be effective in the execution of their duties. The foreword discusses the structure of the strategic plan and mentions a planning booklet to be distributed to district managers in order to facilitate better understanding of the planning process. It also points out that monitoring of service delivery by the department takes place through strategic reviews, quarterly and annual reports, monthly analyses of primary health care, annual quality health care audits in hospitals and clinics. The executive authority also expresses frustration about budget constraints experienced by the department.<sup>17</sup>

The vision and mission of the department, which have remained the same over all the financial years under review, are expressed as follows:

### Vision

'A health service to the people of the Eastern Cape Province promoting a better quality of life for all.'<sup>18</sup>

### Mission

'To provide and ensure accessible comprehensive integrated health services in the Eastern Cape Province emphasising the primary health care approach utilising and developing all resources to enable all its present and future generation to enjoy health and quality of life.'<sup>19</sup>

The strategic plan lists a number of 'Key Players' and 'Other Stakeholders'; including health professionals, unions, tertiary education institutions, NGOs and Local Authorities.<sup>20</sup>

There is no evidence of any consultation of these stakeholders in the preparation of the strategic plan.

The strategic plan then gives a SWOT analysis of Strengths, Weaknesses, Opportunities and Threats faced by the department. This analysis is so poorly done that the numbering of headings and sub-headings does not follow sequentially and the indentation is in disarray. The numbering of sub-headings follows the following numbering arrangement: '1', '2', '2', '4', '1' and '6'.<sup>21</sup>

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17 Eastern Cape Department of Health, Strategic Plan, 2000/01, p. 1.

18 Ibid.

19 Eastern Cape Department of Health, Strategic Plan, 2000/01, p. 2.

20 Eastern Cape Department of Health, Strategic Plan, 2000/01, pp. 4–5.

21 Ibid, p. 5.

On closer inspection, the SWOT analysis reveals some glaring contradictions. Under threats for instance the department identifies the braindrain of 'professionals', including nurses, to other countries such as the UK and Saudi Arabia as a serious concern.<sup>22</sup> Immediately below this discussion the department places, as its first point in its list of strengths, the 'availability of nurses'.

Another strength identified by the department is the 'erection and refurbishment of health facilities to ensure access', only to contradict this under its discussion of weaknesses. Here it lists the lack of infrastructure in rural areas – 'electricity, dilapidated hospitals, communication means, and access roads to facilities'<sup>23</sup> – as a weakness. Similarly, the centralised financial management of the department's budget by the provincial Treasury is listed as both a strength and a weakness without further clarity on the apparent ambiguity provided.<sup>24</sup>

The plan contains no profile information on the existing service delivery environment. In other words there is no evidence of a needs analysis having been conducted by the department. Such needs analysis would be critical in informing current planning. Closely linked to this process is an evaluation of the department's current performance based on the information it collects over a financial year in terms of quarterly reports and other monitoring tools. Such an evaluation is absent from the strategic plan.

The strategic plan then sets out eight strategies which constituted, by its reckoning, its comprehensive plan of action for this financial year. The strategic plan does not have a three-year horizon plan as required in terms of the MTEF. Under each strategy the department identifies at least one objective which is further broken down in terms of 'Key Performance Areas', 'Key Success Indicators', 'Who is Responsible (for the activity)' and a 'Timeline'. The objectives of the plan are sufficiently clear and specific. They are however lacking measurability and consequently a determination of their achievability is not possible.

There is no costing or time-frames linked to any of the activities identified by the department, nor is there any costing per programme. In fact the plan does not identify any of the activities under any programmes or sub-programme. Often there are two or more people responsible for the execution of an activity instead of one person who assumes ultimate responsibility.

For example, under Strategy 1 (Improvement of Access to Primary Health-Care Services), the persons responsible for the drafting of service charters for all branches under the provincial office and for hospitals and clinics are 'all directors and regional directors and district managers'.<sup>25</sup> This situation makes it difficult for oversight bodies such as standing committees to effectively exercise oversight over the department due to these blurred lines of accountability.

Under Strategy 2 (Institute Teamwork and Establish Explicit and Routine Communication and Co-ordination Mechanisms Throughout the Organisation), it becomes clear that

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22 Ibid.

23 Eastern Cape Department of Health, Strategic Plan, 2000/01, p. 5–6.

24 Ibid.

25 Eastern Cape Department of Health, Strategic Plan, 2000/01, p. 6.

this strategic plan was not completed during the year in question, because one of the key success indicators includes the drafting of the department's operational plan for the 2000/01 financial year. The officials responsible for this were the director and deputy director of policy planning.<sup>26</sup> Ordinarily the process of strategic planning commences at the start of a new financial year for the next financial year. So the drafting of this operational plan, which has a deadline to be drawn up three months into 2000, ought to have been completed by the end of the previous financial year in 1999.

The plan does not detail improvement plans for its own revenue collection, nor does it indicate any service delivery improvement plans. It does not detail any service delivery agreements and/or arrangements with any local authorities. There is no plan to address the Auditor General's audit queries arising out of his audit reports on the department. There is also no capital expenditure and maintenance plan detailed in the strategic plan.

### **Strategic plan for 2001/02**

The Eastern Cape Department of Health's 2001/02 strategic plan does not in all material respects meet the requirements set out by legislative framework governing strategic planning. The strategic plan does not have any commitment or statement of policy by the relevant MEC. Similarly, the plan does not offer profile information on the service delivery environment to be confronted in the coming year, and does not provide an analysis of the department's past performance which plays a vital role in terms of forward planning.

The plan starts off by discussing the individual programmes and sub-programmes without detailing its vision, mission and strategic goals. The programmes in some places have budgets indicated at the start of each discussion as well as a budget breakdown for each sub-programme. This represents a step forward in the quality of the department's planning. These budget estimations are important because the final budget allocations for the department are informed by these estimates. The estimates also serve as valuable comparisons with the final allocations in terms of adequacy of funding. As a result of the lack of these budget estimate figures the plan could not reconcile these figures with the previous year's expenditure figures per programme.

In a considerable advance over the previous year, the plan sets out tables for each programme which indicate activities, outputs, targets, officials assuming responsibility for the achievement of activities, the budget allocation and a quarterly break-down of the targets for each activity. This detailed format represented a remarkable improvement in the department's strategic planning in terms of the SMART principles (having objectives that are specific, measurable, achievable, realistic and time-bound).

Most of the department's major programmes are broken down into a number of coherent sub-programmes. For instance, Health Facilities Development and Maintenance will receive R231.071 million, which is broken down in the following manner:

- New facilities = R124.017 million
- Upgrading = R81 million (conditional grant)

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<sup>26</sup> Ibid, p. 7.

- Maintenance = R26 million<sup>27</sup>

However, a significant number of the objectives listed for department's programmes fail to offer any insight into how the department plans to actualise its aims. In other words, they are not specific enough. The aim in Programme 2 (District Health Services), for instance, is 'to develop and support district health services in the Eastern Cape'.<sup>28</sup> The key objectives listed in this regard include the following: 'To develop Government structures with Local Government and make preparatory work for devolution of services' and 'To improve district hospital services'.<sup>29</sup> It is unclear how these strategic objectives are intended to contribute to the achievement of the department's stated strategic goals.

Under each programme, the strategic plan sets out what the activities to be embarked on are. But often these activities are not very clear. For example, under Programme 5 (Health Sciences), the strategic goal is 'to provide adequate and competent nurses and emergency medical rescue personnel for the service in the Eastern Cape'.<sup>30</sup> Here, the key objectives are 'rationalisation of nursing colleges in the province; curriculum (sic) in order to meet the health needs and to being in line with the National Health Policy; Centralisation of the nursing education budget into Programme 5; provision of professional training in emergency medical rescue services for all health professionals in the Eastern Cape Province'.<sup>31</sup>

In going about these objectives, the department set itself the following activities: 'Training of nurses' and 'training of all emergency medical rescue staff to intermediate and advanced levels'.<sup>32</sup> Here again, these activities do not sound materially different from the objectives.

Almost all the stated activities in the plan are costed. But at times it is unclear how the costing matches with the activities. For example, in training all emergency medical rescue staff, the department set aside R1 million. The plan does not specify how many staff members are to be trained or for what purposes, or what the unit cost of the training will be.

The plan does provide a list of time-frames. Using the staff training example, for instance, the plan says that during the first quarter of the financial year personnel to be trained will be identified, during the second quarter the first group will be trained, the third group will be trained in the third quarter and the remainder will be trained in the fourth quarter.<sup>33</sup> This example, however, indicates that the identification of the activity (training) was arbitrarily arrived at as opposed to being based on a proper prior assessment of need. This is evident given that the individuals to be trained still need to be identified.

To its credit, the plan clearly provides the names of officials responsible for the achievement of particular activities, thus enabling oversight bodies to hold specific individual officials to account for action taken with respect to those activities.

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27 *Ibid.*, p. 47.

28 *Ibid.*, p. 29.

29 *Ibid.*

30 *Ibid.*, p. 44.

31 *Ibid.*

32 *Ibid.*

33 *Ibid.*

The plan provides a list of district municipalities it makes transfer payments to for specific hospital and clinic infrastructure projects.<sup>34</sup> For maintenance purposes, the time-frames of these projects are incorrect. The plan does not indicate the mechanisms for monitoring compliance with the terms of the transfer. It gives a short description of the nature of the project as well as its status, cost, start and finish dates. For example Project 5 at the All Saints hospital in Engcobo is described as 'New Wards'. Its status is described as 'Planning Underway', costed at R19.7 million. Its start date is December 2002 and completion date December 2003. The list however pertains to projects planned for 2002/03 through to 2004/05 and not for the year under review. For 2002/03 alone these projects are costed at over R231 million.<sup>35</sup> The project list is presented in tabular form without any accompanying explanatory notes that would indicate the arrangements the department would have made with the municipalities in terms of service-level agreements and other mechanisms to ensure clear lines of accountability for project accountability. While the department does provide some information on infrastructure plans, it does not provide any plans for the year under review.

The plan does not detail plans for improving its own revenue collection. It does not provide co-ordination, co-operation and outsourcing plans for the year under review nor does it set out its plan for addressing AG's queries as set out in his audit reports on the department.

### **Strategic plan for 2002/03**

In its 2002/03 strategic plan the Eastern Cape Department of Health points out that the plan is informed by the relevant 'legislative mandates and it is aligned with the ten-point plan set out by the National Department of Health'.<sup>36</sup>

As mentioned, in terms of the regulatory framework governing the South Africa public sector, the strategic plan should contain a statement of policy and commitment by the MEC setting out the policy priorities and strategic goals of the department. This is lacking in this strategic plan. More disturbingly yet, the plan does not provide an analysis of the service delivery environment and its performance in the previous financial year 2001/02. The plan is also incomplete in that it does not contain the operational plan component of the strategic plan. The department's explanation for this omission is that 'this is still being developed'.<sup>37</sup>

Although the department mentions its key stakeholders in the strategic plan,<sup>38</sup> there is no indication that these stakeholders were involved in the strategic planning process. This raises doubts as to whether the strategic plan is informed by a proper internal or external consultation process.

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34 Eastern Cape Department of Health, Strategic Plan, 2001/02. p. 50–56.

35 Eastern Cape Department of Health, Strategic Plan, 2001/02. p. 56.

36 Eastern Cape Department of Health Strategic plan, 2002/03, p. 2.

37 Eastern Cape Department of Health Strategic plan, 2002/03, p. 30.

38 Ibid, Appendix A, Sect. 8.

While the department provides a brief review of challenges facing it going into the next financial year, this cannot be said to constitute a thoroughly researched needs analysis for the year ahead. For example, the department acknowledges that it is faced with a serious problem of a 'brain-drain of health professionals' in public hospitals, the AIDS epidemic and escalating crime in clinics.<sup>39</sup> However, there is no indication of any plans in place to deal with these challenges.

The department sets out its main strategic goals as follows:

- Equitable access to a comprehensive integrated health system for all communities in the province.
- Health services that meet quality standards.
- Communities in the province that are active and responsible partners in health issues that affect them.
- Capacity building in the department to support improved implementation of its goals.
- Effective management of the department's assets.<sup>40</sup>

In an improvement on previous years, the department's strategic plan sets out a list of clear aims/goals under specific programmes, each containing several key objectives. Under Programme 1 (Administration), for instance, the department aims to 'render administrative and financial support services to the department'. Some of the key objectives set out to 'provide and develop human resources as well as to provide and manage financial and material resources'.<sup>41</sup>

The objectives are further broken down into activities which are linked to outputs, cost measures, quantity and quality measures. The objectives of this plan are generally specific and satisfactorily broken down further. Unfortunately, however, the plan only provides cost estimates for the majority of activities while others are not costed. The provisioning of information technology infrastructure, for instance, is not costed.<sup>42</sup>

From the outset there are glaring inadequacies regarding the coherence of the strategic plan's intended outputs and outcomes. Under Programme 1 (Administration), one of the activities is the building of management capacity within this division. The outputs for this activity are the implementation of capacity building programmes and drafting of reports.<sup>43</sup> This activity is costed at R250 000. The quantitative measure for this activity reads: 'Number of managers capacitated', while the qualitative measure reads: 'Improved management of human, material, financial and time resources'.<sup>44</sup> It is not clear how these latter two measures would be quantified and measured since the specific number of managers to be capacitated is not specified by the plan. Nor is an indication provided as to how improved

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39 Eastern Cape Department of Health Strategic plan, 2002/03, p. 2.

40 Ibid, p. 5.

41 Ibid, p. 6.

42 Ibid, p. 8.

43 It is not immediately clear what use these reports would be for capacity building. A reasonable assumption would perhaps be that these reports would aid in establishing the effectiveness of these capacity building programmes.

44 Eastern Cape Department of Health Strategic Plan, 2002/03, p. 6.



financial management is to be evaluated. The determination of the achievability of these immeasurable activities is therefore not possible. The objectives in themselves however remain realistic.

The financial year 2002/03 represents one of two years (the other being 2004/05) in which the department reconciled its previous year's spending per programme against its intended spending for the coming financial year.<sup>45</sup>

While the department acknowledges HIV/AIDS as a major challenge, it fails to adequately prioritise it in its strategic planning. Very little is mentioned about HIV/AIDS and where it is mentioned, the focus is on the provisioning of voluntary counselling and testing (VCT) services and not treatment.<sup>46</sup> The outputs set for increasing the number of pregnant women testing for HIV is the gathering of statistics on these women accessing VCT services. But as will be discussed in the evaluation of the 2003/04 strategic plans, the accuracy of these statistics can not always be relied on.

More disturbingly, there are no time-frames linked to many of the department's planned activities. For instance, the department indicated that it had planned to revamp 125 clinics, including health centres, at a cost of R37 million.<sup>47</sup> However, no indication is provided as to when this process is to be completed, nor which individual officials would be responsible for this activity. These omissions make it difficult to monitor progress and to hold the responsible officials accountable.

The department does not detail plans to address financial management issues raised by the AG through his audit reports, but simply lists areas within its financial management apparatus that 'require additional input'.<sup>48</sup> The plan does not provide a schedule of infrastructure projects that it is currently involved in. In addition, there are no detailed plans to improve on its own revenue collection for the next financial year.

Although the plan does briefly discuss its linkages with other departments (such as the Education and Social Development on HIV/AIDS co-operation, Agriculture and Water Affairs on cholera control, Home Affairs on the registration of births and deaths, Public Works on infrastructure development of health facilities and the Treasury on budget and skills development)<sup>49</sup> it does not detail the extent and nature of co-operation with the departments mentioned. The plan also notes the existence of linkages with local authorities. However, it does not provide names of the local authorities it has links with, and more importantly that it intends to transfer funds to.

The plan reports that it is considering a PPP to manage the distribution of drugs currently being administered by the two provincial pharmaceutical depots. It does not however say which companies are being considered or provide an indication as to what form the

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45 Eastern Cape Department of Health, *Strategic Plan, 2002/03*, p. 29.

46 *Ibid.*, p. 11–12.

47 Eastern Cape Department of Health, *Strategic Plan, 2002/03*, p. 23.

48 All the issues the department raises in this section are matters that the AG has raised over a number of years in his reports on the department's financial management. The department boasts that it was on the number three spot in the province in terms of compliance with the PFMA yet it had received an audit disclaimer in this year.

49 Eastern Cape Department of Health, *Strategic Plan, 2002/03*, pp. 29–30.

arrangement would take and what usefulness such an agreement would serve the province. No indication is provided as to how the establishment of such a PPP would serve to improve the current weaknesses in the information gathering on monitoring structures responsible for communicating drug needs to the provincial depots and the department itself. The malfunctioning of these monitoring structures (the failure to collect information from LSA pharmacy and therapeutics committees) is as much a factor in accounting for the problems experienced in the effective supply of drugs to provincial clinics and hospitals, as the mismanagement of the depots by department officials. Rather disturbingly, no reference is made to the decision to privatise this essential function being based on a report containing the findings of an investigation into problems currently being experienced with the management and distribution of drugs in the province.

Finally, the plan does not detail its infrastructure provisioning plans for the year under review.

### **Strategic plan for 2003/04**

While the 2003/04 strategic plan indicates a further improvement in the department's compliance with the legislative framework compared to 2002/03, there still remain inconsistencies. In the plan the MEC does not provide, in his overview report, the department's statement of policy. These policy priorities are situated elsewhere in the plan.<sup>50</sup> The plan does not detail strategies to deal with financial queries from the AG, or plans to improve on its own revenue collection. Nor does it provide basic details of its agreements and service delivery arrangements with local governments.

The plan does, however, contain a clear vision, mission and values statement as well as a useful situational analysis under each programme and sub-programme. The plan also contains broad strategic goals and key strategic objectives. Moreover, it sets out what the department's intended programmes and sub-programmes will be as well as how the department's objectives are broken down in terms of these programmes. The plan sets out budget allocation estimates under each programme.

The plan details the department's five main strategic goals along with corresponding strategic objectives. The strategic objectives remain the same from the previous year's plan. More corresponding objectives under each goal are, however included in this year's plan.<sup>51</sup>

In Programme 1 (Health Administration), the aim is 'to render administrative support services to the department'.<sup>52</sup> To this end, the department has, among others, the following objectives: 'Managing administrative, corporate and auxiliary services'; providing guidelines, support and strategic intervention' and 'adequately staffing itself with critical staff'.<sup>53</sup> The department acknowledges that the implementation of these objectives takes place within a context where the phenomenon of professional staff shortages ("brain drain") remains a key

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50 Eastern Cape Department of Health, *Strategic Plan, 2003/04*, p. 31.

51 See *Health Strategic Plan for 2002/03*, p. 5, and *Health Strategic Plan for 2003/04*, pp. 30–31.

52 Eastern Cape Department of Health, *Strategic Plan, 2003/04*, p. 33.

53 *Ibid.*

challenge.<sup>54</sup> It is disturbing to note, therefore, that the department's strategic plan does not provide pro-active strategies to address such challenges. Consequently, it remains unclear how the department hopes to achieve the majority of its goals.

Some of the objectives in the plan are again not immediately relevant to the stated goals. In Programme 2 (District Health Services), for example, the aim is 'to develop and support district health services in the Eastern Cape'.<sup>55</sup> The department's strategic objectives, which include 'developing government structures and delegate PHC functions to competent local government structures' and 'reducing mortality and morbidity rates'.<sup>56</sup> The last objective, does not read like an objective to address the stated goal. It is not clear how the reduction of morbidity will assist in developing and supporting district health services. Surely this is the desired outcome of such capacitation of all district health services.

Another shortcoming with the strategic plan is that while some programmes are clearly stated, and are accompanied by broad strategic goals and specific measurable objectives, the plan fails to assign specific responsibilities to specific people. In other words, it remains unclear as to who should co-ordinate the stated activities. For example, in Programme 7 (Health Care Support Services), the plan talks about facilitating the training of pharmacist's assistants on the accredited training programme, as one of the activities to be embarked on by the department in putting in place the stated objectives.<sup>57</sup> But the question as to who will conduct training, or who is responsible for carrying out the responsibility of training, remains unanswered.

Related to that is the general absence of costing of activities in the plan. Where costing is provided, it is not adequately calculated. The plan only details budgets for the individual programmes and sub-programmes, for the most part.<sup>58</sup> Activities in the plan are merely set out without clear funding proposals. It is therefore difficult to make any meaningful evaluation or comment on the adequacy of allocations under programmes without the itemised costs making up the budgets for activities.

Generally the plan's activities do not have specific time-frames attached to them (other than a reference to the end of the financial year). There are instances however where adequate (in-year) time frames are provided (examples discussed below) and it is for this reason that the department is deemed to have complied with this requirement. The compliance is nonetheless partial.

The objectives of the plan are generally measurable. Programme 2 (District Health Services, for instance, has a target of reducing infant mortality rates to 50 per 1 000 patients (from 60 per 1 000 in the previous year).<sup>59</sup> It plans to increase the number of districts with district managers from 95 per cent in the previous year to 100 per cent in the 2003/04 year

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54 Ibid.

55 Ibid, p. 38.

56 Ibid.

57 Ibid, p. 116.

58 Programme 6 (Health Sciences and Training) does not have a budget estimate attached to it.

59 Eastern Cape Department of Health, Strategic Plan, 2003/04, p. 48.

and upgrade 24 clinics and one community health centre in 2003/04.<sup>60</sup> Under Programme 4 (Provincial Hospital Services) the plan indicates that all health facilities by the 2003/04 year should have costed maintenance priority lists including the per centage ratio of maintenance costs vis-à-vis the hospital's expenditure.<sup>61</sup> It also indicates that three out of the nine provincial academic hospitals need to have completed their skills development work plans by the end of the year under review. Under Programme 6 (Health Sciences and Training), the plan indicates that the merger of various nursing colleges needs to have been finalised by December 2003 and the finalisation of a single provincial college administration's organogram to be completed by April of 2003.<sup>62</sup>

Some of the information utilised in the course of conducting the situational context for the plan is of questionable reliability and could potentially jeopardise the quality of service rendered by the department. Under the HIV/AIDS sub-programme the Eastern Cape population estimate is said to be '6 699 831 million' people.<sup>63</sup> The latest census figures (2001) put the province's population estimate at 6 436 761 million people.<sup>64</sup> Previous estimates (census 1996) indicated a population of 6 302 525 million people<sup>65</sup> for the province. It is unclear how the department arrived at this figure. Obtaining correct population estimates is vital for planning since budgeting in the health sector is largely determined by population figures.

Another example is found under the same sub-programme. A table titled 'Baseline Data on HIV/AIDS on PMTCT sites' tabulates the total number of patients who have enrolled for PMTCT treatment (17 262 patients). It indicates that of these people the total number who have been counselled and tested for HIV/AIDS is 4 713. The number of HIV-negative patients is put at 3 222 and that of HIV-positive patients is put at 1 336.<sup>66</sup> These numbers however do not add up to the original number of 4 713.

In an improvement on previous years, the plan provides a list of infrastructure projects running for across the province. This list was not made available in the previous year's strategic plan (2002/03). The list details the facility's name and a brief, often inadequate, description of the nature of the project. The cost of the project is provided but no timeframes are indicated for the completion of the projects. All indications are that the projects will continue at least until 2005/06.<sup>67</sup> The All Saints hospital, for instance, discussed earlier, will in the 2003/04 financial year receive an amount of R12 million for the construction of wards; in 2004/05 the allocation for this project will increase to R14 million and in 2005/06 the project is estimated to receive R15.3 million.<sup>68</sup> The plan does not provide any information on measures taken to ensure satisfactory implementation of these projects nor does it

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60 Ibid, p. 49.

61 Ibid, p. 80.

62 Ibid, p. 100.

63 Eastern Cape Department of Health, Strategic Plan, 2003/04, p. 52.

64 <http://www.statssa.gov.za/Specialprojects/Census2001/Census/dialog/Saveshow.asp>.

65 <http://www.statssa.gov.za/Specialprojects/Census96/HTML/CIB/Population/25.htm>.

66 Eastern Cape Department of Health, Strategic Plan, 2003/04, p. 55.

67 Ibid, p. 124.

68 Ibid, p. 125.

provide progress reports on the outputs of projects that have been funded for several years. In short, it contains no indication of how it will monitor the department's expenditure on infrastructure and maintenance or its performance in respect of implementation. So while the department is deemed to have complied with the requirement of setting out its infrastructural plans, the detail of these plans is entirely inadequate for the purposes of holding it accountable for its performance.

### **Strategic plan for 2004/05**

While the department's strategic plan indicates a cost amount for most of its programmes, it does not give a global budgetary figure for its activities in this financial year. According to the 2004/05 Budget Speech document, the department was allocated a budget of R5.410 billion for this financial year.<sup>69</sup> The plan also indicates a conditional grant amount of R116.354 million for the year.<sup>70</sup>

The strategic plan starts off by providing, at some length, a sectoral situational analysis including the province's epidemiological profile. It then goes on to list the strategic goals as well as challenges faced by the department. The objectives of the department are broken down under programmes and sub-programmes. These objectives are linked to performance indicators which in turn are linked to yearly targets. The yearly targets begin from 2002/03 through to 2006/07, indicating the progress made by the department in each financial year in terms of performance against each target.

In his foreword to the plan, instead of setting out the department's policy priorities for the year, the MEC for Health lists a number of challenges faced by his department. He does not provide an indication of what the department's policy priorities are and how these have changed from the previous year.

There is a mismatch between some of the department's strategic goals and its strategic objectives. For example, Strategic Goal 1 is "Ensuring equitable access by all communities to an essential package of services through DHS". One of the objectives set to achieve this goal is "Implementation of health programmes to reduce morbidity and mortality rates in our communities".<sup>71</sup> This objective is not immediately relevant to the goal. For the most part, however, the goals are clearly linked to the department's strategic objectives.

It is apparent that the quality of the situational analysis information forming part of the department's strategic plan has improved between 2003/04 and 2004/05. The plan now includes information on socio-economic disparities in the province with a useful epidemiological profile. There is however no detailed demographic or geographical breakdown for important diseases such as HIV/AIDS and TB. These details would serve to identify current and future service delivery needs.

This additional information aside, much of the information cited in the previous year's situational analysis has simply been repeated verbatim for 2004/05. Of concern is the fact

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69 Eastern Cape Budget Speech 2004/05, 26 February 2004, p. 18.

70 Eastern Cape Department of Health, Strategic Plan, 2004/05, p. 141.

71 Eastern Cape Department of Health, Strategic Plan, 2004/05, p. 34.

that the information on District Health Services facilities has not been altered. It cites the same information as the 2003/04 plan,<sup>72</sup> most of which dates back to 1999 or 2000. Some of this information concerns clinics and facilities connected to electricity supplies, with access to piped water and telephones. This defeats the object of undertaking a situational analysis and of basing strategic decisions on this situational analysis.

The department also includes a situational analysis for its main programmes and most important sub-programmes. This constitutes an improvement over previous strategic plans. However, the quality of the information contained in these situational analyses is often limited to providing a list of broad challenges without stipulating the exact details of problems encountered during the financial year.

For instance, under Programme 1 (Health Administration), staff recruitment and staff retention are listed as key challenges.<sup>73</sup> However, no figures for exact staff turnover and vacancies per job category are provided. Consequently, it will not be possible to determine whether sufficient measures have been taken in this regard or if there has been an improvement/deterioration in the department's performance when it produces its annual report.

The department fails to provide an account of the processes followed in order to obtain stakeholder and community input into its planning process. This is despite the fact that one of its strategic goals is identified as the need to ensure that "communities throughout the province become active, responsible partners in health issues that effect them".<sup>74</sup>

The plan provides an indication of its past performance (for 2003/04) in the tables reflecting the objectives, indications and annual targets of the department. These indications of past performance are useful for reflecting on what still needs to be achieved. Under Programme 2 (District Health Services), for example, the department indicates that a number of LSAs need to have 80 per cent functional integration of public health services (with the department). In 2003/04 only one LSA achieved this goal. The target for 2004/05 is to have four LSAs achieve this goal.<sup>75</sup> The same LSAs are expected to draw up integrated district health plans. In 2003/04 none of the LSAs had this plan, but in 2004/05, four LSAs are expected to draw up these plans.<sup>76</sup>

With regards to the department's objectives being 'SMART', the department lists sets of objectives and indicators. No specific outputs are listed and all targets appear to be set for the end of the 2004/05 financial year. None of the objectives are linked to actual activities which are costed. For instance, none of the actual HIV/AIDS sub-programme activities are listed (or costed) in the budget.<sup>77</sup> This makes it impossible to make a judgment on the merits of the budget allocation to this programme.

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72 See Health Strategic Plan for 2003/04, p. 41, and the Health Strategic Plan for 2004/05, p. 49. In both these plans the department presents a table which illustrates the number of health care facilities in the different districts of the province. The last line in the table shows the total number of facilities and beds in the entire province. In the 2003/04 plan the number of health facilities was 856 in the province. This number decreased in the 2004/05 plan to 786 facilities (739 + 47), while the number of beds in the province remained the same at 8 330. This discrepancy is not explained by the department.

73 Eastern Cape Department of Health, Strategic Plan, 2004/05, p. 39.

74 *Ibid.*, p. 35.

75 Eastern Cape Department of Health, Strategic Plan, 2004/05, p. 63.

76 *Ibid.*

77 Eastern Cape Department of Health, Strategic Plan, 2004/05, pp. 75–76.

The figures contained in Table 16 of the department's report (Evolution of expenditure by budget programme and sub programme in current prices), do not add up and appear to be incorrect. The figures do not add up as a result of not being properly aligned from one page to the next. On one page there are seven columns of figures representing seven financial years, whereas on page eight there are only five columns.<sup>78</sup>

Unlike in the previous financial year where a certain number of in-year time-frames were indicated, this plan does not contain any reference to these time-frames. All the time-frames indicated are for the end of the 2004/05 financial year, making it difficult for oversight bodies to adequately monitor activity progress during the year.

In addition the department's strategic plan does not contain any information on its plans for the improvement of its own revenue collection. The plan does however provide a reconciliation of its previous year's expenditure with expected spending per programme for the 2004/05 year.<sup>79</sup>

Of concern, whilst the plan provides a list of transfers to municipalities (under Programme 2),<sup>80</sup> it does not provide a detailed indication of the specific activities these transfers are for (it simply indicates that some of these amounts are for NGOs). It mentions that these transfers are governed by service-level agreements but does not indicate the terms and conditions set out in these agreements.

As regards PPPs listed under Programme 7, the plan indicates the department's intentions to establish a PPP for 'management support for pharmaceutical depots' and for the 'distribution of pharmaceutical, medical and surgical supplies'.<sup>81</sup> However, the terms of the proposed contract, and an indication of who the contract is to be entered into with, are not supplied. Moreover, in terms of the department's analysis of the 'current situation' regarding these depots<sup>82</sup> contained in the strategic plan, it is unclear how the establishment of the PPP will resolve problems relating to broader drug supply management systems in the department. In particular, the vital role played by district and hospital Pharmacy and Therapeutics Committees in communicating ongoing drug requirements is overlooked.

Although Programme 1 (Administration) indicates an intention to reduce the number of emphasis of matter issues contained in the AG's audit report<sup>83</sup> it does not provide a detailed strategy for how it intends to follow-up and address individual audit queries.

The information provided on District Health Service Facilities is exactly the same as that provided for the 2003/04 plan,<sup>84</sup> most of which dates back to 1999 or 2000. Some of this information concerns undertakings to provide infrastructure for clinics and facilities not connected to electricity supplies, and without access to piped water and telephones. Unless this information is regularly updated this defeats the object of undertaking a situational analysis

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78 Eastern Cape Department of Health, Strategic Plan, 2004/05, pp. 32–33.

79 Eastern Cape Department of Health, Strategic Plan, 2004/05, p. 30.

80 Eastern Cape Department of Health, Strategic Plan, 2004/05, pp. 66–67.

81 Ibid, p. 130.

82 Eastern Cape Department of Health, Strategic Plan, 2004/05, pp. 125–126.

83 Ibid, p. 40.

84 See Health Strategic plan for 2003/04, pp. 42–43, and Health Strategic Plan for 2004/05, pp. 49–50.

and of basing strategic decisions regarding infrastructure commitments on this situational analysis.

The department continues to rely on a provincial hospital audit profile undertaken in 1998/99 to describe the infrastructure status of its hospitals.<sup>85</sup> This information is now five years old, and provides no account of the sums of money spent on hospital maintenance and infrastructure during this time.

An Annexure B attached to the strategic plan, sets out an account of budgeted infrastructure expenditure per health facility for the financial years between 2002 and 2005. However, this annexure does not provide a schedule and time-frames for major maintenance projects. Disturbingly, this annexure concludes with the following cautionary remark: 'NB: Schedule of implementation of the clinic building will depend on available funds.'<sup>86</sup> This tends to indicate that the department does not have any indication of how much funds are currently available for spending during the 2004/05 financial year.

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85 Eastern Cape Department of Health, Strategic Plan, 2004/05, pp. 51–57.

86 Eastern Cape Department of Health, Strategic Plan, 2004/05, p. 149.



# Appendix 3

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**CASE NO:**

**IN THE HIGH COURT OF SOUTH AFRICA  
(EASTERN CAPE DIVISION)**

**In the matter between:**

**PUBLIC SERVICE ACCOUNTABILITY MONITOR** **First Applicant**

**COLM ALLAN** **Second Applicant**

**and**

**THE HEAD: DEPARTMENT OF HEALTH  
EASTERN CAPE PROVINCIAL GOVERNMENT** **First Respondent**

**THE MEMBER OF THE EXECUTIVE COUNCIL  
DEPARTMENT OF HEALTH  
EASTERN CAPE PROVINCIAL GOVERNMENT** **Second Respondent**

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## **NOTICE OF MOTION**

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KINDLY TAKE NOTICE THAT the above named applicants intend to apply to this court for the following relief:

1. An order compelling the respondents to provide the applicants with the following records, within 10 days of the date of such order:
  - 1.1. All business plans and/ or operational plans and/or implementation plans compiled by or under the authority of the respondents relating to the treatment, combating and prevention of HIV/AIDS programmes in the public sector of the Eastern Cape Province for the period 1999/00 to 2003/04.
  - 1.2. All monthly, quarterly and any other reports prepared by the accounting officer of the Department of Health on budgeted HIV/AIDS expenditure for the period of and between the financial years 1999/00 to 2002/03 inclusive.
  - 1.3. All monthly, quarterly and any other reports prepared by or under the authority of the respondents on expenditure made of conditional grants allocated to HIV/AIDS programmes in the Eastern Cape Province, for the period of

and between the financial years 1999/00 to 2002/03 inclusive.

- 1.4. The updated version of the Implementation and Training Plan for the Prevention of Mother-to-Child Transmission Programme ('PMTCT') for the Eastern Cape for the period 2003/04.
- 1.5. The following detailed reports in respect of the PMTCT programmes and the Post Exposure Prophylaxis ('PEP') Programme for the treatment of rape survivors:
  - 1.5.1. Reports on capacity audits conducted on all Eastern Cape hospitals in respect of their state of preparedness to introduce PMTCT programmes and to administer anti-retrovirals.
  - 1.5.2. Detailed reports on the implementation of PMTCT programmes at the province's two pilot sites and within hospitals already participating in the department's PMTCT programme.
  - 1.5.3. Implementation plans for the roll-out of the PMTCT programme to all Eastern Cape hospitals.
  - 1.5.4. Reports on the training of nurses and health care workers within hospitals and clinics across the Eastern Cape on the administration of anti-retrovirals for PMTCT purposes.
  - 1.5.5. Standard Treatment Guidelines issued to all clinics and hospitals in the Eastern Cape concerning the administration of anti-retrovirals to pregnant mothers and rape survivors.
  - 1.5.6. Reports and plans detailing the procurement, distribution and supply of anti-retrovirals and HIV test kits for PMTCT and 'PEP for rape survivors' programmes in the Eastern Cape.
  - 1.5.7. Reports and plans detailing the procurement, distribution and supply of milk formula to HIV-positive mothers, participating in PMTCT programmes, in the Eastern Cape.
  - 1.5.8. Reports and plans detailing the procurement, distribution and supply of essential medicines for the treatment of opportunistic infections in HIV-positive patients, such as anti-tuberculosis drugs, fluconazole and cotrimoxazole, in the Eastern Cape.
2. An order directing each of the respondents, jointly and severally, the one paying the other to be absolved, to pay the costs of this application.
3. Further, other or alternative relief.

KINDLY TAKE NOTICE FURTHER THAT the affidavit of the COLM ALLAN, together with annexures thereto, will be used in support of this application.

KINDLY TAKE NOTICE FURTHER THAT the applicants have appointed the office of

their attorneys, Messrs Netteltons of GRAHAMSTOWN, at the address given below, as the address at which they will accept notice and service of all process, documents and notices in these proceedings, marked for the attention of Mr M Rusa.

KINDLY TAKE NOTICE FURTHER THAT if either of the respondents intend opposing this application, they are each required:

1. To notify the applicants' attorney of record in writing, within fifteen (15) days of the service of the notice of motion, of such intention to oppose;
2. Within fifteen (15) days of notifying the applicants' attorney of their intention to oppose the application, to deliver their answering affidavit, if any, together with any relevant documents in answer to the allegations made by the applicants; and
3. To appoint in their notice of opposition an address, within 8 kilometres of the office of the Registrar at which they will accept notice and service of all documents in these proceedings.

If no notice of intention to oppose is given, the application will be made on Thursday 4 September 2003 at IOhOO, or as soon thereafter as counsel may be heard.

DATED at GRAHAMSTOWN this 25th day of JULY 2003.

**NETTELTONS**

Applicants' attorneys

118 High Street

GRAHAMSTOWN

6139

Telefax:(046) 6227197

Telephone:(046) 6227149

(Ref: Mr M Rusa)

**TO:** THE REGISTRAR  
HIGH COURT  
GRAHAMSTOWN

**AND TO:** THE HEAD: DEPARTMENT OF HEALTH  
First Respondent  
Department of Health  
Eastern Cape Provincial Government  
Dukumbana Building  
Independence Boulevard  
c/o STATE ATTORNEY  
BISHO

**AND TO:** THE MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH  
Second Respondent  
Department of Health  
Eastern Cape Provincial Government  
Dukumbana Building  
Independence Boulevard  
c/o STATE ATTORNEY  
BISHO

# Appendix 4

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**IN THE HIGH COURT OF SOUTH AFRICA  
(EASTERN CAPE DIVISION)**

**CASE NO:**

**In the matter between:**

**PUBLIC SERVICE ACCOUNTABILITY MONITOR**

**First Applicant**

**COLM ALLAN**

**Second Applicant**

**and**

**THE HEAD: DEPARTMENT OF HEALTH  
EASTERN CAPE PROVINCIAL GOVERNMENT**

**First Respondent**

**THE MEMBER OF THE EXECUTIVE COUNCIL  
DEPARTMENT OF HEALTH  
EASTERN CAPE PROVINCIAL GOVERNMENT**

**Second Respondent**

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## **FOUNDING AFFIDAVIT**

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I, the undersigned

COLM ALLAN

State under oath:

1. The facts contained in this affidavit are, save where otherwise stated or as appears from the context, within my personal knowledge. The facts to which I depose below are to the best of my knowledge and belief true and correct.
2. I am an adult person and the director of the Public Service Accountability Monitor, ('the PSAM'), a voluntary association and the first applicant in this matter. I am duly authorised to bring this application on behalf of the PSAM and depose to this affidavit on its behalf.

### **A THE PARTIES**

3. The first applicant is the Public Service Accountability Monitor, a voluntary association with perpetual succession, capable of instituting proceedings in its own name, with its

place of business situated at the campus of Rhodes University, Somerset Street, Grahamstown. A copy of the Constitution of the PSAM is annexed to this affidavit and marked 'CA'.

4. I am the second applicant in this matter, an adult person and the director of the PSAM, employed at the address stated above. I bring this application in addition to that stated above, in my personal capacity, only in the event and insofar as it may be found for purposes of these proceedings that I am the 'requester' as defined in the Promotion of Access to Information Act no 2 of 2000 ('the Information Act'), or in the event that the locus standi of the first applicant is rejected for any other reason.
5. The first respondent is the Head of the Department of Health in the Eastern Cape Provincial Government, employed at its offices situated at Room 543 Dukumbana Building, Independence Avenue, Bisho. The first respondent is cited in his capacity as the 'information officer' as defined in the Information Act.
6. The second respondent is the Member of the Executive Council for the Department of Health in the Eastern Cape Provincial Government, at the same address stated in the previous paragraph. The second respondent is cited in his capacity as the 'relevant authority' as defined in the Information Act.

## **B THE ISSUE**

7. This is an application made in terms of sections 78 and 82 of the Information Act to compel the production of public records that the respondents' department is required to compile setting out its budgeted and actual expenditure on all programmes, (completed, current and proposed), dealing with the prevention and combating of the HIV/AIDS pandemic within the Eastern Cape province for the period 1999/00 and the forthcoming 2003/04 financial years.
8. In addition to the above, the applicants seek the respondents' plans and progress reports prepared to implement and monitor the Department of Health's programmes for the prevention of mother-to-child transmission of HIV ('PMTCT') and post-exposure prophylaxis ('PEP') to prevent the transmission of HIV to rape survivors, in the Eastern Cape Province.
9. These records were duly requested by the first alternatively the second applicant in terms of s 18 of the Information Act on 4 April 2003. This elicited no substantive response from the information officer in the provincial Department of Health. An appeal duly noted against this deemed refusal on 27 May 2003 in terms of section 74 of the Information Act to the relevant authority yielded a similar result. This is also deemed to constitute a refusal in terms of the said Act.

## **C STANDING OF THE APPLICANTS**

10. The Public Service Accountability Monitor (PSAM) is an independent monitoring unit, which is dedicated to strengthening democracy in South Africa. The unit is based at Rhodes University in Grahamstown and is accountable to an independent Management Board made up of civil society representatives.
11. We gather information on the management of public resources and the delivery of pub-

lic services by government departments. A particular focus within this is how cases of discovered corruption and mismanagement of these resources are dealt with by the provincial government itself. This information is collected in a rigorous, objective and politically impartial fashion. By publishing this information the PSAM hopes to give members of parliament, civil society organisations and ordinary citizens the tools necessary to hold government ministers and public officials accountable for their performance. Through our website we also hope to give government ministers and officials the opportunity to communicate their successes and explain problems encountered with service delivery to the South African public.

12. The PSAM's mission is to promote the efficient and accountable management of public resources and to improve government service delivery in South Africa, particularly within South Africa's Eastern Cape province.
13. Our strategic objective is to promote accountability and efficiency in the management of public resources by the following 3 main projects:
  - 13.1. Case Monitoring: this involves tracking reported cases of public sector misconduct, mal-administration and corruption, and the corrective action taken in response to these cases.
  - 13.2. Performance Monitoring: this involves looking at the budget allocations of government departments, their strategic plans, problems experienced in the implementation of these plans, and whether the services delivered by these departments meet peoples socio-economic rights and provide value for money.
  - 13.3. Civic Empowerment: this involves providing other civil society organisations with information about the responsibilities of public officials and appropriate mechanisms for voicing complaints about poor public services. It also involves limited monitoring of infrastructure projects and service delivery at welfare pay points and health facilities.
14. All of this information is published on our website (<http://www.psam.org.za/>). Within the next month some of this material will also appear in a provincial newspaper, the *Daily Dispatch*, under a column dedicated to monitoring public services in this province.
15. The present matter arises out of the PSAM's performance monitoring function and in particular the performance of the respondents' department required in terms of the order made against, *inter alia*, the present second respondent by the Constitutional Court on 5 July 2002 in the matter of *Minister of Health and Others v Treatment Action Campaign and Others (no.2)*.<sup>87</sup> In its judgment in that case ('the TAC case'), the Constitutional Court, pertinently noted that:

'The magnitude of the HIV/AIDS challenge facing the country calls for a concerted,

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87 2002 (5) SA 721 (CC) at 762–765 (124–135); 2002 (10) BCLR 1033 (CC) at 1069–1072.

co-ordinated and co-operative national effort in which government in each of its three spheres and the panoply of resources and skills of civil society are marshalled, inspired and led. This can be achieved only if there is proper communication, especially by government. In order for it to be implemented optimally, a public health programme must be made known effectively to all concerned, down to the district nurse and patients. Indeed, for a public programme such as this to meet the constitutional requirements of reasonableness, its contents must be made known appropriately.<sup>88</sup>

16. The PSAM assisted the Treatment Action Campaign ('TAC') by providing a supporting affidavit for the applicants in the TAC case, based on information obtained by us in the pursuit of our activities referred to above. PSAM argued that the Eastern Cape Department of Health's contention that it could not afford to implement a general MTCT programme in the province could not be sustained. We were able to show that the department had not spent R33 million earmarked for AIDS programs and that it had been spending R10.9million a year on the salaries of 240 officials who had passed retirement age. One was 86 years old. In this way we played a small role in contributing toward the successful judgment obtained in favour of TAC regarding the distribution of anti-retroviral medication and the implementation of a comprehensive MTCT treatment programme.
17. The denial of access to information held by public bodies, particularly about matters that concern the provision of health care to prevent and combat the transmission of HIV/AIDS,<sup>89</sup> (more especially where children and rape survivors are involved) are all matters that concern fundamental rights contained in the Bill of Rights in the Constitution of the Republic of South Africa Act, no. 108 of 1996. ('the Constitution'). The applicants allege that these rights are all threatened and infringed by the respondents' refusal to supply the documents requested in this matter.
18. The applicants accordingly approach this Court, in addition to their capacities set out above:
  - 18.1. on behalf of all other persons in the Eastern Cape Province who because of poverty, or other limitation on their access to resources cannot act in their own name; and
  - 18.2. in the public interest as permitted in terms of section 38 of the Constitution.

## **D PURPOSE OF THE REQUEST FOR INFORMATION**

### **Di Introduction**

19. The applicants' request for the respondents' records in terms of the Information Act arises out of our desire to monitor the provincial health department's performance in dealing with the HIV/AIDS pandemic generally as well as our particular concern to monitor the respondents' department's compliance with the terms of the order made by the Constitutional Court in the TAC case against, *inter alia*, the present second respondent.
20. In terms of the Constitutional Court's order in the TAC case, *inter alia*, the second re-

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<sup>88</sup> *Ibid* at (123).

<sup>89</sup> In the TAC case, the Constitutional Court labels HIV/AIDS as '... the greatest threat to public health in our country' (at para 93).



- spondent is required to:<sup>90</sup>
- 20.1. Remove all restrictions preventing nevirapine from being used in public hospitals for MTCT purposes.
  - 20.2. Facilitate making nevirapine available at all public hospitals and clinics in South Africa where the medical practitioner and hospital superintendent prescribe it for MTCT purposes.
  - 20.3. Make provision for counsellors to be trained in how to advise patients in the use of nevirapine.
  - 20.4. Take reasonable measures to extend counselling and testing facilities to all hospitals and clinics in order to expedite and facilitate the use of nevirapine for MTCT purposes.
21. Paragraph 122 of the judgement calls on government to reformulate its current HIV/AIDS policy to establish a more comprehensive policy which encourages the use of all available resources to give pregnant women and their babies access to such resources, including nevirapine and proper counselling in its use.<sup>91</sup>
22. In the TAC case, the Constitutional Court re-affirmed its earlier pronouncements in the *Grootboom*<sup>92</sup> matter that '(A)n otherwise reasonable programme that is not implemented reasonably will not constitute compliance with the State's obligations.'<sup>93</sup> The Constitutional Court furthermore noted the important role to be played by all sectors of the community and in particular civil society, in monitoring whether implementation of the stated programmes does occur as envisaged.<sup>94</sup>
23. The PSAM is committed to providing accurate information to other civil society organizations like TAC, which, in turn are committed to campaigning for people's socio-economic rights. The facts and figures obtained by the PSAM in this matter will help to hold government accountable for the level of public services that it provides in the Eastern Cape Province.

## **Dii Business, Operational and/or Implementation Plans**

24. One of the most effective ways in which civil society can monitor the performance of government departments is by examining its budgeted expenditure for specific projects and comparing this against the actual expenditure recorded for each category reported on within the project.

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90 Paragraph 135 of the judgment *op. cit.*

91 The full text of the order in this regard reads as follows:

'2. It is declared that:

(a) Sections 27(1) and (2) of the Constitution require the government to devise and implement within its available resources a comprehensive and co-ordinated programme to realise progressively the rights of pregnant women and their newborn children to have access to health services to combat mother to child transmission of HIV.

(b) The programme to be realised progressively within available resources must include reasonable measures for counselling and testing pregnant women for HIV, counselling HIV-positive pregnant women on the options open to them to reduce the risk of mother to child transmission of HIV, and making appropriate treatment available to them for such purposes.'

92 *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC) ; 2000 (11) BCLR 1169 (CC) at (para 42).

93 TAC judgment, *op cit* at (para 100).

94 TAC judgment, *op cit* (paras 123 and 126).

25. In terms of the Public Finance Management Act (PFMA), 1999, and the Public Service Act (PSA), 1994 all government departments (both provincial and national) are required to produce annual strategic plans setting out the objectives and activities planned for all individual programmes within that department for the forthcoming year. These plans form the basis of that department's budgetary allocation from the treasury for each individual project which is submitted by the MEC for Finance to the provincial legislature for approval during his annual budget speech at the end of February each year. Thereafter, the MEC responsible will finalise the departmental strategic plan based on the funds to be allocated to specific projects by the treasury and submit the finalised plan to the provincial legislature for approval during or about the middle of March each year.
26. The PFMA and the PSA are fleshed out by a set of Treasury Regulations and Public Service Regulations. These regulations include a number of stipulations when it comes to budgeting and the drawing up of department's strategic plans. All strategic plans must:
- be drawn up by a Minister/MEC responsible for the department;
  - include measurable objectives and outcomes for the institution's programmes;
  - describe the core and support activities necessary to achieve the core objectives;
  - describe the goals or targets to be attained over the medium term;
  - set out a programme for attaining those goals and targets;
  - determine what posts will be required to meet its functions and plan its human resources accordingly; and
  - include details of the Service Delivery Improvement Programme for the department.
27. According to the 'Guide for Accounting Officers, Public Finance Management Act' produced by the National Treasury in October 2002 the first year of the strategic plan is known as the operational plan. The operational plan 'must provide a sufficiently detailed quantification of outputs and resources, together with service delivery indicators, for the legislature to understand exactly what it is buying' for the community when it approves the budget. The plan must contain:
- Descriptions of the various programmes that the department will pursue to achieve its objectives, and for each programme, the measurable objectives, total cost and intended lifespan
  - Information on any conditional grants to be paid or received, including the criteria to be satisfied
  - Information on any new programmes to be implemented, including the justification for such programmes, expected costs, staffing and new capital, as well as future implications
  - Information on any programmes to be scaled down or discontinued during the financial year

- Where two or more departments contribute to the delivery of the same service, a concise summary of the contribution of each department (the accounting officers must ensure that the summaries included in their respective plans are consistent)
  - Summary information, drawn from the strategic plan, of all capital investments planned for the year, including the future impact on the operating budget (this information should be rolled forward, amended as appropriate, to the next year's strategic plan)'.
28. This Guide also stipulates that 'the operational plan will include conditional grants, transfers and capital projects' and that 'the strategic and operational plans must be submitted to the relevant treasury by 30 June, together with the MTEF submissions'.
29. Sect 6 of the Normative Measures for Financial Management, (a guideline produced by the National Treasury, January 2003), which deals with 'Performance requirements for financial management for the public sector' states that: '(T)he use of financial resources to achieve specified outputs must be monitored and controlled against the strategic and operational plans of the department by means of quantitative and qualitative data'.
30. The PSAM is in possession of a draft Eastern Cape HIV/AIDS implementation plan for 2002/03, which was drafted by the Eastern Cape Socio-Economic Consultative Council (ECSECC), a copy of which is annexed to this affidavit and marked 'CB'. However we still require copies of the business, operational and other implementation plans that have been drafted for the years 1999/00 to 2003/04.
31. The Eastern Cape Department of Health is obliged to draw up implementation and operational plans for its HIV/AIDS programmes that meet the above legislative requirements. By obtaining copies of these plans civil society organisations such as PSAM and TAC could more effectively monitor the targets, time-frames and activities of government's HIV/AIDS prevention and combating programmes in general and its MTCT programmes in particular. These can then be compared with the actual expenditure incurred in respect of different items within each individual programme to see whether these targets are being achieved.

### **Diii Reports on Budgeted HIV/AIDS Expenditure between 1999/00 and 2002/03**

32. In terms of Sect 40 (4) (b) and (c) of the PFMA the accounting officer of a department must:
- (b) 'each month submit information in the prescribed format on actual revenue and expenditure for the preceding month and the amounts anticipated for that month in the terms of paragraph (a)
  - (c) 'within 15 days of the end of each month submit to the relevant treasury and the executive authority responsible for that department –
    - (i) the information for that month;
    - (ii) a projection of expected expenditure and revenue collection for the remainder of the current financial year; and;

- (iii) when necessary, an explanation of any material variances and a summary of the steps that are taken to ensure that the projected expenditure and revenue remain within budget.
33. In terms of Sect 5 (3)(1) of the Treasury Regulations, 2001 (read in conjunctions with Section 27(4) and 36(5) of the PFMA)  
 'The accounting officer of an institution must establish procedures for quarterly reporting to the executive authority to facilitate effective performance monitoring, evaluation and corrective action'.
34. In addition, section 16 of the Division of Revenue Act, 2002, sets out a number of reporting duties to be met by the receiving officer (who is the first respondent in this matter) in respect of funds allocated for specific projects to his department.<sup>95</sup>
35. The PSAM is aware of at least the following allocations of funds that have been made to the Eastern Cape Department of Health in terms of the Division of Revenue Acts, for the prevention and combating of HIV/AIDS. All of these allocations attract the aforementioned reporting requirements, in addition to any specific reporting requirements that may be attached to the grant itself:
- 35.1. In terms of the Division of Revenue Act no 1 of 2001, a conditional grant of R2.213 million for HIV/AIDS for the 2000/01 financial year and R3.850 million for the 2001/02 financial year were allocated to the Eastern Cape Department of Health.<sup>96</sup>

The purpose of these grants was:

'To enable the social sector to develop an effective integrated response to the HIV/AIDS epidemic, focusing on children infected and affected by HIV/AIDS.

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<sup>95</sup> The full text of this section reads as follows:

- '16. (1) The relevant receiving officer must, in respect of an allocation transferred to—
- (a) a province, and as part of the report contemplated in section 40(4)(c) of the Public Finance Management Act, within 15 days after the end of each month, submit a report to the relevant provincial treasury, the relevant provincial executive authority and the transferring national officer; and
  - (b) a municipality, within 10 days after the end of each month, submit a report to the relevant transferring national or provincial officer.
- (2) The reports contemplated in subsection (1) must set out—
- (a) the amount received by the province or municipality, as the case may be, in the month reported on and for the financial year up to the end of that month;
  - (b) the amount of funds delayed or withheld from the province or municipality, as the case may be, in the month reported on and for the financial year up to the end of that month;
  - (c) the actual expenditure by the province or municipality, as the case may be, for the month reported on and for the financial year up to the end of that month in respect of allocations set out in Schedules 4 and 5;
  - (d) the extent of compliance with the conditions of an allocation and with this Act;
  - (e) an explanation for any material problems or variations experienced by the province or municipality, as the case may be, regarding an allocation which has been received and a summary of the steps taken to deal with such problems or variations; and
  - (f) such other issues and information as the National Treasury may determine.
- (3) The receiving officer of a municipality which intends to transfer to another municipality an allocation or portion of it transferred to it in terms of this Act must, prior to such transfer, obtain the approval of the National Treasury.
- (4) The Minister may prescribe additional duties for the relevant officers of the municipalities contemplated in subsection (3).'

<sup>96</sup> See Government Notice, National Treasury, No. 427, 15 May 2001.

The responsibility for health includes:

- Expanding access to voluntary HIV counselling and testing (VCT)
- Mobilisation of communities in order to promote counselling and testing’.

35.2. The conditions attached to these grants included the following:

- ‘Business plans in line with the National Integrated Plan must be developed for approval by the head of provincial and national Health Department by 29 June 2001
- Quarterly progress reports to be submitted’.

35.3. Under ‘Monitoring Mechanisms’ the National Department of Health indicated that a ‘System for quarterly reporting on progress is in place’.

35.4. In terms of the Division of Revenue Act no 5 of 2002, the Eastern Cape Department of Health was also awarded a HIV/AIDS Health Grant of R21.130 million for the following purpose:<sup>97</sup>

‘To expand access to voluntary HIV counselling and testing, home based care, prevention of mother-to-child transmission programmes and other HIV/AIDS health related matters’.

35.5. In terms of the Division of Revenue Act 7, 2003, the Eastern Cape Department of Health was allocated an HIV/Aids Health Grant of R38.934 million.<sup>98</sup> The purpose of this grant was ‘to enable the health sector to develop an effective response to the HIV/Aids epidemic, including expanding access to voluntary HIV counseling and testing, home-based care, prevention of mother-to-child transmission programmes, post exposure prophylaxis, step-down care and other HIV/Aids health-related matters’.

35.6. The conditions set out for the use of this grant expressly require the Eastern Cape Department of Health to produce a business plan and quarterly monitoring reports.

35.7. The measurable objectives/outputs for this grant includes:

- Increased access to voluntary counselling and testing facilities
- Number of health districts which have voluntary counselling and testing facilities
- number of mothers receiving VCT and number of mother/baby pairs receiving PMTCT prophylaxis

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97 See Government Gazette, Vol. 441, Cape Town, No. 23290, 28 March 2002.

98 See Government Gazette, 30 April 2003, No. 24834.

- Number of home based care teams in operation, caseload and number of patient contacts
- Number of step down facilities in operation, number of admissions and number of bed days
- Number of adults and children receiving PEP after sexual assault

### **DIV reports on PMTCT and PEP programmes**

36. As has already been noted the PMTCT programme was first implemented by the Department of Health by way of two pilot projects per province which must now be expanded in terms of the Constitutional Court's Order referred to above.
37. The PSAM requested information from the HIV/AIDS unit of the Department of Health about the steps that it had taken to implement this part of the Constitutional Court's order in a letter to the head of the unit dated 13 January 2003, a copy of which is annexed to this affidavit and marked 'CC'. Save for advising that the PMTCT programme had been extended to a number of further hospitals, no further details were forthcoming. This information is contained in a letter from the Director: HIV/AIDS in the Department of Health dated 16 January 2003 and received on 13 March 2003, a copy of which is annexed to this affidavit and marked 'CD'.
38. The PSAM is also in possession of a copy of the Implementation and Training Plan for the Prevention of Mother-to-Child Transmission Programme which was compiled by Mrs NP Makwedini, the Director for HIV/AIDS and STI's and by Mr S Stamper, HOD, Department of Health on 13 March 2002. A copy of this Plan is annexed to this affidavit and marked 'CE'. This document sets out a number of activities and their estimated costs for 2002/03. The PSAM requests an updated copy of this plan for the period 2003/04.
39. The PSAM's specific request for reports on the implementation of these two programmes arises from the above as well as the respondents' responsibility to report on the procurement and supply of all medicines and drugs dispensed in the public sector in terms of the National Drug Policy for South Africa, prepared by the National Department of Health, January 1996.

### **E THE REQUEST FOR INFORMATION**

40. For these reasons, I on behalf of the PSAM, requested copies of the above documents from the Eastern Cape Department of Health in terms of the Promotion of Access to Information Act in the prescribed form on 4 April of 2003. A copy of the request submitted on that date to the first respondent in his capacity as the information officer is annexed to this affidavit and marked 'CF'. The request for information was sent by telefax transmission and per courier the same day. The telefax transmission form and courier delivery note are annexed in confirmation of this and marked 'CG' and 'CH' respectively.
41. On or about 23 April 2003, I received a letter from the Chief Director: District Health Services in the provincial health department acknowledging receipt of the PSAM re-

- quest for information and undertaking to provide a response thereto within 30 days of the date of his letter. A copy of this latter is annexed to this affidavit and marked 'CI'.
42. On 8 May at approximately 10h30, I received a telephone call from Mrs Nomalanga Makwedini who, to the best of my knowledge, is the Head of the Aids unit within the Eastern Cape Department of Health. She said that she was making the call in order to clarify what information the PSAM had requested in its application for information on HIV/AIDS sent to the department on 4 April 2003. Mrs Makwedini said that she had no prior experience of using the Information Act. I referred her to the Open Democracy Advice Centre in Cape Town for advice on how the department should respond to the request.
  43. Mrs Makwedini said that she wanted to clarify what information the PSAM had requested from the department. She asked if we were simply interested in information on the prevention of mother-to-child transmission of HIV or whether we were requesting information on all AIDS spending in the Eastern Cape. I responded that the formal request form sent to the department on 4 April 2003 had set out very clear details of what information was being requested. However, for the sake of clarity I reiterated that we were looking for details of how the budget allocations for all HIV/AIDS programmes within the department, dating back to 1999, had been spent. According to press reports and reports from the Eastern Cape AG's Office substantial amounts allocated for HIV/AIDS programmes had not been spent in this time. I said that we were interested to establish what had happened to this money.
  44. I pointed out to Mrs Makwedini that as a monitoring body we were also interested in obtaining copies of the department's operational and implementation plans for its current HIV/AIDS programmes. This would enable us to make a judgement on whether budget allocations for HIV/AIDS since 1999 had been effectively utilised. We are particularly interested in obtaining the department's operational and implementation plans for the current year (that is, for the 2003/04 financial year). This would enable us to assess whether and in what manner the department intends to comply with the Constitutional Court ruling of 2002 in favour of the Treatment Action Campaign.
  45. Mrs Makwedini responded that she had only started with her current responsibilities for running the department's HIV/AIDS programme in 2000. As a consequence she did not have copies of the documents pre-dating her arrival in her current portfolio. She said she would have to locate these documents in the department's archives.
  46. In answer to a direct question from myself Mrs Makwedini stated that the department was not refusing to provide the documents and plans requested. Mrs Makwedini confirmed that the documents requested are in existence but that she would have to obtain legal permission from the Office of the Premier in order to release them. I asked why this is the case and she said that legal services were centralised in the province under the control of the Office of the Premier.
  47. I reminded Mrs Makwedini of the deadline for the information request and of the need to send us a formal written response stating that she intended to comply with the informa-

tion requested. Mrs Makwedini provided me with her telephone number, undertook to keep me informed of her efforts, and the conversation ended.

48. Notwithstanding the above documents, I heard nothing further from the information officer or any other official from the provincial department of health and the request was accordingly deemed to have been refused in terms of the provisions of the Information Act on 4 May 2003.
49. I thereafter lodged an appeal against the aforesaid refusal, again in duly prescribed form in terms of s 74 of the Information Act. A copy of this appeal dated 22 May 2003 is annexed to this affidavit and marked 'CJ'. This was transmitted by telefax transmission and per courier to the second respondent in his capacity as the relevant authority in terms of the information Act on 27 May 2003. Copies of the telefax transmission report and courier's delivery note of that date in confirmation of delivery are annexed to this affidavit and marked 'CK' and 'CL' respectively.
50. On or about the morning of 25 June 2003 Xolisa Vitsha, the PSAM researcher responsible for monitoring the Eastern Cape Department of Health attempted to contact Mrs Makwedini by telephone to establish why the department had not yet responded to the PSAM's request for information on HIV/AIDS. He was told by a secretary that Mrs Makwedini was not available at that time and that she would return his call by that afternoon.
51. On or about 27 June 2003 Xolisa Vitsha again called Mrs Makwedini's office. He was told by Mrs Makwedini's secretary that Mrs Makwedini was busy and could not take his call. The secretary informed Mr Vitsha that Mrs Makwedini would respond by Monday the 30th June 2003.
52. As at the date of deposing to this affidavit no response has been received from Mrs Makwedini or any other official of the Eastern Cape Department of Health. The confirming affidavit of Xolisa Vitsha is annexed to this affidavit and marked 'CM'.

## **F LEGAL SUBMISSIONS**

53. I submit that the failure and /or refusal by the respondents to provide the records requested by the applicants in terms of the Information Act constitutes a breach of the following:
  - 53.1. their obligations to foster a culture of transparency and accountability imposed in terms of the Constitution and the Information Act;
  - 53.2. their obligations to provide a decision whether to grant access to records requested in the proper form to everyone 'as soon as reasonably possible, but in any event within 30 days, after the request is received' in terms of section 25 of the Information Act;
  - 53.3. their obligation to grant access to everyone to any information held by the state in terms of section 32 of the Constitution;
  - 53.4. their obligation to assist civil society to monitor the progressive realization of the right to health care guaranteed in s 27(1) of the Constitution;



53.5. the spirit of the Constitutional Court's judgment in the TAC case.

**G RELIEF**

54. I accordingly pray for the relief set out in the Notice of Motion to which this affidavit is attached.

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COLM ALLAN

Thus signed and sworn to before me at GRAHAMSTOWN on this the 25<sup>th</sup> day of JULY 2003 by the deponent who has acknowledged that he knows and understand the contents of this affidavit; that it is true and correct; and after I had administered the oath in accordance with the requirements of Regulation R2477 dated November 1984, as amended.

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COMMISSIONER OF OATHS

# Appendix 5

## An Evaluation of Eastern Cape HIV/AIDS Business Plans: 2000 to 2004

What follows is a detailed evaluation of the Eastern Cape Department of Health's business plans for the period 2000 to 2004. These include business plans produced by the department to account for its own expenditure (provincial allocation), and the plans produced for its proposed use of central government funds transferred by the national Department of Health (conditional grants).

### Plans for HIV/AIDS programmes for 2000/01

The Division of Revenue Act No. 1 of 2001, indicates that the Eastern Cape Department of Health was allocated a conditional grant of R2.213 million for HIV/AIDS for the 2000/01 financial year.<sup>99</sup> The purpose of this grant was 'to enable the social sector to develop an effective integrated response to the HIV/AIDS epidemic, focusing on children infected and affected by HIV/AIDS'.

The responsibilities to be met by the provincial Department of Health, in terms of this grant, included:

- Expanding access to voluntary HIV counselling and testing (VCT).
- Mobilisation of communities in order to promote counselling and testing.

The conditions attached to the grant included the submission of quarterly progress reports to the national Department of Health and to the provincial and national Treasuries.

Despite numerous efforts to obtain copies of the Eastern Cape Department of Health's strategic and/or operational plans detailing its proposed expenditure of HIV/AIDS funds for the period between 1999 and 2004 (including the litigation of the department by the PSAM), no plans for the 2000/01 financial year could be located.

The AG's report for this year drew attention to the fact that an amount of R33 million had been transferred to the Fort Hare Foundation for HIV/AIDS purposes on the final day of the financial year.<sup>100</sup> It is of deep concern that the department could not produce a strategic plan or a contractual agreement for the use of this amount. The only conclusion to be drawn from this sequence of events is that the department failed to draw up a plan for the use of the above sum of money.

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<sup>99</sup> See Government Notice, National Treasury, No. 427, 15 May 2001.

<sup>100</sup> Report of the AG to the Provincial Legislature of the Eastern Cape Province on the Financial Statements of Vote 3 – Department of Health for the year ended 31 March 2001, Sect 2.2.

## Plans for HIV/AIDS programmes for 2001/02

### **Business plan for VCT and HBC, 2001–2002 (conditional grant)**

In terms of the Division of Revenue Act No.1 of 2001, the Eastern Cape Department of Health was allocated a conditional grant of R3.850 million for HIV/AIDS for the 2001/02 financial year. The purpose of this grant was 'to enable the social sector to develop an effective integrated response to the HIV/AIDS epidemic, focusing on children infected and affected by HIV/AIDS'.<sup>101</sup>

The responsibilities to be met by the provincial Department of Health, in terms of this grant, included:

- Expanding access to voluntary HIV counselling and testing (VCT).
- Mobilisation of communities in order to promote counselling and testing.<sup>102</sup>

The conditions attached to these grants included the following:

- 'Business plans in line with the National Integrated Plan must be developed for approval by the head of provincial and national Health Department by 29 June 2001.
- Quarterly progress reports to be submitted'.<sup>103</sup>

A schedule attached to the above Act, which details these conditions, under its discussion of 'Monitoring Mechanisms', maintains the following:

- 'System for quarterly reporting on progress is in place'.
- 'Provincial liaison and technical support visits by the national Department of Health.'
- 'Regular meetings by the National Steering Committee'.<sup>104</sup>

Under a discussion of 'past performance' this schedule also notes that 'this grant was introduced in 2000/01, and it was under-spent due to delays in the establishment of processes and capacity at both provincial and national level, resulting mainly from delays in finalisation of the allocation of funds. It is expected that spending will occur as planned in the current year'.<sup>105</sup>

In commenting on the 'capacity and preparedness of the transferring department' (that is, the National Department of Health) the schedule states that 'the structures for planning, co-ordinating and monitoring the implementation of the (HIV/AIDS) programme are in place. The department is in the process of appointing additional staff, mainly co-ordinators at provincial and national level'.<sup>106</sup> In light of the problems experienced by the provincial Department of Health, in spending its allocated budget for the previous year, this would appear to be an overly optimistic prognosis by the national department.

The department's 2001/02 HIV/AIDS (conditional grant) business plan also indicates that a number of problems were experienced in spending its budget during the previous (2000/01) year. It points out that the conditional grant allocations for VCT and Life Skills 'could not be accessed and utilised for the previous financial year 2000/01 due to technical problems with the Finance (Sic)'. It also notes that the HBC conditional grant could only be

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101 Division of Revenue Act No. 1 of 2001, Schedule A, Government Notice, National Treasury, No. 427, 15 May 2001.

102 Ibid.

103 Ibid.

104 Ibid.

105 Ibid.

106 Ibid.

accessed in the thirdquarter of the financial year, viz. in November 2000. It acknowledges that the resulting failure to appoint VCT and HBC co-ordinators 'had a negative impact on the smooth running of the programme'.<sup>107</sup>

The business plan indicates that its service delivery objectives will be limited to six medical sites:

- Umzimkulu, Tsolo/Mhlakulo, Butterworth, Motherwell, Queenstown and Bathurst. An additional three non-medical sites are also identified for inclusion in this plan:

- Butterworth/Technicon, PPASA – PE and Queenstown.<sup>108</sup>

No differentiation is offered between the medical site and non-medical sites listed for Queenstown.

The objectives set out by the department in the plan include:

- To ensure that all health care providers at these sites are trained in counselling and testing.
- To provide the necessary operational material for HBC.

The business plan states that since the introduction of the National Integrated Plan in the 2000/01 financial year, 80 master trainers had been trained for Life Skills, eight for HBC and six for purposes of training-of-trainers (TOTS) for VCT.<sup>109</sup>

The document indicates the following plans for the roll-out of its HIV/AIDS programme:

- 'Butterworth site to include Home-Based Care and LF (sic) in this current year (2001/02)'.<sup>109</sup>
- 'Motherwell, Queenstown and Bathurst sites to include the Life Skills component in this current year (2001/02)'.<sup>109</sup>
- 'In the next financial (2002/03) the Home-Based Care component will be rolled out to the remaining three sites, i.e. Motherwell, Queenstown and Bathurst'.

The total budget contained in this business plan is broken down as follows:

- An amount of R606 300 to conduct workshops and train health care providers on VCT at the above sites:
- An amount of R1.62 million for the purchase of rapid test kits.
- R1 million for the purchase of HBC kits (including bandages, savlon, gloves, etc.).<sup>110</sup>

The plan provides no indication of the number of kits to be purchased for HBC purposes, their exact contents, or of their unit costs, or intended location of the approximately 100 000 kits. It simply lists the above activities as opposed to grouping them under separate programmes. No time-frames or costs are indicated for individual activities. The exact location of the training activities, to be conducted out of the allocated budget, is also not provided. Consequently, it would have been impossible for the senior management of the Department of Health, or staff of the provincial and national Treasuries, or the Legislature's oversight committees for Health or Public Accounts, or interested members of civil society, to track the expenditure and effectiveness of the department's conditional grant budget allocation for 2001/02.

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107 Eastern Cape, Department of Health, Business Plan for VCT and HBC, 2001–2002 (Conditional Grant). No page numbers on document.

108 Ibid.

109 Ibid.

110 Ibid.

## Eastern Cape Department of Health business plan for HIV/AIDS 2001/02 (provincial allocation)

The Eastern Cape Department of Health allocated a budget of R31 910 434 for expenditure against its 2001/02 HIV/AIDS business plan.

In effect, this plan consists of a table containing a breakdown of the department's HIV/AIDS budget allocation. Although it makes reference to antenatal statistics (indicating an increase in the prevalence of HIV in the province from 12.6 per cent in 1997 to 20.2 per cent in 2000) this document does not indicate what the aims and objectives of the department's programme for the 2001/02 financial year were. Despite allocating budgets to a range of programmes and activities, the document fails to attach any time-frames or costs to these activities. It also fails to indicate the exact locations at which the activities were to be implemented.

In this respect the document reads like a summary of the department's proposed activities rather than a detailed guide to inform their implementation.

### Per centage of Budget Allocation by Programme<sup>111</sup>

Budget Category	Amount	Per centage of Total Budget
Administration	R2 410 434	7.6%
Prevention and Training	R 9 500 000	29.8%
Information, Education and Communication	R4 000 000	12.5%
Treatment, Care and Support	R9 000 000	28.2%
Monitoring, Surveillance and Research	R 4 000 000	12.5%
Public Policy Advocacy	R 3 000 000	9.4%
Total	R31 910 434	100%

Under the Prevention and Training sub-programme, which was allocated a budget of R9.5 million, the following activities and budget allocations are listed:

- HIV/TB (tests) (allocated a budget of R1 million).
- Campaigns and condom distribution (allocated a budget of R2 million).
- Voluntary Counselling and Testing (allocated a budget of R1.5 million).
- Prevention of Mother-to-Child Transmission (allocated a budget of R1 million).
- Training non-sentinel sites on: 1. Counselling, 2. Testing (allocated a budget of R1 million).

<sup>111</sup> Department of Health Province of the Eastern Cape, HIV/AIDS Budget 2001–2002. No page numbers on document.

- Training on syndromic approach (allocated a budget of R8 million).
- Youth Education Programmes (allocated a budget of R1.2 million).
- Training on Community-Based Care (allocated a budget of R1 million).<sup>112</sup>

The Treatment, Care and Support sub-programme, with its budget allocation of R9 million, merely lists the following proposed activities and budgets:

- Home-Based Care Kits (allocated a budget of R3.5 million).
- NGO/CBO Funding (allocated a budget of R2 million).
- Treatment of opportunistic infections (allocated a budget of R3.5 million).<sup>113</sup>

The above programme details constitute the only information offered by the department on how and where its funds would be spent, and for what purposes. Clearly, this level of information is completely inadequate for the purposes of establishing whether these proposed budget allocations constituted the best potential value for the department's funds (by senior management within the department, its MEC, and the members of the Eastern Cape Legislature Standing Committee on Health). Nor does it provide sufficient guidance for those seeking to implement its objectives in practice.

## Plans for HIV/AIDS programmes for 2002/03

### Conditional grant budget allocations for 2002/03

In terms of the Division of Revenue Act No. 5 of 2002, the Eastern Cape Department of Health was allocated a HIV/AIDS Health Grant of R21.13 million for the following purpose:

To expand access to voluntary HIV counselling and testing, home-based care, prevention of mother-to-child transmission programmes and other HIV/AIDS health-related matters.<sup>114</sup>

The Eastern Cape Department of Health produced three separate business plans in compliance with the planning requirements set out by the Division of Revenue Act. These plans covered VCT (allocated a budget of R8.33 million), HBC (allocated a budget of R4.697 million) and PMTCT (allocated a budget of R2.9 million). The combined amount of these grants totalled R15.8 million. No plans could be made available for how the department intended to utilise the remaining R5.33 million. However, monthly reports produced by the department (for the national Department of Health and the national and provincial Treasuries) indicate that an additional amount of R4.452 million was budgeted for Step-Down Care, and an extra R745 000 was budgeted for programme management, by the department's HIV/AIDS and STI unit.<sup>115</sup>

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112 Ibid.

113 Ibid.

114 See Government Gazette, Vol. 441, Cape Town, No. 23290, 28 March 2002.

115 See for instance report for June 2002, Conditional Grants to Provinces, Monthly Report by Receiving Provincial Department to Transferring National Department, Provincial Treasury, Eastern Cape, June 2002/03. This document was obtained by the PSAM through a process of litigation in terms of the Promotion of Access to Information Act of 2000, in November 2003.

## **Business plan for VCT, 2002/03 (conditional grant)**

This plan notes that despite South Africa having one of the fastest growing HIV/AIDS epidemics in the world, there has been limited access to VCT services in the Eastern Cape Province. It points out that 'currently there are eight VCT sites, six medical and two non-medical' sites. It notes that in the East London district a PMTCT pilot site has been established and an additional rural pilot site has been established at Rietvlei Hospital in the Umzimkulu area.<sup>116</sup>

The plan notes that VCT 'has started to operate well' in six of the eight sites and in 'the 52 clinics' (without identifying any of their locations), as well as the PMTCT pilot sites. It notes, however, that there is a 'great need' to increase the number of VCT sites to 193 by the end of 2003. One of the stated goals of the programme is to provide VCT to '12.5 per cent of the Eastern Cape adult population from 15–49 years by 2003' (the estimated total population is identified as 7 million).<sup>117</sup>

A conditional grant of R8.33 million was allocated for the purposes of realising the goals set out in the plan.

The plan indicates that an amount of R2 987 750 is allocated to meet Objective 1 - 'increasing the number of VCT sites from 8 to 193 by 03 – 2003'. This amount is intended for training, and is broken down as follows:

- R27 750 for the training of 555 professional nurses on rapid testing (at R50 per person).
- R1.48 million to train two counsellors per site – i.e. 370 counsellors in total (at a cost of R400 per day over a period of 10 days).
- R1.48 million allocated to train two health care providers per site on counselling (at a cost of R400 per day over a period of 10 days).
- R 2.22 million allocated to pay a R500-per-month stipend to 370 lay counsellors.

Objective 2, which is intended to 'improve service delivery to sites by capacity building workshops' is again directed primarily at training. It sets out a budgeted amount of R675 150, which is to be spent on:

- The training of nurses on rapid testing, the training of HIV/AIDS STI co-ordinators on project management (at a cost of R400 per person per day for three days).
- The training of trainers on couple counselling (at a cost of R400 per person per day for three days).
- The provision of counsellor update workshops to 386 lay counsellors (at R400 per person per day for three days).<sup>118</sup>

No rationale is provided for why each of the items of training is costed per person per day, rather than per day per actual trainer.

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116 Province of the Eastern Cape, Department of Health, Voluntary Counselling and Testing (VCT), Business Plan 2002/03, Signed by Mrs Makwedini 21 February 2002, no page numbers.

117 Ibid.

118 Ibid.

Objective 3, intended to 'provide rapid test kits to all VCT sites' sets out a budget of R1.35 million for the purchase of rapid test kits.<sup>119</sup>

Objective 5, which involves providing 'equipment and training materials to districts' sets out (amongst others) the following budget items:

- An amount of R60 000 for the purchase of 10 overhead projectors for 10 districts (at a cost of R6 000 each).
- An amount of R40 000 for the provision of 'VCR/TV to 10 districts' (at a cost of R4 000 each).<sup>120</sup>

Objective 6 deals with 'Quality counselling and support provided to counsellors by 3/02'. It sets out a budget of R196 800 for the purposes of training 48 mentors (at R400 per day per person over a period of five days) and to conduct update workshops for 48 mentors (at R50 per person per day for two days).<sup>121</sup>

No explanation is provided as to why these same 48 mentors would require training and update workshops within a one-year period. Moreover, the costing of these workshops appears to be arbitrary. The update workshops can apparently be conducted at R350 less than the initial training workshops per day despite lasting for the same length of time, and presumably requiring the same resources to conduct.

Although this plan represents an improvement on the quality of planning conducted in previous years, specifically through the breakdown of the budget into objectives and activities, and the costing of activities, it still demonstrates considerable weaknesses. Specifically in respect of the coherence of its costing of activities.

### **Business plan for HBC, 2002/03 (conditional grant)**

This plan is said to represent an integrated programme focusing on children affected by HIV/AIDS, which will be jointly managed by the provincial departments of Health, Education and Social Development. However, it fails to indicate any budget allocations for the Department of Education, or provide details of its role in this 'integrated' plan.

By way of contextualisation, the plan notes that 'the Eastern Cape Province has trained seven trainers-of-trainers', that the training has taken place in the districts, and that two HBC sites have been established at Mhlakulo and Butterworth. As one of its 'overall objectives' the plan notes its intention to establish three HBC 'models' in three districts and to roll-out these models to 11 district municipalities.<sup>122</sup>

The plan indicates that a total conditional grant allocation of R4.697 million was allocated to the Eastern Cape Department of Health to cover its portion of the plan, and a remaining amount of R4.567 million was allocated to the Department of Social Welfare to meet its obligations under the plan.<sup>123</sup>

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119 Ibid.

120 Ibid.

121 Ibid.

122 Province of the Eastern Cape, Department of Health, Home/Community Based Care, Business Plan 2002/03, Signed by Mrs Makwedini on 5 February 2002, no page numbers.

123 Ibid.



Of the R4.697 million allocated to the Department of Health, the plan notes the intention to transfer an amount of R2.2 million to district municipalities to 'replicate the model' (at a cost of R200 000 for each of 11 sites). No indication is provided of what the model is to consist of, or which municipalities these amounts were to be transferred to. Nor does this plan indicate whether service-level agreements will be entered into with these municipalities to prescribe how these funds should be used. No mention is made of monitoring mechanisms being put in place to monitor the performance of municipalities, or of the reporting requirements to be met by municipalities in terms of the plan.

The plan includes an allocation of R1 287 500 to the Department of Health for the purposes of maintaining its existing HBC sites. This includes, amongst others:

- The allocation of R114 000 for the provision of HBC kits to the Bambisanani Project (no unit price is indicated).
- The provision of HBC kits for Butterworth and Mhlakulo at a cost of R230 000 (for 115 families twice a year, which is a unit cost of R1 000).
- An additional amount of R345 000 is allocated to the establishment of HBC models in three additional districts (the identities of which are not indicated).
- R300 000 is allocated for the purposes of providing HBC kits to 300 families (at R1 000 per kit).
- An additional R800 000 is allocated to replenish the supplies in these HBC kits (at a once off cost of R500 per year per family).<sup>124</sup>

No indication is provided as to why families in the Butterworth and Mhlakulo districts require two HBC kits per year.

The plan indicates the intention to replenish 1 600 kits at the three specified sites, whereas it would only have purchased 300 kits for these same sites.<sup>125</sup> Working on the assumption that the unit cost of kits remained the same between 2001 and 2002, the R1 million allocated for HBC kits in 2001 would have resulted in the purchase of 1 000 kits in that year. Even with the addition of the amounts allocated to existing sites (R114 000 and R230 000) this would only account for the need for another 344 kits. However, 115 families would receive kits twice during this financial year, rendering the need for their replenishment redundant. Yet again the figures, against which the department has allocated its budget, appear to have been arrived at arbitrarily.

What is equally disturbing, however, is the fact that the Department of Social Welfare, which was allocated a R4.567 million conditional grant to participate in the same integrated programme, appears to have duplicated some of the budget items listed by the Department of Health. For instance, in the same business plan Social Welfare also lists an amount of R735 000 to replenish supplies in HBC kits for 730 families in the Butterworth and Mhlakulo districts twice a year at a cost of R500 per kit.

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<sup>124</sup> Ibid.

<sup>125</sup> Ibid.

This indicates that the likelihood of duplication in the provision of HBC kits in the Butterworth and Mhlakulo districts was extremely high. It also indicates that the degree of detailed and effective planning and co-ordination between the Health and Social Development departments was poor.

### **Implementation and training plan for PMTCT for 2002/03 (budget source not indicated)**

In April 2002 the Eastern Cape Department of Health produced an Implementation and Training Plan for its PMTCT programme for 2002/03. The budget for the programme is 'estimated' at R17 247 792. No indication is provided as to whether this amount was approved as part of the department's budget and, if so, whether these funds were to be sourced from a conditional grant or the department's provincial allocation.

There are grounds, however, to assume that this business plan was adopted for the 2002/03 financial year. During the course of litigating the Eastern Cape Department of Health to obtain more detailed information on its HIV/AIDS programmes, the PSAM requested 'all business plans and/or operational plans and/or implementation plans by or under the authority of the respondents (i.e. the HOD of Health and the MEC for Health) relating to the treatment, combating and prevention of HIV/AIDS programmes in the public sector of the Eastern Cape Province for the period 1999/00 to 2003/04'. In its response the department provided the above plan (along with copies of the other plans cited in this chapter).

Responding to a subsequent enquiry from the PSAM, which sought to establish whether these were the only plans available for the years in question, the department responded as follows:

'Business plans attached and cited by yourselves are the ones used in the years in question'. 'The Department hereby confirms that there are no other documents other than the ones submitted to you that contain details of plans of the HIV/AIDS and STI programmes in the public sector of the Eastern Cape.'<sup>126</sup>

The abovementioned Implementation and Training Plan, which incomprehensibly is marked 'confidential' on each page, contains a 'background' discussion which sets out details of the situational context in which the plan has been developed. It notes that 'recent statistics' have revealed that the HIV/AIDS epidemic is still on the increase in the Eastern Cape and that 'its impact is being exacerbated by conditions of poverty and unemployment'. It points out that the poorest districts in the province, the OR Tambo and Alfred Nzo districts, are the worst hit by the epidemic in terms of morbidity and mortality.<sup>127</sup>

Interestingly, it cites conventional medical evidence (often disputed by 'AIDS dissidents' influential in shaping President Mbeki's views on the causality between HIV and AIDS) in favour of the use of anti-retroviral drugs:

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126 Eastern Cape Department of Health/ Public Service Accountability Monitor, Response 25 November 2003, p.1 & 2.

127 Eastern Cape Department of Health, Implementation and Training Plan for Prevention of Mother-to-Child Transmission Program, 2002/03, p.1.

‘A central assumption in PMTCT programs is that the intervention works and is cost effective. Nevirapine is 47 per cent more effective when used at 12–16 weeks of pregnancy compared to ZDV (HIVNET 012 study).’<sup>128</sup>

The plan also uses evidence from the HIVNET 012 study to demonstrate the cost-effectiveness of nevirapine, and states that this study ‘forms the basis of the PMTCT approach that is currently being tested’ in the Eastern Cape. It notes that although the National School of Public Health at MEDUNSA and the Human Sciences Research Council have been appointed to evaluate the cost-effectiveness of the Eastern Cape’s two PMTCT pilot sites, insufficient data had been collected in this regard.<sup>129</sup>

It points out that the Eastern Cape PMTCT programme started on 27 July 2001 at the Reilivlei Hospital (with its 12 feeder clinics in the Umzimkulu region) and at the East London Hospital Complex (consisting of the Frere and Cecilia Makiwane Hospitals and 47 feeder clinics in the region). The content of the PMTCT programme is described as follows:

‘Nevirapine (is provided) to HIV-positive pregnant women and their newborn children if the woman agrees to participate. The woman is given one nevirapine tablet at 32 weeks to take during labour and the newborn infant is given a single dose of nevirapine within 72 hours of delivery. For those women who choose to formula feed their infants, the Department of Health provides a six-month supply of Perlargon®.’<sup>130</sup>

The plan notes the department’s reservations concerning the cost-effectiveness of treating PMTCT as ‘an add-on programme in the primary health care setting’. It proposes that PMTCT should rather be integrated into the Reproductive and Child Health Services of the province.

Uniquely, the plan contains a detailed discussion of the proposed programme costs for training counsellors (based on the National Department of Health’s Voluntary Counselling and Testing Strategy document) in the Eastern Cape. It lists the assumptions, on which these training needs have been identified, as follows:

1. ‘That the government will introduce VCT into all health service sites.
2. To make such an intervention work requires the identification and training of a cohort of counsellors and health care workers.
3. Trainee counsellors will be identified in each health care centre according to the minimum standards of selection.
4. Counsellors will be identified in each health care centre according to minimum standards of selection.
5. Individuals must be identified to co-ordinate the counselling training and manage the budgetary and financial aspects of the training of such a large cohort of individuals. This is not included in the costing below, since it is assumed that the provincial HIV/AIDS/STI co-ordinator and her district counterparts will manage the process.

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128 Ibid.

129 Ibid, p. 2.

130 Ibid, p. 4.

6. Counsellors will be supported by mentors.
7. Health care workers will spend approximately 12.5 per cent of their working time providing counselling and testing services.
8. There are seven health districts in the Eastern Cape.
9. There are 655 primary health centres in the Eastern Cape.
10. There are 28 community health centres in the Eastern Cape.
11. There are 64 district hospitals in the Eastern Cape.
12. One counsellor trainer can train 150 counsellors per year.
13. One counsellor mentor can mentor 20 counsellors'.<sup>131</sup>

The plan contains a section on 'Training for PMTCT' which sets out the detailed training requirements for this sub-programme. These appear to be rather broad, and include training for VCT, training for 'good practices for childbirth' (the provincially developed 'Better Birth Initiative') as well as a range of training sessions on PMTCT.

The VCT training consists of the following:

- 'The legal and ethical rights of patients.
- The role and indications for rapid HIV testing.
- Pre and post counselling and rapid test HIV test results.
- Quality assurance.
- Regulations concerning rapid testing'.<sup>132</sup>

The plan also contains a proposal that all doctors and midwives in the Eastern Cape 'will have to undergo training on Best Birth Initiatives (BBI)', which includes the following:

- Epidemiology of HIV infection.
- Risk factors for mother-to-child transmission.
- Obstetrical factors and the interventions in mother-to-child transmission (including: 'avoiding shaving for labour', 'avoid episiotomies during delivery', 'vaginal cleansing', 'reduction of artificial rupture of membranes', and 'reserving suctioning for babies with meconium').

No explanation is given as to why already qualified health professionals should require such training, or why all doctors should require additional training on PMTCT irrespective of their locations and existing skills levels.

The additional training sessions for PMTCT include the following:

- 'Infant factors in mother-to-child transmission.
- Viral factors in mother-to-child transmission.
- Behavioural interventions, therapeutic interventions.
- Modification of infant feeding.
- Management of HIV-positive pregnant women.
- Antenatal care.
- Nutritional interventions, medical interventions.
- Management of labour.
- Post-delivery care of HIV-positive women.

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<sup>131</sup> Ibid, p. 5.

<sup>132</sup> Ibid, p. 7.

- Termination of pregnancy'.<sup>133</sup>

The plan provides a detailed breakdown of the province's PMTCT training needs in terms of the numbers of persons to be trained, the purpose of training and the amount of time to be taken.

Activity	Number of Trainees	Time Allocation
Master Trainers per district	48	2 weeks
Counsellor mentors	10	4 weeks
Two nurse counsellors per primary health care facility	1 310	2 weeks
Six lay counsellors per primary health care facility	1 965	2 weeks
Twenty counsellors per district hospital	1 300	2 weeks
Two doctors per district hospital	130	4 weeks
Six midwives per district hospital	390	4 weeks
All doctors per institution		1 week

### PMTCT training requirements

The budget allocations for the PMTCT programme, which demonstrate a preoccupation with training, are listed below.

### PMTCT Training and Implementation Programme Budget for 2002/03

Budget Category	Amount	Per centage of Total Budget
Training	R8 195 700	47.5 %
Testing (of pregnant women)	R165 296	1%
Testing (of babies)	R165 296	1%
Antiretrovirals	R110 500	0.6%
Infrastructure review costs (includes provision of baby formula)	R8 191 000	47.5%
Surveillance and evaluation	R420 000	2.4%
Total	R17 247 792	100%

<sup>133</sup> Ibid, p. 9.

It is worth noting that less than three per cent of this budget is proposed for spending on actual medical services in the form of testing or the provision of ARVs.

### **Eastern Cape Department of Health PMTCT business plan, 2002/03 (conditional grant allocation)**

In terms of the Division of Revenue Act No. 5 of 2002, the Eastern Cape Department of Health was awarded a HIV/AIDS Health Grant of R21.13 million. Of this, an amount R2.9 million<sup>134</sup> was allocated to 'expand access to prevention of mother-to-child transmission programmes and other HIV/AIDS health related matters'.<sup>135</sup>

The aim of the Eastern Cape Department of Health's 2002/03 PMTCT conditional grant business plan is said to be to protect babies 'from the risk of getting HIV infections from their HIV-positive mothers' and to demonstrate 'the feasibility of existing health services'.

The introduction to the plan notes that PMTCT 'has been introduced at two sites and the uptake is currently at 52 per cent'.<sup>136</sup> The stated goals of the programme are to have '90 per cent of women attending ante-natal care accepting the PMTCT programme', and '60 per cent of women delivered (sic) in rural areas opting for breast feeding'.<sup>137</sup>

The objectives listed for the programme do not specifically mention the provision of ARVs. These objectives include:

- To train and support staff on PMTCT-related issues.
- To provide VCT in facilities that offer antenatal services.
- To provide drugs and consumables, e.g. milk formula and food supplements, to the pilot sites.
- To establish mechanisms for the management of data, monitoring and evaluation of services.

This was despite a High Court ruling in April 2002 that nevirapine had to be made available to all pregnant women who were HIV-positive.

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134 See, for instance, report for June 2002, Conditional Grants to Provinces, Monthly Report by Receiving Provincial Department to Transferring National Department, Provincial Treasury, Eastern Cape, June 2002/03. This document was obtained by the PSAM through a process of litigation in terms of the Promotion of Access to Information Act, 2000 in November 2003.

135 See Government Gazette, Vol. 441, Cape Town, No. 23290, 28 March 2002.

136 Eastern Cape Department of Health PMTCT Business Plan, 2002/03 (document contains no page numbers), 3 June 2002. This document was obtained by the PSAM through a process of litigation involving the Promotion of Access to Information Act of 2000, in November 2003.

137 Ibid.

The budget statement attached to the plan is broken down into four objectives, as follows:

### Percentage of Budget Allocation by Programme

Budget Objective	Amount	Per centage of Total Budget
1. To build capacity of staff to improve quality of service delivery	R1 030 100	36%
2. To procure drugs and consumables for the sites	R400 716	14%
3. To develop comprehensive communication strategy for community awareness and marketing of PMTCT	R1 109 184	38%
4. To establish mechanism for management of data	R360 000	12%
Total	R2 900 000	100%

The activities set out under Objective 1 (To build capacity of staff to improve quality of service delivery) consist primarily of conducting workshops and training. These activities include:

- An amount of R300 000 to train 100 professional nurses, at the two PMTCT sites, on counselling and PMTCT for ten days (at a cost of R300 per person per day including meals and accommodation).
- An amount of R100 000 for a two-day workshop for the 'orientation of trained counsellors and managers on PMTCT' at the two sites (at a cost of R250 per day per person for 200 people).
- An amount of R300 000 for the training of 100 lay counsellors and managers on PMTCT for ten days at these two sites (at a cost of R300 per person per day).
- An amount of R20 000 for two separate workshop updates on PMTCT for 100 nurses at the two sites (at a cost of R100 per person per workshop).
- An amount of R72 000 for the mentoring of 20 counsellors by a trained psychologist during 12 separate sessions (at a cost of R6000 per session).
- An amount of R80 000 for 100 department staff to attend two separate advocacy workshops 'to make them aware of strategy' and 'in preparation for expansion' (at a cost of R400 per person per workshop, including accommodation and meals).
- An amount of R8 100 for the training of nurses on rapid testing at 54 clinics (at a cost of R50 per clinic).

- An amount of R100 000 for two facilitators to each attend five separate 'national and international seminars and workshops' per year (at a cost of R10 000 per workshop).

Under Objective 2 (To procure drugs and consumables for the sites) the following budget items are included:

- An amount of R51 916 for the purchase of nevirapine for the purpose of administering this to '25 per cent of 500 attendees monthly for two sites'.
- An amount of R148 800 for rapid test kits to be administered to 12 000 pregnant women.
- An amount of R200 000 for other medical consumables such as 'gloves, antiseptic, syringes, needles and lab consumables'.

Under Objective 3 (To develop comprehensive communication strategy for community awareness and marketing of PMTCT) the following activities and budgets are proposed:

- To 'hold 24 district health community workshops for CBOs and NGOs' (at a cost of R14 716) per district.
- To 'provide updates through local radio stations, ten sessions' (at a cost of R9 000 per session).
- To develop 'pamphlets and posters' (at a cost of R50 000).
- To 'provide stipends for two lay counsellors per clinic (36)' (at a cost of R500 counsellor).
- 'PMTCT campaigns and publications i.e. mass media, outdoor, advertising, etc.' (at a cost of R400 000).

Finally, under Objective 4 (To establish a mechanism for management of data), the following budget items – among others - are included:

- The allocation of an amount of R160 000 for 'computer and printers for three hospitals at R40 000' and 'Lab top (sic) at R40 000'.
- An amount of R150 000 for the purchase of 'VCRs/TVs for districts piloting at R5 000'.

## Plans for HIV/AIDS programmes for 2003/04

### **HIV/AIDS and TB directorate business plan for 2003/04 (conditional grant and provincial allocation)**

The HIV/AIDS business plan was signed between the 10 and the 15 of April 2003 by the Director: HIV/AIDS and TB, the Chief Director: District Health Services, and on behalf of the Head of Department: Department of Health.<sup>138</sup> This constitutes the most comprehensive and coherent plan produced by the department to date. It includes a clear division of the HIV/AIDS and STI directorate's work into a series of distinct programmes and individual activities, with costs and time-frames attached.

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<sup>138</sup> Eastern Cape Department of Health, HIV/AIDS and TB Directorate, Business Plan 2003/04. This document was obtained by the PSAM through a process of litigation involving the Promotion of Access to Information Act, 2000 in November 2003.



This business plan is based on a total budget allocation of R70.947 million, consisting of R32.013 million from the Eastern Cape Department of Health budget and a conditional grant allocation of R38.934 million from the national Department of Health.

### **Policy priorities**

The plan, said to be in line with the National Health Strategy, identifies eight priority areas:

1. Popular mobilisation.
2. Awareness and prevention.
3. Treatment, care and support, including TB Care.
4. HIV/AIDS in the workplace.
5. Poverty eradication.
6. Provision of basic services.
7. Information management and monitoring.
8. Co-ordination.

It is unclear why 'poverty alleviation' falls under the remit of the Department of Health as opposed to other provincial departments, such as the Department of Social Development. The business plan contains no references to activities relating to poverty alleviation.

The plan claims to provide 'an integrated package of programmes around which participating departments and organisations can plan and budget for in the next three years'. Despite this claim, however, the plan only sets out activities and budgets over a single financial year and these activities are restricted to the Eastern Cape Department of Health alone.

### **Programmes and programme objectives**

The business plan identifies ten programme areas. These include:

- Programme 1: Voluntary Counselling and Testing
- Programme 2: Prevention of Mother-to-Child Transmission
- Programme 3: Sexually-Transmitted Infections
- Programme 4: Commercial Sex Worker Programme
- Programme 5: Non-Occupational Post-Exposure Prophylaxis (PEP)
- Programme 6: Home Community-Based Care
- Programme 7: Step-Down Care
- Programme 8: Management
- Programme 9: Centre of Excellence
- Programme 10: Social Mobilisation

It should be noted that there is no logical connection between a number of the programme areas and the policy priorities listed at the start of the plan. These include policy priorities such as poverty alleviation, HIV/AIDS in the workplace and co-ordination. No programme activities are listed, which set out to address these priorities.

## Budget allocation and outcomes

The plan indicates the following budget allocations, and the division of this budget into the following programmes:

### Budget Source and Programme Divisions

Budget Source		Programmes	
Provincial budget	R32.013m	VCT	R11.021m
Conditional grant	R38.934m	PMTCT	R7.845m
Total	R70.947m	STIs	R2.34m
		Commercial Sex Workers	R2m
		PEP	R4.99m
		Home-Based Care	R19.068
		Step-Down Care	R7.7m
		Management	R862 000
		Centre of Excellence	R6.19m
		Social Mobilisation	R9.108m
		Total	R71.124m

It is significant that when the above budget amounts are added together the total cost of the proposed programmes (R71.124 million) is R177 000 more than the amount contained in the budget (R70.947 million). These incorrect figures indicate a failure to conduct a cursory check on the figures contained in the plan before its publication and authorisation by the HOD of the Department of Health.

### Percentage of Budget Allocation by Proposed Outcomes

Proposed Budget Outcome	Amount	Per centage of Total Budget
Training (includes Umtata Centre for Excellence)	R29 220 000	41%
Social mobilisation	R10 092 550	14%
Stipends to lay counsellors and community health workers	R11 614 000	16%
ARVs for PMTCT	R2 141 832	3%
ARVs for PEP	R3 500 000	4.9%
Other medication	R2 455 000	3.4%
Test kits	R1 800 000	2.5%

The budget division demonstrates an overwhelming emphasis on training of staff, their payment and on social mobilisation:

- 71 per cent of the budget is allocated for training, social mobilisation and the payment of lay counsellors and community workers.
- 7.9 per cent is allocated for the purchase of ARVs.
- 3.4 per cent is allocated to other medication (for opportunistic infections).
- 2.5 per cent of the budget is allocated for the purchase of test kits.

Due to a lack of supporting information listing the most pressing health care needs to be met by those living with HIV in the province, it is impossible to say whether these proposed budget outcomes constitute the best possible use of the department's funds. At no point is an explanation offered for why the amounts required for the training of staff and lay counsellors, or the payment of stipends to these counsellors, are charged against the HIV/AIDS Directorate's budget, as opposed to the human resources or training budgets of the department. These charges have the net effect of reducing the amount of money available for the procurement of medication and equipment for treatment purposes.

### **Identification of health needs to be addressed by the business plan**

The business plan fails to provide any account of the process through which the programme activities were identified. Under a discussion entitled 'Background', the department recognises that the nature of the threat from HIV/AIDS necessitates 'combined action and joint campaigns between Government and civil society organisations' and 'partnerships with trade unions, business faith-based organisations, higher education institutions, donors and NGOs'. However, there is no evidence that any of these stakeholders were consulted in the process of drawing up the current plan.

There is also no indication that the plan has been informed by a thorough needs analysis. Other than a solitary reference to the HIV infection rate of 22.9 per cent in the Alfred Nzo district municipality there are no other hard figures cited in the plan indicating the latest research into how many people have been infected with HIV in the Eastern Cape. No demographic information for persons living with HIV is cited in the plan. Consequently, there is no indication of which demographic groups (including age groups, genders, and geographic locations) would be targeted in the plan.

Despite the fact that the department has run a number of PMTCT test sites, at which extensive counselling, testing and administration of ARVs must have been conducted, none of this information is reflected in the business plan. For instance, there are no average times indicated for counselling and testing of patients. There is also no indication of the quantity of medication consumed by the average patient on opportunistic infections as the basis for ordering medication.

### **Coherence of programme activities and targets**

There does not appear to be a clear and rational relationship between the activities identified in the various programmes and the setting of targets. For instance, in Programme 1, which deals with VCT, an objective is set to increase the number of VCT sites from 150 to

350. No indication is provided of where these sites need to be located in response to pressing health needs. Whilst a target is set to train 768 lay counsellors, it is only proposed to pay stipends to 317 of these counsellors. For this reason the relationship between activities and the setting of targets appears to be arbitrary.

In many instances the activities listed under the various programmes do not make sense. For instance, under Programme 1 the following activity is proposed:

- To 'train professional nurses on counselling and rapid testing at R400 per person for 10 days'.

Another listed activity proposes:

- To 'conduct ten day training for 32 lay counsellors per district (24 districts) at R400 / person per day'.

The question that needs to be posed in respect of these activities is: Why should it take ten days to train an already qualified health professional to undertake voluntary counselling and testing? Why should it take ten days to train a lay counsellor to undertake voluntary counselling? Are two solid weeks of workshops really necessary for these activities? Can the cost of R4 000 per person per workshop really be justified? Why have the workshop costs been calculated on the basis of the number of the participants rather than the cost of materials and the daily rates of the training staff?

The total cost of these two activities alone within Programme 1 amounts to an astronomical R5.472 million (or 7.6 per cent of the total budget).

A subsequent activity listed under Programme 1 also proposes:

- To 'organise mentorship workshops for 768 lay counsellors on VCT/MTCT at R400 / person \* 3 days'.

What is disturbing is that under Programme 2, which deals with PMTCT, an almost identical activity is proposed at an additional cost of R1.572 million:

- To 'conduct a five day PMTCT training workshop for 786 lay counsellors (32 per district, for 24 districts) at R400 per person per day'.

Again, no indication is given as to how these two activities differ from each other, or indeed how the content of the training offered differs from that proposed in the previous training activities listed for Programme 1. Indeed, the coherence of the time-frames as well as the costing is opened to question given that under programme 1 it is proposed to train lay counsellors on VCT and PMTCT in three days, whereas under Programme 2, five days are required for the training of lay counsellors on PMTCT alone. Nor is it clear from this plan whether the same individuals will be subjected to training within both workshops. In light of considerations listed below, this appears to be the case. The implication is that the department has deliberately planned and budgeted to replicate its training activities for PMTCT, and in so doing has planned to unnecessarily incur costs of as high as R1.5 million.

### **Costing of programme activities**

Many of the figures setting out the cost of programme activities appear to have been arbitrarily calculated or have been miscalculated.

In the instance of the proposed training of 786 lay counsellors on PMTCT cited under

Programme 2, the cost figures have clearly been miscalculated. The activity proposes to train a total of 32 counsellors from 24 districts, which would provide a total number of 768 counsellors, not 786. The numbers used to calculate the cost of this activity have clearly been reversed. However, these calculations have not been checked. Consequently the costing for the activity is calculated on the training of 18 more counsellors than necessary, and an extra R36 000 is budgeted for this activity (R1.572 million instead of R1.536 million).

The costs for training under Programme 1 appear to have been arbitrarily arrived at. Whereas the costs of training professional nurses in counselling and rapid testing are set to amount to R400 per day per workshop participant, the 'in-service training of nurses on rapid testing' is costed at a mere R40 per person per workshop. Again the cost of training HIV/AIDS co-ordinators 'on project management' for programme implementation amounts to R1 208 per person trained, as opposed to R4 000 per person for VCT skills. The cost of R40 allocated to VCT/MTCT trainers and managers to attend quarterly meetings appears to be similarly arbitrary.

Also in Programme 2, which deals with PMTCT, an amount of R850 000 is allocated for purposes of social mobilisation (without any costing of individual activities) despite the fact that R9.1 million is allocated to a separate programme (Programme 10) to address this purpose.

Under Programme 9, R6.19 million is allocated for purposes of establishing a Centre of Excellence at the University of the Transkei despite the fact that no breakdown of the costs of the individual activities, or the targets to be achieved by these activities, is provided.

Under Programme 10, which deals with social mobilisation, R750 000 is allocated to the men's forum, FOHAP and WIPPA, to draw up a 'program/plan of action'. No explanation is provided as to who these organisations are, and what activities they will undertake. Nor is there any indication of why it should cost R250 000 per organisation to draw up an action plan. Similarly R250 000 is allocated for the purposes of establishing three district AIDS Councils (in the OR Tambo, Chris Hani and Cacacu districts) at a cost of R250 000 per district. No indication is given as to what these structures will consist of or how this budget allocation will be utilised.

Also under Programme 10, an amount of R4 million (44 per cent of social mobilisation budget and five per cent of budget overall) is allocated to the following activity: 'conduct special events, namely the candle light (sic), partnership anniversary and Condom-STI week both at provincial and at district level'. No internal breakdown is provided as to the costs of these individual activities or the targets to be achieved. Again, the amounts allocated appear to have been arrived at arbitrarily, and are totally disproportionate to the potential impact to be achieved relative, for instance, to the competing need for anti-retroviral and other medicines.

### **Responsibility for programme implementation**

It is significant, when looking at Programme 8 (which deals with Management), that no Financial Administration Officer had been employed up until 2003 'to assist in the manage-

ment of conditional grants'. It is also significant that 'head office' staff had not yet been trained in terms of the Public Finance Management Act or in project management. This is despite their responsibility for managing a budget of over R90 million in the 2002/03 financial year.

The implementation of many of the programme activities seems to rest on five staff members (Makwedini, Nqini, Gobodo, Magenuka and Madonsela). There do not appear to be sufficient numbers of suitably qualified staff and programme managers to run the programmes effectively.

# Appendix 6

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## Reporting on Implementation of Eastern Cape HIV/AIDS Programmes

### Annual reports

#### Regulatory requirements

As indicated in Chapter 1, in terms of the Public Finance Management Act, 1999, the annual reports of all government departments should contain the following information:

- An account of departmental performance – including the achievement of desired outcomes, the delivery of outputs and the use of resources.
- An account of human resource management issues
- A copy of the department's audited financial statements.
- A copy of the AG's comments on these financial statements.
- A report by the department's Audit Committee.
- A report on misconduct and corrective action within the department.<sup>139</sup>

The above reporting requirements took effect on 1 April 2000. As of 1 April 2002, all government departments, constitutional institutions and public entities were required to meet the additional expectation of 'reporting on performance against predetermined objectives'.<sup>140</sup> This means that they would need to report against their progress in the implementation of each objective listed in their strategic and/or business plans.

#### Annual Report 2000/01

The department's 2000/01 annual report failed to meet any of the above reporting requirements. It fails to provide any narrative details of the budget or its expenditure on the HIV/AIDS sub-programme (which is listed under 'Community Health Services').<sup>141</sup> However, the department's Annual Financial Statement indicates that a conditional grant amount of R2.213 million was allocated by the National Department of Health for HIV/AIDS purposes, of which it claimed to have spent the entire amount.<sup>142</sup> This claim should be treated with extreme scepticism given that both the Division of Revenue Act for 2001 and the department's 2001/02 HIV/AIDS business plan make reference to the failure to spend funds during the 2000/01

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<sup>139</sup> Sect. 40 (4) (b) and (c) of the Public Finance Management Act, 1999, and Sect. 5 (3)(1) of the Treasury Regulations, 2001 (read in conjunctions with Section 27(4) and 36(5) of the PFMA).

<sup>140</sup> Sect 40 (3) (a) of the Public Finance Management Act, 1999.

<sup>141</sup> Province of the Eastern Cape, Annual Report of Department of Health for the year ending 31 March 2001, PR212/2001.

<sup>142</sup> Department of Health, Eastern Cape *Annual Financial Statements*, 2000/01, p. 22.

financial year. Under a discussion of 'past performance' a schedule to the Division of Revenue Act 2001 notes that 'this grant was introduced in 2000/01, and it was under-spent due to delays in the establishment of processes and capacity at both provincial and national level, resulting mainly from delays in finalisation of the allocation of funds'.<sup>143</sup>

Moreover, the department's HIV/AIDS (conditional grant) business plan for the following year also refers to a number of problems experienced in the spending of its 2000/01 budget. It points out that the conditional grant allocations for VCT and Life Skills 'could not be accessed and utilised for the 2000/01 financial year due to technical problems with the Finance (Sic)'. In addition, it notes that the department's HBC conditional grant could only be accessed in the third quarter of the financial year, viz. in November 2000. The department acknowledges that the resulting failure to appoint VCT and HBC co-ordinators 'had a negative impact on the smooth running of the programme'.<sup>144</sup>

The 2000/01 Annual Report of the Eastern Cape Department of Health is unclear in highlighting its objectives, and especially in describing the year's results. At best, it offers only cursory remarks. (It also appears to try and shift any blame for failures onto other departments)

Pointing to increased Voluntary Counselling and Testing (VCT) the report states that out of eight VCT sites, two non-health and six health sites, five were operational while the remaining were not operational as personnel were untrained in counselling and testing. The report also notes that three high transmission area sites were fully operational, two in the Port Elizabeth area and one in the East London area. The report also maintains that two PMTCT sites had been identified, one in an urban area and one in a rural area. However, these pilot sites were not operational as the logistics for their implementation had not been finalised, and their financial responsibility lay with the national Department of Health. Finally, concerning the aim to have three HBC sites operational, the report notes that two sites were operational while the other site that was implemented through the integrated plan under the auspices of the Department of Welfare, was not operational as it was awaiting the training of caregivers.<sup>145</sup>

### **Annual Report 2001/02**

In its annual report for 2001/02 the department indicates that it 'had R33 million voted funds for the HIV/AIDS work in the province (sic)'.<sup>146</sup> This amount is not consistent with the R31.9 million stated in its business plan.

The 2001/02 annual report asserts that the Department of Health had successfully launched the PMTCT sites in June 2001, increased the number of VCT sites (though it calls these vocational training sites) and established the high transmission areas. The report does not give any indication of the number of these sites.<sup>147</sup>

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147 Ibid.

143 Ibid.

144 Eastern Cape, Department of Health, Business Plan for VCT and HBC, 2001/02 (Conditional Grant).

145 Eastern Cape Department of Health, *Annual Report*, 2000/01, p. 47.

146 Eastern Cape Department of Health, *Annual Report*, 2001/02, PR161/2002, p. 31.



The report notes that R33 million had been voted for 'HIV/AIDS work' in the Eastern Cape. Of this, R4.6 million had been earmarked for AIDS Training and Information Centres (ATIC's) in municipalities and another R5 million for NGO's that successfully tendered to do HIV/AIDS-related work. A further R5 million was set aside for Research and Capacity Building in the HIV/AIDS field. It is unclear whether the remaining funds were ever spent as the annual report refers to their use in the future tense: 'The remaining funds will be applied to the TB and STI programmes, and to the additional (sic) as drug and laboratory costs incurred at the health facilities as a result of HIV/AIDS clients'.<sup>148</sup>

This means that out of the total of R33 million supposedly budgeted for HIV/AIDS purposes in 2001/02, only R14.6 million was in fact allocated for HIV/AIDS related programmes while the remaining R18.4 million was intended for use on TB and STI programmes.

The Eastern Cape Department of Health annual report also indicates that the department received a conditional grant allocation of R6.26 million. This amount is broken down into R2.55 million for VCT, R1.3 million for HBC and R2.41 million for MTCT.<sup>149</sup> Again, no explanation is offered as to why this amount differs from the R3.85 million allocated in terms of the Division of Revenue Act, 2001, which is listed in the department's monthly financial reports. Nor is there any indication of whether the additional amount of R2.41 million consisted of a new allocation from the national Department of Health or if it was rolled over from the previous year. This report fails to meet the reporting requirements set out in terms of the Public Finance Management Act.

### **Annual Report 2002/03**

Unlike previous years, the department's 2002/03 annual report contains a breakdown of the performance of the HIV/AIDS Unit in terms of the following: output, performance measure, performance target, actual performance and percentage deviation from planned performance. This represents an improvement on the quality of reporting evidenced in previous years and was no doubt motivated by the Public Finance Management Act requirement (which became effective in April 2002) that departments report on their 'performance against predetermined objectives'. Despite this change, however, the report unfortunately fails to provide any breakdown of its expenditure of funds, which ultimately represents a regression in the quality of reporting evident in the 2001/02 financial year.<sup>150</sup>

The report indicates that the department aimed to establish 250 VCT sites by March 2003, and that only 222 'medical and non-medical' sites had been established.<sup>151</sup> It also maintains that, in line with its plan, test kits have been provided to 250 sites across the province. It also notes that 156 PMTCT facilities had been established (at 21 hospitals and 135 clinics) to cover all municipalities. In terms of training, it states that 'five PMTCT coordinators and 800 health professionals (have been) trained in all 24 districts', and '54 councillors (sic) (have been) trained in 24 sub-districts'.<sup>152</sup>

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148 Ibid.

149 Ibid, p. 33.

150 Eastern Cape Department of Health, *Annual Report, 2002/03*, PR 178/2003, p. 57.

151 Ibid.

152 Ibid. p.58.

The report also maintains that HBC projects have been established (through NGOs in municipalities) in six areas: Nelson Mandela Metro, Ukhahlamba, Amatola, Cacadu, Chris Hani and OR Tambo (one less than planned). Contrary to its plans to develop three Step-Down Care sites, the report notes that 'only one step down facility in Umtata (is) operational. Sipetu (is) still preparing the wards for the programme'.<sup>153</sup>

The report lists the following service delivery problems:

- 'Lack of proper infrastructure for provisioning of quality counselling and maintenance of confidentiality'.
- 'No systems for the payment of stipend (sic) for lay Community Health Workers in PHC'.<sup>154</sup> It states that, amongst others, it has taken the following measures to ensure that 'service delivery remains on track':
- 'Service-level agreements developed between departments and district municipalities'.
- Forty-one NGOs/CBOs (have been) funded for HIV/AIDS-related activities (32 funded by the province and nine funded by the national Department of Health).<sup>155</sup>

In terms of expenditure, the report notes that the HIV/AIDS unit was allocated a budget of R90.838 million for the year, whereas it spent only R48.158 million, or 46.9 per cent, of this amount. It maintains that there has been an annual average growth of over 56 per cent in its HIV/AIDS expenditure (see table below).

#### Evolution of Expenditure by Eastern Cape HIV/AIDS Unit<sup>156</sup>

Programme	2000/01	2001/02	2002/03	Average annual growth
HIV/AIDS	R17.795 m	R39.841 m	R48.158 m	56.87%

The report also provides an account of the department's expenditure against its conditional grant allocation. It notes that the department received a conditional grant allocation of R26.915 million for the year. This was made up of a R21.130 million allocation, a R403 000 adjustments estimate, and a roll-over of R5.382 million from the 2001/02 financial year. The report maintains that 179 per cent of this conditional grant allocation was spent. Suspiciously, this amounts to a figure of R48.158 million, the same figure cited for the expenditure by its HIV/AIDS unit (listed above).<sup>157</sup> Clearly the report-writers had made a mistake, which due to the failure to check the text of the report, had resulted in its publication and distribution to members of the legislature's oversight committees. Despite the subsequent acknowledgement that these figures were incorrect, to date no corrected figures have been published.

153 Ibid, p. 59.

154 Ibid.

155 Ibid.

156 Ibid, p. 60.

157 Ibid, p. 206.

# Monthly and Quarterly Reports

## Regulatory requirements

### Requirements for Provincial Allocations

In terms of the Public Finance Management Act, 1999, the accounting officer of a department must meet a number of stringent reporting requirements on the use of all departmental funds under his/her control. These include:

- Each month submitting information in the prescribed format on actual revenue and expenditure for the preceding month and the amounts anticipated for that month.
- Within 15 days of the end of each month submitting to the relevant treasury and the executive authority responsible for that department –
  - (i) The information for that month.
  - (ii) A projection of expected expenditure and revenue collection for the remainder of the current financial year.
  - (iii) When necessary, an explanation of any material variances and a summary of the steps that are taken to ensure that the projected expenditure and revenue remain within budget.<sup>158</sup>

In addition, the Treasury Regulations, 2001, which flesh out the provisions of the Public Finance Management Act, require that: 'The accounting officer of an institution must establish procedures for quarterly reporting to the executive authority to facilitate effective performance monitoring, evaluation and corrective action'.<sup>159</sup>

### Requirements for conditional grant spending

The Division of Revenue Act sets out a number of responsibilities to be met by the receiving officers of provincial departments (in this instance, the head of the Eastern Cape Department of Health) in respect of the allocation of conditional grants.

These responsibilities include:

- The submission of a report in terms of the Public Finance Management Act, within 15 days after the end of each month, to the relevant provincial Treasury, the relevant provincial executive authority and the transferring department.
- This report must set out –
  - (i) The amount received by the province in the month reported on and for the financial year up to the end of that month.
  - (ii) The amount of funds delayed or withheld from the province in the month reported on and for the financial year up to the end of that month.

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<sup>158</sup> Sect 40 (4) (b) and (c), Public Finance Management Act 1, 1999.

<sup>159</sup> Sect 5 (3)(1), Treasury Regulations, 2001 (read in conjunctions with Section 27(4) and 36(5) of the Public Finance Management Act).

- (iii) The actual expenditure by the province for the month reported on and for the financial year up to the end of that month.
- (iv) The extent of compliance with the conditions of an allocation.
- (v) An explanation for any material problems or variations experienced by the province regarding an allocation which has been received and a summary of the steps taken to deal with such problems or variations.<sup>160</sup>

The Act also stipulates that any serious act of non-compliance with its terms, or with the conditions attached to the allocation of funds under the Act, constitute an act of financial misconduct as defined by the Public Finance Management Act, 1999.<sup>161</sup> According to the Public Finance Management Act, the accounting officer of a government department commits an act of financial misconduct if he/she, amongst other things, wilfully or negligently fails to comply with his/her responsibilities for the submission 'of all reports, returns, notices and other information to Parliament or the relevant provincial legislature and to the relevant executive authority or treasury ...'.<sup>162</sup>

In the terms of the Act, financial misconduct is deemed to be grounds for the suspension or dismissal of a head of an 'accounting officer' for a department.<sup>163</sup> Moreover, if it can be shown that an accounting officer 'wilfully or in a grossly negligent way' failed to comply with their reporting responsibilities, they are guilty of a criminal offence and, on conviction, are liable to a fine or 'to imprisonment for a period not exceeding five years'.<sup>164</sup>

### Monthly and quarterly reports on HIV/AIDS conditional grants for 2000/01

The Division of Revenue Act 1, 2001, indicates that the Eastern Cape Department of Health was allocated a conditional grant of R2.213 million for HIV/AIDS for the 2000/01 financial year.<sup>165</sup> No quarterly reports could be located for this year. This is despite numerous efforts to obtain copies of these reports for the period between 1999 and 2004 (including the litigation of the department by the PSAM).

### Monthly and quarterly reports on HIV/AIDS conditional grants for 2001/02

The Division of Revenue Act 1, 2001, indicates that the Eastern Cape Department of Health was allocated a conditional grant of R3.850 million for HIV/AIDS programmes for the 2001/02 financial year.<sup>166</sup> Whilst no quarterly reports were made available in response to PSAM

160 Sect.16, Division of Revenue Act 1, 2001, Government Notice, National Treasury, No. 427, 15 May 2001, see also Section 16, Division of Revenue Act 5, 2002.

161 Sect. 30, Division of Revenue Act 5, 2002.

162 Public Finance Management Act, Act 1 of 1999, Sect. 51(1)(f) read in conjunction with Sect. 83(1)(a).

163 Ibid, Sect. 83(4).

164 Ibid, Sect. 86(1).

165 See Government Notice, National Treasury, No. 427, 15 May 2001.

166 See Government Notice, National Treasury, No. 427, 15 May 2001.

litigation, the Eastern Cape Department of Health did provide a disorganised and uncategoryed list of documents to the PSAM on 8 September 2003. These documents contained what appeared to be a random selection of monthly reports for the period between 2000 and 2003.

The department's monthly reports on expenditure for the 2001/02 financial year indicate ongoing financial management problems, which prevented effective expenditure of this grant. All reports between August 2001 and January 2002 list an annual budget allocation of R 3.85 million, whereas the monthly reports for March and April 2002 list a budget allocation of R8.281 million.<sup>167</sup> Events ran as follows:

- August 2001: An official notes that only R28 000 out of R3.8 million has been spent. The official comments that: 'This fund has been loaded under the item medicine but a recommendation letter for creation of separate objective (codes) has been forwarded to Treasury, because this will confines (sic) the utilisation (of the grant) to medicine related activities only. No response received to all the letters written to Finance (i.e. Treasury)'.<sup>168</sup>
- September 2001: The same official notes that: 'The programme is not in a position to utilise the budget fully due to Finance section problems ... Several processes and letters were sent to Finance/Treasury to correct that with no (sic) much support to that'.<sup>169</sup>
- October 2001: A different official notes that: 'We are currently engaged in process (sic) of restructuring and developing (sic) well co-ordinated financial systems. This process involves a lot of planning, to be effective, and therefore can be time-consuming. We hope to submit comprehensive reports as from next month once this process is finalised'.<sup>170</sup>
- November 2001: Yet another official records the following comment: 'In the absence of an accounting officer, this report has been signed by financial Admin officer (sic) on behalf of accounting officer, who will be available for signing at a date later than reporting date'.<sup>171</sup>
- January 2002: Makwedini, Director of the HIV/AIDS/STI Directorate, acknowledges that an amount of only R652 055 out of R3.8 million has been spent (after 10 months). She notes that: 'There has been a problem with the FMS reports whereby all grants to HIV/AIDS unit were mixed under one objective code. Currently, new objective codes have been created for separate grants to the unit, and journal entries to allocate expenditure are currently in process. This process have (sic) been delayed because people were on leave during December holidays'.<sup>172</sup>

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167 Conditional Grants to Provinces, Monthly Report by Eastern Cape Department of Health to Transferring National Department and Provincial Treasury for the months of August, September, October, November, December 2001, and January, March and April 2002.

168 *Ibid*, August 2001.

169 *Ibid*, September 2001.

170 *Ibid*, October 2001.

171 *Ibid*, November 2001.

172 *Ibid*, January 2002.

- March 2002: The HOD, Stamper, having just returned to work after a 16-month suspension in February 2002, notes that: 'PMTCT conditional grant was not readily accessible and as a result all activities for PMTCT programme were not funded under provincial funding. The journals for such expenditure were not passed due to time factor'. The figures listed on this report indicated that the total conditional grant budget for HIV/AIDS had increased to R8.281 million and that of this amount only R2.898 million had been spent. These figures also indicate that of an amount of R2.431 million allocated for PMTCT purposes the department had spent 'nil'.<sup>173</sup>
- April 2002: Stamper notes that: 'Financial systems in the province were closed on 15 March 2002 which was the due date of the previous monthly report submitted. Since that date no funds were accessible for spending'.<sup>174</sup>

### **Monthly reports on HIV/AIDS conditional grants for 2002/03**

According to the Division of Revenue Act 5 of 2002 the Eastern Cape Department of Health was awarded a HIV/AIDS Health Grant of R21.130 million for the following purpose:

'To expand access to voluntary HIV counselling and testing, home-based care, prevention of mother-to-child transmission programmes and other HIV/AIDS health-related matters'.<sup>175</sup>

This amount was broken down as follows: Voluntary Counselling and Testing, R8.33 million; Home Based Care, R4.697 million; Prevention of Mother-to-Child Transmission R2.9 million; Step-Down Care R4.452 million; and programme management R745 000.<sup>176</sup>

The department's monthly reports against the expenditure of this amount (in terms of the Division of Revenue Act) indicate the continuation of financial management problems from the previous financial year, which serve to prevent effective grant expenditure:

- May 2002: Mjekevu, the acting Accounting Officer, comments that: 'Loading of budget for the whole Department of Health was delayed because the province was shifting its financial systems from FMS (Financial Management Systems) to BAS (Basic Accounting Systems)'.<sup>177</sup>
- June 2002: Stamper, the HOD, notes the following: 'VCT: Shortage of master trainers has caused delays in terms of training trainers for counsellors. HBC: Funds were not available in April 2002. Have committed some funds. MTCT: VCT being entry point, areas for potential expansion had few nurses trained in counselling. Step Down: meetings will be held for step down in the near future'.<sup>178</sup>

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173 Ibid, March 2002.

174 Ibid, April 2002.

175 See Government Gazette, Vol. 441, Cape Town, No. 23290, 28 March 2002.

176 See for instance Conditional Grants to Provinces, Monthly Report by Receiving Provincial Department to Transferring National Department, Provincial Treasury, Eastern Cape, June 2002/03. This document was obtained by the PSAM through a process of litigation in terms of the Promotion of Access to Information Act, 2000 in November 2003.

177 Ibid, May 2002.

178 Ibid, June 2002.

- July 2002: Stamper notes that the following amounts have been spent: R24 000 (out of R8.33 million) for VCT, nil (out of R4.697million) for HBC, R81 000 (out of R2.906 million) for MTCT, R2 600 (out of R4.452 million) for Step-Down Care, and nil (out of R745 000) for programme management. This amounted to an expenditure of only 0.4 per cent (or R88 600 out of R21.13 million) after four months of the year. Stamper comments as follows: 'VCT: Final stage of assessing site readiness for full implementation and roll out. HBC: Money committed in the previous month has been delayed by Department of Finance process. MTCT: Facilities/hospital (sic) still being assessed for readiness in terms of capacity/provision of space and followup systems. Step Down: Awaiting districts to being (sic) sites for step down'.<sup>179</sup>
- August 2002: The report is unsigned, but the handwriting indicates that at least two officials were responsible for its contents. It states that: 'A roll-over for VCT and PMTCT was effected during the month amounting to 2951000 and 2431000 respectively. Business plans developed for VCT/PMT (sic).<sup>180</sup> Marketing strategy for the utilisation of roll over funds from both strategies'.
- September 2002: A new digital reporting format appears to have been introduced during this month. This format effectively eliminates the narrative content of previous reports, which provided an account of progress within each programme. The print-out for the month, signed by Stamper, indicates that a total amount of R880 000 out of R21.13 million (4.1 per cent) HIV/AIDS grant had now been spent. This was despite the fact that six months of the financial year had already passed, and the department's digital print-out indicates that a roll-over amount of R5.382 million had now been added to this original amount. This increased the total conditional grant budget to R26.512 million and meant that only 3.3 per cent of this amount had been spent by the halfway point of the year.<sup>181</sup>
- November 2002: A handwritten table attached to the department's computerised print-out of expenditure figures for the month that indicates the following amounts have been spent: R24 000 (out of R8.33 million) for VCT, nil (out of R4.697million) for HBC, R81 000 (out of R2.906 million) for MTCT, R2 600 (out of R4.452 million) for Step-Down Care, and nil (out of R745 000) for programme management. These figures coincide with the amounts contained on the digital print-out, which states that R6.066 million had now been spent. However, whilst Stamper continued to calculate spending against the original conditional grant allocation of R21.13 million, the digital print-out now indicated that the total national allocation had been increased to R28.253 million. Including the department's roll-over (of R5.382 million) this means that the department's conditional grant budget for 2002/03 had now risen to R33.635 million and its expenditure level had now risen to 18 per cent.<sup>182</sup>

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179 Ibid, July 2002.

180 Ibid, August 2002.

181 Ibid, September 2002.

With the introduction of a new computerised reporting format in September 2002, the Eastern Cape Department of Health ceased complying with the reporting requirements set out in the Division of Revenue Act. These include the requirement to account for the 'extent of compliance with the conditions of an allocation' and, importantly, the requirement to provide 'an explanation for any material problems or variations experienced' and 'a summary of the steps taken to deal with such problems or variations'. Consequently, after this point in time, the national Department of Health, the national Treasury and the Eastern Cape Treasury would not have been in a position to hold the department accountable for its effective use of these funds.

There is no evidence contained in subsequent monthly reports (i.e. after September 2002) of any of the national or provincial Treasuries (responsible for ensuring compliance with the terms of the Division of Revenue Act), requesting more detailed explanations of the department's expenditure and performance.

However, the department's monthly financial reports for the first month of the 2003/04 financial year indicate that an amount of R24.758 million out of a total of R33.635 million had been spent by the end of 2002/03. This amounts to an underspending of the department's conditional grant by 26.3 per cent.<sup>183</sup>

### **Quarterly reports on HIV/AIDS conditional grants for 2002/03**

The Department of Health's quarterly reports on the HIV/AIDS and STI programme for the first, second and third quarters of 2002/03 are the only quarterly reports which have been made publicly available by the department. No other quarterly reports could be located. This is despite numerous efforts to obtain copies of all quarterly and monthly reports for the period between 1999/00 and 2002/03 (including the litigation of the department by the PSAM).

These reports are often unclear and difficult to follow. They are even difficult to distinguish from each other, as the second quarterly report was incorrectly labelled as another third quarter report. It was only possible to ascertain that it was the second report by painstakingly comparing the various statistics.

They also differ in format and structure from each other, especially that of the first quarter from the other three. In terms of content and readability the first quarterly report is more structured with individual concise pages summarising the progress of each aspect of the programme. The remaining reports are in a tabular form with individual columns briefly stating the activities, targets and progress. However, the first quarterly report does not go into specific detail as to the objectives for the year (though it does provide details of progress against these objectives). For example, while stating one of the objectives concerning (VCT), it merely indicates the intention 'to increase the number of voluntary HIV testing and counseling (sic) sites', without stating how many. In contrast, each of the three other quarterly reports quantifies the objective for the year, i.e. 'Establish 193 new VCT sites by end of March 2003'.

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182 Eastern Cape Department of Health Provincial Report 2002/03, HIV/AIDS and STI Programme: 4th Quarterly report.

183 Ibid, November 2002.



In favour of the first quarterly report, however, are its statements of budget expenditure. Though it does not break down the budget allocated for each specific activity, it does note the overall amounts utilised during the first quarter. The remaining reports merely state their allocated budgets with no indication of how much has been spent to date.

There are also various misleading and insufficient comments in the reports. For example, in the fourth quarterly report one activity is named as 'Facilitate training of nurse counselors (sic)' with the target being three counsellors per site. The progress report and comment for this activity simply states: '555 nurse counselors and 387 community counselors (sic)'. What does this mean? It indicates neither whether they have been trained nor if they have met the target of having three counsellors per site.

The department's fourth quarterly report for 2002/03 also purports to provide a report on funding obtained from both sources (conditional grant and provincial allocation). However, for the most part this report fails to provide a clear indication of which budget sources it is reporting against.<sup>184</sup>

The only budget item clearly identifiable as a conditional grant expenditure in this quarterly report is an amount of R2.9 million listed against the activity of 'expand to all seven district municipalities in the province'. Under its 'progress report' the department's fourth quarter report for 2002/03 maintains that '156 PMTCT facilities established (21 hospitals and 135 clinics) in six district municipalities and metro'.<sup>185</sup> However, the department's PMTCT Conditional Grant Business plan for 2002/03 indicates that R980 100 out of this conditional grant of R2.9 million was allocated for various PMTCT training activities.<sup>186</sup> This points to a lack of correlation between the outputs and targets listed in the department's quarterly reports and those appearing in its business plans. The department fails to offer any indication of the implementation of the training conducted out of its conditional grant allocation.

In another case of the mismatch of budget lines listed in the department's business plans and those appearing in its reports, its fourth quarterly report for 2002/03 also refers to the following activity: 'Facilitate training of lay counsellors'. In this report the department maintains that: '100 lay counsellors (have been) trained' out of a budget allocation of R3.93 million. It states that its original target was: '350 lay counsellors trained'.<sup>187</sup> Again, however, the department's HIV/AIDS business plan indicates that this budget amount was only part of the provincial allocation for the training of 5 490 counsellors at a cost of R5.49 million. In other words, the target set in the department's PMTCT business plan was in fact 5 490 lay counsellors as opposed to 350. There is a complete mismatch between the department's planning and its reporting.

The department's quarterly report for the fourth quarter of 2002/03 also maintains that five PMTCT co-ordinators and 800 health professionals have been trained on PMTCT

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184 Conditional Grants to Provinces, Monthly Report by Receiving Provincial Department to Transferring National Department, Provincial Treasury, Eastern Cape, report to the end of April 2003/04.

185 Ibid.

186 Province of the Eastern Cape Department of Health Prevention of Mother-to-Child Transmission (PMTCT) Business Plan, signed HIV/AIDS Director, 3 June 2003.

187 Eastern Cape Department of Health Provincial Report 2002/03, HIV/AIDS and STI Programme: 4th Quarterly report.

protocols in all 24 districts during the course of this year. It indicates that a budget of R4 217 200 was allocated for this purpose and lists a target of: 'seven co-ordinators and 1 400 health providers trained'.<sup>188</sup> Again, by reflecting on the amounts listed in the departments PMTCT business plans for training, this figure fails to reflect the activities or amounts listed in these plans.

Monthly reports on HIV/AIDS conditional grants for 2003/04

In terms of the Division of Revenue Act 7, 2003, the Eastern Cape Department of Health was allocated a conditional grant of R38.934 million. The purpose of this grant was 'to enable the health sector to develop an effective response to the HIV/AIDS epidemic, including expanding access to voluntary HIV counseling and testing, home-based care, prevention of mother-to-child transmission programmes, post-exposure prophylaxis, step-down care and other HIV/Aids health-related matters'.<sup>189</sup>

The conditions set out for the use of this grant require the Eastern Cape Department of Health to produce a business plan and quarterly monitoring reports.

The measurable objectives/outputs for this grant include:

- Increased access to voluntary counselling and testing facilities.
- Number of health districts which have voluntary counselling and testing facilities.
- Number of mothers receiving VCT and number of mother/baby pairs receiving PMTCT prophylaxis.
- Number of home-based care teams in operation, caseload and number of patient contacts
- Number of step-down facilities in operation, number of admissions and number of bed days.
- Number of adults and children receiving PEP after sexual assault.

The department's monthly reports indicate an improvement in its spending capacity. However, as noted, subsequent to September 2002, these reports simply cite a breakdown of figures for its expenditure of budgeted funds for HIV/AIDS programmes per month and a list of projections for future spending plans (until the end of the financial year). Despite the inclusion of a comment box in this computerised report, the contents of this box are restricted to providing an indication of the amounts committed by the HIV/AIDS directorate for the month which still await payment to be effected by the payments section of the department.

It is of serious concern that these reports have stopped fulfilling their narrative reporting requirement to provide an explanation of programme performance, problems encountered and steps taken to resolve these, imposed in terms of the DORA. As noted earlier, this lack of compliance with Section 30 of the Division of Revenue Act, 2002, constitutes an act of 'financial misconduct' as defined by the Public Finance Management Act. If investigated,

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<sup>188</sup> Ibid.

<sup>189</sup> See Government Gazette, 30 April 2003, No. 24834.

the accounting officer for the department could be suspended, dismissed or subjected to criminal prosecution for this state of affairs.

# Appendix 7

## An Evaluation of Eastern Cape HIV/AIDS Training Plans between 2001 and 2004

### Proposed HIV/AIDS training 2001/02

The Eastern Cape Department of Health's HIV/AIDS and TB Directorate's business plans (for conditional grant and provincial budget allocations) proposed to undertake the following training activities during the 2001/02 financial year:

Purpose	Number of participants	Budget
1. To conduct workshops and train health care providers on VCT <sup>190</sup>	Not indicated	R606 300 conditional grant (No budget breakdown provided)
2. Training non-sentinel sites on Counselling and Testing <sup>191</sup>	Not indicated	R1 000 000 provincial allocation (R500 000 for counselling, R500 000 for testing)
3. Training on syndromic approach <sup>192</sup>	Not indicated	R8 000 000 provincial allocation (No budget breakdown provided)
4. Training on Community-Based Care <sup>193</sup>	Not indicated	R1 000 000 provincial allocation (No budget breakdown provided)
		<b>Total: R10 606 300</b>

This indicates that the department budgeted an amount of R10.6 million, out of a combined HIV/AIDS budget of R35.76 million (made up of a R3.85 million conditional grant and R31.91

190 Province of the Eastern Cape Department of Health HIV/AIDS/STI Directorate, Business Plan on Voluntary Counselling and Testing and Community/Home Based Care 2001/02, compiled 7 November 2001.

191 Department of Health Province of the Eastern Cape, HIV/AIDS Budget 2001/02, Signed Mrs Makwedini, 28 March 2001.

192 Ibid.

193 Ibid.

million provincial allocation) – viz. 30 per cent of the total HIV/AIDS budget – for purposes of training in the 2001/02 financial year. The department's business plans for this year provide no hint of the number of persons to be trained through the use of these funds, their location, the unit cost of the training or the content of this training. Consequently, on the basis of these business plans, it would have been impossible for the oversight committees of the Eastern Cape legislature to track the implementation of the undertakings made.

### Proposed VCT training 2002–2004

The Eastern Cape Department of Health's HIV/AIDS and TB Directorate's business plans proposed to undertake the following VCT training activities during the 2002/03 and 2003/04 financial years:

<b>Purpose</b>	<b>Number of Participants 2002/03</b>	<b>Budget 2002/03 (conditional grant)<sup>194</sup></b>	<b>Number of Participants 2003/04</b>	<b>Budget 2003/04 (conditional grant)<sup>195</sup></b>
1. Training of professional nurses on rapid testing	555	R27 750 (R50 per person)	600 (on counselling and rapid testing)	R2 400 000 (R400 per person per day, for 10 days)
2. To train lay counsellors	370 (2 per site, 185 sites)	R1 480 000 (R400 per person per day, for 10 days)	768 (for 32 lay counsellors per district, for 24 districts)	R 3 072 000 (R400 per person day, for 10 days)
3. To train health care providers on counselling	370 (2 per site, 185 sites)	R1 480 000 (R400 per person per day, for 10 days)	560 health care professionals (trained on VCT guidelines)	R22 000 (R40 per person, 14 one-day work shops for 40 persons) (correct calculation should read R22 400)

<sup>194</sup> All activities and figures drawn from Province of the Eastern Cape Department of Health, Voluntary Counselling and Testing Business Plan 2002/03, signed Mrs Makwedini, 21 February 2002.

<sup>195</sup> All activities and figures drawn from Eastern Cape Province Department of Health HIV/AIDS and TB Directorate Business Plan 2003/04, signed Mrs Makwedini, 10 April 2003.

4. In-service training of nurses on rapid testing at 193 sites	579 (3 nurses per 193 sites)	R 28 950 (R50 per person for 2 workshops)	1 050 (3 nurses per 350 sites)	R84 000 (R40 per person per workshop, 2 workshops)
5. Training of HIV/AIDS STI coordinators on project management	48 (2 per district, 24 districts)	R57 600 (R400 per person per day, for 3 days)	48 (2 per district, 24 districts)	R58 000 (R400 per person per day, for 3 days) (correct calculation should read R57 600)
6. Training of trainers on couple counselling	48	R57 600 (R400 per person per day, for 3 days)	48 (2 per district, 24 districts)	R58 000 (R400 per person per day, for 3 days) (correct calculation should read R57 600)
7. Provide counsellor update workshops to lay counsellors	386	R463 200 (R400 per person per day, for 3 days)	370	R444 000 (R400 per person, for 3 days)
8. Training of mentors and conducting update workshops for mentors	48 mentors 48 updates	R196 800 (new training at R400 per person per day, for 5 days; update workshops at R50 per person per day, for 2 days) (correct calculation should read R100 800)	48 mentor trainers (2 per district, 24 districts)	R58 000 (R400 per person per day, for a 3-day workshop) (correct calculation should read R57 600)

9. Mentorship workshops for lay counsellors on VCT/ PMTCT	-	-	768	R906 000 (R400 per person per day, for 3 days) (correct calculation should read R921 600)
10. Provide counsellor update workshops to trainers	48	R57 600 (R400 per person per day, for 3 days)	48	R58 000 (R400 per person per day, for 3 days) (correct calculation should read R57 600)
<b>Total</b>		<b>R3 849 500</b>		<b>R7 160 000</b>

The department's plans provide no indication as to how similar training activities relate to allocations made in previous years' budgets, or why, in some instances, their unit costs have changed so dramatically. For instance, under point 3 above, in 2002/03 it was proposed to train health care providers in voluntary counselling at a cost of R400 per day over a ten-day workshop, whereas in 2003/04 this same activity (training health care professionals on VCT guidelines) is costed at R40 per person for a one-day workshop.

Moreover, some of the proposed training activities contained in the department's plans do not make sense in and of themselves. For instance, why would it be necessary to provide ten days worth of intensive training to already qualified health professionals on how to counsel an HIV/AIDS patient (point 3 above, during the 2002/03 financial year)?

It is also difficult to differentiate the rationale for training activities during the same financial year, which appear to be very similar, if not identical. For instance, the 2003/04 plan indicates the intention to train 600 professional nurses on rapid testing and counselling (point 1) and also to train 560 health care professionals on voluntary counselling and testing guidelines (point 3). Given that professional nurses are also 'health care professionals' the potential for duplication of training in respect of these activities during this year cannot be ruled out.

The activities, numbers of persons to be trained on VCT and the unit costs listed under points 5, 6 and 10 above are identical for the 2002/03 and 2003/04 financial years. The activities and unit costs listed under point 7 are also similar (with a marginal decrease in the number of persons to be trained in 2003/04). Neither business plan for these financial years provides an indication of what the outputs of the same budget line items were for the previous year. For instance, there is no reference in the 2002/03 plan to the number of persons

trained, as a result of the R1.6 million allocated for VCT training, during the 2001/02 financial year.

For this reason it is highly likely that there was a duplication in training during the course of these financial years.

### Proposed PMTCT training 2002–2004

The Eastern Cape Department of Health's HIV/AIDS and TB Directorate's business plans proposed to undertake the following PMTCT training activities during the 2002/03 and 2003/04 financial years:

<b>Purpose</b>	<b>Number of participants 2002/03</b>	<b>Budget 2002/03</b> (CG = Conditional grant <sup>196</sup> PA = Provincial allocation) <sup>197</sup>	<b>Number of participants 2003/04</b>	<b>Budget 2003/04</b> (Conditional grant) <sup>198</sup>
1. To train professional nurses at the 2 PMTCT sites on counselling and PMTCT	100	R300 000 CG (R300 per person per day, for 10 days)	-	-
2. Workshop for the orientation of trained counsellors and managers on PMTCT	200	R100 000 CG (R250 per person per day, 2-day workshop)	-	-

<sup>196</sup> All activities and figures drawn from Province of the Eastern Cape Department of Health Prevention of Mother-to-Child Transmission (PMTCT) Business Plan, signed HIV/AIDS Director, 3 June 2003.

<sup>197</sup> All activities and budget figures drawn from Implementation and Training Plan for Prevention of Mother-to-Child Transmission Programme, Eastern Cape Department of Health, signed Mrs Makwedini, 12 March 2003.

<sup>198</sup> All activities and figures drawn from Eastern Cape Province Department of Health HIV/AIDS and TB Directorate Business Plan 2003/04, signed Mrs Makwedini, 10 April 2003.



3. Training lay counsellors on PMTCT	<p>100</p> <p>3930 PHC counsellors (6 persons per facility, 655 PHC facilities)</p> <p>280 CHC counsellors (10 per 28 CHC facilities)</p> <p>1 280 district hospital counsellors (20 per 64 district hospitals)</p>	<p>R300 000 CG (R300 per person per day, for 10 days)</p> <p>R3 930 000 PA (R1000 per person)</p> <p>R280 000 PA (R1000 per person)</p> <p>R1 280 000 PA (R1000 per person)</p>	<p>786 (32 persons per district, 24 districts) (incorrectly calculated as 786 instead of 768)</p> <p>-</p> <p>-</p> <p>-</p>	<p>R1 572 000 (R400 per person per day, for a five-day workshop)</p> <p>-</p> <p>-</p> <p>-</p>
4. Workshop updates for nurses	100	R20 000 CG (R100 per person per workshop, 2 workshops)	-	-
5. Mentoring of counsellors by trained psychologist	20	R72 000 CG (R6 000 per session, for 12 sessions)	-	-
6. Advocacy workshops for health department staff	100	R80 000 CG (R400 per person per workshop, 2 workshops)	-	-

7. Training of nurses on rapid testing at 54 clinics	162 (3 per clinic at 54 clinics)	R8 100 CG (R50 per clinic) (correct calculation should read R2 700)	-	-
8. Facilitators to attend 5 national and international seminars and workshops	2	R100 000 CG (R10 000 per workshop per facilitator, for 5 workshops/ seminars)	-	-
9. Train master trainers	14 (2 per district, 7 districts)	R21 000 PA (R1 500 per trainer)	-	-
10. Train counsellor mentors on quality assurance and support	70 (10 per district, 7 districts)	R35 000 PA (R500 per person)	-	-
11. Train district co-ordinators on HIV testing	21 (3 per district, 7 districts)	R21 000 PA (R1 000 per person)	-	-
12. Train laboratory staff on quality assurance and stock control	21 (3 per district, 7 districts)	R21 000 PA (R1 000 per person)	-	-
13. Train health care workers on HIV testing	26 172 (36 per service site, 727 sites)	R2 617 200 PA (R100 per person)	-	-
Total		R 980 100 CG R 8 205 200 PA		R1 572 000

The costing of training activities for PMTCT by the department between 2002 and 2004 raises a number of questions. It is unclear why the cost of training of lay counsellors on PMTCT (point 3) should increase by R100 per day between 2002/03 and 2003/04, but the length of the workshops should decrease from 10 to 5 days. Effectively this means that the department was of the belief that lay counsellors in the 2002/03 financial year required twice the number of workshop days on PMTCT training (10 days) than they did in 2003/04 (5 days).

Again, it is difficult to differentiate between the rationale for activities which appear to be identical, which are duplicated between the department's VCT and PMTCT business plans for 2002/03. For instance, it is unclear how the training of 162 nurses at 54 clinics on rapid testing (point 7) differs from the training of 555 and 579 nurses (under points 1 and 4 of VCT training table listed above) for this same year. This amounts to a total of 1296 nurses to be trained in rapid testing for this year (with an additional 2784 nurses to be trained on rapid testing under the VCT in the 2003/04 year [See points 1 and 4 on VCT table above]).

Neither of these business plans contains a schedule of training requirements (listing the estimated training needs per district). Consequently, it is not possible to establish whether these duplicated budget amounts may have resulted in the training of the same individuals. Nor would it have been possible for Legislature oversight committees to form an advance judgement about whether the above allocations constituted the best possible value for money.

### Additional training 2003/04

In the 2003/04 financial year the following training activities were proposed within the Health department's HIV/AIDS and TB Directorate's Business Plan:

<b>Purpose</b>	<b>Number of participants</b>	<b>Budget</b>
1. In-service training on syndromic management of STIs (Programme 3: STIs)	800 (33 health providers, per 24 districts)	R 500 000 (R125 per person, per day, for a 5-day workshop)
2. Facilitate Peer Education training (Programme 4: Commercial Sex Workers)	100 (peer educators)	R1 000 000 (No breakdown provided)
3. Education on HIV/AIDS and STIs to vulnerable groups	6 sites (4 existing, 2 new)	R850 000 (No breakdown provided)
4. Train health professionals on post-exposure prophylaxis (Programme 5: Non-occupational post exposure prophylaxis)	800	R54 000 (No breakdown provided)

5. Facilitate training of additional care-givers for Mhlonto (24), Mnquma (35), Nelson Mandela Metro (40), Buffalo City (30) and Makana (40) (Programme 6: Home Community-Based Care)	169	R600 000 (R15 000 per session, for 40 sessions, 5 groups, 8 weeks, 59 days)
6. Facilitate training of trainers on HBC in 17 LSAs	34 (master trainers in 13 LSAs)	R30 000 (R15 000 per session, 1 session for 2 groups)
7. Facilitate training of HBC carers, 5 clinics per LSA	325 (5 care-givers from 65 clinics)	R 1 200 000 (R15 000 per session, 8 sessions for 10 groups)
8. Mentoring of 72 CBOs to strengthen HBC sites	288 mentors (4 mentors per CBO, 72 CBOs)	R 7 200 000 (R100 000 per CBO) (amounts to a unit cost of R25 000 per trained mentor)
9. Facilitate workshops to train health care workers on policy guidelines for management of opportunistic infections including TB	580 nurses	R500 000 (no breakdown provided)
10. Train nurses on TB/HIV screening and clinical care	50% of nursing staff at clinics and CHC	R250 000 (no breakdown provided)
11. Train and orientate HIV/AIDS/STD and TB directorate staff members	8 staff	R4 000 (R500 per staff member)
12. Train head-office personnel on PFMA and project management	12 officers	R48 000 (R2 000 per person per session, for 2 sessions)
		<b>Total: R12 236 000</b>

Again the department's HIV/AIDS business plan for 2003/04 fails to indicate how the above training activities relate to those proposed in plans from previous years. For instance, it is not clear how the allocation of R500 000 for the training of 800 health care providers in the 'syndromic management of STIs' in 24 districts (point 1 above), relates to its previous budget allocation of R8 million for this purpose in 2001/02 (see point 3, Proposed HIV/AIDS Training 2001/02). No indication is provided as to whether this budget was actually utilised, and if so, who was trained as a result, and in what districts.

Again, under point 8 above, the department proposed to spend R7.2 million on mentoring of CBOs in order to strengthen HBC sites. No indication is provided as to what this mentoring consists of, or how it relates to the allocation of R1 million for training on community-based care in 2001/02 (see point 4 of 2001/01 table above). The plan simply indicates the intention to transfer R100 000 to each CBO, in the 24 LSAs, for the training of 288 mentors. This amounts to a cost of R25 000 per mentor. According to the department's fourth quarterly report for 2002/03, HBC sites had already been established through CBOs in seven LSAs by March 2003. No indication is given as to whether these seven LSAs will obtain duplicate funding, and if so, why.<sup>199</sup>

In addition, although the plan makes reference to the need to develop a tender document for the training of these 72 CBOs, and to submit it to the provincial Tender Board, it makes no mention of the specifications for the training to be undertaken by these CBOs. Specifically, the plan makes no mention of the signing of service-level agreements by the successful CBOs, or the creation of monitoring mechanisms by the department, to ensure compliance with these service level agreements. It is unlikely, given the HIV/AIDS unit's staffing constraints that it would have the capacity to monitor the effective utilisation of this large sum of money. This example serves to again reinforce the need for the department to attach a schedule of training needs (to be met by the HIV/AIDS unit) and a progress report (on existing programmes) to each of its business plans.

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199 Eastern Cape Department of Health Provincial Report 2002/03, HIV/AIDS and STI Programme: 4th Quarterly report.