RETROSPECTIVE INVESTIGATION OF EQUITY IN HEALTH CARE WITHIN EKURHULENI FOR THE PERIOD 2003 TO 2005, UTILISING THE DISTRICT HEALTH INFORMATION SOFTWARE SYSTEM

by

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DECLARATION

I declare that ***RETROSPECTIVE INVESTIGATION OF EQUITY IN HEALTH WITHIN EKURHULENI FOR THE PERIOD 2003 TO 2005 UTILISING THE DISTRICT HEALTH INFORMATION SOFTWARE SYSTEM*** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

…… **……**

Anthony D. Andrews **Date**

ABSTRACT

It was perceived that an imbalance exists between resource allocations for health care within the Ekurhuleni Health District (EHD). This study consequently used a retrospective, quantitative methodology to investigate health equity in the EHD and to collect information on clinic buildings, staffing and budget allocations. Although clinics were oversupplied in terms of the norms set by the National Department of Health, they were found not to be in keeping with population growth in the Ekurhuleni district. The study highlighted an inequitable spread of nursing staff, which would require that nursing personnel be re-deployed. The per capita spending in the different service delivery regions was also found to be inequitable. It was subsequently recommended that spending on clinics be revised (especially in the populous Southern SDR), that staff be reallocated and that budget allocations be reviewed to achieve equity in Ekurhuleni.

KEY CONCEPTS

Equity, fairness, responsiveness, health system reforms

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TABLE OF CONTENTS

LIST OF TABLES **PAGE**

LIST OF FIGURES

LIST OF ABBREVIATIONS

DHIS	District Health Information Software system
DHS	District Health Services
EDS	Essential Data Set
EHD	Ekurhuleni Health District
EMM	Ekurhuleni Metropolitan Municipality
GDoH	Gauteng Department of Health
HDI	Human Development Index
HISP	Health Information System Programmes
HIV/AIDS	Human Immunodeficiency Virus/ Auto-immune Deficiency Syndrome
HMIS	Health Management Information System
MDS	Minimum Data Set
MSA	Municipal Systems Act No. 32 of 2003
NDoH	National Department of Health
NGO	Non-Governmental Organisation
NHISSA	National Health Information System of South Africa
PHC	Primary Health Care
SDR	Service Delivery Region
STI	Sexually Transmitted Infections
TB	Tuberculosis
WHO	World Health Organisation

LIST OF ANNEXURES

CHAPTER 1

Background information

1.1 INTRODUCTION

This dissertation concerns itself with the vexing question of equity in health care within the jurisdiction of the Ekurhuleni Metropolitan Municipal (EMM) area for the period 2003-2005. The background to this problem will be discussed to give an overview of its complexity. Chapter 1 further describes the research problem and states the aim of the study, while research objectives are also formulated to address the research question. Conceptual and operational definitions are given to provide the context of the research. The significance of the study will subsequently be stated.

1.2 BACKGROUND

The aim of health care systems, according to Roemer (1997: 1539), is to:

- promote the health status of persons and populations;
- prevent disease;
- provide medical diagnosis and treatment; and
- rehabilitate individuals to maximum social functioning.

In summary, health care systems attempt to promote the health of the population and deliver quality patient care. According to the World Health Organisation (2000a: 25-26), the health care system must be responsive to the needs of its clientele and the system must be applied equitably to all clients in an accessible manner (see Figure 1.1 below):

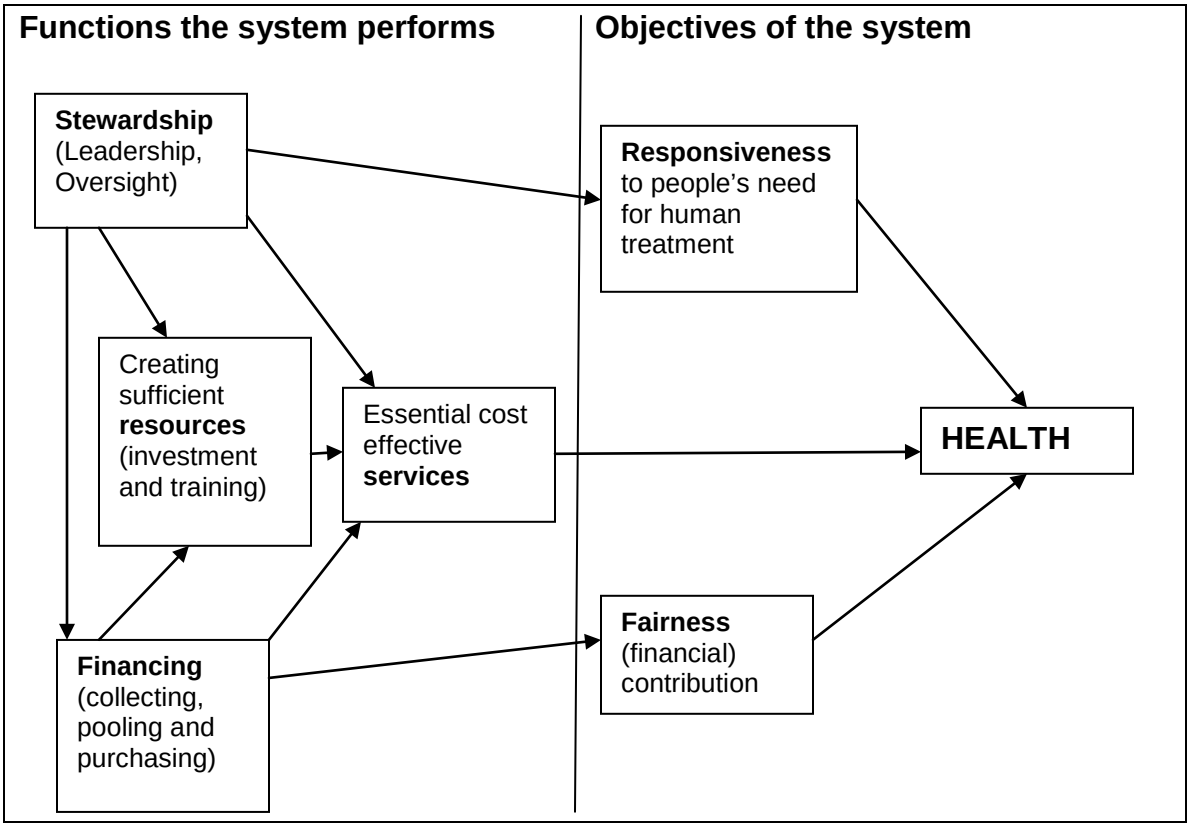

Figure 1.1: Relationship between the functions and objectives of a health system
Source: WHO Report 2000

The World Health Organisation (2000b: 118) furthermore states that governments, as stewards, provide oversight of the health system as a whole, including both public and private health care. In the case of South Africa the majority of citizens – 75% according to the District Health Information Software system (HISP 2003: 4) – rely on public health services.

According to the World Health Organisation (2000a: 26) the second objective of health care services is to obtain the smallest feasible difference between groups for the attainment of equity.

In 1994 the African National Congress (ANC) presented a plan for equitable health care in South Africa, given the legacy of the previous regime where great disparities (NDoH 2002) developed among the different population groups in the country. The ANC health plan (ANC 1994) stated that every person has a right to optimal health and committed itself to attaining that objective by means of the primary health care (PHC) approach.

Since coming to power in 1994, the ANC-led government has enacted the Constitution of South Africa, Act No. 108 of 1996. In terms of section 27 of the Constitution (1996) everyone has the right of access to health care services, sufficient food and water and the right to social security.

Whitehead (2000: 5) states that there is consistent evidence that disadvantaged groups have poor survival chances in all regions, in all political systems, as well as in population groups in different geographical regions.

The concept of equity is difficult to define. Whitehead (2000: 4) further propounds that there is confusion about the concepts of equity in regard to the following:

- **Health inequity**: This refers to differences in the level of health and the quality of health.
- **Health care inequity**: This relates to inequity in the provision and distribution of health care services. Provision refers to capital items such

as the number of clinics and access to these clinics, as well as provision of operational costs and overall funding, while distribution refers to the number and quality of staff (nurses and doctors).

Whitehead (2000: 8) approaches the definition of equity from the perspective of inequity and states that:

> "*The term inequity has a moral and ethical dimension. It refers to differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust. So, in order to describe a certain situation as inequitable, the causes have to be judged to be unfair in the context of what is going on in the rest of society."*

The South African Constitution (1996) promotes equity and participative governance and, as a consequence, ownership of the health service and the setting of health priorities through the integrated development priority (IDP) system. Sanders (2000: 17) agree with the approach of participatory governance by calling for strong community participation, which will further promote equity in health.

Health services are very expensive (WHO 2000: 23) and funding could be supplied privately by individuals or through collective schemes. Kvale (2000: 856) argues from an international perspective that the introduction of user fees perpetuates inequity, since public hospital fees count among these fees.

1.3 DISTRICT HEALTH SYSTEM

In an attempt at decentralisation, the South African Government enacted the Health Act, Act 61 of 2003, which in section 29 establishes the district health system with districts being co-terminous with municipal boundaries. Health districts, according to section 30, may be subdivided into health sub-districts that attempt, among other things, to work towards equity and community participation.

As the health system in the Ekurhuleni Health District is the setting for this research, the particular district will now be discussed in greater detail.

1.4 EKURHULENI HEALTH DISTRICT

The Ekurhuleni Health District (EHD) is composed of primary health care services rendered by the Gauteng Department of Health's Region B, as well as by the Ekurhuleni Metropolitan Municipality (EMM). The EHD is co-terminous with the boundaries of the Ekurhuleni Municipality. Health services are rendered from clinic facilities operated by both institutions.

As shown in Figure 1.2 below, Ekurhuleni is located in the Gauteng province of South Africa. It is situated on the East Rand with Tshwane / Kungwini District as its northern boundary, the City of Johannesburg on its western border, the province of Mpumalanga on its eastern border and Sedibeng District on its southern border.

The EMM is divided into three service delivery regions: Northern (N), Eastern (E) and Southern (S). There are also three health sub-districts per region, namely N1, N2, N3; E1, E2, E3; and S1, S2, S3. The boundaries of these health sub-districts are based on the borders of the municipal wards. In the EHD the fixed external boundaries were determined in terms of the Municipal Structures Act, Act 117 of 1998. Health sub-districts thus follow the fixed boundaries of the wards as determined by the Demarcation Act, Act 27 of 1998, while SDR's are soft boundaries determined by the EMM.

Figure 1.2: Geographic location of Ekurhuleni

The EMM resolved to subdivide the geographic area of the municipality for administrative purposes into three service delivery (SDRs) regions. Each SDR is made up of the following former East Rand towns:

Table 1.1: Towns making up different service delivery regions

SDR	Former Town
Northern	Tembisa, Kempton Park, Edenvale and northern parts of Germiston, Boksburg and Benoni
Eastern	Benoni, Brakpan, Nigel and Springs
Southern	Germiston, Boksburg and Alberton

Source: Health and Social Development Annual Report 2003-04

1.5 RESEARCH SETTING OF THE EKURHULENI HEALTH DISTRICT

Geographical context

Geographically the district covers 19 000 square kilometres with a population distribution as reflected in Table 1.2 and Figure 1.3 below:

Table 1.2: Growth in Ekurhuleni regional populations

	2003	2004	2005
North	758,078	786,586	815,097
East	892,527	925,667	958,804
South	1,003,049	1,040,425	1,077,798

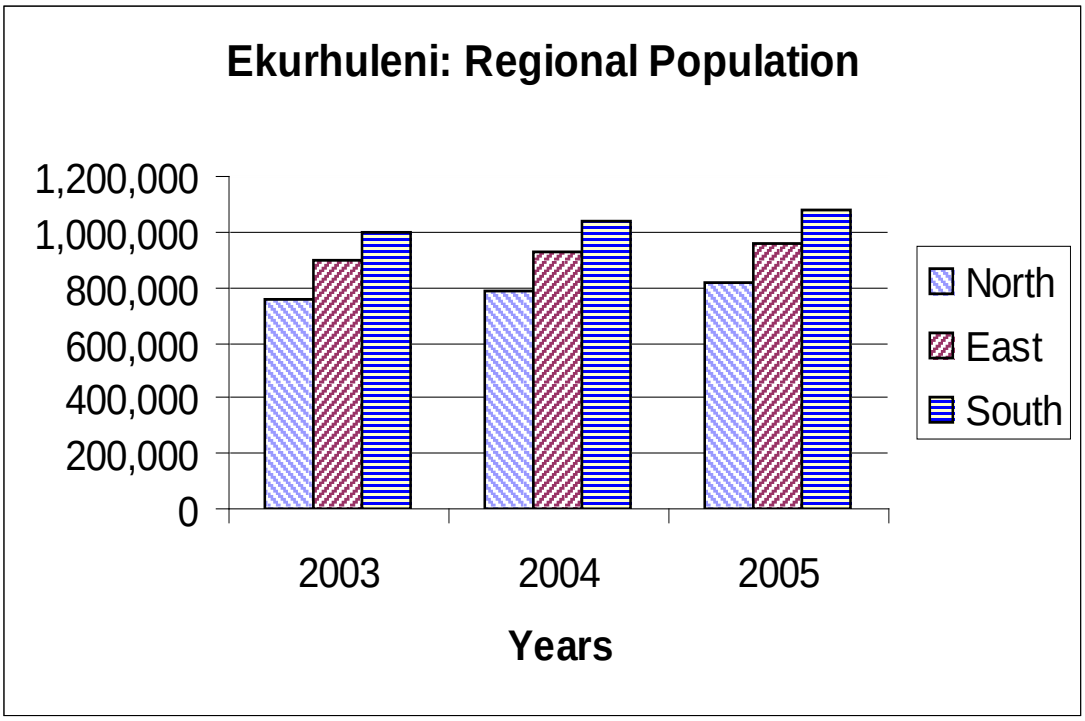

Figure 1.3: Ekurhuleni regional populations

The majority of people reside in the Southern SDR, specifically in the dormitory township complex called Katorus. Most people constituting the population of the SDRs are from the previously disadvantaged communities still caught up in former townships. In the case of Ekurhuleni, four such dormitory complexes exist and are shown in Table 1.3.

Table 1.3: Dormitory complexes per service delivery region

Service Delivery Region	Name of dormitory complex
Northern	Tembisa
Eastern	Daveyton-Etwatwa
	Kwatsaduza
Southern	Katorus

Social context

In ANNEXURE F socio-economic parameters for Ekurhuleni Health District are given and include:

- Number of households
- Average household income
- Annual per capita income (Rand)
- Gini coefficient
- Unemployment
- Percentage of persons in poverty
- Human Development Index (HDI)

The parameters however do not adequately show the inequities within the service delivery regions (SDRs) because they reflect averages calculated for the entire municipal area.

There are 787 000 formal households in these SDRs with 53% of the population economically active. Although socio-economic indicators for Ekurhuleni are discussed in more detail in ANNEXURE F, the following can be stated here:

- There are a total of 112 informal settlements in the entire Ekurhuleni municipal area. These informal settlements are distributed across the entire Health District.
- Formal sanitation and electricity are provided to 787 000 households in Ekurhuleni
- The Human Development Index (HDI) for Ekurhuleni in 2003 was given as 0.67 (ANNEXURE F: IDP 2003).

Since the above information is averages calculated for the entire municipal area, it belies the reality of the socio-economic situation of Ekurhuleni in the dormitory townships. The majority of the latter's population is black and thus the huge number of people living in the informal settlements aggravates their historically disadvantaged position. Formal housing with sanitation and electricity is owned predominantly by the advantaged section of the community. A relatively high human development index (HDI) is skewed by the privileged section of the community. The large black population is still ravaged by poverty and unemployment, with the result that seventy-five percent (75%) (HISP 2003) is dependent on public health services.

The context of health service delivery

Different types of public health clinics are operated in Ekurhuleni as illustrated in Table 1.4. A total of one hundred and thirteen (113) facilities are operated by both the GDoH and EMM. Of these, four (4) are community health centres (CHC), seventy-three (73) are fixed clinics and eighteen (18) are satellite clinics (see Table 1.4 below).

Table 1.4: Primary health care facilities

Facilities	Catchment-area population, census 2001	Type of facility					No. of mobile points	Ext Hrs
		CHC	Fixed	Satellite	Mobile	Dental only		
Eastern SDR	839,633	3	25	7	6	2	32	9
Northern SDR	719,281		18	4	2	2	54	3
Southern SDR	921,368	1	30	7	3	3	7	3
Ekurhuleni Total	**2,480,282**	**4**	**73**	**18**	**11**	**7**	**93**	**15**
		106				**7**		
		113						
Primary Health Care Facilities during 2003/2004								

Source: Ekurhuleni Metropolitan Municipality Health Annual Report 2003/2004.

The primary health care services provided in the EHD comprises the following:

- Clinic services:
  - Community Health Centres (CHC's)
  - Fixed and satellite clinics
  - Mobile clinics
- A community hospital

1.6 DISTRICT HEALTH INFORMATION SOFTWARE (DHIS)

The National Department of Health (NDoH), through the health information department called the National Health Information System of South Africa (NHISSA), developed a list of data elements to monitor and evaluate health service delivery in South Africa. The initial list of elements called the minimum data set (MDS) contained over a thousand data elements. This MDS was trimmed to an essential data set (EDS) with less than two hundred data elements. These data elements were adopted by the nine provinces, collected on a daily basis and progressively reported from clinics to national government.

Data elements converted into indicators cover various aspects of the health information system (Heywood & Rohde [Sa]: 22), for example:

1. Special Programmes	Maternal & reproductive health
	Child health and nutrition
	Chronic illness
	HIV/AIDS, STI and TB
2. Routine Services	Minor ailments
	Non-priority activities
3. Epidemiological Surveillance	Notifiable diseases
	Environmental health
4. Administrative Systems	Infrastructure, equipment
	Human resources
	Drugs, transport, laboratories, finances, budget, staff

5.	Population data	Census: age, sex, place Registration of births and deaths

Data Processing

Data collection at point of first contact, throughout South Africa, is still a manual process and is so for EHD. The NHISSA commissioned a non-governmental organisation (NGO) called Health Information Systems Programme (HISP) to develop a computer application that could improve the capturing of routine data and to assist with the analysis of the health data. The computer-based health information system developed by HISP in 2003 is called the District Health Information Software (DHIS) system Version 1.3.0 (HISP 2003). The developers of DHIS state the following:

> "…the DHIS is not an Electronic Health/Medical Record (EH/MR) system oriented towards clinical management of patients – it is fundamentally a[n] action-oriented Health Management Information System (HMIS) designed to support Health Sector Reform, decentralised decision-making, and local use of information" (HISP 2003: 4)

The DHIS system is developed from an open source database and is implemented nationally. Data elements, after being captured electronically, are reported monthly to the province concerned, who in turn reports to the NHISSA. The analysis of elements, to establish indicators, is based on generally accepted, common definitions for comparisons throughout the system. Comparisons (based

on the indicators) can be drawn between individual clinics on a month-to-month basis, as well as between facilities, health sub-districts, regions, and eventually health districts. The NHISSA uses this system to compare provinces and submits its annual report to Parliament and the World Health Organisation (Heywood & Rohde [Sa]: 7).

1.7 SIGNIFICANCE OF THE STUDY

The significance of this study is to improve equity in health care delivery in the three service delivery regions (SDRs).

Addressing the findings and implementing the recommendations of the study will be of benefit to the Ekurhuleni Metropolitan Municipality as a whole but the SDRs in particular by improving better resource distribution in terms of facilities, staff and budget allocations. In terms of equity this may result in improving accessibility to health care and the health status of all the groups in the SDRs of Ekurhuleni.

1.8 RESEARCH PROBLEM

Within the Ekurhuleni Health District, it is perceived that there is an imbalance between resource allocation (in terms of clinics, staff and finances) for health care and the number of health care consumers.

Health care equity, although generally espoused, is not entrenched in the South African health arena as described by the National Department of Health (NDoH 2001: 2).

Inequity in society is no longer acceptable in the South African context. In 1994 a new dispensation was ushered in – a democratic order based on a constitution considered to be the best in the world.

1.9 RESEARCH QUESTION

To what extent does health care equity exist in the Ekurhuleni Metropolitan Municipal area in terms of resource allocation regarding clinics, staff and budgets?

1.10 AIM OF THE RESEARCH

The aim of this research is to determine the state of health care equity in the three Service Delivery Regions (SDRs) of the Ekurhuleni Health District for the period 2003 to 2005 in terms of the following:

- Capital distribution in the form of clinics
- Staff allocations
- Budget allocations

1.11 RESEARCH OBJECTIVES

The objectives of this research are as follows:

1) To describe the available health resources – clinics, staff allocation and budget/financial support – in each of the three SDRs of Ekurhuleni that were included in the study.
2) To conduct a gap analysis between health resources and financial support for the selected SDRs in terms of their need for clinics, staff and budget support.

1.12 DEFINITION OF CONCEPTS

1.12.1 Equity

Equity refers to the extent that no differences are found in the health status of groups of people in a geographical area, either nationally or internationally (Whitehead 2000: 5).

An operational definition takes the above into account. Whitehead (2000: 7) states that equity concerns itself with providing equal opportunities for health to all groups in the community and bringing down health differentials among the groups to the lowest level. This makes provision for:

- equal access to available care for equal need;
- equal utilisation for equal need; and
- equal quality of care for all members of the population.

1.12.2 Equity in respect of clinics, staff and budgets

With regard to equity, the National Department of Health (NDoH 2003: 4-5) provides guidelines based on a services platform approach. The guidelines state that an equitable distribution of facilities and services must be decided on first. An appropriate allocation of resources can then follow and budget allocations can be made.

1.12.3 Health Information System

A health information system involves the systematic, anonymous and routine collection of health data to answer epidemiological questions concerning health – who gets sick, where, from what, when and why (Heywood & Rohde [Sa]: 3).

In South Africa, the health information system applicable to this study is the system put in place by the National Department of Health, called the District Health Information Software (DHIS) system. This system is described in Paragraph 2.5.

1.13 RESEARCH METHODOLOGY

1.13.1 Research approach

A quantitative approach has been adopted in this research project. As stated in De Vos (2002: 79), it involves the process of measuring the social world objectively, testing a hypothesis and making predictions.

1.13.2 Research design

According to Mouton (2001: 55) a research design is a plan of how the research will be conducted. The research design adopted in this paper is retrospective secondary data analysis, based on a descriptive empirical data analysis approach. Secondary data such as past documentation of records in the Ekurhuleni Health District are used for this purpose. Whitehead (2000: 5) suggests that health profile differences can be measured from standard health statistics.

1.13.3 Study population

The study population in the context of this study is the documentation pertaining to health care delivery in the Ekurhuleni Health District in terms of clinics, staff and budget allocations. The eligibility criteria for inclusion in the study require documents to be related to clinics, staff and budgets.

1.13.4 Research sample and sampling method

The three service delivery regions (SDRs), namely the Northern SDR, Eastern SDR and Southern SDR have been purposively selected to determine equity of health service delivery. All documents from these three SDRs related to clinic facilities, staff and budgets have been included as data sources. The three regions were established in 2000 by the EMM for administrative purposes following the amalgamation and integration of a number of former East Rand towns.

1.13.5 Data collection and analysis

According to De Vos (2002: 184) a checklist is a list containing a series of items to guide data collection.

The researcher developed a checklist on health care equity in the Ekurhuleni Health District based on the approach given by Whitehead (2000: 4). Data elements included were based on the provision (clinics) and distribution (staff and budgets) to guide data collection from the three SDRs (ANNEXURE A). The checklist was sent to all the divisions in the Health Department of Ekurhuleni and the Local Economic Department. The Region B Office of the Gauteng Department of Health was also invited to contribute relevant information.

Data collection using the checklist will be discussed in Paragraph 3.6.

1.14 RELIABILITY AND VALIDITY OF THE STUDY

Reliability refers to consistent measurement by the research instrument decided on (Polit & Hungler 1997: 295), while validity refers to the degree to which an instrument measures what it purports to measure (Polit & Hungler 1997: 299). Both these concepts will be discussed in Chapter 3.

1.15 OVERVIEW OF ETHICAL CONSIDERATIONS OF THIS RESEARCH

The data was collected from existing documents. Consent was obtained from the two relevant institutions, namely the Ekurhuleni Metropolitan Municipality (ANNEXURE B) and the Gauteng Department of Health, Region B (ANNEXURE C). Consent to conduct the research was also obtained from the Ekurhuleni

Metropolitan Municipality Ethics Panel (ANNEXURE D). Beneficence would take the form of future benefits to be had from a more equitable distribution of resources.

1.16 LAYOUT OF THE RESEARCH

Chapter 1 provides the background and context of the study. Chapter 2 provides a review of the available literature on equity in health care. In Chapter 3 the approach towards the research and the methodology adopted are explained. Chapter 4 discusses an analysis of the data, while chapter 5 deals with the study's conclusions and recommendations with regard to the findings.

1.17 SUMMARY

In summary, health care systems attempt to promote the health of the population/ clientele and deliver quality patient care.

Equity refers to the extent of no differences in health status of groups of people in a geographical area, either nationally or internationally (Whitehead 2000: 5).

Since 1994, when a new dispensation was ushered in, inequity in society is no longer acceptable in the South African context. The country now boosts a democratic order based on a constitution that is considered to be the best in the world.

The question to be answered by this research is – to what extent does equity exist in the Ekurhuleni Metropolitan Municipal area in terms of resource allocation of clinics, staff and budgets? The aim of this research is to determine the state of equity in the three Service Delivery Regions (SDRs) of the Ekurhuleni Health District for the period 2003 to 2005. Equity is investigated in terms of capital distribution in the form of clinics, staff allocations and budget allocations.

CHAPTER 2 – Literature review

2.1 INTRODUCTION

2.1.1 The purpose of a literature study

Problem identification constitutes the basis for doing research. According to De Vos (2002: 127), a literature review is necessary to fully understand the nature and meaning of the problem. Literature studies allow the researcher to form an idea of what other researchers have done and the lessons they learnt (Mouton 2001:87).

A research report should be situated within the context of the general body of knowledge and this is achieved through a review of the available and relevant literature (Babbie 2001: 565).

2.1.2 The reasons for conducting a literature study

A literature review is undertaken to establish the extent of available knowledge with regard to the problem being investigated. De Vos (2002: 128) lists a number of reasons why a literature review is necessary:

- It is an excellent source for selecting and/or focusing on a topic.
- It prevents unnecessary repetition.
- It identifies deficiencies in other research.
- Knowledge is gained of the most recent theories and definitions of concepts.

The current literature review seeks to investigate health care equity in the Ekurhuleni Health District and evaluate international literature – however with emphasis on the South African experience. Data for this review was obtained from the following sources:

- Lecture notes from the UNISA course on Health Systems: MPHH5Y-P/2005
- Articles on CD-ROM supplied with the course MPHH5Y-P as well as bibliographies supplied
- Internet search of relevant articles
- Textbooks
- Acts and policy documents

2.2 HEALTH SYSTEMS AND HEALTH SYSTEMS REFORM

In terms of the Alma Ata Declaration (1977), health is broadly defined as "…complete physical, mental and social well being and not merely the absence of disease or infirmity". The Alma Ata Declaration (1977) goes on in article V to place responsibility on governments to seek health for all by the year 2000. It declares that the vehicle to achieve health for all is through primary health care (PHC).

Roemer (1997: 1539) define health systems as all the activities of nations that result in the provision of health services. This definition of health care systems is

expanded on by Van Rensburg (2004: 1-2), who speaks of total health systems that include not only the national health system, but also all extraneous matters directly or indirectly associated with health.

In the health system structure model proposed by Roemer (1997: 1539), the health needs of society are met by the components making up the system. The health system is usually organised as a ministry of health that harnesses resources and provides managerial and economic support in order to deliver services to the society to improve the health status of the population. Van Rensburg (2004: 5) refers to these components of health systems as *intraneous* determinants. In terms of the matrix discussed by Roemer (1997: 1543), he describes South Africa as having a developing and transitional economic framework with an entrepreneurial and permissive political system. The matrix (Roemer 1997: 1543) is constructed by contrasting health system policies (entrepreneurial and permissive, welfare-oriented and socialist and centrally planned) with economic levels (affluent, developing and transitional, very poor and resource rich), and it determines the types of health systems in place.

In terms of the socio-cultural environment, Van Rensburg (2004: 6) introduces the concept of *extraneous* political factors. They concern the

- place and importance of public, voluntary and private sectors in the health organisation;
- financing and actual delivery of health services;

- degree of state control versus autonomy in the healing professions; and
- degree of regulation or deregulation, bureaucratisation, centralisation or regionalisation in health care.

According to Van Rensburg (2004: 6) the extent of political intervention concerns issues such as equality, discrimination and distribution of health services.

As was stated in Paragraph 1.8.4, the National Department of Health (NDoH 2003: 4-5) provides guidelines based on a services platform approach. According to these guidelines a decision must first be reached about the equitable distribution of facilities and services, after which an appropriate allocation of resources and budgeted funds can be made.

Furthermore, the provision of services is dependent on the economic and political history of a country (Roemer 1997: 1542). Since 1994, service provision in South Africa occurs at the primary, secondary and tertiary levels and is based on the PHC approach as advocated in the Alma Ata Declaration (1977).

2.3 MEASUREMENT OF HEALTH CARE SERVICES

The measurement of equity in health is not a standardised process. Measurement is based on socio-political context of countries which determine comparisons between developed versus developing countries. Daniels, Bryant, Castano, Dantes, Khan and Pannarunothai (2000: 740) describe a measuring tool of the determinants of health that was developed through international

cooperation. The benchmarks of fairness emanated from a discussion in 1999 among the collaborating teams in Colombia, Mexico, Pakistan and Thailand aimed at the comprehensiveness of medical insurance reforms. According to Daniels et al. (2000: 740) the benchmarks had an ethical rationale based on justice, and health care. The tool measures fairness, which is broader than equity (Daniels et al. 2000), and assesses nine benchmark criteria that cover the areas indicated:

2.3.1 Intersectoral public health

a) Population
    - Basic nutrition
    - Housing
    - Environmental factors
    - Education and health education
    - Public safety and violence reduction

b) Information infrastructure
    - Regular measurement of health status inequalities
    - Research into interventions

c) Intersectoral efforts
    - At local, regional and national levels
    - Involvement of vulnerable groups.

2.3.2 Financial barriers to equitable access

a) Informal sector coverage

- Universal access – primary health care
- Portability of coverage

b) Insurance for formal sector

- Reduction of obstacles to enrolling formal sector
- Family coverage for enrolled workers
- Drug coverage
- Medical transportation costs
- Producing uniform benefits across all workers
- Integrating various schemes involving those workers

2.3.3 Non-financial barriers to access

a) Reduction in geographical maldistribution

- Facilities and services
- Personnel (mix and training)
- Supplies
- Drugs
- Clinic hours
- Transportation for medical purposes

b) Gender

- Status in family regarding decision making
- Mobility
- Access to resources
- Reproductive autonomy
- Gender sensitive provision of services

c) Cultural

- Language
- Attitudes and practices relevant to disease and health
- Uninformed reliance on untrained traditional practitioners
- Perception of public sector quality

d) Discrimination

- Race
- Religion
- Sexual orientation
- Disease

2.3.4 Comprehensiveness of benefits and tiering

a) All effective and needed services deemed affordable by all.

b) Reform reduces tiering and achieves more uniform quality.

2.3.5 Equitable financing

a) Is financing determined by ability to pay?

- If tax-based scheme

  How progressive?

  How much reliance on cash payments?

- If premium-based

  Is it community-rated?

  Reliance on cash payments

- Out-of-pocket payments

  Main source of shifting burdens to the sick

2.3.6 Efficiency, efficacy and quality of care

a) Primary health care (PHC) focus

- PHC training
- Incentives
- Appropriate allocation of resources to PHC
- Interactive community participation
- Referral mechanisms

b) Implementation of evidence-based practice

- Health policies
- Public health and clinical prevention
- Therapeutic interventions
- Information infrastructure and database

c) Measures to improve quality

- Regular assessment of quality, including satisfaction
- Accreditation of plans and hospitals
- Professional training

2.3.7 Administrative efficiency

a) Minimise administrative overheads

b) Reduce purchasing cost

c) Minimise cost shifting

d) Minimise abuse and fraud and inappropriate incentives

2.3.8 Democratic accountability and empowerment

a) Explicit, public and detailed procedures for evaluating services

b) Explicit deliberative procedures for resource allocation – transparent

c) Global budgeting

d) Full grievance procedures

e) Adequate privacy protection

f) Measures for enforcement of compliance with rules and laws

g) Strengthening civil society

2.3.9 Patient and provider autonomy

a) Degree of consumer choice

b) Degree of practitioner autonomy

A scoring system was developed to evaluate competing reforms both locally, regionally and internationally.

It is clear from the above comprehensive benchmarks of fairness in health that South Africa as a developing country and Ekurhuleni specifically can benefit from comparisons with similar countries in assessing health care reform.

2.4 AN INTERNATIONAL PERSPECTIVE ON HEALTH CARE EQUITY

A fair and just society catering for the needs of all its citizens is an ideal most countries strive for. According to Whitehead (2000a: 3) various social barriers interfere with the access to basic services and render a section of the community vulnerable. These vulnerable members find themselves trapped in a poverty cycle and consequently have to carry the major burden of diseases (Whitehead 2000a : 3).

The vulnerable citizens who are caught in the medical poverty trap (Whitehead, Dahlgren & Evans 2001: 833-836) are also the disadvantaged community members who do not have access to services – and this is described as the paradox of health care.

Internationally, equity is an elusive goal for all countries where there are differences in access to resources, according to Whitehead (2000: 3). Daniels et al. (2002: 740) also argue that inequity affects both developed and less-developed countries. The World Health Organisation (WHO) in its World Health Report (WHO 2000a: 23) states that the raison d'être for health systems is better health for the population. It goes on to state that fairness in financing of health is difficult based on the notion: "Getting what you pay for". The phenomenon of co-payments to obtain health services means poor people are not able to access expensive health care services. The WHO (2000a: 23) categorically states that health care can be catastrophically costly.

Stewardship by governments (WHO 2000a: 24) is key to ensure access to and distribution of resources in respect of both public and private health care. The health care system should be responsive to the health care needs of its clientele, especially the non-health aspects such as adequate housing and access to clean drinking water and the treatment meted out by providers (WHO 2000a: 31). The WHO (2000a: 26) also states that fair financing of the health care system ensures financial protection for everyone. Out-of-pocket expenses should not deny the poor access to health services, and greater pre-payment should be encouraged. Government should therefore perform its oversight role (WHO 2000a: 24-26) by attending to

- service delivery – (responsiveness);
- funding – (fairness);
- investment in health resources; and
- its stewardship function.

Kvale (2000: 856) argues from an international perspective and remarks that the introduction of user fees merely perpetuates inequity. The fees charged by public hospitals deny open access, because poor persons simply cannot afford to pay any user fees.

2.5 EXTERNAL DETERMINANTS THAT CONTRIBUTE TO HEALTH

Roemer (1997: 1539) argues that the following determinants contribute to health:

- Physical environment

  - Geography, climate
  - Food, water, housing, etc.
- Social environment
  - Education, occupation, income
  - Relationships, urbanisation, etc.
- Personal traits
  - Age, sex / gender
  - Immunity, genetic background, habits, etc.
- Health services
  - Health promotion, disease prevention
  - Treatment, rehabilitation, etc.

By providing adequate housing, sanitation and potable water and by ensuring increased education with commensurate increased income, governments actually improve the health status of communities. Similarly, the health system adopted by governments should not only promote good health and disease prevention, but also provide reasonable access to treatment in the event that people fall ill and subsequently require rehabilitation (Roemer 1997: 1539, Daniels et al. 2000: 740-749).

In terms of the socio-cultural environment, Van Rensburg (2004: 6) introduces the concept of *extraneous (external)* political factors: the place and importance of public, voluntary and private sectors in the health organisation, the financing and actual delivery of health services; the degree of state control versus autonomy in

the healing professions, and the degree of regulation or deregulation, bureaucratisation, centralisation or regionalisation in health care.

According to Daniels et al. (2000) a tool to measure fairness – which is broader than equity – assesses nine benchmark criteria that cover the following areas:

1 Intersectoral public health

2 Financial barriers to equitable access

3 Non-financial barriers to access

4 Comprehensiveness of benefits and tiering

5 Equitable financing

6 Efficiency, efficacy and quality of care

7 Administrative efficiency

8 Democratic accountability and empowerment

9 Patient and provider autonomy

Socio-economic determinants of health

The health status of communities also improves where contributory determinants of health such as adequate housing, clean drinking water and proper nutrition are satisfied (UNISA: 2003; Daniels et al. 2000: 740-749).

2.5.1 Control of infectious diseases

According to Knight (UNISA: 2003), a decline in infectious disease had been observed even before the infectious agents were identified (see Figure 2.1 below). Figure 2.1 draws from the long history of data collection in England and demonstrates the decline in TB before the introduction of antibiotics, which is purported to be due to the improvement in socio-economic status of the people in England.

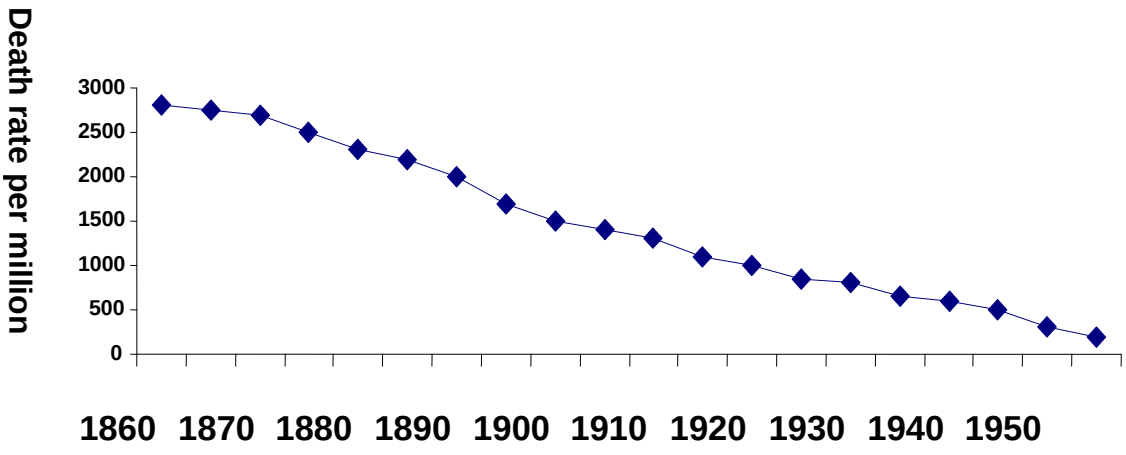

Figure 2.1: Mean annual death rate from tuberculosis in England
Source: UNISA: Knight (2003)

2.5.2 Community participation

Greene (2003: 108) remarks that health status improves at a greater pace where community participation is encouraged. The latter enhances ownership of the health care system and ensures attention to community health needs. Social inequity in the South African context is being systematically eliminated by providing an enabling legal framework (Constitution 1996) and by improving access to and participation in the health delivery system.

2.5.3 Service delivery approach

The service delivery approach of basic versus market-related health care has different outcomes. Cuba, according to Greene (2003: 108), is an example of a low-income country adopting the approach of providing basic health care and adequate community participation maintaining relatively high health outcomes. The United States of America, on the other hand, is as an example of a high-income country where health care is delivered at market-related prices. According to Sanders (2000: 16) this results in large sectors of the community becoming vulnerable.

In terms of poor access to health services, Whitehead (2000: 3) has shown that life expectancy of disadvantaged groups is detrimentally affected in an inequitable society.

2.6 SOUTH AFRICAN PERSPECTIVE ON HEALTH CARE EQUITY

Gross inequalities existed when the Government of National Unity took over the reigns in South Africa in 1995 (SA Demographic and Household Survey 1998: 3, SA NDoH 2001:2). The new democratic government was premised on equity, as stated in the Health Plan of the ANC (1994) and legislated in the South African Constitution (1996). The Alma Ata (1977: 21) principles of primary health care were incorporated in the Health Act, Act 61 of 2003, underpinning the approach of primary health care.

The South African National Department of Health (2001: 2) felt that the inequitable society had left the predominantly black local community vulnerable and consequently caused them to carry the largest burden of disease. In 2003 the National Department of Health (NDoH) (2000: 4) adopted and implemented a set of uniform norms and standards for primary health care. These norms and standards created the platform to improve service efficiency/effectiveness and to ensure equity in resource allocation.

In 1995 the NDoH (2001: 2) informally introduced district health services (DHS) as a means to establish a unified but decentralised national health system. This was seen as an attempt to achieve equity in health care delivery within the provinces (NDoH; 2001: 3). Although local governments were keen to implement the DHS, discrepancies were introduced in the staff salary packages of provincial and local government employees. This confluence of events culminated in the

promulgation of the National Health Act, Act 61 of 2003, which set the legal framework for the introduction of District Health Services.

In its *Growth and Development Strategy 2025* document (2005) (ANNEXURE I), the Ekurhuleni Metropolitan Municipality declares that it is "the smart and developmental city". Its mission statement professes that it provides services in an equitable manner based on the Batho Pele principles – people first (ANNEXURE I).

2.7 SOUTH AFRICAN NORMS AND STANDARDS

The National Department of Health (NDoH) published *The Primary Health Care Package for South Africa – a set of norms and standards* in 2000. In the chapter on CORE NORMS AND STANDARDS FOR HEALTH CLINICS a description is given of the norms and standards to be used in implementing the proposed district health services.

The norms and standards relevant for this dissertation are:

1. Access measured by the proportion of the population, that is one clinic per 100 000 persons.
2. The staff establishment for all categories is known and vacancies are discussed (1 nurse /100 000 population).
3. The clinic, as a cost centre, has a budget divided into main categories.

In the document *Guidelines for District Health Planning and Reporting – Part D* (2003), the NDoH discusses the need for improving effectiveness, equity and efficiency through a process of allocating resources among different

- service levels (effectiveness);
- geographical areas (equity); and
- inputs (efficiency).

The national guidelines (NDoH: 2003) lay down the foundation for minimum norms and standards. By adhering to these guidelines, it makes general comparisons between districts, as well as geographical comparisons between health districts and sub-districts possible.

In terms of this study, the following norms and standards apply in relation to the equity principles involved:

1) Clinics: One clinic per 100 000 persons
2) Staff: Nurse population ratio (1 per 100 000, all professional nurse categories)
3) Budget: Per capita expenditure per service delivery region, no absolute figure given; subsidies are provided based on the population size and the amount available in the national budget and provincial allocations.

Budgets are drawn up annually, using a bottom-up approach where facilities, as cost centres, indicate their needs. A consolidated budget for the municipal health

department is then produced by the support services division and presented by the director to the finance department for eventual approval by Council. Both the Executive Director: Health and the Member of the Mayoral Committee: Health (for political oversight), are responsible for the final submission of the health budget. Budgets and expenditures are audited by internal and external auditors. (Refer to ANNEXURE H for the Ekurhuleni budget).

2.8 SUMMARY

A literature review was conducted to cover the international and South African experience with regard to equity in health care. The purpose of the literature review was to obtain an understanding of and insight into the problem of health care equity.

To afford the reader an international perspective, reference was made to Roemer's (1997: 1539) list of external determinants that contribute to health. A tool for measuring fairness was also introduced by the benchmark approach and assessed nine benchmark criteria.

Attention was lastly given to the norms and standards prescribed by the National Department of Health (NDoH) to be used in the implementation of district health services.

CHAPTER 3

Research methodology

3.1 INTRODUCTION

This chapter discusses the research methodology utilised.

As was stated before, the general, overall aim of this study is to determine health care equity in terms of the distribution of health resources such as clinics, staff and budget allocations among the service delivery regions in the Ekurhuleni Health District for the period 2003 to 2005.

The specific purpose is therefore to determine whether resources and funding were applied equitably across all three service delivery regions of the EHD.

3.2 RESEARCH OBJECTIVES

The different objectives of this research are as follows:

1) To describe the available health resources – clinics, staff allocation and budget/financial support – in each of the three SDRs of Ekurhuleni that were included in the study.
2) To conduct a gap analysis between health resources and financial support for the selected SDRs in terms of their need for clinics, staff and budget support.

3.3 RESEARCH METHODOLOGY

The research follows a quantitative and retrospective approach.

3.3.1 Quantitative research

Quantitative research refers to the quantification or measurement of variables by assigning numbers to the qualities under research (Babbie 2001: 49). This has led to the concept of variable analysis and strict statistical control. A quantitative research design was suitable for this study because the allocation of resources that had been applied to the three service delivery regions (SDRs) could be quantified.

3.3.2 A retrospective study

According to Babbie (2001: 92), the time dimension of studies may involve past events (retrospective), cross-sectional events or future events (longitudinal). In the case of the current study a retrospective approach was followed because resources were applied in the past and a retrospective review would give an indication of the trends set in motion. Data from the period 2003 to 2005 was used for this purpose.

3.3.3 Content analysis and comparison

Content analysis refers to an analysis of the content of relevant documents (Mouton 2001: 165) and comparisons are drawn with regard to words or phrases, meanings (expressed or implied), pictures, symbols, themes and messages.

This research will evaluate and compare the contents of documents from the three service delivery regions in the Ekurhuleni Health District for the period 2003 to 2005 in relation to clinics, staff and budget allocations.

3.4 RESEARCH POPULATION

The Ekurhuleni Health District is co-terminous with the boundaries of the Ekurhuleni Metropolitan Municipality (EMM) that was established in 2000 in terms of the Municipal Structures Act, Act 117 of 1998. The EMM subdivided the municipal area into three service delivery regions (Northern SDR, Eastern SDR and Southern SDR) to facilitate administration.

The documents and records of the three SDRs were used and the service delivery regions themselves constituted the units of measurement. A census approach was essential to determine the level of equity of health service provision throughout the health district.

Although the population sizes within these SDRs differ, the indicators for equity used in the study are distribution of health service facilities and the budget allocation. The population figures will therefore be used to determine proportions.

3.5 THE STUDY SAMPLE

The Northern, Eastern and Southern SDRs were purposively selected to determine equity of health service delivery in the EMM. All their documents

pertaining to clinic facilities, staff and budget allocations were included as data sources for the study. This meant that no sampling was done.

3.6 DATA SOURCES

The following data sources were used to obtain relevant data:

- Lists of clinic facilities; existing and new clinics for 2003-2005
- Lists of personnel allocations for the period 2003-2005
- Budgets for 2003 to 2005 (ANNEXURE H)

Clinic facilities and personnel lists (ANNEXURE G) are reviewed on an annual basis by the family health division within the Health Department of Ekurhuleni. Clinic Heads normally feed the data up from clinic facility level to the corporate head office, where it is processed by senior managers and compared against the data of the previous year. Annexure H is an example of the departmental budget for the Ekurhuleni Metropolitan Municipality.

3.7 DATA COLLECTION

Data collection was done by means of a checklist designed by the researcher. The checklist was based on the matrices on health systems discussed by Roemer (1997: 1539) and Van Rensburg (2004: 5), as well as on the fairness benchmarks in health care reform as extensively discussed in their paper by Daniels et al. (2000: 740). The following nine different benchmarks are discussed, which cover the entire spectrum of indicators for health care reform:

1. Intersectoral public health
2. Financial barriers to equitable access
3. Non-financial barriers to access
4. Comprehensiveness of benefits and tiering
5. Equitable financing
6. Efficacy, efficiency and quality of health care
7. Administrative efficiency
8. Democratic accountability and empowerment
9. Patient and provider autonomy.

The checklist, which was compiled based on some of the health and external determinants of health care, is attached as Annexure A.

Only relevant data pertaining to the aim and objectives of the study were extracted for inclusion in this study, namely:

1. Clinic facilities to provide access and management
2. Staff to provide service that is effective and efficient
3. Budget to provide equitable funding.

The initial checklists were completed in 2006 by the managers as part of their routine daily functions in the various divisions of the EMM Health Department and the Gauteng Department of Health Region B. No training was given and information was supplied based on documents at the disposal of the officials.

3.8 DATA ANALYSIS

The systematic organisation and breakdown of research data is referred to as data analysis (Polit & Hungler 1997: 455; De Vos 2002: 223). An MS-Excel spreadsheet was used to create tables from the data collected and to construct graphs. Data was categorised and summarised, and subsequently converted into tables to obtain meaningful information that covers each individual service delivery region. Ratios and intervals were also calculated to make appropriate comparisons.

Data analysis of the study took into consideration the national norms (NDoH, 2003) expressed as the expected variable (E) as applied to clinics and staff. Collected data of the three SDRs in EMM were compared to these norms:

1) Clinics: one clinic per 100 000 citizens
2) Staff: one nurse per 100 000 citizens
3) Budget allocation: per capita

Data collected were further analysed and converted into the following indicators in terms of expected findings as compared to actual findings, namely:

1. **Expected (E) number of clinics** (norm), less **actual (A) clinics**, so as to calculate the gap; then converted to the number of clinics as a percentage of expected number of clinics
2. **Expected (E) number of staff,** less **actual (A) number of staff**, to calculate the gap; then converted to actual versus expected staff percentage

3. **Per capita budget allocations** based on the regional population size.

These comparisons were used to determine and give meaning to the gaps and to allow conclusions to be drawn. Expected numbers of clinics and staff (allocative criteria) for each region were determined in terms of the national norms (NDoH, 2003). The actual (A) numbers were based on the findings in the study which where then subtracted from the expected (E) norms. (See Chapter 4).

Findings about clinics, staff and budget allocations in the three study areas were further compared in terms of the SDRs. Effectiveness of the allocative criteria was not assessed.

Meaning was concluded through descriptive statistics.

3.9 DATA VALIDITY AND RELIABILITY

3.9.1 Reliability

The consistent measurement of attributes by an instrument is referred to as its reliability (Polit & Hungler 1997: 295).

The routine data collection tool used in this study, namely District Health Information Software (DHIS), was developed by the Health Information Systems Programme (HISP) (2003). It has been in use on a daily basis across all

provinces since 2003. The DHIS system collects national data elements (Heywood & Rohde [Sa]: 7) on either paper-based or electronic source tick sheets. These elements are next captured on a regional (organisational units) basis where they are processed – in the case of Gauteng based on selected provincial indicators, for health district consumption. District information is forwarded to the provincial level, where it is concatenated to produce a provincial health profile. In turn, the provinces send the information to the National Department of Health (NDoH) to collate a national health profile which is eventually shared with international bodies such as the World Health Organisation (WHO).

The DHIS system is tested and re-tested through daily use in clinics by using data validation rules built in by the software. Data quality is assessed on a monthly basis by health information system officers and the programme manager. The DHIS system is revised on an ongoing basis by the HISP to stay abreast of technological advances. The current version of the DHIS in use is 1.3, but the updated version, 1.4, is being piloted. This version, DHIS 1.4, will be Windows based with network functionalities.

Budgets (ANNEXURE H) for both Ekurhuleni and GDoH Region-B were also used as official sources of data for the period 2003 to 2005.

3.9.2 Validity

The degree to which an instrument measures what it purports to measure is referred to as validity (Polit & Hungler 1997: 299).

3.9.2.1 Measures to ensure validity

The DHIS system is based on data elements that are identified on a national basis (NDoH) with a view to monitoring and evaluating health service delivery. The elements and indicators have been trimmed by the NDoH and Provincial Departments of Health from a Minimum Data Set (MDS) to an Essential Data Set (EDS). They have been tested and re-tested in clinics on a daily basis since inception. The DHIS system is used as a research tool by the National Department of Health to track epidemiological trends and to assess health and health care equity in South Africa. The Health Systems Trust (a national health NGO) produces a document, the Health Barometer, on behalf of the NDoH to make comparisons of the entire country on a district-by-district basis, using the indicators of the DHIS system.

The budgets of the Gauteng Department of Health and the Ekurhuleni Metropolitan Municipality are formally approved by the appropriate executive organs. Auditing of their Annual Financial Statements is undertaken by internal and external auditors as well as the Auditor General.

3.9.2.2 Content validity

Content validity is concerned with the adequacy of the sampling method used (Polit & Hungler 1997: 324). In this study, all documents related to clinics, staff and budgets were included and sampling was therefore not done. However, as stated earlier, the elements determined at a national level were trimmed by the NDoH and Provincial Departments of Health from a minimum data set (MDS) to an essential data set (EDS) to reflect the health issues that will be monitored and evaluated.

The annual budget of the Ekurhuleni Metropolitan Municipality is prepared according to the Local Government Municipal Finance Management Act, Act 56 of 2003 (MFMA). This Act is based on generally accepted municipal accounting (GAMAP) standards. Similarly, the provincial budgets are drawn up within the parameters set by the Public Finance Management Act, Act 1 of 1999 (PFMA).

3.9.2.3 Face validity

Face validity is established by the observer by considering the source documentation that comprises the DHIS system reports and the budgets for the Ekurhuleni Health District.

This study is a retrospective review of documents that were used to plan service delivery in the Ekurhuleni Health District. Reliability was ensured by cross-

checking planning lists that were held (after compilation) at headquarters with the programme supervisors, Chief Community Health Nurses and Clinic Heads. This was done manually by the supervisors to verify the correctness of the information. Validity was ensured through reviewing and checking of existing data lists as well as budgets available and in issue.

3.10 ETHICAL CONSIDERATIONS

Consent was obtained from both institutions, namely the EMM's Portfolio Committee: Health and Social Development, and the Gauteng Department of Health (Region B) (ANNEXURES B & C), to use data from the EHD. Approval was also obtained from the EMM: Ethics Panel (ANNEXURE D). By referencing SDRs generically and not mentioning individuals the confidentiality and anonymity of all the involved institutions and workers were respected.

3.11 SUMMARY

The research followed a quantitative and retrospective approach. The three service delivery regions were purposively selected to determine equity of health service delivery. Data collection was done by means of a checklist compiled by the researcher. All the documents relating to clinic facilities, staff and budget allocations in the three regions were included as data sources and no sampling was done.

An MS-Excel spreadsheet was used to create tables from the data collected and to construct graphs. Data was categorised and summarised, and afterwards converted into tables to obtain meaningful information for each individual service delivery region. Ratios and intervals were calculated to make appropriate comparisons.

Chapter 4
Analysis and presentation of data

4.1 INTRODUCTION

The findings of the study on health care equity in the Ekurhuleni Health District for the period 2003-2005 are summarised in this chapter.

Data was collected by using the checklist that was developed by the researcher based on generic socio-economic data categories as discussed in the literature review. The checklist was circulated to all four divisions in the Health Department at the Ekurhuleni Metropolitan Municipality and the Gauteng Department of Health (Region B). All the checklists were returned. The Special Programmes division of the Ekurhuleni Health Department also provided data from the DHIS system, and health economic data was received from the Local Economic Development Department at the Ekurhuleni Municipality (ANNEXURE F).

The analysis and presentation of the information will cover the aims and objectives as stated in Chapter 1. MS Excel spreadsheets were used to analyse the data collected and to produce tables and graphs that would graphically represent the findings of the research.

4.2 PUBLIC HEALTH CARE CONSUMERS IN EKURHULENI HEALTH DISTRICT

Based on the 2001 census, the population of the Ekurhuleni Metropolitan Municipal area stood at 2 480 282 (see Table 1.2). The regional population for the Northern SDR was 719 281, for the Eastern SDR 839 633 and for the

Southern SDR 921 368. Annual growth of the population is based on calculations of midyear estimates made by the DHIS system by escalating census 2001 figures by 2.5%. The public sector or uninsured population (no medical aid) is also calculated by the DHIS system at 75% of census 2001 figures.

4.3 ANALYSIS OF DATA

4.3.1 Distribution of clinics in the Ekurhuleni Health District

Primary health care services are provided from different clinic facilities. The various types of clinics were shown in Table 1.4. The expected number of clinic facilities is based on the SA national norm of one fixed clinic per 100 000 of the population (NDoH 2003). Table 1.4 provides a description of the types of facilities and their distribution across the three regions of the Ekurhuleni Health District. It also provides an estimate of the catchment population, based on the DHIS system calculations.

The distribution of clinic facilities, based on the calculation of expected number of clinics per 100 000 persons (NDoH 2003) and the actual number of clinics recorded for the period 2003 to 2005 in the Service Delivery Regions, is as shown in Table 4.1 below.

Table 4.1: Fixed clinics based on the norm of 1 per 100 000 of the population

SDR	2003		2004		2005	
	Expected (E)	**Actual (A)**	**Expected (E)**	**Actual (A)**	**Expected (E)**	**Actual (A)**
North	19	**16**	20	**16**	20	**16**
East	22	25	23	25	24	26
South	25	28	26	27	27	27
Gap	**66**	**69**	**69**	**68**	**71**	**69**
Total Gap (E-A)	**-3** (Excess in terms of national norm)		**1** (Deficit in terms of national norm)		**2** (Deficit in terms of national norm)	

The facility gap that is calculated by deducting actual from expected number of clinics indicates that in 2003 there was an excess of actual facilities compared to the expected number of facilities for the EHD. This excess turned into a deficit of one and two for the years 2004 and 2005 respectively due to changes in population size of each region.

In terms of the above criterion, the Northern SDR consistently has a deficit of clinics compared to the expected number of clinics, which emphasises the inequitable distribution of clinic facilities. The clinic gap for 2003 was -3, and for 2004 and 2005 it was 4. Table 4.2 shows that the actual number of fixed clinics for the Northern SDR (16/19 and 16/20) did not increase to keep up with the South African national norm (NDoH, 2003). Both the Eastern SDR (25/22 and 25/23, 26/24) and Southern SDR (28/25, 27/26 and 27/27) had more facilities than expected.

To enable clear comparison of actual service delivery, the findings are presented in terms of a percentage of the expected SA norm (NDoH 2003), 100% being reflected as attaining the SA national norm and a figure lower than 100% being an under achievement of the SA national norm.

The total clinic gap (calculated by deducting the actual from the expected number of clinic facilities), Table 4.1, of -3, 1, and 2 for the years 2003, 2004 and 2005 respectively, due to changes in the population size of each region.

Expressing the actual number of clinics as a percentage of the expected produces the results as shown in Table 4.2 and graphically illustrated in Figures 4.1, 4.2 and 4.3.

Table 4.2: Actual clinics as a percentage of expected number of clinics in terms of the SA national norms

SDR	2003	2004	2005
North	84.2%	80.0%	80.0%
East	113.6%	108.7%	108.3%
South	112%	103.8%	100.0%

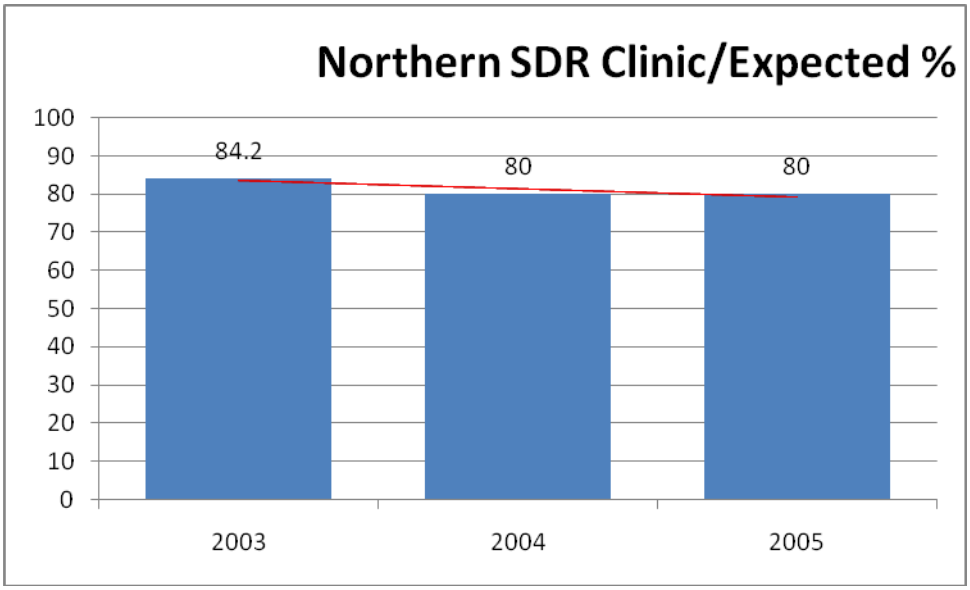

Figure 4.1: SDR North – Clinics actual versus expected as a percentage

One hundred percent will indicate the clinics physically available in terms of the norm (NDoH 2003). Both the Eastern SDR and the Southern SDR have sufficient clinic facilities, based on the national norm. In fact, both have more actual facilities than expected. The number of fixed clinics has however remained static for the Northern SDR, remaining below the expected.

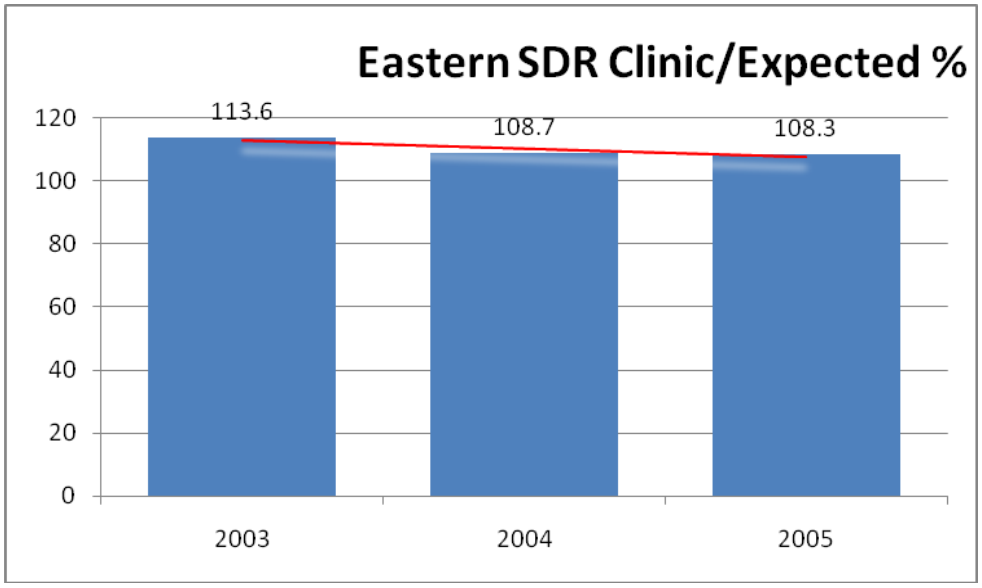

Figure 4.2: SDR East – Clinics actual versus expected as a percentage

When calculating the Pearson correlation (see Table 4.3) between the population and the number of clinics versus expected percentage, it is confirmed that there was a population growth in the Northern SDR, coupled with a static growth in facilities. This is opposed to the Eastern SDR where the correlation is r= 0.8664, indicating a growth in the number of facilities more than the population. The trend is however downward, which indicates an approach to the national norm.

The correlation for the Southern SDR is r= -0.8660, which shows an inverse growth of facilities to the population growth. The trendline is also downward, confirming an increasing deficit in the number of clinic facilities.

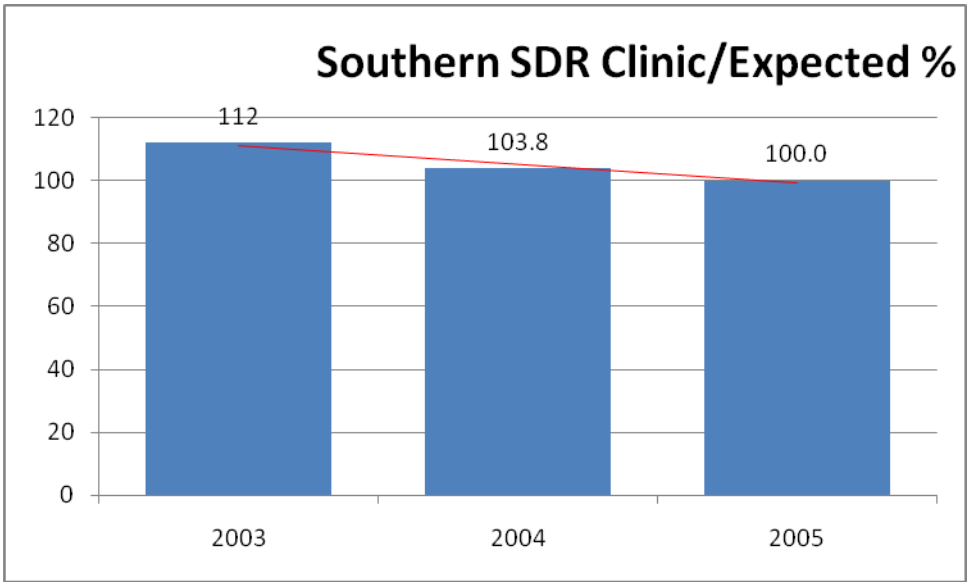

Figure 4.3: SDR South – Clinics actual versus expected, as a percentage

Table: 4.3: Correlation – clinics and the population

SDR	Pearson Correlation coefficient=r
North	0.0
East	0.8664
South	-0.8660

4.3.2 Allocation of nursing staff in the Ekurhuleni Health District

Staff costs as a proportion of total budgeted costs make up the bulk (70%) of operational expenses (see budget - ANNEXURE H). The distribution of nursing staff within Ekurhuleni is as indicated in Table 4.4. Based on the norm of one nurse per 100 000 persons (NDoH 2003), the actual number of staff members exceeded the expected number by 11 for 2003 and 2004. In 2002 a moratorium was placed on the filling of posts in Ekurhuleni, pending the completion of staff placement following the amalgamation and integration of the Ekurhuleni Metropolitan Municipality. By 2005 the excess had diminished to 4, based on the

above norm. The Eastern SDR clearly had more nursing staff in 2005 (13/100 000 according to Table 4.4) than the other two regions (10/100 000, again according to Table 4.4). Judged against the norm, there is a clear maldistribution of nursing personnel across the Ekurhuleni Health District. The inequitable distribution of nursing staff in 2005 visibly favours the Eastern SDR at the expense of the Southern SDR (10/100 000), which is more populous (see Table 1.2). When the total staff gap is determined by deducting the actual number of staff per hundred thousand from the expected, there is an excess of staff for all three years, decreasing from -11 (2003 and 2004) to -4 in 2005 as the population grows.

It is evident from Table 4.4 that the Eastern SDR had the highest actual nurse-to-population ratio compared to the expected ratio. This may be explained by the fact that the Eastern SDR is geographically the largest. On the other hand, in the Southern SDR the number of nurses decreased to below the number expected. Table 4.5 illustrates the result of calculating the actual staff as a percentage of the expected staff for the three years 2003 to 2005. One hundred percent is the target in terms of the norm (NDoH 2003).

Table 4.4: Expected versus actual number of staff in terms of the SA national norms

SDR	2003		2004		2005	
	Expected (E)	Actual (A)	Expected (E)	Actual (A)	Expected (E)	Actual (A)
North	8.00	9.00	8.00	9.00	8.00	10.00
East	9.00	16.00	9.00	16.00	10.00	13.00
South	10.00	**13.00**	10.00	**13.00**	11.00	**10.00**
Total	**27.00**	**38.00**	**27.00**	**38.00**	**29.00**	**33.00**
Gap (E-A)	**-11.00** (Excess in terms of national norm)		**-11.00** (Excess in terms of national norm)		**-4.00** (Excess in terms of national norm)	

Table 4.5: Actual versus expected as a percentage of staff in terms of the SA national norms

SDR	2003	2004	2005
North	113%	113%	125%
East	178%	178%	130%
South	130%	130%	91%

The actual to expected ratio of staff, expressed as a percentage in Table 4.5, clearly shows that, based all the SDRs had an excess, except the Southern SDR (Figure 4.6), which developed a deficit of 91% in 2005.

The ratio of actual versus expected staff in the Northern SDR (Figure 4.4), expressed as a percentage, increased over the period under review, confirming the oversupply of staff based on the national norm (NDoH 2003). The ratio of

actual versus expected staff for the Eastern SDR (Figure 4.5) decreased over time from 178% to 130% – again confirming the oversupply of staff based on the norm.

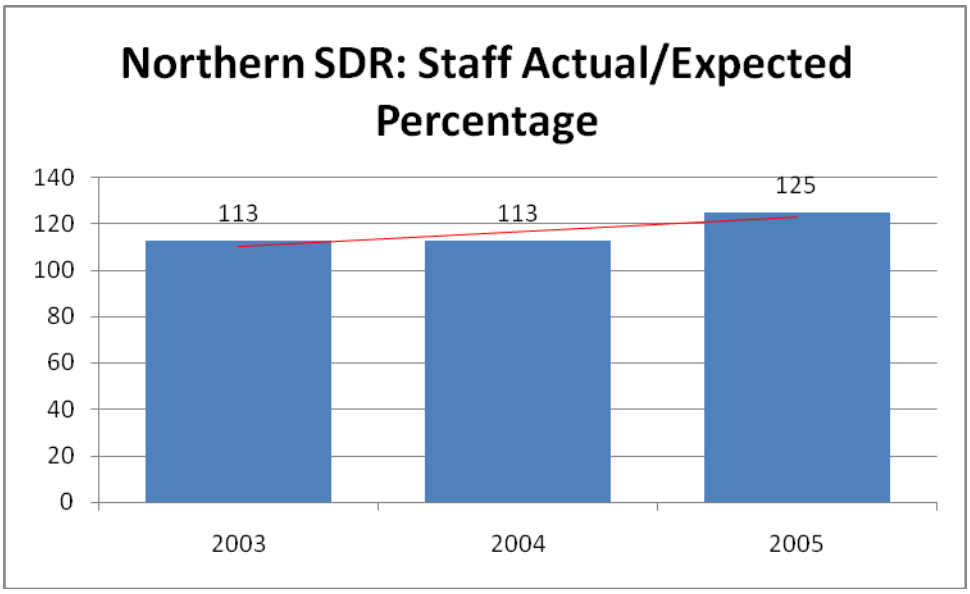

Figure 4.4: SDR North – Staff actual/expected, as a percentage

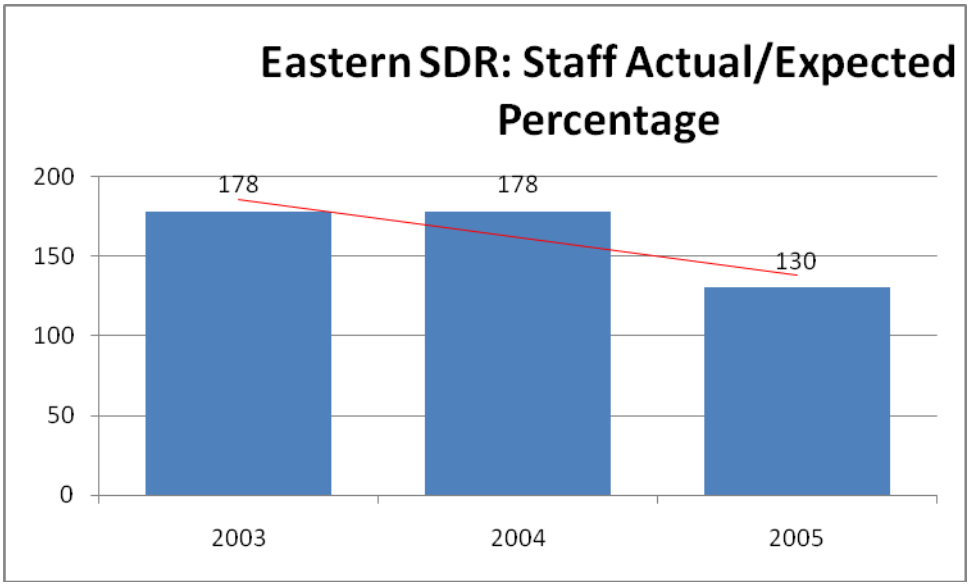

Figure 4.5: SDR East – Staff actual/expected, as a percentage

Based on the Pearson correlation between staff and population (see Table 4.6), it is evident that the Northern SDR (r=0.8660) has a positive correlation, while both the Eastern and Southern SDRs had negative correlations of r=-0.8664 and r= -0.8660 respectively. This demonstrates that there was higher population growth in the Eastern and Southern SDRs, with the South gradually developing a bigger deficit in staff allocation.

Table 4.6: Correlation – Staff and the population

SDR	Pearson Correlation coefficient=r
North	0.8660
East	-0.8664
South	-0.8660

Figure 4.6 graphically illustrates the decline in the Southern SDR of the actual to the expected percentage of staff, which was 91% by 2005. This decline clearly demonstrates the inequity in provision of staff.

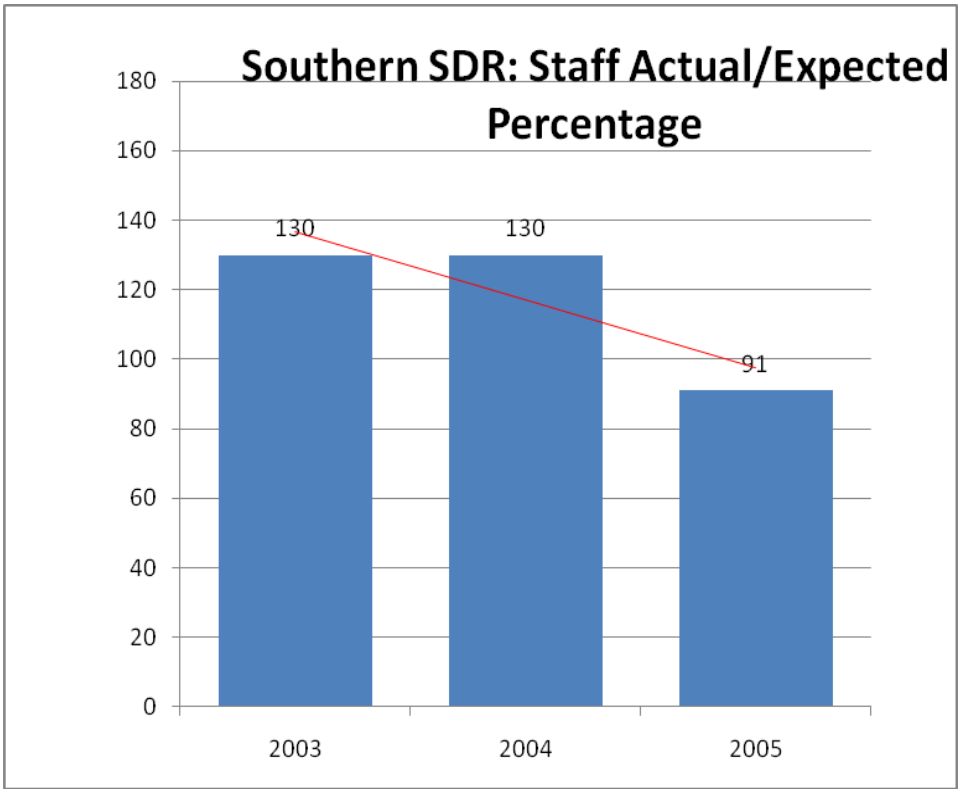

Figure 4.6: SDR South – Staff actual/expected, as a percentage

4.3.3 Budget allocation for health services in the Ekurhuleni Health District

Budget allocation for the three regions is displayed in Table 4.7 and Figure 4.7. The per capita allocation was highest in the Southern SDR at R56.33 in 2003. During 2004 and 2005 the highest per capita budget allocations were for the Eastern SDR, despite the fact that the highest concentration of people (Table 1.2) was in the Southern SDR. The inequitable allocation of the budget, based on absolute per capita allocation, was confirmed and even became pronounced during 2005, where the Southern SDR had the lowest per capita allocation but the highest population growth (see Table 1.2).

In terms of Figures 4.7, 4.8 and 4.9, the trend for per capita allocation remained positive with a positive Pearson correlation of r= 0.9 (see Table 4.8). This indicates that the per capita budget allocation kept up with the population growth.

Table 4.7: Ekurhuleni budget allocation and per capita allocation

	2003		2004		2003/04	2005		2004/05
SDR	Budget R	Per capita R	Budget R	Per capita R	% Per capita growth	Budget R	Per capita R	% Per capita growth
North	27,129,596	47.00	50,683,409	85.10	**81.1**	54,733,740	89.53	5.2
East	36,304,971	54.24	**64,876,282**	**93.45**	32.3	**77,276,176**	**107.46**	**15.0**
South	**42,379,950**	**56.33**	63,618,885	81.53	44.7	70,586,514	87.32	7.1

Figure 4.7 shows that the per capita allocation grew disproportionately in the Eastern SDR. Of the other regions, the Northern SDR showed a higher growth of per capita allocation than the Southern SDR, which had the highest population (Table 1.2). Of concern is the sharp decline in the per capita allocation between 2004 and 2005 across all three service delivery regions.

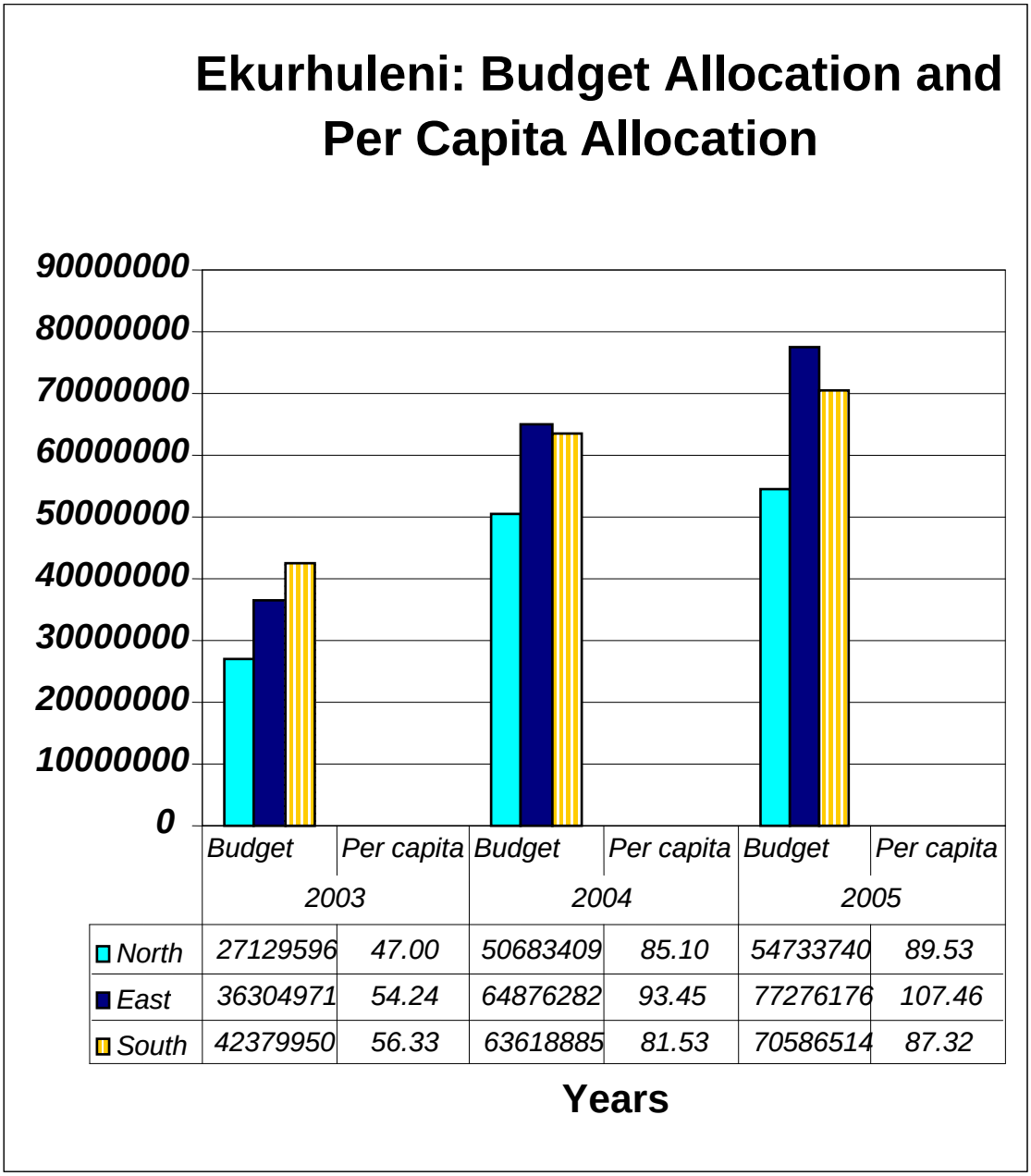

Figure 4.7: Ekurhuleni budget allocation

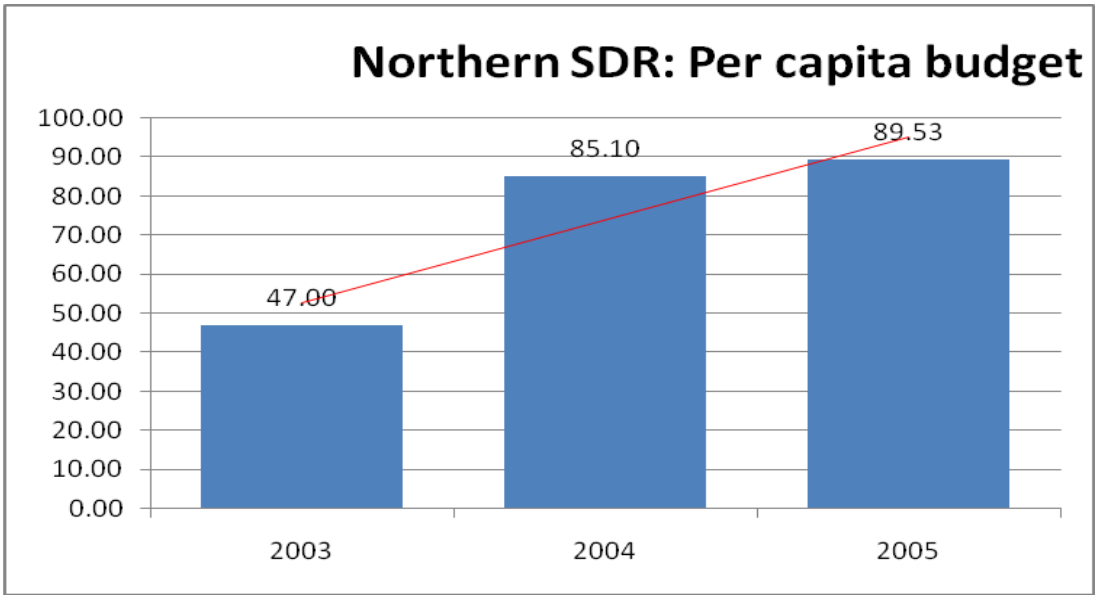

Figure 4.8: SDR North – Per capita budget allocation

Figures 4.8 to 4.10 clearly demonstrate the inequitable allocation of per capita budgets among the three SDRs. The Southern SDR gradually developed a distinct per capita budget deficit, which became pronounced by 2005 even though this SDR was the most populous of the three (see Table 1.2). The rate of growth in its per capita allocation over the three years (2003 to 2005) also indicated that the Southern SDR was worst off. This was confirmed by the data in Table 4.8, where the Pearson correlation between per capita budget versus population growth was r= 0.9095, r= 0.9644 and r= 0.9404 for the Northern, Eastern and Southern SDRs respectively.

Table 4.8: Correlation – per capita budget and population

SDR	Pearson Correlation coefficient=r
North	0.9095
East	0.9644
South	0.9404

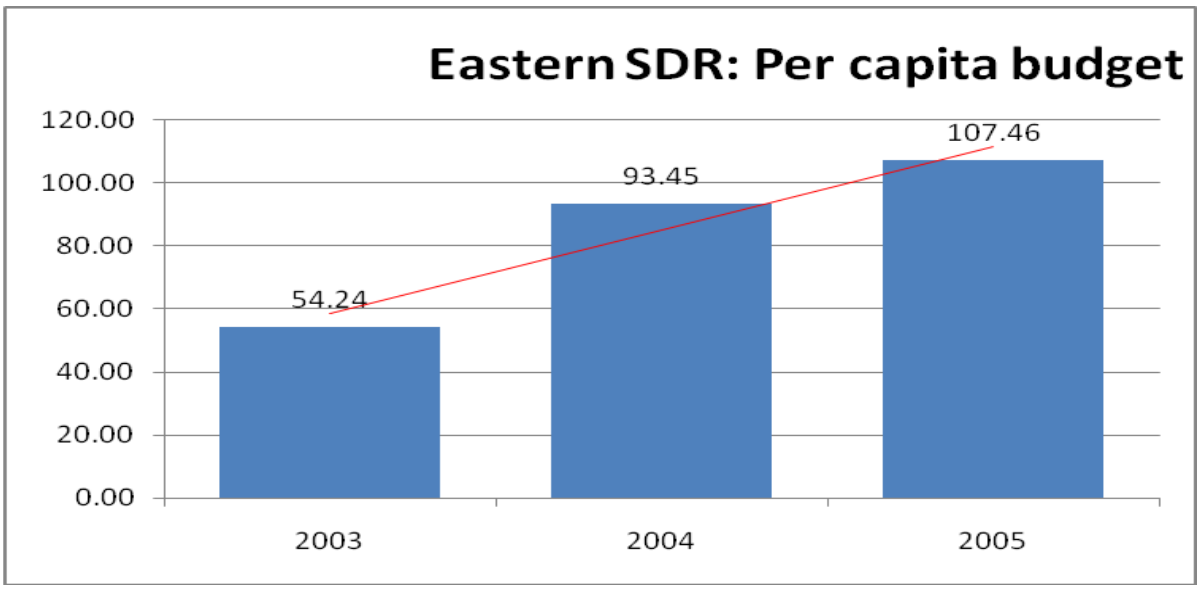

Figure 4.9: SDR East – Per capita budget allocation

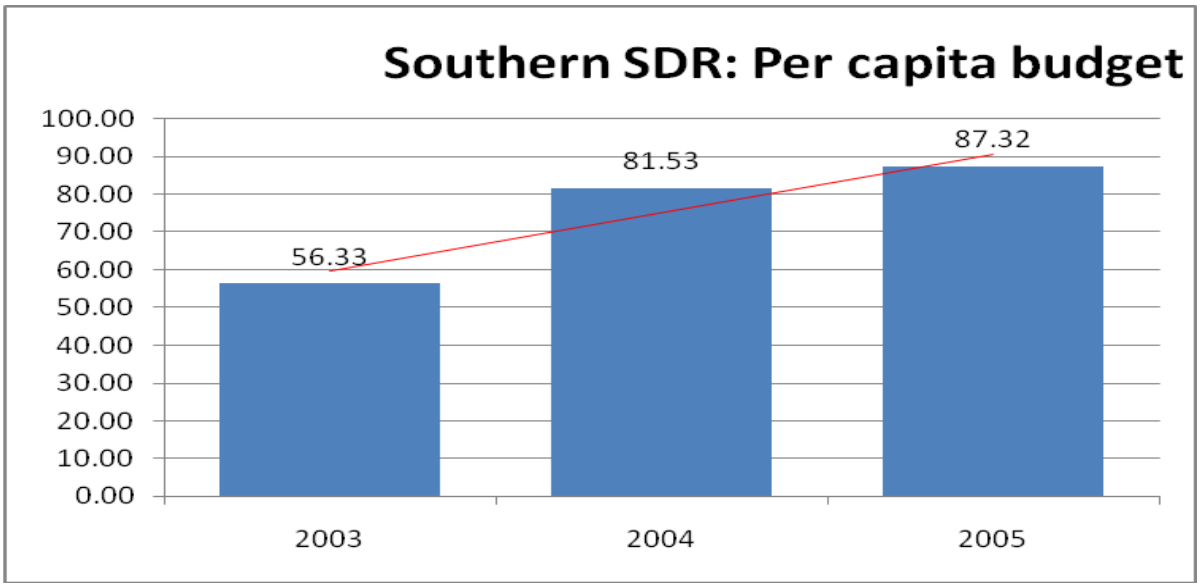

Figure 4.10 SDR South: Per capita budget allocation

4.4 SUMMARY

The findings of the study on health care equity in Ekurhuleni for the period 2003 to 2005 were summarised in this chapter and dealt with in terms of the norms set for each component of the study.

4.4.1 Clinics

The norm

According to the National Department of Health (NDoH 2003) the norm is one clinic per 100 000 persons in the population.

The findings

Access to clinics in terms of the norms provided by the National Department of Health appears adequate.

1) The excess in total number of clinics (-3) in 2003 decreased to a deficit of two clinics by 2005.
2) The difference between actual and expected percentage in Table 4.2 illustrated that the Northern SDR was suffering a persistent deficit in terms of the norm and that access to clinics in the Southern SDR had also decreased to 100% by 2005 – in line with the downward trend.

Interpretation of findings

The ratio of actual to expected percentage of clinics shows an excess of facilities over the national norm (NDoH 2003).

Distribution of clinics, however, is inequitable and by 2005 with the Eastern SDR having 108% of expected clinics compared to 100% and 80% for the Southern and Northern SDRs respectively.

4.4.2 Staff allocation

The norm

The norm set by the National Department of Health (NDoH 2003) for staff is one nurse per 100 000 persons of the population.

The findings

Based on the above national norm (NDoH 2003), Ekurhuleni had an excess of staff. The total gap as shown in Table 4.4 decreased from 11 in 2003 to four in 2005.

Staff distribution was not equitable in the three SDRs, with the Eastern SDR having 130% of expected staff by 2005 (see Table 4.5), compared to 125% and 91% for the Northern and Southern SDRs respectively.

Interpretation of findings

Table 4.5 shows that the EHD had excess staff throughout the period under review, based on the norm set by the National Department of Health (NDoH 2003) and calculated as the actual to expected percentage. It is only in the Southern SDR where staff numbers decreased to below the norm (91%). With

the growth in population until 2005, the inequitable distribution of staff persisted. The ratio between actual and expected percentage of staff (see Table 4.5) varied from 125% for the Northern SDR to 130% and 91% for the East and South respectively.

4.4.3 Budget allocation

The norm

There is no absolute per capita norm indicated by the NDOH. Budget allocations are made based on the population, the funds allocated in the national budget and provincial allocations of subsidies.

The findings

Based on the population for the three SDRs, the budget allocation was disproportionate. Table 4.7 shows that between 2003 and 2004 the per capita expenditure grew by 81.1%, 32.3% and 44.7% for the Northern, Eastern and Southern SDRs respectively. Per capita expenditure growth between 2004 and 2005 for the SDRs was as follows: 5.2%, 15% and 7.1% for the North, East and South respectively.

Interpretation of findings

It is evident that there was an unequal per capita expenditure that favoured the Eastern SDR over the Southern SDR, which was actually more populous (Table 1.2).

Chapter 5

Conclusions, limitations and recommendations of the study

5.1 INTRODUCTION

This final chapter presents a brief background summary, as well as the conclusions reached, recommendations made and limitations identified on the basis of the data analysed during the course of this study.

The aim of this study was to determine the state of equity in the three Service Delivery Regions (SDRs) of Ekurhuleni for the period 2003 to 2005 in terms of capital distribution (clinics), staff allocation (nurses) and budget allocations (financial resources).

A retrospective approach was followed because resources were applied and a retrospective review will give an indication of the trends that were set in motion. A checklist, developed by the researcher, based on the health measurement benchmarks presented by Daniels et al. (2000: 740) was distributed to and returned by the Ekurhuleni Metropolitan and Gauteng Health departments. Selected elements from the checklist were used to address the research question (Par. 1.9), aim (Par. 1.10) and objectives (Par. 1.11) of this study. Routine data gathered on the DHIS was submitted by the Special Programmes division of the Ekurhuleni Metropolitan Municipality: Health Department.

5.2 FINDINGS AND INTERPRETATION OF FINDINGS (TOTAL PICTURE AND PER REGION)

Equity in the provision of health care services is an ideal that all countries strive for. In South Africa, with its divisive past (NDoH: 2001) and a commitment by the present government (Constitution 1996; NDoH 2000) to establish equitable health care, it is important to assess objectively what is happening with health care service delivery.

The findings of this study are presented in summary in Table 5.1:

Table 5.1: Summary of findings on the gaps in health care equity in Ekurhuleni

SERVICE DELIVERY AREA	OBJECTIVE	GAP (A/E %) in terms of SA national norm	RECOMMENDATIONS
NORTH	Facilities	80	Build new clinics to reach SA national norm Place new clinics on the medium term capital budget
	Staff	125	Redistribute staff in line with SA national norm
	Budget-per capita	89.53	Adjust budget to attain fair per capita expenditure

EAST	Facilities	108.3	Review building new clinics to reach SA national norm
	Staff	130	Redistribute staff in line with SA national norm
	Budget-per capita	107.46	Adjust budget to attain fair per capita expenditure
SOUTH	Facilities	100	No new clinics required in terms of SA national norm
	Staff	91	Redistribute staff in line with SA national norm
	Budget-per capita	87.32	Adjust budget to attain fair per capita expenditure

The findings based on the objectives of this study can be summarised as follows:

5.2.1 Clinic facilities per service delivery region

Employing the SA **national norm** (one clinic for every 100 000 persons) set by the National Department of Health (2003), it is clear that in 2003 there was an oversupply of fixed clinics (see Table 4.1). The oversupply of clinics was reversed in 2004 and an increasing gap emerged that is graphically shown in Figures 4.1 to 4.3. A deficit in the number of clinic facilities (Table 4.1), as shown by an increasing total gap (from an excess of -3 in 2003 to a deficit of 2 clinics in

2005), developed, as the population size grew (Table 1.2). The lack of equity in the provision of health facilities is demonstrated by the data for 2005. The Northern SDR was found to be worst affected, having only 18/20 (80%) of expected clinics, while the Eastern SDR had an excess of 26/24 (108%) of the expected number of clinics. The Southern SDR, the most populous SDR (according to Table 2.1), had exactly 27/27 (100%) of expected clinics based on the given norms (NDoH 2003). The number of clinics for Ekurhuleni Health District as a whole was 69/71 (97%). At 97% it is clear there is a deficit in facilities with the populous Southern SDR worst off.

5.2.2 Staff allocation

Table 4.4 and Figures 4.4 to 4.6 clearly demonstrate that, from an excess of nursing personnel (11) in 2003 and 2004 in terms of the national norms (NDoH 2003), the gap decreased to 4 in 2004 to 2005, with the most populous Southern SDR (Table 1.2) being worst affected. By 2005 the inequity in staff allocation per SDR (see Table 4.6) was 10/8 (125%), 13/10 (130%) and 10/11 (91%) of the expected norm (NDoH 2003) for the Northern, Eastern and Southern SDRs respectively.

5.2.3 Budget allocation

The per capita budget allocation (see Table 4.7) was highest for the Southern SDR in 2003, namely R56.33 (see Figure 4.10), but this figure was far exceeded by the eventual allocation for the Eastern SDR for 2005, namely R107.46.

Growth in per capita expenditure for the different SDRs over the period 2003/2004 was 81.1% for the Northern SDR, 32.3% for the Eastern SDR and a low 44.7% for the Southern SDR. For the period 2004/2005 growth in per capita expenditure was only 5.2% for the Northern SDR, a very high 15.0% for the Eastern SDR and 7.1% for the Southern SDR.

Although the Southern SDR had the highest number of people and therefore the greatest need for more clinic facilities, the growth in per capita allocation for 2004 and 2005 did not reflect this state of affairs. The study revealed an inequitable expenditure per capita, as the Eastern SDR received the highest per capita allocation in both 2004 and 2005, despite its lower population.

5.3 RECOMMENDATIONS

5.3.1 Pertaining to clinics

That the oversupply of clinics, Table 4.2, in the Eastern SDR be assessed by management as soon as the next budgetary cycle to strive for health care equity.

That new clinics be place on the medium term capital budget programme in order to address the facility backlog, based on the SA norm (NDoH 2003: 5).

5.3.2 Pertaining to staff

That the allocation of staff be reviewed by management, at the next available budgetary cycle. The inequity in staff distribution Table 4.4, based on the SA

national norm (NDoH 2003:5) should be addressed, after negotiation with representative unions, to redistribute staff and or employ more staff.

5.3.3 Pertaining to the budget allocation

That budget allocations per capita be reviewed in line with the re-allocation of staff, as well as clinic building and upgrading programmes.

That the budget be reviewed to obtain health care equity in respect of per capita expenditure.

5.4 LIMITATIONS

The objectives of this investigation are based on South African national norms and standards (NDoH 1996, 2003) and do not take into account the actual workloads experienced at the clinic facility level. Verbal feedback that has been received states that patients have to stand in long queues and that the morale of primary health care nurses is low. However, the issue of staff workload, that is patients per nurse per day, was not included in the scope of this research study.

Since this study was of a retrospective nature, the implementation of recommendations cannot be guaranteed.

5.5 RECOMMENDATIONS FOR FURTHER STUDIES

This study did not compare the nurse workload per facility. It would be of interest to compare the situation at the different SDRs to get a better impression of the spread of workload.

A meaningful further study could be conducted to evaluate progress for the period after 2005.

5.6 CONCLUSION

In answer to the research question of this study, it is evident that equity of healthcare resources (clinics, staff and per capita expenditure) does not exist in the Ekurhuleni Health District. By implementing the recommendations, although they will have to be phased in over a number of financial years, the benefit would be health care equity so the that the Ekurhuleni Municipality cab discharge its stewardship role and the community will benefit by having improved access to health care services.

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ANNEXURE A: CHECKLIST FOR DATA COLLECTION

EKURHULENI

Ekurhuleni Health District

Data Collection Sheet

HEALTH CARE EQUITY

	Region									
Item	North			East			South.			
	2003	2004	2005	2003	2004	2005	2003	2004	2005	
Population										
Public Sector Component 75%										
Housing:										
Informal Settlements										
Formal Housing Units										
Potable Water Supply										
Sanitation										
Electricity										
Education Levels										
HDI										
Environmental Risks										
HEALTH STATUS										
Morbidity										
Mortality										
Total Deaths										
Crude Death Rate										
IMR										
MMR										
Life Expectancy										
Disability										
DALY										

Nutritional Status										
<5 yr Growth										
Severe malnutrition										
Immunisation rate										
TB Prevalence										
Teenage pregnancy rate										
UTILISATION OF SERVICES										
Attendance										
	Region									
Item	North			East			South.			
	2003	2004	2005	2003	2004	2005	2003	2004	2005	
<5yrs										
>5yrs										
Utilisation rate										
INFRASTRUCTURE										
Clinic facilities										
CHC's										
Fixed Clinics										
Consulting Rooms										
Clinics / 5k radius										
Clinics / 2k radius										
Hospitals:										
District Hospital										
Secondary Hospital										
HUMAN RESOURCES										
PHCN's										
CHCN										
PN's										
Nurse / Population ratio										
Doctors										
Dr / Population ratio										
BUDGETS										
Budget allocation										
Per capita allocation										
GDP										
Gini Co-efficient										
COMMUNITY PARTICIPATION										
CHC functioning										
Health NGO's operating										

ANNEXURE B: APPROVAL FROM EKURHULENI METROPOLITAN MUNICIPALITY

EKURHULENI METROPOLITAN MUNICIPALITY
HEALTH PORTFOLIO COMMITTEE MEETING
2006.05.16

ITEM C-H (40-2006)

HEALTH AND SOCIAL DEVELOPMENT DEPARTMENT: SPECIAL PROGRAMMES: APPROVAL TO CONDUCT RESEARCH ON HEALTH EQUITY IN EKURHULENI

PURPOSE OF THE REPORT

To seek approval from the Portfolio Committee to conduct research in Ekurhuleni Metropolitan Municipality on equity in the Health Department.

MOTIVATION

Terms of reference

The Director: Special Programmes, Dr A D Andrews, is a registered student with the University of South Africa (UNISA) towards a masters degree in Public Health (MPH).

A requirement to complete the degree is to submit a dissertation of limited scope involving research in an appropriate topic.

The topic, research proposal submitted as **ANNEXURE A** and **B,** selected by Dr Andrews is:

"RETROSPECTIVE INVESTIGATION OF EQUITY WITHIN EKURHULENI FOR THE PERIOD 2003/05 UTILISING THE DISTRICT HEALTH INFORMATION SYSTEM".

Discussion

The aim of health care systems is to deliver good quality health and quality patient care. This takes into consideration that the system must be responsive to the needs of the clientele and that the system is applied fairly to all the clients in an accessible manner.

In 1994 the African National Congress (ANC) presented a plan for the health care of South Africans given the legacy of the previous regime where great disparities developed among the groups in the country. The ANC states that every person has a right to optimal health and committed itself to attaining it by using the primary Health Care (PHC) approach.

Since coming into power the ANC led government has enacted the Constitution of South Africa which states that everyone has the right to access to health care services, sufficient food and water and have social security.

The PHC approach was legislated by the enactment of the Health Act 61 of 2003 which introduced District Health Services.

Dr Andrews has been enrolled as a MPH student with UNISA since 2003. For his dissertation he has opted to investigate the extent to which equity has been attained under the new dispensation.

EKURHULENI METROPOLITAN MUNICIPALITY
HEALTH PORTFOLIO COMMITTEE MEETING
2006.05.16

ITEM C-H (40-2006)

In order to protect the ethical rights of the institution, Ekurhuleni Metropolitan Municipality, approval is sought to publish information related to its functioning. Permission will also be obtained from the Gauteng Department of Health (GDoH) as well as ethical approval from UNISA.

FINANCIAL IMPLICATION

There will be no direct financial implication to Council in the submission of this research proposal. All costs will be borne by the student.

COMMENTS FROM OTHER DEPARTMENTS

Not required.

RECOMMENDATION

1. **That** the contents of the report of the Executive Director: Health regarding the approval to conduct research on equity in Ekurhuleni Metropolitan Municipality **BE NOTED.**

2. **That** approval **BE GRANTED** to the Director: Special Programmes: Dr A D Andrews to conduct research on the equity of health services in Ekurhuleni Metropolitan Municipality.

3. **That** a copy of the research report **BE SUBMITTED** to the Ekurhuleni Metropolitan Municipality after completion of the research project.

ANNEXURE C: APPROVAL BY GAUTENG DEPARTMENT OF HEALTH REGION B.

12/2/1/20

17
16

2006 -06- 1

GAUTENG PROVINCIAL GOVERNMENT

Department of Health
Lefapha la Maphelo
Department van Gesondheid
Umnyango wezeMpilo
EKURHULENI HEALTH DISTRICT
Private Bag X1005, Germiston, 1400
Enquiries: Modise Makhudu
Tel: (011) 876-1817
Fax: (011) 876-1818
Email : ModiseMa@gpg.gov.za
DaleenD2@gpg.gov.za

To: Dr. Andrews -Director for Special Programmes at EMM

From: Modise Makhudu – Director for Ekurhuleni Health District

CC: Dr. T. Tanga – Executive Director for Health and Social Development
Dr. F. Benson – Chief Director for Ekurhuleni and Sedibeng Health Region
District Executive Team Members

Ref: DIR/112/5/2006

Date: 31st of May 2006

HEALTH AND SOCIAL DEVELOPMENT DEPARTMENT: SPECIAL PROGRAMMES: APPROVAL TO CONDUCT RESEARCH ON HEALTH EQUITY IN EKURHULENI

1. Please refer to the above mentioned research request.
2. Hereby please be informed that approval is hereby given to conduct the above research in Ekurhuleni.
3. Kindly forward your findings and recommendations to this office.

Regards

MODISE MAKHUDU
DIRECTOR:EKURHULENI HEALTH DISTRICT
DATE: 1/6/2006

ANNEXURE D: ETHICAL APPROVAL FROM EKURHULENI ETHICS PANEL.

Ekurhuleni
METROPOLITAN COUNCIL

26/04/2006

From: Research Ethics Committee
Health & Social Development
Ekurhuleni Metropolitan Municipality
(In collaboration with Gauteng Provincial
Health Department, Ekurhuleni Region B)

Enquiries: **Dr. Joseph Sepuya**
Tel: (011) 861-2539
E-mail: sepuyaj@ekurhuleni.com

Dear Dr. A. Andrews

RE: **RESEARCH ETHICS COMMITTEE APPROVAL TO DO RESEARCH IN EKURHULENI:**
RESEARCH TITLE: RETROSPECTIVE INVESTIGATION OF EQUITY WITHIN EKURHULENI METROPOLITAN MUNICIPALITY FOR THE PERIOD 2003/05 UTILISING THE DISTRICT HEATH INFORMATION SYSTEM

Thank you for your application for Ethics approval to conduct the above-mentioned research within Ekurhuleni Metropolitan Municipality.

I am pleased to inform you that the Technical Committee of the Ethics Research Committee has recommended that permission be granted to you to conduct the above-named research within Ekurhuleni Metropolitan Municipality.

The Ethics Committee wishes you success in your research and you will be expected to present the findings of your study at the Ekurhuleni Annual Research Conference for the benefit of all stakeholders.

Please be informed that this recommendation will have to be ratified by the Executive Director, Health and Social Development, who reserves the right to withdraw this permission. You may nevertheless commence with the research. Should permission be withdrawn by the Executive Director, this will be communicated to you.

Yours Sincerely,

Dr. J. Sepuya

For **Ekurhuleni Health & Social Development Research Ethics Committee**

ANNEXURE E: APPROVAL FROM UNISA.

UNISA university of south africa

Stud nr/no: 379-405-9
Navrae/Enq: Me/Ms L S Msiza
Tel: (012)429-2652
Faks/Fax: (012)429-4150

Dr A D Andrews
P O Box 14058
REIGERPARK
1466

2006-05-25

Dear Dr Andrews

I have pleasure in informing you that the following title has been approved for your projected dissertation of limited scope for the degree of MPH, with Prof S P Human as your supervisor and Mrs H S du Toit as joint supervisor: **RETROSPECTIVE INVESTIGATION OF EQUITY IN HEALTH WITHIN EKURHULENI FOR THE PERIOD 2003 TO 2005 UTILISING THE DISTRICT HEALTH INFORMATION SUPPORT SYSTEM.**

Yours faithfully

REGISTRAR (ACADEMIC)

UNISA university of south africa

Tel: 012-429-6769
Fax: 012-429-6688
E-MAIL: mavuntr@unisa.ac.za

Department of Health Studies
PO Box 392
UNISA
0003

19 May 2006

Student number: 379-405-9
Dr AD Andrews
PO Box 14058
Reiger Park
BOKSBURG
1466

Dear Student

MASTER'S DISSERTATION:
RETROSPECTIVE INVESTIGATION OF EQUITY IN HEALTH WITHIN EKURHULENI FOR THE PERIOD 2003 TO 2005 UTILISING THE DISTRICT HEALTH INFORMATION SUPPORT SYSTEM

At a meeting of the Department of Health Studies, Unisa, held on 19 May 2006 it was decided that

- **Prof SP Human** (Tel 012 429-6290) will be appointed as your supervisor/promoter
- **Mrs HS du Toit** (Tel 012 429-6305) will be appointed as your joint supervisor/joint promoter

You will receive official documentation from Unisa in this regard in due course. This letter is merely a notification in advance so that you can get going with your dissertation/thesis.

In future, please direct **ALL** correspondence about your dissertation/thesis, as well as the proposal and chapters of your dissertation/thesis directly to ***your*** supervisor/promoter, as indicated above, at:

Department of Health Studies
PO Box 392
UNISA
0003

As a matter of principle, always contact your *supervisor/promoter* first, should you encounter any academic problems. If you cannot get hold of your supervisor/promoter, then consult your joint supervisor/joint promoter. In case of administrative problems such as registrations, examinations and accounts, please contact:

The Registrar
Post-graduate Student Affairs
PO Box 392
UNISA 0003

NEVER send any documentation about your dissertation/thesis in assignment covers as the assignment section takes weeks to decipher that it is NOT an assignment but part of a dissertation/thesis - leading to unnecessary delays.

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

In addition, please note that students are expected to submit all documentation concerning their dissertations and theses **typewritten**, in **double spacing**.

If you have not yet submitted a research proposal, please do so at your earliest convenience. Send it to your supervisor/promoter. Include a time frame indicating by what stage you intend submitting chapters so that your supervisor/promoter can advise you about the feasibility of this plan as well as about their availability during the academic year. Always keep a copy of all your work, because this could get lost in the post. Also, always keep copies of all your work on both the computer's hard disc and on stiffy discs. If you employ a typist, always make sure that you get the document on stiffy disc as well as printed on paper.

NB: You need to work with your supervisor/promoter through the dissertation/thesis, from the proposal, chapter by chapter until the dissertation/thesis is ready for submission. Please note that under no circumstances are you allowed to enter the field to conduct empirical research if your supervisor/promoter have not approved your data gathering instruments and the chapter on the research methodology of your dissertation/thesis. The dissertation/thesis can also not be submitted for examination without the approval of your supervisor/promoter. In your planning, please plan realistically for editing of the dissertation/thesis, language control and printing. Also keep in mind that these actions can be very costly in terms of both money and time. All dissertations/theses must be submitted for language control and editing before submission for examination. Again this should be done on advice of your supervisor/promoter.

Remember, you need to register (and pay full registration fees) for your dissertation/thesis each year until you have completed and submitted the dissertation/thesis. This means that if you do not succeed in completing your dissertation/thesis during a specific year, you will need to register and pay the full fees during the next academic year again, and there after should it be necessary.

Wishing you success with your studies.

Yours sincerely

Prof TR Mavundla
DEPARTMENT OF HEALTH STUDIES, UNISA

ANNEXURE F: IDP 2006 – 10, AN APPRAISAL BY THE LED DEPARTMENT (EMM).

IDP 2006-10

Growth and Development of the Local Economy

Ekurhuleni is spread over 15.6% of Gauteng's land mass, houses 5.4% of the country's population, and 29% of Gauteng's population. Migration into the area is a key challenge. This is visible in the number of informal settlements and informal trading activity. The national census records 787 040 households, this is likely to increase when taking migration into account. The area is extremely densely populated (959 people per square km) when compared with both Gauteng (521 people per square km) and the national economy (38 people per square km). The average annual population growth rate within the metro was 2.0 percent over the period 1996 to 2003. This exceeds both the national and Gauteng growth figures for this period.

Ekurhuleni has a resident population of approximately 2.5 million people, of which 53% is economically active. The area contributes approximately 7.6% to national production and has a share of approximately 7.1% of national employment. Over the period 1996 to 2003, Ekurhuleni's economy grew by an estimated average of 2.4% per annum. Ekurhuleni contributes approximately 21% to the total economic output of the Gauteng province. Current Gross Value Add (GVA) is at 3.4%. The main contributing areas are Kempton Park, Germiston and Boksburg within Ekurhuleni.

Ekurhuleni key comparative statistics[1]

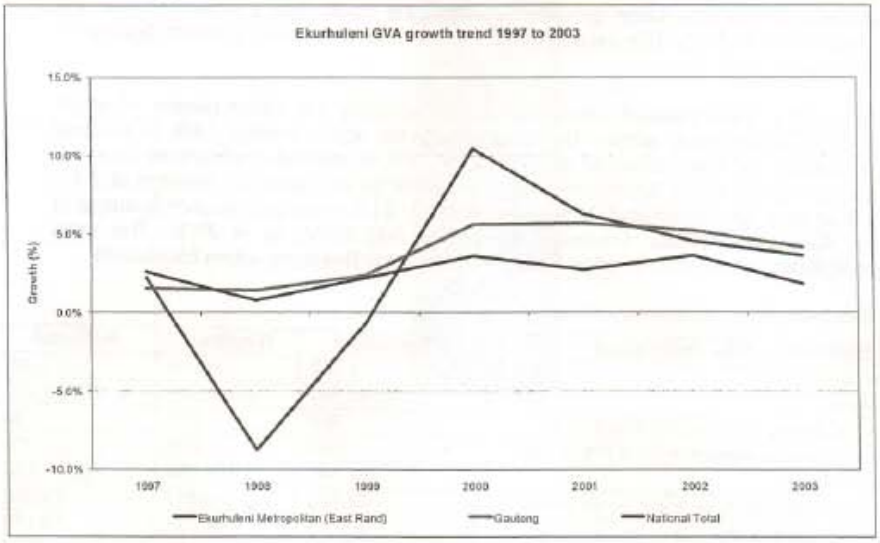
Key Statistics (2003 estimates)	Ekurhuleni	Gauteng	National
Region area (sq km)	2,642	16,975	1,221,246
Population	2,534,180	8,845,741	46,710,858
Population density (nr of people per sq km)	959	521	38
Economically active population (as % of total pop.)	53%	53%	39%
No of households	787,040	2,731,869	12,144,712
Average household income (Rand, current prices)	88,025	115,817	70,326
Annual per capita income (Rand, current prices)	27,338	35,768	18,284
Gini coefficient	0.57	0.60	0.64
Formal sector employment estimates	679,213	3,156,772	9,058,793
Informal sector employment estimates	84,249	362,647	1,699,327
Unemployment rate (expanded definition)	40%	35%	41%
Percentage of persons in poverty	27%	27%	46%
Poverty gap (R million)	974	3,251	32,960
Human development index (HDI)	0.67	0.69	0.59
Index of Buying power (IBP)	0.08	0.34	1.00
Economic output in 2003 (R' million current prices)	84,000	416,562	1,100,929
Share of economic output (GVA % of SA in current prices)	7.6%	37.8%	100%
Economic output in 2003 (R' million constant 1995 prices)	48,074	236,846	619,790
Share of Economic output (GVA % of SA in constant 1995 prices)	7.8%	38.2%	100%
Economic growth performance 1996-2003 (GVA % growth pa constant 1995 prices)	2.4	3.7	2.5

[1] Source: Global Insight Southern Africa – Regional Economic Focus estimates

The information used to derive economic activity estimates are in most cases reported by company head offices. Many manufacturing and warehousing operations have head offices in the Johannesburg and other metro areas, while the production plants and warehouses are located in Ekurhuleni. This may imply that some of the estimates obtained for Ekurhuleni may be on the conservative side.

In 2003, economic output in Ekurhuleni came to R48.1 billion (in constant 1995 prices), contributing close to 8% of total production in South Africa. The metropolitan area's gross value added per capita was R20 899 (in constant 1995 prices), which compares favorably to the national average of R14 480 (in constant 1995 prices).

Ekurhuleni GVA growth trend 1997 to 2003[2]



Over the period 1996 to 2003 the economy of Ekurhuleni registered the second slowest growth, averaging 2.4% per annum, followed by the city of Cape Town with 1.4%. However, this annualized growth is misleading, as it is evident from graph above that this growth trend over this period was quite volatile – reaching both lows of –9.2% and highs of +10.6% over the 6-year window.

The high growth in 2001 and 2002 was mainly due to the exchange rate movements of the South African rand and its effect on the mining and related industries. Construction, transport, trade and financial services also benefited from the depreciation of the rand and contributed to the exceptional growth over this period. The opposite holds true for 2003, when local currency strengths resulted in a slowdown of growth in the various economic sectors. This point serves to illustrate that the economy of Ekurhuleni is relatively sensitive to exchange rate movements.

[2] Source: Global Insight Southern Africa – Regional Economic Focus estimates

Performance of various sectors to the economy[3]

Sector	Ekurhuleni % share GVA	Ekurhuleni % share Employment	National % share GVA	National % share Employment
Agriculture	0.5	1.1	3.8	9.9
Mining	2.5	2.3	7.1	4.8
Manufacturing	27.6	22.4	18.9	13.9
Electricity	1.5	1.1	2.3	0.9
Construction	2.8	4.7	2.6	3.7
Trade	13.5	20.2	13.3	17
Transport	14	7.8	10.1	4.8
Finance	22.5	13.1	20.7	11
Community Service (including households)	15.2	27.3	21.1	34

Manufacturing in Ekurhuleni contributes 22.4% to overall employment in Ekurhuleni. One out of every five of the employed in Ekurhuleni works in the manufacturing sector. Nationally the figure for labour absorption in manufacturing is 13.9%. Manufacturing in Ekurhuleni, as nationally, has recovered strongly in recent years from the slump in the late 1990s. (See graph GVA growth trend 1997 to 2003 above) And, in Ekurhuleni the performance has been much better. The average annual growth of manufacturing output in Ekurhuleni was 7.3% per annum from 1999 to 2004, compared to 3.1% per annum nationally. Manufacturing employment grew at an average annual rate of 3.3% in Ekurhuleni over the five years compared with continued *contraction* nationally (-1.4% change per annum).[4] This is due to both a stronger recovery in Ekurhuleni and sustained growth into 2004 due to the greater orientation of Ekurhuleni industry to local demand.

The metals and machinery sector is proportionately much more important in Ekurhuleni than nationally, accounting for 30.0% of manufacturing value-added compared to 25.6% nationally. In terms of employment the difference is even more striking. Metals and machinery accounts for 31.7% of manufacturing employment in Ekurhuleni and just 17.5% nationally. This reflects both the importance of Ekurhuleni as the workshop of the country making metal structures, components and tools used for industry, as well as the predominance of more labour-intensive activities in Ekurhuleni. Put simply, firms in Ekurhuleni take the steel and aluminium produced elsewhere and adds value to it.

In terms of employment, the labour-intensive sub-sectors of metals and of chemicals (especially the plastic products sub-sector) have underpinned job creation. Both of these sectors have recorded employment increases in recent years with the fuel, chemical, rubber and plastics sector recording annual average growth of 4.2% per annum from 1999 to 2004. The best performers are, however, the furniture and other manufacturing and the wood and wood products sectors with average employment growth of 9.8% and 7.3% per annum respectively over the same period.

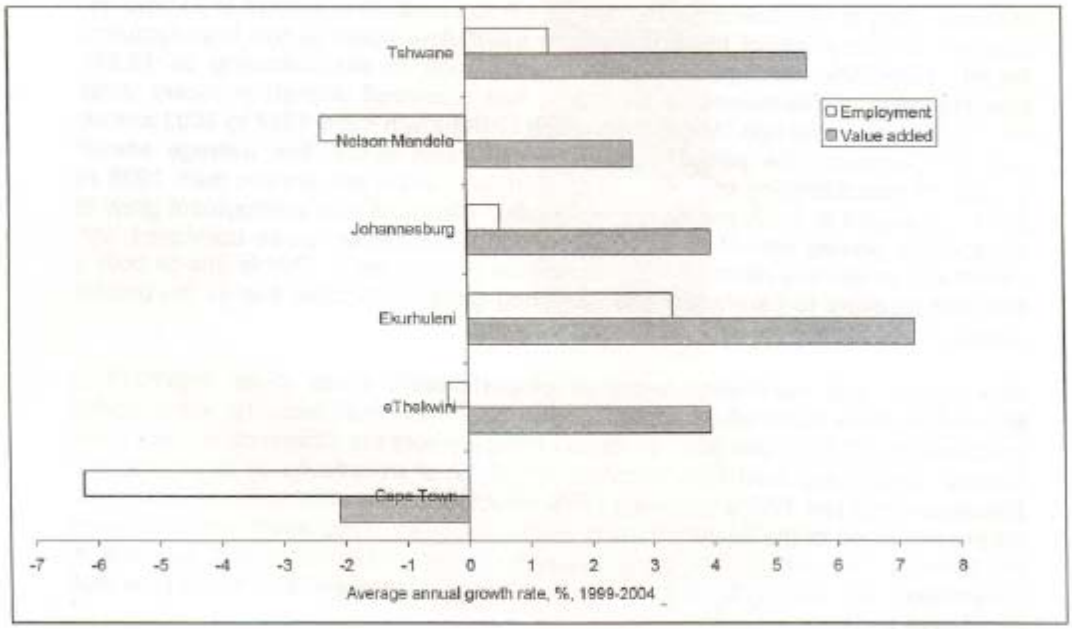
[3] Source: Global Insight Southern Africa – Regional Economic Focus estimates

[4] This was computed from the firms surveys carried out by CSID – Wits, 2003, 2004 and 2005. Revised updates of national economic indicators are likely to reflect this increase in official figures.

Ekurhuleni economy can be expected to continue to outperform the national economy given the continued strong growth of local demand, which is projected and the significant capital spending planned by government and utilities. Ekurhuleni is by far the most important site for the manufacture of machinery and capital equipment for the power generation and transportation sectors.

This is further reflected in a comparison of the relative performance of manufacturing in different metropolitan municipalities. On both manufacturing value-added and employment Ekurhuleni has recorded by far the highest growth rates of any Metro. The employment figure, in particular, reflects the more labour-intensive industries concentrated in Ekurhuleni, its inland location, the importance of growing local demand, and the rate of recovery of these industries from the mid-1990s slump. Long-term sustainable employment generation requires paying attention to these industries, and to what they need for ongoing improvements in their competitiveness.

Manufacturing performance, by Metro, 1999-2004 [5]



Further industrialisation would require a greater diversification of the economy, into value added manufacturing and beneficiation which can be termed sustainable manufacturing as well as inroads into the new quadrant of the economy – ICT industries, value added services and services that help realise sustainable development.

Smart industries include both the high end and the low end of the value chain. Within sustainable manufacturing, the promotion of cleaner technologies is the key to sustainable development. Value added processes before exports, by way of processing and packaging, are considerations for the further development of the

[5] Source: Global Insight Southern Africa – Regional Economic Focus estimates

agricultural sector. Recycling, reuse, renewable energy and organic food production as well as aquaculture are key components to ensure sustainable development.

The ICT sector has potential to absorb and reskill labour as well as bring in new aspects to infrastructure such as optic fibre, wireless communications and bandwidth. These are key drivers to improved global trade and to the leveraging of the new aspects of IT enabled distribution and production.

The services sector of the economy is the new frontier. This has a direct link to social development and longer-term sustainability. These services can be driven in a sustainable manner using the World Cup 2010 programmes as an effective link to tourism. An additional focus for new jobs in the local economy, which can be the pull factor for tourism, is the cultural industry.

Local Economic Development (LED) has a strategic role in fostering economic growth. It is about encouraging economic empowerment and bringing about social transformation. The unfolding of the Accelerated and Shared Growth Initiative (ASGI), the national spatial development perspective as well as the provincial iteration of the growth and development strategy is about LED being realised and aligned at a local level. Stimulating the local economy is a cross cutting function. Service Delivery of almost every department in the municipality impacts on economic indicators. Service delivery is linked to growth, investment, poverty reduction and job creation.

It is vital to clarify where the economic spaces for growth and development are and how these will be developed, maintained and harnessed. The National Spatial Development Perspective and the Gauteng City Region (GCR) processes, the provincial programme to implement and realise growth and development in local economies, will help to ensure the linkages needed for balanced development and hopefully reduce the duplications and replications that increase the value chain in development. The metro spatial development framework, the regional macro economic strategy adopted in 2003 and detailed assessments of the state of industry and the regional economy conducted have spurred a set of catalytic projects to bring about economic development. These interventions are about improving the quality of life whilst facilitating an environment for participation in the economy and society. The interventions in the Ekurhuleni Economic Strategy focus on the core of the region's economy, in particular the aspects that will bring about growth and development of local economy. The comparative advantage of the locality as well as the competitive advantage of the sector informs the interventions. These choices are also informed by a balanced approach to developing the local economy taking both the first and the second economy into account.

The interventions in the formal economy generate the pull force needed to attract skills and labour as well as finance and investment into the region. Thus bringing about an increase in revenue in the area and ensuring that productive activity is constantly improving its capacity to leverage national programmes and develop an international competitive edge. At another level, the interventions in the Ekurhuleni Economy Strategy serve to facilitate the implementation of the Provincial Growth and Development Strategy and sustainable development. The catalytic LED projects are about linkages between the formal developed economy and the marginalised and underdeveloped second economy. These efforts link directly to employment generation, the creation of sustainable livelihoods aimed at reducing poverty and increasing the economic active population in productive activity.

Growth in the economy is about industries harnessing new techniques, which fit in with the biodiversity of the region to bring about sustainable development. Growth in society is when all people equally benefit. Development is about industries creating the space for cultural diversity to flourish, for society to create a future that leads to continued life and improved quality. A future that is sustainable. The regional macro economic strategy adopted by Ekurhuleni takes this into account.

The local economic development count and impact analysis with respect to the municipal capital investment programme - the investment in infrastructure such as roads, electricity, water, sanitation, land fill sites, sports facilities, community halls, clinics, development of parks and cemeteries or provision of housing as well as the social investment in health services, information services, cultural and recreational services remains a challenge. It is only with alignment of planning and delivery that a count of poverty reduction and job creation as well as fluctuations in household income can be seriously considered.

Infrastructure provision and maintenance of infrastructure, transport and mobility for the movement of goods, services and people are contained in the Roads, Civil works and Municipal Infrastructure departmental plans. Exist mechanisms for people who live in poverty are on plan in the various departmental strategies but are not aligned, and with respect to housing provision this is directly linked to transfer of land ownership, which has the effect of increasing the tax base in the region.

All departments of the municipality are required to implement interventions in the economy. In particular, the Development Planning Portfolio and the Environment and Tourism Portfolio need to aggregate towards a holistic strategic view of the medium term economic growth and sustainable development of the region. In addition the capability of industry to provide the supply and price cement, bricks, steel, pumps and valves needed for construction work needs to be seriously considered. A long-term view of the project management and specialised skills needed to execute infrastructure projects is vital for planning and budgeting.

The medium term capital investment programme needs to be aligned to cover strategic projects to stimulate the economy and development of the region. To achieve this is not merely a budgeting function, or an IDP compliance process. It is about strategic and informed choices being made. To implement this within a growth path, provincial and national funding into the region would need to be sought and aligned.

Ekurhuleni Macro Economic Strategy

In November 2002 a medium term economic sustainability plan was developed. This was informed by a regional macro economic strategy, a Local Economic Development (LED) policy adopted in May 2002 and research on the local economy.

In 2003 the Implementation framework for the Ekurhuleni Economic Strategy and LED policy was adopted in response to the need to align and integrate all the economic plans of strategies of the nine towns and two administrations, which constituted the metropole.

A macro economic strategy is a medium term plan and has relevance for 10 to 15 years. The macro economic strategy for Ekurhuleni considered the following:

1. The dual nature of the economy
2. The dominance of the metal industry in manufacturing
3. Unemployment and Informal Sector of the economy
4. The results of mining
5. Protecting the high yielding agricultural land and sensitive areas
6. Hiv and Aids
7. Gender and the economy

In 2005 a process to bring about additional integration was embarked on and an Ekurhuleni Growth and Development Strategy 2025 was adopted. The following agenda issues are contained in the economic focus area of the Ekurhuleni GDS 2025:

- A diversified local economy able to meet local needs, support sustainable development and adapt to changes in accordance with global demands and shifts
- Labour Absorption and Job Creation – Unemployment to be reduced by half in 2014 and by half again in 2025 based on 2004 unemployment figures
- A skilled community exhibiting capabilities in self reliance, innovation and continued reskilling to meet the needs of a growing economy
- To promote the economy of the region, create jobs and a safe and secure environment, by establishing a tourism destination of choice.
- Increased inward investment in skills and technology, property and sustainable development
- Board Based Economic Transformation - An inclusive wealth Generating economy

The social focus area in the Ekurhuleni Growth and Development strategy has an impact on the economy and contains the follow agenda for 2025:

- In line with the national objective, the aim is to halve poverty in the next 10 years up to 2015, and to halve it again in the following 10 years, up to 2025.
- All people in Ekurhuleni to be housed in integrated and functional sustainable human settlements
- Equitable health care and facilities across all sectors of society – substantially reduced rates of poverty–related disease.
- A high level of safety and security – a drastically reduced crime rate
- Ekurhuleni to have world-class parks, sports and recreational facilities

Physical focus area in the Ekurhuleni Growth and Development strategy is the backbone and infrastructure needed to develop the local economy. The following are agenda issues to be realised by 2025:

- An integrated and equitable city.
- High quality, integrated and well-maintained transportation infrastructure, integrated public transport systems, ensuring a high degree of mobility and choices to commuters.
- High quality and well-maintained services, equitable services throughout the urban areas.
- A substantial increase in the general quality of the environment.
- A well-developed and vibrant core economic area, which imparts a unique character and identity to Ekurhuleni.
- Functional, sustainable, and attractive urban areas
- Productive and resourceful application of ICT.

Agriculture - Primary

To ensure economic growth and stability a spread of all economic sectors in the regional economy is essential, with the primary sector of agriculture being firmly in place to build food security. Ekurhuleni has the high yielding agricultural land of Gauteng located within its jurisdiction.

Strategic Interventions on agriculture are backed up by an agricultural strategy adopted by the council.

A process to link into the agricultural development programme and promote food security through a provincial committee is also a part of this intervention.

Organic food production and aquaculture are key components to building food security and ensuring sustainable development. This can be linked to the food gardens and to greening the region, but more importantly are niche productive activities for markets such as retailing and catering in hotels and restaurants.

Value added processes before marketing and exports by way of processing and packaging are considerations for the development of the agricultural sector with side steam linkages to manufacturing, trade and services.

Restructuring of local state assets for greater efficiencies and black economic empowerment to be realised

The marketing of agricultural products in South Africa was regulated until 1994 through commodity boards. Currently marketing services are deregulated and in the hands of the private sector. The process to restructure the Fresh Produce Market has unfolded and is being considered in the institutional review of the municipality.

Mining - Primary

The mining sector although in decline, can be stimulated to make a contribution to the economy, with promoting the expansion of artisanal and small-scale mining, which is currently in place. The obligations linked to mining licences bring about opportunities to develop upstream, downstream and side stream linkages into the economy, thus impacting on the development of the manufacturing sector. In addition taking the life cycle of mining into account the land care work that arises in mining rehabilitation work is linked to the agricultural sector.

Strategic Interventions on Mining is facilitated through the establishment of a Mining Forum and through Job creation projects to clean up the environment

This intervention is about an approach to developing profitable business opportunities through recovering gold and other materials in the surface mine residue deposits. The informal and illegal, small-scale mining ventures recovering material from the mining residue deposits have been capacitated through a partnership with department of Mineral and Energy. The turning this informal, illegal activity into a formal, legal activity facilitates poverty alleviation. With respect to state owned land and derelict mines, this programme has also provides the opportunity for creating a new revenue stream for the Metropolitan Municipality linked to leasing of land. The introduced legislation provides the opportunity for the ownership of minerals and the right to mine to be distributed among the historically disadvantaged people and women in particular through the Mining Charter and business channels.

Manufacturing and Construction - Secondary

Manufacturing as a key strength of the regional economy needs to be sustained. The skills in this sector should be harnessed to low-value finished material that generates

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Manufacturing and Construction - Secondary

Manufacturing as a key strength of the regional economy needs to be sustained. The skills in this sector should be harnessed to low-value finished material that generates

spin-offs in other sectors such as construction of houses. A target for value added beneficiation and downstream linkages is vital.

The ICT sector has potential to absorb and reskill labour as well as bring in new aspects to infrastructure such as optic fibre and bandwidth. These are key to improved global trade and new aspects of IT enabled distribution and production

Construction as a sector of the economy needs to be placed as a trigger in the economy whether it is in the building of infrastructure or housing. The housing policy has suggested that cooperative ventures be used in housing construction and this could be organised to sustain economic long-term prospects for local people. Material supply chains need to be localised and job creation in construction must also be linked to ongoing services in maintenance work such as plumbing, electrical work, woodwork and light manufacturing. The provision and maintenance of infrastructure such as road and storm water drainage links directly to the construction sector of the economy.

Strategic Interventions:

Support and facilitate the sustainability of the manufacturing sector to grow and be competitive

This intervention tackles the crucial problem of the increasing rate of unemployment and inequality in manufacturing in Ekurhuleni region. The main role of local government in terms of facilitating industrial development is the following: engaging with industry to achieve its developmental objectives by anticipating interventions that industry would make, gather information, analyse the strategic path of manufacturing, and coordinating activities and initiatives of institutions engaged in industrial development (e.g., employment equity and skills development). Industrial development occurs within local, national, and global contexts and all of these, impact on growth path of the Metropolitan area. Viable approaches to industrial development must see the multiple levels on which it occurs. The issue of import parity pricing and other regulatory mechanisms are national programmes, with implications at a local level. Facilitation and communications linked to this is one role that the municipality can play.

Upgrade and revitalisation of commercial areas for exchange of commodities

The economic infrastructure of the townships in the Metropolitan region and more specifically, how to consolidate apartheid's legacy of white Commercial Business Districts and black township informal economies into one sustainable urban area taking into account issues of small and micro business development, informal trading, cooperative forms of business and production and the necessary economic infrastructure for economic sustainability all require key interventions, holistic models and sustainable plans.

South African experience of economic development in transition poses many challenges. Deconstructing the concept of local economic development (i.e. stimulating local economy versus job creation), redefining the terms formal and informal economies, and the development of a role for local government institutions in local economic development are among the key challenges.

A programme to consider an upgrade plan linked to placement of street furniture, upgrading of CBD's in areas where natural trading occurs as well as urban renewal has been embarked on. This is linked to small business development in the services and retail sectors and to the efforts of large retailers to development new markets.

Skills Development for growing the economy and ensuring sustainable development

The skills capacity of a population is a key determinant of human development. With rapid changes in the production process the reskilling of the labour for economic growth and stability has become a paramount issue. The consolidation and co-ordination of all the government efforts on skills development and further education and training at the local level is the core of this intervention.

Services - Tertiary

The services sector of the economy must and should respond to HIV and Aids and care work as well as child-care and early childhood education. These aspects have a direct link to social development and longer-term sustainability. In the services sector the challenge also exists around the commercialisation of reproductive activity such as cleaning, laundry and catering skills and other domestic skills. These can be important linkages into the Tourism Industry as well as hotel and conferencing industry.

Allied to the tourism industry are the cultural industry and the sport industry. Both these industries have the potential to create new jobs and utilise the natural environment, heritage and history in the region. The cultural industry covers film, performing arts as well as the craft industry.

Finance - Tertiary

The finance sector of the regional economy needs to consider access to finance for the un-bankable as well as saving credit unions. It is savings among all in the economy that will help to ensure an adequate level of payment for services and a growth path in the regional economy. Furthermore this aspect helps to short-circuit the debt trap, which the poor find themselves in.

Electricity and Water Services – Public Sector

Electricity sector and water services are sectors of the economy that are state led. These sectors must be managed to ensure efficient delivery and ensure the reach and range is to all citizens within levels of affordability. It is likely that a major restructuring of the working entities would need to be effected to ensure improved service delivery as well as capital replacement of infrastructure.

4. Development Zones

Development zones need to cover the entire region to ensure that there is no area left impoverished.

Corridors and nodes for development need to be considered to reverse past planning and to bring about economic development. In order to stimulate the economy, such initiatives must have the following core aspects: transport linkages, residential development, and businesses for the production and exchange of goods as well as government presence for service delivery.

Spatial development initiatives need to have a mix of economic sectors with a range from production to services to ensure economic sustainability and diversification as well as longer-term job creation and wealth generation.

Industrial development zones must be linked to downstream beneficiation and export and support the overall industrial strategy.

5. Harnessing Conditional Grants

To grow the sectors of the economy use of conditional grants for infrastructure, public works (road development and maintenance; provision of electricity, water and sanitation, housing and amenities) and, education (skills development, adult literacy and child education) and, transport for mobility and tourism development is necessary. These should not be dropped into the local economy without a link to a specific local project and programme, as this would impact on the financial sustainability of the municipality. A life cycle cost/benefit analysis must be conducted for all such initiatives.

6. Mainstream the informal sector and women into the formal economy

A key thrust to economic regeneration is the formalisation of informal businesses, in order to move them out of subsistence survival to production of adequate surpluses.

The active involvement of women in the productive economy is also an aspect of growing and revitalising the economy. In this respect the need to support women in businesses in all sectors of the economy is vital. A local network of women entrepreneurs has been facilitated, under the leadership of the women's caucus.

7. *Procurement*

Procurement needs to be local and in support of economic growth and sustainable development.

A set target ensuring that 20% of all procurement is with start-up businesses, including cooperatives, would provide an incentive to ensure that informal businesses are formalised and become more efficient. Targets with respect to BEE have also been set.

The area of buying by any municipality is often riddled with corruption, which is a deterrent to business confidence and growth in the economy. Thus a clearly defined process and programme to manage the procurement carried out by the municipality is needed. The introduction of a supply chain management process assists with this challenge.

The reuse of rubber in the form of tyre crumbs in the tar for roads as well as the procurement of eco-friendly goods and products are aspects that would be taken up to ensure sustainable economic development.

8. Service levels to business and industry linked to retention plans

The quality of services provided to business and industry is directly linked to the willingness to remain in the region. With the new approaches to production and competitive advantages in many other areas, relocation is an attractive prospect for many industries and businesses. With regard to service level, the provision of quality services needs to be linked to a retention plan.

9. Register of businesses-formal and informal

This is vital to:

- Ensure that there is adequate provision made with respect to services for businesses and industry;
- Support business and industry to continue to create and retain jobs;
- Keep track of the growth in the different sectors of the regional economy;
- Monitor start-up and emerging businesses;
- Support the move of informal businesses into the formal economy.

Drivers of the strategy

A strategy is driven through push and pull factors. The main aspect of any strategy is the overall co-ordination and implementation.

Key Drivers of the Strategy are:

Cooperative governance

- Political buy in and support;
- Administrative co-ordination and cooperation;
- A collective response by all departments and political actors.

Partnership

- Sectoral forums with business and communities;
- Grow the cooperative sector;
- Allow the private sector to conduct its business.

Rapid Responsiveness to innovation and investment

- Service delivery linked to total quality management and just in time processing;
- Reduction of unnecessary delays in administrative processes;
- Project management of investment initiatives.

Sound intergovernmental relations

- Involvement of all spheres of government and with other municipalities reducing competition and promoting cooperation;
- Presenting and defending national and provincial policies and strategies of government;
- Speaking with one voice as government and working towards a common goal.

Specific Options and plans linked to the economic strategy are:

Supporting the sustainability of the manufacturing sector to grow and be competitive: In this respect there is a local Industrial Policy that guides the interventions being facilitated. It must be noted that trade and investment, incentives and protection of industries is not a municipal competence. Therefore the work that needed to be carried out is more an intergovernmental relations function.

Ongoing evaluation of existing revenue streams to determine whether they contribute to local economic sustainability and the potential to grow them: In this respect, property matters (which falls under the Corporate and Legal department), waste management, water management, (which are the main functions of the Municipal Infrastructure Department), Roads, Outdoor Advertising and Transport (managed by the Roads, Transport and Civil Works Department) are key focus areas. Revenue streams cannot be underestimated, as they are the key to the Municipality's solvency. One of the legacies of apartheid is the lack of economic resources in certain areas, a problem, which continues to plague local governments. While providing basic public transport is an important issue to be addressed, another issue is whether the Municipality generates revenue from this given the fact that transport (road, rail, and air) in South Africa are privatized.

Linkages of Municipal Procurement to the local economy: The area of buying by any municipality is often riddled with corruption, which is a deterrent to business confidence and growth in the economy. The MFMA considers ethics and linkages into the economy to support the alignment of procurement and economic development. The Supply chain regulations assist to provide a base of data from which trends can be analysed.

Upgrade and revitalisation of commercial areas for exchange of commodities: This intervention seeks to address the economic infrastructure of the townships in the Metropolitan region. More specifically it delves into how to consolidate apartheid's legacy of white Commercial Business Districts and black township informal economies into one sustainable urban area. Economic Infrastructure also considers issues of SMME development, informal trading, and the necessary economic infrastructure for economic sustainability. The challenges facing cities in decline is about urban renewal and the need to consolidate the nine towns into one Metropolitan area. The planning and land use management work is located in the Development Planning Department, while the Sport Recreation Arts and Culture Department attends to the maintenance of parks, lakes cemeteries and sport grounds and facilities, libraries and information services and, culture and heritage work. The maintenance of roads, pavements and inspections of buildings is the responsibility of the Roads Civil Works Department, and the cleaning of the area is the responsibility of the Municipal Infrastructure Department, the health inspections are the responsibility of the Health and Social Development department and pollution control is the attended to by the Environment and Tourism Department while the safety and security matters are dealt with by the Metro Police.

Taking cognisance of environmental degradation and pressures in the economy: This option is about mainstreaming the environment within a holistic approach, as a key principle of the LED policy. The impact of environmental degradation is costly to the economy. For example, many hazardous substances in the ground are the result of industrial and mining process and negatively affect economic growth. It is therefore necessary to ensure an environmental management strategy that assists economic growth is championed. Environmental problems, including contaminated land, facing the Ekurhuleni region. An integrated approach to understanding and addressing environmental issues and water management is necessary. Thus, economic, social, political, and environmental aspects must simultaneously be considered in developing a holistic approach to development. At the same time, certain high-risk problems (e.g., buildings built on sink holes) must be separated out in terms of immediate solutions. The dangers associated with the high concentration of dolomite in the region (e.g., dolomitic conditions aggravate the formation of sink holes) are prevalent.

Job Creation and Cleaning up the Environment: This option is specifically on turning informal, illegal activity into a formal, legal activity that facilitates poverty alleviation. It also considers the unlocking of land for development. Recycling of waste would also mean less volume for landfill sites. This work in the main is carried out by the Environment and Tourism Department.

Restructuring of local State Assets for greater efficiencies and the realization of black economic empowerment: In this option the programme commences with the Fresh Produce Market, of the Ekurhuleni Metropolitan Municipality, which provides a marketing service to the agricultural sector. Employment equity, the broadening of the base of agents and suppliers, increasing access to economic opportunities for local people, restructuring the ownership of the market to ensure that the Municipality derives a revenue from the investment in the property, and encourages the agricultural sector in the region to play a decisive role in the operation of the market are the key deliverables. In 2005 the Fresh Produce Market was transferred to LED, previously it was under the Finance Department.

Wealth creation projects and increasing agricultural exports: This fits in with the provincial strategy to make the best possible use of the richest agricultural soil in Guateng as well as exploit the facilities of the Rand Airport, "city-deep" and the Johannesburg international airport. It is about developing agricultural exports (flower growing and medicinal herbs) and stimulating food production.

Facilitating Child Care facilities: points to childcare and early childhood development as essential to the reproduction of the labour force. With HIV and AIDs the issue of childcare and childhood development is fast becoming a community responsibility. An initial exploration into the role of local government addressing this new challenge has been detailed. It also poses the question of how women can be gainfully employed in areas that they are already involved and skilled in. This area of work resides with the Health and Social Development department.

Facilitating Skills Development to grow the economy and achieve sustainable development: Labour market forces are outside the direct mandate of local government, however, local government can play a significant influential role in facilitating an environment where labour absorption takes place. Through leveraging the National Skills Development Strategy linkages needed in the core and dominant industries can be effectively facilitated by local government to grow the economy and bring about an environment of a dynamic the supply of labour to meet the demands of the economy. One of the most important requirements for sustainable local economic growth is an appropriately skilled local work force, which can support existing economic activity and attract and generate new economic activity. An equally important requirement for sustainable economic activity is a large cohort of entrepreneurs willing to start and grow businesses. Skills capacity and capability is a key determinant of human development. With rapid changes in the production process the reskilling of the labour for economic growth and stability has become a paramount issue. A strategy for consolidating and co-ordinating all the government efforts on skills development and further education and training at the local level is - in place and has been implemented. However the more intangible aspects of information, knowledge, and broadening the base of experience still need to be considers where greater co-ordination is needed to facilitate community education and training.

Local Interventions (2000 to 2005)

Ekurhuleni is popularly known as the "Gold Axis". Mining activity developed the comparative advantage of the well-developed transport linkages in Ekurhuleni. Mining also spurred the development of manufacturing. The gold axis was also the basis for workers to be organised. With the context Ekurhuleni has become the industrial workshop and is the home of the industrial proletariat. The perception of better opportunities has led to increased migration into the region and a number of informal settlements have come about due to a housing shortage. With the slow down in the formal economy and manufacturing during the early 90's a number of new entrants into the region find themselves surviving in the informal sector.

The key focus of LED in Ekurhuleni is an intervention to realise the Growth and Development and a sustainable future. This is about alignment between the Integrated Manufacturing Strategy (IMS), the Advanced Manufacturing Technology Strategy (AMTS), National Skills Development Strategy and Local Economic Development (LED). Without this intervention, further loss of employment and lower labour absorption will be the likely result. Thus local strategies need to be mirrored in the national and provincial strategies.

The engagement with industry, labour and business has been through a participatory approach, involving key stakeholders (including labour and national and provincial government and the communities) in various economic sector forums. The methodology used is to conduct research in the economy, share the analysis and plan and execute interventions.

Since 2002 meetings with various sectors have taken place. This has provided a platform to engage with local stakeholders. Each month a Mayoral Business Initiative takes place, which targets local leaders and various sectors of society. The LED department facilitates regular economic sector forums on mining, agriculture, construction, manufacturing, SMME's, skills development and cooperatives. In partnership with MINTEK, MERSETA and the DTI and also through a cooperative agreement with University of Witwatersrand, industry clusters in the foundaries, plastics industry and capital goods have been set up.

In 2002 an industrial policy was developed. This approach helped to obtain a better understanding of the manufacturing sector in the region. A cooperative agreement with the University of Witwatersrand assisted to obtain expert research capability. Through this cooperative work a deeper and better understanding of the performance of local firms in the local economy has come about. This work has been shared widely with national and provincial government and has informed the National Programme of Action of government.

Over the next five years (2006 –2010) Transnet and Eskom will be spending R133 billion. A significant proportion of this capital expenditure is going to be on capital goods - electrical and non-electrical machinery, transport equipment. By 2008 a new power station in the country will be established. This would mean a redevelopment of capabilities that were lost over the last twenty years, when there was limited State Owned Enterprise investment. Given Ekurhuleni's status as the capital goods manufacturing hub for SA if not for Africa, this is going to result in a massive increase in demand.

In the next five years Spoornet aims to increase its freight capacity by 30%. The plans for a rapid rail link between Johannesburg, Tshwane and the Johannesburg International Airport in Ekurhuleni are far advanced. This is a project of the Gauteng

1. Manufacturing Interventions

The manufacturing sector of Ekurhuleni has experienced growth. Research conducted in partnership with CSID Research Unit based at the University of Witwatersrand indicates that there have been increased levels of investment in new machinery, higher spending on training, and improved production capabilities. These were the key factors for the growth and employment generation that came about.

Local firms' investment and training expenditures jumped in 2004 compared with the previous year. This investment in human development is closely related with the increased employment trend. The main driver has been improved domestic demand. From the firms survey indications were that in 2003 firms in Ekurhuleni were spending an average of R3 700 per employee on training, while in 2004 firms spent an average of R6 232 per employee. In part this reflects that the national skill development strategy is taking off and the skills development incentive is being recognised and used.

Sectors having a substantial presence were identified through research and analysis as plastics, metal fabrication, heavy metal industry and mining equipment. These sectors are trapped into high input costs due to import parity pricing, and are subject to the fluctions of the rand and exchange controls.

The outcome of the research carried out indicated that the municipality must be prepared to advance the cause of businesses in the area. Two issues emerged that were within the control of the municipality and linked to municipal services. Business expects the municipality to provide reliable electricity and public transport for those firms wanting to increase employment by introducing three shifts instead of the current two-shift system. This would have the effect of labour absorption in the first economy and would increase employment.

These aspects require an alignment of local, provincial and national plans linked to the electricity infrastructure and transport planning, budgeting and delivery. Organised labour has also negotiated reinstatement of workers on expansion. The current workforce is living on additional income earned from the overtime paid for two twelve-hour shifts. Any attempts to increase employment must also involve organised labour as a key stakeholder.

In partnership with national government and key parastals such as Mintek, CSIR and the MERSETA, a number of interventions are in place to boost competitiveness in the identified sectors.

These interventions are the foundation to the local, national and provincial strategies on growth and development being realised and can be viewed as triggers to growth and development.

1. A National Tooling Initiative

The plastics industry has been brought into this programme through an industry cluster and a priority skill development programme using the skills development funds. In keeping with the need to improve productivity and build competitiveness, the DTI together with the Advanced Manufacturing Technology Unit based at the CSIR, the Gauteng province and the LED department has embarked on a national tooling initiative for the plastics industry. Deliberations have been concluded at NEDLAC and implementation has commenced. Through participation in the South African Cities Network the successes of the pilot carried out in the Western Cape has been learnt.

2. National Casting Technology Centre

The foundary industry has been involved in an industry cluster to develop core skills needed to sustain the industry. The skills programme of the industry federation will be run from the centre. An old Denel Site, a foundry has been identified for this purpose and is being assessed. Government intervention in this is to relocate research and development from the CSIR in Pretoria to Ekurhuleni to making testing facilities more accessible to local producers. The proximity to the JIA presents the possibility of the national feature of this centre to be tuned into a regional one for the benefit of NEPAD.

3. Industry Cluster linked to Mining Capital Equipment

Industry clusters on pumps and value manufacturing have been set up and skills development programmes for the industry are being considered. This work is essential to productivity being improved to meet the demand for the government's capital investment programme over the next 5 years.

4. Focus on Metal fabrication – an Incubator Programme on Base Metals

An incubator on base metal is being set up by Kumba Resources and Impala Platinum Refineries to conduct downstream beneficiation in zinc, nickel and brass. This is located in the Springs industrial area and would benefit small and medium enterprises. Government support for this programme amounts to a grant of almost R9 million.

5. Aerospace Network

In order to develop world-class practices and to be globally competitive the Advanced Manufacturing Technology Strategy has been implemented to benefit the manufacturing base in the region. As part of this work, Ekurhuleni is a signatory to the Aerospace network. The Aerospace Network has commenced on Flagships programmes on:

- Casting Light Weight Metals
- Advanced Electronics
- Digital Manufacturing

2. Interventions linked to the life cycle of mining

Ekurhuleni was the mining centre of the country. While mining developed the South African Economy in the earlier period, there is a need in the current period to overcome the legacy of mining. Mine dumps on which unsafe and informal mining takes place and informal settlements adjacent to mine dumps which house people need to be rehabilitated.

Project Hloekisa has been launched to help facilitate the clean up of the mine dumps. In this process the value of the land will be unlocked. This strategic intervention is underpinned by the need to further develop and stimulate economic activity. During 2002, the municipality embarked on the development of a medium term economic and financial sustainability strategy. In this the life cycle and sustainability of mining, its linkages and impact of the local economy was considered.

A significant portion of mining land is in private hands. Global best practice about how investments can be harnessed for a post-mining era can be replicated, with the support of companies like Anglo. Discussions are underway linked to the closure of Ergo to try to emulate Cornwall experience where the WSSD's flagship Eden Project is located.

Ekurhuleni has established the first Mining forum at local government level. This is a public participation forum, wherein the local stakeholder and government communicate with each other and find meaningful solutions that can make a significant contribution to the local economy. The rehabilitation of mining land is a part of the agricultural sector and it is about land care. The Ekurhuleni mining forum has encouraged landowners of mining land to present plans linked to the development of property to ensure that these are in line with the SDF.

In this respect the Grootvlei Mine water treatment - desalination project, Skukhuza project as well as the closures of ERGO and ERPM have been deliberated and aligned with the key challenges facing the local economy. From October 2002 the local government and the mining houses, as well a labour have been in on going discussions on the challenges posed by mining activity.

In February 2003, the informal mining of mine dumps was deliberated at the Mining forum and in partnership with the Department of Mineral and Energy a conducive environment for new entrants to participate in mining related activity was facilitated. A small-scale mining company had been set up to work on the rehabilitation of mining land. Informal miners are current being formalised in small-scale mining and the rehabilitation of mine dumps. Technical support has been leveraged from Mintek. The Mining Qualifications Authority appointed the Mining Development Agency to conduct workshops to capacitate emerging miners over the past months. This has been carried out in local information centres set up by the LED department in selected libraries.

With the decline in mining activity a further challenge relating to underground water in mines exists. Currently there are no definitive plans in place to unlock the value of the rich gold veins in the east rand to extend the life cycle of mining. Although mining prospecting permits have been applied for, the key issue is the costs of pumping the underground water, which will create further economic opportunities. With investment the manufacturing of water, through pumping and treatment is a reality. This water could be used for industrial and agricultural purposes thereby ensuring that the scare resource of potable water is available for human consumption.

A national project, which co-ordinates a programme relating to underground water linked to extending the life cycle of mining has been set up. Ekurhuleni, the Departments of Mineral and Energy, Water and Forestry as well as the Geo Science Council have commenced with the development of an integrated plan.

The Informal Sector

The LED focus on the informal sector is linked to mainstreaming the sector to move from survival activities to sustainable activities where possible. This is more likely to occur through up-skilling programmes in conjunction with the Department of Labour.

Work with the informal sheebens in the region but way of information and advice has also been facilitated. New applications for Liquor Licences are decentralised through the Gauteng Liqour Board committee in the region. The LED department has a permanent representative on the committee. The effect of this is that in the liquor industry through provincial regulation informal activities are mainstreamed.

A programme to formalise the street traders into organised formations has taken off. Section 21 companies of street traders in the towns have been registered. In partnership with these organisations, an allocation system has been developed to better organise the spaces used by vendors.

Participatory Democracy and Upgrading Economic Infrastructure

A series of consultative meetings with street traders took place during 2004 in flashpoints and over traded areas. This resulted in a programme wherein the municipality facilitated the organisation of street traders to provide better services to their clientele. An upgrade of facilities and development of trader markets has commenced. In this, a partnership with Intersite has helped to integrated economic planning and passenger transport planning.

A strategic plan to link the MIG funding to the learnerships of CETA for emerging contractors, to involve unemployed and indigent households in the EPWP and to facilitate the reskilling of locals has been devised. This aims to support the municipal capital investment programmes to intervene in a focussed manner on the second economy.

In 2002 and 2003 an amount of R500 000 from the Local Economic Development (LED) fund was invested in micro-enterprise development of 67 potential businesses, by developing business plans. Minor renovations to existing buildings at Club 2000 in Tsakane were carried out and improved technology for existing 15 micro-enterprises was sourced. A marketing and distribution outlet and a development committee were also set up. About 16 newly established, innovative businesses were supported.

The Cooperatives Industrial Hives Programme

During 2003 onwards a catalytic project the Cooperative Industrial Hives Programme has created 12 new economic nodes. The economic nodes are in densely populated areas viz Daveyton, Langaville, Thembisa, Thokoza, Kathlehong, Wattville, Duduza, Kwa Thema, Etwatwa and Vosloorus.

Just over R10 million was invested in renovating old unused government buildings for this programme. This ensures that apartheid spatial planning is reversed, that urban renewal is brought about and that unused Council and government buildings are utilised by local communities. In the process of carrying out the renovations a range of local emerging contractors were engaged and supported to improve their business processes.

The Cooperative Industrial Hives programme extends over 53 wards in Ekurhuleni. A total of 25 cooperatives in manufacturing were established and registered. Set up and start-up funding amounting to R3,5 million was provided through the LED fund

and own funds for the project. The 25 coopertives are housed in 12 Industrial Hives throughout Ekurhuleni. These hives will assist to develop new economic nodes thereby assisting in reversing apartheid spatial planning.

The cooperatives are involved in light manufacturing and local production for local needs. A total of 275 sustainable livelihoods have been created in this programme. As the cooperative grow the number sustainable livelihoods will increase. The cooperatives productive activities cover a vast range within manufacturing: clothing production, condom manufacturing, food production and food packaging, production of household chemicals, construction, road markings, steel production, wood work and recycling.

The 25 cooperatives are being further capacitated through the National Skills Fund. Mentoring and funding for equipment was secured for the Cooperative Industrial Hives through the LED programme "Partnerships for Sustainable Development". The Labour Job Creation Trust as well as local banks supported this programme.

An extension to the programme has been spurred on by the province especially to stimulate the economy in the far eastern region. In this phase a construction contractors network linked to the Cooperative Industrial Hive in Duduza has been set up.

The success of the programme has led to a further five-year programme to place retrenched workers into industrial hives.

Access to Finance

A pilot to develop a curriculum on financial systems particularly linked to micro finance has been carried out in partnership with the bank seta. Work with the SACOL to set up savings and credit unions across the entire region has commenced. The initial participants would be the cooperatives in the region.

Selected industrial hives have been designed to accommodate a banking facility. The common bond from SACOL will improve access to savings mechanisms and is a strategic intervention in the second economy.

The informal cooperatives, such as burial societies have been encouraged to formalise themselves following the promulgation of the Cooperatives Act. The outcome of this will be realistic empowerment mechanisms to support micro entrepreneurs and cooperatives to access and manage finance needed to grow their small ventures.

Municipal Procurement and the EPWP

BEE targets for municipal procurement have been set and are being monitored to access the impact on the local economy. The Metro has signed up a member of Proudly South Africa to encourage local buying.

The challenge of linking the job opportunities provided by the Expanded Public Works programme of government through the Municipal Infrastructure Grants funds and ensuring both the development of emerging contractors as well as exist strategies for indigent households has been considered. The development of the strategy for job creation and monitoring is the responsibly of LED while the implementation of this programme is with departments responsible for infrastructure development.

5 Improving Access to information and reskilling the economy

Through a partnership with the business chambers two new business linkage centres have been established in Germiston and Boksburg using the model of the existing Springs Business Linkage Centre. The business linkage centres harness the procurement opportunities of established business for the benefit of new and emerging local businesses. The municipality has linked these linkage centres to SEDA for tender advice accreditation and to the Further Education Training Colleges for overall monitoring of quality and standards.

In partnership with the Borough of Lewisham and with funding from the Commonwealth Local Government Good Practices Scheme, a pilot project to link the Department of Labour's local labour centres to unemployed people and match them to jobs has been devised. This programme will improve the capacity of ward committees to interact with government services and build linkages to local employers through the Business Linkage Centres.

A demilitarisation project was launched and 1500 ex-combatants have been registered. In partnership with the Gauteng Economic Propeller a reskilling and new venture creation programme is underway for these beneficiaries.

The establishment of Information Centres in seven libraries in 2003 signifies the municipality's commitment to facilitate the provision of quality and accessible information to grow the local economy. This project comprised the redressing of backlogs in the provision of facilities, the retraining of staff to use the latest techniques and the provision of information to citizens.

The seven libraries are Reiger Park Library (Boksburg), Spruitview Library (Germiston), the Phomolong Career Centre (adjacent to Tembisa), Jerry Moloi Library (Benoni), Kwa-Thema Library (Springs), Duduza Library (Nigel) and Tsakane Library (Brakpan). These libraries are situated in the most densely populated areas of Ekurhuleni.

In the context of a rapidly changing global economy, the challenges facing local communities are more intense than the past. The LED programme has adopted a theme "The Past We Inherited the Future We Create". This theme is linked to the work in the information centres in libraries where access to information and empowerment of people is becoming a reality. Training for over 500 people was facilitated as part of the reskilling programme of various SETA's during 2004 and 2005. This training included Telkom's programme on BEE and entrepreneurship development, Mining Qualification Authority training on informal miners, the Wholesale and Retail Seta Training of small retailers and a micro MBA programme which is linked to the casino licence community obligations. The Gauteng Economic Propeller is considering extending its services to people through this programme. A programme to link all libraries with internet is well underway and bodes well for e-procurement and e-business.

Detailed Analysis of the Economy (2002 to 2005)

The restructuring of the South African economy during the 1990s has greatly exacerbated the already high levels of unemployment leaving a large proportion of the population in poverty and with insecure sources of income. Various reasons have been put forward for this change. These include liberalisation of international trade and capital movements, changes in technology, the tightening of macroeconomic policy in order to reduce inflation, and changing work organisation with outsourcing and subcontracting. Undoubtedly these have all been contributing factors to the decline in the local economy. In the last decade firms have focused on cost-minimisation in response to trade liberalisation and weak domestic demand. This has led to reductions in employment and increasing insecurity and lower incomes of workers in outsourced operations. Many firms unable to effectively respond have closed down.

It is within this context that the Local Economic Development (LED) department is attempting to realise LED policy. Among the Key Performance Areas for LED adopted in 2002 are:

- Develop and sustain all economic sectors
- Mainstream all economic activity into the formal economy
- Promote and market investment for sustainable job creation

This research into the Ekurhuleni economy was commissioned to inform the municipality and government on how to maintain and sustain the base of 90 percent of Gauteng's manufacturing in the region. This work is carried out through a strategic partnership between the Local Economic Development Department and an international organisation - Global Insight.

The economic forecasts presented herein are based on official statistics and computed estimates. This presents one side of the equation. A number of other factors need to be considered to arrive at interventions to close the gap between employment and unemployment and resulting income disparities.

To effectively manage the local economy and the global and domestic trends impacting on industrial and competition policies, poverty eradication strategies, the labour market and investment strategies including the investments in infrastructure need to inform the building of models for appropriate interventions, as well as the spatial and developmental planning processes.

Ekurhuleni the "Workshop"[6]

Ekurhuleni is a large and significant local economy in the South African economic context. The metro has a resident population of approximately 2.5 million people and contributes approximately 7.6% to national production and 7.1% to national employment.

The area not only has a high population density, housing 29% of the Gauteng province's total population, but also has high levels of unemployment and poverty. 7% of the country's spending power is located in Ekurhuleni compared with 34% in Gauteng as a whole.

Over the period 1996 to 2006 the total population of Ekurhuleni is expected to grow by 1.8% per year, whilst the population between ages 15 and 64 is expected to grow by 1.4% per year. The slower growth in the population between ages 15 to 64 is the result of a decline in the ratio of people aged between15 to 64 to the total population. This decline is concentrated in the Black population of Ekurhuleni. For the other population groups the ratio increases between 1996 and 2006. These trends are based on modelled demographic trends and the expected impact of HIV/AIDS. Growth in the potentially employable people in the metro is forecast to decline in the period from 2001 to 2006, compared to the period 1996 to 2001.

Net migration into the metropolitan area is estimated to be about 66 000 in the period from 1996 to 2001 and 39 000 in the period from 2001 to 2006. Migration to urban areas will continue to take place even in the presence of high levels of unemployment.

Less than half of the population of Ekurhuleni is economically active, and of the economically active population, an average of 40% is unemployed. Informal employment makes for a share of between 10% and 20% of total employment.

Employment in agriculture and mining make small contributions to production i.e. 1.1% and 2.3% respectively. Manufacturing, on the other hand, makes a significant contribution to output and employment in Ekurhuleni. It contributes a 27.6% share of employment in the Ekurhuleni, compared to the 13.9% national average.

In the trade, transport and finance sectors significantly greater than national average shares of employment are recorded.

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6 The data presented in this section has been sourced from Global Insight Southern Africa – Regional Economic Focus (REF). The REF is a system of integrated databases that provide accurate and up-to-date economic, socio-economic and development information on a sub-national level within South Africa.

The REF draws together many different sources of sub-national economic information from Statistics South Africa (StatsSA), development agencies, Regional Services Councils (RSC), South African Revenue (Services (SARS), Bureau for Market Research (BMR), SA Reserve Bank (SARB), National Treasury, Department of Mineral and Energy - Minerals Bureau, Eskom, Chamber of Mines, Cement and Concrete Institute, South African Council of Geosciences, the Independent Electoral Commission IEC), Department of Provincial and Local Government, South African Weather Services, various other government departments and private research houses and Global Insight's own data. Data components are reworked to ensure internal consistency whilst national and sub national verification tests are applied. REF indicators are updated to current periods using Global Insight's suite of forecasting models. These include a macroeconomic model, industry model and income distribution-forecasting model.

The data collated herein was extracted from four reports produced by Global Insight for the LED department. For the purposes of planning forward-looking estimates (or forecasts) were developed. Economic and demographic estimates in the REF are based on magisterial boundary geographic regions. It is important to interpret the estimates for the Ekurhuleni metro area in the correct context. The magisterial areas used were approximated to the Ekurhuleni metro area at ward-level areas. The match did not fit in all instances, as data on municipal ward level is not available from the multiple sources of data. Late in 2004 enough information was available to update some of the estimates to 2003 levels. The labour market data was computed from 2002 data as should be viewed as estimates up to 2002 level.

The household sector is an important source of employment (11.1%) in Ekurhuleni. Moreover, as this sector is providing employment to predominantly low and unskilled female labour, it is an important sector for alleviating poverty. The unemployment rate of females in Ekurhuleni in 2002 is estimated at 51.8% and is much higher than the estimated 31.8% amongst males.

Ekurhuleni shares similar problems to that of the other metropolitan areas in terms of the building of human capital and the containment and prevention of AIDS. Ekurhuleni is probably more exposed to the vagaries of globalization than the other metros as its production base is more concentrated on goods and less on services.

Another challenge facing the area relates to the production structure of the economy. In Ekurhuleni the manufacturing sector bears the brunt of the adjustment in the economy. The sacrifice the area makes in terms of the adjustment is much greater than that of other metropolitan areas. This is the major reason why the demand for labour for formal employment in the area is forecast to hardly grow up to 2006.

Ekurhuleni accounts for a sizable share of South Africa's overall international trade. In fact, Ekurhuleni on average accounted for 17.6% of national imports between 1996 and 2003 (on a metro level, second only to the share of City of Johannesburg) and for 6.7% of national exports over the same period.

Ekurhuleni's trade contribution to the Gauteng province was even greater, with the region accounting for almost 30% of the value of imports into the province between 1996 and 2003 and for 12.3% of the value of exports over this period. In total, Ekurhuleni contributed more than one-fifth to the total value of international trade within the Gauteng province.

Merchandise exports on average accounted for 24% of the Ekurhuleni's GVA between 1996 and 2003, whilst total trade (including imports) accounted for almost 79% of GVA over the same period illustrating the strong role that imports plays within the local economy.

On a broad sectoral level, the manufacturing sector makes the largest contribution to Ekurhuleni's international trade and also exhibited the largest total trade to GVA ratios. In contrast, the mining sector is predominantly outward-focused and relies heavily on the export market.

What follows hereunder are additional details on the socio-economic profile of Ekurhuleni, which includes demographics, income distribution and spending patterns, poverty, employment, and Human Development; the profile of the labour market of Ekurhuleni, which covers the openness of the economy and how HIV and AIDS impacts on it, labour participation rates and forecasts on key sectors of the economy with respect to labour absorption and productivity and the international trade profile of Ekurhuleni.

In collating the socio-economic profile of Ekurhuleni benchmarking to both the national and Gauteng figures was carried out and an analysis was conducted on the how the socio-economic situation has changed over time. The profile of the labour market of Ekurhuleni considers the labour supply elements such as population, migration, participation rates and potential labour supply, and labour demand factors. The international trade profile was developed through a focus on the national trade policy framework, an analysis of the data on imports and exports with a focus on recent trends.

Socio- Economic Profile

Demographics

Population changes 1996-2003

Area	1996	2003	Average annual growth
National Total	42,204,536	46,710,858	1.5%
Gauteng	7,782,920	8,845,741	1.8%
Ekurhuleni	2,211,018	2,534,180	2.0%

Source: Global Insight Southern Africa - Regional Economic Focus REF version 1.6h (186)

The Black population is the largest population group in Ekurhuleni. It comprises approximately three quarters of the area's total population, and it is also growing at rates significantly higher than any of the other population groups within the area.

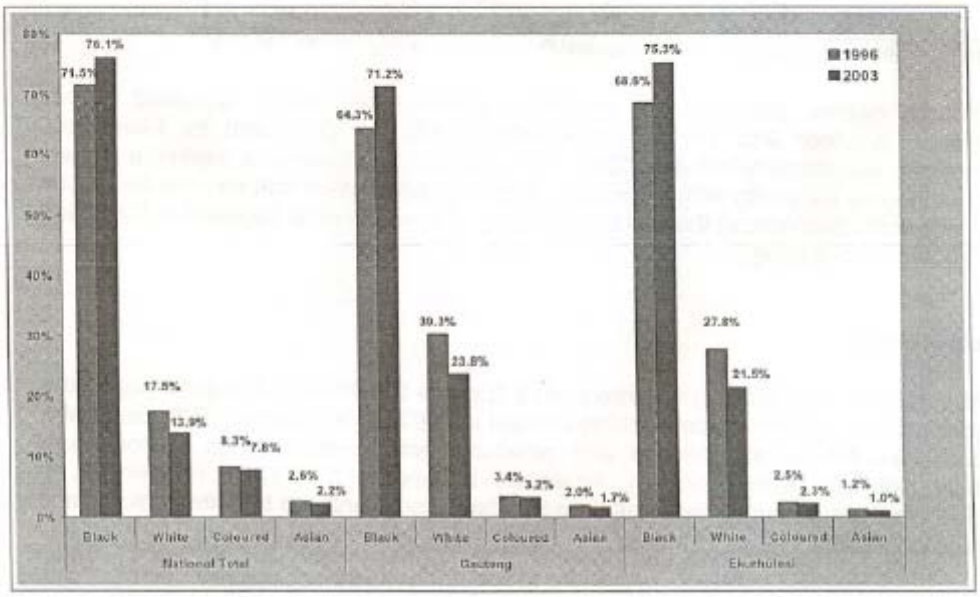
Population groups growth rate (Average annual growth 1996-2003)

Area	Black	White	Coloured	Asian
National Total	1.7%	0.2%	1.4%	1.0%
Gauteng	2.4%	0.2%	1.5%	1.7%
Ekurhuleni	2.5%	0.2%	1.3%	1.5%

Source: Global Insight Southern Africa - Regional Economic Focus REF version 1.6h (186)

The Black population's share of total national population is estimated to have increased substantially over the period 1996 to 2003 in all areas. Even more so in the case of Ekurhuleni and Gauteng where a 7% point increase was estimated between 1996 and 2003. In 2003, the Black population represented approximately three quarters of Ekurhuleni's total population.

Population group's share of total population 1999 & 2003



Income Distribution

The Gini coefficient is a summary statistic of income inequality, which varies from 0 (in the case of perfect equality where all households earn equal income) to 1 (in the case where one household earns all the income and other households earn nothing). In practice the coefficient is likely to vary from approximately 0.25 to 0.70.

Gini coefficient – 1996 &2003

Area	1996	2003
National Total	0.60	0.64
Gauteng	0.58	0.60
Ekurhuleni	0.45	0.58

Source: Global Insight Southern Africa - Regional Economic Focus REF version 1.6h (186)

A comparison can be made on how the Gini coefficient, for each population group, varies between the different areas. A comparison can also be made on how the Gini coefficient changed over the period

Gini per population group and area – 1996 & 2003

Area	Population Group	1996	2003
National Total	Black	0.53	0.62
	White	0.45	0.46
	Coloured	0.48	0.55
	Asian	0.47	0.51
Gauteng	Black	0.50	0.60
	White	0.43	0.42
	Coloured	0.46	0.52
	Asian	0.46	0.46
Ekurhuleni	Black	0.48	0.56
	White	0.42	0.43
	Coloured	0.46	0.52
	Asian	0.45	0.46

Source: Global Insight Southern Africa - Regional Economic Focus REF version 1.6h (186)

Although income distribution is less skew in Ekurhuleni when compared to the Gauteng province and the national economy, the Gini coefficient for Ekurhuleni increased substantially between 1996 and 2003, pointing towards a marked increase in the income inequality within the area. The estimates reveal that income was more evenly distributed among the Black community of Ekurhuleni as opposed to the Black population in Gauteng.

Household Income

On a national, provincial and metro level it appears that households generally hold a more equitable share in each income bracket in 2003 as opposed to 1996. Generally, Ekurhuleni follows the national and provincial profile with regards to household distribution by income bracket. However, it appears that Black households in Ekurhuleni are generally better off than the Black community on both the national and provincial level.

Households hold a more equitable share in each income bracket in 2003 as opposed to 1996. Nationally 51.7% of the households fell in the R6 000 to R30 000 income bracket in 1996, in 2003 the figure dropped to 38.4 %.

In 1996 only 4.1% of all households fell in the R192 000 p.a. and higher category, while 8.9% of all households fell in the same category in 2003.

Generally the areas follow the same household per income bracket allocation trend, with the exception of households on the top end in Gauteng in 2003. Here, almost 10.2% of all households earn in excess of R360 000, with only 4.4% of households nationally and 4.9% of households in Ekurhuleni falling in that category.

A remarkable change is evident in the estimates of distribution of Black households in each income bracket between 1996 and 2003. Nationally, the percentage of Black people earning between R6 000 and R30 000 decreased from 62.5% in 1996 to 45% in 2003, with the number of households earning more than R96 000 increasing from 4.1% in 1996 to 11.4% in 2003.

Within Black households, the Ekurhuleni Black households are better of than the Black community on a national level. Less of the Black households are represented in the lower income brackets while more are to found in the higher income brackets.

When compared to Gauteng, Ekurhuleni has a lower percentage of Black households in the lower income brackets, and a higher percentage in the middle to higher income brackets. Gauteng however, has a higher percentage of its Black households in the high-income brackets, relative to Ekurhuleni.

Percentage of households per income bracket for Ekurhuleni – 1996 & 2003

Income Bracket	Black		White		Coloured		Asian	
(R' value)	1996	2003	1996	2003	1996	2003	1996	2003
0-2,400	98.2%	98.8%	1.3%	0.5%	0.5%	0.6%	0.0%	0.0%
2,400-6,000	97.0%	97.9%	2.3%	1.2%	0.6%	0.9%	0.0%	0.1%
6,000-12,000	95.1%	94.6%	3.4%	3.7%	1.3%	1.5%	0.2%	0.2%
12,000-18,000	93.1%	94.3%	4.7%	4.1%	2.0%	1.3%	0.2%	0.2%
18,000-30000	89.4%	90.8%	7.7%	6.8%	2.4%	2.0%	0.5%	0.4%
30000-42,000	81.5%	88.4%	13.9%	8.7%	3.5%	2.3%	1.1%	0.6%
42,000-54,000	67.9%	84.7%	26.6%	12.3%	3.7%	2.3%	1.8%	0.7%
54,000-72,000	53.3%	76.4%	39.9%	19.9%	4.7%	2.6%	2.2%	1.1%
72,000-96,000	36.8%	67.9%	57.2%	28.1%	3.7%	2.8%	2.3%	1.2%
96,000-132,000	26.3%	56.0%	69.3%	39.5%	1.9%	2.8%	2.5%	1.6%
132,000-192,000	16.8%	46.8%	78.7%	48.7%	2.0%	2.8%	2.6%	1.6%
192,000-360,000	11.4%	39.3%	85.0%	54.8%	1.0%	3.4%	2.6%	2.4%
360,000+	11.7%	32.9%	83.8%	61.6%	1.2%	2.2%	3.4%	3.3%

Source: Global Insight Southern Africa - Regional Economic Focus REF version 1.6h (186)

Spending Patterns of Disposable Income

An analysis of spending patterns in the various regions over the 1996 to 2003 period allows one to identify whether an area's economic prosperity increased over time or whether certain structural changes in spending habits are evident.

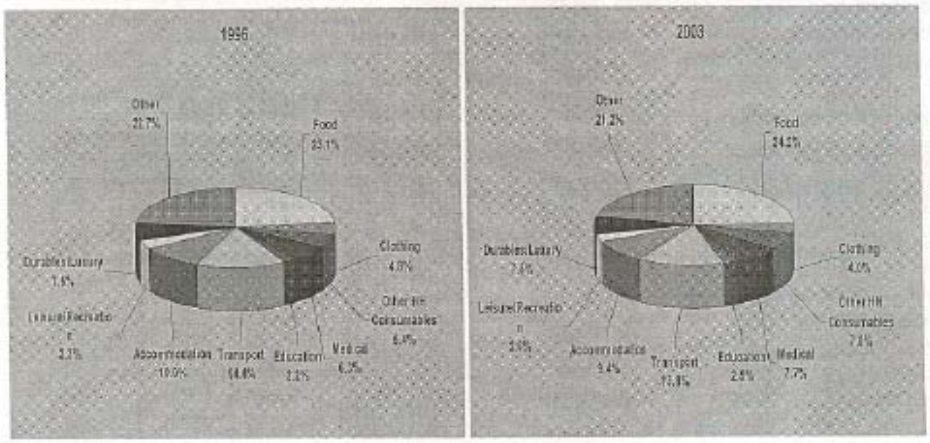
A very high percentage of income is still spent on basic need categories i.e. food, clothing, accommodation and other household consumables and medical services, satisfying the first level of needs.

In the second level safety needs are addressed, physical safety in particular. Only when you and your family feel save can you advance to the next level of love. Attaining this level is more a function of state of mind and environment and as a result, no data can indicate the attainment of the second level.

In the third level love needs are addressed. In this level people will join sport clubs, social clubs and work groups to feel loved and accepted by others. From the data we see a very small percentage of income spent on leisure and recreation. This possibly indicates that the households in each area, in general, are stuck in the second level.

In the fourth level the need for esteem/prestige has to be fulfilled. Esteem from competency and mastering of a task and esteem that comes from the attention and recognition of others. The second form of esteem can be attained by driving a very expensive car for example. Luxury/durable goods consist of furniture, appliances and computers. Although these items won't attract the same level of attention/recognition that a new luxury vehicle would, it will surely point to that direction. Spending on luxury/durable goods has remained fairly stagnant in all the areas under discussion.

Estimates of spending patterns of disposable income Ekurhuleni - 1996 & 2003



On inspection of the spending patterns in the various areas one finds that a large percentage of disposable income is still used to satisfy basic needs. In addition, spending patterns have remained fairly stagnant over the course of the period under review. This probably indicates that very few people have actually reached a state in their lives where they can live life at its optimum

Poverty

Although poverty levels are lower in Gauteng and Ekurhuleni relative to South Africa, the percentage of people living in poverty have increased in all cases. In Ekurhuleni almost 27 percent of people were living in poverty in 2003. This signals an ever-increasing burden on society to combat and alleviate the pressures of poverty.

The aggregate poverty gap is calculated by summating the poverty gaps of each poor household. It is thus equivalent to the total amount by which the incomes of poor households need to be raised each year to bring all households up to the poverty line and hence out of poverty.

The table below shows the percentage of people living in poverty, the actual poverty gap and the average amount needed to bring the average person in poverty up to the poverty line.

Percentage of people in poverty and the poverty gap 1996 & 2003

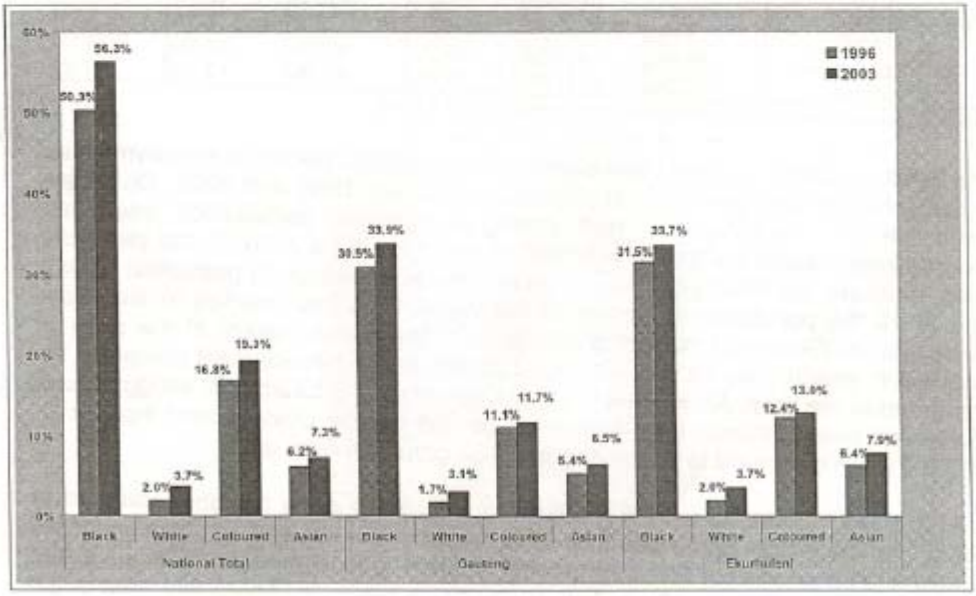
Area	% of people in poverty		Poverty gap (R million)		Poverty gap per capita	
	1996	2003	1996	2003	1996	2003
National Total	40.5%	46.2%	18,280	32,960	1,069	1,528
Gauteng	22.3%	25.6%	1,747	3,251	1,007	1,435
Ekurhuleni	23.7%	26.6%	539	974	1,027	1,447

Source: Global Insight Southern Africa - Regional Economic Focus REF version 1.6h (186)

The increase in the actual number of people in poverty is estimated to have averaged 3.4%, 3.9% and 3.6% p.a. for South Africa, Gauteng and Ekurhuleni respectively from 1996 to 2003.

The actual poverty gap of Ekurhuleni is estimated to have increased at a faster rate than that of the country as a whole, but at a slower rate than that of the Gauteng province on average.

Percentage of each population group in poverty 1996 & 2003



Number of people in poverty – Average annual change 1996 to 2003

Area	Black	White	Coloured	Asian	Total
National Total	3.3%	9.7%	3.4%	3.4%	3.4%
Gauteng	3.8%	9.2%	2.3%	4.5%	3.9%
Ekurhuleni	3.5%	9.5%	2.0%	4.6%	3.6%

Source: Global Insight Southern Africa - Regional Economic Focus REF version 1.6h (

Unemployment[7]

Whilst unemployment increased in all areas over the 1996 to 2003 period, the highest increase in the unemployment rate was recorded for Ekurhuleni, with an 8% point increase from 32.2% in 1996 to 40.3% in 2003. In Ekurhuleni, the Coloured population group (males in particular) experienced the highest increase in unemployment between 1996 and 2003, followed by the Asian and Black communities.

Unemployment rate per gender and region – 1996 & 2003

	Population	Male		Female		Total	
Area	Group	1996	2003	1996	2003	1996	2003
National	Black	34.8%	39.7%	51.6%	61.3%	42.6%	49.7%
	White	4.5%	6.3%	8.6%	10.7%	6.3%	8.2%
	Coloured	16.9%	22.8%	24.9%	34.7%	20.6%	28.2%
	Asian	10.3%	15.9%	18.3%	32.7%	13.2%	22.0%
Gauteng	Black	27.7%	32.6%	46.5%	56.2%	35.9%	42.9%
	White	5.0%	7.0%	8.5%	10.5%	6.6%	8.6%
	Coloured	22.8%	29.0%	26.7%	35.9%	24.7%	32.3%
	Asian	8.6%	13.2%	15.6%	27.7%	11.1%	18.4%
Ekurhuleni	Black	31.6%	38.0%	51.9%	63.7%	40.3%	49.0%
	White	5.4%	7.7%	9.2%	11.8%	7.0%	9.5%
	Coloured	25.3%	32.5%	29.2%	40.3%	27.1%	36.1%
	Asian	10.3%	16.2%	18.6%	33.1%	13.1%	22.0%

Source: Global Insight Southern Africa - Regional Economic Focus version 1.6i(190)

The Black population in Ekurhuleni experienced a marginal decline in employment as a percentage of the group's total population between 1996 and 2003. On closer inspection the sub-group has high levels of economic participation rates and unemployment levels consistent with that of the group on a national and provincial level. However, the Black population in Ekurhuleni had the highest population growth rate of all the population groups in all the areas. This has resulted in the Black population in Ekurhuleni not being absorbed in the labour market at the pace of population growth. This caused a general decline in the development prospects for the group in the area. As a result the Black community in Ekurhuleni struggles with the lowest level of human development as per the Human Development Index (HDI of 0.61) when compared to the other population groups in each area.

Nonetheless, population groups in Ekurhuleni generally enjoy a higher standard of living than the groups on a national level and between Ekurhuleni and Gauteng there appears to be very little differences in living levels. The most notable exception is that of the White population in Ekurhuleni, which has a lower HDI figure than that of the group on a national level in 2003

7 The expanded definition of unemployment includes persons who are unemployed and looking for work as well as persons who are unemployed and are not looking for work but would accept work if it was offered to them.

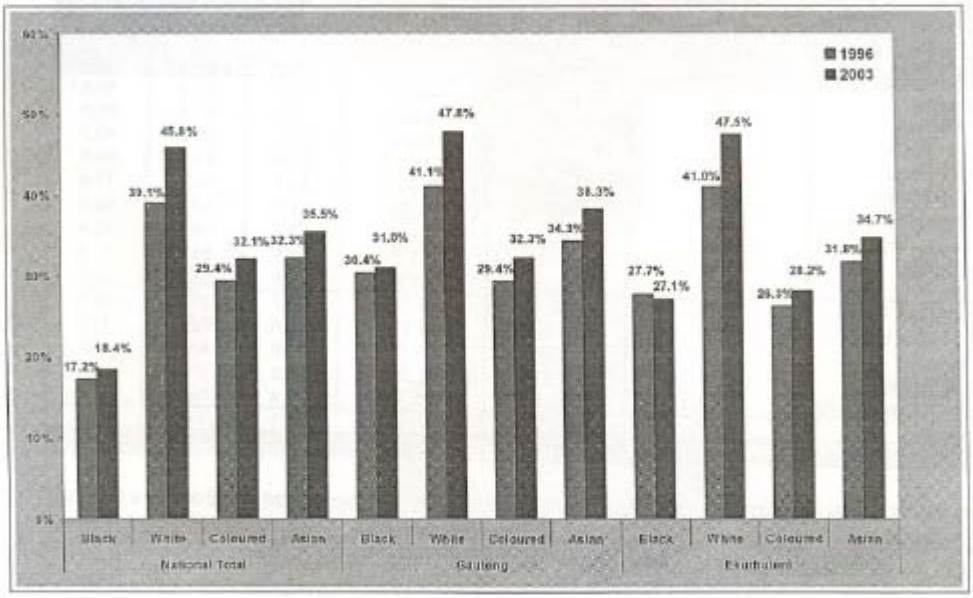
The Economically Active Population[8]

EAP as a % of population, per gender and area – 1996 & 2003

Area	Population Group	Male		Female		Total	
		1996	2003	1996	2003	1996	2003
National Total	Black	32.7%	40.3%	27.4%	33.2%	30.0%	36.7%
	White	48.2%	58.1%	35.3%	42.1%	41.7%	49.9%
	Coloured	41.2%	49.8%	33.1%	39.9%	37.1%	44.8%
	Asian	48.0%	59.1%	26.6%	32.4%	37.2%	45.5%
Gauteng	Black	50.0%	58.5%	44.3%	49.6%	47.3%	54.3%
	White	49.8%	54.3%	38.3%	45.3%	44.0%	52.3%
	Coloured	41.7%	51.1%	36.4%	44.5%	39.0%	47.7%
	Asian	49.1%	60.2%	27.9%	33.8%	38.6%	47.0%
Ekurhuleni	Black	49.7%	57.9%	42.8%	48.0%	46.5%	53.2%
	White	50.5%	60.5%	37.8%	44.7%	44.1%	52.5%
	Coloured	39.8%	48.7%	32.4%	48.7%	36.1%	44.1%
	Asian	47.7%	58.5%	25.3%	30.5%	36.6%	44.5%

Source: Global Insight Southern Africa - Regional Economic Focus REF version 1.6h (186)

Employment as a percentage of total group population – 1996 & 2003



If a certain population group has a high percentage of its population that are economically active, coupled with a low unemployment rate, the group will likely have a high employment to population ratio. This situation in itself will point towards a higher per capita income and a higher level of development for the group in general.

[8] The economically active population (EAP) is defined as the number of persons that are able and willing to work between the ages of 15 and 65. It includes both employed and unemployed persons. Persons who consider themselves unemployed and did not take recent active steps to find employment are considered part of the economically active population. The EAP is measured at place of residence.

Formal Employment estimates by area (2002)

2002 Estimates of formal employment	Ekurhuleni	Alberton	Benoni	Boksburg	Germiston	Kempton Park	Brakpan	Springs	Nigel
	Number	Percentage of Ekurhuleni							
1 Agriculture	7,151	6.6	6.8	17.1	14.1	14.4	7.9	9.3	21.8
2 Mining	12,935	5.2	7.9	38.1	2.0	0.6	13.9	30.5	0.8
3 Manufacturing	**147,619**	**14.4**	**8.2**	**12.7**	**24.7**	**22.3**	**4.0**	**9.5**	**4.2**
4 Electricity	6,894	12.3	8.7	9.9	33.2	18.1	9.5	5.1	3.2
5 Construction	29,292	14.1	12.0	15.7	20.8	21.4	6.5	6.0	3.5
6 Trade	130,115	12.9	11.4	16.2	20.5	22.2	4.7	8.1	3.9
7 Transport	52,305	10.4	9.2	12.1	16.7	35.9	4.3	8.9	2.6
8 Finance	87,729	11.6	10.8	17.0	23.9	21.8	4.0	8.3	2.6
9 Community services	100,829	13.9	15.2	13.3	19.2	18.2	6.1	9.6	4.4
Households	68,872	14.0	15.9	12.9	21.8	15.8	6.3	9.4	3.9
Total	643,749	12.9	11.4	14.8	21.3	21.4	5.1	9.2	3.9
Manufacturing	147,619	21.2	12.1	18.8	36.5	7.9	5.9	14.1	6.1
30 Food, beverages and tobacco products	14,815	14.3	5.9	12.5	22.9	13.9	2.9	6.9	2.5
31 Textiles, clothing and leather goods	4,476	11.3	15.0	11.2	18.4	4.0	4.1	7.3	16.2
32 Wood and wood products	15,527	13.2	8.9	9.7	23.9	9.5	3.4	19.8	1.6
33 Fuel, petroleum, chemical and rubber products	28,718	13.8	5.9	14.0	19.6	6.5	5.1	6.2	2.8
34 Other non-metallic mineral products	7,034	8.7	7.9	8.4	24.4	4.7	5.5	17.5	8.8
35 Metal products, machinery and household appliances	48,441	15.6	8.4	13.7	28.7	4.3	4.4	10.5	3.8
36 Electrical machinery and apparatus	11,406	14.3	11.8	11.0	32.6	4.0	1.3	4.1	1.0
37 Electronic, sound/vision, medical & other appliances	2,068	7.4	9.1	15.0	26.7	6.1	3.1	15.0	0.8
38 Transport equipment	9,798	14.1	9.7	13.8	17.4	6.3	3.5	4.6	12.9
39 Furniture and other items NEC and recycling	6,337	21.6	8.2	13.6	24.7	5.1	4.0	5.8	3.7

Employment and unemployment in 2002

Place	Economically active population (% of total population)	Total employment	Informal employment[14]	Unemployment rate (%) (expanded definition)		
				Male	Female	Total
Ekurhuleni	52	722,330	78,590	31.8	51.8	40.4
Alberton	53	95,421	12,059	36.8	58.7	46.3
Benoni	49	83,606	10,262	33.5	56.2	43.3
Boksburg	51.4	106,535	11,574	23.6	43.9	32.5
Germiston	59.3	149,875	12,976	14.8	20.6	17.4
Kempton Park	54.8	154,305	16,598	34.9	57.9	44.3
Brakpan	49.2	38,274	5,151	33.7	54.2	42.9
Springs	49.8	65,559	6,138	34.6	51.1	41.6
Nigel	44.7	28,756	3,832	33.6	55.6	42.9
City of Cape Town	47.3	1,017,391	99,744	22.7	31.6	26.8
Nelson Mandela	43.8	284,223	40,787	38.6	52.9	45.4
eThekwini	47.7	913,984	191,681	33.8	47.6	40
City of Tshwane	47.2	881,578	98,285	25.9	37.8	31.5
City of Johannesburg	55.1	1,333,885	141,151	27.4	39.4	32.9
Gauteng	52.7	3,313,828	348,323	26.9	44.9	34.8
National	38.3	10,437,165	1,683,788	32.6	50.7	40.8

The informal employment reported on is derived from theoretical models and is not supported by empirical studies or surveys in the area. A more accurate estimation would be possible if such studies were conducted.

Human development[9]

Gauteng has a higher level of development as opposed to South Africa as a whole. Ekurhuleni, on the other hand, falls a little behind Gauteng with a slightly lower HDI, although human development is still slightly higher than in South Africa on average. All of the regions however increased their standard of living from 1996 to 2003.

[9] The Human Development Index (HDI) is a composite, relative index that attempts to quantify the extent of human development of a community. It is based on measures of life expectancy, literacy and income. It is thus seen as a measure of people's ability to live a long and healthy life, to communicate, to participate in the life of the community and to have sufficient resources to obtain a decent living. The HDI can assume a maximum level of 1, indicating a high level of human development, and a minimum value of 0.

The Human Development Index (HDI) – 1996 & 2003

Area	1996	2003
National Total	0.56	0.59
Gauteng	0.67	0.69
Ekurhuleni	0.65	0.67

Source: Global Insight Southern Africa - Regional Economic Focus REF version 1.6h (186)

The standards of living are broadly the same for the population groups in Ekurhuleni relative to the same population groups in Gauteng. The white population group in Ekurhuleni has a noticeable lower standard of living relative to Gauteng, and is also the only subset that experienced a decline in the HDI from 1996 to 2003.

HDI per area and population group– 1996 & 2003

Area	Population Group	1996	2003
National Total	Black	0.46	0.52
	White	0.86	0.85
	Coloured	0.57	0.61
	Asian	0.72	0.74
Gauteng	Black	0.55	0.61
	White	0.87	0.87
	Coloured	0.68	0.72
	Asian	0.77	0.78
Ekurhuleni	Black	0.55	0.61
	White	0.86	0.84
	Coloured	0.67	0.70
	Asian	0.77	0.77

Source: Global Insight Southern Africa - Regional Economic Focus REF version 1.6h (186)

Human capital base

Metropolitan	1996				2002			
	No	Matric-	Matric	Matric+	No	Matric-	Matric	Matric+
Ekurhuleni	8.9	62.6	20.8	7.8	3.8	59.6	26.8	9.9
City of Cape Town	4.2	64.2	20.0	11.6	2.4	60.1	24.9	12.6
Nelson Mandela	5.6	69.9	17.3	7.3	2.7	67.7	20.4	9.2
Ethekwini	9.7	61.7	20.6	8.0	4.4	59.3	26.6	9.7
City of Tshwane	9.5	54.8	23.7	12.1	4.7	51.5	30.0	13.8
City of Johannesbu	6.5	58.6	24.1	10.8	2.6	53.8	30.8	12.8
National	16.2	62.2	15.2	6.4	8.7	63.7	19.5	8.1

The human capital base for the metropolitan areas for 1996 and 2002 for people older than 15 years of age is the foundation for the labour market. It appears that great strides have been made over this period to improve the human capital base. Ekurhuleni has also improved its position relative to the other metropolitan areas.

Notwithstanding this, there may be some issues with the quality of the education that come about, in particular, whether the education system is adequately preparing the children for the new weightless or knowledge economy. Of even greater concern is that the level of achievement in Mathematics by eighth graders in South Africa has dropped from a score of 278 in 1995 to 275 in 1999, whilst the international average score has increased from 519 to 521.

In addition, education is not uniform in the country and there are vast differences between provinces and metropolitan areas. Although it is not possible to quantify these differences it is sufficient to say that the differences in the quality of education

may be so large that it could have a material effect on the human capital in a metropolitan area as well as a province.

Contrasting population, employment, unemployment and income levels (2003 estimates)

Area	Population (number)	Employment (number)	Unemployment		Per capita income (Rand, current prices)
			Number	Rate	
National economy	46,710,858	10,758,120	7,473,617	41%	18,284
Gauteng	8,845,741	3,519,418	1,633,370	35%	35,768
Ekurhuleni	**2,534,180**	**763,763**	**537,530**	**40%**	**27,338**
Alberton	495,629	100,615	122,762	46%	22,205
Benoni	448,490	89,126	96,060	43%	22,664
Boksburg	319,533	113,151	53,682	32%	31,245
Germiston	192,567	158,052	199,05	17%	68,230
Kempton Park	543,486	160,618	134,643	45%	24,105
Brakpan	210,230	41,446	44,757	42%	19,905
Nigel	127,951	70,200	24,850	43%	19,470
Springs	196,294	30252	40,871	41%	26,542

The Supply and Demand for labour

Openness of economies of Metros

Metropolitan	1996	2002
Ekurhuleni	70.6%	94.1%
City of Cape Town	25.8%	47.0%
Nelson Mandela	53.5%	102.5%
eThekwini	53.2%	74.2%
City of Tshwane	27.6%	58.1%
City of Johannesburg	101.6%	107.6%
National	44.0%	60.6%

Ekurhuleni's economy opened up over time with the share of trade in gross value added having increased from 70.6% in 1996 to 94.1% by 2002.

Globalisation therefore has a definitive impact on the structure of production and on the demand for labour. Only Nelson Mandela and Tshwane opened up more than Ekurhuleni over this period, mainly due to the motor vehicles sector developments in these two metros.

The Impact of HIV and AIDS

The following are areas in which productivity is likely to be affected by HIVand AIDS:

- Increased absenteeism
- Increased compassionate leave
- Increased staff turnover
- Loss of skills
- Loss of tacit and institutional knowledge
- Declining moral

Another indirect consequence of AIDS indicated on the briefing is that access to capital is likely to be affected negatively. This will depend largely on the degree to which commercial perceptions of the HIV and AIDS pandemic are viewed by lending institutions and individuals. Overall, higher costs, lower productivity, skill shortages,

ANNEXURE G: LIST OF CLINICS

Name	Address	Type Detail	Sub District Nos	Ward No	Acceptable Structure
Alrapark Clinic	Peach Ave, Alrapark	Fixed Clinic	E1	88	yes
Andries Raditsela Clinic	1718 Phooko Drive, Tsakane	Fixed Clinic	E1	81	
Bakerton Clinic	1 Teabush Road, Bakerton	Satellite Clinic	E3	72	yes
Barcelona Clinic	Stand 17042 Ext 28, Barcelona	Fixed Clinic	E3	26	yes
Calcot Dlephu Clinic (Rockville)	9489 Kolobeng Street, Tsakane	Fixed Clinic	E1	84	
Dan Kubheka Clinic	701 Duduzile Street, Kingsway, Benoni	Fixed Clinic	E3	73	yes
Daveyton East Clinic (New)	Stand No 869, Chris Hani, Ext 9 Daveyton East	Fixed Clinic		68	
Daveyton Extension Clinic	14108 Tom Boya Street, Daveyton	Fixed Clinic	E3	68	
Daveyton Main Clinic & (Dental)	Stand 9307, Empilsweni Str, Daveyton	Fixed Clinic	E3	70	yes
Duduza Clinic & (Dental)	3 Nala Street, Duduza, Nigel	Fixed Clinic	E1	87	
Emaphupheni Clinic	13625 Ext 10, Emaphupheni	Fixed Clinic	E3	26	no
First Avenue Clinic & (Dental)	1 Avenue, Springs	Fixed Clinic	E1	76	no
Geluksdal Clinic & (Dental)	1 Uittog Ave, Geluksdal	Fixed Clinic	E1	82	
Joy Clinic	Stand 343, 4748 Etwatwa West	Fixed Clinic	E3	26	no
Kemston Clinic	98 Kemston Ave, Benoni	Fixed Clinic	E2	28	no
Kemston Mobile	98 Kemston Ave, Benoni	Mobile Clinic		closed	
Kingsway Clinic & (Dental)	113 E Kingsway Ave, Brakpan (Town Hall building)	Fixed Clinic	E2	75	no
Kingsway Mobile	113 E Kingsway Ave, Brakpan (Town Hall building)	Mobile Clinic		closed	
Kwathema CHC & (Dental & MOU)	7001 Moshoeshoe Str., Kwathema	CHC	E2	78	yes
Kwa-Thema Ext3 Clinic (New)	Stand No 25659, Kwa- Thema Ext3	Fixed Clinic		77	
Kwathema Mobile	7001 Moshoeshoe Str., Kwathema	Mobile Clinic	E2	80,77	
Kwathema Old Age Home	11472 Tokollo street, Kwathema	Satellite Clinic		77	
Lethabong Clinic	1038 c/o Ngengebule & Nkosi Street, Wattville	Fixed Clinic	E2	30	yes
Lucky Makwanazi Clinic (Zamani)	4073 Antherium, Zamani, Duduza	Fixed Clinic	E1	87	yes
Mary Moodley Memorial Clinic & (Dental)	732 Khan Crescent, Actonville	Fixed Clinic	E2	29	yes
Mary Moodley Memorial Mobile	732 Khan Crescent, Actonville	Mobile Clinic	E2	24,26	
Nigel Clinic	1 Court Street, Nigel	Fixed Clinic	E1	88	no
Nokuthela Ngwenya CHC & MOU	Vlakfontein Road, Private bag x 508, Dunnottar, 1590	CHC	E1	81	
Payneville Clinic	1868 Chikane Street, Payneville	Fixed Clinic	E3	72	yes
Phillip Moyo CHC & (Dental & MOU)	6944 Etwatwa Ext 9, Etwatwa	CHC	E3	26	yes
Phutanang Clinic	7255 Kgakga Street, Tsakane	Fixed Clinic	E1	84	no
Sead Clinic	1 Ntonga Street, Mashabaview, Duduza	Fixed Clinic	E1	86	yes
Simunye Clinic	20067 Ext 8, Tsakane	Fixed Clinic	E1	85	no
Sonto Thobela Clinic	Mkotane street 1832, Bluegum	Fixed Clinic	E1	86	yes
Thembelisha Clinic	11377 Mothlaping Street,	Fixed Clinic	E2	80	yes

	Kwathema				
Tsakane Clinic	10890 Zulu Street, Tskane	Fixed Clinic	E1	82	yes
Tsakane Mobile	10890 Zulu Street, Tskane	Mobile Clinic	E1	closed	
Welgedacht Clinic	c/o 4th Ave & Hera Rd, Welgedacht	Mobile Clinic		72	mobile point
White City Clinic	Thema Road, Kwathema, Springs	Fixed Clinic	E2	79	no
Bedfordview Clinic	3 Skeen Boulevard, Bedfordview	Fixed Clinic	N3	20	
Birchleigh Clinic	c/o Olienhout & Houtkapper Str. Birchleigh	Fixed Clinic	N3	15	
Birchleigh North Clinic	Coen Scholtz Centre, Mooifontein Road, Birchleigh North	Fixed Clinic	N2	14	
Bonaero Park Clinic	c/o Alder Grove & Louis Botha ave BONAERO PARK	Fixed Clinic	N2	23	Yes
Bromberg- Bapsfontein Clinic	Venter Centre, Old Pretoria Road	Fixed Clinic	N2	25	
Crystal Park Clinic	Stand 565, Strand Street, Crystal Park, Benoni	Satellite Clinic	N2	24	
Edenvale Clinic & (Dental)	c/o 8th Avenue & De Wet Road, Edenvale	Fixed Clinic	N3	19	
Edenvale Mobile	c/o 8th Avenue & De Wet Road, Edenvale	Mobile Clinic			
Erin Clinic	676 Tlama-Tlama Section Tembisa, Tembisa	Fixed Clinic	N1	7	
Esangweni Clinic & (Dental)	219 Esangweni Section, Tembisa	CHC	N1	10	
Ethafeni Clinic	43 Bennin Street, Ethafeni Section, Ethafeni Park	Fixed Clinic	N1	14	
Itereleng Clinic	Mokoena Drive, Phomolong	Fixed Clinic	N3	12	
Kempton Park Civic Centre Clinic	Civic Centre, c/o CR Swart & Pretoria Road, Kempton Park	Fixed Clinic	N3	16	Yes
Kempton Park Mobile	Civic Centre, c/o CR Swart & Pretoria Road, Kempton Park	Mobile Clinic	N2		
Klopper Park Clinic	Dries Klopper Hall, Kruin Street, Klopperpark	Satellite Clinic	N3	17	
Northmead Clinic & (Dental)	c/o Hospital & Aster St, Northmead	Fixed Clinic	N2	27	Yes
Olifantsfontein Clinic	c/o Reginald & Pearce street, Olifantsfontein	Fixed Clinic	N1	1	
Spartan Clinic	H Lewis Street, Spartan	Fixed Clinic	N1	17	
Tembisa Health Care Centre	19 Emkhathini Section, c/o Andrew Mapheto & George Nyanga Str, Tembisa	Fixed Clinic	N1	8	Yes
Tembisa Main Clinic	11 Isithebe Section Tembisa	Fixed Clinic	N1	5	
Wannenburg Clinic	10 -3rd Ave, Wannenburg	Satellite Clinic	N3	21	
Winnie Mandela Clinic	9044 Zone 6, Margaret Zuma Street, Tembisa	Fixed Clinic	N1	2	
Alberton North Clinic	c/o Hendik Potgieter & 2nd Ave, Alberton North	Fixed Clinic	S1	37	yes
Boksburg Civic Centre Clinic	Civic Centre Clinic, c/o Trichardt & Commisioner Road, Boksburg	Fixed Clinic	S1	32	
Boksburg North Clinic	Cason Road, Boksburg North (Behind Wrestling Hall)	Fixed Clinic	S1	32	
Brackenhurst Clinic	Roy Campbell Str, Brackenhurst	Fixed Clinic	S1	38	
Dawn Park Clinic (Villa Liza)	Rondebult Road, Dawn Park	Fixed Clinic	S3	43	
Dresser Clinic	2521 Everest, c/o Mokoena & Moepshe str, Thokoza	Fixed Clinic	S2	57	
Dukathole Clinic	9 th Street, Dukathole	Fixed Clinic	S1	35	
Edenpark Clinic	c/o Abram & Ferrari Str, Edenpark	Fixed Clinic	S2	53	
Elsburg Clinic & (Dental)	c/o Els and Voortrekker Str., Elsburg	Fixed Clinic	S1	39	yes
Freeway Park Clinic	Outspan Shopping Centre, Kingfisher Ave, Freeway Park,	Satellite Clinic	S1	42	

	Boksburg				
Germiston City Clinic	c/o Queen & Cross Street, Germiston	Fixed Clinic	S1	36	
Goba Clinic	310 Goba Section, Katlehong	Fixed Clinic	S2	55	yes
Jabulane Dumani CHC & (Dental & MOU)	257 Nguza Street, Ext 2, Vosloorus	CHC	S3	64	
Katlehong North Clinic	2110 Administration Block, Katlehong	Fixed Clinic	S1	40	
Khumalo Clinic	181 Seluma View, Katlehong	Fixed Clinic	S2	60	
Leondale Clinic	Community Hall, 19 Nerine Rd, Leondale	Fixed Clinic	S1	40	
Magagula Clinic	114 Silbuka St, Kanana	Fixed Clinic	S3	62	
Moleleki Clinic	7703 Moleleki Ext 2, Katlehong	Fixed Clinic	S3	63	yes
Motsamai Clinic	Motsamai Section, Katlehong	Fixed Clinic	S1	50	
Palmridge Clinic	RE 41 Palmridge Road, Palmridge Community Centre, Palmridge	Fixed Clinic	S2	58	
Phenduka Clinic	279 Madondo Street, Phenduka Section, Thokoza	Fixed Clinic	S2	54	yes
Pholapark Clinic & (Dental)	10054 Mzimkulu & Letutula St, Ext 5, Phola Park	CHC	S2	58	yes
Phomolong Mobile (Katlehong HCC)	Tsietsi Section,	Mobile Clinic	S2	61	
Ramokonopi Clinic	819 portion B, Ramokonopi West Section, Ramokonopi	CHC	S2	59	yes
Reiger Park Clinic & (Dental)	Leon Fereirra Drive, Reiger Park, Boksburg	Fixed Clinic	S1	34	yes
Rondebult Clinic (New)	Garlic Street, Rondebult	Fixed Clinic		41	new
Sunriseview Clinic	7871 Sunrise View, Katlehong	Satellite Clinic	S3	62	yes
Tamaho Cllinic	94 Mandela Section Katlehong	Fixed Clinic	S1	51	
Tswelopele Clinic	22 Leseka Street, Eastfield	Fixed Clinic	S3	44	
Van Dyk Park Clinic	Olive Street, Van Dyk Park Shopping Cnt, Van Dyk Park	Satellite Clinic	S1	31	

Vosloorus Ext 28 Clinic	Stand 20925, Nyamapanda Place Phase 1 Ext 28, Vosloorus	Fixed Clinic	S3	64	
Vosloorus Ext 9 Clinic	Marimba Gardens Vosloorus Vosloorus	Fixed Clinic	S3	46	
Vosloorus Poly Clinic & (Dental)	30 Ditshego Street, Vosloorus	Fixed Clinic	S3	47	
Vosloorus Poly Mobile	Ward 33	Mobile Clinic		47	
Zonkizizwe 1 Clinic	1400 Zone 4, Zonkizizwe	Fixed Clinic	S3	62	
Zonkizizwe 2 Clinic	5306 Zone 5, Zonkizizwe	Fixed Clinic	S3	62	
NEW & PLANNED FACILITIES					
Nigel Clinic	address not known yet.		E1	88	new
Endayeni	c/o James Moleya & 1st street, Endayeni	Fixed (being built)	N1	11	
Tswelopelo WM (Deduza)	857 Southern Way, Tswelopele	Fixed (being built)	N1	2	
Greenfields	address not known yet.	Fixed (being built)	S2	61	new

ANNEXURE H: EMM DEPARTMENT OF HEALTH BUDGET (EXAMPLE).

EKURHULENI METROPOLITAN MUNICIPALITY

MONTHLY OPERATING STATEMENT
For the Month Ended July 31, 2005

HEALTH and SOCIAL DEVELOPMENT

	CURRENT YEAR 2005 / 2006			
	BUDGET ANNUAL	**ACTUAL Y. T. D.**	**UNEXPENDED BUDGET**	**PERCENTAGE SPENT**
INCOME				
Property Rates	R 0	R 0	R 0	
Plus Penalties Imposed	R 0	R 0	R 0	
User Charges for Services	R 0	R 0	R 0	
Regional Services Levies	R 0	R 0	R 0	
Rent of Facilities and Equipment	R 0	R 0	R 0	
Interest Earned - External Investments	R 0	R 0	R 0	
Interest Earned - Outstanding Debtors	R 0	R 0	R 0	
Dividends Received - External Entities	R 0	R 0	R 0	
Fines	R 4,500	R 929	R 3,571	
Licenses & Permits	R 4,500	R 185	R 4,316	
Income for Agency Services	R 0	R 0	R 0	
Operating Grants & Subsidies	R 58,400,100	R 15,313,724	R 43,086,376	
Other Income	R 1,505,100	R 3,839	R 1,501,261	
Gain on Sale of Assets	R 0	R 0	R 0	
OPERATING INCOME GENERATED	**R 59,914,200**	**R 15,318,676**	**R 44,595,524**	
Less: Income foregone	R 0	R 0	R 0	
TOTAL OPERATING INCOME	**R 59,914,200**	**R 15,318,676**	**R 44,595,524**	
Internal Transfers:				
Interest Received - Internal Loans	R 0	R 0	R 0	
Redemption Received - Internal Loans	R 0	R 0	R 0	
Dividends Received - Internal	R 0	R 0	R 0	
Internal Recoveries	R 0	R 0	R 0	
Internal Transfers - sub-total	R 0	R 0	R 0	
NET OPERATING INCOME	**R 59,914,200**	**R 15,318,676**	**R 44,595,524**	

EXPENDITURE				
Employee Related Costs - Salaries & Wages	R 159,235,221	R 483	R 159,234,738	
Employee Related Costs - Social Contributions	R 49,298,696	R 0	R 49,298,696	
Less Employee Costs Capitalized	R 0	R 0	R 0	
Less Employee Costs Allocated to Operating	R 0	R 0	R 0	
Remuneration of Councillors	R 0	R 0	R 0	
Bad Debts (Provision for Bad Debts)	R 0	R 0	R 0	
Collection Costs	R 0	R 0	R 0	
Depreciation	R 13,576,601	R 0	R 13,576,601	
Repairs and Maintenance - External	R 5,998,022	R 355,845	R 5,642,177	
Repairs and Maintenance - Internal	R 1,541,876	R 21,741	R 1,520,136	
Interest Expense - External Borrowings	R 0	R 0	R 0	
Redemption Payments - External Borrowings	R 0	R 0	R 0	
Bulk Purchases	R 0	R 0	R 0	
Contracted Services	R 2,693,800	R 49,891	R 2,643,909	
Grants & Subsidies Paid	R 0	R 0	R 0	
General Expenses - Other	R 19,903,734	R 547,810	R 19,355,924	
Loss on Sale of Assets	R 0	R 0	R 0	
TOTAL OPERATING EXPENDITURE	**R 252,247,950**	**R 975,770**	**R 251,272,180**	
Internal Transfers:				
Interest - Internal Borrowings	R 0	R 0	R 0	
Redemption - Internal Borrowings	R 0	R 0	R 0	
Internal Charges	R 22,354,837	R 0	R 22,354,837	
Internal Transfers - sub-total	R 22,354,837	R 0	R 22,354,837	
NET OPERATING EXPENDITURE	**R 274,602,787**	**R 975,770**	**R 273,627,017**	
OPERATING SURPLUS/(-DEFICIT)	**-R 214,688,587**	**R 14,342,906**	**-R 229,031,493**	

ANNEXURE I: EKURHULENI GROWTH AND DEVELOPMENT STRATEGY 2025

EKURHULENI GROWTH AND DEVELOPMENT STRATEGY, 2025

EXECUTIVE SUMMARY

Eum, 2011, Ekurhuleni Growth and Development Strat 2025

TABLE OF CONTENTS

SUPPORTING DOCUMENTS

United Nations Human Development Report, 2003 – Millennium Goals

National Spatial Development Perspective.

2014 National Government Strategy and Plan of Action

Gauteng GDS, 2005

Discussion Document: Building Gauteng as a Globally Competitive City-Region

Joburg 2030

Tshwane City Strategy

Ekurhuleni Integrated Development Plan, 2005

Ekurhuleni Spatial Development Framework, 2004

Ekurhuleni Development Corridors Study, 2004

Ekurhuleni Regional Retail Sector Investigation, 2004

Strategy for the Ekurhuleni Core Economic Development Triangle, 2004

Ekurhuleni Strategic Integrated Transport Plan, 2003

Ekurhuleni Draft Stormwater Management Plan

Ekurhuleni Water Services Development Plan, 2002

Ekurhuleni State of the Environment Report, 2004

Ekurhuleni NSDR Environmental Management Framework, 2005

Ekurhuleni LED Policy, Strategy & Implementation Framework

Ekurhuleni Housing Integrated Development Plan, 2005

District Health Plan for Ekurhuleni, 2003

Ekurhuleni Disaster Management Policy

1. INTRODUCTION

Ekurhuleni Metropolitan Municipality (EMM) was established in 2000 with the amalgamation of eleven East Rand local authorities during the final phase of local government rationalization and transformation in post-apartheid South Africa.

The socio-economic and spatial challenges caused by apartheid social engineering cannot be solved over the short term – they call for a response which is both strategic and long term in nature. EMM recognized this and in 2004 embarked on a process to formulate a long-term development strategy.

During a Mayoral Committee workshop on 29 January 2005 it was resolved to term the strategy the "Ekurhuleni Growth and Development Strategy (GDS), 2025". A GDS Steering Committee comprising of the senior management of the Municipality, supported by a Political Oversight Committee of MMC's, formulated the strategy, and in June 2005 the draft GDS was introduced to and discussed with the broader community. The final GDS document was approved by the EMM Council in August 2005.

The GDS is a strategy for all sectors of society. It is intended to build a common vision and purpose across traditional barriers between government, the private sector and civil society. The GDS provides a framework and point of reference for all the EMM's plans, policies and strategies in its various areas of operation. The broad development strategies and targets contained in the GDS will be further contextualized and refined in the IDP and in the various sectoral strategies and policies of the metro.

2. STATUS QUO ANALYSIS

2.1 EKURHULENI IN CONTEXT

Ekurhuleni covers the eastern part of Gauteng from Germiston in the west to Springs in the east. It has a total land area of ±2000km², accommodating ±2.5 million people.

The Ekurhuleni Metropolitan economy is larger and more diverse than that of many of the smaller countries in Africa, including all the countries in Southern Africa. It accounts for nearly a quarter of the Gauteng economy, which in turn contributes over a third to the national GDP. Ekurhuleni contributes ±7% to the country's spending power and ±7.4% to the nation's production. Because of the largest concentration of industry in the whole of South Africa [and in Africa], Ekurhuleni is often referred to as "Africa's Workshop".

Ekurhuleni has a network of roads, airports, rail lines, telephones, electricity grid and telecommunications that rivals that of Europe and America – a first world infrastructure supporting a well established industrial and commercial complex. Ekurhuleni can in fact be regarded as the transportation hub of the country. The municipality is home to the Johannesburg International Airport [JIA], the busiest airport in Africa. South Africa's largest railway hub is in Ekurhuleni [Germiston] and links the city with all the major population centres and ports in the Southern African region. A number of South Africa's modern freeways and express-ways connect Ekurhuleni with other cities and provinces.

The EMM's annual budget is in the region of R10 billion, of which ±R1 billion is annually being budgeted for capital projects in line with the priorities set in the Integrated Development Plan [IDP]. The bulk of this expenditure is dedicated to upgrading facilities and infrastructure backlogs that resulted from apartheid.

2.2 BROAD OVERVIEW

The GDS 2025 follows a landscape approach, describing the status quo in terms of three broad development landscapes, namely the **physical, economic** and **social development landscapes.** The main characteristics of each development landscape are summarized hereunder. These characteristics determined the focus areas around which the GDS was formulated.

2.2.1. PHYSICAL DEVELOPMENT STATUS QUO

- Ekurhuleni **lacks a clear identity** and should find innovative ways of creating a unique identity for itself.

  * Nine CBD's
  * No clearly identifyable core area.
  * No central theme.

- Ekurhuleni is a **spatially fragmented, inequitable city**.

  * Conglomeration of nine East Rand towns.
  * Large vacant land parcels in the mining belt around the urban core.
  * Low development densities.
  * Historically disadvantaged communities situated on the urban periphery.

- Many areas in the city have poor **transportation linkages and mobility is low.**

  * High levels of congestion on national and provincial road network and freeway interchanges.
  * Large parts of the planned provincial road system not built.
  * Inadequate linkages between certain nodes in the EMM.
  * 22% of the municipal road network still gravel.
  * Good rail network – underutilised.
  * Lack of integrated public transport nodes/systems.

- Many areas in the city have **ageing and poorly-maintained trading services infrastructure** and many communities have **inadequate access to basic services.**

  * Services infrastructure in the core areas of the municipality is old, inadequately maintained and subject to frequent breakdowns.
  * Infrastructure backlogs are experienced in the township areas and informal settlements.

- Ekurhuleni is characterised by large areas of degraded **environment** [e.g. old mining areas, industrial areas], however, some unique environmental opportunities [e.g. the wetlands] have also been identified.

  * Environmental degradation due to mining activities, urbanisation and industrialisation.
  * Environmental problems include dolomite, mining, informal settlements, industry, pollution.
  * Environmental opportunities include rivers and wetlands, ridges, agricultural potential.

- Many areas in the city are decayed and are in need of **urban renewal,** but at the same time present an opportunity to capitalise on existing infrastructure to build vibrant urban communities.

  * Decaying inner-city and poorly performing urban areas.

- Current **ICT infrastructure is inadequate** to accommodate the rapid technological growth which is required.

* Inadequate infrastructure [e.g. broadband] to accommodate potential demand, especially in high-tech hubs, e.g. around JIA.

2.2.2 Economic Development Status Quo

- The local **economy** requires a greater degree of **sustainable diversification.**
  * Local economy is dominated by the manufacturing sector.

- As elsewhere in South Africa, unemployment is high, and policies to promote **labour absorption and job creation** will be of crucial importance to the future of the city.
  * Current unemployment rate of ±40%.

- The **improvement of skills levels** to attract and support local economic growth is of critical importance
  * Literacy rate of 84%.
  * Technical skills levels are low and not a good fit for the skills demands of the local economy.
  * Low computer literacy.

- Ekurhuleni is a gateway into Africa and opportunities for **tourism promotion and development** locally should be taken advantage of.
  * JIA is a gateway into Africa.
  * Opportunities for business and retail tourism.
  * Klipriviersberg, Wetlands and Bird Sanctuaries

- No city can survive without new investment [into physical, economic and social infrastructure] and **investment promotion and facilitation** will therefore be a key focus area.
  * Varying levels of investment throughout the Metro.
  * Opportunity to attract entrepreneurs.

- The greatest portion of the wealth in the city is still in the hands of a small elite, and **broad-based economic transformation** as well as entrepreneurial activity will therefore be promoted at every opportunity.
  * Skewed distribution of wealth and resources.

2.2.3 Social Development Status Quo

- The levels of **poverty and unemployment** in Ekurhuleni are unacceptably high, and need to be addressed in a sustainable way.
  * ±30% of the local population live in poverty.
  * Current unemployment rate is ±40%.
  * Majority of people below the poverty line live on the urban periphery, far away from job opportunities and social amenities.

- Many people in Ekurhuleni still live in informal settlements without adequate access to engineering and social infrastructure, and the **creation and promotion of sustainable human settlements** is therefore an important priority.

  * Current housing backlog : 134 000 shacks in informal settlements and 36 000 backyard shacks. Overcrowding. Influx to continue.
  * Many informal settlements situated on land not suitable for housing.
  * Past subsidy schemes resulted in monofunctional, non-sustainable areas.
  * Scarcity of well-located land suitable for housing development.

- High levels of **HIV/Aids and other poverty–related disease** are experienced in the poor communities and **access to health care** is inequitable.

  * High rates of HIV/Aids and other poverty related diseases such as TB.
  * High rate of infant and child malnutrition.

- The crime rate is unacceptably high and a higher level of **safety and security** for the inhabitants of the city will be pursued.

  * High crime and domestic violence rates.
  * Various disaster risks, e.g. the airports, gas pipelines, old mining areas, etc.

- The city is characterised by **inadequate and inequitable** provision and **poorly-maintained parks, sports/recreational facilities, public places and cemeteries.**

  * Parks and sports facilities are generally poorly maintained.
  * Underprovision in previously disadvantaged areas.
  * Green areas are fragmented, disjointed – no central theme.

3. VISION, MISSION & VALUES

The strategic focus of the Ekurhuleni GDS 2025 is to build on the **vision** of the Ekurhuleni Metropolitan Municipality :

The Smart, Creative and Developmental City.

It is based on this vision that a mission statement was developed, as a way of forging ahead for achievement. The **mission statement** is as follows :

Ekurhuleni provides sustainable and people centred development services that are affordable, appropriate and of high quality. We are focused on social, environmental and economic regeneration of our city and communities, as guided by the principles of Batho Pele and through the commitment of a motivated and dedicated team.

In pursuing the above-mentioned vision and mission the EMM is committed to uphold the following **core values :**

- **Performance Excellence**
- **Integrity**
- **Community Centeredness**
- **Transparency**
- **Cooperative Governance**

4. GROWTH AND DEVELOPMENT 2025 AGENDA

4.1 PHYSICAL DEVELOPMENT AGENDA AND STRATEGY

4.1.1 KEY FOCUS AREA : IDENTITY

- **2025 AGENDA : A well-developed and vibrant core economic area which imparts a unique character and identity to Ekurhuleni.**

- STRATEGIC IMPERATIVES AND GUIDELINES

  * The core economic development triangle situated between the Kempton Park, Germiston, Boksburg and Benoni CBD's will receive priority in terms of future investment.

  * The influence of the JIA and the potential spin-offs from the adjacent Blue IQ projects [Gautrain and IDZ] will be maximized by means of further infrastructural investment.

  * A number of urban regeneration projects will be launched in the triangle, of which the proposed Germiston Government Precinct will be the first.

4.1.2 KEY FOCUS AREA: SPATIAL DEVELOPMENT

- **2025 Agenda: An Integrated and Equitable City**

- STRATEGIC IMPERATIVES AND GUIDELINES

  * The prevailing pattern of outward urban growth and expansion will be redirected inwards. No urban development will be allowed outside the urban edge as demarcated in the SDF.

  * Infill development will be promoted at all times, especially in and around the urban core areas.

  * Accessibility to the urban core areas will be improved.

  * The old, degraded mining areas will be upgraded and rehabilitated and developable vacant land parcels will be released for development.

  * Existing informal settlements in the core areas will be upgraded or removed.

  * Private development in the core areas will be incentivised and rewarded.

4.1.3 KEY FOCUS AREA : ROADS AND TRANSPORT

- **2025 AGENDA : High quality, integrated and well-maintained transportation infrastructure, integrated public transport systems, ensuring a high degree of mobility and choices to commuters.**

- STRATEGIC IMPERATIVES AND GUIDELINES

  * An integrated land use / transportation plan will be undertaken.

  * EMM will lobby for the extension of the current freeway and provincial road system.

  * EMM will continue to improve its own road system.

  * Public transport will be promoted through a range of initiatives, including:
    - densification along major corridors;

- promotion of more effective services; and
- integration of public transport modes and systems.

* Alternative modes of transport such as walking and cycling will be promoted.

4.1.4 KEY FOCUS AREA : SERVICES INFRASTRUCTURE

- **2025 AGENDA : High quality and well-maintained services, equitable services throughout the urban areas.**
- **STRATEGIC IMPERATIVES AND GUIDELINES**

  * Densification and infilling will be promoted to ensure maximum, cost-effective utilization of existing infrastructure.

  * Equity in service provision will be ensured by eliminating the backlogs in the townships and informal settlements. High-growth areas in Ekurhuleni will, however, not be neglected.

  * Water savings will be promoted and alternative energy sources will be explored.

4.1.5 KEY FOCUS AREA : ENVIRONMENT

- **2025 AGENDA : A substantial increase in the general quality of the environment.**
- **STRATEGIC IMPERATIVES AND GUIDELINES**

  * Environmental upgrading in areas such as the mining belt and the old industrial areas will be a major focus in years to come.

  * Ekurhuleni's unique environmental assets, eg. the wetlands and water bodies, will be protected and improved.

  * Sustainable development within the parameters set by the EMF will be pursued.

4.1.6 KEY FOCUS AREA : URBAN RENEWAL

- **2025 AGENDA : Functional, sustainable, and attractive urban areas**
- **STRATEGIC IMPERATIVES AND GUIDELINES**

  * The focus will be on all poorly performing "urban economy areas", not only on the CBD's.

  * A long term urban renewal strategy and institutional vehicle will be developed.

  * EMM will provide a co-ordination function and strategic advice to development agencies in the private and public sectors.

4.1.7 KEY FOCUS AREA : ICT INFRASTRUCTURE

- **2025 AGENDA : Productive and resourceful application of ICT.**
- **STRATEGIC IMPERATIVES AND GUIDELINES**

  * EMM will on an ongoing basis liaise and co-operate with the main service providers.

* Broadband infrastructure will be provided in selected priority high-tech hubs (eg. the JIA and surrounds).

* EMM will work jointly with Joburg and Tshwane to promote the "Smart Province" concept.

4.2 ECONOMIC DEVELOPMENT AGENDA AND STRATEGY

4.2.1 KEY FOCUS AREA : ECONOMIC DIVERSIFICATION

- **2025 AGENDA : A diversified local economy able to meet local needs, support sustainable development and adapt to changes in accordance with global demands and shifts.**

- STRATEGIC IMPERATIVES AND GUIDELINES

  * Value-added manufacturing and beneficiation will be promoted.

  * Further development of the transport and logistics industries will be promoted.

  * Intensive agriculture will be promoted, including organic food production, aquaculture and the beneficiation of agricultural products.

  * Small-scale mining opportunities will be promoted.

4.2.2 KEY FOCUS AREA : JOB CREATION

- **2025 AGENDA : Unemployment to be reduced by half in 2014 and by half again in 2025 based on the unemployment figures of 2004.**

- STRATEGIC IMPERATIVES AND GUIDELINES

  * Skills development programmes should be aligned with the needs of the local economy.

  * EMM will work towards a climate which is conducive to entrepreneurial activities.

  * EMM will implement labour-intensive public works programmes.

  * EMM will promote local employment creation as part of its procurement supply chain process.

4.2.3 KEY FOCUS AREA : SKILLS DEVELOPMENT

- **2025 AGENDA : A skilled community exhibiting capabilities in self–reliance, innovation and continued reskilling to meet the needs of a growing economy**

- STRATEGIC IMPERATIVES AND GUIDELINES

  * Information on local skills needs and gaps will be fed into the national skills development strategy.

  * Entrepreneurial skills development will be promoted en encouraged.

  * EMM will lobby for tertiary learning institutions and research and development facilities.

  * EMM library services will be utilized in skills development initiatives.

* EMM procurement policy will promote and encourage skills transfer.

4.2.4 KEY FOCUS AREA : TOURISM

- **2025 AGENDA : To promote the economy of the region, create jobs and a safe and secure environment, by establishing a tourism destination of choice.**
- STRATEGIC IMPERATIVES AND GUIDELINES
  * Opportunities presented by the JIA gateway into Africa will be utilized. Business and shopping tourism will be specifically promoted.
  * The townships and wetland areas are recognized as potential tourism drawcards and will feature strongly in the EMM's tourism development strategy.
  * EMM will promote and lobby for the establishment of a regional tourism organisation as well as the development of a gateway information centre at the JIA.

4.2.5 KEY FOCUS AREA : INVESTMENT PROMOTION

- **2025 AGENDA : Increased inward investment in skills and technology, property and sustainable development.**
- STRATEGIC IMPERATIVES AND GUIDELINES
  * The provision of quality services at affordable, competitive prices, prompt, efficient service and a safe, secure environment will be the primary tools at the disposal of the EMM to promote ongoing investment and development.
  * EMM will develop effective information dissemination and marketing programmes.
  * The "Customer Care Centre" concept will ensure effective service delivery.

4.2.6 KEY FOCUS AREA : ECONOMIC TRANSFORMATION

- **2025 AGENDA : An inclusive, wealth-generating economy.**
- STRATEGIC IMPERATIVES AND GUIDELINES
  * EMM's procurement policy will reflect the desire to achieve broad-based economic transformation.
  * The informal sector of the economy will be supported through various means.
  * Skills development will be promoted and supported.
  * EMM will leverage its assets to promote BBBEE.

4.3 SOCIAL DEVELOPMENT AGENDA AND STRATEGY

4.3.1 KEY FOCUS AREA : POVERTY AND UNEMPLOYMENT

- **2025 AGENDA : In line with the national objective, the aim is to halve poverty in the next 10 years up to 2015, and to halve it again in the following 10 years, up to 2025.**

- **STRATEGIC IMPERATIVES AND GUIDELINES**

  * Sustainable job creation in excess of new entrants into the labour market will be pursued.

  * Skills development, and specifically entrepreneurial skills development, will be promoted.

  * EMM will lobby for public investment initiatives and public works programmes.

  * Sustainable urban agriculture and small-scale farming initiatives will be targeted as an important mechanism to ensure food security for the poor.

4.3.2 KEY FOCUS AREA : HUMAN SETTLEMENTS.

- **2025 AGENDA : All people in Ekurhuleni to be housed in integrated and functional sustainable human settlements.**

- **STRATEGIC IMPERATIVES AND GUIDELINES**

  * Housing infilling and densification will be prioritized.

  * Housing provision will be integrated with engineering and social services provision. Sustainable communities will be created.

  * A functioning property market will be created through the development of mixed income human settlements.

  * A range of alternative housing typologies and tenure options will be provided.

4.3.3 KEY FOCUS AREA : HEALTH CARE AND FACILITIES

- **2025 AGENDA : Equitable health care and facilities across all sectors of society – substantially reduced rates of poverty–related disease.**

- **STRATEGIC IMPERATIVES AND GUIDELINES**

  * EMM recognizes that the best way to fight disease is to reduce poverty and to ensure increased access to shelter and basic services.

  * EMM will promote improved co-operation and co-ordination between all role players in the health sector.

  * EMM will ensure better access to primary health care facilities.

  * Community involvement and awareness will be promoted.

4.3.4 KEY FOCUS AREA : SAFETY AND SECURITY

- **2025 AGENDA : A high level of safety and security – a drastically reduced crime rate.**

- **STRATEGIC IMPERATIVES AND GUIDELINES**

  * EMM recognizes the correlation between poverty and the safety and security risk in communities. Strategies aimed at economic growth and poverty relief is relevant to this sector.

* EMM will promote improved co-operation and co-ordination between all role players in the safety and security sector.

* Community education and involvement will be promoted.

* A range of programmes will be undertaken, including the establishment of precinct police stations, installation of CCTV surveillance systems and ongoing modernization of fleet and equipment.

4.3.5 KEY FOCUS AREA : PARKS, SPORTS AND RECREATIONAL FACILITIES

- **2025 AGENDA : Ekurhuleni to have world-class parks, sports and recreational facilities.**

- **STRATEGIC IMPERATIVES AND GUIDELINES**

  * Facilities will be clustered in strategic localities. Multi-functional sports and recreation nodes will be developed.

  * With regard to sporting facilities, the successful staging of international events, in particular the 2010 Soccer World Cup tournament, is a key priority, and to this end the EMM will work closely with the various organising bodies.

  * As far as parks and recreational facilities are concerned, selected existing well-developed and maintained regional facilities will be further upgraded and extended to become flagship facilities.

  * A regional open space system will be developed, predicated mainly on the natural features in the region, such as the various streams, dams, pans, wetlands and ridges in the metro.

  * EMM will focus on the aesthetic upgrading of high-visibility areas, such as the main entrances to the city, areas abutting the freeways and main arterials, and the area around the JIA.

5. GOOD GOVERNANCE AND IMPLEMENTATION

5.1 GOOD GOVERNANCE PRINCIPLES

The EMM will adhere to *inter alia* the following general principles pertaining to good governance:

- **Leadership**
  Sound political and management leadership is required to steer the EMM towards the fulfillment of its vision, mission and the desired GDS outcomes.

- **Service Delivery**
  Better service delivery through the principles of Batho Pele will underpin all activities which the EMM are engaged in.

- **Discipline**
  Corporate discipline is a commitment by the EMM's senior management to adhere to behaviour that is universally recognised and accepted to be correct and proper.

- **Transparency**
  Transparency is the ease with which an outsider is able to make meaningful analysis of the EMM's actions, its economic fundamentals and the non-financial aspects pertinent to the organisation. It reflects whether or not stakeholders obtain a true picture of what is happening inside the organisation.

- **Independence**
  Independence is the extent to which mechanisms have been put in place to minimise or avoid potential conflicts of interest that may exist.

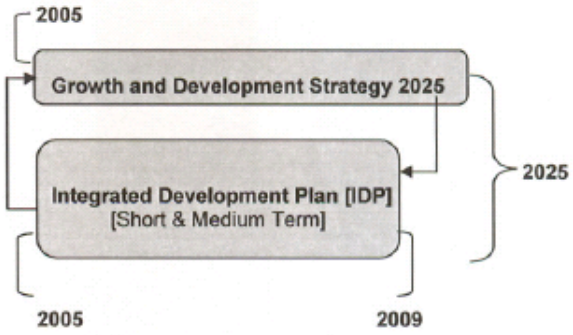
- **Accountability**
  Individuals or groups in the EMM, who make decisions and take actions on specific issues, need to be accountable for their decisions and actions. Mechanisms must exist and be effective to allow for accountability.

- **Responsibility**
  With regard to management, responsibility pertains to behaviour that allows for corrective action and for penalising mismanagement.

- **Fairness**
  The systems that exist within the EMM must be balanced in taking into account all those that have an interest in Ekurhuleni and its future. The rights of various groups have to be acknowledged, respected and balanced against each other.

5.2 GDS IMPLEMENTATION MECHANISM

The implementation of the GDS agenda will take place through the IDP. The linkage between the GDS and IDP is shown schematically hereunder:



The IDP in turn determines the budget which, together with detail performance management targets, will ensure implementation of projects and service delivery.

5.3 KEY FOCUS AREA OUTCOMES AND MILESTONES

Specific outcomes and milestones have been set for each GDS focus area, as indicated hereunder. These will be further refined in the IDP.

KEY FOCUS AREA OUTCOMES AND MILESTONES		
KEY FOCUS AREA	**2025 AGENDA**	**OUTCOMES AND MILESTONES**
PHYSICAL DEVELOPMENT		
Identity	A well-developed and vibrant core economic area which imparts a unique character and identity to Ekurhuleni	• An identified core economic area : * Area identified in **2004** to be prioritized i.t.o. development. • Increased development and investment in the core economic triangle of Ekurhuleni: * Gautrain construction and related development adjacent to JIA.

KEY FOCUS AREA OUTCOMES AND MILESTONES		
KEY FOCUS AREA	**2025 AGENDA**	**OUTCOMES AND MILESTONES**
		* Successful development of the R21 corridor. * Successful development of the Government Precinct in Germiston. * Subsidy-linked housing development in the mining belt.
Spatial Development	An integrated and equitable city.	• Improved accessibility and mobility throughout the metropolitan area. • Strong east-west corridor along the N12 / N17 freeways and north-south corridor along the R21 freeway. • Densified urban areas – infill development on vacant and underutilized land between the urban core and the peripheral township areas. • A managed and respected urban edge.
Roads & Transport	High quality, integrated and well-maintained transportation infrastructure, integrated public transport systems, ensuring a high degree of mobility and choices to commuters.	• Effective and integrated planning and implementation: * Integrated Transport Plan in place by **2007**. * Transport Authority established by **2009.** * Road Agency established by **2012.** • High quality integrated and well-maintained infrastructure : * Roads building programme in place by **2006**. * Current backlog of gravel roads to be eradicated in 2015. • Additional freeways built : * Upgrading R21 and R24 for additional capacity and HOV lanes by **2010**. * PWV 13/14 built by **2020**. * PWV 15 built by **2025**. • A strategic network of public transport corridors providing sub-regional linkages. • Improved usage of public transport services : * Taxi recapitalization by **2010.** * Modal integration for public transport to Gautrain by **2010**. * Bus services to cover all areas in Ekurhuleni by **2015**. * Transport information center established by **2020**. * Start building additional rail linkages by **2020**. * Modal transfer facilities provided at all stations by **2025**. • More use of non-motorised transport: * Pedestrian and bicycle-strategies in place by **2007**.
Services infrastructure	High quality and well-maintained services, equitable services throughout the urban areas	• Well-maintained services in all areas. * All maintenance backlogs to be eradicated by **2010**. • All communities to have equitable access to services: * All people to have access to potable water by **2008**. * All people to have access to basic sanitation services by **2010**. * All people to have access to electricity by **2012**. • More sustainable disposal of solid waste: * Comprehensive waste minimization strategy [including recycling] to be in place by **2007**.

KEY FOCUS AREA OUTCOMES AND MILESTONES		
KEY FOCUS AREA	**2025 AGENDA**	**OUTCOMES AND MILESTONES**
		• Improved stormwater management : * Stormwater Masterplan to be in place by **2007**. * Stormwater system backlogs to be eradicated by **2020**.
Environment	A substantial increase in the general quality of the environment	• A clearly defined and functional open space network: * Open space plan to be finalised by **2007**. * 50% of open space system to be developed by **2015**. * 100% of open space system to be developed by **2025**. • All development to be guided by an EMF: * EMF's for the entire Ekurhuleni area to be in place by **2006**. • Measurable decline in land, water and air pollution : * Pollution monitoring systems to be in place by **2010**. • Measurable increase in the utilisation of alternative energy sources: * Strategy to be in place by **2010**. • Substantial environmental improvement in the mining belt: * Implementation of Hloekisa project to commence by **2006**. * All mine dumps/slimes dams with economically viable mineral content to be removed by **2025**. * All other mine dumps/slimes dams to be rehabilitated to acceptable standards by **2025**. • Integrated and sustainable protection of natural resources: * Wetland conservation strategy and programme to be in place by **2007**.
Urban renewal	Functional, sustainable, and attractive urban areas	• Normalisation of urban economy areas reflected through minimal vacancy rates, high investor confidence and high demand for expansion. Quality public environment guiding, promoting and sustaining private investment and development expansion in urban economy areas. Supportive institutional capacity, commitment and approach. * By **2010** : - Basic prerogatives for implementation in place: - Service delivery, security, incentives, land use support, initial catalysts. - Administrative structure in place ensuring accountability and support. - PPP's in place. - Development agency in place. * By **2015** : - Committed public investment framework and programme. - Committed large-scale private investments. - Measurable and sustainable growth in urban economy areas.
ICT Infrastructure	Productive and resourceful application of ICT.	• World-class ICT infrastructure in support of the Gauteng "Smart Province" vision and economic growth in Ekurhuleni. * Institutional structure to support/accommodate external ICT focus by **2006**. * 100% Synergy and connectivity with our development partners, including government, by **2010**.

KEY FOCUS AREA OUTCOMES AND MILESTONES		
KEY FOCUS AREA	**2025 AGENDA**	**OUTCOMES AND MILESTONES**
ECONOMIC DEVELOPMENT		
Economic Diversification	A diversified local economy able to meet local needs, support sustainable development and adapt to changes in accordance with global demands and shifts.	• Sustainable growth in a variety of local economic sectors. * By **2010** : - A range of Government incentives to be in place. - A measurable increase in "Smart Industries" [Aerospace, I.T., Logistics, Plastics, Agro-processing]. * By **2015**: - A measurable increase of exports into Africa.
Job Creation	Unemployment to be reduced by half in 2014 and by half again in 2025 based on the unemployment figures of 2004.	• Reduced unemployment. * EMM Job summit to be held in **2006**. * 50% reduction in unemployment by **2015**. * 75% reduction in unemployment by **2025**.
Skills Development	A skilled community exhibiting capabilities in self–reliance, innovation and continued reskilling to meet the needs of a growing economy	• Improved mechanisms and programmes to impart skills: * EMM Centre of Excellence to be established by **2006**. * Mentoring programme for project management and technical skills to be implemented by **2007**. * Institute of Technology to be established by **2010**. * Ongoing strengthening of ties with Educational Institutions. • Improved Skills: * Measurable increase in the % of the population which is technically and scientifically skilled by **2015**. * Adult illiteracy wiped out by **2020**.
Tourism	To promote the economy of the region, create jobs and a safe and secure environment, by establishing a tourism destination of choice.	• Development of tourism facilities: * By **2010** : - Exploitation of opportunities created by Soccer World Cup. - African Shopping Hub, Craft Market and Wine Emporium developed. - Business tourism facilities around the JIA. • Increased tourism: * Ekurhuleni to be the preferred sporting/cultural/heritage destination by **2015**. * Business tourism to increase by 50% by **2020**.
Investment Promotion	Increased inward investment in skills and technology, property and sustainable development.	• Increased levels of public and private investment in all areas: * By **2010** : - A range of government investment incentives to be in place. - Measurable increase in effective service delivery and information dissemination through "Customer Care Centre" implementation. - CID's in place. * From **2015** onwards: - Measurable increase in investment in strategic priority areas such as the mining belt.
Economic Transformation	An inclusive, wealth-generating economy.	• Greater participation in the formal economy by all sectors of society. * Strategy i.r.o. leveraging EMM assets to ensure BBBEE to be in place by **2007**. * Enabling procurement policy to be fully implemented by **2008**.

KEY FOCUS AREA OUTCOMES AND MILESTONES		
KEY FOCUS AREA	2025 AGENDA	OUTCOMES AND MILESTONES
		• By **2025:** * Equitable provision of facilities to all communities in Ekurhuleni. * 100% of the Metro-wide open space system to be developed and maintained.

5.4 SERVICE DELIVERY CONCEPT

The current EMM service delivery concept is one of Service Delivery Regions [SDR's] and Customer Care Centres [CCC's]. In order to ensure quality service delivery, CCC's have been established throughout the municipality to ensure that the EMM applies the principles of Batho Pele (people first).

5.5 STAKEHOLDER ALIGNMENT AND PARTICIPATION

The solutions to many of the critical development issues in Ekurhuleni lie outside the ambit of the local government mandate and a joint, cooperative and integrated approach to the implementation of the GDS is therefore of the utmost importance – the GDS must be owned and embraced by all the development stakeholders in the area, not only by the municipality.

6. MONITORING, EVALUATION AND REVIEW

The process of monitoring, evaluation and review of the GDS outcomes and milestones through the IDP, is schematically illustrated hereunder.