



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

STRATEGIC PLAN

2020 / 21 - 2024 / 25



 KwaZulu-Natal Department of Health

 KZN Department of Health

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MY HEALTH, YOUR HEALTH, OUR HEALTH: A HEALTHY KWAZULU-NATAL.

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FOREWORD BY THE EXECUTIVE AUTHORITY

The Strategic Plan of the KZN Department of Health presents the opportunity to give meaningful response to the health challenges facing the people of our Province. The plan aims to integrate key elements of service delivery into providing a long term framework that will guide the annual planning and budget cycles.

There are three overarching outcomes for the forthcoming planning cycle that aim to address a single impact of "Increased life Expectancy". The outcomes that seek to merge to achieve this impact are "Universal Health Coverage", "Improved client experience of care" and "reduced morbidity and mortality".

The first outcome of universal health coverage goes beyond just looking at how accessible we are making the services to our people. The outcome looks at overhauling the Provincial Health Services through Improved quality of care, improved governance through functional clinic committees and hospital boards, access to professional nurses and medical officers. This outcome seeks to track the Department's progress in achieving a clean audit. The Department will continue to focus on Primary Health Care Re-engineering to strengthen prevention and promotion of health by investing in the Community Based Model.

The outcome of "Improved client experience of care" Looks at our clients' perception of the services that we provide. The outcome tracks the clients' satisfaction with the services provided, the use of the complaints systems and patient safety at the different levels of care.

The outcome of "Reduced Morbidity and Mortality" focuses on improving our understanding of deaths that occur at the different levels of care in order to further reduce under 5 and maternal deaths. Improving child and maternal health is paramount and the department plans to invest considerable resources in further improving health for this target group. The focus is on the reduction of morbidity and mortality for communicable and non-communicable diseases. The department continues to invest in prevention and treatment efforts to reverse the spread of HIV and AIDS and progressively improve TB prevention and cure in line with the NDP 2030 objective.

The strategic plan is a genuine confirmation of the department's commitment to meeting our constitutional mandate. We endorse the strategic plan and remain committed to ensuring its implementation.



A handwritten signature in black ink, appearing to read "Nomagugu Simelane-Zulu".

MS NOMAGUGU SIMELANE-ZULU
MEC for Health
KwaZulu-Natal Department of Health

DATE: 20/3/2020

STATEMENT BY THE ACCOUNTING OFFICER

The 2020-2025 Strategic Plan encapsulates the Vision, Mission, Core values, Impact and Outcomes of the KZN Department of Health for the period 2020 to 2025. It articulates the approach that will be pursued by the Department in responding to the priorities of the new Government. The Department envisions continuing to work towards providing optimal health for all persons in KwaZulu-Natal through a sustainable, coordinated, integrated and comprehensive health system at all levels, based on the Primary Health Care approach through the District Health System, to ensure universal access to health care.

The strategic plan is a product of extensive consultations with internal and external stakeholders. It was further shaped by the priorities of the National Development 2030, the Medium Term Strategic Framework 2019-2024, the Provincial Growth and development Plan 2030 as well as other sector priorities, the burden of disease and the demand for services. This work will be done by a team of HealthCare workers from Head office, District offices and health institutions who strive towards the same shared core values. The core values include:

- Trustworthiness, honesty and integrity
- Open communication, transparency and consultation
- Professionalism, accountability and commitment to excellence
- Loyalty and compassion
- Continuous learning, amenable to change and innovation
- Respect

During the previous planning period, the strategic goals included focus on strengthening the health system effectiveness, Reducing the burden of disease, universal health coverage, strengthening human resources for health and improving the quality of care. What was learned in this period will be used to improve the impact of our current planning interventions.

The department has implemented a number of strategic interventions to accelerate turnaround in terms of fiscal discipline and with a view to addressing the negative outcomes of the previous years. In addition, strategies have been developed and are being implemented to enhance Human Resources for Health in line with the National Guidelines. Much work has been done to achieve the streamlining of Human Resources for Health based on need and workload and this will go a long way towards building appropriate human capital for the delivery of healthcare services in the Province.

The fight against Fraud and Corruption has gathered momentum since 2010 and we have seen a number of convictions and recoveries of monies that the Department was defrauded of. With the same strength and conviction guided by prescripts and discipline, consequence management will be unleashed where necessary but support will also be availed to all.

The Department has embarked upon the Rationalization of Health facilities in order to maximize services at the appropriate levels of care in accordance with the classification of the health facilities. This will improve the quality of care, access to care and contribute to the overall health and wellbeing of the communities we serve.

The Department's aim was to maintain the gains already made and further focus on interventions to accelerate health system effectiveness and further improve health outcomes and patient satisfaction. With improved leadership and clinical governance the department will do this by ensuring that we will all:

- Robustly monitor implementation of the Turn-Around Strategy, as part of the Long Term Plan, to inter alia, improve audit outcomes; improve financial and supply chain management and human resource management services; rationalize hospital services to improve efficiencies and equitable access to clinical services; strengthen governance, leadership and oversight; and re-position infrastructure development as integral part of improved service delivery.
- Accelerate implementation of the 90-90-90 strategy for HIV, AIDS, TB and non-communicable diseases.
- Scale up integrated programmes to reduce maternal and child morbidity and mortality and improve adolescent and women's health.
- Accelerate Primary Health Care re-engineering including expansion of community-based services and the Ideal Clinic Programme.
- Implement Phase 2 of National Health Insurance.
- Accelerate rollout of the Central Chronic Medicines Dispensing and Distribution (CCMDD) Programme to improve access to chronic medicines at community level.
- Implement the National Core Standards (NCS) to improve quality and patient satisfaction.

The Department had introduced a number of new initiatives to accelerate the existing programmes in order to enhance service delivery and improve health outcomes. High impact initiatives from the previous cycle are reflected under the following:

- Combating HIV and AIDS and Decreasing the Burden of Disease.
- Dual protection Campaign.
- Decreasing Maternal and Child Mortality.
- Tuberculosis interventions.
- Medical Male Circumcision.
- McCord Provincial Eye Hospital.
- Reducing Non-Communicable Diseases.
- Make me Look like a Hospital Project.
- Infrastructure Development Projects.
- Healthy Lifestyle Initiatives.

Over the next five years, the Departmental plan will make provision for:

- Improving the quality of and access to care – Universal health coverage - and readiness for the National Health Insurance
- Improving the client experience of care with a focus on the perception of health through the eyes of the client and

- Reduced morbidity and mortality through intensified cases finding, improved treatment outcomes and intensified prevention efforts.

We wish to acknowledge the efforts of all stakeholders in crafting this strategic plan. I am looking forward to this new phase of development and consolidation in the Department and remain committed in leading and facilitating the process towards the implementation of the strategic plan.



A handwritten signature in black ink, appearing to be 'S. Tshabalala', written over a horizontal line.

DR SC TSHABALALA

Head: Health

KwaZulu-Natal Department of Health

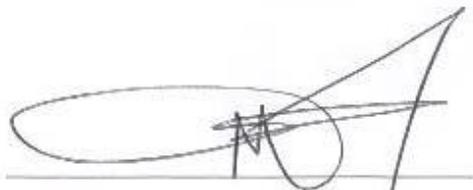
DATE

25/05/2020

OFFICIAL SIGN OFF

It is hereby certified that this Strategic Plan:

- Was developed by the Management of the KwaZulu-Natal Department of Health under the guidance of the MEC for Health: Ms. Nomagugu Simelane-Zulu.
- Takes into account all the relevant policies, legislation and other mandates for which the KwaZulu-Natal Department of Health is responsible.
- Accurately reflects the Impact and Outcomes which the KwaZulu-Natal Department of Health will endeavor to achieve over the period 2020-2025.



Dr M Gumede

DDG: Specialised Services and Clinical Support

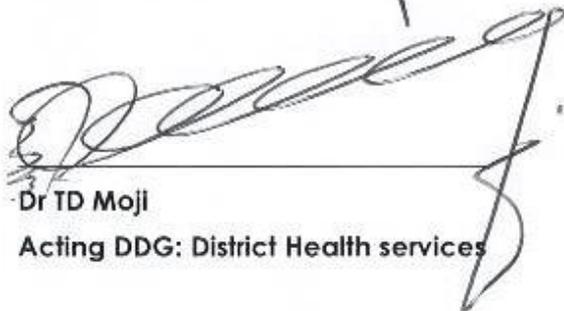
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Mr. M Zungu

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Date 19 MAR 2020



Dr TD Moji

Acting DDG: District Health services

Date 19/3/2020



Mr. TPB Shezi

DDG: Corporate Management Services

Date 2020/03/19



Mr. B Gcaba

Chief Director: Infrastructure Development

Date 20/3/2020



Ms. T Mngqithi
Acting Chief Director: Risk Assurance Management Services

Date 18/03/2020



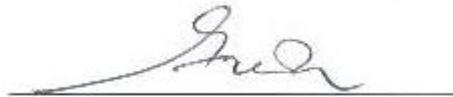
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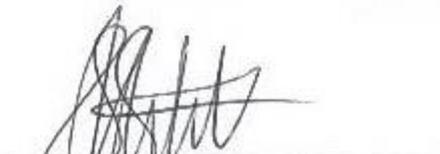
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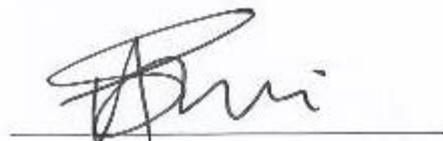
Date 18/3/2020



Dr SC Tshabalala
Head: Health - KwaZulu-Natal Department of Health

Date 20/03/2020

Approved by



Ms. Nomagugu Simelane-Zulu
MEC for Health - KwaZulu-Natal Department of Health

Date 20/3/2020

PART A: OUR MANDATE

1. CONSTITUTIONAL MANDATE

In terms of the Constitutional provisions, the Department is guided by the following sections and schedules, among others:

The Constitution of the Republic of South Africa, 1996, places obligations on the state to progressively realise socio-economic rights, including access to (*affordable and quality*) health care.

Schedule 4 of the Constitution reflects health services as a concurrent national and provincial legislative competence

Section 9 of the Constitution states that everyone has the right to equality, including access to health care services. This means that individuals should not be unfairly excluded in the provision of health care.

- People also have the right to access information if it is required for the exercise or protection of a right;
- This may arise in relation to accessing one's own medical records from a health facility for the purposes of lodging a complaint or for giving consent for medical treatment; and
- This right also enables people to exercise their autonomy in decisions related to their own health, an important part of the right to human dignity and bodily integrity in terms of sections 9 and 12 of the Constitutions respectively.

Section 27 of the Constitution states as follows: with regards to Health care, food, water, and social security:

- (1) Everyone has the right to have access to:
 - (a) Health care services, including reproductive health care;
 - (b) Sufficient food and water; and
 - (c) Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.
- (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights; and
- (3) No one may be refused emergency medical treatment.

Section 28 of the Constitution provides that every child has the right to 'basic nutrition, shelter, basic health care services and social services'.

2. LEGISLATIVE AND POLICY MANDATES

2.1. Legislation falling under the Department of Health's Portfolio

National Health Act, 2003 (Act No. 61 of 2003)

Provides a framework for a structured health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services. The objectives of the National Health Act (NHA) are to:

- unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa;
- provide for a system of co-operative governance and management of health services, within national guidelines, norms and standards, in which each province, municipality and health district must deliver quality health care services;
- establish a health system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognized standards of research and a spirit of enquiry and advocacy which encourage participation;
- promote a spirit of co-operation and shared responsibility among public and private health professionals and providers and other relevant sectors within the context of national, provincial and district health plans; and
- create the foundation of the health care system, and understood alongside other laws and policies which relate to health in South Africa.

Medicines and Related Substances Act, 1965 (Act No. 101 of 1965) - Provides for the registration of medicines and other medicinal products to ensure their safety, quality and efficacy, and also provides for transparency in the pricing of medicines.

Hazardous Substances Act, 1973 (Act No. 15 of 1973) - Provides for the control of hazardous substances, in particular those emitting radiation.

Occupational Diseases in Mines and Works Act, 1973 (Act No. 78 of 1973) - Provides for medical examinations on persons suspected of having contracted occupational diseases, especially in mines, and for compensation in respect of those diseases.

Pharmacy Act, 1974 (Act No. 53 of 1974) - Provides for the regulation of the pharmacy profession, including community service by pharmacists

Health Professions Act, 1974 (Act No. 56 of 1974) - Provides for the regulation of health professions, in particular medical practitioners, dentists, psychologists and other related health professions, including community service by these professionals.

Dental Technicians Act, 1979 (Act No.19 of 1979) - Provides for the regulation of dental technicians and for the establishment of a council to regulate the profession.

Allied Health Professions Act, 1982 (Act No. 63 of 1982) - Provides for the regulation of health practitioners such as chiropractors, homeopaths, etc., and for the establishment of a council to regulate these professions.

SA Medical Research Council Act, 1991 (Act No. 58 of 1991) - Provides for the establishment of the South African Medical Research Council and its role in relation to health Research.

Academic Health Centres Act, 86 of 1993 - Provides for the establishment, management and operation of academic health centres.

Choice on Termination of Pregnancy Act, 196 (Act No. 92 of 1996) - Provides a legal framework for the termination of pregnancies based on choice under certain circumstances.

Sterilisation Act, 1998 (Act No. 44 of 1998) - Provides a legal framework for sterilisations, including for persons with mental health challenges.

Medical Schemes Act, 1998 (Act No.131 of 1998) - Provides for the regulation of the medical schemes industry to ensure consonance with national health objectives.

Council for Medical Schemes Levy Act, 2000 (Act 58 of 2000) - Provides a legal framework for the Council to charge medical schemes certain fees.

Tobacco Products Control Amendment Act, 1999 (Act No 12 of 1999) - Provides for the control of tobacco products, prohibition of smoking in public places and advertisements of tobacco products, as well as the sponsoring of events by the tobacco industry.

Mental Health Care 2002 (Act No. 17 of 2002) - Provides a legal framework for mental health in the Republic and in particular the admission and discharge of mental health patients in mental health institutions with an emphasis on human rights for mentally ill patients.

National Health Laboratory Service Act, 2000 (Act No. 37 of 2000) - Provides for a statutory body that offers laboratory services to the public health sector.

Nursing Act, 2005 (Act No. 33 of 2005) - Provides for the regulation of the nursing profession and for the establishment of a council to regulate these professionals including community service by these professionals.

Higher Education Act (Act No 101 of 1997) as amended: Provides for the regulation of Higher Education Institutions and its registration, including the formation of governance structures guiding education and training of students.

National Qualifications Act (Act No 67 of 2008): Provides for a single integrated system comprising three co-ordinated qualifications Sub-Frameworks

Traditional Health Practitioners Act, 2007 (Act No. 22 of 2007) - Provides for the establishment of the Interim Traditional Health Practitioners Council, and registration, training and practices of traditional health practitioners in the Republic.

Foodstuffs, Cosmetics and Disinfectants Act, 1972 (Act No. 54 of 1972) - Provides for the regulation of foodstuffs, cosmetics and disinfectants, in particular quality standards that must be complied with by manufacturers, as well as the importation and exportation of these items.

KwaZulu-Natal Health Act (Act No. 1 of 2009) and Regulations: Provides for a transformed Provincial Health System within framework of the National Health Act of 2003.

Public Service Act No 64 of 1994: To provide for the organisation and administration of the public service of the Republic, the regulation of the conditions of employment, terms of office, discipline, retirement and discharge of members of the public service, and matters connected therewith.

2.2. Other legislation applicable to the Department

Criminal Procedure Act, 1977 (Act No.51 of 1977), Sections 212 4(a) and 212 8(a) - Provides for establishing the cause of non-natural deaths.

Children's Act, 2005 (Act No. 38 of 2005) - The Act gives effect to certain rights of children as contained in the Constitution; to set out principles relating to the care and protection of children, to define parental responsibilities and rights, to make further provision regarding children's court.

Occupational Health and Safety Act, 1993 (Act No.85 of 1993) - Provides for the requirements that employers must comply with in order to create a safe working environment for employees in the workplace.

Compensation for Occupational Injuries and Diseases Act, 1993 (Act No.130 of 1993) - Provides for compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment, and for death resulting from such injuries or disease.

National Roads Traffic Act, 1996 (Act No.93 of 1996) - Provides for the testing and analysis of drunk drivers.

Employment Equity Act, 1998 (Act No.55 of 1998) - Provides for the measures that must be put into operation in the workplace in order to eliminate discrimination and promote affirmative action.

State Information Technology Act, 1998 (Act No.88 of 1998) - Provides for the creation and administration of an institution responsible for the state's information technology system.

Skills Development Act, 1998 (Act No 97 of 1998) - Provides for the measures that employers are required to take to improve the levels of skills of employees in workplaces.

Public Finance Management Act, 1999 (Act No. 1 of 1999) - Provides for the administration of state funds by functionaries, their responsibilities and incidental matters.

Promotion of Access to Information Act, 2000 (Act No.2 of 2000) - Amplifies the constitutional provision pertaining to accessing information under the control of various bodies.

Promotion of Administrative Justice Act, 2000 (Act No.3 of 2000) - Amplifies the constitutional provisions pertaining to administrative law by codifying it.

Promotion of Equality and the Prevention of Unfair Discrimination Act, 2000 (Act No.4 of 2000)
Provides for the further amplification of the constitutional principles of equality and elimination of unfair discrimination.

Division of Revenue Act, (Act No 7 of 2003) - Provides for the manner in which revenue generated may be disbursed.

Broad-based Black Economic Empowerment Act, 2003 (Act No.53 of 2003) - Provides for the promotion of black economic empowerment in the manner that the state awards contracts for services to be rendered, and incidental matters.

Labour Relations Act, 1995 (Act No. 66 of 1995) - Establishes a framework to regulate key aspects of relationship between employer and employee at individual and collective level.

Basic Conditions of Employment Act, 1997 (Act No.75 of 1997) - Prescribes the basic or minimum conditions of employment that an employer must provide for employees covered by the Act.

3. HEALTH SECTOR POLICIES AND STRATEGIES OVER THE FIVE YEAR PLANNING PERIOD

3.1. Provincial Strategy alignment to the revised draft DPME Planning Framework

The Department's 5 strategic goals in the 2014/15 – 2019/20 strategic planning cycle were as follows:

- Strengthen Health Systems Effectiveness
- Reduce and manage the burden of disease
- Universal Health Coverage
- Strengthen Human resources for Health
- Improved Quality of Health Care

The NDP implementation plan proposes 4 goals, namely:

Goal 1: Increase Life Expectancy Improve Health and Prevent Disease

Goal 2: Achieve Universal health coverage by Implementing NHI

Goal 3: Quality Improvement in the provision of care

Goal 4: Build Health Infrastructure for effective service delivery

The DPME framework terminology uses the terms “Impact and Outcomes”. With this logic model in mind as well as seeking to align to the DPME planning framework, the following Impact and Outcomes were adopted by The Department:

Impact: Increased Life Expectancy

Outcome: Universal Health Coverage

Outcome: Improved Client Experience of Care

Outcome: Reduced Morbidity and Mortality

The impact and outcomes were confirmed through consultations at cluster planning workshops (Cluster sessions held between 21 August 2019 and 6 September 2019) and the Provincial Strategic planning workshop (12-13 October 2019)

3.2. Alignment of the KwaZulu-Natal Department of Health Impact and Outcome Statements to Health Sector Policies and Strategies

The following National and Provincial Policies, Frameworks and Strategies are relevant to 2020-2025:

- National Health Insurance Bill
- National Development Plan: Vision 2030
- Sustainable Development Goals
- Medium Term Strategic Framework and NDP Implementation Plan 2019-2024
- Provincial Growth and Development plan

Table showing the alignment of the Provincial Department of Health's Impact and outcomes to Health Sector Policies and Strategies follow below:

STRATEGIC PLAN 2020/21 – 2024/25

Table 1: Alignment of the PDoH Impact and outcomes to Health Sector Policies and Strategies

KZN DOH Impact and outcome 2020-2025	Medium Term Strategic Framework 2019-2024 Impacts	MTSF Priorities 2019-2024	National Development Plan: Vision 2030 goals	Sustainable Development Goals	PGDP 2030	Health sector's strategy 2019-2024
Impact: Increased Life Expectancy	Life expectancy of South Africans improved to 70 years by 2030	Priority 3: Education Skills and Health	Average male and female life expectancy at birth increases to at least 70 years		Goal Indicator: • Life expectancy at birth. Strategic Objective 3.2: Enhance the health of communities and citizens	Goal 1: Increase Life Expectancy improve Health and Prevent Disease <i>Inter sectoral collaboration to address social determinants of health</i>
Outcome: Universal Health Coverage	Universal Health Coverage for all South Africans achieved and all citizens protected from the catastrophic financial impact of seeking health care by 2030	Priority 3: Education Skills and Health Priority 2: Economic Transformation and Job creation Priority 3: Capable, Ethical and Developmental State	Complete Health System Reforms (Strengthen the District Health System) Primary Health Care teams provide care to families and communities Universal Health Care Coverage Fill posts with skilled, committed and competent individuals	3.8 - Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all 3. c - Substantially increase health financing and the ... health workforce in developing countries... Strengthen the capacity of all countries ... for early warning, risk reduction and management of national and global health risks	3.2(a) Scale up implementation of strategic interventions to fast track transformation of public health services towards universal health coverage. 3.2(e) Facilitate health research and knowledge management to inform evidence-based and responsive planning and decision-making.	Goal 2: Achieve UHC by Implementing NHI <i>SO: Progressively achieve Universal Health Coverage through NHI</i> <i>SO: Improve quality and safety of care</i> <i>SO: Provide leadership and enhance governance in the health sector for improved quality of care</i> <i>SO: Improve community engagement and reorient the system towards Primary Health</i>

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KZN DOH Impact and outcome 2020-2025	Medium Term Strategic Framework 2019-2024 Impacts	MTSF Priorities 2019-2024	National Development Plan: Vision 2030 goals	Sustainable Development Goals	PGDP 2030	Health sector's strategy 2019-2024
						<p><i>Care through Community based health Programmes to promote health</i></p> <p><i>SO: Improve equity, training and enhance management of Human Resources for Health</i></p> <p><i>SO: Improving availability to medical products, and equipment</i></p> <p><i>SO: Robust and effective health information systems to automate business processes and improve evidence based decision making</i></p> <p><i>SO: Execute the infrastructure plan to ensure adequate, appropriately distributed and well maintained health facilities</i></p>
Improved Client Experience of Care	Outcome: Progressive improvement in the total life expectancy of South Africans	Priority 3: Education Skills and Health			Strategic Objective 3.2: Enhance the health of communities and citizens	SO: Improve community engagement and reorient the system towards Primary Health

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KZN DOH Impact and outcome 2020-2025	Medium Term Strategic Framework 2019-2024 Impacts	MTSF Priorities 2019-2024	National Development Plan: Vision 2030 goals	Sustainable Development Goals	PGDP 2030	Health sector's strategy 2019-2024
						<i>Care through Community based health Programmes to promote health</i>
Reduced Morbidity and Mortality	<p>Outcome: Reduce Maternal and Child Mortality</p> <p>Outcome: Progressive improvement in the total life expectancy of South Africans</p> <p>Outcome: Improved educational and health outcomes and skills development for all women, girls, youth and persons with disability</p>	Priority 3: Education Skills and Health	<p>Improvement in evidence-Based preventative and therapeutic interventions for HIV</p> <p>Progressively improve TB prevention and cure</p> <p>Reduce maternal and child mortality</p> <p>Reduce the prevalence of non-communicable chronic diseases by 28 percent</p> <p>Reduce Injury, accidents and violence by 50% from 2010 levels</p>	<p>3.1 - By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births</p> <p>3.2 - By 2030, end preventable deaths of new-borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births</p> <p>3.3 - By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases</p> <p>3.4 - By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote</p>	<p>3.2(b) Implement the KZN 2017-2022 Multi-Sectoral Response Plan for HIV, TB and STIs to reduce the burden of communicable diseases.</p> <p>3.2(c) Accelerate implementation of comprehensive integrated community- and facility-based services/ interventions to improve maternal, neonatal and child health.</p> <p>3.2(d) Accelerate implementation of comprehensive and integrated community- and facility-based services/ interventions to reduce the burden of non-communicable diseases.</p>	<p>Goal 1: Increase Life Expectancy improve Health and Prevent Disease</p> <p>SO: <i>Improve health outcomes by responding to the quadruple burden of disease of South Africa</i></p>

STRATEGIC PLAN 2020/21 – 2024/25

KZN DOH Impact and outcome 2020-2025	Medium Term Strategic Framework 2019-2024 Impacts	MTSF Priorities 2019-2024	National Development Plan: Vision 2030 goals	Sustainable Development Goals	PGDP 2030	Health sector's strategy 2019-2024
				mental health and well-being 3.5 - Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol 3.6 - By 2020, halve the number of global deaths and injuries from road traffic accidents 3.7 - By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes 3.9 - By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination 3.a - Strengthen the implementation of the World Health Organization Framework		

STRATEGIC PLAN 2020/21 – 2024/25

KZN DOH Impact and outcome 2020-2025	Medium Term Strategic Framework 2019-2024 Impacts	MTSF Priorities 2019-2024	National Development Plan: Vision 2030 goals	Sustainable Development Goals	PGDP 2030	Health sector's strategy 2019-2024
				Convention on Tobacco Control in all countries, as appropriate 3.b - Support the research and development of vaccines and medicines for the communicable and non-communicable diseases ...		

The Strategic and Annual Performance Plans are further aligned to the National Health Insurance Bill, the Public service regulations and the Health Compact pillars.

4. UPDATES TO RELEVANT COURT RULINGS

Provincially, the Trial Register details claims against The Department namely: the nature of the claim, and the amount claimed, as at January 2020.

- As at January 2020, the total medico legal claims paid to date equalled to R141 009 233.
- There were 228 civil matters received by Legal Services for the year 2019/20 (As at Jan 2020)
- There were a total of 46 Labour matters received for the 2019/20 year (as at Jan 2020).
- A total of 162 collision matters were received as at Jan 2020.

Nationally, the Constitutional Court judgement in the cannabis cases referred from the Cape High Court is one of the most pressing court decisions in recent years (HST, 2019) (HST, 2019). Cannabis may be addictive in nature. It has been linked to lung cancer, impaired respiratory function, cardiovascular disease, elevated systolic blood pressure, stroke and mental disorders. Cannabis has also been linked to traffic and non-traffic accidents, workplace injuries and work performance (Mokwena, 2019).

The Supreme Court of Appeal dismissed an appeal against a previous High Court judgment which found that a mother had failed to prove that the damage sustained by her child (due to hypoxaemia during childbirth) was due to the negligent failure of the hospital staff involved in the child's delivery (Aug 2019) (HST, 2019).

PART B: OUR STRATEGIC FOCUS

VISION

Optimal health for all persons in KwaZulu-Natal

MISSION

To develop and implement a sustainable, coordinated, integrated and comprehensive health system at all levels, based on the Primary Health Care approach through the District Health System, to ensure universal access to health care.

VALUES

- ⇒ Trustworthiness, honesty and integrity
- ⇒ Open communication, transparency and consultation
- ⇒ Professionalism, accountability and commitment to excellence
- ⇒ Loyalty and compassion
- ⇒ Continuous learning, amenable to change and innovation
- ⇒ Respect

5. UPDATED SITUATIONAL ANALYSIS

5.1. Overview of Province

KwaZulu-Natal is located in the south-east of South Africa bordering the Indian Ocean. It also borders on the Eastern Cape, Free State and Mpumalanga provinces, as well as Lesotho, Swaziland and Mozambique. The 'Garden Province' of South Africa stretches from the lush subtropical east coast washed by the warm Indian Ocean, to the sweeping savannah in the east and the majestic Drakensberg Mountain Range in the west.

It covers an area of 94 361km², the third-smallest in the country, and has a population of 11 289 086 (Statistics South Africa, 2019), making it the second most populous province in South Africa following Gauteng. The capital is Pietermaritzburg and the largest city is Durban. Other major cities and towns include Richards Bay, Port Shepstone, Newcastle, Estcourt, Ladysmith and Richmond.

The province's manufacturing sector is the largest in terms of contribution to GDP. Richards Bay is the centre of operations for South Africa's aluminium industry. The Richards Bay Coal Terminal is instrumental in securing the country's position as the second-largest exporter of steam coal in the world. The province has undergone rapid industrialisation owing to its abundant water supply and labour resources.

Agriculture is also central to the economy. The sugar cane plantations along the coastal belt are the mainstay of KwaZulu-Natal's agriculture. The coastal belt is also a large producer of subtropical fruit, while the farmers inland concentrate on vegetable, dairy and stock farming.

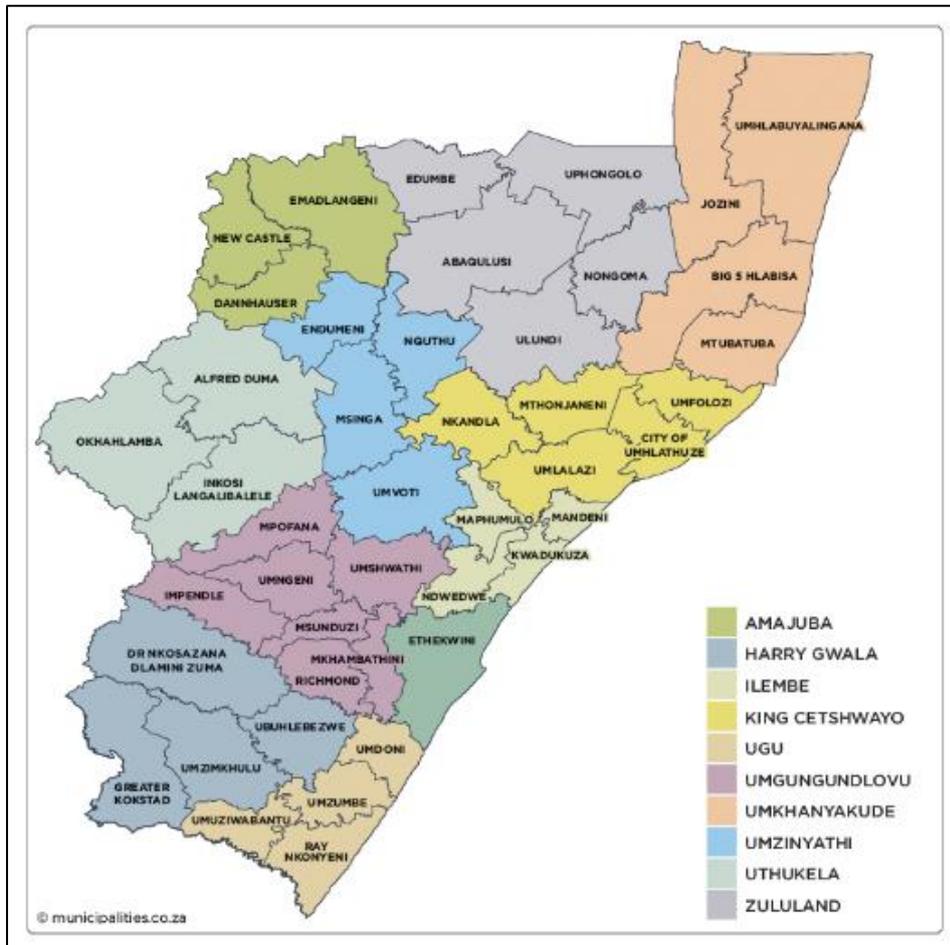
Another source of income is forestry in the areas around Vryheid, Eshowe, Richmond, Harding and Ngome.

KwaZulu-Natal is divided into one metropolitan municipality (eThekweni Metropolitan Municipality) and 10 district municipalities, which are further subdivided into 43 local municipalities (National Department of Health, 2019).

Table 2: KwaZulu-Natal Demographic Data (National Department of Health 2019)

Demographic Data	KZN	Unit of Measure
Geographical area	94,361	Km ²
Total population (Statistics South Africa, 2019)	11 289 086	Number
Population density (Based on SA Mid-year estimates 2019)	120	Per Km ²
Percentage of population with medical insurance (General Household Survey, 2017)	12.6	%

Map 1: Map of KZN and Districts/Metro (Nationalgovernment.co.za)¹



¹ eThekweni is classified as a Metropolitan

6. EXTERNAL ENVIRONMENT ANALYSIS

6.1. Demography

Graph 1: Population pyramid KwaZulu-Natal vs South Africa



The narrowing base of the pyramids for both the South African and KZN population pyramids shows a decline in the birth rate. The 2030 projections show a bullet shaped Province and Country. The Province appears to be more youthful than the Country profile with the under 19 population being a larger percentage of the population compared to the South African norm (40.3% and 36.7% respectively)(Mid-Year Population Estimates, 2019 StatsSA). The child health programmes in KZN need to cater for this under-19 age dynamic. The growing percentage of the population over 60 in the Province is evident of the increasing life expectancy and also points to the need for programmes around palliative care and chronic diseases of lifestyle.

6.2. Social Determinants of Health for Province and Districts

Globally, it is recognized that health and health outcomes are not only affected by healthcare or access to health services. They result from multidimensional and complex factors linked to the social determinants of health which include a range of social, political, economic, environmental, and cultural factors, including human rights and gender equality (National Department of Health, 2019).

South Africa is classified as an upper-middle-income country with a per capita income of R55 258. Despite the perceived wealth, most of the country's households are plagued by poverty. Although significant progress was made prior to the economic crisis in addressing poverty, many South African households have fallen back or still remain in the trap of poverty through inadequate access to clean water, proper health care facilities and household infrastructure (Provincial Treasury, 2019).

Health is influenced by the environment in which people live and work as well as societal risk conditions such as polluted environments, inadequate housing, poor sanitation, unemployment, poverty, racial and gender discrimination, destruction and violence (National Department of Health, 2019).

Comparing 2011 and 2016 data, there is a decline in people living in informal dwelling and an increase in traditional dwellings. The Province has made gains in the access to piped water and electricity but uMkhanyakude still remains at unacceptably high percentages of households with no access to piped water and electricity for lighting, food preparation and storage.

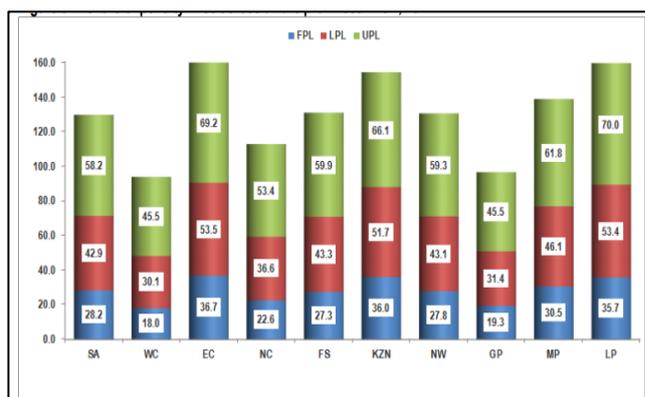
In 2012, Statistics South Africa published a suite of three important national poverty lines for measuring poverty: The food poverty line (FPL), the lower-bound poverty line (LBPL) and the upper-bound poverty line (UBPL). The absolute poverty line is a measure of the minimum level of resources that individuals should have access to in order to meet their basic needs (Provincial Treasury, 2019).

Table 3: Social Determinants of Health, 2016

District	Population	Households	Intensity of poverty	2015 Grants and subsidies received as a % of Total income	Access to piped or tap water	Households (HH) No Access to piped water	% No access piped water (HH)	No access to sanitation (HH)	% No access to sanitation (HH)	No Electricity (HH)	% No access to electricity (HH)
Ugu	789 953	180 921	42,3%	66,5%	158 402	22 519	12%	7 628	4,2%	26 562	14,7%
uMgungundlovu	1 111 872	300 953	42,1%	80,0%	274 567	26 386	9%	3 948	1,3%	19 424	6,5%
uThukela	706 808	161 864	42,5%	78,8%	122 362	39 502	24%	3 708	2,3%	16 954	10,5%
uMzinyathi	551 177	126 071	43,7%	59,3%	79642	46 429	37%	2937	2,3%	26882	21,3%
Amajuba	531 107	117 181	41,4%	89,4%	111623	5 558	5%	2324	2,0%	8641	7,4%
Zululand	892 310	178 516	42,8%	93,5%	115071	63 445	36%	13901	7,8%	24494	13,7%
uMkhanyakude	689 090	151 245	44,1%	90,5%	75 672	75 573	50%	15 460	10,2%	62 887	41,6%
King Cetshwayo	971 135	225 797	43,1%	86,8%	190 303	35 494	16%	5 486	2,4%	14 064	6,2%
ILembe	657 612	191 369	43,0%	69,8%	144 923	46 446	24%	5 201	2,7%	25 731	13,4%
Harry Gwala	502 265	122 436	43,5%	89,1%	83 175	39 261	32%	2 428	2,0%	20 192	16,5%
eThekwini	3 661 911	1 119 492	40,8%	18,3%	1 101 610	17 882	2%	9 408	0,8%	40393	3,6%
KwaZulu-Natal	11 065 240	2 875 843	42,5%	-	2 457 350	418 493	15%	72 428	2,5%	286 224	10,0%

Source: 2016 Stats SA Community Survey

Graph 2: Share of Poverty Lines across all Provinces in SA 2017, (HIS MARKET 2019)



The adjacent graph shows the share of people living below the food poverty line, the lower-bound poverty and the Upper-bound poverty line. Around 36 per cent of the KZN population was living below the FPL in 2017. This figure was the second highest in the country and had increased slightly (1.1 per cent) from 34.9 per cent in 2016. In terms of the share of people living below the LBPL, KZN had 51.7 per cent of its population living

within this classification of poverty. This was the third highest rate in the country, and had also increased marginally from 50.6 per cent in the previous year (Provincial Treasury, 2019).

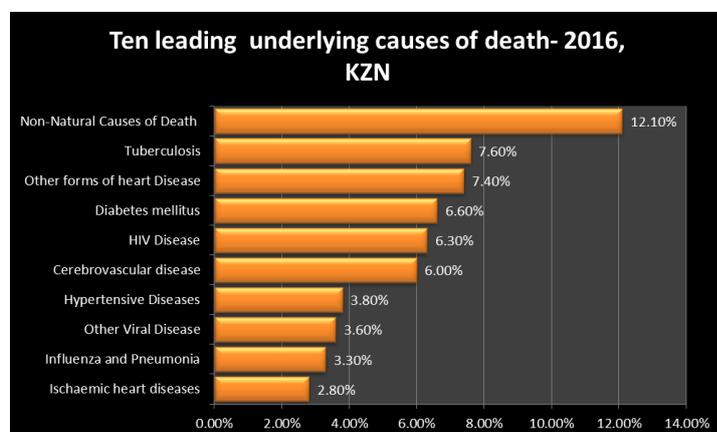
Poor people suffer worse health and die younger. People affected by poverty tend to have higher than average child and maternal mortality, higher levels of disease and more limited access to health care and social protection. When a member from a poor household is affected by poor health, the entire household can become trapped in a downward spiral due to lost income and healthcare costs (World Health Organisation, 2003).

Over 2011 to 2016, KZN was above the country average for stunting among under 5s. Data for 2017/18 shows that KZN was above the country average for children under 5 years severe acute malnutrition incidence and HIV prevalence. The maternal mortality in facility ratio, however, was less than the country average for this time period. It was in fact the 3rd lowest in the country following Western Cape and North West (Health Systems Trust, 2018).

6.3. Epidemiology and Quadruple Burden of Disease

Epidemiologically South Africa is confronted with a quadruple burden of disease (BOD) because of HIV and TB, high maternal and child morbidity and mortality, rising non-communicable diseases and high levels of violence and trauma (National Department of Health, 2019).

Graph 3: Leading causes of Death 2016 KwaZulu-Natal



The causes of death in KwaZulu-Natal reflects that the province continues to grapple with a complex burden of disease. This consists of communicable diseases such as pneumonia which have long been important causes of death, as well as relatively new health problems which have emerged over the past few decades, such as HIV and trauma, and finally, tuberculosis, which has

been important cause of death globally for centuries but which, in the presence of HIV, has developed into a new and refractory epidemic.

The order of the top ten causes of death in KZN is changing, and reflects the massive effort and expenditure on the HIV epidemic in the last two decades, which have reduced the contribution of deaths due to HIV in the province. This effort has resulted in a strengthening of the primary level of care, as HIV treatment became available at clinic level and thus accessible to the whole population. The success of this massive programme of antiretroviral treatment, with its progressively earlier initiation of treatment in the course of the disease, has resulted in an improvement in life expectancy in the Province, from 47.5 years to 57.7 years in men, and from 52.6 years to 64.1 years in women over the past two decades (Statistics South Africa, 2019).

The success in managing HIV has not extended to success in reducing the impact of TB on morbidity and mortality in the province. Tuberculosis still causes a high proportion of all deaths, and the resistant strains that have emerged with the development of the HIV epidemic have posed new threats to public health. KZN has been the home of important health research that has revolutionized the treatment of both these diseases; however, in both HIV and TB, an important challenge in control is the retention of patients within the treatment programmes. Similarly, the continued presence of pneumonia and viral diseases on the list of priority causes of death in KZN reflects slow change in the conditions of life for the majority of people in the province. Under-nutrition and poor housing conditions with overcrowding, poor ventilation and poor sanitation increase the risk and spread of pneumonia and other viral diseases, and require the intervention of a number of government departments, including the Department of Health.

The increasing importance of non-communicable diseases, particularly diabetes mellitus (type 2) and hypertension reflect the ageing of the population as well as changing lifestyles (reduced physical activity and increasing consumption of foods high in salt and sugar). Both diabetes and hypertension contribute directly to the development of cardio- and cerebrovascular diseases which are becoming increasingly important causes of death in the province. The high incidence of injury (both intentional and unintentional) has complex aetiologies but reflects the sub-optimal conditions of society, as well as the poor safety on the province's roads. Again, interventions to address these causes of death should come not only from the department of health but from numerous other government departments.

This complex burden of disease, illustrated by the priority causes of death, requires the provision of a complex set of health services. Whilst the community and primary levels of health care have been strengthened in the past few years, and remain the most important level of care for many communicable diseases, HIV and TB, the hospital level of care needs strengthening in response to the increasing importance of cardio- and cerebra-vascular diseases, and injury. As life expectancy in KZN increases, and as HIV becomes a manageable chronic disease, attention must be paid to the diseases affecting the ageing population, as well as the increasing incidence of injuries, all of which frequently require complex treatment at the hospital level. This strengthening of hospital care should be done whilst improving the quality of care at community and primary level, to address the diseases that continue to take their toll on the population. Finally, service delivery from the

Department of Health must be integrated with the interventions of a number of other government departments, so that the factors causing and exacerbating the health problems within the population are holistically addressed (KZN Department of Health Epidemiology; Health Research and Knowledge Management, 2019).

The causes of death (by rank) are unpacked according to age and sex in the table and graph below:

Communicable diseases together with perinatal, maternal and nutritional conditions are a leading cause of death in under 5s for both sexes in all districts. One of the most noticeable differences in cause of death between women and men in the 15 to 24 age group is that deaths due to Injury is much higher in males compared to females who have a high percentage dying from HIV and TB related diseases. Non Communicable diseases is the major cause of death of people aged 50 and above.

Graph 4: Broad Causes of death by sex and age group 2013-2015

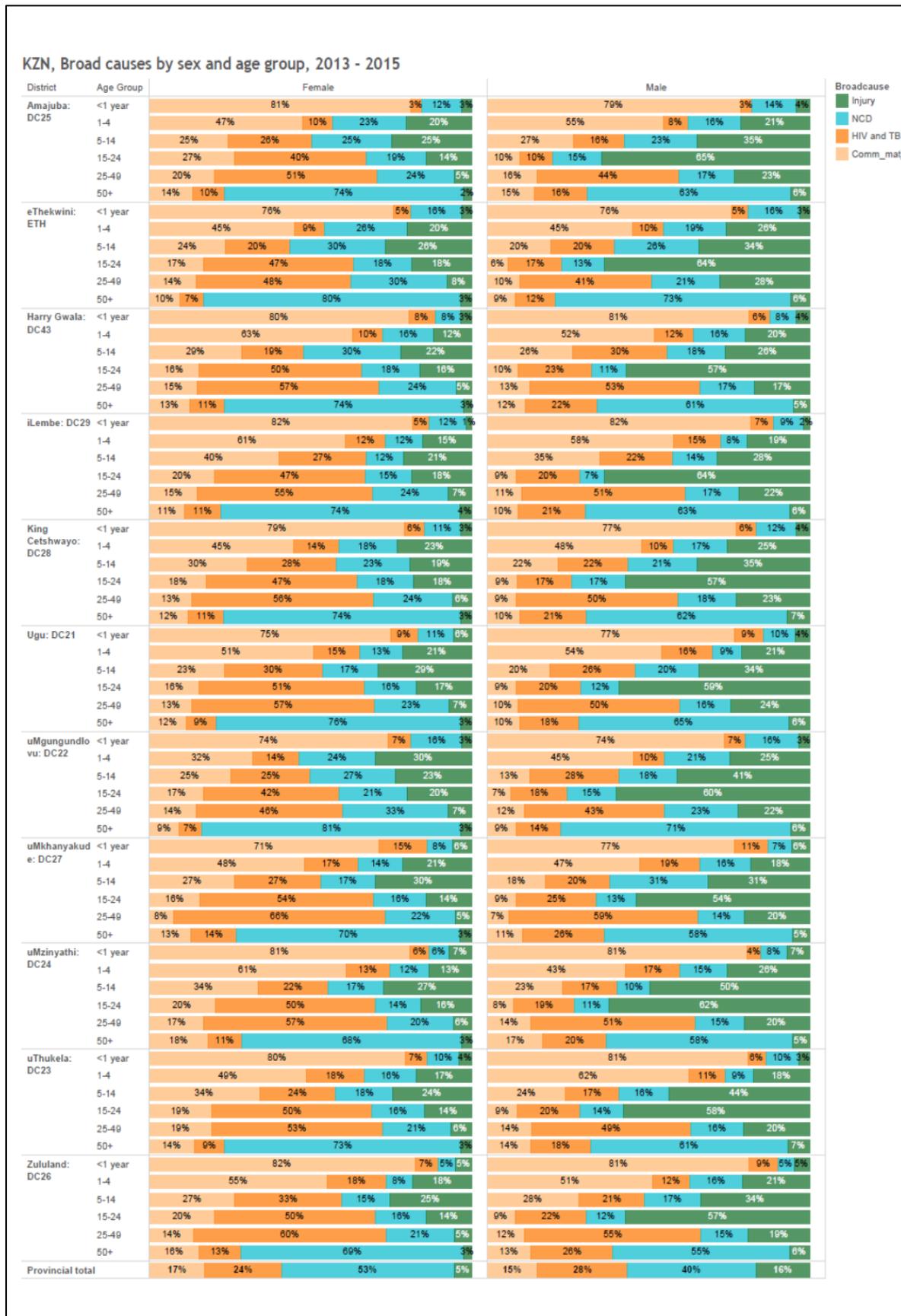


Table 4: Top 5 Broad Causes of Death Ranked per Age and Sex, KwaZulu-Natal 2016 (StatsSA Mortality and Causes of Death)

Cause of death	All Ages		0		1-14		15-44		45-64		65+	
	M	F	M	F	M	F	M	F	M	F	M	F
TB	1	4	-	-	3	4	1	2	1	5	-	-
HIV Disease	2	5	-	-	5	5	2	1	3	3	-	-
Other Forms of Heart Disease	3	2	-	-	4	3	4	5	2	2	1	3
Cerebrovascular Disease	4	3	-	-	-	-	-	-	5	4	3	2
Diabetes Mellitus	5	1	-	-	-	-	-	-	4	1	2	1
Respiratory and cardio disorders specific to perinatal period	-	-	1	1	-	-	-	-	-	-	-	-
Intestinal and infectious diseases	-	-	2	4	2	2	-	-	-	-	-	-
Influenza and pneumonia	-	-	3	3	1	1	-	-	-	-	-	-
Disorders related to length of gestation and foetal growth	-	-	4	2	-	-	-	-	-	-	-	-
Infections specific to perinatal period	-	-	5	5	-	-	-	-	-	-	-	-
Other viral disease	-	-	-	-	-	-	3	3	-	-	-	-
Disorders involving the immune mechanism	-	-	-	-	-	-	5	4	-	-	-	-
Ischaemic Heart Disease	-	-	-	-	-	-	-	-	-	-	4	5
Hypertensive diseases	-	-	-	-	-	-	-	-	-	-	5	4

TB, HIV and other forms of heart disease are common top causes of death for all age groups and both sexes apart from babies under 1. Respiratory and cardio disorders specific to perinatal period is the main cause of death for both sexes of babies under 1. Diabetes is the top cause of death for women 45 years and older.

7. INTERNAL ENVIRONMENT ANALYSIS

7.1. Service Delivery Platform/Public Health Facilities

There are 72 hospitals in KZN that are run by the Department of Health. This includes the KZN Children's Hospital, which runs as an outpatients' unit. In many instances, previous missionary hospitals have been taken over by the Department of Health, so their location is not strategically ideal. This has meant that in some instances hospitals are not operating in an efficient or financially viable manner. The public health service delivery platform needs to be reconfigured in alignment with budget cuts at both a National and Provincial level as well as changes in the efficiency in operations while still allowing ease of access to public health services.

Map 2: Map with Service Delivery Platform (National Department of Health)

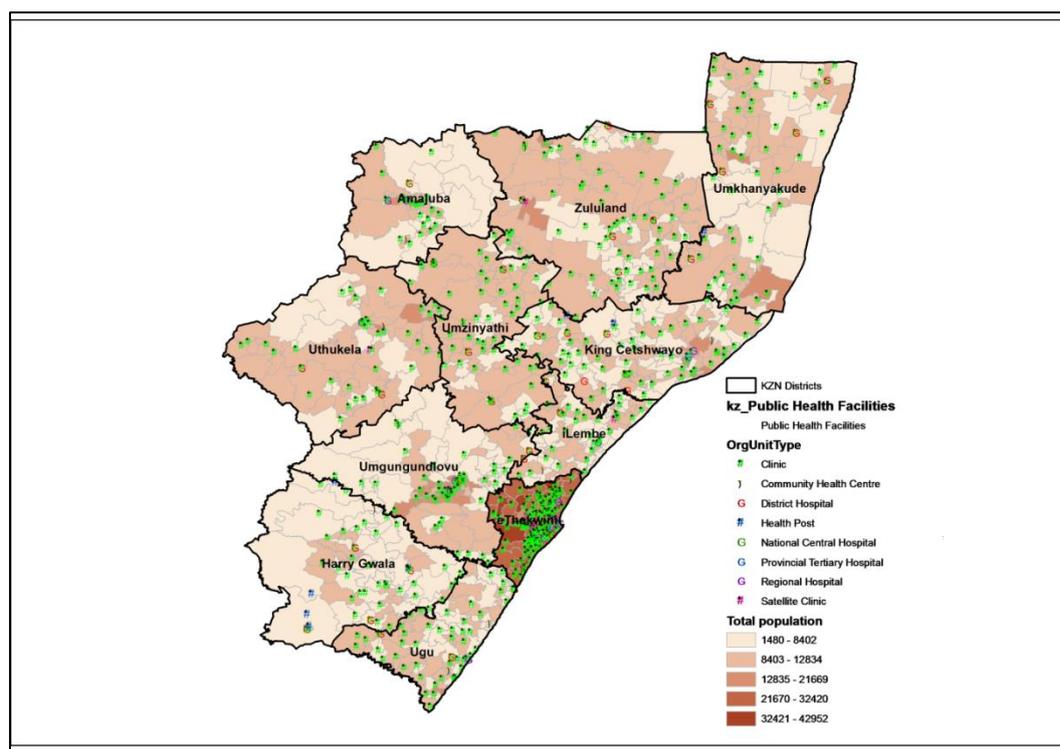
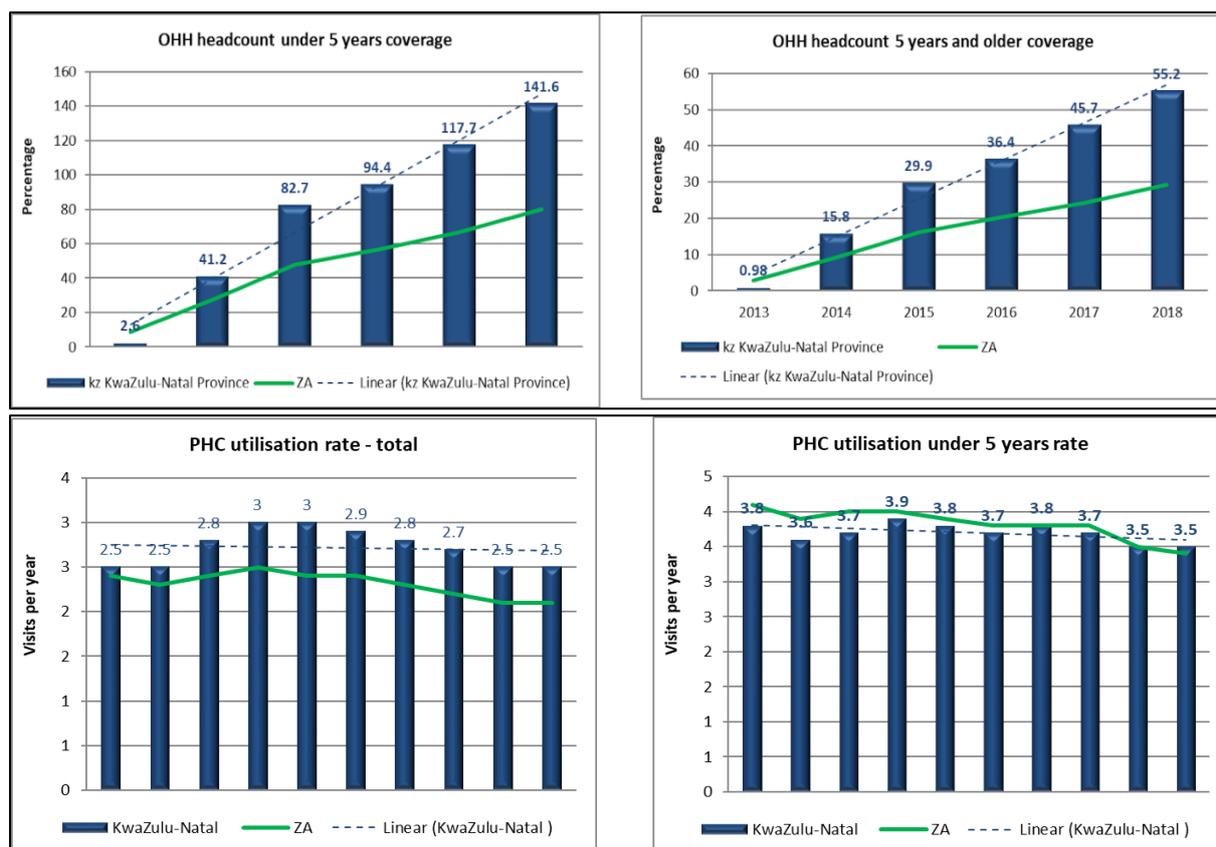


Table 5: Health facilities per District, KZN, and (DHIS Quarter 3 of 2019/20)

District	PHC		Hospitals							
	Fixed Clinics ²	CHCs	District	Regional	Tertiary	Central	Specialised TB	Specialised Other	Specialised Psych	Chronic / Sub-Acute
Ugu	52	2	3	1	0	0	0	0	0	0
uMgungundlovu	50	3	2	1	1	0	2	0	3	0
Uthukela	37	1	2	1	0	0	0	0	0	0
Umzinyathi	53	1	4	0	0	0	1	0	0	0
Amajuba	25	1	1	2	0	0	0	0	0	0
Zululand	73	1	5	0	0	0	1	0	1	0
Umkhanyakude	58	1	5	0	0	0	0	0	0	0
King Cetshwayo	63	1	6	1	1	0	0	0	0	0
iLembe	34	2	3	1	0	0	0	0	0	0
Harry Gwala	39	1	4	0	0	0	1	0	1	0
eThekweni	106	8	4	6	1	1	2	1	1	2
KZN Total	590	22	39	13	3	1	7	1	6	2

² Provincial and Local Authority

Graph 5: Efficiency indicators, KZN



COMMUNITY HEALTH WORKERS PROGRAMME

Ward Based Primary Health Care Outreach Teams (WBPHCOTs) are linked to a PHC facility and consist of CHWs lead by a nurse. CHWs assess the health status of individuals and households and provide health education and promotion service. They identify and refer those in need of preventive, curative or rehabilitative services to relevant PHC facilities.

OUTREACH VISITS

Support visit types monitor the different types of basic health care provided to households as proportion of total number households visited by the WBPHCOT. Most of the household visits are for child health and adherence support. The Outreach household coverage under 5 years and 5 years and older appears much higher for KZN compared to the country average.

PHC UTILIZATION RATE

The primary health care (PHC) utilisation rate indicators measures the average number of PHC visits per person per year to a public PHC facility. It is calculated by dividing the PHC total annual headcount by the total catchment population. The 2013 to 2018 data shows a general negative decline in utilization rates for under 5s while the PHC utilization rate has remained at 2.5. Both these indicators are showing a negative growth at the country level. While the total PHC utilization rate for KZN is still higher than the country average, the under 5 utilisation rate has generally been below the country average with the exception of the 2018 year where the KZN PHC under 5 utilisation rate exceeded the country average.

HOSPITAL CARE

OPD new client not referred rate is new OPD clients not referred as a proportion of total OPD new clients and does not include OPD follow-up and emergency clients in the denominator. The indicator monitors utilisation trends of client's by-passing PHC facilities and the effect of PHC re-engineering on OPD utilisation.

A high OPD new client not referred rate value could indicate overburdened PHC facilities or a sub-optimal referral system. In light of the National Health Insurance Policy, a PHC level is the first point of contact with the health system and therefore key to ensure health system sustainability. If PHC works well and the referral system is seamless, it will result in fewer visits to specialists in referral hospitals and emergency rooms.

Table 6: KZN Hospital efficiency indicators: 2016/17 to 2018/19

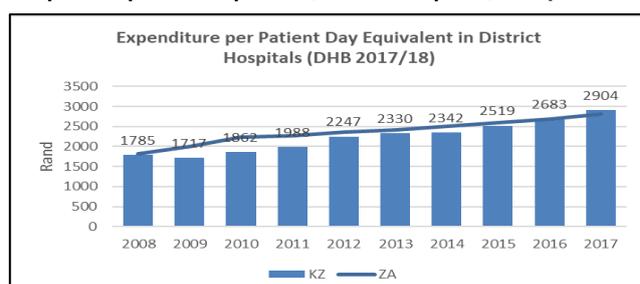
Hospital Type	OPD new client not referred rate			Average length of stay - total			Inpatient bed utilisation rate		
	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
District	49.4%	50.4%	52.4%	5.4 Days	5.4 Days	5.4 Days	56.2%	57.5%	59.5%
Regional	35.8%	43%	44.6%	6.1 Days	6.3 Days	6.3 Days	67.9%	71.7%	73.3%
Tertiary	31.6%	31.5%	30.1%	7.7 Days	7.5 Days	7.9 Days	71.6%	67.8%	69.7%
Central	0.05%	0.1%	0.25%	8.7 Days	8.4 Days	8.7 Days	66.6%	65.6%	65.8%

Table 7: KZN Hospital efficiency indicators: 2016/17 to 2018/19

Hospital Type	Inpatient crude death rate			Delivery by Caesarean section rate		
	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
District Hospital	5.4%	5.4%	5%	28.6%	28.5%	27.5%
Regional Hospital	5.5%	5.3%	4.9%	40.8%	40.4%	41.2%
Provincial Tertiary Hospital	6.3%	6%	5.8%	50.5%	50.3%	51.7%
National Central Hospital	3.2%	3.2%	3.4%	78.5%	77.3%	77.8%

- The Inpatient crude death rate has decreased in all hospitals apart from the central hospital.
- The delivery by Caesarean section rate is increasing in all hospitals apart from district hospitals where is dropped from 28.6% in 2016/17 to 27.5% in 2018/19 and the central hospital that dropped from 78.5% to 77.8% over the same period.
- There is a general drop in bed utilisation rates in most hospitals.

Graph 6: Expenditure per PDE, district hospitals, KZN (DHB 2017/18)



The Expenditure per PDE has been increasing in KZN. The KZN expenditure per PDE has overtaken the Country average from the 2016 year onwards.

Table 8: Hospital Efficiency Indicators per facility (DHIS)

Referral Hospitals		OPD new client not referred rate			Average length of stay - total			Inpatient bed utilisation rate		
		2016/17	2017/18	2018/19	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
Regional Hospital	Addington Hospital	58%	70.7%	66.4%	5.4 Days	5.6 Days	6 Days	79.3%	75.3%	79.7%
	Edendale Hospital	18.1%	30.5%	22.1%	7.4 Days	7.2 Days	7.1 Days	73.8%	71.8%	75.4%
	King Dinuzulu Hospital	53.5%	52.8%	59.5%	11.6 Days	12.2 Days	12.2 Days	65.3%	68.5%	65.6%
	Ladysmith Hospital	29.3%	38.8%	32.5%	6.3 Days	6.3 Days	6.7 Days	83.6%	83.2%	85.1%
	Madadeni Hospital	37.5%	41.9%	40.7%	11.7 Days	11.9 Days	11 Days	64.4%	64.8%	62.6%
	Mahatma Gandhi Hospital	29.5%	44.2%	25.3%	4.9 Days	5.2 Days	5.5 Days	85.1%	84.9%	86.6%
	Newcastle Hospital	43.2%	64.5%	65.7%	3.8 Days	3.9 Days	3.8 Days	73.8%	76.2%	79.1%
	Port Shepstone Hospital	22.9%	20.8%	59.8%	5.3 Days	4.8 Days	5.2 Days	71.8%	72.2%	84.7%
	Prince Mshiyeni Memorial Hospital	27.5%	27.2%	25.1%	6.6 Days	6.8 Days	6.6 Days	46.6%	68.2%	68.4%
	Queen Nandi Regional Hospital	6%	16.1%	25%	5.2 Days	5.1 Days	5.1 Days	65.9%	63.6%	67.8%
	RK Khan Hospital	39.9%	49.7%	53.3%	5 Days	4.8 Days	4.9 Days	97.1%	88.1%	88.1%
	St Aidan's Hospital	10%	2.1%	0%	5.8 Days	1.7 Days	1.5 Days	15.2%	13.6%	20.1%
	General Justice Gizenga Mpanza	56.8%	59.2%	58.9%	5.8 Days	5.4 Days	5.4 Days	76.3%	71.6%	74.3%
Tertiary Hospital	Grey's Hospital	0%	0%	0%	10.6 Days	9.8 Days	9.5 Days	79.5%	69.6%	70.8%
	King Edward VIII Hospital	33.1%	33.3%	33.3%	6.3 Days	6.3 Days	6.6 Days	69.1%	60.8%	63%
	Ngwelezana Hospital	46.3%	47.7%	42%	8.3 Days	7.7 Days	8.9 Days	78.3%	77.7%	81.1%
Central Hospital	Inkosi Albert Luthuli Central Hospital	0.05%	0.1%	0.25%	8.7 Days	8.4 Days	8.7 Days	66.6%	65.6%	65.8%

- a. The high OPD new client not referred rate is highest at Addington, Newcastle and Port Shepstone Hospitals
- b. The lowest bed utilisation is found at St Aidan's, Madadeni and King Edward VIII Hospitals. The 2018 closure of wards at King Edward VIII, due to storm damage contributed to the low utilisation. St Aidan's, though gazetted as a Regional Hospital, provides part of the package of care of a Regional Hospital-as an extension of King Edward VIII Hospital. In Madadeni the non-availability of an urologist has seen the urology ward occupancy dropping to around 30%. The rationalisation team is looking at these efficiencies when deliberating on the rationalisation plan for The Department.
- c. Average length of stay ranged between 1.5 days in St Aidan's to 12.2 days in King Dinuzulu Hospitals

STRATEGIC PLAN 2020/21 – 2024/25

Table 9: Hospital Case Management Indicators

Referral Hospitals		Inpatient crude death rate			Delivery by Caesarean section rate		
		2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
Regional Hospital	Addington Hospital	6.7%	4.7%	4.9%	47.1%	39.7%	39.9%
	Edendale Hospital	5.8%	5.5%	5.6%	46.6%	47.6%	46.6%
	King Dinuzulu Hospital	6.2%	7%	6.9%	36.1%	33.6%	34.3%
	Ladysmith Hospital	6.3%	6.2%	6.1%	39.4%	37.1%	35.3%
	Madadeni Hospital	11%	10.2%	9.2%	N/A	N/A	N/A
	Mahatma Gandhi Hospital	5.4%	5.2%	5.3%	38.5%	37.7%	40%
	Newcastle Hospital	0.89%	1.2%	0.82%	38.6%	36.4%	34.3%
	Port Shepstone Hospital	5.2%	4.7%	5%	45.4%	47.7%	47.6%
	Prince Mshiyeni Memorial Hospital	5.3%	5.3%	4.4%	35.3%	36.7%	39.5%
	Queen Nandi Regional Hospital	2.2%	2.2%	2.2%	53.8%	55.3%	56.2%
	RK Khan Hospital	6%	5.8%	5.5%	34.5%	32.6%	35.2%
	St Aidan's Hospital	1.9%	0.24%	0.27%	N/A	N/A	N/A
	General Justice Gizenga Mpanza	5.1%	5.8%	5%	37.9%	41.6%	42%
Provincial Tertiary Hospital	Grey's Hospital	4.6%	3.8%	3.7%	72.9%	69.9%	73.2%
	King Edward VIII Hospital	4.7%	4.6%	4.5%	47.1%	46.7%	48.3%
	Ngwelezana Hospital	11.4%	10%	10.5%	N/A	N/A	N/A
Central Hospital	Inkosi Albert Luthuli Central Hospital	3.2%	3.2%	3.4%	78.5%	77.3%	77.8%

Source: DHIS

The 2018/19 data shows that the Ngwelezana crude death rate is the highest of all KZN hospitals. St Aidan's and Newcastle have the lowest crude death rates. The 73.2% Delivery by Caesarean section in Greys is the highest in KZN (Apart from the Central hospital).

Challenges with the service delivery platform include:

- Ill-defined Service delivery platform and referral pathway (Configuration of facilities not aligned to package of services provided resulting in inefficiencies, Coverage of PHC facilities not well defined)
- Limited access to healthcare services in periphery – inequity of resourcing
- Insufficient number of specialised beds (incl. for Adolescents, Mental Health, Neonatal Intensive Care Unit (NICU), etc.)
- Unavailability of bed norms to be used in assessing and approving new beds in the Province
- No Stroke Unit in KZN
- No policy / defined parameters for the location of health facilities
- Emergency Medical Services (EMS) poor efficiencies
- Hybrid Model of service delivery of Forensic Pathology Services (FPS) and EMS in the Province leads to ambiguous accountability lines

8. OUTCOME: UNIVERSAL HEALTH COVERAGE (POPULATION AND SERVICE COVERAGE)

The South African health sector is characterized by the following challenges:-

- High cost drivers in the public sector.
- Costly private sector (refer Competition Commission report and OECD reports).
- Quality of health services.
- Curative hospi-centric focus health system.
- Maldistribution and inadequate Human Resource for Health (HRH).
- Fragmentation in funding pools.
- Out-of-pocket payments.
- Financing system that punishes the poor.
- High burden of disease.

Some of the challenges experienced with universal health coverage include poor access to IT due to server challenges, ground roots level technical support and limited broadband access. Food services in the Province faces the challenge with processes at district levels including the monitoring and reporting of performance. The infrastructure, maintenance and HR resource constraints impact on the Department's ability to deliver food services that is of a good standard.

The Departmental policies are often not costed, not developed in consultation with transversal programme and not driving the change in strategies.

The Medical sins (overstocking of medication, theft and incineration, moonlighting) continue to be a challenge in optimally using resources in a financially constrained environment. The management of health care risk waste has also been found to be a challenge as a result of prescripts not being complied to. There is also a poor response to outbreak investigations.

The access to emergency medical services further challenges the access of our clients to good quality of health care. The resource constraints including vehicle, infrastructure and staffing all yield performance that is suboptimal. The challenges faced by the support services for health include the Forensic pathology minimum staff establishment not being finalized, pharmacy infrastructure challenges, shortages in linen, Central Chronic Medicine Dispensing and Distribution (CCMDD) programme data challenges making it difficult to track the performance of the programme.

Health Facilities Management experienced overspending due to unanticipated corrective maintenance. Jobs were created through the Department's Gardens and Grounds Programme and Dr Pixley ka Isaka Seme Memorial Hospital project, which is informed by available funding. Apart from health facilities management, the financial woes facing the Department included financial constraints, delays in SCM processes and poor financial audit outcomes which are further unpacked below.

The strategic priorities for NHI include:

- Costing the current services especially the package services of services at various level of care including costing of protocols
- Capacity building programs to be in place in line with the implementation of NHI
- Develop change management strategy that will support the implementation of NHI
- Improving access to quality appropriate health services and clinical governance
- Continuous improvement of governance and leadership skills of health managers in all levels.
- Quality health infrastructure Improvements.
- Building a strong Primary Health Care (PHC) system.
- Digitalization of the health system including Health Patient registration.
- Improving the health hotel services and continuous quality improvement. Obtaining 100 % compliance with the Office of the Health Standard Compliance (OHSC) quality standards.
- Piloting of PHC Patients Queuing management system in the NHI Pilot Districts in CHCs and clinics in the outer years
- Sustainable supply of Human Resources for health.

AUDIT OUTCOME

- For the 2018/19 year, the Department obtained a qualified audit opinion. The Department attained unauthorized expenditure, irregular expenditure and fruitless and wasteful expenditure amounting to R14.2 million, R4 518 Million and R26.7 million respectively. The Department incurred over-expenditure relating to higher than budgeted medico-legal claims and legal services costs relating to these claims.

Higher than anticipated security services renewal price increases was another contributing factor to the over- expenditure.

The Department has begun to implement the following:

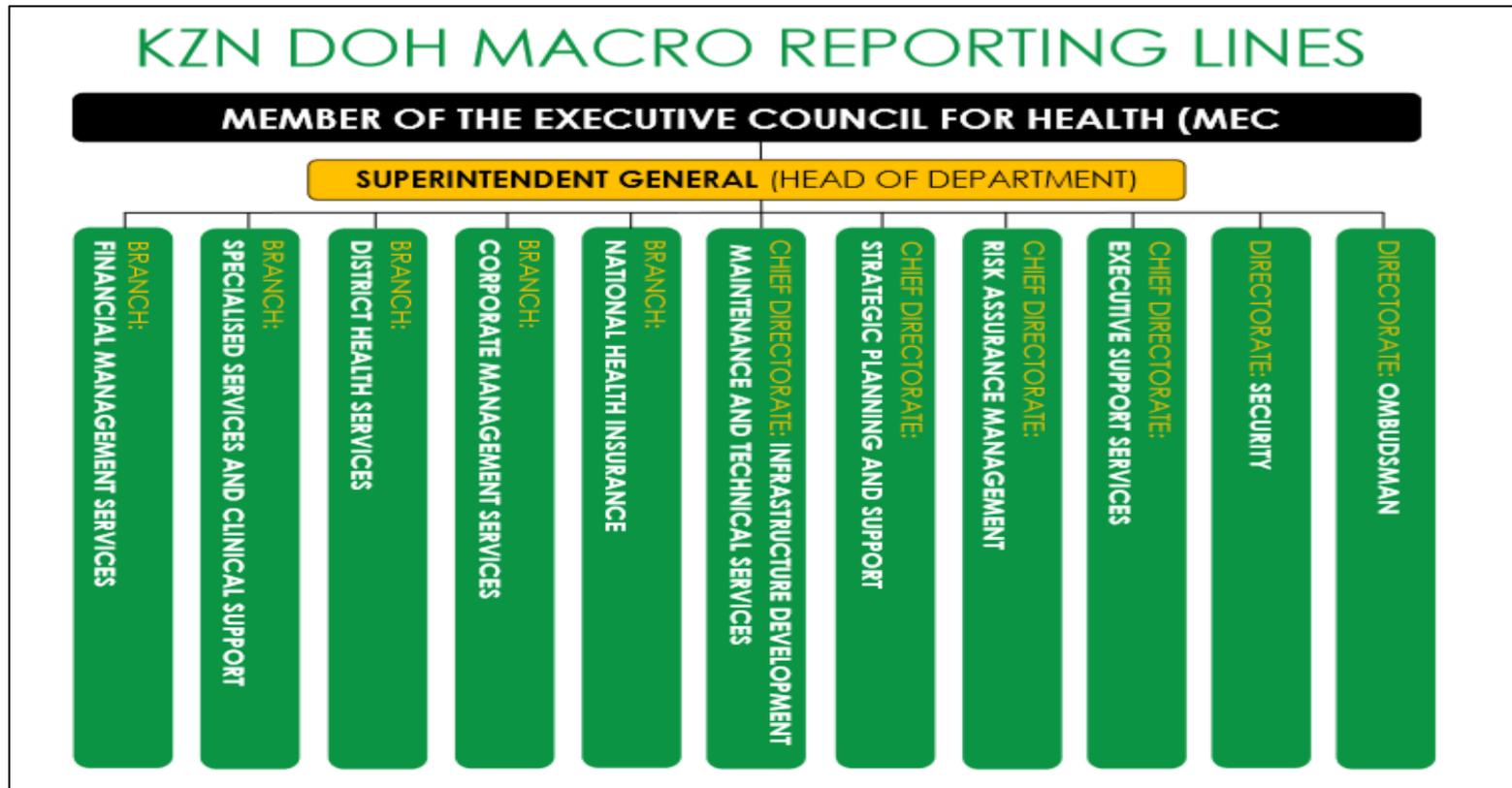
- The Irregular Expenditure register which lists the items from the prior years has been compiled and is in the process of being submitted to the Provincial Treasury for condonation. The period contracts in respect of services (cleaning, security, etc..) have been responsible for the bulk of the irregular expenditure that has been incurred. In addressing this matter, bids for new contracts have been advertised and some are in the evaluation process.
- The creation of Control sheets for all transactions to deal with identification and prevention of irregular expenditure.
- Workshops / forums conducted in all districts to create awareness among SCM officials.
- In an attempt to minimise the occurrence of fruitless and wasteful expenditure, the Departments IT unit has white-listed the eThekweni Metros online portal thereby enabling institutions to access their bills sooner than the posted accounts. This facilitates faster payment of accounts. The Department has also finalised a new set of Financial delegations among which is a delegation to process municipal payments immediately and then submit to the cash flow committee for ratification. This reduces the interest on late payments.

HUMAN RESOURCES FOR HEALTH

The challenges relating to Human Resources include poor implementation of Employee Health and Wellness which is a valuable asset to the Department. The Department is further plagued by inadequate staffing of the correct skills mix. This includes challenges with the attraction and retention of specialists. Accountability remains a challenge in the Department-Employee performance management processes are in place though managers concerns around labour relations commonly results in accountability not being followed through. Governance in both the clinical and corporate spheres of the Department is suboptimal. The HR training, reporting and accountability platform has been integrated into programme six (6). Lack of change management strategies and acceptance of innovations at service delivery level slows down progress. The financial constraints mentioned above also impact on the Department's ability to absorb bursary holders into the KZN health system.

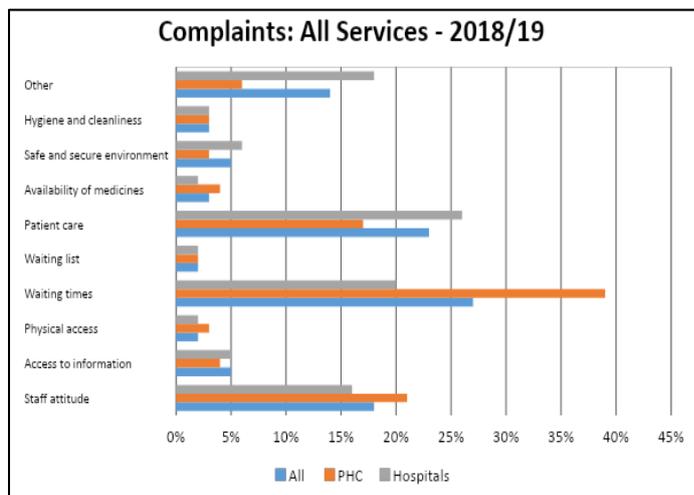
The **Department of Health reporting line structure** is below. A review of the Head Office and District Office Macro structures will be completed during 2020/21. The structure at head office is segmented and not in line with population based planning and interventions.

Figure 1: KZN DOH REPORTING LINES (Graphics by KZN DoH Corporate Communications, 2020)



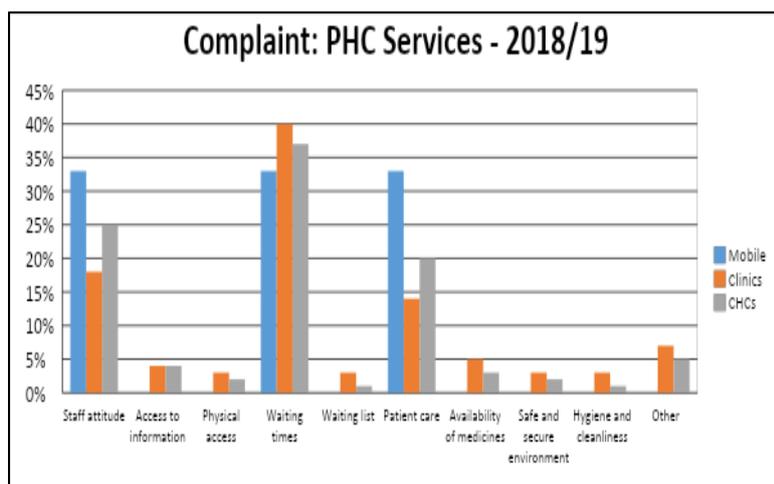
9. OUTCOME: CLIENT EXPERIENCE OF CARE

Graph 7: All Services Complaints, KZN DOH, 2018/19 (Ideal Health Facility Monitoring System)



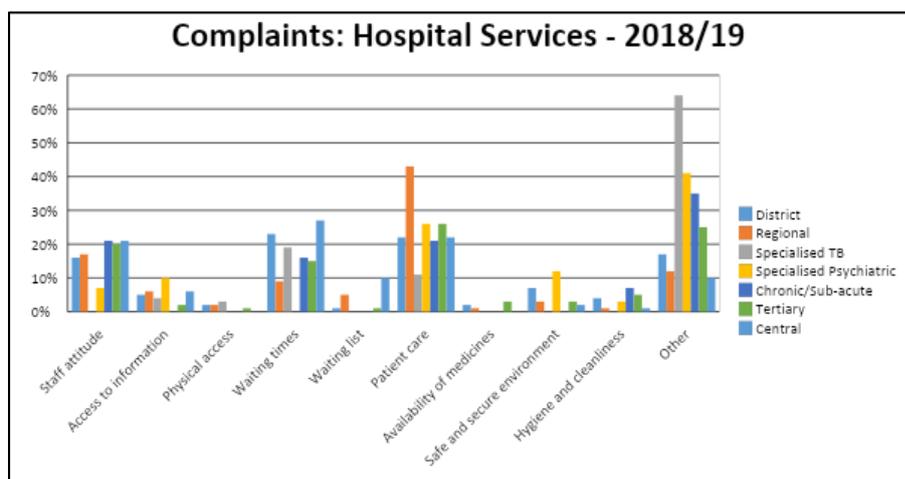
The top three complaints for all services were 1) waiting times, 2) patient care and 3) staff attitudes, in that order. The common factor with the top 3 categories of complaints, is that they are directly related to health personnel. The biggest proportion of complaints for PHC services was on waiting times followed by staff attitude and patient care. Patient care was the leading complaint for hospital services followed by waiting times and staff attitude.

Graph 8: Complaints: PHC Services 2018/19 (Ideal Health Facility Monitoring System)



Mobile services had the same proportions (33%) for staff attitude, waiting times and patient care. It should be noted that mobile services had three complaints in 2018/19, one for each of the three categories mentioned above. Both CHCs and clinics had the biggest proportion of complaints under waiting times followed by staff attitude and patient care.

Graph 9: Hospital Services Complaints 2018/19 (Ideal Health Facility Monitoring System)



The top three complaint categories for hospital services were patient care, waiting times and staff attitude. Regional hospital services had the most complaints under patient care. Central hospital services had the

most complaints under waiting times. Chronic, tertiary and central hospitals services had the most complaints under staff attitude.

10. OUTCOME: REDUCING MORBIDITY AND MORTALITY

In piecing together the content for this section “Reducing Morbidity and Mortality” the Department programme managers were engaged to provide a situational analysis to inform planning. In addition, the Epidemiology, Health Research and Knowledge Management component has produced research reports on EMS; Malaria and Bilharzia; HIV/AIDS, TB and Trauma; MCWH; NCDs; Community Health; PHC and Hospitals and immunisation and selected child diseases. The research findings have been included in the sections below

CHILD HEALTH AND NUTRITION

Globally there is a paradigm shift in the provision of health services for children from one focused on reducing mortality to a broader focus of “Survive, Thrive and Transform”. The aim of child health and nutrition services is to produce a 19-year-old person in optimal health (physical, mental and emotional), raised in a safe and secure environment, appropriately educated and able to contribute socially and economically to society.

This global shift is a response to a change in the population pyramid as fertility rates are decreasing with life expectancy increasing and change in the burden of childhood diseases. This trend is seen globally, except in Sub-Sahara Africa where fertility continues to increase and mortality remains high. However, South Africa has started to follow global trends with fertility rates static and child mortality rates decreasing. Currently, in South Africa, the Infant Mortality Rate is 22.1 / 1000 live births and the under 5 mortality rate is 28.5 / 1000 live births, as per Stats SA.

Within this global paradigm shift explained above, there are 3 focus areas namely 1) survive, 2) thrive and 3) transform

1. Survive

To date the focus for survival has been on under-5 deaths but this will shift to under-1 and late adolescent deaths. However, in South Africa under-5 remains a key focus and this will continue for the next planning cycle within the KZN context. The main focus amongst under-5 deaths is, a) neonatal deaths, b) untreated deaths (or deaths that occur outside of the health system), c) non-natural deaths and d) deaths related to severe acute malnutrition (SAM), pneumonia and diarrhoea.

Within in the public health system, modifiable factors for under 5 child mortality are identified at 5 broad levels, each with the following recurring failures:-

- a. Home – failure to recognize the severity of the child's condition; and a resulting delayed entry into the health service. Inadequate household food security (quality and quantity).

- b. PHC clinic – Poor Infant and Young Child feeding counselling contributing to poor practices, inadequate growth monitoring and failure to recognize growth faltering and malnutrition. Poor implementation of IMCI (Integrated Management of Childhood Illnesses) and delayed referral to the next level of care.
- c. In transit – delayed response in transporting child from PHC facility to hospital
- d. On arrive at the hospital – failure by clinical staff to correctly assess and manage the child.
- e. In the ward – there is a failure by clinical staff to monitor the condition of the child recognize signs of deterioration.

2. Thrive

Children thrive through love, growth and play. This concept has been implemented through the initiation of the ECD's (Early Childhood Development) centres that are located within communities. This concept promotes optimal growth and development within the 1st 1000 days of life (starting from conception) and is important as it determines the child's ability to function later in life as an adult within society. Implementation of Nutrition guidelines for ECD programmes further aims to deliver nutrition and health interventions targeting the first 1 000 days.

The paradigm shift within World Health Organisation (WHO) regarding child health also includes the optimal functionality of disabled children and children with long term chronic conditions with palliative care, where appropriate to support the child and the family structure

3. Transform

The change in WHO definition for child health has also meant that the focus has now shifted to include adolescents, specifically mortality in the 15 – 19 age group due to the high number unnatural deaths (suicide, combined with intra & interpersonal violence). The public health system needs to transform to encompass the full definition of a child up to 19 years old.

South Africa needs to create a health system that can support and implement this global paradigm shift; however, the challenge will be in monitoring the interventions put in place, as the current information systems and surveys are not conducive to this change in focus, but remain focused instead on under 5 child mortality.

In KwaZulu-Natal, there are 3 main focus areas to reduce under 5 mortality, namely neonatal care; Nutrition and Emergency care. For each of these 3 focus areas there are specific interventions being implemented at the different levels of care seen below. These strategies and interventions correspondence with the modifiable factors discussed under the situational analysis for child health, however they also align to the global initiatives being implemented by the WHO, as discussed above.

Table 10: Focus Areas and Interventions to Reduce Under 5 Mortality

	Nutrition	Emergency Care	Neonatal care
Home	Improve household access to food security and education on child health nutrition. Maternal nutrition during pregnancy and lactation to improve neonatal and infant outcomes	Educate the community and parents on the danger signs with regards to child health, including when health services should be accessed.	Planned pregnancy and early booking Linkage of all new-born babies to CCGs for ongoing monitoring and support
PHC Clinic	Infant and young child feeding interventions Inc. promotion of exclusive breastfeeding for the first 6 months of life and continued breastfeeding for 2 years and beyond. Timorous introduction of appropriate complementary feeding. Nutrition education. Active growth monitoring and promotion. Vitamin A supplementation Improved clinical management of SAM cases	Correct implementation of IMCI practices	
In transit (Referral of child to next level of care)	Non-delayed and appropriate up referral of child	No delayed response in up-referral of child to the next level of care	Effective neonatal transport systems and service
On arrival at Hospital	Improved assessment and management of SAM cases. Implementation and integration of Mother Baby Friendly Initiative principles in standards of care to improve neonatal and infant outcomes.	Improved assessment of the condition of the child and the ability to recognize the severity of the condition of the child	
At ward level	Improved management of SAM cases within the integrated treatment of the child	Improved clinical management of children including the ability to recognize the deterioration of condition of the child	Kangaroo Mother Care Surfactant and Nasal continuous positive airway pressure (NCPAP) for respiratory support Management of neonatal sepsis

Other strategic challenges identified via the Departmental reporting processes include:

- Poor access of health services by children under 5. This impacts on coverage for screening and immunisation; initiation and retention in care for Communicable Diseases.
- Poor clinical management of children and ANC clients

MATERNAL AND WOMEN'S HEALTH

- The Department of Health resources are being drained by Litigation. By far the greatest litigation claim burden relates to cerebral palsy alleged to have been caused by substandard care during labour. Ensuring a good quality of care during labour can yield fewer adverse outcomes, and reduce expenditure on compensation.

- Safe care during labour cannot be provided unless there is one-to-one midwife to patient care during labour. Guidelines for the staffing of labour wards are available, but staffing norms are not officially sanctioned and there is often mal-distribution of midwives within a district. The staffing of labour wards needs to be considered over the next 5 year planning cycle.
- The decentralisation of delivery sites was a strategy to improve access to safe delivery site. The strategy was counterproductive for the following reasons: the minimum number of midwives needed per delivery site is 2 midwives (to care for both mother and baby) per shift. This requirement stretches the midwife resource that is already constrained. In addition, the few number of deliveries results in midwives at these decentralised sites “losing” their skill due to the low number of deliveries they conduct infrequently. The centralisation of delivery sites should be explored over the next 5 years
- Busy district hospitals and most regional hospitals are further burdened by conducting deliveries that are not high risk. For example, at Newcastle hospital, around 2 in every 7 deliveries are low risk and could be conducted by Midwives at a primary health level, without supervision from doctors. The next 5 to 10 years should be used to explore the implementation of Onsite Midwife Birthing Units (OMBU) at busy district and regional hospitals. The women who present for delivery will be triaged and low risk deliveries conducted at the OMBU
- The benefit of lodges at the centralised delivery sites/hospitals includes access to catering, cleaning, security and reduced need for ambulances. Feasibility of Waiting Mothers Lodges at Hospitals to be explored over the next 5 years.
- The assessment of hospitals as safe Caesarean section sites has yielded improvements in the quality of care. Currently every hospital offers C/S. This has a high staff complement need for every hospital, even when the deliveries are few. Further feasibility study needs to be undertaken on the rationalisation of Caesarean Section sites within the Province.
- The majority of regional hospitals in KZN struggle to recruit and retain the recommended 6 Obstetrics & Gynaecology (OBGYN) specialists required for a Regional hospital. A further challenge affecting the filling of specialist OBGYN posts especially in rural/outlying areas is due to the cut in the number of registrars. The Department to conduct feasibility on the rationalisation of regional Hospitals in the Province.

Reduction of maternal deaths can be achieved quickest by taking action to reduce deaths associated with HIV infection and those due obstetric haemorrhage and hypertensive disorders of pregnancy (the 3 Hs) by involving all levels of the health care system from policy makers to health care professionals to the community.

The strategies needed to achieve these reductions include clinicians being committed to providing quality care to all pregnant women (in all areas), safe caesarean deliveries, preventing unwanted pregnancies and engaging the community to ensure the women know what to do when pregnant (5 C's). This is built upon a health system that has knowledgeable and skilled health care professionals, facilities that have the appropriate resources and an effective emergency service to rapidly transport patients to the appropriate level of care. To ensure continued functioning of these strategies the service must continually be monitored and evaluated and where appropriate remedial action taken where appropriate. The Essential Steps in Management of Obstetric Emergencies (ESMOE)

programme in priority districts has shown a significant reduction in Maternal Mortality Rate in facility (iMMR) overall of 29.3% and for direct causes of maternal death a 17.5% reduction and should be implemented widely.

Challenges identified through the departmental reporting processes include:

- Poor clinical management
- Teenage pregnancies
- Inequitable distribution of resources Inc. staff, infrastructure
- Uptake of maternal and women's services

Priority outputs for implementation for maternal health

- Review the proposal on the establishment of OMBU's
- Introduction of new protocols
- Reduce death due to pregnancy related hypertension
- Implementation of the Safe Caesarean Delivery standards
- Improve inter-facility transfers for obstetric cases
- Improve management of non-related pregnancy infections by
 - improving TB screening,
 - improving ART adherence and
 - viral load monitoring

MEN'S HEALTH

The challenge identified through the Departmental reporting processes includes men not accessing health services timeously. This late presentation has an implication for prognosis.

HIV AIDS

The interventions for HIV/AIDS that are being implemented, such as HIV testing, male condom distribution rates and the number of medical male circumcisions (MMC) has been increasing over the past 10 years. Risk factors for HIV/AIDS such as male urethritis syndrome and new episodes of other sexually transmitted infections have been steadily decreasing as well.

HIV prevalence amongst clients tested (excluding antenatal (ANC)) has been decreasing and this may be attributed to the scale up of ART treatment which is known to decrease HIV incidence and mortality. The number of total clients remaining on ART at the end of the month (TROA) has been increasing at a steep rate. However, on the other hand ART drug stock out rates has also been increasing over the years and this may be due to the expansion of the ART treatment programme.

Poor ART treatment outcomes (ART death rate and ART Loss to Follow up rate) in adults and children seem to be decreasing in the Province. However, the rate of ART viral load done which is a health system effectiveness indicator has been decreasing since 2016/2017. This

may be due to the “Test and Treat” approach whereby clients found to HIV positive are immediately placed on ART treatment regardless of CD4 count cell numbers. Those patients that are on ART and virally suppressed has reached rates of over 90% in the past five years.

When looking at the associations between HIV prevalence and various factors, this report found that increasing MMC as a preventative measure, decreasing risk factors such as Male Urethritis syndrome incidence and STI treated new episode incidence, expanding ART treatment and increasing viral load suppression assists with curbing the scourge of HIV (KZN DoH Epidemiology; Health Research and Knowledge Management, 2019).

TB

TB prevention interventions, such as Bacillus Calmette-Guerin (BCG) vaccination coverage has been over 60% in the last ten years except in 2015/2016, whereby it decreased. The 60% is considered to be poor coverage, as all babies should be vaccinated.

The rate of clients screened for TB symptoms in facilities has been increasing, reaching almost 100% in 2018/2019 whilst the rate of TB sputum tested in 5 years and older reached 90% in 2016/2017 and decreased to 88% in 2018/2019.

Factors associated with TB prevalence such as the rate of TB clients knowing their HIV status dropped from 94% in 2014/2015 to 86% in 2018/2019 and the rate of TB clients who were known to be HIV positive was over 60% up until 2018/2019 whereby it dropped to 56%.

The rate of TB clients 5 years and older that have started on treatment was above 100% in the past five years except in 2016/2017. New Sputum Smear Positive conversion rates at 2 and 3 months have decreased from 2016/2017 onwards to almost 50% in 2018/2019.

Associations between TB cases (new and all) show that prevention interventions implemented by the Department such as HIV testing, placing HIV positive new clients on IPT and ART treatment should continue since they were found to decrease TB cases.

The risk factors for TB such as HIV co-infection demonstrated by HIV prevalence and TB clients with known HIV status are associated with increases in TB cases. There were no statistically significant associations between TB cases and treatment outcomes as anticipated (KZN DoH Epidemiology; Health Research and Knowledge Management, 2019).

GLOBAL OUTBREAKS

On the 31st December 2019, the World Health Organization (WHO) China Country Office reported a cluster of pneumonia cases in Wuhan City, Hubei Province in China. A novel coronavirus (Covid-19) was confirmed as a causative virus. Several other cities in China as well as other countries have also reported cases.

The provincial readiness includes the formulation of Revised Case definition(s) that has been distributed to all health facilities through Communicable Diseases Control (CDC)

Coordinators and Infection Prevention Control Practitioners (IPCP). This is being updated regularly as per updates from NICD. The National Hotline for community members 0800 029 999 has been established and shared for any queries. Screening of returning travelers from China at the Ports of Entry have been intensified and NICD has developed and distributed clinical guidelines to all Provinces for doctors and nurses to use, in both the public and private sector, these documents include the following:

- Case investigation form
- Specimen collection guideline
- Contact tracing flow chat
- Contact tracing form (For confirmed cases)
- Standard operating procedure (South Africa)

There is currently no standard treatment guideline for Covid-19 as yet. The National Essential Medicines List Committee is drafting a protocol which will focus on symptomatic treatment.

There were initially four designated hospitals (Greys, Ngwelezana, Manguzi and Addington) for treating patients diagnosed with Covid-19. Subsequently, a number of District Hospitals have been reconfigured and prepared to accommodate the increasing cases requiring hospitalization. Engagements with the Military Health and Private Health sectors are continuing to expand the number of facilities to house patients needing hospitalization.

11. MTEF BUDGETS

Table 11: Expenditure Estimates (R'000) for the Department of Health

Sub-Programme	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
	R'000	2016/17	2017/18				2018/19	2019/20	
Administration	845 674	836 655	810 858	933 361	811 045	811 045	964 600	931 581	979 809
District Health Services	18 147 911	19 732 316	20 802 064	22 436 939	22 568 220	22 568 220	23 841 532	25 879 819	27 346 783
Emergency Medical Services	1 209 263	1 377 577	1 446 650	1 631 158	1 571 046	1 604 739	1 612 375	1 780 043	1 873 820
Provincial Hospital Services	9 398 975	10 133 671	10 964 094	11 330 404	11 449 357	11 426 824	12 698 812	12 909 862	13 282 259
Central Hospital Services	4 534 157	4 864 123	5 098 203	5 279 898	5 280 198	5 273 391	5 428 662	5 730 572	6 043 338
Health Sciences and Training	1 201 074	1 246 050	1 181 630	1 281 885	1 343 637	1 343 637	1 383 264	1 523 538	1 626 126
Health Care Support Services	268 768	198 202	485 637	332 359	317 359	313 006	338 644	364 122	382 949
Health Facilities Management	1 420 575	1 522 727	1 760 694	1 810 974	1 810 974	1 810 974	1 789 792	1 772 539	1 859 034
Sub-Total	37 026 397	39 911 321	42 549 830	45 036 978	45 151 836	45 151 836	48 057 681	50 892 076	53 394 118
Unauthorized expenditure (1st charge) not available for spending	-	-	-	-	-	-	-	-	-
Baseline available for spending after 1st charge	37 026 397	39 911 321	42 549 830	45 036 978	45 151 836	45 151 836	48 057 681	50 892 076	53 394 118

Table 12: Summary of Payments and Estimates by Economic Classification (R'000) for the Department of Health

Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
	R'000	2016/17	2017/18				2018/19	2019/20	
Current payments	34 739 862	36 961 386	39 684 474	42 316 279	42 381 329	42 318 959	45 670 760	48 078 958	50 303 054
Compensation of employees	23 354 896	24 614 793	26 336 189	28 942 177	28 408 488	28 348 729	30 750 273	31 911 530	33 507 830
Goods and services	11 382 844	12 343 292	13 342 400	13 373 683	13 971 832	13 968 896	14 920 045	16 166 961	16 794 735

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Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
	R'000	2016/17	2017/18				2018/19	2019/20	
Communication	116 893	103 890	103 146	119 185	103 272	103 100	106 384	111 329	116 672
Computer Services	163 632	132 347	110 171	174 004	116 608	110 365	120 112	126 394	132 462
Consultants, Contractors and special services	1 308 107	1 457 574	1 380 829	1 464 514	1 463 541	1 397 763	1 432 733	1 510 364	1 582 864
Inventory	5 885 762	5 898 582	6 655 548	6 283 088	6 460 370	6 502 647	7 252 056	8 131 509	8 530 805
Operating leases	139 376	137 524	139 357	139 941	150 871	152 547	170 925	156 055	86 455
Travel and subsistence	83 199	73 547	68 068	90 306	86 034	89 686	87 762	92 373	96 807
Maintenance, repair and running costs	301 898	375 931	388 612	389 929	365 678	402 654	390 348	420 447	440 624
Other including Assets<5000, training and development, property payments, operating expenditure and venues and facilities	3 383 977	4 163 897	4 496 669	4 712 716	5 225 458	5 210 134	5 359 725	5 618 490	5 808 046
Interest and rent on land	2 122	3 301	5 885	419	1 009	1 334	442	467	489
Transfers and subsidies to	1 035 657	1 248 707	1 106 595	750 139	773 551	826 051	700 512	740 445	775 986
Provinces and municipalities	159 755	225 674	219 387	232 091	231 742	224 173	244 607	258 324	270 723
Departmental agencies and accounts	20 131	19 280	21 157	22 246	22 246	22 378	23 469	24 759	25 947
Higher education institutions	-	-	-	-	-	-	-	-	-
Non-profit institutions	203 929	141 396	62 473	56 513	56 513	54 467	58 508	61 726	64 689
Households	651 842	862 357	803 578	439 289	463 050	525 033	373 928	395 636	414 627
Payments for capital assets	1 106 314	1 592 882	1 758 330	1 970 560	1 996 956	2 006 553	1 686 409	2 072 673	2 315 078
Buildings and other fixed structures	910 917	1 069 333	1 249 066	786 945	899 373	908 264	904 683	1 301 415	1 525 920
Machinery and equipment	195 397	523 549	509 264	1 183 615	1 097 583	1 098 289	781 726	771 258	789 158
Payment for financial assets	144 564	108 346	431	-	-	273	-	-	-

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Economic Classification	Audited Expenditure Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Expenditure Estimates		
	R'000	2016/17	2017/18				2018/19	2019/20	2020/21
Total economic classification	37 026 397	39 911 321	42 549 830	45 036 978	45 151 836	45 151 836	48 057 681	50 892 076	53 394 118
Unauthorised expenditure (1 st charge) not available for spending	-	-	-	-	-	-	-	-	-
Total economic classification	37 026 397	39 911 321	42 549 830	45 036 978	45 151 836	45 151 836	48 057 681	50 892 076	53 394 118

PART C: MEASURING OUR PERFORMANCE

12. INSTITUTIONAL PROGRAMME PERFORMANCE INFORMATION

Table 13: Measuring the Impact

Impact Statement: Increased Life Expectancy	South Africa		Provincial	
	Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)
Life Expectancy at Birth	To be determined	To be determined	60.9 years	62.2 years
Life Expectancy at birth: Female	To be determined	To be determined	64.1 years	65.4 years
Life Expectancy at birth: Male	To be determined	To be determined	57.7 years	59 years

Key to the shaded colours for the indicators	Meaning
	PDGP INDICATOR WITH FIXED TARGETS MONITORED THROUGH ACTION WORK GROUP 10
	NATIONAL INDICATORS (CUSTOMISED)
	PROVINCIAL INDICATORS

MEASURING THE OUTCOMES

Table 14: Outcome: Universal Health Coverage

Outcome Indicator	Data Source	South Africa		Provincial	
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)
1. UHC service Index ³	SAHR	68%	75%	71.7%	73.5%
1. Audit opinion of Provincial DoH	Annual Reports	Unqualified	Clean Audit	Qualified	Unqualified
2. Contingent liability of medico-legal cases	Medico-legal case management system	R 90 Bn	R18 Bn	R20 Bn	R 18 Bn
3. Percentage of facilities certified by OHSC	To be determined	NA	NA	New indicator	71.4%
4. Number of districts with Quality Improvement; monitoring and response forums formalized and convened quarterly	Terms of reference for response forums	Baseline to be determined	52	New indicator	11
5. Ideal clinic status obtained rate	Ideal Health Facility Software	56% (1920/3400)	100%	75.6%	100% (610 / 610)
6. Percentage of PHC facilities with functional clinic committees	Attendance registers of meetings of clinic committees	Baseline to be determined	TBD	New	100% (610/610)
7. Percentage of hospitals with functional hospital boards	Attendance registers of meetings of hospital board meetings	Baseline to be determined	TBD	New	100% (72/72)
8. Professional nurses per 100 000 population	Persal/ StatsSA	NA	NA	153 / 100k (17 444 / 11 417 126)	152.5 / 100k (18 421 / 12 079 648)
9. Medical officers per 100 000 population	Persal/ StatsSA	NA	NA	34 / 100k (3 879 / 11 417 126)	27.4 / 100k (3 310 /12 079 648)

³Performance measurement to commence once NHI Fund is operational and purchasing health services on behalf of the population.

EXPLANATION OF PLANNED PERFORMANCE OVER THE FIVE YEAR PLANNING PERIOD

The outcome universal health coverage is directly linked to the 2024 Impact as unpacked in the MTSF “Universal Health Coverage for all South Africans achieved and all citizens protected from the catastrophic financial impact of seeking health care”. Further, the strategic plan outcome links to the MTSF outcome “Universal Health Coverage for all South Africans achieved”. The indicator “Universal Health Coverage (UHC)” intends to show how the department delivers on its mandate to provide quality health services to the users of the public health care system. Some of the enablers include the resources including financial and human required to improve access to health care facilities and health care professionals. This outcome of universal health coverage will contribute towards the IMPACT of Increased life expectancy through enhanced prevention efforts as well as improved access to curative care at the various levels of health facilities. This outcome also looks into issues of governance which is an enabler in the provision of universal health coverage. One cannot remove the quality of care from discussion on universal health coverage. The outcome also aims to have 100% of PHC facilities certified as ideal over the 5 year period.

Table 15: Key Risks for the Outcome: Universal Health Coverage

Outcome	Key Risks	Risk Mitigation
Universal Health Coverage	Increase in Medico-Legal Contingent Liability	<ul style="list-style-type: none"> Migrate to an electronic records management system to overcome loss of files Appointment of a panel of legal experts covering all medical sub-specialties Roll out of the approved clinical governance and quality improvement policy in order to standardize structures, management approach and activities at all levels.
Universal Health Coverage	Potential litigation/court challenges regarding licensing of Private Health Establishments	<ul style="list-style-type: none"> Develop the Provincial Private Licensing Regulation. Resource Private Licensing Unit adequately.
Universal Health Coverage	Misstatement of financial statements	<ul style="list-style-type: none"> Review gaps on Commuted Overtime policy Enforce compliance once the policy has been finalised"
Universal Health Coverage	SCM inefficiencies including delays in procurement of goods and services, and inadequate asset management which will impact on audit outcomes	<ul style="list-style-type: none"> Automation of the SCM system and inventory management. Filling of essential posts. Centralisation of SCM services at district level to reduce bottlenecks and improve turnaround times.
Universal health coverage	Mismanagement of HRMS Processes (e.g. Leave Management, Overtime Management)	<ul style="list-style-type: none"> Service Conditions to obtain certification from HR Managers and CEOs that leave forms received are captured on PERSAL
Universal Health Coverage	Poor Strategic plan alignment with the organisational structure	<ul style="list-style-type: none"> Finalise Service platform documents Finalize Organizational Structures for all Institutions
Universal health coverage	Management of Pharmaceutical Stock	<ul style="list-style-type: none"> PHC: Co-ordinate annual trainings on KZN PHC Medicine Supply Management SOPs per District/Su-district and monitor compliance to the SOPs using a Provincial standardised tool. Hospitals: Revise and strengthen the implementation of Rx Solution SOPs and standardise Rx

Outcome	Key Risks	Risk Mitigation
		Solution Management Reports
Universal Health Coverage	Missing equipment in ambulances (Medical equipment and Vehicle equipment)	<ul style="list-style-type: none"> Filling of posts; Shift Leaders, Station Leaders, Sub-District Managers, EMS District Managers
Universal Health Coverage	Shortage of emergency Ambulances to meet service demand (to comply with the norm 1:10000)	<ul style="list-style-type: none"> Vehicle Replacement Plan Lobby for funding for the implementation of vehicle replacement policy
Universal Health Coverage	Potential litigation/court challenges regarding licensing of Private Health Establishments	Resource Private Licensing Unit adequately. The proposed new licensing unit to be established in conjunction with EMS will include staffing for private licensing.
Universal Health Coverage	Inadequate administration and management of Pharmaceutical Stock	<ul style="list-style-type: none"> Appointment of Pharmacist Assistants at PHC Clinics Train Pharmacists on the National DOH Tool for Demand Planning;
Universal Health Coverage	SCM for infrastructure	<ul style="list-style-type: none"> Adopt the framework for infrastructure delivery and procurement
Universal Health Coverage	Non-availability of and unreliable Infrastructure	<ul style="list-style-type: none"> Prioritise existing infrastructure over the building of new infrastructure to improve condition and reliability of the existing infrastructure Increasing capacity at existing facilities to meet the demand for services (Equitable distribution of services within districts)
Universal health coverage	Non availability of medical equipment	<ul style="list-style-type: none"> Programme for replacement of existing unreliable equipment Improve on maintenance strategies

Table 16: Outcome: Improved Client Experience of Care

Outcome Indicator	Data Source	South Africa		Provincial	
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)
1. Patient Experience of Care satisfaction rate – PHC	Patient surveys	76.5%	85%	68% (31 326/46 068)	71.4% (34 586/48 418)
2. Patient Experience of Care satisfaction rate - District Hospitals	Patient surveys	TBD	TBD	81% (2 923/3 609)	85.1% (3 227/3 793)
3. Patient Experience of Care satisfaction rate - Regional Hospitals	Patient surveys	TBD	TBD	81% (4547/5613)	85.1% (5020/5899)
4. Patient Experience of Care satisfaction rate (TB Hospitals)	Patient surveys	TBD	TBD	92% (131 / 142)	97.3% (145 / 149)
5. Patient Experience of Care satisfaction rate (Specialised Psychiatric hospitals)	Patient surveys	TBD	TBD	88% (169 / 192)	92.6% (187 / 202)
6. Patient Experience of Care satisfaction rate (Chronic/Sub-Acute Hospitals)	Patient surveys	TBD	TBD	79% (122 / 154)	83.3% (135 / 162)
7. Patient Experience of Care satisfaction rate (Tertiary Hospitals)	Patient surveys	TBD	TBD	74% (585 / 790)	77.8% (646 / 830)
8. Patient Experience of Care satisfaction rate (Central Hospitals)	Patient surveys	TBD	TBD	90% (343 / 381)	94.8% (379 / 400)
9. Patient Safety Incident (PSI) case closure rate -PHC	Patient safety incident software	TBD	TBD	65.9% (270/410)	93% (198/212)
10. Patient Safety Incident (PSI) case closure rate (District Hospital)	Patient safety incident software	TBD	TBD	88.3% (1 166/1 252)	99% (1 013/1 023)
11. Patient Safety Incident (PSI) case closure rate (Regional Hospital)	Patient safety incident software	TBD	TBD	86% (240 /279)	93.2% (247/265)

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Outcome Indicator	Data Source	South Africa		Provincial	
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)
12. Patient Safety Incident (PSI) case closure rate (TB Hospitals)	Patient safety incident software	TBD	TBD	88% (44 / 50)	97.9% (46 / 47)
13. Patient Safety Incident (PSI) case closure rate (Psychiatric Hospitals)	Patient safety incident software	TBD	TBD	94.6% (192 / 203)	96% (190 / 198)
14. Patient Safety Incident (PSI) case closure rate (Sub acute, step down and chronic medical hospitals)	Patient safety incident software	TBD	TBD	95.8% (136 / 142)	100% (137 / 137)
15. Patient Safety Incident (PSI) case closure rate (Tertiary Hospitals)	Patient safety incident software	TBD	TBD	72.1% (310 / 430)	78% (319 / 409)
16. Patient Safety Incident (PSI) case closure rate (Central Hospital)	Patient safety incident software	TBD	TBD	100% (38 / 38)	100% (33 / 33)

EXPLANATION OF PLANNED PERFORMANCE OVER THE FIVE YEAR PLANNING PERIOD

Over the next 5 years the department will focus on Improved Supervision for optimal performance of limited human resources in meeting client expectations. The Department endeavors to decrease harm to patients during care and procedures, decrease misdiagnosis of patients' Condition, implement the Medico Legal Turnaround Plan, Enforce adherence to treatment protocols and ensure that no client is turned away.

Measures to treat Patients and family with courtesy and consideration include plans to correctly implement the appointment system, reduce waiting times and implement radical programme on improving staff attitudes

Table 17: Key Risks for the Outcome: Improved Client Experience of Care

Outcome	Key Risks	Risk Mitigation
Improved Client Experience of Care	Inaccessible Primary Health Care services- in excess of 5 km away from public health service users ^{4 5}	<ul style="list-style-type: none"> Alternative modes of health service delivery inc Mobiles and WBOTS⁶
Improved Client Experience of Care	Infrastructure not meeting Health and safety standards	<ul style="list-style-type: none"> Prioritise and budget for health and safety compliance
Improved Client Experience of Care	The shortage of key health professionals experienced in the increased population, faced with increased burden of the disease. Failure to retain health professionals	<ul style="list-style-type: none"> Increase budget for staffing and equipment. Expand accessibility to specialists through Telemedicine and other E-Health platforms

⁴ PGDP AWG Business Plan

⁵ (CSIR GUIDELINES)

⁶ Programme 2

Table 18: Outcome: Reduced Morbidity and Mortality

Outcome Indicator	Data Source	South Africa		Provincial	
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)
1. Maternal Mortality in facility Ratio (total)	Maternal death register, Delivery Register	129/100 000	<100 /100 000	88.4 /100 000 <i>(188 /212 723)</i>	70/100 000 <i>(146 /208 003)</i>
2. Maternal Mortality in facility ratio -District Hospitals		TBD	TBD	58.1 / 100 000 <i>(51 / 87 811)</i>	47.8/100 000 <i>(44 / 92 393)</i>
3. Maternal Mortality in facility ratio - Regional Hospitals		TBD	TBD	107.9 / 100 000 <i>(82 / 76 025)</i>	79.4/100 000 <i>(62/77 516)</i>
4. Maternal Mortality in facility ratio - Tertiary Hospitals		TBD	TBD	355.5 / 100 000 <i>(29 / 8 158)</i>	305.7/100 000 <i>(24 / 7 879))</i>
5. Maternal Mortality in facility ratio - Central Hospitals		TBD	TBD	1 431.5 / 100 000 <i>(7 / 489)</i>	798/100 000 <i>(4 / 470)</i>
6. Live Birth under 2 500 g in facility rate	Delivery register, Midnight report	TBD	TBD	11.9% <i>(24 035 /201 947)</i>	11% <i>(22 665 /206 041)</i>
7. Neonatal death in facility rate - total	Delivery register, Midnight report	TBD	TBD	11.5 /1000 <i>(2315 / 201 947))</i>	10.5/1 000 <i>(2 077/197 850)</i>
8. Neonatal death in facility rate – District Hospital		TBD	TBD	9.1/1 000 <i>(927 /100 973)</i>	8.4/1 000 <i>(743/88 412)</i>
9. Neonatal death in facility rate – Regional hospitals		TBD	TBD	16.4 / 1000 <i>(1 157 / 70 681)</i>	15/1 000 <i>(1 336 /75 725)</i>
10. Neonatal death in facility rate – Tertiary hospitals		TBD	TBD	22.9 / 1000 <i>1 825 / 8 078)</i>	21/1 000 <i>(164 / 7 799))</i>
11. Neonatal death in facility rate – Central hospitals		TBD	TBD	190 / 1000 <i>(93 / 489)</i>	124/100 000 <i>(58 / 470)</i>

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Outcome Indicator	Data Source	South Africa		Provincial	
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)
12. Infant PCR test positive around 10 weeks rate	PHC comprehensive tick register	TBD	TBD	0.62% (332/53 330)	0.4% (213/53 330)
13. Over-weight or obese child under 5 years incidence	SADHS 2016	13%	10%	22.8⁷	To be determined
14. School learner overweight rate	DHIS	TBD	TBD	Not monitored	To be determined
15. Children <5 who are stunted	SADHS 2016	27%	To be determined	14.3%⁸	20%
16. Death under 5 years against live birth rate – total	Deliver, Maternity register, midnight report	TBD	TBD	Not available	1.7% (3 363 /197 8501)
17. Death under 5 years against live births –District Hospital		TBD	TBD	1.3% (1 334/100 973)	1.0% (884/88 412)
18. Death in facility under 5 years against live birth rate – Regional Hospital		TBD	TBD	2.1% (1 566 /76 025)	1.5% (1 336/75 725)
19. Death under 5 years against live birth rate – Tertiary Hospital		TBD	TBD	2.8% (229 / 8 158)	2.1% (177 8 574)
20. Death under 5 years against live birth rate- Central Hospital		TBD	TBD	43.6% (213 / 489)	37.3% (165 / 442)
21. Child under 5 years diarrhoea case fatality rate (total)	DHIS, Midnight register, Ward Register	TBD	TBD	2.2% (171 / 7 702)	1.6% (118/7 403)
22. Child under 5 years diarrhoea case fatality rate –District Hospital		TBD	TBD	2.2% (94 /4 360)	1.5% (56/3 744)
23. Child under 5 years diarrhoea case fatality rate –Regional Hospital		TBD	TBD	2.4% (68 / 2 874)	1.3% 40 / 3 173){

⁷ SADHS, 2018: Nutrient-related risk factor indicators by province : Obesity both sexes 0–14 years NiDS (2011–2016)

⁸ SAHR 2018, Stunting both sexes 0-14 years NIDS, p 200

STRATEGIC PLAN 2020/21 – 2024/25

Outcome Indicator	Data Source	South Africa		Provincial	
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)
24. Child under 5 years diarrhoea case fatality rate- Tertiary Hospital		TBD	TBD	1.8% (8 / 440)	1.2% (6 / 486)
25. Child under 5 years diarrhoea case fatality rate – Central Hospital		TBD	TBD	No deaths	No deaths
26. Child under 5 years Pneumonia case fatality rate (total)	DHIS, Midnight Report, Ward Register	TBD	TBD	2.2% (279 / 12370)	1.8% (214 / 11 914)
27. Child under 5 years pneumonia case fatality rate –District Hospital		TBD	TBD	1.8% (28 / 6 938)	1.3% (76 / 5 958)
28. Child under 5 years pneumonia case fatality rate –Regional Hospital		TBD	TBD	2.4% (100 / 4 241)	1.3% (59 / 4682)
29. Child under 5 years pneumonia case fatality rate- Tertiary Hospital		TBD	TBD	0.67% (6 / 892)	0.4% (4 / 985)
30. Child under 5 years pneumonia case fatality rate – Central Hospital		TBD	TBD	15.6% (45/ 289)	11.5% (35 / 304)
31. Child under 5 years Severe acute malnutrition case fatality rate (Total)		DHIS, Midnight register, Ward Register	TBD	TBD	7.8% (179 / 2 289)
32. Child under 5 years diarrhoea case fatality rate –District Hospital	TBD		TBD	7% (94 / 1 336)	4.8% (48 / 990)
33. Child under 5 years Severe acute malnutrition case fatality rate – Regional Hospital	TBD		TBD	9.0% (76 / 839)	5.8% (40 / 690)
34. Child under 5 years Severe acute malnutrition case fatality rate- Tertiary Hospital	TBD		TBD	4.3% (5 / 118)	0.9% (1 / 110)
35. Child under 5 years Severe acute malnutrition case fatality rate – Central Hospital	TBD		TBD	23.5% (4 / 17)	10% (1 / 10)
36. Death in facility under 1 year rate –total	DHIS, Midnight	NA	NA	5.4%	4.6%

STRATEGIC PLAN 2020/21 – 2024/25

Outcome Indicator	Data Source	South Africa		Provincial	
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)
	register, Ward Register			(3 055 / 57 009)	(2 498 / 60 820)
37. Death in facility under 1 year rate – District Hospital		NA	NA	5.3% (1 153)	3.7% (892 / 24 257)
38. Death in facility under 1 year rate – Regional Hospital		NA	NA	5.3% (1 422 / 27 059)	4.8% (1 296 / 27 000)
39. Death in facility under 1 year rate – Tertiary Hospital		NA	NA	4.4% (195 / 4 445)	3.1% (151 4 908)
40. Death in facility under 1 year rate – Central Hospital		NA	NA	9.3% (184 / 1 977)	7.6% (142 1 800)
41. Death in facility under 5 years rate (Total)	DHIS, Midnight register, Ward Register	NA	NA	3.9% (3 444/88 844)	3.8% (3 557/94 142)
42. Death in facility under 5 years rate –District Hospital		NA	NA	3.9% (1 334/37 674)	3.8% (1 032 /41 565)
43. Death in facility under 5 years rate –Regional Hospital		NA	NA	4.4% (1 703 / 38 610)	4% (1 710 / 42 629)
44. Death in facility under 5 years rate –Tertiary Hospital		NA	NA	4% (229 / 5 777)	2.8% (177 / 6 378)
45. Death in facility under 5 years rate –Central Hospital		NA	NA	5.7% (213 / 3754)	4.6% (165 3 570)
46. Still Birth Rate in Facility – total	Ward register, midnight report	NA	NA	21.8 / 1000 (45 003 / 206 438)	19/1 000 (3 840 / 202 109)
47. Still Birth Rate in Facility – district hospital		NA	NA	18.9/1 000 (1 616 / 85 3222)	14/1 000 (1 259 / 89 9212)
48. Still Birth Rate in Facility – regional hospital		NA	NA	28.8/1000	20.2/1 000

STRATEGIC PLAN 2020/21 – 2024/25

Outcome Indicator	Data Source	South Africa		Provincial	
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)
				(2 209 / 76 587)	(1 572/77 834)
49. Still Birth Rate in Facility – tertiary hospital		NA	NA	31.1/1 000 (258 / 8 306)	21.8/1000 (177/8 131)
50. Still Birth Rate in Facility – central hospital		NA	NA	29.8/1 000 (15 / 503)	24.3/1 000 (12 / 468)
51. Early Neonatal death Rate – Total	Ward register, midnight report	NA	NA	9/1 000 (1 818 / 201 947)	7.9/1 000 (1 628 / 206 041)
52. TB Rifampicin Resistant/MDR/pre-XDR treatment success rate - Long	DR-TB Clinical Stationery; TIER.Net	TBD	TBD	59.7% (1 720 / 2 882)	65% (1 515 / 2 330)
53. TB Rifampicin Resistant/MDR/pre-XDR treatment success rate - Short		TBD	TBD	70.2% (1 130 / 1 609)	75% (935 / 1 250)
54. All DS-TB Client death rate	DR-TB Clinical Stationery; TIER.Net	TBD	TBD	7.4% (254 / 38 451)	4% (1 920 / 48 000)
55. All DS- TB client Treatment success Rate	DS-TB Clinical Stationery; TIER>net	TBD	TBD	79.2% (31 280 / 38 451)	90% (43 200 / 48 000)
56. ART Death rate at 6 months	ART register; TIER.net: DHIS	TBD	TBD	1.2% (2 435 / 202 938)	1% (2 029 / 202 938)
57. ART adult death rate at 6 months	ART register; TIER.net: DHIS	NA	NA	1.2% (2 375/ 197 918)	1% (1 979 / 197 918)
58. ART child death rate at 6 months	ART register; TIER.net: DHIS	NA	NA	1.4% (70 / 5 020)	1% (50 / 5 020)
59. HIV positive 15 -24 years (Exc ANC) Rate	HTS Register (HIV testing)	TBD	TBD	New	To be determined

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Outcome Indicator	Data Source	South Africa		Provincial	
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)
	services)TIER.net; DHIS				
60. ART Adult viral load suppressed rate at 12 months	ART paper register;TIER.net; DHIS	TBD	TBD	90.6% (38 136 / 42 375)	90% (38 136 / 42 374)
61. ART child viral load suppressed rate at 12 months	ART paper register;TIER.net; DHIS	TBD	TBD	68.7% (826 / 1 203)	90% (1 082 / 1 203)
62. ART Client remain on ART end of month total	ART register; TIER.net; DHIS	TBD	TBD	1 387 688	1 959 000
63. Infant Mortality Rate	ASSA 2008	NA	NA	30.9/1 000	27/1 000
64. Under 5 mortality rate	ASSA 2008	NA	NA	41.7/1 000	38/1 000
65. Child under 5 years Diarrhoea incidence	DHIS, PHC tick register, StatsSA	NA	NA	7.9 /1000 (10 553 / 1 330 900)	5/1 000 (5 751 / 1 150 228)
66. Child under 5 years pneumonia incidence	DHIS, PHC tick register, StatsSA	NA	NA	39.2 /1000 (52 169 / 1 330 900)	29/1 000 (33 357 / 1 150 228)
67. Child under 5 years severe acute malnutrition incidence	DHIS, PHC tick register, StatsSA	NA	NA	1.9 /1000 (2 575 / 1 330 900)	1/1 000 (1 150 / 1 150 228)
68. Diabetes Incidence	DHIS, PHC tick register, StatsSA	NA	NA	2.9/1 000 (17 616 / 11 417 132)	2.5/1 000 (30 199 / 12 079 648)
69. Hypertension Incidence	DHIS, PHC tick register, StatsSA	NA	NA	29.5/1 000 336 805 / 11 417 132)	20/1 000 (241 593 / 12 079 648)
70. HIV incidence	Thembisa	NA	NA	0.55%	<1%

STRATEGIC PLAN 2020/21 – 2024/25

Outcome Indicator	Data Source	South Africa		Provincial	
		Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)
	Model				
71. TB Incidence	DHIS, PHC tick register, StatsSA	NA	NA	507.3 / 100 000 <i>(57 921 / 11 417 132)</i>	200/100 000 <i>(24 159 / 12 079 648)</i>
72. Malaria Incidence	Malaria information system	NA	NA	0.23/1 000 <i>(162 / 696 042)</i>	0/1 000 <i>(50 / 686 893)</i>
73. Malaria case fatality rate	Malaria Information system	70 / 581 700	Malaria eliminated by 2023	0.5% <i>(7 / 1 493)</i>	0% <i>(0 / 1000)</i>

EXPLANATION OF PLANNED PERFORMANCE OVER THE FIVE YEAR PLANNING PERIOD

The outcome of reduced Morbidity and Mortality links to the MTSF outcomes of progressive improvement in the total life expectancy of South Africans where the focus lies on finding the clients who have TB through intensified screening, improvements in TB treatment success, Clients who are HIV positive knowing their status and being placed on ARTs, with specific emphasis on youthful populations, improved management of pregnant and postnatal women, improved child health prevention and treatment of childhood illnesses and well as intensified screening for Chronic diseases of lifestyle and mental health problems. The anticipated reduction in the morbidity and mortality will directly contribute towards an increase in the life expectancy of the people of the Province. The enablers to the outcome being achieved include the sustainable supply of resources including human, infrastructure, financial and pharmaceuticals. Further enablers include Digitalization of patients' management tools to reduce reliance on paper based system, Centralised web-based patient information data warehouse which will allow all patients information from all health facilities is accessible to all facilities, use of South Africa Identity document as a Unique Identifier for all who access health care services and institutionalisation of Ideal Clinic Realisation and Maintenance framework across the province

Table 19: Key Risks for the Outcome: Reduced Morbidity and Mortality

Outcome	Key Risks	Risk Mitigation
Reduce morbidity and mortality	Inability to reduce the burden of disease from TB and HIV	<ul style="list-style-type: none"> Establish a call centre that will monitor and call back patients who have defaulted
Reduce morbidity and mortality	Inability to effectively manage SHP programmes.	<ul style="list-style-type: none"> Engage SCM & IT to procure and install (high capacity desk top computers for TB, desktop computers for clinics, laptops for staff and connectivity especially in clinics)
Reduced morbidity and mortality	Inability to reduce burden of non-communicable disease	<ul style="list-style-type: none"> Initiate recruitment of required allied professional staff (Implementation depends on approval of the minimum staff establishment) Lobby at ManCo to engage treasury and Cabinet to rescind the HR circular on non-exempt posts.
Reduce morbidity and mortality	High turnover of medical , nursing and allied specialists	<ul style="list-style-type: none"> Implement the Decentralized Clinical Training Programme. Centralise co-ordination of clinical outreach and inreach Programme
Reduce morbidity and mortality	High turnover of medical , nursing and allied specialists	<ul style="list-style-type: none"> Implement the Decentralized Clinical Training Programme. Centralise co-ordination of clinical outreach and inreach Programme
Reduced Morbidity and Mortality	Global outbreaks	<ul style="list-style-type: none"> Identification of CUSTOMISED VEHICLES FOR ISOLATION UNITS Epidemic Preparedness Plans in place and implemented in line with NICD guidelines Isolation facilities available

13. PUBLIC-PRIVATE PARTNERSHIPS (PPPS)

Table 20: Public Private Partnership

Name of PPP	Purpose	Output	Current Annual Budget R'000	Date of Termination
<p>Inkosi Albert Luthuli Central Hospital</p> <p>The Department is in partnership with Impilo Consortium (Pty) Ltd and Cowslip Investments (Pty) Ltd</p>	<p>Supply equipment and information management and technology systems and replace the equipment and systems to ensure that they remain state of the art.</p> <p>Supply and replace non-medical equipment.</p> <p>Provide the services necessary to manage project assets in accordance with best industry practice.</p> <p>Maintain and replace Departmental assets in terms of replacement schedules.</p> <p>Provide or procure utilities, consumables and surgical Instruments.</p> <p>Provide facility management services.</p>	<p>Delivery of non-clinical services to IALCH</p>	<p>The PPP agreement contract for a further 18 Months contract extension was signed on the 30th January 2020. The commitment / obligation are as follows:</p> <p>2019/20: R766, Million</p> <p>2020/21: R383 Million</p> <p>The total obligation to remaining period is R 1.149 billion.</p>	<p>The 18 months contract extension with Impilo Consortium (Pty) Ltd will terminate on the 31 July 2021</p>

14. PUBLIC ENTITIES

Not applicable to KZN DoH

PART D: TECHNICAL INDICATOR DESCRIPTION (TID) FOR STRATEGIC PLAN

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator								
UHC service Index	UHC Service Coverage Index is a measurement of coverage of essential health services and is calculated as the product of Reproductive, maternal, newborn and child health coverage; Infectious disease control; Non-communicable diseases and Service capacity and access.	South African Health Review (SAHR 2018)	Not Applicable	Not Applicable	Not required for Strategic Plan 2020-2025	Not Applicable	Not Applicable	All Districts	Not required for Strategic Plans	Annual progress against the five year target	Higher	DHS Manager
Audit opinion of Provincial DoH	Audit opinion for Provincial Departments of Health for financial performance	Annual Report – AGSA Findings	N/A	N/A	NA	NA	N/A	N/A	Categorical	Annual	Unqualified audit opinion from the Auditor General of SA.	CFO; All Senior Managers Provincial Departments of Health

STRATEGIC PLAN 2020/21 – 2024/25

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator								
Contingent liability of medico-legal cases	Total rand value of the medico legal claims for all backlog cases that were on the case register as at 31 March 2019	Medico-legal case management system	Total rand value of the medico legal claims for all backlog cases that were on the case register as at 31 March 2019	Not Applicable	Not required for Strategic Plan 2020-2025	Accuracy dependent of reporting of data into the system	Not Applicable	All Districts	Not required for Strategic Plans	Annual progress against the five year target	Lower	Legal services
Percentage of facilities certified by OHSC	NA	NA	Not Applicable	Not Applicable	Not required for Strategic Plan 2020-2025	Not Applicable	Not Applicable	All Districts	Not required for Strategic Plans	Annual progress against the five year target	Higher	DHS Manager
Percentage of PHC facilities with functional Clinic committees	Improve quality of services at PHC facilities conducting regular meetings with functional Clinic committees	Attendance Registers of meetings of Clinic committees	Number of functional clinic committees	Number of PHC Facilities	Not required for Strategic Plan 2020-2025	Attendance Registers are accurately kept	Not Applicable	All Districts	Not required for Strategic Plans	Annual progress against the five year target	Higher	Quality Assurance
Percentage of hospitals with functional hospital boards	Improve quality of services at Hospitals conducting regular meetings with functional Hospital Boards	Attendance Registers of meetings of hospital boards	Number of functional Hospital Boards	Number of Hospitals	Not required for Strategic Plan 2020-2025	Attendance Registers are accurately kept	Not Applicable	All Districts	Not required for Strategic Plans	Annual progress against the five year target	Higher	Quality Assurance

STRATEGIC PLAN 2020/21 – 2024/25

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator								
Professional nurses per 100 000 population	The number of Professional Nurses in posts on the last day of March of the reporting year per 100 000 population.	Persal (Professional Nurses) DHIS (Stats SA population)	Number of Professional Nurse posts filled	Total population	TBD	TBD	TBD	All Districts	Number/100 000 population	Annual	Increase in the number of Professional Nurses contributes to improving access to and quality of clinical care.	HRMS Manager/ DDG's
Medical Officers per 100 000 population	The number of Medical Officers in posts on the last day of March of the reporting year per 100 000 population.	Persal (Medical Officers) DHIS (Stats SA population)	Number of Medical Officer posts filled in reporting year	Total population	TBD	TBD	TBD	All Districts	Number/100 000 population	Annual	Increase in the number of Medical Officers contributes to improving access to and quality of clinical care.	HRMS Manager/ DDG's

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator								
Ideal clinic status obtained rate	Fixed PHC health facilities that obtained Ideal Clinic status (bronze, silver, gold) as a proportion of fixed PHC clinics and CHCs/CDCs	Ideal Health Facility software	Fixed PHC health facilities have obtained Ideal Clinic status	Fixed PHC clinics or fixed CHCs and or CDCs	Not required for Strategic Plan 2020-2025	Accuracy dependent of reporting of data into the system	Not Applicable	All Districts	Not required for Strategic Plans	Annual progress against the five year target	Higher	Quality Assurance

STRATEGIC PLAN 2020/21 – 2024/25

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator								
TB Rifampicin Resistant/MDR/pre-XDR treatment success rate – Short regime	TB Rifampicin Resistant/MDR/pre-XDR clients successfully completing treatment as a proportion of TB Rifampicin Resistant/MDR/pre-XDR clients started on treatment	DR-TB Clinical stationery; EDR Web	TB Rifampicin Resistant /MDR/pre-XDR client successfully complete treatment – short regime	TB Rifampicin Resistant/MDR/pre-XDR start on treatment – long regime	DR-TB Clinical stationery EDR Web	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Cumulative (year-to-date)	Annual	Higher	TB Programme Manager
TB Rifampicin Resistant/MDR/pre-XDR treatment success rate – long regime	TB Rifampicin Resistant/MDR/pre-XDR clients successfully completing treatment as a proportion of TB Rifampicin Resistant/MDR/pre-XDR clients started on treatment	DR-TB Clinical stationery; EDR Web	TB Rifampicin Resistant /MDR/pre-XDR client successfully complete treatment – long regime	TB Rifampicin Resistant/MDR/pre-XDR start on treatment – short regime	DR-TB Clinical stationery EDR Web	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Cumulative (year-to-date)	Annual	Higher	TB Programme Manager
All DS-TB Client Death Rate	TB clients who started drug-susceptible tuberculosis (DS-TB) treatment and who subsequently died as a proportion of all those in the treatment	DS -TB Clinical stationery;TIER. Net	All DS- TB client died	All DS- TB patients in treatment outcome cohort	Not required for Strategic Plan 2020-2025	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Not required for Strategic Plans	Annual progress against the five year target	Lower	TB Programme Manager

STRATEGIC PLAN 2020/21 – 2024/25

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator								
	outcome cohort											
All DS-TB Client Treatment Success Rate	TB clients who started drug-susceptible tuberculosis (DS-TB) treatment and who subsequently successfully completed treatment as a proportion of all those in the treatment outcome cohort	DS-TB Clinical Stationery;TIER.Net	All DS-TB client successfully completed treatment	All DS- TB patients in treatment outcome cohort	DS-TB Clinical Stationery;TIER.Net	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Cumulative (year-to-date)	Quarterly	Higher	TB Programme Manager
ART adult death rate at 6 months	ART adult cumulative death as a proportion of ART adult start minus cumulative transfer out	HIV registers; TIER.Net	ART adult cumulative death	ART adult start minus cumulative transfer out	HIV registers; TIER.Net	None	Population 15 years and older	None	%	Quarterly (Annualised)	Decreased percentage	HIV / AIDS Manager
ART child death rate at 6 months	ART child cumulative death as a proportion of ART child start minus cumulative transfer out	HIV registers; TIER.Net	ART child cumulative death	ART child start minus cumulative transfer out	HIV registers; TIER.Net	None	Children under 15 years	None	%	Quarterly (Annualised)	Decreased percentage	HIV / AIDS Manager
ART Adult viral load suppressed rate	ART adult viral load under 400 as a proportion of ART adult	ART paper Register; TIER.Net; DHIS	ART adult viral load under 400	ART adult viral load done	ART paper Register; TIER.Net; DHIS	Accuracy dependent on quality of	Not Applicable	All Districts	Cumulative (year-to-date)	Quarterly	Higher	HIV/AIDS Programme Manager

STRATEGIC PLAN 2020/21 – 2024/25

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator								
	viral load done					data submitted by health facilities						
ART child viral load suppressed rate	ART child viral load under 400 as a proportion of ART child viral load done	ART paper Register; TIER.Net; DHIS	ART child viral load under 400	ART child viral load done	ART paper Register; TIER.Net; DHIS	Accuracy dependent on quality of data submitted by health facilities	Children and adolescent	All Districts	Cumulative (year-to-date)	Quarterly	Higher	HIV/AIDS Programme Manager
HIV positive 15-24 years (excl ANC) rate	Adolescents and youth 15 to 24 years who tested HIV positive as a proportion of youth who were tested for HIV in this age group	PHC Comprehensive Tick Register; HTS Register (HIV Testing Services) or HCT module in TIER.Net,DHIS	HIV positive 15-24 years (excl ANC)	HIV test 15-24 years (excl ANC)	PHC Comprehensive Tick Register; HTS Register (HIV Testing Services) or HCT module in TIER.Net,DHIS	Accuracy dependent on individuals self-reporting HIV-positive status and/or individuals with detectable ART metabolites among all PLHIV (antibody test)	Youth	All Districts	Not required for Strategic Plans	Annual progress against the five year target	Lower	HIV/AIDS Programme Manager
ART client remain on ART end of month - total	Total clients remaining on ART (TROA) are the sum of the following: - Any client on treatment in the reporting month - Any client	ART Register; TIER.Net; DHIS	ART adult and child under 15 years remaining on ART end of month	None	ART Register; TIER.Net; DHIS	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Not required for Strategic Plans	Annual progress against the five year target	Higher	HIV/AIDS Programme Manager

STRATEGIC PLAN 2020/21 – 2024/25

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator								
	without an outcome reported in the reporting month Clients remaining on ART equals [new starts (naive) + Experienced (Exp) + Transfer in (TFI) + Restart] minus [Died (RIP) + loss to follow-up (LTF) + Transfer out (TFO)] Clients remaining on ART equals [new starts (naive) + Experienced (Exp) + Transfer in (TFI) + Restart] minus [Died (RIP) + loss to follow-up (LTF) + Transfer out (TFO)]											
HIV incidence	New HIV infections in the general population.	ASSA2008 projections	ASSA2008 published projections		Not routinely collected therefore using ASSA2008 or Stats SA projections.	the Department is not collecting this indicator – dependent on research and	Population	No	%	Annual	Reduced incidence indicating effective prevention programmes.	HIV/AIDS Manager

STRATEGIC PLAN 2020/21 – 2024/25

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator								
						projections)						
TB incidence (per 100 000 population)	The number of new TB infections per 100,000 population	TB Register; TIER.Net; ETR.Net; DHIS (population)	New confirmed TB cases	Total population in KZN	TB Register; TIER.Net; ETR.Net; DHIS (population)	None	None	No	Number per 100,000 population	Annual	Reduced Annual incidence desired to indicate a reduction in new infections.	TB Manager

Indicator Title	Definition	Source of Data	Method of Calculation / Assessment		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator								
Maternal Mortality in facility Ratio	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric)	Maternal death register, Delivery register	Maternal death in facility	Live births known to facility (Live birth in facility + Born alive before arrival at facility)	Maternal death register, Delivery register	Accuracy dependent on quality of data submitted by health facilities	Females	All Districts	Cumulative (year-to-date)	Annual progress against the five year target	Lower	MCWH&N Programme

STRATEGIC PLAN 2020/21 – 2024/25

Indicator Title	Definition	Source of Data	Method of Calculation / Assessment		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator								
	per 100,000 live births in facility											
Live birth under 2500g in facility rate	Infants born alive weighing less than 2500g as proportion of total Infants born alive in health facilities (Low birth weight)	Delivery register, Midnight report	Live birth under 2500g in facility	Live birth in facility	Delivery register, Midnight report	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Cumulative (year-to-date)	Quarterly	Lower	MCWH&N Programme
Neonatal death in facility rate	Infants 0-28 days who died during their stay in the facility per 1000 live births in facility	Delivery register, Midnight report	Neonatal deaths (under 28 days) in facility (Death in facility 0-6 days) + [Death in facility 7-28 days)	Live birth in facility	Delivery register, Midnight report	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Cumulative (year-to-date)	Quarterly	Lower	MCWH&N Programme
Infant PCR test positive around 10 weeks rate	Infants PCR tested around 10 weeks as a proportion of HIV exposed infants excluding those that tested positive at birth.	PHC Comprehensive Tick Register	Infant PCR test positive around 10 weeks	Infant PCR test around 10 weeks	PHC Comprehensive Tick Register	Accuracy dependent on quality of data submitted by health facilities	Children	All Districts	Cumulative (year-to-date)	Quarterly	Lower	PMTCT Programme
Death under 5 years against live birth rate	Children under 5 years who died during their stay in the facility as a proportion of all live births	Midnight Report	Death in facility under 5 years total	Live birth in facility	Midnight report	Accuracy dependent on quality of data submitted by health facilities	Children	All Districts	Cumulative (year-to-date)	Annual progress against the five year target	Lower	MCWH&N Programme

STRATEGIC PLAN 2020/21 – 2024/25

Indicator Title	Definition	Source of Data	Method of Calculation / Assessment		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator								
Child under 5 years diarrhoea case fatality rate	Diarrhoea deaths in children under 5 years as a proportion of diarrhoea separations under 5 years in health facilities	Ward register	Diarrhoea death under 5 years	Diarrhoea separation under 5 years	Ward register	Accuracy dependent on quality of data submitted by health facilities	Children	All Districts	Cumulative (year-to-date)	Quarterly	Lower	MCWH&N Programme
Child under 5 years pneumonia case fatality rate	Pneumonia deaths in children under 5 years as a proportion of pneumonia separations under 5 years in health facilities	Ward register	Pneumonia death under 5 years	Pneumonia separation under 5 years	Ward register	Accuracy dependent on quality of data submitted by health facilities	Children	All Districts	Cumulative (year-to-date)	Quarterly	Lower	MCWH&N Programme
Child under 5 years Severe acute malnutrition case fatality rate	Severe acute malnutrition deaths in children under 5 years as a proportion of total deaths in facility under 5 years	Ward register	Severe acute malnutrition (SAM) death under 5 years	Severe acute malnutrition inpatient under 5 years	Ward register	Accuracy dependent on quality of data submitted by health facilities	Children	All Districts	Cumulative (year-to-date)	Quarterly	Lower	MCWH&N Programme
Infant mortality rate	Proportion of children less than 1 year old that died in one year per 1000 population under 1-years.	Stats SA and Rapid Mortality Surveillance (RMS) from 2012 onwards	Children less than 1 year that die in one year in the province	Total population under 1 year <i>Estimates from Stats SA and Rapid Mortality Surveillance as the Department is not routinely monitoring this population-</i>	Stats SA and Rapid Mortality Surveillance (RMS) from 2012 onwards	Empirical population-based data are not frequently available – reporting estimates.	Children under 1 years	None	Number per 1000 population	Annual	Lower mortality rate desired.	MNCWH Manager

STRATEGIC PLAN 2020/21 – 2024/25

Indicator Title	Definition	Source of Data	Method of Calculation / Assessment		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator								
				<i>based indicator</i>								
Under 5 mortality rate	Proportion of children less than five years old that died in one year per 1000 population under 5 years.	Stats SA and Rapid Mortality Surveillance (RMS) from 2012 onwards	Children less than five years that die in one year in the province	Total population under 5 years <i>Estimates from Stats SA and Rapid Mortality Surveillance as the Department is not routinely monitoring this population-based indicator</i>	Stats SA and Rapid Mortality Surveillance (RMS) from 2012 onwards	Empirical population-based data are not frequently available – reporting estimates.	Children under 5 years	None	Number per 1000 population	Annual	Lower mortality rate desired.	MNCWH Manager
Still birth rate in facility	Infants born still as proportion of total infants born in health facilities	Ward register, Midnight census	Still birth in facility – total	Live birth in facility + still birth in facility	Ward register, Midnight census	None	Newborn children	None	Per 1000	Quarterly (Annualised)	Lower percentage	MCWH Programme Manager
Early Neonatal death Rate – Total	Early neonatal deaths per 1000 infants who were born alive in health facilities	Ward register, Midnight census	Death in facility 0-6 days - Total	Live birth in facility - Total	Ward register, Midnight census	None	Newborn children	None	Per 1000	Quarterly (Annualised)	Lower percentage	MCWH Programme Manager
Death in facility under 1 year rate (annualised)	Children under 1 year who died during their stay in the facility as a proportion of inpatient separations under 1 year. Inpatient separations	Midnight census; Admission, Discharge & Death registers	SUM([Death in facility under 1 year total])	SUM([Death in facility 0-7 days]) + SUM([Death in facility 8-28 days]) + SUM([Death in facility 29 days-11 months]) +	Midnight census; Admission, Discharge & Death registers	None	Children under 1 years	No	%	Quarterly (Annualised)	Lower rate desired – fewer children under-1 year dying in public health facilities.	MNCWH Manager

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Indicator Title	Definition	Source of Data	Method of Calculation / Assessment		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator								
	under- year is the total of inpatient discharges, inpatient deaths and inpatient transfers out.			SUM([Inpatient discharge under 1 year]) + SUM([Inpatient transfer out under 1 year])								
Death in facility under 5 years rate (annualised)	Children under 5 years who died during their stay in the facility as a proportion of inpatient separations under 5 years. Inpatient separations under 5 years is the total of inpatient discharges, inpatient deaths and inpatient transfers out.	Midnight census; Admission, Discharge & Death registers	SUM([Death in facility under 5 year total])	SUM([Death in facility 0-7 days]) + SUM([Death in facility 8-28 days]) + SUM([Death in facility 29 days-11 months]) + SUM([Death in facility 12-59 months]) + SUM([Inpatient discharge under 5 years]) + ([Inpatient transfers out under 5 years])	Midnight census; Admission, Discharge & Death registers	Non	Children under 5 years	No	%	Quarterly (Annual)	Lower rate desired – fewer children under-5 years dying in public health facilities.	MNCWH Manager
Child under 5 years Diarrhoea incidence	Children under 5 years newly diagnosed with diarrhoea with dehydration per 1000 children under-5 years in the population.	PHC register; DHIS; Stats SA	SUM([Child under 5 years diarrhoea with dehydration new])	SUM([Female under 5 years]) + ([Male under 5 years])	PHC register; DHIS; Stats SA	None	Children under 5 years	None	Number per 1000	Quarterly (Annualised)	Lower incidence desired indicating improved child health.	MC&WH Manager
Child under 5 years Pneumonia	Children under 5 years newly diagnosed with	PHC register; DHIS; Stats SA	SUM([Child under 5 years with	SUM([Female under 5 years]) +	PHC register; DHIS; Stats SA	None	Children under 5 years	None	Number per 1000	Quarterly (Annualised)	Lower incidence desired	MC&WH Manager

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Indicator Title	Definition	Source of Data	Method of Calculation / Assessment		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator								
incidence	pneumonia per 1000 children under-5 years in the population.		pneumonia new])	((Male under 5 years))							indicating improved child health.	
Child under 5 years severe acute malnutrition incidence	Children under 5 years newly diagnosed with severe acute malnutrition per 1000 children under-5 years in the population.	PHC register; DHIS; Stats Sa	SUM([Child under 5 years with severe acute malnutrition new])	SUM([Female under 5 years]) + ([Male under 5 years])	PHC register; DHIS; Stats Sa	None	Children under 5 years	None	Number per 1000	Quarterly (Annualised)	Lower incidence desired indicating improved child health.	Nutrition & MCWH Managers

Indicator Title	Definition	Source of Data	Method of Calculation / Assessment		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator								
Malaria case fatality rate (nb: Indicator applicable to endemic provinces)	Malaria deaths reported in South Africa. The death resulting from primary malaria diagnosis at the time of death	Malaria Information System	Malaria deaths reported	Malaria new case reported	Malaria Information System	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Non-cumulative	Annual progress against the five year target	Lower	Environmental Health-Malaria Program
Malaria incidence per 1 000 population at risk	New malaria cases as proportion of 1000 population at risk (high-risk malaria areas (Umkhanyakude) based on malaria cases.	PHC register; CDC Surveillance database; Malaria database; Stats SA; GHS	SUM([Number of malaria cases – new])	SUM([Total population of Umkhanyakude District])	Malaria database	None	None	Umkhanyakude Population	Number per 1000 population at risk	Annual	Lower incidence desired – improved prevention towards elimination of malaria.	Malaria Control Manager

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Indicator Title	Definition	Source of Data	Method of Calculation / Assessment		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator								
Diabetes Incidence (annualised)	Newly diagnosed diabetes clients initiated on treatment per 1000 population.	PHC & OPD registers; Stats SA	SUM([Diabetes clients treatment - new])	SUM([Total population])	PHC register	None	None	None	Number per 1000 population	Quarterly (annualised)	Lower incidence desired – improved prevention and management of diabetic patients.	Chronic Diseases Manager
Hypertension incidence (annualised)	Newly diagnosed hypertension cases initiated on treatment per 1000 population	PHC & OPD registers; Stats SA	SUM([Hypertension client treatment new])	SUM([Total population 4])	PHC register	None	None	None	Number per 1000 population	Quarterly (annualised)	Lower incidence desired – improved prevention and management of hypertensive patients.	Chronic Diseases Manager
Mental disorders screening rate	Clients screened for mental disorders (depression, anxiety, dementia, psychosis, mania, suicide, developmental disorders, behavioural disorders and substance use disorders) at PHC facilities.	PHC register	SUM([PHC client screened for mental disorders])	SUM([PHC headcount under 5 years]) + SUM([PHC headcount 5 years and older])	PHC register	None	None	None	%	Quarterly	Increased screening numbers indicates improved detection of mental disorders.	Mental Health Manager
Clients accessing rehab services	All clients receiving rehabilitation services from either Physiotherapy,	PHC tick register, OPD register	SUM[Clients seen by Physiotherapists]+ [Clients seen by Occupational Therapists]+[Not applicable	PHC register, OPD register	None	Disabled persons	None	Number	Quarterly	Increase the number of clients accessing rehab services	Disability and rehabilitation programme

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Indicator Title	Definition	Source of Data	Method of Calculation / Assessment		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator								
	Occupational Therapy, Speech Therapy and Audiology departments at all levels of care		Clients seen by Speech Therapists]+ [Clients seen by Audiologists]									

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator								
Severity assessment code (SAC) 1 incident reported within 24 hours rate	Severity assessment code (SAC) 1 incidents reported within 24 hours as a proportion of Severity assessment code (SAC) 1 incident reported	Patient Safety Incident Software	Severity assessment code (SAC) 1 incident reported within 24 hours	Severity assessment code (SAC) 1 incident reported	Patient Safety Incident Software	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Cumulative (year-to-date)	Quarterly	Lower	Quality Assurance
Patient Safety Incident (PSI) case closure rate	Patient Safety Incident (PSI) case closed in the reporting month as a proportion of Patient Safety Incident (PSI) cases reported in the reporting month	Patient Safety Incident Software	Patient Safety Incident (PSI) case closed	Patient Safety Incident (PSI) case reported	Not required for Strategic Plan 2020-2025	Accuracy dependent on reporting of data at facility level	Not Applicable	All Districts	Not required for Strategic Plans	Annual progress against the five year target	Higher	Quality Assurance

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Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Means of Verification	Assumptions	Disaggregation of Beneficiaries	Spatial Transformation	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
			Numerator	Denominator								
Patient Experience of Care satisfaction rate	Total number of Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	Patient Surveys	Patient Experience of Care survey satisfied responses	Patient Experience of Care survey total responses	Patient Surveys	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Cumulative (year-to-date)	Annual	Higher	Quality Assurance

ANNEXURES

ANNEXURE A: District Development Model

	Project Description	Budget Allocation	District Municipality	Location GPS	Project Leader	Social Partners	Date by:
Health services	Establish 160 ward based Outreach teams (5 year target is 172) Establish 215 School Health Teams (5 year target is 225)	R19 000 000	ALL	NA	DoH	NA	31 March 2021
Infrastructure	Mandleni Clinic - Replacing of Existing Sewer system Eshane Clinic: Replacement of Existing Sewer System Douglas Clinic - Replacing of Existing Sewer System (Additional 3 clinics targeted for major and minor refurbishment in NHI Pilot District)	R 10 762 748	uMzinyathu	Umzinyathi District Municipality Msinga Local Municipality -28.72375883 30.357548 Umzinyathi District Municipality Umvoti Local Municipality -29.10188767 30.83387217 Umzinyathi District Municipality Msinga Local Municipality -28.52949417 30.28317217	DoH	NA	5 year
Infrastructure	Dr Pixley Ka Isaka Seme Memorial Hospital: <ul style="list-style-type: none"> Practical Completion Commissioning of Services 	R 2 800 000 000 R 29 000 000	eThekwini		DOH	NA	DPKISMH- Revised completion date - 01 June 2020 Construction progress on site is at 98%. Commissioning of services is 5

STRATEGIC PLAN 2020/21 – 2024/25

	Project Description	Budget Allocation	District Municipality	Location GPS	Project Leader	Social Partners	Date by:
							year
Infrastructure	New King Edward The V111 Academic Hospital-Upgrade Nursery	R 111,981,789.53	eThekwini	30.98950733 -29.8822222	DOH	NA	5 year
Infrastructure	Stanger Hospital - New Labour and Neo Natal Wards	R 175,068,787.71	iLembe	31.28516 -29.33279	DOH	NA	5 year
Infrastructure	Groutville Clinic - Replacement of existing clinic with XL Clinic and Provision of PMTCT Unit	R 87,720,000.00		-29.38898 31.25236	DOH	NA	5 year
Infrastructure	Hlabisa hospital- upgrade OPD	R201 603 150		31.88069667 -28.1455475	DOH	NA	5 Year
Infrastructure	Port Shepstone hospital-new 28 bedded psychiatric unit	R118 237 428	Ugu	30.450878 -30.7435007	DOH	NA	5 Year
Infrastructure	Benedictine hospital - construction of new OPD core block	R120 000 000		31.639325 -27.8910013	DOH	NA	5 year
Infrastructure	Bethesda hospital - construction of new OPD core block	R120 000 000		32.0820982 -27.5741112	DOH	NA	5 year
Infrastructure	General Justice Gizenga Mpanza Regional hospital new 28 bedded psychiatric unit	R73 928 790	iLembe	31.28516 -29.33279	DOH	NA	5 year
Human Resources	Implement HWSETA accredited middle (43) and Junior managers (405) leadership programmes	R2 195 266 (Skills)	Province Wide	NA	DOH	NA	March 2021
Quality	100% of clinics achieving Ideal Clinic Status	14 201 431 000 (PHC budget)	Province Wide	NA	DOH	NA	5 years

ABBREVIATIONS

Abbreviation	Description
A	
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
APP	Annual Performance Plan
ART	Anti-Retroviral Therapy
ASSA	AIDS Committee of Actuarial Society of South Africa
B	
BAS	Basic Accounting System
BLS	Basic Life Support
C	
CCG(s)	Community Care Giver(s)
CCMDD	Centralised Chronic Medicine Dispensing and Distribution
CEO(s)	Chief Executive Officers
CDC	Communicable Disease Control
CHC(s)	Community Health Centre(s)
COE	Compensation of Employees
CSS	Client Satisfaction Survey
CPAP	Continuous Positive Airway Pressure
D	
DHB	District Health Barometer
DHIS	District Health Information System
DHS	District Health System
DPC	Disease Prevention and Control
DPME	Department Planning Monitoring and Evaluation
DPSA	Department of Public Service and Administration
DR-TB	Drug Resistant Tuberculosis
DUT	Durban University of Technology
E	
ECD	Early Child Development
ECP	Emergency Care Practitioner

Abbreviation	Description
ECT	Emergency Care Technician
EMS	Emergency Medical Services
EPMDS	Employee Performance Management System
EPWP	Expanded Public Works Programme
ESMOE	Essential Steps in Management of Obstetric Emergencies
ETR.Net	Electronic Register for TB
F, G, H	
FPL	Food Poverty Line
FPS	Forensic Pathology Services
HCSS	Health Care Support Services
HIV	Human Immuno Virus
HOH	Head of Health
HPV	Human Papilloma Virus
HRD	Human Resource Development
HTA's	High Transmission Areas
HWSETA	Health and Welfare Sector Education and Training Authority
I	
IALCH	Inkosi Albert Luthuli Central Hospital
ICRM	Ideal Clinic Realisation and Maintenance
ICT	Information Communication Technology
IDT	Independent Development Trust
ILS	Intermediate Life Support
IMCI	Integrated Management of Child Illnesses
IPMP	Infrastructure Programme Management Plan
IPT	Ionized Preventive Therapy
IT	Information Technology
K, L	
LBPL	Lower-Bound Poverty Line
KZN	KwaZulu-Natal
KZNCN	KwaZulu-Natal College of Nursing
LG	Local Government

Abbreviation	Description
M	
M&E	Monitoring and Evaluation
MDR-TB	Multi Drug Resistant Tuberculosis
MEC	Member of the Executive Council
MMC	Medical Male Circumcision
MMS	
MCWH	Maternal Child and Women's Health
MNC&WH	Maternal, Neonatal, Child & Women's Health
MOP	Medical Ortho Prosthetics
MTEF	Medium Term Expenditure Framework
MTSF	Medium Term Strategic Framework
N	
NCS	National Core Standards
NCD(s)	Non-Communicable Disease(s)
NDP	National Development Plan
NGO(s)	Non-Governmental Organisation(s)
NHA	National Health Act
NHI	National Health Insurance
NICU	Neonatal Intensive Care Unit
NIDS	National Information Data Set
NIMART	Nurse Initiated and Managed Antiretroviral Therapy
O	
OES	Occupation Efficiency Service
OECD	Organisation for Economic Co-operation and Development
OHH	Outreach Households
OMBU's	Obstetric Maternity Birth Units
OPD	Out-Patient Department
OTP	Office of the Premier
P	
PCR	Polymerase Chain Reaction
PDE	Patient Day Equivalent
PGDP	Provincial Growth and Development Plan

Abbreviation	Description
PHC	Primary Health Care
PMDS	Performance Management and Development System
PMTCT	Prevention of Mother to Child Transmission
PPSD	Provincial Pharmaceutical Supply Depot
PPT	Planned Patient Transport
PTB	Pulmonary Tuberculosis
PTS	Patient Transport Services
Q, R, S	
SA	South Africa
SAM	Severe Acute Malnutrition
SCM	Supply Chain Management
SDIP	Service Delivery Improvement Plan
SMS	
Stats SA	Statistics South Africa
STI(s)	Sexually Transmitted Infection(s)
T	
TB	Tuberculosis
TVET	Technical Vocational Education and Training
U	
UBPL	Upper-Bound Poverty Line
UKZN	University of KwaZulu-Natal
U-AMP	User-Asset Management Plan
UTT	Universal Test and Treat
V, W, X	
WBOT(s)	Ward Based Outreach Team(s)
WHO	World Health Organisation
XDR-TB	Extreme Drug Resistant Tuberculosis

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